

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE  694 Isaac Prugh Way Kettering, OH 45429	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, interviews, review of Google Maps, and policy review, the facility failed to notify the physician and the Legal Guardian a resident was exiting the facility without supervision and left the facility property unsupervised. This affected one (#51) out of three residents reviewed for elopement. The facility census was 82. Findings include: Medical record review for Resident #51 revealed he was admitted to the facility on [DATE]. Diagnoses included cognitive deficit, old myocardial infarction, anemia, depression, hypertensive heart disease, cerebral infarction, aphasia, insomnia, mood disorder, and adjustment disorder. Review of the legal guardian paperwork revealed the court found by clean and convincing evidence that Resident #51 was incompetent and assigned a guardian effective 04/22/25. Review of the current care plans for Resident #51 revealed at the top of the care plan was a special instruction box that revealed Resident #51 has a guardian. The staff were directed to not allow Resident #51 to leave without permission from the guardian. A care plan, dated 05/15/25, revealed the resident required for twenty-four hour care related to cognition. The interventions listed included to observe for risk/desire to elope. Interview on 04/20/26 at 12:30 P.M. Resident #51 stated he went down the hill in front of the facility and then down the street with no staff members present. Resident #51 revealed the staff at the facility were upset with him when they found out and told him he was not permitted to go outside of the facility unattended. Resident #51 also stated the staff told him he was not permitted to go down the hill and into the street outside of the facility. Resident #51 stated he left the facility grounds last week on another day but could not say what day it was. Interview on 04/20/26 at 1:19 P.M. Social Service Director (SSD) #284 stated Resident #51 was found outside the facility on 04/16/26 around 6:00 P.M. SSD #284 revealed the Director of Nursing (DON) called the facility and reported Resident #51 was observed at [NAME] Park down the street from facility, past [NAME] Park Pond. SSD #284 confirmed she joined the search and found Resident #51 at the end of the facility's long sidewalk near the road, on the left side of the facility property. SSD #284 confirmed Resident #51 refused to go inside the facility. SSD #284 confirmed Resident #51 had a legal guardian of person on file at the facility. Review of Google Maps revealed [NAME] Park is 0.6 miles from the facility. Interview on 04/20/26 at 1:45 P.M. Licensed Practical Nurse (LPN) #158 stated she was Resident #51's nurse when he was found down the street from the facility on 04/16/26 around 6:00 P.M. LPN #158 stated she was not sure how far he got from the facility. LPN #158 stated on this date Resident #51 sat at the end of the property outside, near the road, and refused to enter the facility. LPN #158 confirmed when she saw Resident #51 on 04/16/26 he was sitting next to the road at the base of the hill on the left side of the facility property. Interview on 04/20/26 at 1:59 P.M. Receptionist #210 revealed on the evening of 04/16/26 at 6:00 P.M. the DON called and reported Resident #51 was outside and down the street from the facility. Receptionist #210 reported she observed Resident #51 at the end of sidewalk near the road to the left of the facility property. He refused to come into the facility. Receptionist #210 revealed she told Resident #51 she was not aware he went so far from the property and Resident #51 reported to her he had been even further away than where Resident #51 was found that day. Receptionist #210 stated because (continued on next page)</p>

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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #51 has impaired cognition and a Legal Guardian he was supposed to report to her when he exits the facility. Receptionist #210 revealed Resident #51 was aware of the need to report to her when he goes outside the facility. Receptionist #210 stated on 04/12/26 and 04/19/26 she observed Resident #51 enter the facility and was not aware he had gone outside. Additional review of the medical record revealed no documentation of Resident #51's physician being notified the resident had left the facility property. There was no notification the Legal Guardian was notified the resident had left the property or was going outside unsupervised. Interview on 04/20/26 at 3:48 P.M. Resident #51's Legal Guardian stated the facility failed to notify her of the incident with Resident #51 being outside the facility and down the street on 04/16/26. Resident #51's guardian confirmed she was upset to learn he could go outside the facility unsupervised. Interview on 04/21/26 at 1:02 P.M. Medical Director (MD) #302 confirmed the facility failed to notify her when Resident #51 was found either down the street or near the street on 04/16/26. Review of the facility policy titled Elopement Policy, dated 05/01/22, revealed it is the policy of the facility to prevent the elopement of guests from the facility. An elopement occurs when a resident who needs supervision leaves a safe area without authorization or necessary supervision to do so. If a guest leaves the facility, upon return the Director of Nursing (DON) should notify the Administrator, examine the resident, contact the physician, and contact the resident's legal representative. This was non-compliance discovered during the complaint investigation for Complaint Number 2987791.