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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on record review, review of care plan, and staff interviews, the facility failed to properly develop comprehensive care plans. This affected two residents (#33 and #6) of two residents reviewed for care plans. The facility census was 101. Findings include: 1. Review of medical record for Resident #33 revealed an admitted [DATE]. Diagnoses include diabetes mellitus type two, bipolar disorder, neuropathy, atherosclerotic heart disease, gout, chronic pain, and edema. Review of the care plan on 05/28/24 8:59 A.M. for Resident #33 dated 04/16/24 revealed diabetes mellitus type two and bipolar disorder diagnoses not included in care planning. Interview on 05/28/24 at 10:41 A.M. with the Director of Nursing (DON) confirmed the care plan did not address Resident #33's diabetes or bipolar disorder diagnoses. 41266 2. Review of the medical record for Resident #6 revealed an initial admitted on 12/12/22 and a readmitted to the facility on [DATE]. Medical diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cerebral infarction (CVA), dysarthria following cerebral infarction, and dysphagia following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had impaired cognition. Resident #6 did not have any impairments in his upper extremities and had an impairment on one side of his lower extremity. Resident #6 required setup or clean-up assistance from staff with eating, upper body dressing, and personal hygiene; substantial or maximal assistance with bathing, bed mobility, lower body dressing, and transfers; and total dependence on staff to complete oral hygiene and toileting. Review of the hospital records dated 02/26/24 revealed Resident #6 had a past medical history which included a diagnosis of CVA (stroke). (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366457	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 02/26/24 at an unknown time revealed Physician Assistant (PA) #620 noted Resident #6 had a prior history of CVA (stroke). Review of the care plan revised 03/11/24 revealed Resident #6's history of CVA or monitoring for signs and symptoms of a stroke was not addressed in the resident's care plan. Interview on 05/28/24 at 3:30 P.M. with the DON confirmed Resident #6's care plan did not address the resident's prior history of CVA (stroke) or monitoring for signs and symptoms of a possible CVA.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 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** 41266 Based on medical record review, review of hospital medical records, observations, resident and staff interviews, and facility policy review, the facility failed to provide timely treatment and care in response to resident's change in condition resulting in hospitalization s. This resulted in actual harm for Resident #37, who was admitted to the facility on [DATE], was sent to the hospital from an outside appointment on 07/18/23 due to abdominal distention and a concern for a bowel obstruction related to multiple days of having no bowel movements and no treatment. Resident #37 received a computed topography (CT) scan of her abdomen in the emergency department which revealed a bowel obstruction. A gastrointestinal (GI) consult was completed, and Resident #37 received surgery for a loop colostomy to be placed. This resulted in actual harm when Resident #6, who was initially admitted on [DATE] and readmitted to the facility on [DATE], reported to the facility staff he was having a stroke on 02/25/24 and requested to be sent out to the hospital. Registered Nurse (RN) #732 did not send Resident #6 out to the hospital as requested or inform the physician of Resident #6's desire to go to the hospital. Resident #6 had a history of cerebral infarction (CVA) (stroke). Physician Assistant (PA) #620 assessed Resident #6 on 02/26/24 and found the resident presented with dysarthria, significant left facial droop, and significant left side hemiparesis, likely consistent with an acute CVA. Resident #6 was sent to the hospital where a diagnosis of acute CVA was confirmed. This resulted in actual harm for Resident #85, who was initially admitted on [DATE] and readmitted to the facility on [DATE], was transferred to the hospital on 04/17/24 at approximately 6:45 P.M. due to an altered mental status after the facility was unable to obtain STAT (immediate) laboratory values ordered by the provider. Resident #85 was nearly unresponsive, hypotensive (low blood pressure), tachycardic, and febrile with a temperature of 104.8 degrees Fahrenheit upon arrival at the hospital. Resident #85 was diagnosed with septic shock related to a catheter associated urinary tract infection (CAUTI) and was admitted to the hospital. Resident #85 remained in the hospital for further treatment until 04/22/24. This affected three residents (#37, #6 and #85) of four residents reviewed for changes in condition. The facility census was 101. Findings include: 1. Review of the medical record for Resident #37 revealed an admitted on 03/07/19. Diagnoses include colostomy status (07/21/23), malignant neoplasm of brain (03/07/19), abnormal posture (07/28/23), constipation (03/07/19), and encounter for surgical aftercare following surgery on the digestive system (07/28/23). (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had impaired cognition and scored an eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #37 required setup or clean-up assistance from staff with eating; supervision or touching assistance with oral hygiene; substantial or maximum assistance with upper body dressing; and was totally dependent on staff assistance to complete toileting, bathing, lower body dressing, bed mobility, and transfers. Resident #37 did not have an ostomy and was always incontinent of bowel and bladder. Review of the clinical census for Resident #37 revealed the resident was hospitalized from 07/18/23 until 07/28/23 (ten days). Review of the Medication Administration Record (MAR) dated July 2023 revealed Resident #37 received Miralax Oral Powder 17 grams (GM) per scoop daily for constipation and Senna Oral Tablet 8.6 milligrams (mg) daily for constipation. Resident #37 had an additional order for Bisacodyl Rectal Suppository 10 mg every 24 hours as needed (PRN) for constipation. The PRN suppository was not administered to Resident #37 in the month of July 2023. Review of the Treatment Administration Record (TAR) dated July 2023 revealed Resident #37 had an order to please schedule abdominal computed tomography (CT) scan related to abdominal distention dated 06/29/23. This order was not marked as completed. An additional order to obtain the results of the abdominal CT scan completed on 07/14/23 and upload to Resident #37's medical record for review by the physician/Certified Nurse Practitioner (CNP) dated 07/18/23. This order was marked as completed on 07/18/23. Review of Toileting Documentation dated July 2023 revealed Resident #37 had normal stools on 07/01/23. No bowel movements were documented from 07/02/23 through 07/05/23 (four days). Loose stools were documented on 07/06/23 and 07/07/23. No bowel movements were documented from 07/08/23 through 07/10/23 (three days). A loose stool was documented on 07/11/23. No bowel movement was documented on 07/12/23. Loose stools were documented on 07/13/23 and 07/14/23. No bowel movements were documented from 07/15/23 through 07/17/23 (three days). A loose stool was documented on 07/18/23. Review of progress notes dated from 07/01/23 through 07/31/23 revealed on 07/13/23 at an unknown time, Resident #37 was seen by CNP #612 for follow up on abdominal distention. A previous kidney, ureter, and bladder (KUB) x-ray showed progressed colonic ileus (a motility disorder that causes a nonmechanical obstruction in the colon) with moderate stool burden. Scheduled Miralax and Senna medications (laxatives) were ordered. Outputs were to be monitored. If no improvement, consider an abdominal CT scan. No worsening of symptoms or issues were noted but not resolved. A CT scan of the resident's abdomen was scheduled for 07/14/23. On 07/14/23 at 6:14 P.M., Resident #37 was noted to have returned from an abdominal CT scan appointment at around 12:00 P.M. with no new orders. On 07/18/23 at 9:00 A.M., Resident #37 was noted to leave the facility to attend an outside appointment. On 07/18/23 at 5:36 P.M., Resident #37 was noted to be sent to the hospital from her appointment. Resident #37 was in the emergency room and was awaiting a bed. