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	10/29/2025

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 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 record review, staff interview, and policy review, the facility failed to ensure an allegation of verbal/ emotional abuse was reported to the State survey agency as required. This affected one (Resident #14) of two residents reviewed for abuse. The facility census was 104. Findings include: Review of Resident #14's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (a condition where the brain did not function properly due to an underlying metabolic disturbance causing cognitive impairment, changes in behaviors, and other neurological symptoms), Bipolar disorder, malignant neoplasm of the uterus, adult failure to thrive, and depression. Review of Resident #14's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any vision or hearing problems and had clear speech. She was able to make herself understood and was able to understand others. She was cognitively intact and was not noted to have any behaviors or rejection of care during the seven days of the assessment period. Review of Resident #14's progress notes revealed a nurse's note dated 10/05/25 at 9:11 A.M. by Licensed Practical Nurse (LPN) #100 that indicated the resident was unresponsive and was having apneic breathing patterns (a temporary cessation of breathing where the body does not inhale or exhale for a period of time). The nurse was unable to get a blood pressure or a recording of the resident's oxygen saturation level. The nurse's progress note did not provide details of any specific assessments that were performed to evaluate the resident's change in condition. The local hospital was called and made a pick-up at 9:15 A.M. Subsequent notes revealed the resident was admitted to the hospital with the diagnoses of sepsis (a life threatening medical emergency caused by the body's overwhelming response to an infection that could lead to tissue damage, organ failure, or death) and an acute kidney injury.Review of the Nursing Daily Schedule for 10/05/25 revealed Certified Nursing Assistant (CNA) #150 was one of two CNA's assigned to work Resident #14's unit when the resident had a change in condition requiring her to be in the emergency room for an evaluation. She was assigned to work day shift from 6:00 A.M. to 6:00 P.M. On 10/28/25 at 10:59 A.M., an interview with CNA #150 confirmed she worked on 10/05/25 when Resident #14 was found unresponsive. She reported the resident was known to go up and down a lot and the resident seemed tired that day. She was also not eating much and was just not herself. She reported she was present when LPN #100 was in Resident #14's room assessing her change in condition. The resident was able to respond verbally, but was not clear in what she was saying. That was somewhat normal for the resident, as she was not always able to make herself clear when speaking. She heard the nurse ask the resident to squeeze his fingers when assessing the resident. She then heard LPN #100 say Oh (saying resident's first name), that was not my fingers. She denied the resident made any acknowledgement to that comment as the resident was out of it. She felt the nurse was insinuating by that comment that the resident had grabbed his penis and not his fingers. She heard that nurse make comments like that in the past. She indicated the comment felt inappropriate to her and made her feel uncomfortable. She was asked if she reported it and confirmed that she had. She reported she told the unit manager (LPN #200) about it. She was given a paper to write out her statement and gave it back to LPN #200, after she completed it. On 10/28/25 at 11:08 A.M., an interview with the facility's Director of Nursing (DON) revealed she was not aware of any incident that had occurred between LPN #100 and Resident #14 on 10/05/25 (where inappropriate comments were made with sexual innuendoes). She denied she had received any witness statements pertaining to any incident occurring on that day and did not recall any concerns being reported by the unit manager on that day. She reported the unit manager was off on 10/28/25, but should be returning to work the following day. She would follow up with the unit manager to see if she had knowledge of any incidents occurring that day. She would also check with the facility's Administrator to see if she had anything on that. On 10/28/25 at 11:30 A.M., the facility's DON came in and reported she spoke to the unit manager about any incidents that occurred on 10/05/25 involving LPN #100 and Resident #14. The DON reported she had been made aware of the situation, but was looking at it more from the perspective of Resident #14's change in condition not being appropriately addressed or her receiving timely care. She thought the CNA's main concern was that the nurse was not addressing the change in condition. She was informed by the surveyor what was being investigated was an inappropriate comment that LPN #100 allegedly made when he was assessing Resident #14 for her change in condition on 10/05/25. She was told LPN #100 was allegedly observed to check Resident #14's hand grasp strength

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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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