STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365558	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Hamilton	2923 Hamilton Mason Road Hamilton, OH 45011

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure staff provided the appropriate level of resident supervision during mechanical lift transfers. This affected one (Resident #31) of three residents reviewed for falls. The facility census was 76 residents. Findings include: Review of the medical record for Resident #31 revealed an admission date of 08/06/25 with diagnoses including cerebral infarction, chronic obstructive pulmonary disease (COPD), and respiratory failure. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 11/13/25 revealed the resident was dependent on staff to transfer between surfaces.Review of the nurse progress note for Resident #31 dated 12/03/25 at 6:00 P.M. revealing the resident slid out of a mechanical lift (Hoyer) during transfer. Staff assessed Resident #31 and the resident was transferred to the emergency room for evaluation.Review of a hospital note for Resident #31 dated 12/03/25 revealed the resident was evaluated in the emergency department for a fall from a mechanical lift and returned to the facility on [DATE]. Interview on 02/23/26 at 10:10 AM with the Director of Nursing (DON) confirmed on 12/03/25 Resident #31 slid from the Hoyer lift during a transfer. The DON confirmed Certified Nurse Assistant (CNA) #111 and family member of Resident #31 performed the transfer at the time of the incident. The DON confirmed the facility's policy required two trained staff members for all mechanical lift transfers and stated her expectation was that at least two trained staff members always operated mechanical lifts.Interview on 02/23/26 at 10:50 AM with CNA #111 confirmed she performed a transfer from chair to bed for Resident #31 on 12/03/25 utilizing a Hoyer lift. CNA #111 stated the resident's family member offered to assist with the transfer, but the aide stated she told the family member she would find another staff member. CNA #111 stated when Resident #31's family member insisted on helping with the transfer, the aide and the family member completed the transfer. CNA #111 stated Resident #31 was in a chair, and she attempted to reposition the Hoyer pad below the resident's knees prior to initiating the lift. CNA #111 stated she began lifting the resident with the mechanical lift when the resident started screaming and jiggling. CNA #111 stated she lowered the mechanical lift and the resident slid down onto the floor. CNA #111 confirmed Resident #31 has required a Hoyer lift since admission and is always a two-person assist for transfers with trained staff.Review of the facility policy titled Mechanical Lift dated 07/15/25 revealed during transfers staff are to use the required number of trained staff and follow manufacturer instructions. This deficiency represents noncompliance investigated under Complaint Number 2722681 and Complaint Number 2701173 and Complaint Number 2701465.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected two (Residents #65 and #66) of four residents reviewed for medication administration. The facility census was 76 residents. Findings include: Review of the medical record for Resident #65 revealed an admission date of 04/02/19 with diagnoses including seizure disorder, disorganized schizophrenia, and anxiety. Review of the Minimum Data Set (MDS) assessment for Resident #65 dated 11/02/25 revealed the resident had severe cognitive impairment.Review of the medication error report for Resident #65 dated 11/14/25 revealed on 11/14/25 at approximately 8:30 P.M. Licensed Practical Nurse (LPN)#188 administered Ativan one milligram (mg), Metformin 500 mg, and Remeron 7.5 mg to Resident #65. Resident #65 did not have orders for these medications. Review of the medical record for Resident #66 revealed an admission date of 07/18/25 with diagnoses including dementia, diabetes mellitus type two, and schizoaffective disorder. Review of the MDS assessment for Resident #66 dated 10/30/25 revealed the resident had severe cognitive impairment. Review of medication error report for Resident #66 dated 11/14/25 revealed on 11/14/25 at approximately 8:30 P.M. LPN #188 administered Lithium 750 mg, Lamictal 150 mg, Clozapine 300 mg, atorvastatin 20 mg, and Risperdal one mg to Resident #66. Resident #65 did not have orders for these medications.Review of the progress note for Resident #66 dated 11/14/25 revealed that following the medication administration on 11/14/25 at 11:00 P.M. Resident #66 was found unresponsive. and was transferred via emergency medical services to the hospital for evaluation. Hospital documentation revealed the resident was admitted with a diagnosis of complicated urinary tract infection.Review of the facility's medication error investigation revealed LPN #188 administered medications prescribed for Resident #66 to Resident #65 and medications prescribed for Resident #65 to Resident #66. The medication error investigation report further revealed that LPN #188 was orienting with Registered Nurse (RN) #151.Interview on 02/19/26 at 3:11 P.M. with RN #151 confirmed she was orienting LPN #188 on 11/14/25. RN #151 stated she instructed LPN #188 to administer medications as part of his orientation and informed him she was available if he needed assistance or had questions. RN #151 stated she remained on the unit and was accessible, but she did not enter the room with LPN #188 during the medication administration that resulted in the error. RN #151 stated LPN #188 notified her of the medication error after they observed Resident #66's change in conditionInterview on 02/23/26 at 10:03 A.M. with the Director of Nursing (DON) confirmed LPN #188 was in orientation during the incident on 11/14/25 and that he entered the resident's room for medication administration by himself The DON further confirmed LPN #188 stated he confused the residents residing in the shared room and administered the medications incorrectly.Review of the facility policy titled Medication Administration dated 06/17/25 revealed medications are to be administered in accordance with professional standards of practice and that staff must ensure the six rights of medication administration are followed, including right resident, right medication, right dose, right route, right time, and right documentation. The policy requires staff to compare the medication source with the Medication Administration Record (MAR) to verify the correct resident prior to administration.This deficiency represents noncompliance investigated under Complaint Number 2722681 and Complaint Number 2701173.