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	02/09/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, review of wound notes, review of hospital records and policy review, the facility failed to prevent the development of pressure ulcers and failed to ensure interventions were in place as ordered to prevent new or worsening pressure ulcers for Residents #20, #10, and #30. Actual harm occurred on 12/16/25 when it was discovered that Resident #20, who was at risk for skin breakdown with no pressure ulcers upon admission, developed an avoidable facility acquired unstageable (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound) pressure ulcer injury to the right heel. On 01/27/26, Resident #20 developed a facility acquired unstageable pressure injury to coccyx that was previously documented as Moisture Associated Skin Damage (MASD). This affected three residents (Residents #20, #10, and #30) of three reviewed for pressure ulcers. The facility census was 116. Findings include: 1.Review of the medical record for Resident #20 revealed an admission date of 10/18/25. Diagnoses included Alzheimer's disease, depression, spinal stenosis and primary generalized osteoarthritis. Review of the admission nursing comprehensive evaluation dated 10/18/25 for Resident #20 revealed the resident required total assistance with bed mobility. Review of the plan of care initiated 10/19/25 for Resident #20 revealed the resident is at risk for impaired skin integrity/pressure injury related to: weakness, decreased mobility, and Alzheimer's disease. Interventions included a pressure reduction mattress to bed and when the resident chooses not to reposition as often as needed, explain consequences and continue to attempt to get them to comply. There was no intervention for assistance to turn and reposition in bed. Review of Resident #20's Braden Scale for Predicting Pressure Sore Risk dated 10/21/25 revealed a score of 13, moderate risk for skin breakdown. The scale was six (high risk) to 23 (no risk).Review of the most recent Minimum Data Set (MDS) assessment, dated 10/25/25, revealed Resident #20 had severe cognitive impairment. The resident required substantial/maximal assistance with bed mobility, and total dependence on toilet hygiene, shower/bathe self, and transfers. This resident was frequently incontinent with bladder and bowel and was at risk for developing pressure ulcers. Review of Resident #20's Braden Scale for Predicting Pressure Sore Risk dated 11/11/25 revealed a score of 18, no risk for skin breakdown.Review of the skin check assessment dated [DATE] for Resident #20 completed by Registered Nurse (RN) #2323 revealed no skin issues. Review of the Physician Note dated 12/15/25 for Resident #20 by Physician # 200 revealed the resident was unable to care for self and has generalized weakness being bed bound for the previous few weeks with bilateral heel pain. Assessment of the feet revealed scaling/dry skin. Review of the progress note dated 12/15/25 at 9:04 P.M., documented by RN #2345 revealed a skin injury on the right heel which was painful to touch. The heel was cleansed with normal saline and covered with clean, dry dressing. Facility wound nurse Licensed Practical Nurse (LPN) #1500 was notified. Review of the medical record from admission to 12/15/25 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER: Laurels of Norworth The		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Actual harm Residents Affected - Few	for Resident #20 revealed no documented refusals and reinforcement of turning and repositioning while in bed. Review of the skin issues assessment dated [DATE] at 6:00 P.M. for Resident #20 by LPN #1500 revealed an in-house facility acquired right heel unstageable pressure ulcer measuring 1.38 centimeters (cm) by 1.19 cm by 0.1cm with wound bed tissue composition 10 percent granulation and 90 percent slough (a yellowish, stringy dead tissue.) Additional care to turning/repositioning program and educated the resident on turning every two hours. Review of the assessment evaluations dated 12/16/25 for Resident #20 revealed no reevaluation of the Braden Scale for Predicting Pressure Sore Risk and no unavoidable pressure ulcer injury assessment. Review of the physician orders dated 12/17/25 revealed an air pressure mattress to bed, check placement and function every shift, and bilateral off-loading boots while in bed, check placement every shift. There were no settings for the air mattress listed. Review of the plan of care initiated on 12/17/25 revealed the resident had an actual impaired skin integrity related to an in-house pressure injury of the right heel. Interventions did not include assisting to turn and reposition in bed or elevating heels while in bed if the resident refuses the offloading boots. Review of