STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366481	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of West Columbus, The	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, and policy review, the facility failed to ensure residents received necessary care and services so they could attend outside medical appointments. This affected two (#14, #81) of three residents reviewed for appointments. The census was 79. Findings include: Medical record review for Resident #14 revealed an admission date of 04/26/25. Medical diagnoses included malignant neoplasm of part of right bronchus lung, cancer, malnutrition, depression, and history of falling. Review of fax from the chemotherapy physician dated 07/31/25 revealed to draw these labs on 08/01/25 and every other Friday. The labs were B-12 Folate, Iron study with ferritin, Cortisol random, Thyroid Stimulating Hormone (TSH) with reflex, free T-4, Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC) with differential, and Adrenocorticotropic Hormone Blood Test (ATCH). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact. His functional status was partial/moderate assistance for eating, dependent for toileting, substantial/maximal assistance for bed mobility, and transfers were non-applicable. He was occasionally incontinent of bladder and frequently incontinent for bowel. He was coded for a feeding tube. Review of the chemotherapy appointments for Resident #14 revealed he had one scheduled for 08/21/25. Further review for this appointment revealed it had to be rescheduled due to labs done incorrectly. Interview with Resident #14 on 08/28/25 at 10:32 A.M. revealed he has missed a chemotherapy treatment due to the labs not being collected correctly but couldn't remember the dates. Interview with Licensed Practical Nurse (LPN) #250 on 08/28/25 at 10:45 A.M. revealed Resident #14's labs were messed up on 08/18/25 when they came out to draw blood, they got a PT and INR and that was wrong. Then she ordered them to come back on 08/19/25 and she put in a STAT lab so the facility could get the resident to chemotherapy, but the lab drew everything except the CMP. She reported his 08/21/125 appointment had to be cancelled and rescheduled for 08/26/25. She confirmed the resident missed his appointment due to the lab work not being collected properly. 2. Review of records for Resident #81 revealed admission date 09/13/22. discharge date [DATE]. Diagnoses included chronic diastolic heart failure, hypertension, chronic kidney disease stage two, irritable bowel syndrome, non-pressure chronic ulcer right calf with fat layer exposed, anxiety disorder, and overactive bladder. Review of quarterly MDS dated [DATE] revealed that Resident #81 was cognitively intact. She required setup or clean-up for meals, and dressing upper body. Resident #81 was substantial to maximum for dressing lower body and putting on and off shoes. Resident #81 was partial to moderate assistance for bathing, personal hygiene, toileting, and oral hygiene. Resident #81 used a wheelchair and ambulating with no assistance at the facility. Review of physician orders dated 08/26/25 revealed Calcitriol Capsule 0.5 microgram (mcg) to give one a day for low calcium at 9:00 A.M. Review of the medical appointments for Resident #81 revealed she had one dated 09/02/25 at 11:15 A.M. for a bone density testing. Interview with Resident #81 on 09/02/25 at 10:08 A.M. revealed she wasn't going to her appointment for a bone density at 11:15 A.M. because the staff gave her a calcium medication last night. Interview with LPN #200 on 09/02/25 at 10:15 A.M. confirmed Resident #81's appointment had to be rescheduled for 09/04/25 because there wasn't an order to hold the Calcitriol before the appointment and the resident was given medication on 09/01/25. Review of policy entitled Resident Rights dated 09/13/25 revealed the facility must protect and promote the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This deficiency represents non-compliance investigated under Complaint Number 2599291.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, staff interview, Power of Attorney (POA) interview, closed medical record review, review of a facility submitted Self-Reported Incident (SRI), review of hospital records and review of the facility policy, the facility failed to ensure Resident #83, who had a diagnosis of dementia, had a previous elopement attempt from the facility, and had a Wanderguard (wearable bracelet that triggers alarms at the doors to alert when a resident attempts to exit) applied to his left ankle, did not elope from the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injury and/or death when on 08/03/25 Resident #83 was able to exit the facility through an unknown facility door and staff reported they did not hear the door alarms sound. Resident #83 was subsequently found lying in the local hospital parking lot, approximately one mile from the facility, by the hospital security staff. The resident was missing for an undetermined length of time and facility staff were unaware the resident was missing until the hospital staff called to notify them that the resident was in their emergency department (ED). This affected one (#83) of three residents reviewed for elopement. The facility identified three (#83, #52 and #84) residents at risk for elopement. The facility census was 79. On 08/21/25 at 2:46 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 