STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365222	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Norworth The	6830 North High Street Worthington, OH 43085

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, review of the State agency reporting system (CALS), review of emergency medical services (EMS) reports, review of police reports, review of facility emails, and policy review, the facility failed to timely report allegations of inappropriate sexual behavior made by four residents to the state agency and/or local law enforcement. This affected four residents (#33, #58, #77, #97) out of five residents reviewed for abuse. The facility census was 106.Findings include:1. Review of the record for Resident #33 revealed the resident was admitted to the facility on [DATE]. Pertinent diagnoses included epilepsy, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), type two diabetes, chronic kidney disease stage four (CKD4), acquired left leg absence above right knee, and depression.Review of the Minimum Data Set (MDS) dated [DATE] for Resident #33 revealed she was moderately cognitively impaired, was dependent on staff for toileting, toilet transfers and chair transfers and required substantial/maximum assistance for showering, lower body dressing and putting on footwear.Review of the social work progress note dated 11/19/25 at 10:18 A.M. revealed the social services note author provided comfort to Resident #33, as resident presented as agitated and sad. The note went on to say the resident declined for her power of attorney to be contacted and that she had to wait for the police to come take her.Review of the certified nurse practitioner (CNP) progress note dated 11/20/25 at 12:00 A.M. revealed Resident #33 was seen for general laboratory follow up in the context of Resident #33's multiple medical issues. Resident #33 was noted to be alert and oriented times three and calm at the time of the appointment that day. The CNP noted Resident #33 had some dysuria (urinary pain) but tested negative for urinary tract infection. Pyridium was ordered for three days for symptom management. Review of the Change in Condition Evaluation dated 11/24/25 at 12:56 P.M. revealed Resident #33 was identified to have altered mental status, behavioral symptoms of agitation and psychosis, had been refusing medications and needed more assistance with activities of daily living (ADL). The note indicated the primary care physician had recommended for Resident #33 to be sent to the hospital.Review of the nurses progress note dated 11/24/25 at 1:46 P.M. noted Resident #33 was sent to the hospital for further evaluation, the residents power of attorney was notified of the transfer. Resident #33 was picked up by the ambulance company for altered mental status at 1:37 P.M. and transported to the hospital. There was no documentation in this note or any other progress note of any allegations made on this date.Review of the emergency medical services (EMS) run report for 11/24/25 for the transport of Resident #33 revealed Resident #33 was described as agitated and aggressive. Per the note, the EMS staff had difficulty with getting the residents blood pressure and the facility Registered Nurse (RN) #505 offered to assist when Resident #33 turned to RN #505 and said that he had raped her and that she was leaving her blood on her face so that they will know what he did.Review of the transport incident report dated 11/24/25 at 5:37 P.M. revealed Resident #33 screamed at the facility RN [#505] and to EMS how she (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:	(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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been raped by the RN. The resident stated you raped me, to RN #505.Review of the hospital medical records for Resident #33 from 11/24/25 to 12/04/25 revealed no indication that a Sexual Assault Forensic Exam was completed.Review of the Certification and Licensure System (CALS) revealed the sexual abuse allegation made by Resident #33 towards RN #505 on 11/24/25 was not reported to the State agency.Interview on 12/03/25 at 5:43 P.M. with Emergency Medical Technician (EMT) #701 confirmed the details of the written reports and described in detail the experience of preparing Resident #33 to go to the hospital. She said that when RN #505 attempted to assist EMT with getting the resident's blood pressure, the resident stated the allegation to RN #505, Do you think I forgot? I know you raped me. You [explicit] raped me. You used your fingers and put blood all over my face. EMT #701 said that RN #505 looked distraught and stepped back when the resident made her statements. EMT #701 said a female staff member wearing grey went up to RN #505 as if to console him. EMT #701 said she had no doubt that RN #505 had heard the accusation as Resident #33 was screaming. EMT #701 also shared that since Resident #33 was so agitated, they had to call a second level emergency crew to provide a higher level of care, however, she chose to ride with the resident in order for her to have a familiar face and also so EMT #701 could report the allegation to the hospital. She said she made sure the hospital nurse at the emergency room knew what was said. She said she did not get the name of the hospital nurse.Interview on 12/04/25 at 7:54 A.M. with RN #505 revealed that he heard the accusation that Resident #33 made that he raped