STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER The Laurels of Heath		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, the facility failed to protect a resident's right to privacy when staff took a picture of the resident without consent. This affected one (Resident #42) of three residents reviewed for privacy. The facility census was 107.Findings include:Review of the medical record for Resident #42 revealed an admission date of 02/15/23 with diagnoses including paraplegia, seizure, severe-protein-calorie malnutrition, hypertensive without heart failure, insomnia, amaurosis fugax, dilated cardiomyopathy, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #42 had a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Additionally, the MDS revealed Resident #42 was dependent on staff for all activities of daily living (ADLs) to include showering and bathing. Furthermore, Resident #42 was dependent on staff to move from side to side in bed.Interview on 01/29/26 at 8:16 A.M. with Resident #42 revealed a Certified Nursing Assistant (CNA) took a picture of his naked back without his consent. Interview on 01/29/26 at 1:16 P.M. with CNA #55 revealed staff are not to be on their cell phones in patient care areas and absolutely no taking pictures with their cell phone.Interview on 01/29/26 at 1:17 P.M. with CNA #206 revealed the wound nurse is the only person who should be taking pictures of residents and that is with a facility phone so the pictures can be uploaded for wound measurements.Interview on 01/29/26 at 1:30 P.M. with CNA #336 revealed the facility is serious about resident privacy and staff are not to take pictures of residents at any time. Interview on 01/29/26 at 2:14 P.M. with Licensed Practical Nurse (LPN) #500 revealed she was off the unit on 01/04/26 and when she returned to the unit, CNA #233 showed her a picture of Resident #42's back on CNA #233's personal cell phone. LPN #500 stated she went into Resident #42's room and asked him to see the skin issue on his back from the picture and Resident #42 had asked her what picture and LPN #500 stated she told Resident #42 that CNA #233 had taken a picture of his back and showed it to her. LPN #500 stated Resident #42 told her he did not like the fact CNA #233 had taken a picture of his back without asking him first. Additionally, LPN #500 stated she did not report the picture incident to management.Interview on 01/29/26 at 3:29 P.M. with LPN #15 revealed she was working on 01/04/26. LPN #15 stated CNA #233 came to her and told her she had taken a picture of Resident #42's back and then sent the picture to LPN #500, who sent the picture to Resident #42's mother. LPN #15 stated she immediately notified the Assistant Director of Nursing (ADON), who told her he would let the Director of Nursing (DON) and the Administrator know what occurred. LPN #15 stated she did not talk to Resident #42 on 01/04/26 about the picture. LPN #15 stated that she did talk to Resident #42 on 01/05/26 about the picture and Resident #42 told her he was not happy about CNA #233 taking a picture of his back without his permission. Interview on 01/29/26 at 4:03 P.M. with the ADON revealed a CNA had taken a picture of Resident #42's back and sent it to the nurse on the unit who was supposed to send the picture to the wound nurse but had sent the picture to the resident's parents. The ADON stated Resident #42 was upset because he had a BIMS of 15 and was his own person to (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: 365466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make decisions. The ADON stated the cell phone policy is that staff should never have them in direct care areas in the hallways or where residents can see them. Interview on 01/29/26 at 4:19 P.M. with the Administrator revealed she was notified immediately, within two hours of the picture being taken. The Administrator stated she did notify her corporate office immediately. The Administrator stated she did not talk to CNA #233 or Resident #42 about the picture being taken. The Administrator stated the cell phone policy is that staff should not have their cell phones in personal care areas.Interview on 01/29/26 at 4:53 P.M. with Resident #42 revealed he did not know the picture of his naked back had been taken until he received a call from his father who asked him why he would not let the staff take care of him. Resident #42 stated he asked his father what he was talking about and his father texted him the picture of his naked back. Resident #42 stated that was the first time he knew about any picture being taken of his naked back and he was upset. Resident #42 stated that no one asked his permission to take a picture of his naked back.Interview on 01/30/26 at 1:40 P.M. with CNA #233 revealed while giving Resident #42 a bed bath, she took a picture of Resident #42's naked back without his knowledge. Review of the facility policy, Residents Rights, dated 05/14/24 revealed the facility protects and promotes the rights of each resident. The resident has the right to a dignified existence, self-determination, and communication. Facility staff will not hamper, compel by force, treat differently, or retaliate against a resident for exercising his or her rights. Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations affecting resident conduct and those regulations governing protection of resident health and safety. These resident rights include privacy and confidentiality.Review of the facility policy, Telephone, Pager, and Electronic Devices, dated 06/01/24 revealed unless specifically designated otherwise, cellular phones, iPods, tablets, MP3 players, pagers, or any other electronic devices are not permitted to be worn or used in any area outside of the designated staff member break room. Although cellular phones are equipped with cameras and video recording, staff members are strictly prohibited from taking any pictures or videos in any resident area of the facility using personal cell phones.Review of the Centers for Medicare and Medicaid Services (CMS),Center for Clinical Standards and Quality/Survey and Certification Group Memorandum, dated 08/05/16 with the subject of, Regarding Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff, revealed taking photographs or recordings of a resident and/or his/her private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality.This deficiency represents non-compliance investigated under Complaint Number 2708290.

