STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366457	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton Road Columbus, OH 43230

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, resident and staff interviews, and review of facility policy, the facility failed to conduct admission and quarterly care conferences in a timely manner. This affected five (Residents #8, #34, #45, #48, and #75) of five residents reviewed for care planning. The facility census was 111 residents.Findings include: 1. Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE] and diagnoses included cerebral infarction, hemiplegia and hemiparesis, and need for assistance with personal care. The Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed Resident #34 was cognitively intact. Review of Resident #34's care conferences in the medical record revealed Resident #34 had his most current care conference on 03/28/25. The progress notes revealed there were no care conferences held for Resident #34 after 03/28/25. An interview with Social Services Director #243 on 01/07/25 at 5:18 P.M. confirmed Resident #34 did not have any care conferences since 03/08/25. 2. Review of Resident #45's medical record revealed he was admitted to the facility on [DATE] and diagnoses included end stage renal disease, polyneuropathy and acquired absence of right leg above knee. The Minimum Data Set (MDS) MDS 3.0 comprehensive assessment dated [DATE] revealed Resident #45 had intact cognition. Review of Resident #45's care conferences in the medical record revealed there was no record of care conferences held with Resident #45. Review of Resident #45's progress notes revealed there was no record of care conferences held with Resident #45. An interview with Resident #45 on 01/05/26 at 9:05 A.M. revealed Resident #45 was upset that he had not had a care conference with the facility and he was uninformed about the progression of his discharge planning. An interview with Social Services Director #243 on 01/07/25 at 2:09 P.M. confirmed Resident #45 did not have any care conferences since admission and could not provide proof that discharge planning had been discussed with Resident #45. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #75's medical record revealed the was admitted to the facility on [DATE] and diagnoses included cognitive communication deficit, traumatic brain injury, and need for assistance with personal care. Review of Resident #75's care conferences in the medical record revealed the only care conference held was on 10/22/25 and there was no care conference held within 72-hours of his admission date of 09/01/25. An interview with Social Services Director #243 on 01/07/26 at 2:09 P.M. confirmed the only care conference held was on 10/22/25 and there was no care conference held within 72-hours of his admission date of 09/01/25. 4. Review of the medical record for Resident #8 revealed an admission date of 11/17/25 with diagnoses including plural effusion, end stage renal disease, chronic respiratory failure, heart failure, and malignant neoplasm of bone and left breast. The admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact and had a plan to discharge to the community. Review of 72-hour admission conference dated 12/02/25 revealed responsible party, social services and MDS nurse were present at meeting. Interview on 01/07/26 at 2:50 P.M. with Discharge Planner (DP) #249 confirmed admission care conferences should be completed within 72 hours of admission. 5. Review of Resident #48's medical record revealed an admission date of 08/23/23. Diagnoses include complete lesion T7-T10 level of thoracic spinal cord, paraplegia, obstructive and reflex uropathy and neuromuscular dysfunction of bladder. Resident of Resident #48's care conferences revealed Resident #48 had conferences completed on 09/24/24, 11/25/24, and 02/27/25.There were no care conferences held after 02/27/25. Interview on 01/07/25 at 2:09 P.M. with Social Services Director #243 confirmed Resident #48 did not have his quarterly care conferences and the last care conference was held on 02/27/25. Review of the facility's policy titled Care Planning Conference, dated 03/03/25, revealed the purpose of care planning conference on admission, quarterly, annually, and with a significant change and as needed, the interdisciplinary team will hold a care planning conference with the resident, family, or representative in participation. The care conference will be used to identify the resident's potential or actual problems, needs, goals, and discharge plans. Interdisciplinary care conferences will be held for the following reasons: admission, annually, quarterly, significant change, discharge as needed, and as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, resident representative and staff interviews and review of facility policy, the facility failed to provide a resident who was dependent on staff assistance with personal hygiene received adequate and timely assistance with nail care. This affected one (Resident #75) of three residents reviewed for activities of daily living (ADL). The facility census was 111 residents.Findings include: Review of Resident #75's medical record revealed he was admitted to the facility with diagnoses including schizophrenia and mental health disorder. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #74 had severely impaired cognition. Resident #75 required moderate assistance from staff for personal hygiene and did not have rejection of care. Review of Resident #75's functional ability care plan dated 09/01/25 revealed Resident #75 required assistance with self-care related to his impaired cognition and impaired mobility. A listed intervention dated 09/01/25 was to keep Resident #75's fingernails trimmed and clean. The care plan listed Resident #75 as requiring substantial or maximal assistance with personal hygiene. The cognitive care plan dated 09/14/25 revealed Resident #75 had severely impaired cognition. A listed goal was to anticipate Resident #75's needs based on his past preferences. Observations of Resident #75 on 01/05/26 at 10:03 A.M. revealed Resident #75's fingernails were long and jagged.An interview with Resident #75's spouse/ representative on 01/05/26 at 11:28 A.M. revealed Resident #75 preferred to keep his fingernails short and trimmed. A subsequent observation of Resident #75 on 01/06/25 at 9:21 A.M. revealed Resident #75's fingernails were long and jagged.An interview with Licensed Practical Nurse (LPN) #210 on 01/06/26 at 9:27 A.M. confirmed Resident #75's fingernails were long and jagged. An interview with Unit Manager (UM) #307 on 01/06/26 at 9:48 A.M. stated Resident #75 was cooperative with grooming and nail care. Review of a facility policy titled Standards of Certified Nursing Assistant (CNA) Practice, revised 08/15/23, revealed CNAs provide services and care for residents under the supervision of the licensed nurse. The CNA assists the resident in activities of daily living, such as grooming and nail care. This deficiency represents noncompliance investigated under Complaint Number 2701180.