STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365466	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Heath	717 South 30th Street Heath, OH 43056

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 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 observation, policy review, record review and interview, the facility failed to ensure call bells were within reach. This affected three (Resident's #1, #3 and #4) of six residents observed. The census was 117. Findings include:1. Review of Resident #3's medical record revealed an admission date of 08/22/22 with diagnoses including Alzheimer's disease, dementia, chronic obstructive pulmonary disease, dysphasia, and osteoarthritis.Review of Resident #3's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. He was independent of eating and required supervision or touching assistance for toilet transfers.Observation 07/09/25 at 10:10 A.M. of Resident #3 revealed the resident was in bed without a call bell/light near him. The call bell was plugged in the wall side of bed one and hanging on the floor. The resident was in bed two. There was not a call bell plugged into the wall on the bed two side. There was not a call bell in sight in the room for the bed two side.Interview 07/09/25 at 10:10 A.M. with Licensed Practical Nurse (LPN) #15 verified the resident did not have a call bell in reach. LPN #15 verified the resident was able to activate a call bell.2. Review of Resident #1 revealed a 06/04/25 admission with diagnoses including encounter for surgical aftercare following surgery on the nervous system, encounter for surgical aftercare following surgery on the digestive system, acute respiratory failure with hypoxia, muscle weakness, difficulty in walking, need for assistance with personal care, dysphasia, cognitive communication deficit, severe protein calorie malnutrition, hypertensive heart disease, insomnia, attention deficit hyperactivity disorder, acute post hemorrhagic anemia, cerebral infarction, seizures, traumatic brain injury with loss of consciousness, ileus, thrombocytosis and anxiety disorder.Review of the 06/10/25 admission MDS revealed the resident was moderately impaired for daily decision making. The resident has upper and lower extremity impairment on one side, needs substantial/maximum assistance for eating, dependent on toileting and bathing, substantial/maximum assist for rolling side to side or sitting up, and is always incontinent of bowel and bladder.Observation 07/09/25 at 9:14 A.M. revealed Resident #1 was in bed. He did not have a call bell in reach. The resident's call bell was draped across the resident's open top drawer of his bedside table. The control was draped over the far side of the drawer away from the resident's bed.Certified Nurse Aide (CNA) #125 entered the room at 9:15 A.M. She verified the resident's call light was not in reach. CNA #125 stated it was her first time in the resident's room that day. CNA #41 entered the room and said she was the resident's aide. She revealed she arrived at 6:00 A.M. and had not moved the resident's call light. She indicated it would have been placed across his drawer out of reach before she arrived. The resident had a traumatic brain injury and had limited movement of his right arm/hand. He indicated he would need to reach across with his left hand and try to reach the call bell. When he attempted, he was unable to reach the cord to the call light. The CNAs verified the resident was able to activate the call light when in reach.3. Resident #4 was admitted [DATE] with diagnoses including cerebral infarction, chronic obstructive pulmonary disease, ataxia, hypertension, chronic kidney disease, type 2 diabetes, iron deficiency anemia, vitamin D deficiency, difficulty walking, major depressive disorder, anxiety, chronic atrial fibrillation, osteoarthritis, muscle wasting and atrophy, anxiety disorder, dementia with mood disturbance, gout, radiculopathy cervical region, need for assistance with personal care, legal blindness, sick sinus syndrome, alcohol dependence in remission, old myocardial infarction, hyperlipidemia, morbid severe obesity, personal history of sudden cardiac arrest, and congestive heart failure. Review of the 05/14/25 Quarterly MDS revealed the resident was moderately impaired for daily decision making. The resident had no upper or lower extremity impairment. He was independent for eating, set up for toileting, and supervision for bathing. Observation of Resident #4 07/09/25 at 9:33 A.M. revealed he was sitting in his recliner with his legs elevated. His call light was activated. Upon entering the room, the resident's call light was out of reach pulled out of the wall and lying on the floor.On 07/09/25 at 9:48 A.M. Certified Nurse Aide (CNA) #132 was walked down the hall past the resident's room. The surveyor went into the hall and spoke with CNA #132. CNA #132 entered Resident #132's room, acknowledged the resident's call light was activated, on the floor detached from the wall out of reach.Review of the facility's Call Lights policy revised 03/15/25 included call lights will be placed within the resident's reach and answered in a timely manner. The deficiency represents non-compliance investigated under Complaint Number OH00166783 (1330314).

