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	10/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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F 0609 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 interview, resident family interview, and review of self-reported incidents, the facility failed to conduct an investigation and report an allegation of potential neglect related to a resident elopement to the State Survey Agency. This affected one (#94) of three residents reviewed for elopements. The census was 89.Findings include:Review of the medical record for Resident #94 revealed an admission date of 08/29/25. Diagnoses included senile degeneration of the brain, chronic kidney disease, hypertension, diabetes, and heart failure.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had impaired cognition. The resident was assessed as independent for ambulation. Review of the nursing notes dated 09/05/25 at 3:26 P.M. revealed on that date, a staff member reported seeing a resident (#94) in her power wheelchair outside of a pizza restaurant down the street from the facility. Staff located the resident on [NAME] Road and escorted her back to the facility by 2:08 P.M. Resident #94 was assessed with no visible injuries but appeared confused and indicated she was trying to find her son's house and got lost. Further review revealed earlier the resident asked staff to remove her oxygen so she could go outside to smoke, and was last seen near the facility around 1:00 P.M.During an interview with Certified Nurse Aide (CNA) #164 on 10/05/25 at 3:17 P.M. confirmed she was off duty on 09/05/25 and was running errands about a mile away from the facility. She noticed Resident #94 riding away on her electric scooter from the facility. CNA #164 stated she called the facility staff to report the sighting of Resident #94 and the facility staff admitted to not realizing Resident #94 was outside the facility.Interview on 10/15/25 between 11:30 A.M. and 4:00 P.M. with three staff members who were working at the facility on 09/05/25 (Maintenance Director #136, Receptionist #119, and Licensed Practical Nurse (LPN) #179) all confirmed Resident #94 was found by staff about a mile from the facility on the afternoon of 09/05/25, and she appeared confused. During an interview with LPN #179 at 3:34 P.M. on 10/15/25, she stated she was not aware Resident #94 was outside of the facility prior to receiving the telephone call from CNA #164. She also confirmed Resident #94 had not signed herself out of the facility that day to notify the nursing staff that was leaving.During an interview with Resident #94's Family Member on 10/15/25 at 5:21 P.M., confirmed she was notified by the facility of Resident #94's elopement from the facility on 09/05/25. She confirmed Resident #94 had dementia and when Resident #94 was found by facility staff, the resident did not know where she was.Review of self-reported incidents submitted to the State Survey Agency from September and October 2025 revealed no submissions related to potential allegations of neglect regarding Resident #94's elopement from the facility on 09/05/25. No documentation was provided related to an investigation into the elopement. The elopement investigation file and the self-reported incident information were requested from the facility staff during the complaint investigation on 10/15/25 and 10/16/25. Interview on 10/15/25 at 2:40 P.M. with Regional Leader #800 confirmed a formal investigation did not commence regarding Resident #94's elopement and the incident was not reported to the State Survey Agency. Regional Leader #800 stated it was not reported because to his knowledge because Resident #94 had taken a temporary leave of absence from the facility by signing herself out at the nurses' station.This deficiency represents non-compliance investigated under Complaint Number 2642442.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to provide residents and representatives with discharge summaries to ensure a safe and orderly discharge from the facility. This affected one (#92) of three residents reviewed for discharge. The census was 89.Findings Include:Review of Resident #92's medical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Review of Resident #92's progress notes dated 09/27/25 revealed her son came to the facility and stated he wanted to take his mother home. The note revealed the nurse told her son he would need to sign against medical advice (AMA) documents prior to taking Resident #92 home. Further review revealed there was nothing else listed in the progress note about Resident #92 leaving the facility to go home. The note also revealed a nurse practitioner was made aware of the AMA decision. Review of Resident #92's progress note dated 09/28/25 revealed Resident #92 was in her wheelchair, in a taxi to leave, but there was no information to support Resident #92 was actually discharged from the facility. Review of Resident #92's medical documents found no documentation to support required discharge information, including a discharge summary, was offered or sent with Resident #92 or her family, and there was no documentation to support the facility attempted to have Resident #92 or her family sign any AMA documents. Interview with Licensed Practical Nurse (LPN) #129 on 10/16/25 at 2:15 P.M. confirmed there was no documentation to support a safe and orderly discharge was completed for Resident #92. She confirmed there should have been documentation to support a discharge summary was reviewed prior to leaving. Review of