the wound consult visit notes dated 12/23/25 revealed Resident #20 was seen by Wound Nurse Practitioner (WNP) #300. The right heel was an unstageable pressure ulcer measuring 1.28 cm by 1.02 cm with no depth with the wound bed tissue composition 90 percent slough and 10 percent granulation. A treatment plan to continue current treatment orders and to continue supportive care of turn and reposition frequently, support with pillows or a wedge to prevent pressure on the wound, heels should be elevated off the bed and continue proper nutrition and hydration for healing. Review of the wound consult visit notes dated 12/30/25 revealed Resident #20 was seen by WNP #300. The right heel unstageable pressure ulcer was stable, measuring 1.25 cm by 0.93 cm with no depth with the wound bed tissue composition 70 percent slough and 30 percent granulation. A treatment plan to continue current treatment orders and to continue supportive care of turn and reposition frequently, support with pillows or a wedge to prevent pressure on the wound, heels should be elevated off the bed and continue proper nutrition and hydration for healing. Review of the medical record from 12/16/25 through 01/04/26 for Resident #20 revealed no documented refusals and reinforcement of turning and repositioning while in bed. Resident #20 was hospitalized for an unrelated health issue from 01/04/26 through 01/08/26. Review of the progress note dated 01/08/26 at 3:19 P.M. revealed Resident #20 returned to the facility from the hospital. Review of the discharge hospital documentation dated 01/08/26 for Resident #20 revealed no instructions for wound care. Review of the admission nursing comprehensive evaluation dated 01/08/26 revealed Resident #20 had an open area on the right heel and a blanchable area on the coccyx. Resident #20 required two people to assist with bed mobility. Review of the care plan, revised on 01/08/26, revealed Resident #20 was at risk for impaired skin integrity/pressure injury related to weakness, decreased mobility, and Alzheimer's disease. Interventions included an air pressure mattress still in place. No Interventions to assist to turn and reposition in bed or elevating heels while in bed if the resident refuses the offloading boots. Review of the physician orders dated 01/08/26 revealed no physician's order was in place for settings for the air pressure mattress to bed and for bilateral off-loading boots while in bed. Review of the progress note dated 01/09/26 at 12:51 P.M. for Resident #20 revealed a second skin sweep was completed by LPN #1500. Resident #20 had moisture associated skin damage (MASD) on the coccyx with blanchable redness with no drainage. There were no measurements documented and no treatment in place. Review of Resident #20's Braden Scale for Predicting Pressure Sore Risk dated 1/10/26 revealed a score of 15, mild risk for skin breakdown. Review of the progress note dated 01/12/26 at 12:07 P.M. by LPN #1500 for this resident revealed the right heel prior wound was still present. There were no ulcer stages (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Laurels of Norworth The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	or measurements documented. Review of the physician orders dated 01/12/26 for Resident #20 revealed an air pressure mattress to bed, check placement and function every shift and bilateral off-loading boots while in bed, check placement every shift. No air mattress settings were listed. Review of the skin issues assessment dated [DATE] at 2:50 P.M. for Resident #20 by LPN #1500 revealed a right heel stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) acquired in house on 12/16/25, measuring 0.67cm by 1.18 cm by 0.1 cm with a wound bed tissue composition 70 percent granulation and 30 percent slough. Odor noted after being cleansed. Additional care to turning/repositioning program, mattress with pump, heel suspension/ protection device and educate the resident on turning every two hours. Review of WNP #300's progress note dated 01/14/26 revealed Resident #20 had a pressure injury of the right heel. Encourage suspension boots to bilateral lower extremities and offloading to heels. There was no documentation of MASD of the coccyx. Review of the plan of care, revised on 01/15/26, revealed Resident #20 had an actual impaired skin integrity related to an in-house pressure injury of the right heel and MASD to the coccyx. There were no interventions listed related to assisting to turn and reposition in bed or elevating the heels while in bed. Review of the skin issues assessment dated [DATE] at 12:05 P.M., by LPN #1500 revealed Resident #20 had a stable right heel stage III pressure ulcer measuring 0.90cm by .92 cm by 0.1 cm with a wound bed tissue composition 100 percent granulation. Odor noted after being