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of job description the facility failed to ensure the social worker assisted the resident to address his preferences of transferring to a different facility. This affected one resident (#2) of one residents reviewed for transfers. The facility census was 117.Findings include:Review of Resident #2's medical record revealed an admission date of 02/15/23 and diagnoses including paraplegia, unspecified protein-calorie malnutrition, generalized anxiety, and chronic respiratory failure.Review of Resident #2's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #2's care conference note dated 08/15/24 revealed the resident wanted to transfer to a facility in Cleveland or [NAME]. The resident's mother was to research the facilities and report to the social worker. Review of Resident #2's care conference note dated 11/13/24 revealed the resident wanted to go to a facility in [NAME]. The social worker was to search for facilities in the requested area.Review of Resident #2's care conference note dated 05/22/25 revealed the resident requested to move closer to [NAME], the social worker was to work on finding him a facility.Review of Resident #2's medical record from 08/15/24 to 07/09/25 revealed no evidence the social worker had made attempts to contact facilities near [NAME].Interview on 07/10/25 at 10:50 A.M. with Resident #2 revealed he had been requesting to move from the facility for years and they had not made any efforts to do so. He reported the facility kept listening to his mother despite the fact that he was his own responsible party. Interview on 07/10/25 at 11:50 A.M. with Social Service Designee (SSD) #54 revealed she was aware the resident wanted to move to a different facility. She reported the resident's mom was supposed to find a place that suited them and that she had followed up with the mother. She verified there was no documented evidence she had followed up. She reported Resident #2 wanted to go somewhere his mother would agree to and that was why he had yet to move. She again verified there was no evidence SSD #54 had followed up on his requests to transfer facilities.Review of the job description for the social service designee revealed it was an essential function and responsibility to assist the residents in obtaining the residents needs and advocating for the residents. This deficiency represents non-compliance investigated under Complaint Number OH00166863 (1330317).

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were provided drinking water. This affected three (Resident's #1, #3 and #4) of five residents observed for water availability. The census was 117.Findings include: 1. Review of Resident #3's medical record revealed an admission date of 08/22/22 with diagnoses including Alzheimer's disease, dementia, chronic obstructive pulmonary disease, dysphasia, and osteoarthritis.Review of Resident #3's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. He was independent of eating and required supervision or touching assistance for toilet transfers.Observation 07/09/25 at 10:10 A.M. of Resident #3 revealed the resident was in bed without water or beverages on his overbed table or available in the room.Interview 07/09/25 at 10:10 A.M. with Licensed Practical Nurse (LPN) #15 verified the resident did not have water in reach. LPN #15 asked him if he wanted water and he said yes, cold water.2. Review of Resident #1 revealed a 06/04/25 admission with diagnoses including encounter for surgical aftercare following surgery on the nervous system, encounter for surgical aftercare following surgery on the digestive system, cognitive communication deficit, severe protein calorie malnutrition, anemia, cerebral infarction, seizures, traumatic brain injury with loss of consciousness, and anxiety disorder.Review of the 06/10/25 admission MDS revealed the resident was moderately impaired for daily decision making. The resident had upper and lower extremity impairment on one side, needed substantial/maximum assistance for eating, dependent on toileting and bathing, substantial/maximum assist for rolling side to side or sitting up, and is always incontinent of bowel and bladder.Physician orders included a 07/01/25 order for a regular diet, regular texture, thin consistency (fluids).Observation 07/09/25 at 9:14 A.M. revealed Resident #1 was in bed. He did not have water on his overbed table or in reach.Certified Nurse Aide (CNA) #125 entered the room at 9:15 A.M. She verified the resident did not have water or ice water. She located an empty lidded cup with straw across the room on a counter. She asked him if he wanted water and he said yes. He stated he liked ice in his water. CNA #125 left the room and returned with what she stated was a clean lidded mug and ice water. CNA #41 entered the room and said she was the resident's aide. She