her. He said that because of the statement she made, he made a point to tell the second EMS crew about her agitation towards him and suggested they might want to avoid having male caregivers due to her emotional state. He said that he told Unit Manager #461 afterwards. Interview on 12/04/25 at 9:40 A.M. with Unit Manager #461 revealed that RN #505 did not tell her that Resident #33 accused him of rape. She said she would expect RN #505 to tell her if an accusation like that had happened. She denied consoling RN #505 during the allegation. She did say that she apologized to the EMT crew for the resident scratching them. She said that if RN #505 had told her that Resident #33 had made an allegation of rape, she would have reported it.Interview on 12/04/25 at 9:45 A.M. with both RN #505 and Unit Manager #461. RN #505 said to Unit Manager #461 that he did tell her about the allegation. Unit Manager #461 denied that he did. He said he told her at the doorway, however, he admitted that he didn't confirm that she heard him. He repeated that he even updated the EMS crew that the resident was afraid of men. Unit Manager #461 said again that if she had been told, she would have reported it. RN #505 said he should have documented what was said.During a telephone interview on 12/04/25 at 10:45 A.M. Resident #33's family stated that he had not heard Resident #33's allegation that she had been raped, however, she had previously made statements to him that someone at the facility had hurt her. He went on to say that with her current mental state, he didn't know what was true. He said he did not think she had been raped. Interview on 12/04/25 at 12:20 P.M. with the Director of Nursing confirmed that the allegation had not been reported to the State agency. She said that they would report an allegation of rape or assault and they always error on the side of caution.2. Review of the record for Resident #97 revealed the resident was initially admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including Alzheimer's disease with late onset, hypertensive heart and chronic kidney disease with heart failure and chronic systolic (congestive) heart failure.Review of the Brief Interview for Mental Status (BIMS) results dated 05/14/25 for Resident #97 indicated a score of 13, which is defined as cognitively intact.Review of the social services progress note dated 05/14/25 at 1:29 P.M. revealed Resident #97 had approached the social services worker and stated that her roommate touched her private part with her toes. The social worker documented that she notified the Director of Nursing regarding the matter (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the two roommates were separated. The social worker charted that she called the resident's daughter to offer for the resident to be transported to the hospital for an exam and for a police report to be filed. The daughter declined, noting she did not believe her mother, given a conflict the days prior in which the resident was angry and made accusations that the daughter was homosexual.Review of the facility self-reported incident investigation typed witness statement dated 05/14/25 revealed the Director of Nursing had documented that when she interviewed Resident #97 and the resident said that when she walks by the roommate, she pinches her on the butt. The typed statement said that the Resident #97 had said that her roommate was homosexual and that she was not sleeping well and had bad dreams and woke up to see people standing over her.Further review of the investigation documentation revealed no evidence that the police were notified regarding the allegation of sexual assault. Interview on 12/04/25 at 12:20 P.M. with the Director of Nursing who said she did not report the allegation of sexual assault to law enforcement because the daughter had said she did not want it to be reported. 3. Review of Resident #18's record revealed he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type two diabetes mellitus, chronic kidney disease, and bipolar disorder.Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #18 revealed he was cognitively intact and needed partial/moderate assistance with toileting, showering and lower body dressing. Resident #18 was assessed to need supervision or touching assistance to walk 50 feet and was assessed to be independent with use of wheelchair for 50 feet.a. Review of the nursing progress note for Resident #18 dated 07/24/25 at 6:24 P.M. revealed the nurse was notified that Resident #18 was smoking outside with other guests when he stood up, brought out his penis and urinated in front of other guests. Per the note, the guest was educated about using bathrooms or urinal, call for help when in need and to not urinate in front of guests.Review of nursing progress note dated 07/24/25 at 6:51 P.M. revealed all residents in the courtyard were interviewed and had no complaints at the time.Review of facility documentation revealed no documented evidence regarding what residents were interviewed about the incident or if any other residents in the building within sight of the window were interviewed.Interview on 12/09/25 at 8:40 A.M. with the facility Administrator confirmed she did not file an incident report or police report regarding the public urination on 07/24/25. She referenced the nurse having documented that there were no complaints about the incident, however, she relayed that she had asked the nurse and the nurse had not documented and did not remember what residents she spoke with. She confirmed there was no documentation that any residents within view of the courtyard through the window were interviewed.b. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, polyneuropathy, bipolar disorder, anxiety disorder, and post-traumatic stress disorder (PTSD).Review of the police report dated 08/07/25 revealed the Administrator had called the police per report from Resident #77 who said that Resident #18 had exposed himself to Resident #77 while urinating in the courtyard on 08/05/25. The police report did not have documentation of an interviews with residents. The police officer documented that he was told by the facility Administrator that the resident likely did not know what he was doing and that he was being treated for cognitive impairments and that she was buying pants that fit the resident to mitigate the situation from happening in the future. Interview on 12/03/25 at 9:38 A.M. with Resident #77 revealed it happened three times to her where she saw Resident #18's penis and she felt like Resident #18 knew what he was doing. She said she felt disrespected by staff and that they didn't take her seriously that it was upsetting to her.c. Review of the police report dated 11/08/25 at 5:25 P.M. revealed the officer was investigating a sexual offense and that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 had filed the report because Resident #18 had urinated in front of others in the past and Resident #58 was sick of it and wanted Resident #18 charged. The officer noted he spoke with Social Services Supervisor #520, whom he incorrectly identified as the Administrator. The officer noted that Social Services Supervisor #520 said that Resident #18 had behavioral and mental disabilities and had loose fitting clothes that sometimes fell down. The officer noted Social Services Supervisor #520 said they were working on getting him better fitting clothes. The report states the offense was public indecency [exposure] and the incident was coded as a sexual offense.Review of the email documentation dated 11/08/25 at 6:27 P.M. authored by Social Services Supervisor #520 and sent to the Administrator and the DON revealed that the Social Services Supervisor #520 was notified by a nurse that Resident #18 had been found urinating in the courtyard in front of other residents. She said that she spoke with Resident #77 and Resident #58 and they were frustrated by the reoccurring incidents, and that Resident #77 had grandchildren visiting and she did not want her grandchildren to see that. The email noted that Resident #58 had called the police. The email went on to say that Social Services Supervisor #520 had spoken with Resident #18 who admitted that he urinated in the courtyard because he was unable to hold it. She said she recommended that he use the restroom prior to going to the courtyard to smoke.Review of the Certification and Licensure System (CALS) revealed the sexual abuse allegation made by Resident #58 towards Resident #18 on 11/08/25 was not reported to the State agency.Review of psychiatric note for Resident #18 dated 11/13/25 at 1:45 P.M. revealed Resident #18 had a diagnosis of schizophrenia. The note referenced the incident of indecent exposure in the courtyard and said that Resident #18 stated he urgently needed to urinate and ensured his back was turned away from other residents.Review of progress note dated 11/23/25 at 10:08 P.M. for Resident #18 revealed Resident #18 was seen walking outside his room unclothed and exposing his private areas. Per the progress note, witnesses stated that he intentionally exposed himself. Before this, nursing staff and caregivers attempted multiple times to dress the resident however he repeatedly removed his clothes.Interview on 12/04/25 at 11:12 A.M. with Columbus Police Sexual Assault Unit Detective #702 confirmed that public urination was considered public indecency [exposure] and the incident was coded as a sexual offense. Interview on 12/08/25 at 8:46 A.M. with the Administrator revealed she was unaware of the incident on 11/08/25 with Resident #18 or that there was a police report. She said she would expect to be told this type of information.During an interview on 12/08/25 at 12:52 P.M., Social Services Supervisor #520 acknowledged that Resident #58 and Resident #77 both had sexual trauma history and that it was understandable that they were concerned regarding the multiple incidents with Resident #18 exposing himself. Interview on 12/08/25 at 4:35 P.M. with Social Services Supervisor #520 stated that she did not know why an incident report wasn't filed with the State agency for the 11/08/25 incident with Resident #18 as she had sent a detailed email to both the Administrator and the DON. Interview on 12/08/25 at 5:36 P.M. with Resident #18 revealed he admitted to urinating in the courtyard where the smoking area was. He said he wore Depends and didn't like to go in them and sometimes when he was outside he didn't think he'd make it to the toilet. He said he tried to turn away so that other residents didn't see anything. Review of the facility policy titled, Abuse Prohibition Policy, dated 09/09/22, revealed allegations of verbal, physical, mental, sexual abuse and mistreatment must be reported to the Administrator and then an incident report will be completed. It also noted that any allegation of sexual abuse would be reported to local law enforcement per state law. The policy further stated that allegations of abuse would be thoroughly investigated and documented by the Administrator and reported to the State agency. The policy stated the Administrator, or designee, would notify the State agency of allegations per state guidelines (two hours if abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation or serious injury; all others no later than 24 hours). This deficiency represents non-compliance investigated under Complaint Number OH2680058.