08/03/25 when Resident #83 was able to exit the facility at an unconfirmed time during the early morning hours, through locked doors, without the door alarms sounding, and without staff knowledge. The facility did not have camera surveillance to verify which door the resident exited through or how the resident was able to elope without the door alarms sounding. Licensed Practical Nurse (LPN) #326 stated she believed she last saw Resident #83 at approximately 4:00 A.M. Resident #83 traveled with his walker down a four to five lane road with posted speed limits of 40 miles per hour (MPH) that was under construction and had manhole covers protruding from the ground. The local hospital ED staff contacted the facility at approximately 5:30 A.M., after the resident was found lying in their parking lot by their security staff. Although the Immediate Jeopardy was removed on 08/04/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until the deficient practice was corrected on 08/18/25 when the facility implemented the following corrective actions: On 08/03/25 at 8:00 A.M., Resident #83 returned to the facility. Licensed Practical Nurse (LPN) #303 assessed the resident and no new injuries were identified. On 08/03/25, Unit Manager (UM) #307 reassessed Resident #83's elopement risk and identified the resident at high risk for elopement. UM #307 reviewed Resident #83's care plan to ensure the accuracy of the resident's needs and interventions. On 08/03/25, UM #307 reassessed all residents for elopement risk and updated care plans as needed. Evidence was received verifying elopement risk assessments were completed and care plans were updated, as needed, on 08/03/25. On 08/03/25, Resident #83 was placed on one-to-one (1:1) staff supervision. The resident remained on 1:1 staff supervision until 08/13/25, when he discharged to another facility with a secured memory care unit. On 08/03/25 at 8:30 A.M., the Administrator performed a Root Cause Analysis and determined staff failed to provide adequate supervision to prevent Resident #83's elopement. Staff working at the time of the incident stated they did not hear the door alarm and did not see the resident exit the facility. On 08/03/25 at 9:00 A.M., Director of Maintenance (DOM) #331 checked all current residents (#52, #83, and #84) with Wanderguards for placement and functionality, with no negative findings. Evidence was received verifying this was completed on 08/03/25. On 08/03/25, DOM #331 checked all 11 of the facility's egress doors to ensure Wanderguard door alarms were operational, with no negative findings. Evidence was received verifying this was completed on 08/03/25. On 08/03/25, DOM #331 changed the access codes for all of the facility's egress doors. Evidence was received verifying this was completed on 08/03/25. On 08/03/25, the Administrator or designee conducted an elopement drill on each of the facility's two shifts, with no negative findings. DOM #331 or designee will continue to conduct elopement drills one-time weekly on each shift for four weeks. Any concerns will be addressed immediately. Evidence was received verifying elopement drills were completed on 08/03/25 on first and second shift, 08/09/25 on first and second shift, and 08/13/25 on first and second shift. Beginning on 08/03/25 and completed by 08/04/25, the Administrator or designee provided education to all staff on the facility's elopement policy, specifically the alarm activation procedure, code search investigation procedure (missing resident procedure), and control of

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure tube feeding was provided as physician ordered. This affected one (#14) of two residents reviewed for tube feeding. The census was 79.Findings include: Medical record review for Resident #14 revealed an admission date of 04/26/25. Medical diagnoses included malignant neoplasm of part of right bronchus lung, cancer, malnutrition, depression, and history of falling. Review of the care plan dated 04/26/25 revealed Resident #14 was unable to nutritionally consume adequate food or fluids by mouth. He required a tube feeding related to malnutrition and weight loss. Intervention was to administer tube feeding as ordered. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact. His functional status was partial/moderate assistance for eating, dependent for toileting, substantial/maximal assistance for bed mobility, and transfers were non-applicable. He was occasionally incontinent of bladder and frequently incontinent for bowel. He was coded for a feeding tube. Review of the admission orders dated 07/29/25 revealed Resident #14 was to be on an Enteral Feed Order one time a day Jevity 1.5 at 70 milliliters per hour (mL/hrs), at night (nocturnally) from 8:00 P.M. to 6:00 A.M. via PEG, via pump. Further review of Resident #14's medical record revealed on 07/31/25 the Jevity 1.2 was initiated for the resident, rather than the ordered Jevity 1.5. Interview with Licensed Practical Nurse (LPN) #250 on 08/28/25 at 12:56 P.M. revealed Resident #14 was admitted on [DATE] at 2:30 P.M. with orders for enteral feed for nighttime. LPN #250 stated the facility was out of the Jevity 1.5, so she asked if he could get the Jevity 1.2 until the Jevity 1.5 came in. LPN #250 confirmed he went without the Jevity 1.5 for two nights and the Jevity 1.2 was started on 07/31/25. This deficiency represents non-compliance investigated under Complaint Number 2599291.