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	01/29/2026

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

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report an allegation of abuse to the State Agency (SA). This affected one (Resident #42) of three residents reviewed for abuse. The facility census was 107. Findings include: Review of the medical record for Resident #42 revealed an admission date of 02/15/23 with diagnoses including paraplegia, seizure, severe-protein-calorie malnutrition, hypertensive without heart failure, insomnia, amaurosis fugax, dilated cardiomyopathy, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #42 had a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Additionally, the MDS revealed Resident #42 was dependent on staff for all activities of daily living (ADLs) to include showering and bathing. Furthermore, Resident #42 was dependent on staff to move from side to side in bed.Interview on 01/29/26 at 8:16 A.M. with Resident #42 revealed a Certified Nursing Assistant (CNA) took a picture of his naked back without his consent. Interview on 01/29/26 at 1:16 P.M. with CNA #55 revealed staff are not to be on their cell phones in patient care areas and absolutely no taking pictures with their cell phone.Interview on 01/29/26 at 1:17 P.M. with CNA #206 revealed the wound nurse is the only person who should be taking pictures of residents and that is with a facility phone so the pictures can be uploaded for wound measurements.Interview on 01/29/26 at 1:30 P.M. with CNA #336 revealed the facility is serious about resident privacy and staff are not to take pictures of residents at any time. Interview on 01/29/26 at 2:14 P.M. with Licensed Practical Nurse (LPN) #500 revealed she was off the unit on 01/04/26 and when she returned to the unit, CNA #233 showed her a picture of Resident #42's back on CNA #233's personal cell phone. LPN #500 stated she went into Resident #42's room and asked him to see the skin issue on his back from the picture and Resident #42 had asked her what picture and LPN #500 stated she told Resident #42 that CNA #233 had taken a picture of his back and showed it to her. LPN #500 stated Resident #42 told her he did not like the fact CNA #233 had taken a picture of his back without asking him first. Additionally, LPN #500 stated she did not report the picture incident to management.Interview on 01/29/26 at 3:29 P.M. with LPN #15 revealed she was working on 01/04/26. LPN #15 stated CNA #233 came to her and told her she had taken a picture of Resident #42's back and then sent the picture to LPN #500, who sent the picture to Resident #42's mother. LPN #15 stated she immediately notified the Assistant Director of Nursing (ADON), who told her he would let the Director of Nursing (DON) and the Administrator know what occurred. LPN #15 stated she did not talk to Resident #42 on 01/04/26 about the picture. LPN #15 stated that she did talk to Resident #42 on 01/05/26 about the picture and Resident #42 told her he was not happy about CNA #233 taking a picture of his back without his permission. Interview on 01/29/26 at 4:03 P.M. with the ADON revealed a CNA had taken a picture of Resident #42's back and sent it to the nurse on the unit who was supposed to send the picture to the wound nurse but had sent the picture to the resident's parents. The ADON stated Resident #42 was upset because he had a BIMS of 15 and was his own person to make decisions. The ADON stated the cell phone policy is that staff should never have them in direct care areas in the hallways or where residents can see them. Interview on 01/29/26 at 4:19 P.M. with the Administrator revealed she was notified immediately, within two hours of the picture being taken. The Administrator stated she did notify her corporate office immediately. Interview on 01/29/26 at 4:43 P.M. with the Administrator revealed she could not find a formal investigation and that LPN #15 did the interviews when the incident occurred. The Administrator stated she did not feel there was intent to do harm, so taking the picture of Resident #42's naked back was not abuse. The Administrator stated she did not complete a report to a State Agency. The Administrator stated it was more of HIPAA violation since CNA #233 took the (continued on next page)

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