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital records dated 07/19/23 revealed Resident #37 had a diagnosis of bowel obstruction. Resident #37 presented to the emergency room from her neuro oncology appointment due to abdominal distention and concern for a bowel obstruction. An abdominal CT scan was completed and showed continued sigmoid colon dilation with transition point in the distal sigmoid colon, which may represent partial obstruction. A gastrointestinal (GI) consult was recommended. An abdominal x-ray was completed on 07/18/23 which showed gaseous colonic dilation that had increased compared to the recent CT scan. A large amount of stool burden was found especially in the right hemicolon. A GI consult was completed on 07/19/23. The risk for perforation was too high to perform a flexible sigmoidoscopy (a diagnostic procedure that allows a doctor to examine the lower colon and rectum) and planned for a loop colostomy surgery completed on 07/21/24. On 07/28/23 at 1:35 P.M., Resident #37 returned to the facility from the hospital. Review of the After Visit Summary (AVS) dated 07/28/23 revealed Resident #37 was discharged from the hospital with a colostomy in place. Review of the care plan, (initially dated 10/21/19) and revised 07/29/23, revealed Resident #37 was at risk for constipation related to decreased mobility, medication side effects, and rectal mass on 10/21/19. Interventions included administer medications as ordered, increase fiber and fluid intake, observe for signs and symptoms of bowel obstruction: abdominal distention, decreased appetite, and/or diarrhea with continued feelings of fullness and report findings to the physician, record bowel movement pattern after each occurrence describing amount and consistency. The revised care plan dated 07/29/23 revealed Resident #37 was at risk for complications related to a colostomy in place related to a small bowel obstruction (SBO). Interventions included change colostomy bag as needed, check for proper fit of colostomy bag to stoma, empty colostomy bag every shift and as needed, observe for air in the colostomy bag frequently and release as needed, observe for bowel movement and document, report a lack of bowel movement to nursing and physician, observe for diarrhea, constipation, dehydration, and pain every shift, observe for ostomy functioning, and observe stoma site and surrounding skin during each change for warmth, redness, or tenderness. Review of a follow-up surgical note, dated 08/15/23, revealed Resident #37 had a post-operative visit after creation of a loop transverse colostomy. A follow-up flexible sigmoidoscopy which did not reveal any masses or strictures. Interview on 05/22/24 at 3:33 P.M. with the Director of Nursing (DON) revealed if a resident did not have a bowel movement for three days, the physician or CNP should be notified, and any ordered PRN laxatives or suppositories should be administered. Interview on 05/23/24 at 10:35 A.M. with the DON confirmed Resident #37 had documented normal stools on 07/01/23 followed by not having a bowel movement for several days and then having loose stools until the resident was sent to the hospital on 07/18/23 from an outside appointment. The DON confirmed loose stools could be a sign of a bowel obstruction when the resident was noted to be able to form normal stools previously. The DON confirmed Resident #37 did not receive a PRN suppository when she was noted without a bowel movement for at least three days in a row. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	A facility policy related to treatment of constipation and/or treatment for a change in condition was requested at the time of the survey, however, the facility did not have any policies which addressed either area. 2. Review of the medical record for Resident #6 revealed an initial admitted on 12/12/22 and a readmitted to the facility on [DATE]. Diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and paralysis on one side of the body) (03/02/24), cerebral infarction (CVA) (stroke) (03/02/24), dysarthria following cerebral infarction (slurred speech) (03/02/24), and dysphagia following cerebral infarction (difficulty swallowing) (03/02/24). Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #6 had impaired cognition and scored an 11 out of 15 on the BIMS assessment. Resident #6 did not have any impairments in his upper extremities and had an impairment on one side of his lower extremity. Resident #6 required setup or clean-up assistance from staff with eating, upper body dressing, and personal hygiene; substantial or maximal assistance with bathing, bed mobility, lower body dressing, and transfers; and total dependence on staff to complete oral hygiene and toileting. Review of Resident #6's clinical census revealed the resident was hospitalized from 02/26/24 to 03/02/24 (six days). Review of the MAR dated February 2024 revealed Resident #6 received Aspirin 81 milligrams (mg) daily and Plavix 75 mg daily (an antiplatelet medication). Review of the progress notes for Resident #6 revealed on 02/25/24 at 3:20 P.M., Registered Nurse (RN) #732 noted a change in condition evaluation due to Resident #6 being tired, weak, confused, and drowsy. Resident #6's vital signs were blood pressure 137/76, pulse 72, respiration rate 18, temperature 97.6, pulse oximetry 98%, and blood glucose 181 (on 01/19/23). Resident #6 verbalized that he was having a stroke around 3:20 P.M. Range of motion (ROM) was performed, and the resident was able to raise both arms and legs. Resident #6 denied any pain. The physician was informed and recommended to continue to monitor Resident #6. On 02/26/24 at an unknown time, PA #620 completed an acute visit with Resident #6 with a chief complaint of weakness. PA #620 noted the nursing staff reported that the resident complained yesterday (02/25/24) that he may have had a stroke. On exam today, Resident #6 had dysarthria, had significant left-sided hemiparesis with left-sided facial droop. Resident #6 did have a history of prior CVA and was currently treated with Plavix and Aspirin. It is unclear when Resident #6 was last known well. National Institute of Health (NIH) stroke score is 15. (The scoring range is zero to 42 points, with higher numbers indicating a greater severity. A score of five to 15 represents a moderate stroke). The physical exam noted left sided facial droop and loss of left nasolabial fold (a skin crease that runs from the bottom of the nose to the outer corner of the mouth) with an asymmetric smile, ROM at baseline, left upper and lower extremity weakness, and confusion. Resident #6's presentation was likely consistent with an acute CVA and he would be sent to the emergency department for further management. Resident #6 was sent to the hospital via stretcher at 1:10 P.M. on 02/26/24. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital records dated 02/26/24 revealed Resident #6 presented to the hospital at 1:33 P.M. for evaluation of stroke-like symptoms. The resident had dysarthria, facial droop, and left-sided weakness that started yesterday (02/25/24). The resident's wife was at bedside and reported symptoms had started on Thursday, 02/22/24 or Friday, 02/23/24 but worsened on 02/25/24. Deep vein thrombosis prophylaxis with sequential compression devices (SCD's) (shaped like sleeves that wrap around the legs and inflate with air). Resident #6 required admission due to concern of stroke-like symptoms and urinary tract infection (UTI) due to posed a threat to life and organ dysfunction. Review of the After Visit Summary (AVS) dated 03/02/24 revealed Resident #6 had a diagnosis of stroke (cerebrum). Resident #6's medications were changed to stop taking Plavix and start taking Apixaban (Eliquis) (an anticoagulant). Recommended dysphagia (difficulty swallowing) treatment. A regular diet and mildly thickened liquids was recommended. Review of the progress note dated 03/02/24 at 4:15 P.M. revealed Resident #6 returned to the facility. On 03/04/24 at an unknown time, PA #620 completed a follow-up visit with Resident #6 with a chief complaint of urinary tract infection (UTI) and CVA. A magnetic resonance imaging (MRI) of the brain showed a faint area of restricted diffusion in the right aspect of the [NAME] (any obstruction of blood supply to the [NAME], whether or acute or chronic, causes pontine infarction, a type of ischemic stroke) with chronic pontine, cerebellar, and cerebral infarcts and extensive small vessel disease. Resident #6 was alert and oriented but did have dysarthria and dysphagia secondary to CVA. Resident #6 could consume regular solids with thickened liquids. Resident #6 was also noted to have multidrug-resistant Klebsiella and Pseudomonas UTI and had completed antibiotics. Resident #6 still had significant left-sided hemiparesis. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #6 had impaired cognition. Resident #6 had impairments on both sides of his upper extremities and impairment on one side of his lower extremity. Resident #6 required substantial or maximal assistance with upper body dressing and personal hygiene and total dependence on staff with lower body dressing and bathing. Review of the care plan, revised 03/11/24, revealed Resident #6's history of CVA or monitoring for signs and symptoms of a stroke was not addressed in the resident's care plan. Interview on 05/21/24 at 10:23 A.M. with Resident #6 revealed he had a stroke in February 2024. Resident #6 stated he knew he had one and reported it to the facility staff. Resident #6 stated he requested to go to the hospital but the staff did not send him out due to needing approval from the physician and the physician was off. Resident #6 stated he was not sent out to the hospital for two days. Resident #6 stated prior to having the stroke, he was able to do almost everything for himself and now he is way worse. Interview on 05/23/24 at 1:32 P.M. with PA #620 confirmed he had not been notified Resident #6 complained of having a stroke on 02/25/24 until he saw the resident on 02/26/24. PA #620 stated he was not sure which on-call physician had been contacted as there were not any notes entered on 02/25/24. PA #620 stated he could not confirm when exactly Resident #6's symptoms started but confirmed when he did see Resident #6 on 02/26/24, he definitely showed signs of a stroke and that is why he sent the resident to the emergency room . PA #620 stated he educated the DON on the importance of identifying signs and symptoms of a stroke and responding quickly to strokes as they are one of the biggest emergencies that could occur in the facility. PA #620 stated the facility staff reported to him Resident #6 did not have any signs of a stroke on 02/25/24 but he was still thinking about that one. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview via telephone on 05/23/24 at 4:14 P.M. with RN #732 confirmed Resident #6 complained he was having a stroke and requested to be sent out to the hospital. RN #732 assessed Resident #6, checked his vital signs, and ROM. RN #732 stated Resident #6 was able to raise arms and legs and stuck out his tongue. RN #732 notified the on-call provider of the resident's report of having a stroke, his vital signs, and that his ROM was normal. RN #732 confirmed she did not inform the on-call provider of Resident #6's request to be sent to the hospital. RN #732 stated the on-call provider instructed to continue monitoring Resident #6. RN #732 stated she and State tested Nurse Aide (STNA) #630 monitored Resident #6 three times during her shift from 7:00 A.M. to 7:00 P.M. RN #732 stated she notified the night-shift nurse on 02/25/24 and PA #620 the following day on 02/26/24. Interview on 05/23/24 at 4:13 P.M. with the DON confirmed PA #620 did have a conversation with her regarding Resident #6's reporting of having stroke symptoms. The DON stated RN #732 informed the on-call provider and did verify with the resident that he could move his arms and legs and took his vital signs. PA #620 suggested providing stroke education to the staff. The DON confirmed she provided RN #732 with a teachable moment. After RN #732 received the additional education, she did show improvement when she noted another resident who had symptoms of a CVA and was sent out to the hospital timely. Interviews with the on-call provider, PA #609, STNA #630, and the night shift nurse, RN #669, were attempted but unsuccessful. Review of the facility policy titled, Notification of Change, dated 02/14/24, revealed the facility must inform the resident, consult with the resident's practitioner, and notify the resident's representative when there was a change in status including a significant change in the resident's physical, mental, or psychosocial status. The policy did not address providing timely treatment when a resident experienced a change in condition. No other facility policies were provided at the time of the survey. 3. Review of the medical record for Resident #85 revealed an initial admitted on 06/08/23 and a readmitted on 04/22/24. Diagnoses include infection and inflammatory reaction due to indwelling urethral catheter (04/22/24), urinary tract infection (04/22/24), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (06/08/23), neuromuscular dysfunction of bladder (06/08/23), and retention of urine (06/08/23). Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #85 had intact cognition and scored a 15 out of 15 on the BIMS assessment. Resident #85 required total dependence on staff to complete toileting. Resident #85 had an indwelling catheter. Review of the clinic census for Resident #85 revealed the resident was hospitalized from 04/17/24 to 04/22/24 (five days). Review of the TAR dated March 2024 revealed Resident #85's Foley catheter was changed on 03/28/24 as ordered. Review of the MAR dated April 2024 revealed Resident #85 received Finasteride Oral Tablet five milligrams (mg) daily for BPH as ordered and Tamsulosin Hydrochloride Oral Capsule 0.4 mg daily for BPH as ordered. There was no order to monitor urine outputs from Resident #85's Foley catheter. