

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 04/13/2026
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure bags of enteral nutrition product and water for tube feeding were labeled and dated appropriately for Residents #56 and #79. This affected two (#56 and #79) of two residents in the facility with active orders for tube feeding. The facility census was 79. Findings include: 1. Review of the medical record for Resident #56 revealed the resident was admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus, adult failure to thrive, mild protein-calorie malnutrition, and gastrostomy status (a gastrostomy is a surgical opening in the abdominal wall, often for the use of a feeding tube). Further review of the medical record for Resident #56 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Additional review of Resident #56's medical record revealed physician orders for a nothing by mouth diet, with an enteral (tube) feeding order for Osmolite 1.2 to start daily in the evenings at 6:00 P.M. and run at 100 milliliters (mL) per hour for 14 hours with flushes of water through the feeding tube running at 40 mL per hour. Resident #56 also had an active order for enhanced barrier precautions related to enteral feedings. Observations on 04/08/26 at 6:16 P.M. revealed two full bags, one of enteral nutrition and one bag of water hanging on a pole next to Resident #56's bedside, with lines attached to both bags though not hooked up to the resident. Observation revealed the enteral nutrition formula was not hung on the pole in its original packaging, rather the formula appeared to have been poured into an unlabeled plastic bag used for tube feeding. The feeding tube pump was not running. Observation revealed neither bag was labeled at all, including no label or marking available to indicate the date/time the water and tube feed formula was poured into the bags, and no label marked on the bag of tube feeding formula to indicate which type of tube feeding formula was in the bag, nor was there any marking to indicate the amount of formula to be administered per hour or over a set amount of time to reflect the rate ordered by the physician. Further observation at this time revealed the door to resident #56's room was marked with an enhanced barrier precautions sign and personal protective equipment (PPE) was available outside the door. Observation on 04/08/26 at 6:26 P.M. revealed Licensed Practical Nurse (LPN) #101 entered Resident #56's room to start the 6:00 P.M. tube feeding. Further observation at this time revealed LPN #101 accessed Resident #56's feeding tube and then proceeded to flush the feeding tube using a syringe of water and then connecting the unlabeled bags of tube feeding formula and water to the resident's gastrostomy site. Observation on 04/08/26 at 6:28 P.M. revealed LPN #101 had started the tube feeding pump without labeling or date-marking the enteral nutrition formula or the water being used in the tube feeding. Observation on 04/08/26 at 6:30 P.M. revealed LPN #101 started to walk out of Resident #56's room and stated, thank you, see you in the morning, to Resident #56, while the tube feeding was running and there was still no date or time marked on either the water or the enteral nutrition bag. Interview on 04/08/26 at 6:30 P.M. with LPN #101 revealed bags of enteral nutrition and bags of water used for tube feeding should both be labeled with the date and time the bags were prepared. Further interview with LPN #101 at this time verified neither of the bags being used for Resident #56's tube feeding were properly labeled. 2. Review of the medical record for Resident #79 (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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revealed the resident was admitted to the facility on [DATE] and had diagnoses that included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right dominant side, dysphagia (difficulty swallowing) following cerebral infarction, unspecified protein-calorie malnutrition, and gastrostomy amongst other diagnoses. Further review of Resident #79's medical record revealed the resident had a BIMS score of 12 indicating moderate cognitive impairment. Additional review of Resident #79's medical record revealed physician orders pertinent to their tube feeding included Glucerna 1.5 at 55 mL per hour continuously running through a feeding tube, with 50 cubic centimeters (cc) of water to flush through the feeding tube every hour. Resident #79's medical record also contained an order to change the tube feeding bag and tubing every night shift, and instructions that read must put name, date, time, amount per hour on new bag/bottle. This also applies to water. Observation on 04/08/26 at 5:50 P.M. at Resident #79's bedside revealed the bag of water hung next to the enteral nutrition bag was not labeled with date/time while actively running and flushing the tube feeding line for Resident #79. Interview on 04/08/26 at 6:40 P.M. with Registered Nurse (RN) #134 verified the bag of water that was actively running and flushing the tube feeding line for Resident #79 was not labeled with the date and time of preparation. Further interview with RN #134 revealed the bag of water is usually prepared at the same time as the bag of enteral nutrition formula (which was labeled with date/time) but each individual bag should still be labeled with time and date of preparation. Additional interview with RN #134 revealed they did not prepare the bag of water, but they believed it was likely prepared at the same time as the enteral nutrition formula, which was labeled 0600 04/08/26. This deficiency represents non-compliance investigated under Complaint Number 2795632.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of facility policy regarding enhanced barrier precautions, the facility failed to ensure infection control protocols were followed during the use of a tube feeding device for Resident #56. This affected one (#56) of two residents reviewed for tube feeding infection control. The facility census was 79. Review of the medical record for Resident #56 revealed the resident was admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus, adult failure to thrive, mild protein-calorie malnutrition, and gastrostomy status (a gastrostomy is a surgical opening in the abdominal wall, often for the use of a feeding tube). Further review of the medical record for Resident #56 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Additional review of Resident #56's medical record revealed physician orders for a nothing by mouth diet, with an enteral (tube) feeding order for Osmolite 1.2 to start daily in the evenings at 6:00 P.M. and run at 100 milliliters (mL) per hour for 14 hours with flushes of water through the feeding tube running at 40 mL per hour. Resident #56 also had an active order for enhanced barrier precautions related to enteral feedings. Observation on 04/08/26 at 6:26 P.M. revealed Licensed Practical Nurse (LPN) #101 entered Resident #56's room to start the 6:00 P.M. tube feeding. Further observation at this time revealed LPN #101 washed their hands and donned gloves, but they did not don a gown prior to accessing Resident #56's feeding tube and then proceeding to flush the feeding tube using a syringe of water and then connecting the unlabeled bags of tube feeding formula and water to the resident's gastrostomy site. Interview on 04/08/26 at 6:32 P.M. with LPN #101 revealed they don't typically wear a gown while providing care such as starting a tube feeding pump, working with a tube feeding line, or administering medications through a resident's tube feeding site. Further interview at this time revealed LPN #101 was not aware that the enhanced barrier precautions signage on Resident #56's door directed staff to wear a gown and gloves while providing high contact resident care services, such as using a feeding tube. Review of the facility policy titled Enhanced Barrier Precautions (EBP), last revised 03/05/25 revealed enhanced barrier precautions are indicated for residents with a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a multi drug resistant organism (MDRO) and should remain in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at higher risk. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. Further review of this policy revealed health care personnel caring for residents on Enhanced Precautions should wear gloves and gowns during high contact resident care, and examples of high contact resident care activities requiring glove and gown use include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care: chronic wounds.</p>		