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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** Based on medical record review, observations and staff and resident interviews, the facility failed to ensure medications were available from the pharmacy for administration. This affected one (#81) out of three residents reviewed for medication administration. The facility census was 79. Findings included: Review of the medical record for Resident #81 revealed the resident had a recent admission date 07/23/25. Diagnoses included chronic diastolic heart failure, hypertension, chronic kidney disease stage two, irritable bowel syndrome, non-pressure chronic ulcer right calf with fat layer exposed, anxiety disorder, and overactive bladder. Review of plan of care dated 09/22/22 revealed that Resident #81 was at risk for discomfort or adverse side effects related to receiving diuretics therapy related to congestive heart failure. Inventions included administering medication as ordered, encouraging residents to drink fluids, observe possible side effects every shift, and observing and reporting to physician dehydration or no urine. Review of plan of care dated 12/08/22 revealed that Resident #81 had risk for potential complications related to having ileostomy. Interventions included administer medication as ordered, use colostomy bag frequently, observe for diarrhea and report, and observe ostomy functioning every shift and amounts of stool passed. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #81 had Brief Interview of Mental Status (BIMS) of 15 that indicated cognitively intact. Resident #81 required setup or clean-up for meals, and dressing upper body. Resident #81 was substantial to maximum for dressing lower body and putting on and off shoes. Resident #81 was partial to moderate assistance for bathing, personal hygiene, toileting, and oral hygiene. Resident #81 used a wheelchair and ambulating with no assistance at the facility. Review of the physician order dated 08/25/25 at 4:30 P.M. revealed Resident #81 had an order for Lomotil 2.5-0.025 mg to give one tablet by mouth every four hours as needed for diarrhea. Observation on 08/25/25 at 11:01 A.M. with Resident #81 who asked for Lomotil 2.5-0.025 mg tablet from Licensed Practical Nurse (LPN) #284 during medication pass. Resident #81 told LPN #284 she asked last night with the night nurse and still had diarrhea. Interview on 08/27/25 at 11:03 A.M. with LPN #284 who stated Resident #81's Lomotil 2.5-0.025 mg tablets were not in her medication cart. LPN #284 verified that there was a physician orders active dated 08/25/25 for Lomotil for Resident #81. Interview on 08/27/25 at 11:05 A.M. with Director of Nursing (DON) stated that she expected staff to drop ship order the medication from pharmacy when ordering medication that was necessary. DON stated that the drop ship usually took four hours to receive the medication. Interview on 08/27/25 at 11:10 A.M. with Resident #81 stated she requested the Lomotil 2.5-0.025 mg tablet last night from the nurse, who stated it was not in stock. Resident #81 stated she would like Lomotil medication right now, because she was still having diarrhea. Interview on 08/27/25 at 4:07 P.M. with DON who stated that she called pharmacy about Resident #81 Lomotil 2.5-0.025 mg tablet. DON stated that Resident #81 arrived to the facility returning from the hospital on [DATE] at 5:34 P.M. DON stated she called the pharmacy who stated they needed a new prescription for Lomotil 2.5-0.025 mg tablet. DON stated the Lomotil 2.5-0.025 mg had not arrived at the at the facility yet. DON stated that the nurses were instructed for any resident who had medication that needed dropped shipped. DON stated that when medication was delivered was what the pharmacy was expecting in time frame. DON stated she had no facility policy on when facility had pharmacy delivering medication. This deficiency represents non-compliance investigated under Complaint Numbers 2597140 and 2567001.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff and resident interviews, the facility failed to ensure laboratory testing was completed as physician ordered. This affected one (#14) of three residents reviewed for laboratory testing. This census was 79. Findings include: Medical record review for Resident #14 revealed an admission date of 04/26/25. Medical diagnoses included malignant neoplasm of part of right bronchus lung, cancer, malnutrition, depression, and history of falling. Review of fax from the chemotherapy physician dated 07/31/25 revealed to draw these labs on 08/01/25 and every other Friday. The labs were B-12 Folate, Iron study with ferritin, Cortisol random, Thyroid Stimulating Hormone (TSH) with reflex, free T-4, Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC) with differential, and Adrenocorticotropic Hormone Blood Test (ATCH). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact. His functional status was partial/moderate assistance for eating, dependent for toileting, substantial/maximal assistance for bed mobility, and transfers were non-applicable. He was occasionally incontinent of bladder and frequently incontinent for bowel. He was coded for a feeding tube. Review of lab results dated 08/18/25 revealed the above labs were supposed to be collected, but a Prothrombin Time (PT) and International Normalized Ratio (INR) was collected. On 08/19/25 the above lab orders were supposed to be collected but all were collected except for CMP. Further review of the lab orders revealed to collect a CMP on 08/21/25. Interview with Resident #14 on 08/28/25 at 10:32 A.M. revealed he has missed a chemotherapy treatment due to the labs not being collected correctly but couldn't remember the dates. Interview with Licensed Practical Nurse (LPN) #250 on 08/28/25 at 10:45 A.M. revealed the labs were messed up on 08/18/25 when they came out to draw blood, they got a PT and INR and that was wrong. Then she ordered them to come back on 08/19/25 and she put in a STAT lab so the facility could get the resident to chemotherapy, but the lab drew everything except the CMP. She reported she had to get the CMP ordered for 08/21/25. She confirmed the labs were not collected properly. This deficiency represents non-compliance investigated under Complaint Number 2599291.