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	09/15/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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 0561 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, resident interview, and staff interview, the facility failed to allow a resident to choose to eat a diet texture of their preference when the resident's diet was downgraded without appropriate tests or evaluations completed. This affected one (#49) of one residents reviewed for choices. The census was 112. Findings Include:Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. His diagnoses included amyotrophic lateral sclerosis (ALS), congestive heart failure, hypertensive heart failure, type II diabetes, hyperlipidemia, dysphagia, ischemic cardiomyopathy, atherosclerotic heart disease, old myocardial infarction, nicotine dependence, and non-compliance with other medical treatment and regimen. Review of Resident #49's Minimum Data Set (MDS) assessment, dated 07/02/25, revealed he was cognitively intact. Review of Resident #49's After Visit Summary Hospital form, dated 01/04/24, revealed he was admitted to the hospital for teeth extraction and to treat a tooth/mouth infection. He was admitted back to the facility on [DATE]. Further review revealed a recommendation was made from the hospital for Resident #49 to utilize a soft diet of, **** days after the procedure, but the specific number of days were not identified. There was no documentation that the hospital recommended a long-term diet texture downgrade or a downgrade of his nutritional status.Review of Resident #49's progress note, dated 01/09/24, revealed the resident was referred to speech therapy services. The note revealed nursing reported the resident was coughing on thin liquids and eliciting difficulty with whole medications. Speech Language Pathologist (SLP) #102 spoke with the resident who became agitated when given recommendations and education on diet recommendations/swallow strategies. Resident #49 was educated on reducing aspiration with thickened liquids/crushed medications and the resident reported he only coughed because he was sick and wants staff to leave him be. SLP #102 educated the resident that he was at risk for aspiration, pneumonia, and death if diet recommendations and swallow strategies were not followed and the resident continued to aspirate. Resident #49 returned understanding of the information. Resident #49 also recently had teeth pulled and the resident's swallow function continued to decline due to ALS. Resident #49 was educated on prognosis regarding swallowing, given SLP's name, and encouraged to participate. Resident #49 nodded his head acknowledging the clinician.Review of Resident #49's SLP Discharge Summary document, dated 05/20/24, revealed Resident #49's therapy was to be primarily focused on education. Resident #49 asked to complete a modified barium swallow study (MBSS) to establish a baseline. There was no documentation presented in the document that Resident #49 had a MBSS completed to support the downgrade of his diet.Review of Resident #49's current dietary orders revealed the facility ordered the resident to be downgraded to a pureed texture diet. There was no documentation provided to support medical tests or assessments that were completed to warrant the downgrade.Review of Resident #49's clinical progress notes, dated 02/09/24, 02/28/24, 03/27/24, 05/29/24, 08/14/24, 12/27/24, and 05/13/25, confirmed Resident #49 expression of displeasure for having a pureed texture diet order. There was no documentation to support the facility giving him the option to revert back to a regular texture diet order with the understanding the resident understood the risks associated with it.Interview with Resident #49 (through electronic means) on 09/08/25 at 2:00 P.M. and 09/15/25 at 1:23 P.M. confirmed he refused meals in the facility because he did not want to eat pureed texture food. He confirmed the facility had not offered him any other choices or abilities to eat food provided by the facility, unless it was pureed. He confirmed he had to purchase his own food since January 2024, because the facility will not provide food other than food that was pureed.Interview with Dietitian #101 on 09/11/25 at 9:15 A.M. confirmed Resident #49 had a pureed texture diet order. She confirmed the facility did not offer him any food that was not pureed texture.Interview with SLP #102 on 09/15/25 at 2:52 P.M. confirmed he was not able to change Resident #49's diet order back to mechanical soft or regular texture until he had another swallow study done. SLP #102 confirmed the facility was to provide a pureed texture diet.Interview with Licensed Practical Nurse (LPN) #214 on 09/15/25 at 3:24 P.M. confirmed Resident #49 had a pureed texture diet order. She confirmed the facility does not offer Resident #49 food that would not be pureed.This deficiency represents non-compliance investigated with Complaint Number 2586509.