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure and admission [NAME] Data Set (MDS) 3.0 assesment was completed timely for one (#37) of four residents reviewed for MDS assessments. The facility census was 82. Findings include: Review of the medical record revealed Resident #37 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, myasthenia gravis without exacerbation, and dysphagia. Review on 04/22/26 at 9:30 A.M of the admission MDS 3.0 assessment in the electronic medical record revealed an assessment reference date of 04/12/26. The MDS assessment was identified as still in process and should be completed by 04/19/26. Sections A, B, H, I J, L, M, N, O, P, S were identified as still in progress and not complete. Section V, the Care Area Assessment (CAA) summary was not completed. The document was identified as unsigned. Interview on 04/22/26 at 11:25 A.M. with MDS Coordinator #94 verified the admission MDS assessment for Resident #37 was not completed and was overdue. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, dated October 2023, revealed an admission assessment must be completed within 14 days, with the admission date considered day one. This was an incidental example of non-compliance discovered during the complaint investigation.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, and policy review, the facility failed to ensure the baseline care plan included a resident's hearing status and interventions. This affected one (#85) of four residents reviewed for care plans. The facility census was 82. Findings include: Review of the medical record revealed Resident #85 was admitted to the facility on [DATE] and discharged on 04/03/26. Diagnoses included anemia, vesicointestinal fistula, spinal stenosis, congenital kyphosis, and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #85 was cognitively intact and had moderate difficulty with hearing. Review of the Nursing Comprehensive Evaluation dated 03/23/26 revealed Resident #85 had moderate difficulty with hearing. Review of the baseline care plan for Resident #85 revealed no plan of care related to hearing impairment needs or interventions. Interview on 04/22/26 at 1:14 P.M. with Social Service Assistant (SSA) #203 revealed not aware of any hearing issues or impairment for Resident #85. Interview on 04/22/26 at 1:19 P.M. with Social Service Director (SSD) #204 revealed not aware of any hearing issues or impairment for Resident #85. Interview on 04/22/26 at 1:46 P.M. the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #93 confirmed if a resident has moderate impairment with hearing it would trigger inclusion in the baseline care plan. Both verified Resident #85's hearing impairment was not addressed in the baseline care plan. The DON confirmed there was no discussion regarding audiology services with Resident #85. Review of the policy titled Care Planning, dated 03/03/25, revealed a baseline care plan will be developed within 48 hours identifying any immediate needs, initial goals and interventions needed to provide effective and person-centered care. This deficiency represents non-compliance investigated under Complaint Number 2978380.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews, review of Google Maps, and policy review, the facility failed to ensure a resident with directions from legal guardians not to leave the facility and residents with cognitive impairment did not leave the facility properly unsupervised. This affected two (#51 and #84) of three residents reviewed for elopements. The facility census was 82. Findings include: 1. Medical record review for Resident #84 revealed he was admitted to the facility on [DATE] and discharged to a hospice facility on 04/04/26. Diagnoses included malignant neoplasm of overlapping sites in the brain, hypertension, bipolar disorder, and cerebral edema. Review of the hospital referral for Resident #84, dated 03/26/26, revealed a diagnosis of brain mass, large left posterior frontal lobe and temporal lobe mass, vasogenic edema, and acute encephalopathy. Neurocognitive and functional assessments revealed persistent cognitive deficits, including impaired executive function, memory, and expressive/receptive language, with a St. [NAME] University Memory Score (SLUMS) score consistent with dementia. Review of the Nursing Comprehensive Evaluation dated 03/27/26 revealed under the area of elopement the resident was mobile with a device, had cognitive