STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365222	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Norworth The	6830 North High Street Worthington, OH 43085

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, review of the State agency reporting system (CALS), review of emergency medical services (EMS) reports, review of police reports, review of facility emails, and policy review, the facility failed to timely report allegations of inappropriate sexual behavior made by four residents to the state agency and/or local law enforcement. This affected four residents (#33, #58, #77, #97) out of five residents reviewed for abuse. The facility census was 106.Findings include:1. Review of the record for Resident #33 revealed the resident was admitted to the facility on [DATE]. Pertinent diagnoses included epilepsy, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), type two diabetes, chronic kidney disease stage four (CKD4), acquired left leg absence above right knee, and depression.Review of the Minimum Data Set (MDS) dated [DATE] for Resident #33 revealed she was moderately cognitively impaired, was dependent on staff for toileting, toilet transfers and chair transfers and required substantial/maximum assistance for showering, lower body dressing and putting on footwear.Review of the social work progress note dated 11/19/25 at 10:18 A.M. revealed the social services note author provided comfort to Resident #33, as resident presented as agitated and sad. The note went on to say the resident declined for her power of attorney to be contacted and that she had to wait for the police to come take her.Review of the certified nurse practitioner (CNP) progress note dated 11/20/25 at 12:00 A.M. revealed Resident #33 was seen for general laboratory follow up in the context of Resident #33's multiple medical issues. Resident #33 was noted to be alert and oriented times three and calm at the time of the appointment that day. The CNP noted Resident #33 had some dysuria (urinary pain) but tested negative for urinary tract infection. Pyridium was ordered for three days for symptom management. Review of the Change in Condition Evaluation dated 11/24/25 at 12:56 P.M. revealed Resident #33 was identified to have altered mental status, behavioral symptoms of agitation and psychosis, had been refusing medications and needed more assistance with activities of daily living (ADL). The note indicated the primary care physician had recommended for Resident #33 to be sent to the hospital.Review of the nurses progress note dated 11/24/25 at 1:46 P.M. noted Resident #33 was sent to the hospital for further evaluation, the residents power of attorney was notified of the transfer. Resident #33 was picked up by the ambulance company for altered mental status at 1:37 P.M. and transported to the hospital. There was no documentation in this note or any other progress note of any allegations made on this date.Review of the emergency medical services (EMS) run report for 11/24/25 for the transport of Resident #33 revealed Resident #33 was described as agitated and aggressive. Per the note, the EMS staff had difficulty with getting the residents blood pressure and the facility Registered Nurse (RN) #505 offered to assist when Resident #33 turned to RN #505 and said that he had raped her and that she was leaving her blood on her face so that they will know what he did.Review of the transport incident report dated 11/24/25 at 5:37 P.M. revealed Resident #33 screamed at the facility RN [#505] and to EMS how she had been raped by the RN. The resident stated you raped me, to RN #505.Review of the hospital medical records for Resident #33 from 11/24/25 to 12/04/25 revealed no indication that a Sexual Assault Forensic Exam was completed.Review of the Certification and Licensure System (CALS) revealed the sexual abuse allegation made by Resident #33 towards RN #505 on 11/24/25 was not reported to the State agency. Interview on 12/03/25 at 5:43 P.M. with Emergency Medical Technician (EMT) #701 confirmed the details of the written reports and described in detail the experience of preparing Resident #33 to go to the hospital. She said that when RN #505 attempted to assist EMT with getting the resident's blood pressure, the resident stated the allegation to RN #505, Do you think I forgot? I know you raped me. You [explicit] raped me. You used your fingers and put blood all over my face. EMT #701 said that RN #505 looked distraught and stepped back when the resident made her statements. EMT #701 said a female staff member wearing grey went up to RN #505 as if to console him. EMT #701 said she had no doubt that RN #505 had heard the accusation as Resident #33 was screaming. EMT #701 also shared that since Resident #33 was so agitated, they had to call a second level emergency crew to provide a higher level of care, however, she chose to ride with the resident in order for her to have a familiar face and also so EMT #701 could report the allegation to the hospital. She said she made sure the hospital nurse at the emergency room knew what was said. She said she did not get the name of the hospital nurse.Interview on 12/04/25 at 7:54 A.M. with RN #505 revealed that he heard the accusation that Resident #33 made that he raped her. He said that because of the statement she made, he made a point to tell the second EMS crew about her agitation towards him and