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, review of cleaning schedules, and facility policy review, the facility failed to maintain an clean and homelike environment. This deficient practice affected four (#3, #60, #93, and #105) of 112 residents observed for homelike environment. The facility census was 112.Findings Include:An observation on 09/08/25 at 10:30 A.M. revealed Resident #3 lying in bed with the bed covers pulled up to cover lower body. There were several dark brown stains noted on the white window blinds which were in the half-open position.An observation on 09/08/25 at 2:21 P.M. revealed Resident #93's room had cobwebs located in the corners where the wall met the ceiling and in the windowsill. The floor was dirty with noted stains along the baseboard under the heating and cooling unit and under the three-drawer dresser beside the bed. Further observation revealed Resident #93's fitted and flat sheets were noted to be soiled with dark brown stains near the edge of the bed.An observation on 09/08/25 at 2:30 P.M. revealed Resident #105 sitting in his wheelchair completing a puzzle on the empty bed in his room. The wall directly behind the empty bed was noted to be deeply scratched with several areas of exposed dry wall material noted. The scratches appeared to be approximately one-half inch deep and covered the majority of the lower part of the wall.An observation on 09/10/25 at 8:15 A.M. revealed Resident #60's room with the over the bed light fixture, for bed A, to be uncovered exposing the two florescent light bulbs, the light was turned on. There was no bed located under the light fixture. Resident #60's bed was located closest to the window.A review of the housekeeping room cleaning schedules dated 09/08/25 and 09/09/25 revealed Resident #3 and Resident #93's rooms had been marked as being cleaned by the housekeeping staff.An interview on 09/15/25 at 11:52 A.M. with Maintenance Director (MD) #531 confirmed the unclean conditions in Resident #3 and Resident #93's rooms, the exposed dry wall material in Resident #105's room, and the exposed light bulbs in Resident #60's room.Review of the facility's housekeeping services policy, dated 07/08/25, revealed the purpose was to promote a sanitary environment. This deficiency represents non-compliance investigated under Master Complaint Number 2614276 and Complaint Number 2573417.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to provide assistance with personal hygiene for a resident who was dependent for care. This deficient practice affected one (#63) of eight residents reviewed for activities of daily living. The census was 112.Findings Include:Review of the medical record for Resident #63 revealed an admission date of 07/11/23 with diagnoses including but not limited to heart disease, depression, seizures, and intellectual disabilities. Review of Resident #63 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of seven out possible 15, and required moderate to dependent assistance from staff to complete activities of daily living (ADLs) tasks including personal hygiene and shaving of facial hair.Review of Resident #63's functional ability deficit care plan dated 06/06/24 revealed assistance from staff was required to complete personal hygiene tasks.An observation on 09/08/25 at 10:14 A.M. revealed Resident #63 resting in bed and watching television. Resident #63 had noticeable facial hair on her upper lip and chin area.An observation on 09/09/25 at 8:43 A.M. revealed Resident #63 consuming the breakfast meal. Resident #63 continued to have noticeable facial hair on her upper lip and chin.An interview on 09/09/25 at 3:20 P.M. with Unit Manager (UM) #373 confirmed Resident #63 had noticeable facial hair on upper lip and chin. UM #373 stated the staff should be offering to shave Resident #63 during her shower and as needed when facial hair was noticeable to others. UM #373 further stated Resident #63 does go to activities and will be out in the unit lounge, where she would be seen by peer residents and facility visitors.This deficiency represents non-compliance investigated under Complaint Number 2586509.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 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, resident interview, staff interview, and facility policy review, the facility failed to properly assess a resident prior to making a diet order change, and failed to properly, accurately, and timely obtain resident weights and notify the physician of weight changes as ordered. This affected three (#49, #2, and #9) of eight residents reviewed for nutrition. The census was 112. Findings Include:1. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. His diagnoses included amyotrophic lateral sclerosis (ALS), congestive heart failure, hypertensive heart failure, type II diabetes, hyperlipidemia, dysphagia, ischemic cardiomyopathy, atherosclerotic heart disease, old myocardial infarction, nicotine dependence, and non-compliance with other medical treatment and regimen. Review of Resident #49's Minimum Data Set (MDS) assessment, dated 07/02/25, revealed he was cognitively intact. Review of Resident #49's After Visit Summary Hospital form, dated 01/04/24, revealed he was admitted to the hospital for teeth extraction and to treat a tooth/mouth infection. He was admitted back to the facility on [DATE]. Further review revealed a recommendation was made from the hospital for Resident #49 to utilize a soft diet of, **** days after the procedure, but the specific number of days were not identified. There was no documentation that the hospital recommended a long-term diet texture downgrade or a downgrade of his nutritional status. Review of Resident #49's progress note, dated 01/09/24, revealed the resident was referred to speech therapy services. The note revealed nursing reported the resident was coughing on thin liquids and eliciting difficulty with whole medications. Speech Language Pathologist (SLP) #102 spoke with the resident who became agitated when given recommendations and education on diet recommendations/swallow strategies. Resident #49 was educated on reducing aspiration with thickened liquids/crushed medications and the resident