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, family, and staff interviews, and policy review, the facility failed to implement an individualized skin program to ensure necessary care and services were provided to timely identify the resident's skin breakdown, including diabetic ulcers and failed to provide necessary and care services to a resident who was not to receive food by mouth due to an esophageal repair. In addition, the facility failed to provide timely care and services to a resident's chest tube drain. Actual harm occurred to Resident #37, who had a history of amputation, required substantial/maximal assistance with lower body dressing, and had a diagnosis of diabetic polyneuropathy when the facility failed to identify four arterial wounds the hospital had identified prior to admission. 16 days after admission, the facility identified the four arterial wounds on the right heel, left heel, right medial foot, and left medial foot had deteriorated since hospitalization. This affected one (Resident #37) of nine residents identified with skin impairments, one (Resident #132) of eight residents who required enteral feedings, and one (#8) of one resident reviewed for chest tube drains. The facility census was 111.Findings include: Review of the medical record for Resident #37 revealed an admission date of 11/26/25. Diagnoses included chronic kidney disease, muscle weakness, type two diabetes mellitus, acute respiratory failure with hypoxia, and systolic heart failure. Review of the hospital records from 11/18/25 to 11/26/25 revealed on 11/25/25, a wound consult identified multiple wounds. Resident #37 had a deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.) to the left heel measuring 5.5 centimeters (cm) in length by five cm in width with a surface area of 21.6 2 square (sq) cm with purple non blanchable erythema with red peri wound. The right heel had a deep tissue injury measuring 2.5 cm in length by one cm in width with a surface area 1.96 sq cm with purple non- blanchable erythema with red peri wound. The left plantar foot had an unstageable pressure injury (Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar) measuring 5.5 cm in length by 9.5 cm in width with a surface area of 41.04 sq cm with serosanguinous drainage with pink moist tissue with purple non blanchable areas and red peri wound. The right plantar foot had a wound measuring two cm in length by 3.5 cm in width with a surface area of 5.5 sq cm with purple non blanchable erythema with red peri wound. Treatments were in place to treat the wounds. Hospital records documented peripheral neuropathy and height related foot contact with the bed frame with a low air loss surface and bed extender ordered. Past medical history included ulcer of foot due to type two diabetes mellitus noted 11/03/19, ulcer of foot noted 11/10/19, amputated toe noted 06/06/22, and magnetic resonance imaging (MRI) dated 10/14/19 of the left foot with impression of osteomyelitis involving the second toe and cellulitis. The After Visit Summary (AVS) for hospital stay from 11/18/25 to 11/26/25 revealed a heart and vascular specialist appointment scheduled for 12/03/25 at 11:30 A.M. The nursing comprehensive evaluation dated 11/26/25 by Licensed Practical Nurse (LPN) #900 revealed no skin conditions were identified. The physician orders dated 11/26/25 revealed wound care practitioner and podiatry to evaluate and treat as indicated. There were no physician orders to treat any skin breakdown to the feet and heels until 12/12/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The care plan dated 11/26/25 revealed Resident #37 was at risk for impaired skin integrity or pressure injury related to actual skin impairment on bilateral heels bilateral medial feet with limitations including impaired bed mobility, chronic kidney disease, and diabetes mellitus. There were no specific interventions included in the care plan until 12/02/25. The second skin check was completed on 11/27/25 by LPN #900 and no skin issues were identified on Resident #37. The Skin Issues Evaluation completed 11/28/25 by Unit Manager (UM) #307 identified no skin breakdown on both heels and feet. The skin issues evaluation dated 11/30/25 by Registered Nurse (RN) #319 identified no skin breakdown on both heels and feet. The physician orders dated 12/01/25 revealed a heart and vascular appointment scheduled on 12/03/25 at 11:00 A.M. The medical records dated 12/02/25 through 12/04/25 revealed no documentation pertaining to illness or the resident's refusal to attend the cardiology and vascular specialist appointment. The vital signs summaries dated 12/02/25 through 12/04/25 revealed blood pressure, heart rate, temperature and blood sugar without abnormalities. The dialysis record dated 12/03/25 at 11:30 A.M. documented the treatment was tolerated with hypotension resolved. On 12/02/25, the care plan had updated interventions including weekly head-to-toe skin assessments, observing skin during shower or care, notifying the nurse of new areas of skin breakdown, placing a pressure reduction mattress on the bed, and turning and repositioning every care round and as needed. The admission Minimum Data Set (MDS) assessment, dated 12/03/25, revealed Resident #37 was mildly cognitively impaired, required substantial/maximal assistance with lower body dressing, and did not have any open skin areas. The physician order dated 12/08/25 revealed the vascular appointment rescheduled for 02/13/26. The skin check evaluation dated 12/10/25 revealed completion of a foot evaluation with no new skin issues found. The progress note dated 12/12/25 revealed areas to bilateral heels and bilateral medial forefoot were noted and the resident stated these areas were present at the hospital. Resident #37 stated they were caused because he was too tall for the for the hospital bed resulting in increased pressure to the feet. Wound Nurse Practitioner (WNP) #502 was notified, and new wound care treatments were ordered and initiated. The wound nurse progress notes dated 12/12/25 completed by Wound Nurse (WN) #303 revealed there were four new diabetic ulcers found. There was a new in-house acquired diabetic foot ulcer of left medial forefoot and measured 8.16 cm in length by 5.21 cm in width with a surface area 31.72 sq cm. The second new in-house acquired left heel diabetic foot ulcer and measured 3.9 cm in lengthy by 3.61 cm in width with a surface area of 11.1 sq cm. The third new in-house acquired right medial forefoot diabetic foot ulcer and measured 5.7 cm in length by 2.83 cm in width with a surface area of 7.69 sq (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	cm. The fourth new in-house acquired right heel diabetic foot ulcer and measured 14.8 cm in length by 15.9 cm in width with a surface area 170.77 sq cm. The physician orders dated 12/12/25 revealed the bilateral heels were to be cleansed with normal saline apply gauze soaked in betadine cover with absorbent dressing and secure with kerlix and as needed until resolved. The bilateral medial feet were to be cleansed with normal saline apply gauze soaked in betadine cover with absorbent dressing and secure with kerlix. The skin issues evaluation dated 12/18/25 by WN #303 revealed the wounds have not been evaluated and were in house acquired. The diabetic foot ulcer of left medial forefoot measured 4.51 cm in length by 7.69 cm in width with a surface area 21.13 sq cm. The left heel diabetic foot ulcer measured 3.99 cm in length by 2.45 cm in width with a surface area of 7.37 sq cm. The right medial forefoot diabetic foot ulcer measured 3.61 cm in length by 7.27 cm in width with a surface area 9.82 sq cm. The right heel diabetic foot ulcer measured 1.62 cm in length by 1.52 cm in width with a surface area 1.87 sq cm. Additional recommendations included heel suspension or protection devices, pressure reducing device for bed, bilateral heels to be always floated for offloading. WNP #502's progress note dated 12/18/25 revealed initial assessment completed on right medial forefoot, left medial forefoot, and left and right heels. Ulcers to be treated with betadine, continue supportive care, frequent repositioning, heels elevated off the bed, pressure relief measures and proper nutrition and hydration to support wound healing. Some wounds may be unavoidable due to advanced age, chronic illnesses, immobility, or poor circulation which increased risk of skin breakdown and impaired healing. The progress note dated 01/08/26 revealed updated measurements for four diabetic foot ulcers. The diabetic foot ulcer of left medial forefoot measured 3.78 cm in length by 3.39 cm in width by 0.1 cm depth with a surface area 8.22 sq cm. The left heel diabetic foot ulcer measured 3.59 cm in length by 2.87 cm in width by 0.1 cm in depth with a surface area of 7.6 sq cm. The right medial forefoot diabetic foot ulcer measured 2.56 cm in length by 1.06 cm in width and a surface area of 1.12 sq cm. The right heel diabetic foot ulcer measured 2.13 cm in length by 1.34 cm in width by 0.1 cm in depth and a surface area of 2.14 sq cm. During an interview on 01/08/26 at 10:15 A.M., Resident #37 had wounds present on his feet and buttocks, which were currently being seen by the wound care nurse practitioner. The resident reported his bed was not extended upon initial admission to the facility that caused discomfort, and that some wounds obtained were related to the bed not being extended and stated the facility extended his bed later in his admission. During an interview on 01/08/26 at 3:46 P.M., WNP #502 confirmed she was notified of the wounds on 12/12/25 and completed her own in house assessment on 12/18/25. WNP #502 stated she had concerns nursing staff did not identify wounds timely and skin issues located on his feet may never heal due to the resident's history. During an interview on 01/09/26 at 9:33 A.M., the Administrator confirmed Resident #37 missed his vascular appointment on 12/03/25 due to the resident reporting he was ill. The Administrator confirmed the medical record did not contain evidence supporting the resident was ill. During an interview on 01/09/26 at 12:03 P.M., Assistant Director of Nursing (ADON) #315 stated Resident #37 was supposed to have an appointment on 12/03/25 but it was cancelled due to the resident (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	increased wound drainage, and suspicion that the infection may be causing intermittent metabolic encephalopathy. CT of the head showed no acute intracranial process. CT of the neck soft tissue with contract showed a 1.5 centimeters length by 0.6 cm width by 2.1 cm depth abscess at the right thoracic inlet (opening at the top of the chest on the right side, a vital junction between neck and chest) extending to the right superior mediastinum (upper, central chest area above the heart), just to the right of the trachea. There is a sinus tract extending to the skin surface and probable open wound anteriorly. The findings were discussed with the on-call Ear, Nose, Throat (ENT) physician, and recommendations were made to transfer to a facility (Hospital #2) that could manage the potential need for a flap surgery procedure. A request for Resident #132's medical records from Hospital #2 was made during the survey and was not received as of 01/15/25. During an interview on 01/09/26 at 3:03 P.M., Nurse #234 stated she was working in the evening on 12/29/25 and knew about an incident that happened that night. A new Certified Nursing Assistant (CNA) (unidentified) was working that evening and did not know Resident #132 was NPO. The CNA delivered a room tray to Resident #132. Resident #132 started to have a choking episode and complications from the feeding and had to send to the hospital. Nurse #234 was going to document the incident note, but her supervisor told her not to document this in the medical record and indicated it would cause the facility to be shutdown (by the State Survey Agency.) So, the nurse did not document the incident in Resident #132's medical record. During an interview on 01/12/26 at 11:25 A.M., LPN #280 revealed she could not remember how medications were administered to Resident #132 on 12/25/25. LPN #120 confirmed she documented the medications were given by mouth in the MAR. During an interview on 01/12/26 at 12:00 P.M., Registered Nurse (RN) #271 revealed Resident #132 was admitted [DATE] and was the nurse who received a verbal nursing report called from the hospital. The nursing report indicated all medications and feedings should be given through the gastrostomy tube. The paperwork the resident brought with her from the hospital indicated a tube feeding the facility did not have on hand, so LPN #220 called the registered dietitian to obtain an order for Glucerna (enteral nutrition). RN #271 confirmed he reported to LPN #220 to administer medications via gastrostomy tube and RN #271 did not record this nursing report in the medical record. RN #271 stated he did not administer medications to Resident #132 on 12/24/25. During an interview on 01/12/26 at 1:10 P.M., Resident #132's Emergency Contact #1 revealed Resident #132 was alert most of the time but was easily confused. No one from the family or friends [NAME] her any food or drink to the facility because everyone knew she was not to take anything by mouth. When Resident #132 was admitted to the facility, she had no active drainage from her neck wound. By the time she went to the emergency room on [DATE], there was copious amounts of green draining from the wound on her neck. On 12/29/25, Emergency Contact #1 and another friend from church saw food and drink on her bedside table and saw Resident #132 drank some Sprite. Emergency Contact #1 stopped Resident #132 from continuing to eat or drink anything by mouth. Resident #132 then started to have nausea and vomiting. On 12/30/25, Resident #132 was sent to the emergency room for further evaluation. Resident #132 in the Medical Intensive Care Unit (ICU) until two days ago (01/10/26) when she transferred out to a regular room. During an interview on 01/12/26 at 4:45 P.M., LPN #220 revealed she could not remember how medications were administered to Resident #132 on 12/24/25 at 9:00 P.M. LPN #220 confirmed she documented (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton Road Columbus, OH 43230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0684

