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	10/20/2025

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed resident record review, review of a facility medication error report, review of pharmacy labels, staff interview, and policy review, the facility failed to ensure a resident was free from a significant medication error. This affected one (#105) of three residents reviewed for medication errors. Actual Harm occurred on 09/30/25 for Resident #105, when a nurse crushed and administered an extended release Morphine (narcotic pain medication) tablet to the resident, while also administering double the ordered dose of prescribed Lyrica (anticonvulsant analgesic) to the resident, resulting in the need to administer Narcan (opioid reversal agent) to the resident to reverse the effects of a drug overdose and to be evaluated at the local emergency department (ED), after the overdose occurred. Findings include: Review of Resident #105's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included chronic pain syndrome, opioid dependence, low back pain, Barret's Esophagus (a condition in which the lining of the swallowing tube/ esophagus that connected the mouth to the stomach became damaged by acid reflux causing the lining to thicken, which could result in difficulty swallowing), and adult-onset diabetes mellitus. Review of Resident #105's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He was not coded as having displayed any behaviors during the 14 days of the assessment period. He was indicated on the MDS as having received scheduled pain medication, but no pain medications had been administered on an as needed (prn) basis. He complained of occasional pain in the past 5 days reporting having had pain that was a three on a 1-10 pain scale that did not affect his sleep or day to day activities. The medication section was coded to reflect he had been given opioid pain medications during the seven day assessment period. Review of Resident #105's care plans revealed he had an active care plan in place for being at risk for pain and known to have chronic pain related to low back pain (LBP), chronic pain syndrome, back pain, wounds right hip, and taking opioids. The care plan was initiated on 03/26/24 and was last revised on 09/19/25. The goal was for the resident to verbalize adequate relief of his pain or the ability to cope with incompletely relieved pain. The interventions included administering medications as ordered, observe for ineffectiveness and side effects of pain medication (confusion. hallucinations etc.), and report abnormal findings to the physician. Review of Resident #105's physician's orders revealed the resident had an order to receive MS Contin (an extended release, opioid medication used for the long-term, around the clock management of severe pain) Extended Release (ER) 15 milligrams (mg) by mouth (po) twice a day for chronic pain. The order originated on 09/26/25 and continued until 10/01/25, when the order was altered to reflect the additional directive to Do Not Crush the medication. The resident also had an order to receive Lyrica (an anti-convulsant medication used to treat nerve pain from various conditions) 150 mg po three times a day for neuropathy pain. That order had recently been re-ordered as of 09/28/25. The physician's orders did not provide any directive allowing staff to crush medications as needed. Review of Resident #105's progress notes revealed the resident was sent out to the hospital on [DATE] for worsening of the pressure ulcer to his coccyx. The wound had an increase in size, an increase in pain, and an increase in purulent drainage with a foul odor. He returned to the facility on [DATE] on intravenous antibiotics and a new order for MS Contin 15 mg po twice a day for pain. He did not return with an order for the use of Lyrica 150 mg po three times a day that had been ordered prior to his transfer to the hospital on [DATE]. Review of a telehealth note dated 09/28/25 at 8:00 A. M. revealed the nurse practitioner was notified by nursing that Resident #105's previously prescribed Lyrica that was ordered at 150 mg po three times a day for neuropathy was not on the hospital's discharge summary upon his return to the facility on [DATE]. The resident was requesting his Lyrica to be re-instated for pain. An order was given for Lyrica 150 mg po three times a day to be given on a scheduled basis with directions to hold for sedation. Review of a nurse's progress note from registered nurse (RN) #100 on 09/30/25 at 4:45 P.M. revealed a nurse had alerted her that Resident #105 had confusion and was showing slight sedation effects. The resident was noted to be oriented to self and place when assessed by RN #100 with the following vital signs: Blood pressure 95/75, pulse 65 beats per minute, respirations at 17/ minute, and a temperature of 98 degrees Fahrenheit. The resident's oxygen level was normal at 95% on room air. The nurse reviewed the resident's medication and reported he received an extra dose of medication (not specified) and his extended-release medication (not specified) was given crushed with his other scheduled medications. The physician's assistant (PA) was notified immediately regarding the resident's current