a facility transfer and discharge policy, dated 2025, revealed the transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. The contents of the notice must have the reason for the transfer or discharge, the effective date of transfer or discharge, the specific location to which the resident is transferred or discharged , a statement of the resident's appeal rights, and the contact name, address, and telephone number of the ombudsman. When an anticipated discharge is scheduled, the post discharge plan of care and summary is developed prior to his or her discharge. Social services/designee will review the plan with the resident and, with consent, the resident's representative, at least 24 hours prior to discharge or as soon as practicable of the resident's discharge from the facility. Nursing is to document the discharge or transfer in the progress note. This deficiency represented non-compliance investigated under Complaint Number 2622442.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure treatments for care of spine incisions were completed as ordered. This affected one (#91) of three residents reviewed for treatments. The census was 89.Findings Include:Review of the medical record revealed Resident #91 was admitted to the facility on [DATE]. Diagnoses included infection and inflammatory reaction, fusion of the spine, chronic obstructive pulmonary disease, alcohol dependence, atherosclerotic heart disease, congestive heart failure, hypertensive heart disease, presence of coronary angioplasty implant and graft, hyperlipidemia, anemia, hypo-osmolality and hyponatremia, depression, cardiomyopathy, and other seizures. Review of Resident #91's Minimum Data Set (MDS) assessment, dated 09/19/25, revealed the resident was cognitively intact. Review of Resident #91 After Visit Summary dated 09/17/25 revealed instructions to check his cervical spine incision daily for redness or drainage. Further review revealed the resident needed to keep the wound covered with a Medipore island dressing to be changed daily or as needed. Also, for the Jackson Pratt (JP) drain (a thin, flexible tube with a bulb on the end that drains fluid away from a wound after surgery), basic care was instructed as cleaning around the tube exit site daily.Review of Resident #91 treatment administration records (TAR), dated September 2025, revealed an order for staff to cleanse his incision to the cervical spine with normal saline and patted dry then apply a conventional compress dressing (CCD) to the site. The treatment was to be completed daily. Also for Resident #91's JP drain site, it was to be cleansed with normal saline and patted dry then apply a sponge to site. This was to be completed daily. Both of these treatments were ordered and entered into Resident #91's medical record to be completed starting 09/20/25. Further review revealed Resident #91 was discharged from the facility on 09/19/25, so for the entirety of his stay, 09/17/25 to 09/19/25, he did not have either treatment/dressing change completed. Interview with Licensed Practical Nurse (LPN) #129 on 10/16/25 at 2:15 P.M. confirmed the orders for the treatments listed above for Resident #91 should have been in place and completed at the time he was admitted , but were not completed, and confirmed she was not sure why the orders were not confirmed at the time of admission and put in place to be completed.This deficiency represented non-compliance investigated under Complaint Number 2622442 and continued non-compliance from the survey dated 09/08/25 .

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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** Based on medical record review, staff interview, and policy review, the facility failed to ensure residents were free from significant medication errors. This effected one (#93) of three residents reviewed for medication administration. The facility census was 89.Findings include:Record review for Resident #93 revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, dysphagia, orthostatic hypertension, and chronic heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #93 had intact cognition and was assessed to require self-care assistance.Review of physician orders for Resident #93 revealed medication orders including three furosemide (Lasix) 20 milligram (mg) oral tablets once daily, ordered on 09/27/25 and discontinued 09/30/25 for a diuretic. In addition, there was an order for one furosemide 80 mg oral tablet once daily, beginning 09/29/25 and discontinued 10/06/25.Review of the September 2025 medication administration record (MAR) for Resident #93 revealed that both orders of furosemide (three 20 mg tablets and one 80 mg tablet) were administered on 09/29/25 and 09/30/25.During an interview with Medical Director #1 (Resident #93's physician) on 10/16/25 at 1:48 P.M. confirmed the order for three furosemide 20mg oral tablets once daily should have been discontinued on 09/29/25, when the second order (one furosemide 80mg oral tablet once daily) was initiated on 09/29/25. Medical Director #1 stated Resident #93 should have received 80 mg of furosemide per day, and not 140 mg total, which she received on 09/29/25 and 09/30/25 and confirmed the resident received the additional doses of the medication on 09/29/25 and 09/30/25.Review of the facility policy titled, Medication Administration, revised 10/17/23, revealed medications are to be administered in accordance with the orders of the attending physician.This deficiency represents non-compliance investigated under Complaint Number 2642442.