Level of Harm - Actual harm

Residents Affected - Few

the medications were given by mouth in the MAR.

During an interview on 01/13/26 at 8:30 A.M., the Director of Nursing (DON) and Corporate Nurse #501 revealed the evening medications on 12/24/25 and morning medications on 12/25/25 were documented as administered orally then in the afternoon on 12/25/25 the medications were changed to be administered through the gastrostomy tube. The orders were initially transcribed from the AVS to be administered orally then later changed to gastrostomy tube. The DON was unable to find any enteral feeding ordered or documentation of administration of administration enteral feeding until 12/26/25 at 7:00 P.M. There was documentation in the medical record Resident #132 ate or drank orally on 12/29/25 and confirmed there was no investigation in it either. The DON stated it was something that would be an incident and should be investigated.

During an interview on 01/13/26 at 9:02 A.M., LPN #210 revealed she completed a second skin assessment on Resident #132 on 12/24/25 and there was no enteral feeding being administered to Resident #132 at that time.

During an interview on 01/13/26 at 10:42 A.M., Unit Manager (UM) #307 confirmed Resident #132 was admitted [DATE] with a gastrostomy tube and was to receive NPO and had a surgical wound on her neck. A floor nurse obtained an enteral feeding formula of Glucerna on 12/24/25 and UM #307 confirmed the conversation with the dietician was not documented anywhere in the medical record. UM #307 confirmed there was no documentation of administering enteral feedings from 12/24/25 until 12/26/25 in the medical record. UM #307 confirmed the initial medications orders included medications to be given by mouth. RN #307 stated on 12/29/25, Resident #132 was found to have open containers of food and beverages on the bedside table between 5:00 and 6:00 P.M. Family was present in the room with Resident #132. A stat order for chest X-ray was placed on 12/29/25 around 7:00 PM. Resident #132 had no symptoms of distress. The X-ray was a precaution. The next morning 12/30/25, the X-ray was yet completed. There were no signs or symptoms of aspiration but there was increased green draining from Resident #132's neck wound so the physician decided to send Resident #132 to the emergency room for further evaluation and treatment. RN #307 stated because Resident #132 decided to take a drink on her own this would not consider it an incident.

During an interview on 01/13/26 at 12:14 P.M., RN #315 confirmed orders for enteral feedings and gastrostomy tube care were placed on 12/26/25. RN #315 stated it was part of her chart review process. If something was missing, then RN #315 placed the order to be sure the charting was complete.

3. Review of the medical record for Resident #8 revealed an admission date of 11/07/25. Diagnoses included plural effusion, end stage renal disease, chronic respiratory failure, heart failure, gastro-esophageal reflux disease, and malignant neoplasm of bone and left breast.

Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact, required continuous oxygen administration and required substantial/maximal assistance with bathing.

Review of the hospital After Visit Summary (AVS) dated 12/06/25 through 12/13/25 revealed staff were required to drain PleurX (chest drain) three times per week. Staff should drain up to 1,000 milliliters (ml.) or one bottle each time. If you drain 200 ml or less for three days in a row, call the office. Keep a drainage log including the date and time, amount of fluid drained, color of the fluid, and symptoms.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The progress note dated 12/14/25 revealed Resident #8 had a PleurX drain (chest drain) noted to left upper flank area that was covered with dressing. No signs or symptoms of infection noted. The physician order dated 12/14/25 revealed to monitor the left flank for infection and cleanse with normal saline, pat dry and apply dressing. The physician visit dated 12/16/25 revealed a drain has placed for long term drainage secondary to it being a malignant effusion for persistent drainage. Staff were to monitor for complications such as dislodgement, obstruction or infection. The progress note dated 12/16/25 revealed medical director in and assessed the residents' PleurX drain. An order was given to monitor site for signs and symptoms of infection. The resident will be set up with interventional radiology to have drain removed or changed. There were no physician orders to drain Resident #8's PleurX three times per week and no evidence the PleurX was drained from 12/13/25 to 12/22/25. The physician order dated 12/23/25 revealed left flank PleurX to be drained every shift every Monday, Wednesday and Friday. Drain up to 1,000 ml. each time tube was drained. Do not exceed amount notify physician if draining less than 200 ml. The progress note dated 12/23/25 revealed the nurse assessed PleurX drain, the left flank tube was drained, output of 900 ml. The resident tolerated it well, no shortness of breath noted. Resident to complete PleurX draining every Monday, Wednesday and Friday. no infection noted at site. The care plan created updated 01/07/26 revealed Resident #8 had a potential for difficulty breathing and risk for respiratory complications related to the use of oxygen, diagnoses of chronic heart failure, chronic hypoxic respiratory failure, pleural effusions and history of smoking. Interventions included pleurex drain to left flank staff were required to monitor site for infection, drain as ordered, and notify of low drainage output. Interview on 01/07/26 at 3:47 P.M. with Regional Nurse #500, Corporate Nurse #501 and Assistant Director of Nursing (ADON) #315 confirmed Resident #8 was readmitted to the facility on [DATE], and the PleurX drain was not drained until 12/23/25. Physician orders for draining the PleurX were not entered until 12/23/25. ADON #315 stated the physician was notified on 12/16/25 that staff were unable to drain the PleurX. The physician advised the resident would be evaluated by interventional radiology for possible removal or replacement of the drain. ADON #315 reported she understood PleurX drain management but explained the drain arrived with a protective sheath over the tube, which prevented connection to the drainage kit. On 12/23/25, ADON #315 removed the sheath and successfully drained the PleurX without radiology intervention. ADON #315 stated she was unaware the sheath was intended to be removed and served as protection against external contamination. She confirmed the drainage tube was functional the entire time but she lacked knowledge on how to drain it given the circumstance. ADON #315 acknowledged that attempts to drain the PleurX prior to 12/23/25 were not documented in the medical record and confirmed the drain was not managed according to hospital discharge instructions. This deficiency represents non-compliance under Complaint Numbers 2711068 and 2701180.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), and policy review, the facility failed to accurately assess and provide timely interventions to prevent the development of pressure ulcers or healing of existing pressure ulcers; and failed to timely identify the resident's pressure ulcers until it reached an advanced stage. This resulted in Actual Harm to Residents #37 and #117 who were at risk for pressure ulcers and dependent on staff for toileting. Resident #37 developed three unstageable pressure ulcers (Slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar). Resident #117 developed one pressure ulcer as a stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed). This affected three (Residents #37, #82, and #117) of three residents identified with in-house acquired wounds. The facility census was 111.Findings include: 1. Review of the medical record for Resident #37 revealed an admission date of 11/26/25. Diagnoses included chronic kidney disease, muscle weakness, type two diabetes mellitus, acute respiratory failure with hypoxia, and systolic heart failure. Review of the hospital records from 11/18/25 to 11/26/25 revealed on 11/25/25, a wound consult identified multiple wounds. Resident #37 had wounds including a skin tear on the left buttock, and it was burgundy and denuded with redness. The coccyx showed brown ecchymosis discoloration. Preventive measures included turning every two hours, keeping skin cleansed dry and protected, using a low air loss mattress with a maximum of two linen layers, and avoid briefs to reduce moisture-related breakdown. The nursing comprehensive evaluation completed 11/26/25 by Licensed Practical Nurse (LPN) #900 documented Resident #37 had no skin conditions and had the potential for skin breakdown. Review of the physician orders dated 11/26/25 revealed wound care practitioner and podiatry to evaluate and treat as indicated. There were no physician orders to treat any skin breakdown on the left buttocks or coccyx as indicated in hospital records on 11/25/25. Review of the care plan initiated on 11/26/25 revealed Resident #37 was at risk for impaired skin integrity or pressure injury related to actual skin impairment on bilateral buttocks, bilateral heels, bilateral medial feet, and coccyx. Limitations included impaired bed mobility, episodes of bowel and bladder incontinence, chronic kidney disease, and diabetes mellitus. Interventions were documented as follows: on 11/26/25, the care plan was initiated for impaired skin integrity and pressure injury risk. There were no specific interventions included in the care plan until 12/02/25. A second skin check was completed on 11/27/25 by LPN #900 and no skin issues were identified on Resident #37. The Braden Scale for pressure ulcer risk, dated 11/27/25, revealed a score of 16, placing the resident at risk for skin breakdown. The scoring