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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	picture of Resident #42's back so that he could get care. Interview on 01/29/26 at 4:53 P.M. with Resident #42 revealed he did not know the picture of his naked back had been taken until he received a call from his father who asked him why he would not let the staff take care of him. Resident #42 stated that he asked his father what he was talking about and his father texted him the picture of his naked back. Resident #42 stated that was the first time he knew about any picture being taken of his naked back and he was upset. Resident #42 stated that no one asked his permission to take a picture of his back. Resident #42 stated that he felt violated when he found out about the picture of his naked back being taken without his consent because he does not know who saw the picture and that he does not want other people to see him in this condition. Interview on 01/30/26 at 1:40 P.M. with CNA #233 revelaed did not ask Resident #42 if she could take a picture of his naked back while she was giving him a shower. CNA #233 stated that she was never suspended and does not know if any investigation occurred. CNA #233 stated that LPN #15 had told her today not to speak with anyone about the picture of Resident #42's back.Review of the facility policy, Abuse Prohibition Policy, dated 10/14/22 stated that allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative.Review of the Centers for Medicare and Medicaid Services (CMS), Center for Clinical Standards and Quality/Survey and Certification Group Memorandum dated 08/05/16 with subject of Regarding Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff, stated that the facility must report all allegations of abuse, provide protections for any resident involved in allegations, conduct a thorough investigation, implement corrective actions to prohibit further abuse, and to report the findings as required. Anytime that the nursing home receives an allegation of abuse, including those involving posting of an unauthorized photograph or recording of a resident on social media, the facility must not only report the alleged violation to the Administrator and other officials, but must also initiate an immediate investigation.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record review, the facility failed to complete a thorough investigation when informed of staff taking a photo of a resident without consent. This affected one (Resident #42) of three residents reviewed for abuse. The facility census was 107. Findings include:Review of the medical record for Resident #42 revealed an admission date of 02/15/23 with diagnoses including paraplegia, seizure, severe-protein-calorie malnutrition, hypertensive without heart failure, insomnia, amaurosis fugax, dilated cardiomyopathy, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #42 had a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Additionally, the MDS revealed Resident #42 was dependent on staff for all activities of daily living (ADLs) to include showering and bathing. Furthermore, Resident #42 was dependent on staff to move from side to side in bed.Interview on 01/29/26 at 8:16 A.M. with Resident #42 revealed a Certified Nursing Assistant (CNA) took a picture of his naked back without his consent. Interview on 01/29/26 at 1:16 P.M. with CNA #55 revealed staff are not to be on their cell phones in patient care areas and absolutely no taking pictures with their cell phone.Interview on 01/29/26 at 1:17 P.M. with CNA #206 revealed the wound nurse is the only person who should be taking pictures of residents and that is with a facility phone so the pictures can be uploaded for wound measurements.Interview on 01/29/26 at 1:30 P.M. with CNA #336 revealed the facility is serious about resident privacy and staff are not to take pictures of residents at any time. Interview on 01/29/26 at 2:14 P.M. with Licensed Practical Nurse (LPN) #500 revealed she was off the unit on 01/04/26 and when she returned to the unit, CNA #233 showed her a picture of Resident #42's back on CNA #233's personal cell phone. LPN #500 stated she went into Resident #42's room and asked him to see the skin issue on his back from the picture and Resident #42 had asked her what picture and LPN #500 stated she told Resident #42 that CNA #233 had taken a picture of his back and showed it to her. LPN #500 stated Resident #42 told her he did not like the fact CNA #233 had taken a picture of his back without asking him first. Additionally, LPN #500 stated she did not report the picture incident to management.Interview on 01/29/26 at 3:29 P.M. with LPN #15 revealed she was working on 01/04/26. LPN #15 