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, review of facility emails, review of self-reported incident investigations (SRI) and review of facility policy, the facility failed to thoroughly investigate incidents involving allegations of inappropriate sexual behavior. This affected two residents (#58 and #77) out of five residents reviewed for abuse. The facility census was 106.Findings include:1. Review of Resident #18's record revealed he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type two diabetes mellitus, chronic kidney disease, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #18 revealed he was cognitively intact and needed partial/moderate assistance with toileting, showering and lower body dressing. Resident #18 was assessed to need supervision or touching assistance to walk 50 feet and was assessed to be independent with use of wheelchair for 50 feet.Review of the nursing progress note for Resident #18 dated 07/24/25 at 6:24 P.M. revealed the nurse was notified that Resident #18 was smoking outside with other guests when he stood up, brought out his penis and urinated in front of other guests. Per the note, the guest was educated about using bathrooms or urinal, call for help when in need and to not urinate in front of guests. Review of nursing progress note dated 07/24/25 at 6:51 P.M. revealed all residents in the courtyard were interviewed and had no complaints at the time. Review of facility documentation revealed no documented evidence regarding what residents were interviewed about the incident or if any other residents in the building within sight of the window were interviewed. Interview on 12/09/25 at 8:40 A.M. with the facility Administrator confirmed she did not file an incident report or police report regarding the public urination on 07/24/25. She referenced the nurse having documented that there were no complaints about the incident, however, she relayed that she had asked the nurse and the nurse had not documented and did not remember what residents she spoke with. She confirmed there was no documentation that any residents within view of the courtyard through the window were interviewed.2. Review of the police report dated 11/08/25 at 5:25 P.M. revealed the officer was investigating a sexual offense and that Resident #58 had filed the report because Resident #18 had urinated in front of others in the past and Resident #58 was sick of it and wanted Resident #18 charged. The officer noted he spoke with Social Services Supervisor #520, whom he incorrectly identified as the Administrator. The officer noted that Social Services Supervisor #520 said that Resident #18 had behavioral and mental disabilities and had loose fitting clothes that sometimes fell down. The officer noted Social Services Supervisor #520 said they were working on getting him better fitting clothes. The report states the offense was public indecency [exposure] and the incident was coded as a sexual offense.Review of the email documentation dated 11/08/25 at 6:27 P.M. authored by Social Services Supervisor #520 and sent to the Administrator and the DON revealed that the Social Services Supervisor #520 was notified by a nurse that Resident #18 had been found urinating in the courtyard in front of other residents. She said that she spoke with Resident #77 and Resident #58 and they were frustrated by the reoccurring incidents, and that Resident #77 had grandchildren visiting and she did not want her grandchildren to see that. The email noted that Resident #58 had called the police. The email went on to say that Social Services Supervisor #520 had spoken with Resident #18 who admitted that he urinated in the courtyard because he was unable to hold it. She said she recommended that he use the restroom prior to going to the courtyard to smoke.Review of facility information revealed no documented evidence of an investigation into Resident #58 and Resident #77's allegations towards Resident #18.Interview on 12/08/25 at 8:46 A.M. with the Administrator revealed she was unaware of the incident on 11/08/25 with Resident #18 and confirmed there was no formal (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation. Interview on 12/08/25 at 4:35 P.M. with Social Services Supervisor #520 revealed she had sent a detailed email to both the Administrator and the DON about the 11/08/25 incident. Review of the facility policy titled, Abuse Prohibition Policy, dated 09/09/22, revealed allegations of verbal, physical, mental, sexual abuse and mistreatment must be reported to the Administrator and then an incident report will be completed. The policy further stated that allegations of abuse would be thoroughly investigated and documented by the Administrator and reported to the State agency. This deficiency represents non-compliance investigated under Complaint Number OH2680058.