revealed Resident #37 was very limited with mobility, skin was occasionally moist, walks occasionally, has adequate nutrition and potential problem related to friction and shear. The physician order dated 11/27/25 directed follow up skin assessment on day shift for three days (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and cleanse skin with normal saline, pat dry, and apply Triad at dime thickness. The skin area for the treatment was not specified. The Skin Issues Evaluation completed 11/28/25 by Unit Manager (UM) #307 identified moisture associated skin damage (MASD) on the right buttock with progress noted as new wound present on admission, measuring 4.24 centimeters (cm) in length and 2.16 cm in width with no depth. The surface area measured 4.26 square (sq)cm. The MASD on the left buttock with progress noted as new wound present on admission, measuring 5.28 cm in length, 3.78 in width with no depth. The surface area 8.75 sq cm. The physician orders dated 11/28/25 revealed to cleanse wound (location not specified) with normal saline, pat dry, apply zinc oxide, and leave open to air every shift as needed. This order continued through 12/01/25. The Skin Issues Evaluation completed 11/30/25 by Registered Nurse (RN) #319 and 12/01/25 documented MASD on left and right buttocks. There were no measurements on these two wounds. The physician orders dated 12/01/25 revealed the bilateral buttocks were to be cleansed with normal saline, pat dry, apply zinc oxide, and leave open to air every shift as needed. This order continued until 12/14/25. The Skin Issues Evaluations completed 12/02/25 by LPN #280 documented MASD on left and right buttocks. There were no measurements on these two wounds. On 12/02/25, the care plan had updated interventions including weekly head-to-toe skin assessments, observing skin during shower or care, notifying the nurse of new areas of skin breakdown, placing a pressure reduction mattress on the bed, providing incontinence care and applying protective ointment, and turning and repositioning every care round and as needed. Review of the admission Minimum Data Set (MDS) completed 12/03/25 documented Resident #37 was mildly cognitively impaired, dependent on staff for toileting, and was frequently incontinent of bowel and bladder. Resident #37 was at risk for developing pressure areas and did not have any pressure ulcers. The Skin Issues Evaluations completed 12/03/25 by LPN #280 documented MASD on left and right buttocks. There were no measurements on these two wounds. The physician order dated 12/03/25 directed weekly skin assessment on day shift on Wednesdays. The progress notes dated 12/08/25 completed by RN #260 revealed Resident #37 had MASD on rear left thigh and right thigh. RN #260 documented these were present upon admission; However, there was no mention in the medical record these two areas were identified prior to 12/08/25. There was also no treatment order for these two newly identified wounds and no measurement of these wounds. The skin check evaluation completed 12/10/25 completed by LPN #900 documented MASD on the left and right buttock. A second evaluation completed on 12/10/25 by LPN #900 documented the same information. Review of the activities of daily tasks from 11/26/25 to 12/12/25 revealed Resident #37 received routine incontinence care by staff. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin Issues Evaluation completed 12/12/25 by Wound Nurse #303 identified a new pressure ulcer on the rear right thigh and measured 1.06 cm in length, 1.26 cm in width, and no depth. The surface area was 0.99 sq cm. A new pressure ulcer was acquired in house on the coccyx, and measured 1.33 cm in length, 1.65 cm in width with no depth. The surface area was 1.66 sq cm. There was a third new pressure ulcer acquired in house on the left buttock, acquired in house, 2.09 cm in length, 5.42 cm in width with no depth. The surface area was 6.51 sq cm. The three new pressure ulcers were not staged. The progress note dated 12/12/25 revealed Wound Nurse Practitioner (WNP) #502 was notified of the findings and new wound care treatments were ordered and initiated. The resident was educated on the importance of wound care, offloading, and pressure reduction. Risk versus benefits were reviewed, including risk of worsening skin breakdown, delayed healing, and infection if pressure relief measures are not followed, versus benefits of ongoing treatment and prevention of further injury. The resident verbalized understanding. Interventions were in place, including pressure relief measures, routine skin monitoring, and continuation of wound care per order. All responsible parties have been notified. Resident #37 will continue to be monitored for any changes in skin integrity per the care plan. The physician order dated 12/12/25 revealed for the coccyx, right rear thigh, and left buttocks wounds, there were new orders to cleanse with normal saline, apply silver calcium alginate, and cover with silicone dressing daily and as needed until resolved. The physician order dated 12/14/25 revealed there was a new order for an alternating pressure mattress and set it to four. The care plan had a new intervention added on 12/15/25 for an alternating pressure mattress with a setting of four. The Skin Issues Evaluation completed 12/18/25 by Wound Nurse #303 identified the right rear thigh pressure ulcer as unstageable and measured 1.68 cm. length, 1.22 cm. width, 0.1 cm. depth The coccyx pressure ulcer measured 0.83 cm. length, 1.44 cm. width, 0.1 cm. depth, and surface area 0.94 sq cm, and there was no tunneling or undermining. The left buttocks measured 1.4 cm. length, 1.1 cm. depth, and surface area 2.01 sq cm, and there was no tunneling or undermining. WNP #502's progress note dated 12/18/25 revealed the right rear thigh, coccyx, and left buttocks were staged as unstageable pressure ulcer. The care plan had a new intervention added on 12/22/25 for a pressure reduction cushion to be added to the wheelchair. The physician order dated 12/23/25 revealed Prostat (protein supplement) two times a day for wound healing. The Skin Issues Evaluation completed 01/08/26 revealed the right rear thigh wound healed. The unstageable pressure ulcer on the coccyx measured 0.84 cm in length, 0.63 cm in width, 0.1 cm in depth. The surface area was 0.4 sq cm, and there was no undermining or tunneling. The unstageable pressure ulcer on the left buttocks measured 4.44 cm in length, 3.67 cm in width with no depth. The surface area 5.03 sq cm, and there was no undermining or tunneling. During an interview on 01/08/26 at 10:15 A.M., Resident #37 reported awareness of wounds on feet and buttock. Resident #37 reported the wound care nurse practitioner had seen him and reported wounds (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