cleansed. Additional care to turning/repositioning program, mattress with pump, heel suspension/ protection device and educate the resident on turning every two hours. Review of the progress note dated 01/20/26 at 5:01 P.M. by LPN #1500 revealed Resident #20 had MASD to bilateral buttocks stable at this time. Continue current treatment. Review of the medical record dated 01/20/26 revealed no treatment order was in place for MASD to the bilateral buttocks and no measurement or assessment of the area was completed. There was no wound consult visit note by WNP #300 and no physician, Nurse Practitioner or Registered Nurse assessment of the MASD to the coccyx. Review of Resident #20's Braden Scale for Predicting Pressure Sore Risk dated 1/23/26 revealed a score of 16, mild risk for skin breakdown. Review of the skin issues assessment dated [DATE] at 11:50 A.M., documented as a late entry by LPN #1500 revealed Resident #20 had an in-house facility acquired unstageable pressure ulcer to the coccyx measuring 3.32 cm by 3.18 cm by 0.1 cm. The wound bed tissue composition of 10 percent granulation and 90 percent slough.Review of the medical record from Resident #20's readmission date of 01/08/26 to 01/27/26 for revealed no documented refusals and reinforcement of turning and repositioning while in bed. During an observation on 01/27/26 at 11:06 A.M., Resident #20 was resting with her eyes closed. She was lying in bed on her back, on an air mattress with setting options based on weight only, set to 350 pounds. She was not wearing offloading boots and her heels were not elevated. During an observation on 01/27/26 at11:41 A.M., LPN #1500 and LPN #1111 changed the right heel pressure ulcer dressing. Resident #20's offloading boots were in the room on a chair. LPN #1500 measured and staged the right heel pressure ulcer as stage III measuring 0.38 cm by 0.65. cm by 0.1 cm. During an interview at this time, LPN #1500 verified the Resident #20's air mattress was set to 350 pounds and the resident weighed112.9 pounds. It was also verified Resident #20 was not wearing the offloading boots and her heels were not elevated. LPN #1500 stated the facility utilizes several types of air mattresses and no education has been provided to maintain them. The physician order should have settings to follow for the air mattresses, and it is the responsibility of the nurse who is caring for the resident to maintain the air mattress per physician order. It is the responsibility of the Certified Nursing Assistant (CNA) to apply the offloading boots and to elevate the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Laurels of Norworth The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	resident's heels per their plan of care. The nurse who is caring for the resident is responsible for following up. During an interview on 01/27/26 at 12:03 P.M., LPN #1500 stated the facility had a consulting Wound Nurse Practioner, WNP #300, coming to the facility every Tuesday, but she has not been to the facility for the past several Tuesdays. When she was rounding, LPN #1500 would round with her and take verbal orders for changes to residents she treated as her notes were not always entered into the electronic medical record for several days. Since WNP #300 has not been rounding, LPN #1500 has been rounding on Tuesdays, assessing, staging and evaluating pressure ulcers and other skin alterations. LPN #1500 verified no physician, nurse practitioner or RN rounds with her and verified she is assessing the pressure ulcers. She stated based on her assessment, nursing judgment, and what treatment the resident should receive, she discusses it with the physician and/or nurse practitioner. The process of a resident being admitted with a pressure ulcer is documented on their admission assessment with a brief description. The unit managers are responsible for a second skin sweep, but no measurements are obtained at that time with brief descriptions. She is notified of the pressure ulcer from the unit manager, and the Wound Nurse Practitioner would evaluate, stage and measure on Tuesday. If the Wound Nurse Practitioner is unable to round, then it is her responsibility to round. When it comes to MASD areas, she does document in the progress notes if the area is better, worse or the same, but there are no measurements or descriptions of the area. During an interview on 01/27/26 at 1:31 P.M., the DON stated when a resident gets admitted , the admitting nurse on the floor documents any skin alterations under the admission assessment, but it is a general description as they are not allowed to stage and assess pressure ulcers. On the second skin sweep, completed by the unit managers, areas are documented under the progress notes, and no measurements are obtained regardless of what they are as