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the TAR dated April 2024 revealed Resident #85 received Foley catheter care every shift (twice a day) as ordered, Resident #85's Foley catheter was noted to be straight draining every shift as ordered. Review of blood pressures (BP's) revealed on 04/16/24 at 7:53 A.M., Resident #85's BP was 116/73. On 04/17/24 at 7:10 A.M., his BP was 112/66 and at 1:49 P.M., Resident #85's BP was 99/81. There were no additional BP's documented. Review of oxygen saturations (O2 sats) revealed on 04/16/24 at 7:53 A.M., Resident #85's O2 saturation was 95% on room air. On 04/17/24 at 7:10 A.M., his O2 saturation was 89% on room air and at 3:56 P.M., Resident #85's O2 saturation was 90% on room air. There were no additional O2 saturations documented. Review of pulse rates revealed on 04/16/24 at 7:53 A.M., Resident #85's pulse was 59 beats per minute (bpm). On 04/17/24 at 7:10 A.M., it was 122 bpm and at 1:55 P.M., Resident #85's pulse was 108 bpm. There were no additional pulse rates documented. Review of meal and fluid intakes dated April 2024 revealed Resident #85 was noted to eat 51-75% of all three meals and drank between 220 and 230 mL of fluid at each meal on 04/16/24. On 04/17/24, Resident #85 ate 26-50% of breakfast and drank 230 milliliters (mL) of fluids. Resident #85 did not eat or drink anything at lunch and refused dinner. Resident #85 did not drink any fluids at dinner. Review of the Change in Condition Evaluation dated 04/17/24 and completed by Registered Nurse (RN) #733 revealed Resident #85 experienced a change in condition which started on the morning of 04/17/24. The resident was lethargic. Vital signs included blood pressure (BP) 99/81, pulse 108, apical heart rate 110, temperature 97.6, and oxygen saturation was 90% on room air. Resident #85 had all of the following: a systolic BP below 100, a heart rate above 100, a temperature above 100, and signs and symptoms suggested possible sepsis. Functional changes indicated included: needed more assistance with Activities of Daily Living (ADL's), decreased mobility, a decline in the ability to perform mobility, bowel and bladder, dressing, and eating. The symptoms were noted as having a recent onset without resolving spontaneously. The symptoms were noted as staying the same. The clinician was notified on 04/17/24 at 12:12 P.M. and ordered complete blood count (CBC) and basic metabolic panel (BMP) labs. Resident #85's wife was notified on 04/17/24 at 1:38 P.M. of the change in condition. Review of the Transfer Form dated 04/17/24 and completed by RN #733 revealed Resident #85 was discharged to the hospital from the facility on 04/17/24 at 7:49 P.M. due to abdominal pain. The resident had a pain level of four out of ten where ten was the worst pain imagined. Resident #85 was not alert. Review of the progress notes revealed on 04/17/24 at 3:48 P.M., a change in condition note was entered for Resident #85 by the DON. Resident #85's BP was 99/81 at 1:49 P.M. and pulse oximetry (ox) was 90% on room air at 3:56 P.M. Resident #85's mental status was noted as other. Resident #85 needed more assistance with completing ADL's and had decreased mobility. CBC and BMP labs were ordered. On 04/17/24 at 4:03 P.M., RN #733 noted Resident #85 was lethargic since this morning and unable to awake after several attempts. Vital signs were taken. BP 99/81, pulse 108, respiration rate 16, temperature 97.6, and oxygen saturation was 90%. The on-call physician was notified and ordered STAT (immediate) CBC and BMP labs. The family was notified and will continue to monitor. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	The electronic MAR (e-MAR) notes dated 04/17/24 from 7:24 P.M. to 7:27 P.M. revealed Resident #85 was not able to swallow his evening medications and the medications were held. Review of the hospital records revealed Resident #85 presented to the ED on 04/17/24 at 7:49 P.M. with altered mental status after the resident was found fairly unresponsive at the facility. When Resident #85 was seen in the ED, no history could be obtained. Resident #85 was found to have evidence of septic shock and was admitted . Resident #85 was diagnosed with septic shock with an acute UTI (later determined on 04/21/24 to be due to bactermia with E. Coli and Proteus bacteria). Initial assessment and treatment indicated Resident #85 was hypotensive (low blood pressure) with a blood pressure in the 60's and 70's despite adequate volume resuscitation, was fairly febrile with a temperature as high as 104.8 degrees Fahrenheit, and was tachycardic upon arrival at the ED. Vital signs were: BP 74/53, heart rate 121, respiration rate 17, temperature 104.8, O2 sat 97%. Resident #85's Foley catheter was exchanged in the ED and over a liter of urine came out, likely indication Resident #85's Foley catheter was clogged on arrival. Initial treatment included: the resident was started on norepinephrine (or noradrenaline, a neurotransmitter and hormone used for blood pressure support), admitted for further evaluation and treatment, a urinalysis with significant pyuria (contains high levels of white blood cells or pus) was completed, a culture had been obtained and Resident #85 would be started on broad-spectrum antibiotics, and continue vasopressor support. On 04/17/24 at 8:00 P.M., RN #733 noted Resident #85 was sleeping all day which was unusual for him. An assessment was completed. The on-call physician was notified. STAT CBC and BMP labs were ordered. Resident #85's condition continued to decline, and the physician ordered to send the resident to the emergency room (ER) for further evaluation. Resident #85 was transferred to the hospital via Emergency Medical Services (EMS) at 6:45 P.M. The physician, DON, and family were notified. On 04/22/24 at 7:29 P.M., Resident #85 returned to the facility from the hospital at approximately 4:40 P.M. The resident had a Foley catheter in place. On 04/23/24 at an unknown time, Medical Doctor (MD) #750 completed a history and physical visit with Resident #85. The chief complaint was a catheter associated urinary tract infection (CAUTI) with sepsis. Resident #85 was seen for readmission after hospitalization for sepsis related to urinary catheter infection with cystitis (inflammation of the bladder, usually caused by a bladder infection). Resident #85 would complete the course of oral antibiotic therapy for the CAUTI of Cefdinir Oral Capsule 300 mg. Dark amber urine was noted in the Foley bag. On 04/24/24 at an unknown time, PA #620 completed an acute visit for UTI with Resident #85. Resident #85 was receiving Cefdinir (an antibiotic) 300 mg twice daily through 05/01/24 for treatment of his UTI. The Foley catheter was now draining yellow-colored urine. Review of lab results for Resident #85 revealed the STAT labs ordered on 04/17/24 had not been completed. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan (originally dated 06/09/23) and revised on 05/07/24 revealed Resident #85 was at risk for UTI and catheter-related trauma due to having an indwelling catheter. Interventions included change catheter and tubing per facility policy, enhanced barrier precautions (added on 05/07/24), may irrigate catheter for occlusion as ordered (added on 05/07/24), observe and document for pain or discomfort due to catheter, observe and document output as per facility policy (added on 05/07/24), observe, record, and report to the physician signs or symptoms of UTI including: pain, burning, red tinged urine, cloudiness, no output, deepening of urine color, increased temperature, foul smelling urine, fever, chills, altered mental status, changes in behavior, or changes in eating patterns, position catheter bag and tubing below the level of the bladder and observe for any kinks each shift, and provide catheter care per policy. Interview via telephone on 05/22/24 at 9:40 A.M. with RN #733 confirmed she first saw Resident #85 at approximately 8:30 A.M. on 04/17/24. RN #733 was able to wake Resident #85 up, the resident took his medications, and then fell back asleep. RN #733 stated Resident #85 did eat breakfast, but not as much as usual. RN #733 next saw Resident #85 around lunch time for his next dose of medications which was around 12:30 P.M. RN #733 stated Resident #85 was not able to be aroused at that time. RN #733 stated the aide then reported Resident #85 had not eaten lunch. RN #733 checked on the resident again around 1:00 P.M. and Resident #85's vital signs were taken and were within normal limits (WNL). RN #733 notified the on-call provider who directed the nurse to continue monitoring Resident #85. RN #733 stated she checked on Resident #85 every two hours and checked the resident's vital signs but did not document them. RN #733 stated she tried to arouse Resident #85 but the resident would not wake up. Around dinner time, Resident #85 still would not