were cleaned by staff.

During an interview on 01/08/26 at 3:46 P.M., WNP #502 confirmed the facility notified her of Resident #37's wound on 12/12/25, and WNP #502 completed her first in house assessment on 12/18/25. WNP #502 voiced nursing staff did not identify Resident #37's wounds timely.

During an interview on 01/12/26 at 10:26 A.M., the Director of Nursing (DON) confirmed licensed nursing staff did not capture Resident #37's wounds timely. The DON confirmed nursing staff did not complete a thorough skin assessment, and if completed the areas would have been identified timely.

During an interview on 01/12/26 at 10:55 A.M., Corporate Nurse #501 confirmed wounds were not identified on Resident #37 until 12/12/25, and the wound nurse did not stage and assess the wounds until 12/18/25. Corporate Nurse #501 confirmed nursing staff did not complete a thorough skin assessment, and if completed the areas would have been identified timely.

During an interview on 01/12/26 at 12:16 P.M., Central Supply #205 confirmed Resident #37 required usage of adult briefs for incontinence care needs. The hospital recommended to avoid use of adult briefs to reduce moisture related breakdown.

During an interview on 01/13/26 at 1:44 P.M., LPN #900 confirmed completion of skin assessments on 11/27/25 and 12/10/25 and noted there were no significant concerns on buttocks besides MASD.

During an interview on 01/13/26 at 1:51 P.M., RN #319 confirmed she completed a skin assessment on 11/30/25 for Resident #37 and [NAME] bilateral buttocks with MASD.

During an interview on 01/13/26 at 2:02 P.M., UM #307 confirmed nursing staff did not identify Resident #37's wounds timely. UM #307 confirmed a skin assessment documented on 11/28/25 noted no skin impairments and the hospital report dated 11/27/25 reported skin issues on bilateral buttocks. UM #307 confirmed a complete follow-up skin assessment was not done. UM #307 stated the wound nurse did not see Resident #37 prior to 12/12/25 because there were no open areas documented, and once an open area was identified, the wound nurse becomes involved in the resident's care.

2. Review of Resident #117's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, cognitive communication deficit and need for assistance with personal care.

Review of the admission MDS assessment dated [DATE] revealed Resident #117 was cognitively intact. Resident #117 was dependent on staff for toileting hygiene and frequently incontinent of bowel and bladder. Resident #117 was at risk for developing pressure injuries, but did not have any pressure injuries, venous or arterial ulcers at that time.

The nursing progress notes dated 11/28/25 revealed Resident #117 was sent to the hospital due to diaphoresis, fever, and elevated heart rate.

The hospital records dated 11/28/25 to 12/01/25 revealed Resident #117 was treated in the hospital for sepsis pneumonia. The hospital records contained no documentation Resident #117 had any pressure ulcers or skin alterations.

The nursing readmission assessment dated [DATE] revealed Resident #117 had no skin conditions. The