in MASD, skin tear or a pressure ulcer. WNP #300 visits on Tuesdays and would round on pressure ulcer areas only and assess, stage and measure the area. If she is unavailable, LPN #1500 completes the rounds. If she is out, it is herself, or she has LPN #1111 round. The DON verified the WNP #300 has not been at the facility for a few weeks as she is on leave from the company and no replacement has been sent. The facility is in the process of finding another company, so for residents with pressure ulcers who need treatments, LPN#1500 assesses and relays the information about the areas to the providing team and they order the treatments. To her knowledge, the team provided does not assess the areas unless asked to by the staff, so orders are based on an assessment of LPN #1500. With other skin alterations, measurements are taken within a week of admission, but MASD does not get measured and has no descriptions documented in resident's medical records except on a weekly progress note indicating if it is better, worse or the same by the rounding nurse on Tuesday. The DON verified if there are no measurements and assessments documented on MASD, the floor nurse is unable to notify a provider if the area is deteriorating. The DON stated LPN #1500 has been rounding for the past several weeks in the absence of WNP #300. LPN #1500 has been assessing, staging, and measuring the areas with no verification of accuracy from a physician, nurse Practitioner or RN. The facility utilizes several different kinds of air mattresses and has not educated the staff on how each air mattress functions. Resident #20 did obtain an in-house facility acquired pressure area to the right heel on 12/15/25 with LPN #1500 assessing, staging and measuring the area on 12/16/25 and another Braden scale was not completed at this time. No interventions were in place on the plan of care from admission to 12/15/25 to assist with turning and repositioning as the resident was assessed to be substantial/maximal assistance with bed mobility. It was also verified that the plan of care did not have assist to turn and reposition and air mattress settings from 12/17/25 to current. The plan of care did indicate if the resident chooses not to turn to attempt to get her to comply and that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	should be documented as well as refusals to turn and reposition. Resident #20 has no documented refusals to turn and reposition. Resident #20 was readmitted to the facility on [DATE] with a right heel open area and blanchable coccyx, with ongoing assessments of the right heel completed only by LPN#1500 as a stage III pressure ulcer. The MASD has also only been documented on in the progress notes weekly by LPN#1500 with no measurements and assessments and was erroneously documented on 01/20/26 as bilateral buttocks instead of the coccyx. During an observation on 01/27/26 at 2:44 P.M. revealed Resident #20 in bed on her back. During an interview at 2:49 P.M., CNA #101verified Resident #20 was on her back and has been most of the day and does need assistance to turn in bed. She charts in the computer when a resident is turned and refuses, but only when she has time, so it doesn't always get charted. She is unsure if a resident is assessed to need to be turned as the Kardex for the residents does not indicate if a resident needed turned and repositioned every two hours. During an interview on 01/27/26 at 2:51 P.M., RN #2325 stated the CNAs are responsible for turning and repositioning residents. She is unsure if a resident has been turned as the aides don't always chart residents being turned on the computer. She doesn't always visualize her residents every two hours to verify they are being turned. If one of her residents is assessed as needing to be turned and repositioned every two hours, there are no orders to indicate that for her to check to make sure they are and the care plans do not indicate that on them. If a resident refuses and or needs reminded to turn and reposition, that should be documented. She is aware that Resident #20 does need assistance to be turned and repositioned and verified she has been on her back all day in bed. RN #2325 stated she has several residents on air pressure mattresses and has not received education for them. If issues arise, she reaches out to the unit manager, but she does not know what settings they are to be on for each resident, the orders are to check them for function. 