wake up to eat dinner and did not take any medications. RN #733 stated Resident #85's vital signs also became abnormal. RN #733 stated the resident's catheter bag had been emptied and the catheter was draining but she could not recall how much it was draining or the color of the urine. RN #733 contacted the on-call provider again around dinner time and at that time, Resident #85 was sent out to the hospital. Interview on 05/22/24 at 4:35 P.M. with the DON and Regional Nurse (RGN) #810 confirmed outputs from Resident #85's Foley catheter had not been monitored prior to the resident being sent out to the hospital on 04/17/24. The staff would only monitor outputs if there was a physician order. Interview on 05/23/24 at 1:15 P.M. with PA #620 revealed Resident #85 had a history of UTI's. PA #620 stated signs of possible sepsis may include a sudden, significant change in a resident's vital signs. PA #620 would be particularly interested in the resident's blood pressure, heart rate, and temperature. PA #620 stated when he ordered staff to monitor a resident, he would expect that resident to be checked on every two hours, including checking and documenting vital signs. Interview via telephone on 05/23/24 at 2:46 P.M. with PA #607 confirmed he was the on-call provider for the facility from 1:00 P.M. to 7:00 P.M. on 04/17/24 when Resident #85 was transferred to the hospital. PA #607 stated when RN #733 first contacted him, he ordered STAT (immediate) CBC and BMP labs. PA #607 expected the labs to be completed and resulted within four hours, but he did not receive any results before Resident #85 was sent to the hospital. PA #607 stated RN #733 contacted him again later and reported Resident #85 was still lethargic. At that time, he agreed to have the resident sent to the hospital. PA #607 stated he did not give RN #733 specific instructions on how frequently he wanted Resident #85 to be checked on or vital signs to be obtained. PA #607 stated he felt it was understood the nurse would continue watching the resident because there was clearly a change in his condition that needed to be addressed. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview via email on 05/28/24 at 12:39 P.M. with the DON confirmed STAT labs were expected to be drawn within four hours and then resulted within another four hours after being drawn. Physicians, PA's, or Certified Nurse Practitioner's (CNP's) who ordered the labs or the on-call provider scheduled depending on when the results are reported to the facility should be notified immediately of any critical or abnormal lab results. The DON confirmed the STAT lab turnaround times had not been communicated to the on-call providers to her knowledge. A facility policy related to responding to a change in condition was requested at the time of the survey, however, the facility did not have a policy. The deficiency represents non-compliance related to allegations contained in Complaint Number OH00153177.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on record review, interviews, observations, and policy review, the facility failed to ensure residents were seen by a podiatrist when needed. This affected three residents (#41, #75 and #89) of three residents reviewed for foot care. The census was 101. Findings include: 1. Review of Resident #41's medical record revealed an admitted [DATE] with diagnoses of cerebral infarction, weakness, soft tissue disorder, and diabetes type II. Review of Resident #41's plan of care dated 4/23/24 revealed interventions to refer to podiatrist/foot care. Observation and interview on 05/20/24 at 02:09 P.M. with Resident #41 revealed her toenails on both feet were long, thick, and curled around each toe. Resident #41 revealed she could not wear socks because they are too irritating to her toes. Interview and observation on 05/22/24 at 4:15 P.M. of Resident #41's feet with Licensed Practical Nurse (LPN) #650 confirmed Resident #41 is a diabetic and should have been referred to a podiatrist to care for her toes. The podiatrist visited the facility on 04/15/24. Interview on 05/22/24 at 3:50 P.M. with the Social Services Designee #663 confirmed Resident #41 has not been seen by a podiatrist. 49794 2. Review of medical chart for Resident #89 revealed an admitted [DATE]. Diagnoses include diabetes mellitus type two, wound left lower leg, peripheral vascular disease, and chronic obstructive pulmonary disease. Review of Minimum Data Set (MDS) assessment dated [DATE] for Resident #89 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, suggesting the resident was cognitively intact. The MDS revealed Resident #89 uses a wheelchair and a walker for mobility and is independent with eating and needs minimal assistance with activities of daily living such as dressing, transferring, and hygiene. Review of Resident #89 medical chart revealed no documentation of being seen by podiatry. Observation and interview with Resident #89 on 05/20/24 at 4:36 P.M. revealed bilateral toenails were approximately one inch past the end of his toes. The resident verified he would like them cut, and confirmed the facility is aware but stated no one would cut them. Observation on 05/22/24 at 4:20 P.M. with Unit Manager #650 confirmed Resident #89 needed to have his toenails cut. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 05/22/24 at 4:20 P.M. with Unit Manager #650 confirmed the staff provide skin treatment to the feet of Resident #89 daily and verified the staff would see that the nails needed to be cut. 41266 3. Review of the medical record for Resident #75 revealed an admitted on 07/05/22. Medical diagnoses included other psoriatic arthropathy, Hidradenitis suppurativa, schizophrenia, adjustment disorder with mixed anxiety and depressed mood, severe protein-calorie malnutrition, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #75 had intact cognition. Resident #75 required substantial to maximal assistance from staff to complete bathing and bed mobility, partial to moderate assistance with lower body dressing and refused to complete any transfers. Review of the HealthDrive Request for Services/Consultation form dated 04/02/24 revealed Resident #75 requested podiatry services. Review of the list of residents who were seen by the podiatrist on 04/15/24 revealed Resident #75 was not seen. Review of the progress notes revealed on 04/21/24 at an unknown time, Resident #75 was seen by Physician Assistant (PA) #620 for an ingrown toenail. The resident was noted to have an ingrown toenail to the medial aspect of her right first toe. The toe was nontender with palpation. The resident reported the pain was six out of ten (where ten was the worst pain) in severity. PA #620 recommended Resident #75 follow up with podiatry in house for further management. There was not any further documentation of follow up with podiatry services. Interview on 05/21/24 at 9:43 A.M. with Resident #75 revealed the resident had an ingrown toenail on her right foot. The resident stated she needed to receive treatment as it had been present for at least one month and was painful. Resident #75 stated when she first reported it to the facility staff, the staff did clean it and put a bandage on it. Resident #75 also stated she needed her toenails to be trimmed. Observation on 05/21/24 at 9:43 A.M. of Resident #75's toenails revealed the resident's toenails were very long and yellowish in color. The toenail on her great toes were observed to be so long that they had started to curve downward over the top of her toe. Observation and interview on 05/22/24 at 4:25 P.M. with Unit Manager (UM) #668 confirmed Resident #75's toenails were too long. Resident #75 stated, I have asked for them to be cut, but no one has addressed the issue. UM #668 confirmed the resident's toenails needed to be trimmed and she agreed to address it for the resident. Observation on 05/23/24 at 9:47 A.M. revealed the resident's toenails remained very long and yellowish in color. Resident #75 confirmed she had received a bed bath on Monday, 05/20/24 but her toenails were not addressed. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note dated 05/23/24 at an unknown time (after surveyor intervention), confirmed Resident #75 was seen by Certified Nurse Practitioner (CNP) #720 for an evaluation and management of painful of ingrown toenail of her right great toe. The resident's right great toe area was intact, slightly pink, with no swelling or drainage. The area was painful with palpitation. Resident #75 reported previously having an ingrown toenail to the same area before. Toenails to bilateral lower extremities appeared very long and pointy with normal thickness. Toenails would be clipped today and evaluate for the need for a nail extraction in the future if the problem persists. Toenails were clipped today and Resident #75 expressed relief of pain after the procedure. Review of the facility policy, Social Services Referral to Outside Providers, dated 10/27/23 revealed the policy stated, Referrals to ancillary providers will be made in order to meet the psychosical and/or concrete needs of a resident while safeguarding protected health information. Referrals would be made with consent from the resident as needed. A social service staff member, a licensed nurse, or a member of the Interdisciplinary Team (IDT) will make the referral based on a resident's individualized, specific needs as identified through interviews, evaluations, and assessments.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review and resident and staff interviews, the facility failed to ensure staff consistently implemented a resident's indwelling urinary catheter care. This affected one (#85) out of one residents reviewed for indwelling catheter care. Facility census was 101. Findings include: Review of the medical record for Resident #85 revealed an initial admitted on 06/08/23 and a readmitted on 04/22/24. Diagnoses include infection and inflammatory reaction due to indwelling urethral catheter (04/22/24), urinary tract infection (04/22/24), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (06/08/23), neuromuscular dysfunction of bladder (06/08/23), and retention of urine (06/08/23). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #85 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #85 required total dependence on staff to complete toileting. Resident #85 had an indwelling catheter. Review of the Treatment Administration Record (TAR) dated March 2024 revealed Resident #85's Foley catheter was changed on 03/28/24 as ordered. Review of the Medication Administration Record (MAR) dated April 2024 revealed Resident #85 received Finasteride Oral Tablet five milligrams (mg) daily for BPH as ordered and Tamsulosin Hydrochloride Oral Capsule 0.4 mg daily for BPH as ordered. There was no order to monitor urine outputs from Resident #85's Foley catheter. Review of the TAR dated April 2024 revealed Resident #85 received Foley catheter care every shift (twice a day) as ordered, Resident #85's Foley catheter was noted to be straight draining every shift as ordered. Review of the care plan dated 06/09/23 and revised on 05/07/24 revealed Resident #85 was at risk for UTI and catheter-related trauma due to having an indwelling catheter. Interventions included change catheter and tubing per facility policy, enhanced barrier precautions (added on 05/07/24), may irrigate catheter for occlusion as ordered (added on 05/07/24) , observe and document for pain or discomfort due to catheter, observe and document output as per facility policy (added on 05/07/24), observe, record, and report to the physician signs or symptoms of UTI including: pain, burning, red tinged urine, cloudiness, no output, deepening of urine color, increased temperature, foul smelling urine, fever, chills, altered mental status, changes in behavior, or changes in eating patterns, position catheter bag and tubing below the level of the bladder and observe for any kinks each shift, and provide catheter care per policy. Interviews on 05/20/24 at 3:37 P.M. and 05/22/24 at 1:06 P.M. with Resident #85 revealed his Foley catheter care had not been completed by the facility staff daily. Resident #85 stated, they may clean it once a month. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 2:02 P.M. and 2:05 P.M. the Director of Nursing (DON) and Regional Nurse (RGN) #810 were interviewed regarding documentation of Resident #85's catheter care. The DON stated the nurses documented it and RGN #810 stated, No. It is documented by the STNA's under a task in the electronic medical record. Task documentation for Resident #85 was reviewed with RGN #810 and it was confirmed there was not a task created for Foley catheter care. The DON and RGN #810 confirmed after further review, there was not a task created in any of the residents' electronic medical records who had a Foley catheter for documentation of Foley catheter care by the STNA's. Interview on 05/23/24 at 2:05 P.M. with RN #733 confirmed she marked Foley catheter care as completed when she emptied the catheter bag. Reviewed of the TAR for Resident #85 dated April 2024 with RN #733 revealed the nurse confirmed she marked Foley catheter care as administered on 04/10/24, 04/14/24, and 04/17/24 during day shift but only the catheter bag had been emptied and she did not perform catheter care.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, staff interview and facility policy review, the facility failed to ensure a residents pain medication was available and administered as physician ordered. This affected one (#85) out of three residents reviewed for medication administration. Facility census was 101. Findings include: Review of the medical record for Resident #85 revealed an initial admitted on 06/08/23 and a readmitted on 04/22/24. Medical diagnoses included infection and inflammatory reaction due to indwelling urethral catheter (04/22/24), urinary tract infection (04/22/24), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (06/08/23), neuromuscular dysfunction of bladder (06/08/23), and retention of urine (06/08/23). Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had impaired cognition and scored an eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #37 required setup or clean-up assistance from staff with eating; supervision or touching assistance with oral hygiene; substantial or maximum assistance with upper body dressing; and was totally dependent on staff assistance to complete toileting, bathing, lower body dressing, bed mobility, and transfers. Review of the Medication Administration Record (MAR) dated April 2024 revealed Resident #85 had a physician's order for Meloxicam five milligrams (mg) to be administered once daily related to Osteoarthritis. Resident #85 did not receive the medication on 04/13/24, 04/16/24, 04/24/24, 04/25/24, or 04/29/24. Review of the electronic MAR progress notes (e-MAR) revealed on 04/13/24 at 12:44 P.M., Meloxicam medication was not in the facility. Followed up with the pharmacy and awaiting the pharmacy to drop ship the medication. On 04/16/24 at 11:06 A.M., Meloxicam medication was on order and the nurse would follow up with the pharmacy. On 04/24/24 at 1:15 P.M., Meloxicam medication was not in house. Followed up with the pharmacy. The pharmacy stated they did not carry the medication and recommended an alternative medication, Celebrex 200 mg once daily. On 04/25/24 at 1:31 P.M., Meloxicam medication was on order. On 04/29/24 at 10:45 A.M., Meloxicam medication was on order. The pharmacy stated Resident #85's insurance did not cover the cost of the medication. Review of the progress notes dated April 2024 revealed there was no indication Resident #85's physician was notified the resident had missed six doses of Meloxicam due to the medication not being available in the facility. Interview on 05/22/24 at 2:36 P.M. with the Director of Nursing (DON) confirmed Resident #85 did not receive Meloxicam medication for arthritis pain on the above dates due to the medication was not available in the facility. The DON confirmed the nursing staff should have followed up Resident #85's physician prior to the resident missing six doses of the medication for further instruction. Review of the facility policy, Physician's Order, dated 10/20/23, revealed the policy stated, treatment rendered to a resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The deficiency represents non-compliance related to allegations contained in Complaint Number OH00153714.