stated CNA #233 came to her and told her she had taken a picture of Resident #42's back and then sent the picture to LPN #500, who sent the picture to Resident #42's mother. LPN #15 stated she immediately notified the Assistant Director of Nursing (ADON), who told her he would let the Director of Nursing (DON) and the Administrator know what occurred. LPN #15 stated she did not talk to Resident #42 on 01/04/26 about the picture. LPN #15 stated that she did talk to Resident #42 on 01/05/26 about the picture and Resident #42 told her he was not happy about CNA #233 taking a picture of his back without his permission. Interview on 01/29/26 at 4:03 P.M. with the ADON revealed a CNA had taken a picture of Resident #42's back and sent it to the nurse on the unit who was supposed to send the picture to the wound nurse but had sent the picture to the resident's parents. The ADON stated Resident #42 was upset because he had a BIMS of 15 and was his own person to make decisions. The ADON stated the cell phone policy is that staff should never have them in direct care areas in the hallways or where residents can see them. Interview on 01/29/26 at 4:19 P.M. with the Administrator revealed she was notified immediately, within two hours of the picture being taken. The Administrator stated she did notify her corporate office immediately. The Administrator stated she did not talk to CNA #233 or Resident #42 about the picture being taken. The Administrator stated the cell phone policy is that staff should not have their cell phones in personal care areas.Interview on 01/29/26 at 4:29 P.M. with the Administrator and the ADON verified they did not talk to CNA #233 or LPN #500 about the picture of Resident #42's back and they did not verify that CNA #233 or LPN #500 had deleted the picture of Resident #42's back from their (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal cell phones.Interview on 01/29/26 at 4:43 P.M. with the Administrator revealed she could not find a formal investigation and that LPN #15 did the interviews when the incident occurred. The Administrator stated she did not feel there was intent to do harm, so taking the picture of Resident #42's naked back was not abuse. The Administrator stated she did not complete a report to a State Agency. The Administrator stated it was more of HIPAA violation since CNA #233 took the picture of Resident #42's back so that he could get care. Interview on 01/29/26 at 4:53 P.M. with Resident #42 revealed he did not know the picture of his naked back had been taken until he received a call from his father who asked him why he would not let the staff take care of him. Resident #42 stated that he asked his father what he was talking about and his father texted him the picture of his naked back. Resident #42 stated that was the first time he knew about any picture being taken of his naked back and he was upset. Resident #42 stated that no one asked his permission to take a picture of his back. Resident #42 stated that he felt violated when he found out about the picture of his naked back being taken without his consent because he does not know who saw the picture and that he does not want other people to see him in this condition. Interview on 01/30/26 at 1:40 P.M. with CNA #233 revelaed did not ask Resident #42 if she could take a picture of his naked back while she was giving him a shower. CNA #233 stated that she was never suspended and does not know if any investigation occurred. CNA #233 stated that LPN #15 had told her today not to speak with anyone about the picture of Resident #42's back.Review of the facility policy, Abuse Prohibition Policy, dated 10/14/22 stated that allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative.Review of the Centers for Medicare and Medicaid Services (CMS), Center for Clinical Standards and Quality/Survey and Certification Group Memorandum dated 08/05/16 with subject of Regarding Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff, stated that the facility must report all allegations of abuse, provide protections for any resident involved in allegations, conduct a thorough investigation, implement corrective actions to prohibit further abuse, and to report the findings as required. Anytime that the nursing home receives an allegation of abuse, including those involving posting of an unauthorized photograph or recording of a resident on social media, the facility must not only report the alleged violation to the Administrator and other officials, but must also initiate an immediate investigation.