impairment, and was not identified to be a high risk for elopement. Review of the progress notes for Resident #84, dated 03/30/26 at 7:26 P.M., revealed the resident left the facility this evening and decided to walk outside the facility. Resident #84 wanted to smoke and get fresh air. Resident #84 returned to the facility with no injuries. A Wanderguard was put in place on Resident #84's right lower leg. Review of the facility Self-Reported Incident (SRI) #2750 for neglect, dated 03/31/26 at 11:39 A.M., revealed the incident was identified on 03/30/26 around 4:52 P.M. and involved an elopement of Resident #84. On 03/30/26 at 4:52 P.M. the facility reported Resident #84 asked Activity Aide (AA) #174 to direct him toward the front door. At 5:30 P.M. Licensed Practical Nurse (LPN) #114 reported Resident #84 missing from the facility. The family of Resident #84 was notified of the missing resident at 5:50 P.M. At 6:00 P.M. LPN #114 contacted the local police department and reported Resident #84 missing. On 03/30/26 at 6:10 P.M. the local police department found Resident #84 approximately 1.6 miles away at a car parts store. The facility assessed Resident #84 upon return and Resident #84 did not have injuries. The facility placed a Wanderguard on Resident #84 and updated the medical record. Continued review of the medical record revealed Resident #84's care plan was updated on 03/31/26 to address exit seeking behavior and wandering. Interview with LPN #114 on 04/21/26 at 10:32 A.M. revealed she was the nurse on 03/30/26 around 4:52 P.M. when Resident #84 eloped from the facility. LPN #114 stated the resident had just returned from a family visit around 4:15 P.M. and Resident #84 made the statement that he wanted to smoke. LPN #114 revealed she met with Resident #84's daughter prior to the elopement on 03/30/26 and Resident #84's daughter revealed Resident #84 had the cognition of a twelve-year-old. LPN #114 stated she observed Resident #84 walk through the unit and go back to his room after his daughter had left. LPN #114 stated she went into Resident #84's room and noted he was not there and questioned other staff where he could be. LPN #114 stated she was concerned because no one knew where the resident was so she did a head count. She notified management Resident #84 was missing on 03/30/26 around 5:00 P.M. LPN #114 revealed the family, physician, and police were called. LPN #114 confirmed the local police located Resident #84 at a car parts store and brought him back to the facility. LPN #114 revealed she assessed Resident #84 and he did not have any injuries. LPN #114 obtained an order for the use of Wanderguard. LPN #114 confirmed Resident #114 had some mild confusion; however, it was hard to tell the extent because his daughter would answer for Resident #84 most of the time. Interview on 04/21/26 at 1:02 P.M. Medical Director (MD) #302 revealed you would have to spend a lot of time with Resident #84 to identify his confusion because Resident #84 would answer questions appropriately. Interview on 04/21/26 at 3:45 P.M. LPN #160 confirmed she was the admission nurse for Resident #84 on 03/27/26. LPN #160 (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>confirmed Resident #84 could answer questions; however, the daughter would take over the conversations. LPN #160 confirmed she marked Resident #84 on her assessment as having cognitive issues based on his hospital paperwork. Interview on 04/21/26 at 4:12 P.M. the Administrator reported Resident #84 had no plan and walked 1.5 miles from the facility and did not know where he was. The Administrator identified this as an elopement. Interview on 04/22/26 at 11:05 P.M. AA #174 revealed on 03/30/26 at 4:52 P.M. Resident #84 walked up to her and look confused. Resident #84 asked AA #174 where the front door was. AA #174 reported she had no idea Resident #84 was a resident at the facility and directed him to the front door. Later that day when AA #174 learned Resident #84 had eloped she confirmed she had directed him to the front door. 2. Review of the medical record for Resident #51 revealed he was admitted to the facility on [DATE]. Diagnoses included cognitive deficit, old myocardial infarction, anemia, depression, hypertensive heart disease, cerebral infarction, aphasia, insomnia, mood disorder, and adjustment disorder. Review of the legal guardian paperwork revealed the court found by clean and convincing evidence Resident #51 was incompetent and assigned a guardian effective 04/22/25. Review of the MDS assessment, dated 01/12/26, revealed Resident #51 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 2. Review of the current care plans for Resident #51 revealed at the top of the care plan was a special instruction box that revealed Resident #51 had a guardian. The staff were directed to not allow Resident #51 to leave without permission from the guardian. A care plan, dated 05/15/25, revealed the resident required for twenty-four hour care related to cognition. The interventions listed included to observe for risk/desire