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on observations, medical chart review, policy review, and staff interviews, the facility failed to ensure a medication error rate of less than 5%. Four medication errors out 33 medication administration observations resulted in an error rate of 12%. This affected two residents (#35,and #159) of four residents (#35, #71, #159, and #73) observed for medication administration. The facility census was 101. Findings include: 1. Review of medical records for Resident #35 revealed an admitted [DATE]. Diagnoses include diabetes mellitus type two (DMII), chronic kidney disease, polyosteoarthritis, cellulitis, and generalized weakness. Review of orders dated 03/20/23 for Resident #35 revealed an order for blood glucose (sugar) monitoring (BGM) twice a day. Orders dated 02/15/23 for Resident #35 revealed order for Lantus Solution 100 unit/milliliter (ml) (Insulin Glargine) 65 units twice a day for DMII. Observation on 5/22/24 at 7:35 A.M. of Nurse #667 revealed Nurse #667 entered the room of Resident # 35 without completing hand hygiene. Further observation revealed Nurse #667 placed the blood glucose monitor (BGM), lancet, Lantus Solution 100 units/milliliter (insulin glargine) pen, alcohol prep pad, and container of blood glucose monitoring strips (BGMS) on the bed next to the resident. After wiping Resident #35 's finger with an alcohol wipe, Nurse #667 removed their gloves, did not perform hand hygiene and left the room to get another alcohol wipe from the cart. Nurse #667 put on clean gloves and reentered Resident #35's room but did not perform hand hygiene. Nurse #667 preceded to get a test strip out of the test strip container, pick up the glucometer from the bed, place the test strip in the glucometer, cleanse the resident's finger with a alcohol prep pad, stick the residents finger with the lancet, obtained a drop of blood from the resident's finger and placed the resident's finger at the end of the test strip so the drop of blood could transfer to the test strip and obtain a blood glucose reading. Nurse #667 then removed their gloves and discarded the used glucose monitoring strip. Nurse #667 put on new gloves and used an alcohol wipe to cleanse the administration site and then administered 65 units of Lantus Solution from the insulin pen. Nurse #667 did not prime the insulin pen prior to administering 65 units. Interview on 05/22/24 at 7:45 A.M. with Nurse #667 confirmed insulin pen was not primed prior to administration. Review of Safe Insulin Pen Practices document revealed staff should always prime then dial for the correct dosage when using insulin pens. Review of Medication administration policy dated 3/01/13 last revised 10/17/23 revealed medications should be administered in an accurate, safe, timely, and sanitary manner and that hand hygiene should be performed prior to medication preparation and after patient contact. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Review of medical chart for Resident #159 revealed and admitted [DATE]. Diagnoses include fracture of left femur, diabetes mellitus type two, hypertension, depression, Vitamin D deficiency, supraventricular tachycardia, and hyperparathyroidism. Review of orders for Resident #159 revealed orders include order dated 5/17/24 for Cyanocobalamin Injection Solution 1000 micrograms/milliliter (mcg/ml) (Cyanocobalamin) Inject 3 ml intramuscularly one time a day every Monday, Wednesday, Friday for Vitamin B12 Deficiency, order dated 5/17/24 for Calcium Carbonate-Vitamin D oral tablet 500 milligram(mg)-5 mcg (Calcium Carbonate-Vitamin D) 1 tablet by mouth one time a day for supplement, and order dated 5/17/24 for Carvedilol oral tablet 6.25 mg (Carvedilol) give 3 tablets (18.75 mg) by mouth two times a day for hypertension. Observation on 05/22/24 at 8:58 A.M. of medication administration with Nurse #657 revealed Resident #159 was given one tablet of 6.25 mg carvedilol when order was for three tablets equaling 18.75 mg of carvedilol. Nurse #657 gave Resident #159 calcium carbonate 500mg without Vitamin D and did not administer Vitamin B12 (cyanocobalamin) 1000 (mcg/ml) 3 ml injection per order. Interview on 5/22/24 at 9:17 A.M. with Nurse #657 and ADON confirmed 1 tablet of 6.25 mg of carvedilol was given, and order was for calcium carbonate with Vitamin D 500mg/5mcg but calcium carbonate 500mg without Vitamin D was given and that Resident #159 was not given B12 injection as ordered. Review of Medication administration policy dated 3/01/13 last revised 10/17/23 revealed medications should be administered in an accurate, safe, timely, and sanitary manner. The deficiency represents non-compliance related to allegations contained in Complaint Number OH00153714.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on observation, medical records review, policy review, and staff interview, the facility failed to prime an insulin pen prior to administration, resulting in a significant medication error. This affected one (Resident #35) of four residents observed for medication administration. Facility census was 101 Findings include: Review of medical records for Resident #35 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type two (DMII), chronic kidney disease, polyosteoarthritis, cellulitis, and generalized weakness. Review of physician orders dated 03/20/23 for Resident #35 revealed an order for blood glucose (blood sugar) monitoring twice a day. Orders dated 02/15/23 for Lantus Solution 100 unit/milliliter (ml) (Insulin Glargine) 65 units twice a day for DMII. Observation on 05/22/24 at 7:35 A.M. revealed Registered Nurse (RN) #667 administered 65 units of Lantura Soluation from the insulin pen to Resident #35 without priming the insulin pen prior to administration. Interview on 05/22/24 at 7:45 A.M. with RN #667 confirmed the insulin pen was not primed prior to administration. Review of Safe Insulin Pen Practices document revealed staff should always prime then dial for the correct dosage when using insulin pens. Review of Medication administration policy last revised 10/17/23 revealed medications should be administered in an accurate, safe, timely, and sanitary manner. The deficiency represents non-compliance related to allegations contained in Complaint Number OH00153714.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 36648 Based on observations and staff interview, the facility failed to ensure garbage and refuse is disposed of properly. This had the potential to affect all 101 residents residing in the facility. The census was 101. Findings include: Observation of the facility parking lot on 05/21/24, at 6:50 A.M. revealed one large garbage dumpster and three large recycling dumpster's located in the back of the building parking lot. The garbage dumpster was separated from the three recycling dumpster's. To the right of the dumpster revealed several broken porcelain tiles in a pile with white powder around each tile. Observation of the area to the left close of the dumpster revealed an extra-large rolling plastic garbage can no lid filled with garbage bags and yellow like refuse stuck to the handle of the can. Directly below the handle was additional yellow refuse. Around the outside of the dumpster there were four scattered used rubber gloves, plastic bottles, used face masks and additional refuse laying on the cement around the dumpster. Tour of the garbage dumpster area on 05/21/24, at 7:10 A.M. with Dietary Employee #716 verified there was an extra-large rolling plastic garbage can, no lid filled with garbage bags and yellow like refuse stuck to the handle of the can. Directly below the handle was additional yellow refuse. Around the outside of the dumpster there were four scattered used rubber gloves, plastic bottles, used face masks and additional refuse laying on the cement around the dumpster. To the right of the dumpster were several broken porcelain tiles in a pile with white powder around each tile.

