

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Laurels of West Columbus, The		STREET ADDRESS, CITY, STATE, ZIP CODE 441 Norton Road Columbus, OH 43228	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review, facility investigation review, staff interview, and facility policy review, the facility failed to complete a thorough investigation in regard to a resident's injury of unknown origin. This affected one (Resident #44) of three residents investigations reviewed. The census was 88.</p> <p>Findings Include:</p> <p>Resident #44 was admitted to the facility on [DATE]. Her diagnoses were displaced bicondylar fracture of left tibia, muscle weakness, need for assistance with personal care, Type II Diabetes, atrial fibrillation, ischemic cardiomyopathy, congestive heart failure, hypertensive heart disease, pulmonary hypertension, obstructive sleep apnea, anemia, insomnia, hypothyroidism, atherosclerotic heart disease, chronic kidney disease, and personal history of trans ischemic attack (TIA). Review of the Minimum Data Set (MDS) assessment, dated 02/11/25, revealed the resident was cognitively intact.</p> <p>Review of Resident #44's progress note, dated 03/15/25, revealed Resident #44 complained of pain in left leg. The nurse assessed her leg and found Resident #44's knee to be red and warm to touch. The nurse contacted the nurse practitioner who ordered ultrasound of leg, increased Tylenol (analgesic) every four hours as needed, and ordered Lidocaine (local anesthetic) 4% patch.</p> <p>Review of Resident #44's progress note, dated 03/16/25, revealed she had a Doppler procedure (a non-invasive test that uses sound waves to visualize and assess blood flow in arteries and veins) completed and found she did not have a deep vein thrombosis (DVT), so that was not causing her pain.</p> <p>Review of Resident #44's progress note, dated 03/17/25, revealed she had an orthopedic appointment scheduled for 03/24/25 to determine the cause of the pain in her left leg.</p> <p>Review of Resident #44's physical therapy note, dated 03/17/25, revealed Resident #44's daughter went to the gym and informed the therapists she was in increased pain. She also informed the therapists the facility had a Doppler completed to rule out a DVT, which the results were negative.</p> <p>Review of Resident #44's x-ray results, dated 03/18/25, revealed it appeared she had an acute appearing proximal tibia stress fracture. She was to follow up with her orthopedic physician.</p> <p>(continued on next page)</p>

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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #44's progress notes, dated 03/20/25, revealed she went to an orthopedic physician appointment, and within this appointment, it confirmed she had a left patellar fracture. There was no evidence to support this fracture was related or an extension of her existing left tibia fracture that she was admitted to the facility with.</p> <p>Review of Resident #44's nurse practitioner progress note, dated 03/20/25, revealed a post orthopedic follow up found a new minimally displaced midpole patella fracture (occurs when a bone breaks, and the fractured ends are no longer properly aligned). There was nothing documented to determine whether this was an extension of her existing fracture or a new fracture.</p> <p>Review of facility Self Reported Incident (SRI) number 258407, dated 03/19/25, revealed an investigation for an injury of unknown origin was opened regarding Resident #44's new fracture that was identified on 03/18/25. The facility interviewed residents, certified nursing aides (CNA), and nurses regarding this newly identified fracture with no answers as to how it occurred; therapy staff was not interviewed. The investigation was officially closed on 03/24/25, with the findings stating that the fracture was identified as being part of the existing tibia fracture; which ultimately ended up being inaccurate.</p> <p>Review of Resident #44's physician progress note, dated 03/26/25 (late entry added on 04/16/25), confirmed the patellar fracture from 03/18/25 was not an extension of the existing tibia fracture, but was a new fracture.</p> <p>Interview with Admin on 04/14/25 at 1:55 P.M. confirmed she closed the SRI on 03/24/25 after it was determined that the fracture was an extension of the existing fracture she was admitted with. She confirmed she found out after she closed the investigation the physician's determination of the fracture being an extension of the admission injury was incorrect. She confirmed she probably should have opened the SRI back up and made the findings more accurate. She also confirmed they did not interview any therapy staff to determine if they knew when/how the injury occurred.</p> <p>Review of facility Abuse Prohibition policy, dated 10/14/22, revealed each resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Injuries of unknown source was defined as an injury the source of the injury with all the following criteria met: the source of the injury was not observed by any person, the source of the injury could not be explained by the resident, the injury is suspicious because of the extent of the injury or the location of the injury, or the number of injuries observed at one particular point in time or the incidence of injuries over time. The investigation may consist (as appropriate) of: a review of the completed incident report, an interview with the person reporting the incident, interviews with any witnesses to the incident, an interview with the guest/resident (if possible), a review of the resident's medical records, and a review of all circumstances surrounding the incident.</p>		