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 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 interviews, medical record review, review of facility emails, review of self-reported incident investigations (SRI) and review of facility policy, the facility failed to thoroughly investigate incidents involving allegations of inappropriate sexual behavior. This affected two residents (#58 and #77) out of five residents reviewed for abuse. The facility census was 106.Findings include:1. Review of Resident #18's record revealed he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type two diabetes mellitus, chronic kidney disease, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #18 revealed he was cognitively intact and needed partial/moderate assistance with toileting, showering and lower body dressing. Resident #18 was assessed to need supervision or touching assistance to walk 50 feet and was assessed to be independent with use of wheelchair for 50 feet.Review of the nursing progress note for Resident #18 dated 07/24/25 at 6:24 P.M. revealed the nurse was notified that Resident #18 was smoking outside with other guests when he stood up, brought out his penis and urinated in front of other guests. Per the note, the guest was educated about using bathrooms or urinal, call for help when in need and to not urinate in front of guests. Review of nursing progress note dated 07/24/25 at 6:51 P.M. revealed all residents in the courtyard were interviewed and had no complaints at the time. Review of facility documentation revealed no documented evidence regarding what residents were interviewed about the incident or if any other residents in the building within sight of the window were interviewed. Interview on 12/09/25 at 8:40 A.M. with the facility Administrator confirmed she did not file an incident report or police report regarding the public urination on 07/24/25. She referenced the nurse having documented that there were no complaints about the incident, however, she relayed that she had asked the nurse and the nurse had not documented and did not remember what residents she spoke with. She confirmed there was no documentation that any residents within view of the courtyard through the window were interviewed.2. Review of the police report dated 11/08/25 at 5:25 P.M. revealed the officer was investigating a sexual offense and that Resident #58 had filed the report because Resident #18 had urinated in front of others in the past and Resident #58 was sick of it and wanted Resident #18 charged. The officer noted he spoke with Social Services Supervisor #520, whom he incorrectly identified as the Administrator. The officer noted that Social Services Supervisor #520 said that Resident #18 had behavioral and mental disabilities and had loose fitting clothes that sometimes fell down. The officer noted Social Services Supervisor #520 said they were working on getting him better fitting clothes. The report states the offense was public indecency [exposure] and the incident was coded as a sexual offense.Review of the email documentation dated 11/08/25 at 6:27 P.M. authored by Social Services Supervisor #520 and sent to the Administrator and the DON revealed that the Social Services Supervisor #520 was notified by a nurse that Resident #18 had been found urinating in the courtyard in front of other residents. She said that she spoke with Resident #77 and Resident #58 and they were frustrated by the reoccurring incidents, and that Resident #77 had grandchildren visiting and she did not want her grandchildren to see that. The email noted that Resident #58 had called the police. The email went on to say that Social Services Supervisor #520 had spoken with Resident #18 who admitted that he urinated in the courtyard because he was unable to hold it. She said she recommended that he use the restroom prior to going to the courtyard to smoke.Review of facility information revealed no documented evidence of an investigation into Resident #58 and Resident #77's allegations towards Resident #18.Interview on 12/08/25 at 8:46 A.M. with the Administrator revealed she was unaware of the incident on 11/08/25 with Resident #18 and confirmed there was no formal investigation. Interview on 12/08/25 at 4:35 P.M. with Social Services Supervisor #520 revealed she had sent a detailed email to both the Administrator and the DON about the 11/08/25 incident. Review of the facility policy titled, Abuse Prohibition Policy, dated 09/09/22, revealed allegations of verbal, physical, mental, sexual abuse and mistreatment must be reported to the Administrator and then an incident report will be completed. The policy further stated that allegations of abuse would be thoroughly investigated and documented by the Administrator and reported to the State agency. This deficiency represents non-compliance investigated under Complaint Number OH2680058.