reported he only coughed because he was sick and wants staff to leave him be. SLP #102 educated the resident that he was at risk for aspiration, pneumonia, and death if diet recommendations and swallow strategies were not followed and the resident continued to aspirate. Resident #49 returned understanding of the information. Resident #49 also recently had teeth pulled and the resident's swallow function continued to decline due to ALS. Resident #49 was educated on prognosis regarding swallowing, given SLP's name, and encouraged to participate. Resident #49 nodded his head acknowledging the clinician Review of Resident #49's nutritional orders, dated 01/22/24, revealed on that date, the facility changed his diet texture order from regular texture to pureed texture. Review of Resident #49 progress notes, dated 02/09/24, 02/28/24, 03/27/24, 05/29/24, 08/14/24, 12/27/24, and 05/13/25, revealed documentation to support Resident #49 was refusing meals at the facility due to the facility only offering meals with a pureed texture diet. There was no documentation to support a risk agreement/consent form was offered to Resident #49 to accept acknowledgement and responsibility for defying SLP recommendation/order for a pureed texture diet, which was not the diet texture he wanted. Review of Resident #49's SLP Discharge Summary document, dated 05/20/24, revealed Resident #49's therapy was to be primarily focused on education. Resident #49 asked to complete a modified barium swallow study (MBSS) to establish a baseline. There was no documentation presented in the document that Resident #49 had a MBSS completed to support the downgrade of his diet. Review of Resident #49 nutritional assessments, dated 07/08/24 and 07/03/25, revealed the resident was educated on risks of aspiration but continued to be non-compliant with diet texture. There was no documentation to support a medical assessment had been completed to confirm the resident medically needed to change his diet texture to puree. Review of Resident #49's medication administration records (MAR), dated July 2025 to September 2025, revealed multiple days in which Resident #49 refused his medications. But, when he did take his medications, they were whole pills with no modifications, including oxycodone, Baclofen, Lasix, and Senna. There were no orders for his medication to be crushed and there was no documentation to support the facility crushed his medications prior to giving them to him. Interview with Resident #49 on 09/08/25 at 2:00 P.M. and 09/15/25 at 1:23 P.M. confirmed he does not want to eat a pureed texture diet. He confirmed he had never received a swallow study or medical assessment to determine if he needed a pureed texture diet. He confirmed he has refused to have one because he has not shown signs that he needs to have an assessment completed or that he was having trouble swallowing. He orders his own food to be delivered and eats it with no issues. He confirmed he had never been given the opportunity to sign a risk agreement, understanding that he knows the risks of eating a regular texture diet. He stated the facility only offered food

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, resident and staff interview, review of pest control records, and facility policy review, the facility failed to maintain an effective pest control program. This deficient practice affected three (#3, #52, and #93) of 112 residents observed for environment and pest control. The facility census was 112.Findings Include:An observation on 09/08/25 at 10:15 A.M. revealed Resident #105 sitting at edge of the bed looking out the window. There were multiple house flies noted on the windowsill and bed covers.An observation on 09/08/25 at 11:25 A.M. revealed Resident #52 sitting in a wheelchair in her room awaiting lunch meal service. There were several house flies observed in the room. Resident #52 would occasionally swat at one house fly as it flew around her face.An observation on 09/08/25 at 2:21 P.M. revealed Resident #3 resting in bed with the bed covers pulled up to his chest area. There were multiple house flies on the bed covers and windowsill.An observation on 09/09/25 at 11:00 A.M. revealed Resident #3 sitting up in bed with the bed covers pulled up to cover his lower body. There were multiple flies on the bed covers and flying around Resident #3's face.An interview on 09/09/25 at 11:05 A.M. with Resident #3 revealed there were always flies in his room and he does not like the flies being in his room.An interview on 09/09/25 at 2:00 P.M. with Certified Nurse Aide (CNA) #343 confirmed there are flies throughout the facility, especially in Resident #3's and Resident #105's rooms. CNA #343 stated sometimes there was a pest control company that came to the facility.Review of the facility's pest control visit summary dated 03/25/25 to 09/08/25 revealed the facility was treated for fly activity in the kitchen and in several resident rooms. Further review revealed the pest control company noted the contributing factor for fly activity was poor sanitation in resident bathrooms and recommended cleaning and sanitize the bathrooms of urine and fecal matter on a regular basis.Review of the facility's pest control policy dated 03/05/25 revealed the purpose was to provide an environment free of pests. The facility will have a pest control contract that provides frequent treatment of the environment for pests. It will allow for additional visits when a problem is detected. Monitoring of the environment will be done by the facility's staff. Pest control problems will be reported promptly.