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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 0689 Level of Harm - 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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEYBased on resident interview, medical record review, review of the self-reported incident (SRI) investigation and witness statements, review of hospital records, policy review, and review of the facility plan of correction documents, the facility failed to ensure a resident requiring transfers with a medical lift was transferred safely and with two staff assistance. Actual Harm occurred on 09/02/25 when Resident #60, who was dependent upon two staff for mechanical lift transfers, was being transferred via one staff assistance in a mechanical lift. The lift fell resulting in the resident sustaining a right femur fracture and subsequent surgery. This affected one (Resident #60) of three residents reviewed for injuries of unknown origin. The facility census was 106.Findings include: Record review revealed Resident #60 was initially admitted to the facility on [DATE] with diagnoses including chronic diastolic (congestive) heart failure, age-related osteoporosis without current pathological fracture, multiple sclerosis, other symptoms and signs involving cognitive functions and awareness.Review of the physician order dated 06/05/23 for Resident #60 revealed staff may use a mechanical lift for transferring the resident.Review of the nursing progress note dated 09/02/25 at 8:57 A.M. and 8:59 A.M. revealed Resident #60 had a rectangular purple bruise to [initially reported as the left thigh and then corrected] the right inner thigh. Resident #60 was unable to describe what happened however the roommate said she thought resident had fallen. The progress note indicated an investigation was to follow.Review of the post fall evaluation, undated and completed by the Director of Nursing (DON), revealed Resident #60 was lowered into wheelchair from a mechanical lift and landed on the wheelchair armrest with her right hip.Review of the facility's Self-Reported Investigation Report (SRI) dated 09/02/25 at 6:04 P.M. revealed that staff noted Resident #60 had a bruise of unknown origin and was unable to describe what had happened. The report said the roommate was interviewed and had heard a thud noise from behind the privacy curtain but did not see a fall.Review of the facility timeline and interview documentation by the DON from the SRI dated 09/02/25 revealed Resident #60 was in her wheelchair when staff arrived for the day shift on 09/02/25. Licensed Practical Nurse (LPN) #446 saw Resident #60 up in her chair in the morning and there were no signs of pain or discomfort. Per the written statements, no incident or accident was reported to the nurse until the afternoon when Certified Nursing Assistant (CNA) #283 reported to the DON that she noticed a new bruise on Resident #60 and that Resident #60 cried out in pain when being transferred. When interviewed, the night shift aide, CNA #286, admitted that he had transferred Resident #60 into her wheelchair using a mechanical lift without assistance, when her chair tipped to the left side. He tried to catch the chair and quickly lower her into it, but she landed on the right side of the wheelchair arm instead. He stated he did get her posture corrected in the chair and did not notice an injury at that time. He asked her if she was okay and she said yes. He said the roommate asked if she fell and he said no, she landed on the chair. He said he did not alert the nurse as he was able to transfer the resident successfully and was not aware at the time an injury had occurred.Review of the Medication Administration Record (MAR) for September 2025 revealed Resident #60 had an order for Acetaminophen Tablet 650 milligrams (mg) to be given every four hours as needed for mild pain. No pain was noted in the medical record on 09/02/25. Review of the facility Situation Background Assessment Recommendation (SBAR) Communication note dated 09/02/25 at 5:30 P.M. revealed Resident #60 had new pain and was described as having occasional labored breathing, short periods of hyperventilation, repeated troublesome calling out, such as loud moaning or groaning. The note documented the primary care (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	physician had recommended hospitalization.Review of the facility transfer form dated 09/02/25 at 5:38 P.M. revealed Resident #60's pain ranged from the right hip to the right knee, and a behavioral note that stated the resident did normally say ouch when receiving care so that was not abnormal however, the resident seemed to be in more pain than usual with noted bruising and pain upon moving the extremity.Review of the emergency room Provider Note dated 09/02/25 at 9:07 P.M. revealed Resident #60 was reportedly either dropped out of bed or out of her chair around 5:30 A.M. and presented to the emergency room at 7:00 P.M. with a possible hip deformity. The note documented they were unable to get any history from the resident.Review of the History and Physical (H&P) Note from the hospital dated 09/02/25 at 10:33 P.M. revealed Resident #60 had an acute femoral neck (hip) fracture with osteoporosis. The H&P noted