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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 - Actual harm 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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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEYBased on resident interview, medical record review, review of the self-reported incident (SRI) investigation and witness statements, review of hospital records, policy review, and review of the facility plan of correction documents, the facility failed to ensure a resident requiring transfers with a medical lift was transferred safely and with two staff assistance. Actual Harm occurred on 09/02/25 when Resident #60, who was dependent upon two staff for mechanical lift transfers, was being transferred via one staff assistance in a mechanical lift. The lift fell resulting in the resident sustaining a right femur fracture and subsequent surgery. This affected one (Resident #60) of three residents reviewed for injuries of unknown origin. The facility census was 106.Findings include: Record review revealed Resident #60 was initially admitted to the facility on [DATE] with diagnoses including chronic diastolic (congestive) heart failure, age-related osteoporosis without current pathological fracture, multiple sclerosis, other symptoms and signs involving cognitive functions and awareness.Review of the physician order dated 06/05/23 for Resident #60 revealed staff may use a mechanical lift for transferring the resident. Review of the nursing progress note dated 09/02/25 at 8:57 A.M. and 8:59 A.M. revealed Resident #60 had a rectangular purple bruise to [initially reported as the left thigh and then corrected] the right inner thigh. Resident #60 was unable to describe what happened however the roommate said she thought resident had fallen. The progress note indicated an investigation was to follow.Review of the post fall evaluation, undated and completed by the Director of Nursing (DON), revealed Resident #60 was lowered into wheelchair from a mechanical lift and landed on the wheelchair armrest with her right hip.Review of the facility's Self-Reported Investigation Report (SRI) dated 09/02/25 at 6:04 P.M. revealed that staff noted Resident #60 had a bruise of unknown origin and was unable to describe what had happened. The report said the roommate was interviewed and had heard a thud noise from behind the privacy curtain but did not see a fall.Review of the facility timeline and interview documentation by the DON from the SRI dated 09/02/25 revealed Resident #60 was in her wheelchair when staff arrived for the day shift on 09/02/25. Licensed Practical Nurse (LPN) #446 saw Resident #60 up in her chair in the morning and there were no signs of pain or discomfort. Per the written statements, no incident or accident was reported to the nurse until the afternoon when Certified Nursing Assistant (CNA) #283 reported to the DON that she noticed a new bruise on Resident #60 and that Resident #60 cried out in pain when being transferred. When interviewed, the night shift aide, CNA #286, admitted that he had transferred Resident #60 into her wheelchair using a mechanical lift without assistance, when her chair tipped to the left side. He tried to catch the chair and quickly lower her into it, but she landed on the right side of the wheelchair arm instead. He stated he did get her posture corrected in the chair and did not notice an injury at that time. He asked her if she was okay and she said yes. He said the roommate asked if she fell and he said no, she landed on the chair. He said he did not alert the nurse as he was able to transfer the resident successfully and was not aware at the time an injury had occurred.Review of the Medication Administration Record (MAR) for September 2025 revealed Resident #60 had an order for Acetaminophen Tablet 650 milligrams (mg) to be given every four hours as needed for mild pain. No pain was noted in the medical record on 09/02/25. Review of the facility Situation Background Assessment Recommendation (SBAR) Communication note dated 09/02/25 at 5:30 P.M. revealed Resident #60 had new pain and was described as having occasional labored breathing, short periods of hyperventilation, repeated troublesome calling out, such as loud moaning or groaning. The note documented the primary care physician had recommended hospitalization.Review of the facility transfer form dated 09/02/25 at 5:38 P.M. revealed Resident #60's pain ranged from the right hip to the right knee, and a behavioral note that stated the resident did normally say ouch when receiving care so that was not abnormal however, the resident seemed to be in more pain than usual with noted bruising and pain upon moving the extremity.Review of the emergency room Provider Note dated 09/02/25 at 9:07 P.M. revealed Resident #60 was reportedly either dropped out of bed or out of her chair around 5:30 A.M. and presented to the emergency room at 7:00 P.M. with a possible hip deformity. The note documented they were unable to get any history from the resident.Review of the History and Physical (H&P) Note from the hospital dated 09/02/25 at 10:33 P.M. revealed Resident #60 had an acute femoral neck (hip) fracture with osteoporosis. The H&P noted that Resident #60 was non-ambulatory at baseline. The physician author noted the resident was oriented to name, winced occasionally, and was