to elope. Review of the Risk for Elopement assessment, dated 03/31/26 at 3:56 P.M., revealed Resident #51 was identified to be at risk for elopement. The assessment revealed Resident #51 was mobile with a device. Review of the Risk for Elopement assessment, dated 04/20/26 at 12:30 P.M. revealed Resident #51 was not at risk for elopement. Review of the progress notes for Resident #51, dated 04/20/26 at 12:32 P.M., written by the Director of Nursing (DON), revealed the interdisciplinary team (IDT) met to discuss potential elopement risk. The note documented Resident #51 was alert and oriented. The resident has expressive aphasia and cannot voice what he needs. He will go to the courtyard (secured) when the weather is nice. Resident #51 is able to go out front of the facility and around the facility. Resident is able to leave and return independently. Staff does provide checks when the resident is out front or on the patio. The record contained no documentation Resident #51 had left the facility property unsupervised. Interview on 04/20/26 at 12:30 P.M. Resident #51 stated he went down the hill in front of the facility and then down the street with no staff members present. Resident #51 revealed the staff at the facility was upset with him when they found out and told him he was not permitted to go outside of the facility unattended. Resident #51 also stated the staff told him he was not permitted to go down the hill and into the street outside of the facility. Resident #51 stated he left the facility grounds last week on another day but could not say what day it was. Resident #51 stated if he could get out of the facility he would. Interview on 04/20/26 at 12:48 P.M. the DON stated Resident #51 had an incident occur on 04/16/26 around 6:00 P.M. and she did not feel it was an elopement because he has an inaccurate BIMS score due to his aphasia. The DON stated the IDT team voiced concerns related to the safety of Resident #51 and his low BIMS score of 2 after the incident on 04/16/26. The DON stated Social Service Director (SSD) #284 voiced the concern for Resident #51's safety related to his ability to be outside unsupervised due to his low BIMS score and the need for a guardian. The DON stated she thought the guardian was just for his finances. The DON confirmed the IDT team meeting held on 04/20/26 included the unit managers and the Administrator. The IDT team meeting did not include SSD #284. Interview on 04/20/26 at 1:19 P.M. SSD #284 stated Resident #51 was found outside the facility on 04/16/26 around 6:00 P.M. SSD #284 revealed the DON called the facility and reported Resident #51 was observed at [NAME] Park down the street from facility, past [NAME] Park Pond. SSD #284 confirmed she joined the search and found Resident #51 near the road at the end of the facility's long sidewalk on the left side of the facility property. SSD #284 confirmed Resident #51 refused to go inside the facility. SSD #284 stated Resident #51 had a (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>BIMs score of 2 on his last MDS assessment. However, Resident #51 has a current MDS in progress and his current BIMs score was a 1. SSD #284 confirmed Resident #51 had a legal guardian of person on file at the facility. Review of Google Maps revealed [NAME] Park is 0.6 miles from the facility. Interview on 04/20/26 at 1:45 P.M. LPN #158 stated she was Resident #51's nurse when he was found down the street from the facility on 04/16/26 around 6:00 P.M. LPN #158 state she was not sure how far he got from the facility. LPN #158 stated on this date Resident #51 sat at the end of the property outside, near the road, and refused to enter the facility. LPN #158 stated the DON advised her not to report anything inside Resident #158's chart regarding the elopement because the DON did not consider it an elopement. LPN #158 revealed Resident #51 will usually sit outside the rehabilitation doors in the secured courtyard and she was surprised to learn he was down the street from the facility unattended by staff. LPN #158 confirmed when she saw Resident #51 on 04/16/26 he was sitting next to the road at the base of the hill on the left side of the facility property. Interview on 04/20/26 at 1:59 P.M. Receptionist #210 revealed on the evening of 04/16/26 at 6:00 P.M. the DON called and reported Resident #51 was outside and down the street from the facility. Receptionist #210 reported she observed Resident #51 at the end of sidewalk near the road to the left of the facility property. He refused to come into the facility. Receptionist #210 revealed she told Resident #51 she was not aware he went so far from the property and Resident #51 reported to her he had been even further away than where he was found that day. Receptionist #210 stated because Resident #51 has impaired cognition and a Legal Guardian he was supposed to report to her when he exits the facility. Receptionist #210 revealed Resident #51 was aware of the need to report to her when he goes outside the facility. Receptionist #210 stated on 04/12/26 and 