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 and wait to be invited in before entering the room. (continued on next page)

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

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	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
	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 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.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure resident care conferences were held quarterly. This affected two (Residents #13 and #14) and had the potential to affect all of the residents residing in the facility. The facility census was 132 residents.Findings include:1. Review of the medical record for Resident #13 revealed an admission date of 01/30/25 with diagnoses including chronic obstructive pulmonary disease, acute and chronic respiratory failure, diabetes mellitus type two, and morbid obesity. Review of the Minimum Data Set (MDS) assessment for Resident #13 dated 10/22/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of care conference documentation for Resident #13 revealed the facility did not offer or conduct care conferences for the first quarter of 2025 (January, February and March) and third quarter of 2025 (July, August and September) of 2025. Interview on 01/28/26 at 3:00 P.M. with Resident #13 confirmed the facility had not offered or provided care conferences on a quarterly basis. 2. Review of the medical record for Resident #14 revealed an admission [DATE] with diagnoses of malignant neoplasm of rectosigmoid junction, progressive multiple sclerosis, chronic kidney disease stage III, diabetes mellitus type II, and morbid obesity. Review of care conference documentation for Resident #14 revealed the facility did not offer or conduct care conferences for the first quarter of 2025 (January, February and March) and third quarter of 2025 (July, August and September) of 2025. Review of the MDS assessment for Resident #14 dated 01/08/26 revealed the resident had intact cognition and required staff assistance with ADLs. Interview on 01/28/26 at 3:21 P.M. with Resident #14 confirmed the facility had not offered or provided care conferences on a quarterly basis. Interview on 01/29/26 at 3:11 P.M. with the Administrator verified Residents #13 and #14 were not offered or provided care conferences for the first and third quarters of 2025. Review of policy titled Care Planning Conference revised 03/03/25 revealed the interdisciplinary team would hold a care planning conference with the resident and/or their representative upon admission, quarterly, annually, with a significant change, and as needed. The care conference would be used to identify the resident's potential or actual problems, needs, goals, and discharge plans. This deficiency represents noncompliance investigated under Complaint Number 2700797.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure proper medication storage of an inhaler. This affected one (Resident #86) of one residents with medications stored on the J2 medication cart with orders for Spiriva inhaler. The facility also failed to label and date an insulin pen upon opening. This affected one unknown resident and had the potential to affect seven residents with medications stored on the J1 cart with orders for insulin. The facility census was 132 residents. Findings include: Review of the medical record for Resident #86 revealed an admission date of 04/06/10 with diagnoses including chronic obstructive pulmonary disease (COPD), emphysema, diabetes mellitus type two, and dementia. Review of the physician's orders for Resident #86 revealed an order dated 10/01/22 for Spiriva inhale once daily related to COPD.Review of the Minimum Data Set (MDS) for Resident #86 dated 01/26/26 revealed the resident was cognitively intact. Observation on 01/29/26 from 2:00 P.M. of medication cart J1 with Licensed Practical Nurse (LPN) #371 revealed the cart contained an open Lantus insulin pen with no resident name or open date. Observation of medication cart J2 with LPN #371 revealed the cart contained a Spiriva inhaler with for Resident #86 with an 18mcg capsule being stored in the chamber.Interview on 01/29/26 at 2:01 P.M. with LPN #371 confirmed the Lantus insulin had no resident name or date. LPN #371 confirmed Resident #86's Spiriva inhaler should not be stored with the capsule in the chamber. The capsule should be placed just prior to administration. Interview on 01/29/26 with Unit Manager (UM) #208 confirmed the insulin pen was not properly labeled and should be discarded. UM #208 confirmed the chamber of a Spiriva inhaler should be empty following a medication administration, and the capsules should be placed in the chamber just prior to administration.Review of facility policy titled Medication Administration dated 10/17/23 revealed staff should never administer medications from an unmarked container and should prepare medications immediately prior to administration.