revealed she arrived at 6:00 A.M. and did not know why his water was not there. She stated she passes water once a day unless they ask for it. 3. Resident #4 was admitted [DATE] with diagnoses including cerebral infarction, chronic obstructive pulmonary disease, ataxia, hypertension, chronic kidney disease, type 2 diabetes, iron deficiency anemia, vitamin D deficiency, difficulty walking, major depressive disorder, anxiety, chronic atrial fibrillation, osteoarthritis, muscle wasting and atrophy, anxiety disorder, dementia with mood disturbance, gout, radiculopathy cervical region, need for assistance with personal care, legal blindness, sick sinus syndrome, alcohol dependence in remission, old myocardial infarction, hyperlipidemia, morbid severe obesity, personal history of sudden cardiac arrest, and congestive heart failure. Review of the 05/14/25 Quarterly MDS revealed the resident was moderately impaired for daily decision making. The resident had no upper or lower extremity impairment. He was independent for eating, set up for toileting, and supervision for bathing. Observation of Resident #4 07/09/25 at 9:33 A.M. revealed he was sitting in his recliner with his legs elevated. He had no water or fluids at bedside. His overbed table dirty smeared dirty with an open applesauce with a spoon in it and an empty box of Ritz peanut butter crackersOn 07/09/25 at 9:48 A.M. Certified Nurse Aide (CNA) #132 was walked down the hall past the resident's room. The surveyor went into the hall and spoke with CNA #132. CNA #132 entered Resident #132's room, acknowledged the resident did not have water or fluids in reach.The facility did not have an ice water policy. This deficiency represents non-compliance investigated under Complaint Number OH00166783 (1330314).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to maintain toilet rails, thresholds, walls, floors and dressers. This affected six (Resident's #2, #3, #4, #5 #8, and #9) of 117 residents in the facility.Findings include:Observations 07/09/25 between 9:33 A.M. and 10:27 A.M. revealed:- Resident #3's bathroom toilet had handrails attached to the bolts that held the toilet seat on the toilet. The rails moved when touched. The right railed moved approximately six inches and the left rail four inches. The toilet water was a milky pink color. The bathroom had an incontinence odor. The door frames entering the room and bathroom were scraped heavily with the paint off. The sink bowl was dirty a rusty color. There were seven broken tiles on the bathroom walls.- The community shower room between three and four the handrails attached to the toilet moved two to four inches when touched. There was molding off the wall between on the right exiting the shower. The linoleum type tile blocks at the threshold of the bathroom door were broken off on the hall side.- Resident #2's bathroom had rails attached to the toilet. The rails moved several inches when held onto making a jiggle motion. There were six tiles off the bathroom wall. Two tiles behind the toilet and four at the shower room were off the wall. Resident #2 did not use the [NAME] and [NAME] bathroom but Resident's #8 and #9 in the adjoining room utilized the bathroom.- Resident #4's floor was sticky. You could hear shoes sticking on floor when walking in the room. A urinal was on the floor. There were three puddles of liquid on the floor in front of the recliner he was sitting in at the time. The rails on his toilet were very loose moving approximately six inches on the left when jiggled and six on the right. The bath tub was blacked on the front quarter. There was black grout around 12 of the wall tiles around the tub, - Resident #5's rails on her toilet were loose moving approximately three inches when jiggled. The doorframe into the bathroom had the paint scrapped off. All four of her dresser drawers were damaged with the facing damaged. Interview 07/09/25 at 9:58 A.M. with Registered Nurse (RN) #83 verified Resident #4's sticky bedroom floor, liquid on the floor, loose toilet rails, and blacked bath tub and grout.Interview 07/09/25 at 10:10 A.M. with Licensed Practical Nurse (LPN) #15 verified the unstable toilet seat rails, toilet bowl water, damaged door frames, broken tiles, dirty sink and odor in Resident #3 room. LPN #15 verified the loose toilet rails in the community shower room, the molding off the wall and damaged floor. LPN #15 verified Resident #2's loose toilet rails, and missing wall tiles affecting Resident's #8 and #9. Interview 07/09/27 at 10:27 A.M. with Certified Nurse Aide #118 verified the toilet rails were loose on Resident #5 toilet, damaged dresser drawers and damaged door frames.The deficiency represents non-compliance investigated under Master Complaint Number OH00167350 (133320) and Complaint Numbers OH00166976 (1330318), OH00166863 (1330317) and OH00166783 (1330314).