04/19/26 she observed Resident #51 enter the facility and was not aware he had gone outside. Interview on 04/20/26 at 3:48 P.M. Resident #51's Legal Guardian stated the facility failed to notify her of the incident with Resident #51 being outside the facility and down the street on 04/16/26. Resident #51's guardian confirmed she was upset to learn Resident #51 could go outside the facility unsupervised. Resident #51's guardian stated concern over Resident #51's safety with a BIMs score of 2. Interview on 04/20/26 at 5:03 P.M. Unit Manager (UM) #92 revealed she received a call from the DON on 04/16/26 around 6:00 P.M. UM #92 revealed the DON reported she saw Resident #51 down the street on [NAME] Park Road. (The main road in front of the facility driveway) UM #92 reported by the time she got to Resident #51 he was near the street at the end of the sidewalk at the top of the hill on the left side of the facility property. UM #92 revealed Resident #51 refused to come into the facility. UM #92 stated Resident #51 told her he left the facility on Sunday 04/12/26 and had been even further away than where he was found on 04/16/26. UM #92 revealed Resident #51 would usually go to the secured courtyard to sun bath on the rehabilitation patio. UM #92 confirmed she heard the DON advise LPN #158 not to document about Resident #51 being found outside the facility near the road. Interview on 04/21/26 at 1:29 P.M. Physician Assistant (PA) #301 stated if a resident has a BIMs score of 2 and a legal guardian then the resident should not be outside the facility unsupervised. Observation on 04/22/26 at 2:23 P.M. revealed Resident #51 was seated in his wheelchair up the hill on the left side of the facility property at the end of the walkway near the street. Interview on 04/22/26 at 2:23 P.M. Resident #51 stated he was allowed to sit at the top of the hill near the street as long as he does not cross the sidewalk line. Resident #51 confirmed he has left the facility property but would not tell anyone so that he does not get into trouble. Review of the facility policy titled Elopement Policy, dated 05/01/22, confirmed it is the policy of the facility to prevent the elopement of guests from the facility. An elopement occurs when a resident who needs supervision leaves a safe area without authorization or necessary supervision to do so. If an employee observes a guest attempt to leave the facility they should complete an incident report and review the current elopement risk and re-evaluate if needed. If a guest leaves the facility, upon return the Director of Nursing (DON) should notify the administrator, examine the resident, contact the physician, contact the resident's legal representative and inform them of the incident, complete and file an incident report, make appropriate notations in the resident's (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review and policy review, the facility failed to follow physician orders for non-pharmaceutical pain interventions for one (#86) of four residents reviewed for pain management. The facility census was 82. Findings include-Review of the medical record revealed Resident #86 was admitted to the facility on [DATE] and discharged on 03/30/26. Diagnoses included polyarthritis, anxiety disorder, pain in unspecified shoulder, hypertension, and diastolic heart failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 had moderately impaired cognition, was independent with eating and toileting, and required supervision with bathing. Review of the care plan for Resident #86, dated 03/11/26, revealed the resident was at risk for pain and/or has acute pain related to left shoulder replacement, and chronic pain related to polyarthritis. Interventions included to notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Review of the provider orders dated 03/11/26 revealed pain-non-pharmacological interventions: massage, meditation, relaxation, positioning, ice therapy on 20 minutes every hour, diversional activity, guided imagery, rest, and social interaction. Review of the pain level summary for Resident #86 from admission to discharge revealed out of 163 times the resident was checked for pain only 11 times did the resident have a pain level at zero. Review of the Medication Administration Records (MAR) for Resident #86 revealed no non-pharmacological interventions were provided to Resident #86 from admission to discharge. Interview on 04/21/26 at 1:12 P.M. with the Physician Assistant (PA) #301 revealed non-pharmacological interventions should be completed or offered to residents with pain. Interview on 04/21/26 at 1:26 P.M. with Licensed Practical Nurse (LPN) #114 verified non-pharmacological interventions were not done for Resident #86 when pain was reported. Interview on 04/21/26 at 1:52 P.M. with the Unit Manager #92 confirmed the non-pharmacological interventions were not offered for Resident #86 when pain was reported. Interview on 04/22/26 at 1:46 P.M. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #93 revealed Resident #86 had repeated and almost constant complaints about pain and non-pharmacological interventions should have been offered and they were not. Review of the policy titled Pain Management, dated 03/05/25, revealed the staff will implement the care plan, monitor the residents, and administer therapeutic interventions for pain. This deficiency represents non-compliance investigated under Master Complaint Number 2987791 and Complaint Number 2986526.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE  694 Isaac Prugh Way Kettering, OH 45429	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review and policy review, the facility failed to meet the needs of residents with regard to the timeliness of reporting stat and critical laboratory (lab) results and have a lab policy. This affected two Residents (#85 and #87) of three residents reviewed for labs. Findings include: 1. Review of the medical record revealed Resident #85 was admitted to the facility on [DATE] and discharged on 04/03/26. Diagnoses included anemia, vesicointestinal fistula, spinal stenosis, congenital kyphosis, and chronic obstructive pulmonary disease. Review of provider orders for Resident #85 dated 03/20/26 revealed Prottime (PT)/ International Normalized Ratio (INR) on Monday and Thursday. Review of physician orders for Resident #85 dated 03/31/26 revealed warfarin at bedtime every Tuesday, Thursday, and Saturday for treating/preventing blood clots, contact doctor with PT/INR results. Review of PT/INR results dated 04/02/26 for revealed PT 70.4 (high abnormal results) and INR 7.0 (abnormal critical high results). The record had no evidence the physician was notified of the elevated PT/INR levels on 04/20/26. Interview on 04/21/26 at 12:08 P.M. with Medical Director #302 confirmed the critical PT/INR result for Resident #85 was not called to her on 04/02/26. MD #302 confirmed she knew of the result the next day. Interview on 04/21/26 at 1:52 P.M. with the Unit Manager (UM) #92 revealed critical laboratory tests (labs) are to be called to resident's provider and obtain new orders. UM #92 revealed the PT/INR result for Resident #85 results were available but she did not see it until the next morning. UM #92 also confirmed the nurses are instructed to look at labs in the system. Interview on 04/21/26 at 2:23 P.M. with Registered Nurse (RN) #102 revealed they were not aware of the PT/INR result for Resident #85 until 04/21/26. Interview on 04/22/26 at 8:36 A.M. Client Representative (CR) #300 with the facility's lab services American Health Associates, revealed the PT/INR lab drawn on 04/02/26 for Resident #85 with a critical result was called to the facility on [DATE] at 11:36 A.M. CR #300 stated there was only one person working that night so that representative was unable to call right away. CR #300 revealed the PT/INR result was released on 04/02/26 at 6:30 P.M. into the lab system and confirmed the nurses at the facility had access at that time. CR #300 stated their system faxes results however the fax did not go through and failed two times. Review of the American Health Associates (AHA) contract with the facility, dated 08/11/21, revealed critical lab results will be phoned to the facility when they are available. 2. Review of the medical record revealed Resident #87 was admitted to the facility on [DATE] and discharged on 04/07/26. Diagnoses included hyposmolality and hyponatremia, morbid obesity, single subsegmental thrombotic pulmonary embolism without acute cor pulmonale, and hypertension. Review of the medical record revealed Resident #87 had physician orders dated 03/19/26 for PT/INR weekly due to use of coumadin. Review of the medical record revealed Resident #87 had physician orders dated 03/19/26 for a PT/INR STAT for elevated lab levels. Review of the STAT PT/INR results dated 03/20/26 at 4:00 P.M. revealed a PT of 31.9 and an INR of 3.1. There was no documentation the lab test was called to the facility by AHA labs. Review of Resident #87's progress note dated 03/21/2026 at 1:53 P.M. revealed the PT/INR results were reviewed by the nurse and the physician notified. Interview on 04/22/26 at 1:46 P.M. the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #93 revealed critical and STAT labs results usually are called from the lab, but the facility nurses should be looking to see if the labs are in the system. The DON and ADON #93 confirmed the lab didn't call the STAT labs to the facility and the nurse didn't review the lab tests until almost 22 hours after they were available. Review of the AHA contract with the facility, dated 08/11/21, revealed laboratory STAT testing will be reported within five hours. STAT results will be phoned to the facility when they are available. This was an incidental example of non-compliance discovered during the complaint investigation.