that Resident #60 was non-ambulatory at baseline. The physician author noted the resident was oriented to name, winced occasionally, and was unable to describe where the pain was or how she ended up in the hospital.Review of the Orthopedic Consult Note dated 09/03/25 at 6:46 A.M. revealed results for Resident #60's computed tomography (CT) of the right hip result included an acute slightly impacted right subcapital femoral neck fracture with underlying suspected osteoporosis. The X-ray of the right hip also revealed a displaced subcapital fracture of the of the right femoral neck. The Orthopedic Surgeon noted he had discussed risks and benefits with the Power of Attorney (POA) who had agreed for Resident #60 to have surgical fixation with right hip hemiarthroplasty.Review of the care plan dated 09/03/25 revealed Resident #60 required two person assistance with toileting and the assistance of two people for transfers using a mechanical lift. Review of the disciplinary action record document dated 09/03/25 revealed CNA #286 was given a final written warning on 09/03/25 with the explanation that staff members shall follow safety rules and report unsafe conditions to the supervisor. The employee improperly utilized a mechanical lift with a resident. The plan for improvement was stated as education on the mechanical lift policy, mechanical lift competency and follow up audits to ensure compliance with safety rules. The disciplinary document was signed by CNA #286 and the DON on 09/03/25.Review of the nursing progress note dated 09/05/25 at 2:50 P.M. revealed Resident #60 returned [from the hospital] at 1:35 P.M. via stretcher accompanied by emergency medical services and had a surgical wound on right hip and bruises on the right thigh and bilateral upper extremities.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired and she was dependent on staff for bed to chair transfers. During an interview on 12/10/25 at 8:09 A.M., LPN #446 said that due to Resident #60's osteoporosis, it was not unusual for Resident #60 to cry out when receiving personal care, however, that day, her cries were different. LPN #446 said she was doing medication pass and a CNA [#283] came to notify her regarding the bruise and the change in Resident #60's baseline response to personal care. LPN #446 said she notified the manager they assessed the pain and were able to identify the area in which Resident #60 was sore. During an interview on 12/10/25 at 9:27 A.M., CNA #286 revealed there was nothing wrong with the mechanical lift, but rather the wheelchair had slipped. He said he normally was with another CNA when using a mechanical lift, however, he admitted he was alone on the morning of 09/02/25 when he was using the mechanical lift to transfer Resident #60. He said the chair slipped because one side was not locking, but he did say they fixed the brakes on the chair. He stated he did not know at the time that she was hurt. During an interview on 12/10/25 at 9:12 A.M., the Administrator confirmed that CNA #286 had operated the manual lift by himself on 09/02/25. She said that because CAN #286 had mentioned that the brakes gave out on the wheelchair, she had the maintenance manager check all the wheelchair brakes. She said CNA #286 was suspended while they completed the investigation, he was retrained on the mechanical lift and the importance of only operating it with two (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365222	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Norworth The	6830 North High Street Worthington, OH 43085

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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 0689 Level of Harm - Actual harm Residents Affected - Few	people and given a final written warning. Review of the facility policy titled, Lippincott procedures Transfer with a mechanical lift, long-term care, undated, revealed all mechanical lifts require two staff members when moving a resident.The deficient practice was corrected on 09/04/25 when the facility implemented the following corrective actions: -On 09/02/25 all residents who required a mechanical lift to transfer, who resided on the same unit, were audited/evaluated by the Assistant Director of Nursing (ADON) to ensure they had no new skin impairments.-On 09/03/25 the Quality Assurance Performance Improvement Committee (QAPI) met to review the incident and determined the cause of the fracture was related to one staff utilizing the mechanical lift instead of two. -On 09/03/25 the Director of Nursing met with CNA #286, educated him on the mechanical lift policy, tested him for competency and gave him a written final warning. -On 09/03/25 the Assistant Director of Nursing (ADON) provided education to all facility CNA's on the mechanical lift policy and required the CNA's to perform a return demonstration via competency checks before their next scheduled shift.-On 09/04/25 the Maintenance Manager #473 performed an audit on all of the wheelchairs in the facility, including the wheelchair used by Resident #60, with no concerns noted. -Ongoing, the Director of Nursing completed compliance audits three times a week for four weeks, weekly for three weeks and random audits thereafter. No concerns were noted with the audits.