2. Review of the medical record for Resident #10 revealed an admission date of 05/28/25. Diagnoses included chronic pain, type 2 diabetes without complications, venous insufficiency and a new diagnosis of vascular dementia with the date of 09/15/25. Review of the most recent MDS assessment, dated 12/06/25, revealed Resident #10 was cognitively intact. The resident required substantial/maximal assistance with bed mobility, and total dependence on toilet hygiene, shower/bathe self, and transfers. This resident was always incontinent with bladder and bowel. Review of the care plan, last revised on 9/09/25, revealed Resident #10 was at risk for impaired skin integrity/pressure injury related to weakness and decreased mobility. Interventions included offloading boots to bilateral lower extremities as ordered. Review of the progress note dated 11/14/25 revealed Resident #10 complained of pain to the right heel. Upon assessment, a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) was discovered. No measurements or descriptions were documented. Review of the wound consult visit notes dated 11/18/25 revealed Resident #10 was seen by WNP #300 and the right heel deep tissue injury was measured and described for the first time. Resident #10 was hospitalized for an unrelated health issue from 12/06/25 through 12/11/25. Review of the admission nursing comprehensive evaluation dated 12/11/25 for Resident #10 revealed a right heel open area and bilateral buttocks were red and blanchable. Review of the progress note dated 12/12/25 revealed a second skin sweep completed on Resident #10 with the right heel assessed as an unstageable pressure ulcer and the bilateral buttocks as MASD. No measurements or descriptions were documented. Review of the wound consult visit notes dated 12/16/25 revealed Resident #10 was seen by WNP #300 on 12/16/25. The right heel deep tissue injury was measured and described for the first time. No assessment of the MASD was completed. Review of the progress note dated 12/16/25 and 12/23/25 by LPN #1500 revealed the MASD to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Laurels of Norworth The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	the bilateral buttocks was improving. No measurements or descriptions were documented. Resident #10 was hospitalized for an unrelated health issue from 12/30/25 through 01/20/25. Review of the admission nursing comprehensive evaluation dated 01/20/26 revealed Resident #10 no longer had the right heel deep tissue injury and bilateral buttocks MASD. Review of the physician orders upon readmission to the facility on [DATE] through 01/27/26 for Resident #10 revealed no order for offloading boots to be applied to bilateral lower extremities. Review of Resident #10's Braden Scale for Predicting Pressure Sore Risk dated 01/23/26 revealed a score of 18, no risk for skin breakdown. During an observation on 01/27/26 at 11:03 A.M. and 12:54 P.M., Resident #10 was resting in bed with his eyes closed. He was lying on his back and no off-loading boots were on his feet. During an observation at 2:31 P.M., Resident #10 was still lying in bed on his back, with no off-loading boots on his feet. During an interview at that time, Resident #10 said he does not remember the last time he had the off-loading boots on his feet. He is on his back a lot in bed. He has a lot of pain and is weak and needs help to turn in bed but only gets turned if he asks the staff. During an interview on 01/27/26 at 2:35 P.M., CNA #101 verified Resident #10 was on his back and needs assistance in bed to turn. She verified he was not wearing the off-loading boots. CNA #101 was not sure if he needed the boots and said she would have to look at the Kardex. During an interview on 01/27/26 at 2:13 P.M., the DON stated Resident #10 does have a history of a right heel deep tissue injury that was facility acquired. She verified that no measurements or a description of the heel ulcer was completed upon discovery. Upon readmission on [DATE], no measurements and assessments of the right heel open area were completed until 12/16/25. While the resident had bilateral buttocks MASD from 12/11/25 through 12/30/25, no measurements and descriptions were completed. Resident #10 does have the off-loading boots but there is no active order. He has been in and out of the hospital several times since the offloading boots were originally ordered, and orders do not carry over. It is the unit manager's responsibility to review past orders and plans of care to reorder and reinitiate them. The order is for the caring nurse to verify the boots are on and off as ordered and the care plan for the aides to know to apply them. 3. Review of the medical record for Resident #30, revealed an admission date of 01/02/26. Diagnoses included severe protein calorie malnutrition, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness and a stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer of the sacral region. Review of the most recent MDS assessment dated [DATE] revealed Resident #30 was rarely or never understood. The resident was totally dependent on staff for bed mobility, transfers, bathing