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews, review of Google Maps, and policy review, the facility failed to document in the medical record when a resident was identified to have left the facility property unsupervised. This affected one (#51) of three residents reviewed for elopement. The facility census was 82. Finding include: Medical record review for Resident #51 revealed he was admitted to the facility on [DATE]. Diagnoses included cognitive deficit, old myocardial infarction, anemia, depression, hypertensive heart disease, cerebral infarction, aphasia, insomnia, mood disorder, and adjustment disorder. Review of the legal guardian paperwork revealed the court found by clean and convincing evidence Resident #51 was incompetent and assigned a guardian effective 04/22/25. Review of the MDS assessment, dated 01/12/26, revealed Resident #51 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 2. Review of the current care plans for Resident #51 revealed at the top of the care plan was a special instruction box that revealed Resident #51 had a guardian. The staff were directed to not allow Resident #51 to leave without permission from the guardian. A care plan, dated 05/15/25, revealed the resident required for twenty-four hour care related to cognition. The interventions listed included to observe for risk/desire to elope. Review of the Risk for Elopement assessment, dated 03/31/26 at 3:56 P.M., revealed Resident #51 was identified to be at risk for elopement. The assessment revealed Resident #51 was mobile with a device. Interview on 04/20/26 at 12:30 P.M. Resident #51 stated he went down the hill in front of the facility and then down the street with no staff members present. Resident #51 revealed the staff at the facility was upset with him when they found out and told him he was not permitted to go outside of the facility unattended. Resident #51 also stated the staff told him he was not permitted to go down the hill and into the street outside of the facility. Resident #51 stated he left the facility grounds last week on another day, but could not say what day it was. Resident #51 stated if he could get out of the facility he would. Interview on 04/20/26 at 12:48 P.M. the Director of Nursing (DON) stated Resident #51 had an incident occur on 04/16/26 around 6:00 P.M. The DON stated she did not feel it was an elopement because she feels he has an inaccurate BIMS score due to his aphasia. Continued review of Resident #51's medical record revealed no documentation regarding the resident leaving the facility property on 04/16/26. Interview on 04/20/26 at 1:19 P.M. Social Service Director (SSD) #284 stated Resident #51 was found outside the facility on 04/16/26 around 6:00 P.M. SSD #284 revealed the DON called the facility and reported Resident #51 was observed at [NAME] Park down the street from facility, past [NAME] Park Pond. SSD #284 confirmed she joined the search and found Resident #51 near the road at the end of the facility's long sidewalk on the left side of the facility property. SSD #284 confirmed Resident #51 refused to go inside the facility. Review of Google Maps revealed [NAME] Park is 0.6 miles from the facility. Interview on 04/20/26 at 1:45 P.M. Licensed Practical Nurse (LPN) #158 stated she was Resident #51's nurse when he was found down the street from the facility on 04/16/26 around 6:00 P.M. LPN #158 stated she was not sure how far he got from the facility. LPN #158 confirmed Resident #51 sat at the end of the property outside, near the road, and refused to enter the facility. LPN #158 stated the DON advised her not to report anything inside Resident #158's chart regarding the elopement because the DON did not consider it an elopement. LPN #158 confirmed when she saw Resident #51 on 04/16/26 he was sitting at the base of the hill on the left side of the facility next to the road. Interview on 04/20/26 at 5:03 P.M. Unit Manager (UM) #92 revealed she received a call from the DON on 04/16/26 around 6:00 P.M. UM #92 revealed the DON reported she saw Resident #51 down the street on [NAME] Park Road. (The main road in front of the facility drive) UM #92 reported by the time she got to Resident #51 he was at the end of the sidewalk at the top of the hill on the left side of the facility property near the street. UM #92 revealed Resident #51 refused to come into the facility. UM #92 confirmed she heard the DON advise LPN #158 not to document (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>about Resident #51 being found outside the facility near the road. Review of the facility policy titled Elopement Policy, dated 05/01/22, confirmed it is the policy of the facility to prevent the elopement of guests from the facility. An elopement occurs when a resident who needs supervision leaves a safe area without authorization or necessary supervision to do so. If an employee observes a guest attempt to leave the facility they should complete an incident report and review the current elopement risk and re-evaluate if needed. If a guest leaves the facility, upon return the Director of Nursing (DON) should complete and file an incident report and make appropriate notations in the resident's medical record. This was an incidental example of non-compliance discovered during the complaint investigation.</p>		