STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365443	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Milford	934 State Route 28 Milford, OH 45150

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 medical record review, observation, staff interview, and resident interview, the facility failed to provide resident care in a dignified manner. This affected two (Residents #3 and #41) of three residents reviewed for dignity. The facility census was 132 residents.Findings include:1.Review of the medical record for Resident #41 revealed an admission date of 01/13/26 with diagnoses included anxiety, epilepsy, and anxiety. Review of the Minimum Data Set (MDS) assessment for Resident #41 dated 01/18/26 revealed the resident was cognitively intact and was frequently incontinent of urine. Observation on 01/27/26 at 9:45 A.M. revealed Resident #41 had her call light on. Social Services (SS) #243 answered the call light and came to the edge of the doorway and yelled down the hall using the resident's name telling the nurse at the other end of the hallway that the resident had to go to the bathroom. Interview on 01/27/26 at 9:48 A.M with SS #243 confirmed she had called out in the hallway to the nurse that Resident #41 needed to go to the restroom. Interview on 01/27/26 at 9:50 A.M. with Resident #41 confirmed she hoped no residents or visitors heard SS #243 yell down the hall regarding her toileting needs. Interview on 01/27/26 at 10:00 A.M. with the Director of Nursing (DON) confirmed SS #243 should not have yelled Resident #41's name down the hall. Review of the facility policy titled Privacy/Dignity dated 03/12/25 revealed residents should be treated with dignity. 2. Review of the MDS assessment for Resident #3 dated 10/31/25 revealed the resident was cognitively intact. Observation on 01/28/26 at 11:45 A.M. revealed the Surveyor was interviewing Resident #3 with the door closed when Certified Nursing Assistant (CNA) #336 entered the resident's room without permission, left a meal tray, and exited the room. Interview 01/28/26 at 12:00 P.M. with Resident #3 confirmed staff frequently entered the room without permission and she felt she had no privacy. Interview on 01/28/26 at 12:17 P.M. with CNA #336 confirmed staff should knock on residents' doors (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
	365443	A. Building B. Wing	02/10/2026

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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	and wait to be invited in before entering the room. Review of the facility policy titled Privacy/Dignity dated 03/12/25 revealed staff should knock on residents' doors before entering. Residents should be treated with dignity Review of the facility policy dated 03/12/25 revealed staff should knock on resident's doors before entering. Residents should be treated with dignity for all care needs. This deficiency represents noncompliance investigated under Complaint Number 2728079 and Complaint Number 2700797 and Complaint Number 2664306 and Complaint Number 1287403 and Complaint Number 1287402.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident interview, and staff interview, the facility failed to maintain a homelike, safe environment. This affected three (Residents #3,# 4, #80) reviewed for safe homelike environment. The facility census was 132 residents.Findings include:Based on observation, resident interview, and staff interview, the facility failed to maintain a homelike, safe environment. This affected three (Residents #3,# 4, #80) reviewed for safe homelike environment. The facility census was 132 residents. Findings include: Random observations throughout the day on 01/27/26 and 01/28/26 revealed there were cable boxes hanging over residents' beds and/or resting on the heating unit in the room. The boxes were hanging from the televisions (tvs) by a cord. Interview on 01/27/26 at 10:30 A.M with Resident #80 confirmed he had asked the facility staff on multiple occasions to place the cable box in a safe area and not to place it on his heater. Resident #80 stated the cable box was frequently hot to the touch and the resident further confirmed he thought the cable box looked bad. Interview on 01/28/26 at 9:00 A.M with Resident # 3 confirmed the tv and cable box were located on the wall beside the resident's bed which was against the wall. Resident #3 confirmed the box hung down from the tv over the resident's bed, and the resident was afraid it might hit him in the head. Resident #3 noted he had asked the facility many times to secure it. Interview on 01/29/26 at 11:30 A.M. with Resident #4 confirmed she worried the cable box might get too hot because it was sitting on the heater. Resident #3 noted she had asked the facility to fix it. Interview 02/11/26 at 10:00 A.M with Maintenance Director (MD) #245 confirmed the cable company left the boxes hanging over resident beds or stored on top of heaters. MD#245 further confirmed the boxes were not hung properly and should be fixed. This deficiency represents noncompliance investigated under Complaint Number 2715071 and Complaint Number 2690717 and Complaint Number 2694603 and Complaint Number 2689028 and 2620519 and Complaint Number 2591315 and Complaint Number 1287417 and Complaint Number 1284703 and Complaint Number 1287402.