and toilet hygiene. Review of the discharge hospital documentation dated 01/02/26 for Resident #30 revealed a sacrum stage IV pressure ulcer. Review of the admission nursing comprehensive evaluation dated 01/02/26 for Resident #20 revealed a coccyx pressure ulcer and Resident #30 was totally dependent on bed mobility. Review of the wound consult visit notes dated 01/06/26 revealed Resident #30 was seen by WNP #300. The note documented the sacrum pressure ulcer measured 0.88 cm by 0.52 cm by 0.4 cm. Review of the plan of care dated 01/02/26 for Resident #30 revealed this resident has an actual impaired skin integrity related to pressure injury with intervention including but not limited to when resident chooses not to reposition as often as needed, explain consequences and continue to attempt to get them to comply, but no intervention for assistance to turn and reposition. Further review of the care plan revised on 01/05/26 for this resident revealed at risk for impaired skin integrity/pressure injury related to right side hemiparesis, and pressure injuries. Interventions included but were not limited to an air pressure mattress. No intervention added for offloading boots bilaterally to lower extremities. There were no (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Laurels of Norworth The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	settings for the air mattress listed. Review of the physician orders dated 01/05/26 for Resident #30 revealed an air pressure mattress, to check placement and function every shift, and offloading boots to bilateral lower extremities every shift. There were no air mattress settings listed. Review of the skin issues assessment dated [DATE] for Resident #30 by LPN #1500 revealed the sacrum ulcer was a stage IV, measuring 4.82 cm by 2.2 cm by 0.3 cm and had deteriorated. Review of CNP #330's note dated 01/14/26 revealed Resident #30 was bed bound and unable to reposition on her own. Staff needed to assist with repositioning frequently. Review of the skin issues assessment dated [DATE] by LPN #1500 revealed Resident #30's sacrum ulcer was a stage IV and measured 4.82 cm by 1.55 cm by 0.3 cm. Review of CNP #330's note dated 01/20/26 revealed Resident #30 was bed bound and unable to reposition on her own. Staff needed to assist with repositioning frequently. During an observation on 01/27/26 at 11:35 A.M., Resident #30 was in bed on her left side. She did not have off-loading boots on her feet. The air mattress was leaning against the wall in her room. During an interview at the time of the observation, CNA #102 verified Resident #30 was not wearing the boots and did not know why the air mattress was not on the bed. During an observation on 01/27/26 at 12:58 P.M., Resident #30 now had the air mattress on her bed. The air mattress setting was 10, maximum firmness. During an interview at the time of the observation, LPN #1550 stated the mattress was for comfort and Resident #30 could not communicate comfort settings for the air mattress. This was a new mattress as the old one had malfunctioned. LPN #1550 stated the physician was not notified of the change in mattress and she was not sure what the setting should be on. She stated she has never received education on the function of the air mattresses and the facility does utilize several types. During an interview on 01/27/26 at 2:39 P.M., the DON stated that when a resident requires an air pressure mattress, the resident's height, weight and skin condition are sent to one of their supply companies and an air mattress is sent based on that information. They are set up by the supply company. Orders from the physicians are obtained to maintain and check function, but settings are based on the type of air pressure mattress. The DON verified staff have not been educated to maintain the different types of air pressure mattresses the facility uses. During an observation on 01/27/26 at 2:54 P.M., Resident #30 was still on her left side in bed. CNA #102 verified at that time Resident #30 was still on her left side and was totally dependent on turning and repositioning. CNA #102 stated he does not always have time to document in the computer if a resident is turned or if they refuse. During an interview on 01/27/26 at 2:57 P.M., LPN #1550 stated Resident #30 was still on her left side and stated the resident like that side and would move herself. Review of the facility policy titled Skin Management, revised 08/14/24, revealed the facility should identify and implement preventions to prevent the development of clinically unavoidable pressure injuries. Upon admission/readmission, all residents are evaluated for skin integrity and documented in the medical record which includes the location, measurements and characteristics. Appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan. The Braden Scale will be completed with significant changes to determine the risk of pressure injury development. This deficiency represents non-compliance investigated under Complaint Number OH00270375.