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on record review, observations, staff interviews, and policy review, the facility failed to follow infection control protocols during glucose testing for Resident #35. This affected one (#35) out of three residents observed for glucometer checks and had the potential to affect 10 (#15, #24, #33, #35, #77, #38, #71, #69, #35 and #7) residents that receive blood glucose monitoring (BGM) using a shared glucometer. Additionally, the facility failed to ensure infection control practices were followed during catheter care for Resident #85. This affected one (#85) of one resident observed for catheter care. The facility census was 101. Findings include: 1. Review of medical records for Resident #35 revealed an admitted [DATE]. Diagnoses include diabetes mellitus type two (DMII), chronic kidney disease, polyosteoarthritis, cellulitis, and generalized weakness. Review of orders dated 03/20/23 for Resident #35 revealed an order for blood glucose (sugar) monitoring (BGM) twice a day. Orders dated 02/15/23 for Resident #35 revealed order for Lantus Solution 100 unit/milliliter (ml) (Insulin Glargine) 65 units twice a day for DMII. Observation on 5/22/24 at 7:35 A.M. of Registered Nurse (RN) #667 revealed the nurse entered the room of Resident #35 without completing hand hygiene. Further observation revealed RN #667 placed the blood glucose monitor (BGM), lancet, Lantus Solution 100 units/milliliter (insulin glargine) pen, alcohol prep pad, and container of blood glucose monitoring strips (BGMS) on the bed next to the resident. After wiping Resident #35 's finger with an alcohol wipe, RN #667 removed their gloves, did not perform hand hygiene and left the room to get another alcohol wipe from the cart. RN #667 put on clean gloves and reentered Resident #35's room but did not perform hand hygiene. RN #667 preceded to get a test strip out of the test strip container, pick up the glucometer from the bed, place the test strip in the glucometer, cleanse the resident's finger with a alcohol prep pad, stick the residents finger with the lancet, obtained a drop of blood from the resident's finger and placed the resident's finger at the end of the test strip so the drop of blood could transfer to the test strip and obtain a blood glucose reading. RN #667 then removed their gloves and discarded the used glucose monitoring strip. RN #667 put on new gloves and used an alcohol wipe to cleanse the administration site and then administered 65 units of Lantus Solution from the insulin pen. RN #667 returned to the cart, removed gloves and completed hand hygiene. RN #667 cleaned the BGM by wiping it with an alcohol pad and used the same alcohol pad to wipe a small section of the BGMS container. Interview on 05/22/24 at 7:45 A.M. with RN #667 confirmed the BGM and BGMS container was taken into Resident #35's room, wiped with an alcohol wipe and device/container was placed back in cart. During observation on 05/22/24 at 7:47 A.M. of medication administration with RN #667, Unit Manager #668 came to also watch RN #667 during medication administration. Interview on 05/22/24 at 7:48 with Unit Manager #668 confirmed staff should be performing hand hygiene prior to going into room and putting on gloves. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/22/24 at 7:50 A.M. with RN #667 revealed the nurse returned to Resident #35's room to apply a lidocaine patch and give two tablets of Tylenol 325 milligrams. Observation on 05/22/24 at approximately 7:52 A.M., the ADON joined to also watch medication administration with RN #667. Observation on 05/22/24 at 7:58 A.M. Unit Manager #668 asked RN #667 if they cleaned the glucometer and RN #667 said yes. RN #667 confirmed they cleaned the glucometer with an alcohol pad. Unit Manager #668 and ADON confirmed that was incorrect and not the facility policy and further advised RN #667 to reclean glucometer with sanitizing wipes per policy and that they would need to wait the allotted contact time before next use. RN #667 recleaned glucometer using Super SANI- Cloths located in the bottom of the nursing cart and allowed the required two-minute contact time. Interview on 5/22/24 at 8:21 A.M. with ADON confirmed glucometer's should not be cleaned with alcohol pads. The ADON stated they do audits of medication administration on a weekly basis with all of the nursing staff to ensure glucometer's are disinfected appropriately. The facility confirmed there are 10 (#15, #24, #33, #35, #77, #38, #71, #69, #35 and #7) residents that shared the facility glucometer. Review of Glucometer and PT/INR Decontamination policy dated 6/24/22 confirmed the correct procedure is to perform hand hygiene after performing testing, apply gloves, use disinfectant wipe to clean all external parts of glucometer, allow glucometer to remain wet for the required contact time, remove gloves and perform hand hygiene. 36297 2. Review of Resident #85's medical record revealed the resident was admitted on [DATE] with the most recent readmitted [DATE]. Diagnoses include infection and inflammatory reaction related to indwelling urethral catheter, urinary tract infection, benign prostatic hyperplasia, neuromuscular dysfunction of the bladder, anxiety, Vancomycin resistance, and schizoaffective disorder. Review of Resident #85's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact, had an indwelling urinary catheter, was incontinent of stool and was coded as dependent on staff for toileting. Review of Resident #85's physician orders included an order for Foley catheter care every shift dated 04/25/24. (continued on next page)

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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of Resident #85's indwelling Foley catheter care on 05/22/24 at 1:12 P.M. by State tested Nursing Assistant (STNA) #637. STNA #85 was observed to enter the room with gown and gloves on as the resident was in enhanced barrier precautions. Resident #85's penis was cleansed with a soapy washcloth in a circular pattern from the inner aspect of the tip of the penis toward the outside using a different clean part of the washcloth with each swipe of the cloth. The tip of the penis was then rinsed with different wash cloth in the same manner. STNA #637 then stated he was changing gloves and was observed to remove his soiled gloves and there were other gloves on his hands under the gloves he removed from his hands. STNA #637 was asked if he had two pairs of gloves on and he stated yes the STNA was observed to take a soapy wash cloth and cleanse the Foley catheter from the tip of the penis away from the penis. STNA #637 was then observed to rinse the Foley catheter tubing in the same pattern. STNA #637 then removed gloves and repositioned the resident bed covers. STNA #637 completed hand hygiene at the end of the procedure. Interview with the Director of Nursing (DON) and Regional Nurse #810 on 05/22/24 at 2:02 P.M. confirmed double gloves are not the standard and gloves should only be worn one pair at a time.