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F 0686 Level of Harm - Actual harm Residents Affected - Few	nursing assessment noted Resident #117 would be turned and repositioned every two hours and as needed, and weekly head-to-toe skin assessments would be completed. The skin checks on 12/03/25 revealed Resident #117 had a new Moisture Associated Skin Damage (MASD) area to both buttocks measuring 4.89 cm in length by 2.81 cm in width and 0.1 cm in depth. The physician orders dated 12/04/25 revealed her coccyx should be cleaned with normal saline, patted dry, apply zinc oxide and leave open to air. The skin assessment dated [DATE] revealed Resident #117 had MASD to her coccyx measuring 2.36 cm in length by 2.1 cm in width and no depth recorded. The physician orders dated 12/15/25 revealed a treatment order for a hydrocolloid dressing to be applied every three days and as needed to coccyx area. The care plan dated last updated 12/15/25 revealed Resident #117 was at risk for impaired skin integrity and pressure injury related to impaired bed mobility, incontinence of bowel and bladder, neuropathy and a history of skin breakdown to the coccyx. The interventions to help minimize risk of skin breakdown included conduct weekly head-to-toe skin assessments, observe skin with showers and care and notify nurse of any new skin breakdown, and to turn and reposition Resident #117 every two hours and as needed. Review of the shower and bath tasks dated 12/18/25, 12/22/25 and 12/25/25 revealed Resident #117 did not have any open skin areas. The skin assessments dated 12/20/25 through 12/27/25 revealed Resident #117 continued to have MASD on her coccyx, though no measurements were made of the skin impairment. On 12/29/25, the skin issues assessment revealed the MASD to her coccyx had progressed to a stage III pressure injury. The stage III pressure injury was assessed as in-house acquired and measured 1.6 cm in length by 1.49 cm in width. There was no depth recorded. The physician orders dated 12/29/25 revealed the coccyx area should be cleaned with soap and water or normal saline and a hydrogel honey cover with sacrum silicone/ foam dressing should be applied daily and as needed. Wound Nurse Practitioner (WNP) #502's wound assessment dated [DATE] revealed Resident #117 had a stage III pressure ulcer to her sacral region which was 80 percent granulation tissue and 20 percent slough. The size was 0.51 cm in length by 0.83 cm in width by 0.19 cm in depth. During an interview on 01/08/26 at 3:55 P.M., Assistant Director of Nursing (ADON) #315 revealed there had been some recent staffing changes with the nurse at the facility who oversaw wounds. The wound nurse at the facility prior to 12/31/25 had been a licensed practical nurse (LPN), who was not wound certified. During an interview on 01/08/26 at 2:39 P.M., WNP #503 revealed the first time WNP #503 saw Resident #117 was on 01/08/26. WNP #503 revealed a wound nurse practitioner or doctor had not been in the facility for the past two weeks due to the holiday schedule. WNP #503 revealed the facility nurses would have overseen monitoring wound progression during this time. WNP #503 revealed when she examined (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #117's pressure ulcer on 01/08/26, it was small, but the injury was still staged as a stage III pressure injury. WNP #503 revealed she had no new treatment orders for Resident #117's pressure injury. During a follow up interview on 01/09/26 at 12:57 P.M., WNP #503 revealed MASD can worsen into a stage III pressure injury if a resident was not being turned and repositioned consistently. She confirmed that if a resident was being monitored with check and changes every two hours, the wound could have been caught at stage II (a partial-thickness skin loss presenting as a shallow open wound that exposes the dermis, the middle layer of skin) pressure ulcer. During an interview on 01/09/26 at 4:06 P.M., the Director of Nursing (DON) revealed that during the week of 12/21/25 and the week of 12/28/25, she had LPNs in the facility staging pressure ulcers, which they should not do. 3. Review of Resident #82's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, cerebral infarction, and adult failure to thrive. Review of the quarterly nursing assessment dated [DATE] revealed Resident #82 had no skin abnormalities present. The Braden scale assessment dated [DATE] revealed Resident #82 was at risk for developing pressure ulcers. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #82 had severe cognitive impairment. Resident #82 was dependent on staff for toileting hygiene, lower body dressing, and putting on footwear, and substantial maximal assistance for bed mobility. The physician order dated 10/16/25 revealed to encourage Prevalon boots (a pressure relieving offloading boot) to feet as tolerated on every shift daily. The care plan dated 01/17/23 revealed Resident #82 was at risk for impaired skin integrity/pressure injury related to weakness and impaired mobility. Interventions included to encourage to float heels while in bed and assist as needed. Observation of Resident #82's peri care on 01/07/26 from 3:13 P.M. to 3:23 P.M. revealed Resident #82 was not wearing offloading boots. An interview with Certified Nursing Aide (CNA) #268 and CNA #304 on 01/07/26 at 3:27 P.M. revealed Resident #82 does not have any offloading boots at all and has reddened skin areas to her bilateral heels. Observation of Resident #82 on 01/08/26 from 8:22 A.M. to 9:16 A.M. revealed Resident #82 was not wearing offloading boots or floating her heels off the bed. During an interview on 01/08/26 at 9:16 A.M., Licensed Practical Nurse (LPN) LPN #255 confirmed Resident #82 was not wearing her offloading boots or floating her heels. During an interview on 01/08/26 at 9:26 A.M., Wound Nurse Practitioner #503 revealed Resident #82's left heel was reddened, but it was blanchable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton Road Columbus, OH 43230

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the NPUAP guidelines dated 2014 revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. Review of the facility policy titled Skin Management, revised on 08/14/24, revealed upon admission, all residents are evaluated for skin integrity and this is documented in the electronic health record. Appropriate preventative measures will be implemented, and the interventions will be documented. Residents admitted with any skin impairment will have appropriate interventions implemented to promote healing and a physician's order for treatment. Ongoing monitoring and evaluation are provided to ensure optimal guest outcomes. The Certified Nursing Aide will report any new skin impairment to the licensed nurse that is identified during daily care. Residents with pressure injuries and lower extremity ulcers will be evaluated, measured, and staged weekly. The care plan may address preventative devices. This represents non-compliance investigated under Complaint Numbers 2711068 and 2701180.