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, interviews, and facility job descriptions, the facility failed to ensure Licensed Practical Nurses (LPN's) acted within their professional standards and their scope of training related to pressure ulcer wound assessments and staging of wounds. This affected two residents (#20 and #30) of three residents reviewed. The facility census was 116.1. Review of the medical record for Resident #20, revealed an admission date of 10/18/25. Diagnoses included but were not limited to Alzheimer's disease, depression, spinal stenosis and primary generalized osteoarthritis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 03 (00 to 15) indicated severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with bed mobility, and total dependence on toilet hygiene, shower/bathe self, and transfers. This resident was also assessed to be frequently incontinent of bladder and bowel and to be at risk for developing pressure ulcers. Review of the skin issues assessment dated [DATE] for Resident #20 by Licensed Practical Nurse (LPN) #1500 revealed an in-house facility acquired right heel unstageable (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound) pressure ulcer measured 1.38 centimeters (cm) by 1.19 cm by 0.1 with the wound bed tissue composition 10 percent granulation and 90 percent slough. Review of the skin issues assessment dated [DATE] for Resident #20 by LPN #1500 revealed a right heel stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcer, acquired in house on 12/16/25, measured .67 cm by 1.18 cm by 0.1 cm with a wound bed tissue composition 70 percent granulation and 30 percent slough. Review of the skin issues assessment dated [DATE] for Resident #20 by LPN #1500 revealed a stable right heel stage 3 pressure ulcer measured .90 cm by .92 cm by 0.1 cm with a wound bed tissue composition 100 percent granulation. Observation and interview on 01/27/26 at 11:41 A.M. with LPN#1500 of Resident #20 revealed for the right heel pressure ulcer measured and staged as a stage 3 with measurements of .38 cm by .65. cm by .1 cm. Verified she staged and measured the right heel and will be documenting the assessment in the residents chart. Interview on 01/27/26 at 12:03 P.M. with LPN #1500 verified she stages and measures pressure ulcers for residents on Tuesdays if the Wound Nurse Practitioner #300 cannot do so. Interview on 01/27/26 at 1:31 P.M. with the Director of Nursing (DON) verified Resident #20's pressure ulcer to the right heel was staged and measured by LPN #1500 only on 12/16/25, 1/13/26, and 1/20/26. 2. Review of the medical record for Resident #30, revealed an admission date of 01/02/26. Diagnoses included but were not limited to severe protein calorie malnutrition, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness and a stage 4 pressure ulcer of the sacral region. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of never/rarely understood. The resident was assessed to require total dependence on bed mobility, transfers, shower/bathe self and toilet hygiene. Review of the skin issues assessment dated [DATE] for Resident #30 by LPN #1500 revealed a sacrum stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer measured 4.82 cm by 2.12 cm by 0.3 cm with the wound bed tissue composition 60 percent granulation and 30 percent slough. Review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the skin issues assessment dated [DATE] for Resident #30 by LPN #1500 revealed a sacrum stage 4 pressure ulcer measured 4.72 cm by 1.55 cm by 0.3 cm with the wound bed tissue composition 80 percent granulation and 20 percent slough. Interview on 01/27/26 at 2:37 P.M. with the Director of Nursing (DON) verified LPN #1500 assessed, staged and measured Resident #30's sacrum stage 4 pressure ulcer on 01/13/26 and 01/20/26. Review of the facility job description for the job title Treatment Nurse in the Nursing Department with no date, revealed no pressure ulcer wound assessments which include measuring, staging and assessments to be part of their position summary and essential functions and responsibilities. Review of the facility job description for the job title Unit Manager in the Nursing Department with no date, revealed no pressure ulcer wound assessments which include measuring, staging and assessments to be part of their position summary and essential functions and responsibilities. The facility was unable to provide a job description for their Licensed Practical Nurses. This deficiency represents non-compliance investigated under Complaint Number OH00270375.