STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366457	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton Road Columbus, OH 43230

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility policy review, and Elder Abuse Act regulation review, the facility failed to report allegations of misappropriation to law enforcement in a timely manner. This affected two (Residents #85 and #101) of three resident investigations reviewed. The census was 98. Findings Include:1.Resident #85 was admitted to the facility on [DATE]. Her diagnoses were urinary tract infection, klebsiella pneumoniae, bacteremia, muscle wasting, muscle weakness, hypertensive heart and chronic kidney disease, congestive heart failure, sciatica, atherosclerotic heart disease, chronic kidney disease, polyneuropathy, hyperlipidemia, vitamin D deficiency, major depressive disorder, insomnia, arthritis, anemia, polyarthritis, and retention of urine. Review of her minimum data set (MDS) assessment, dated 05/20/26, revealed she was cognitively intact. Review of Resident #85's self reported incident (SRI) investigation documentation found that she made an allegation of misappropriation to the facility on [DATE]. She initially reported that she was missing between $30 and $40 from her personal items while she was in the hospital. The facility completed the SRI to the state agency on 05/15/26, but law enforcement was not notified until 05/22/26 when an online theft report was made. 2. Resident #101 was admitted to the facility on [DATE]. His diagnoses were pleural effusion, congestive heart failure, acute and chronic respiratory failure, muscle weakness, lack of coordination, cognitive communication deficit, atherosclerotic heart disease, atrioventricular block, chronic kidney disease, atrial fibrillation, chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease, Type II Diabetes, major depressive disorder, hyperlipidemia, ischemic cardiomyopathy, and dependence on supplemental oxygen. Review of his minimum data set (MDS) assessment, dated 04/20/26, revealed he was cognitively intact. Review of Resident #101's SRI investigation documentation found that his family made an allegation of misappropriation to the facility on [DATE]. They reported that he had his wallet with two credit cards, two blank checks, two quarters, cell phone, watch, jewelry and all his clothing that he had prior to his hospital admission/discharge from the facility. The facility completed the SRI to the state agency on 06/05/26, but law enforcement was not notified until 06/08/26 when an online theft report was made. On 06/09/26, the facility received notification that their online submission was rejected and had to contact local law enforcement via telephone to make the report, which they did. Interview with Administrator on 06/22/26 at 2:30 P.M. stated their abuse policy does not have anything specific regarding a timeframe to report allegation to law enforcement. He confirmed that Resident #85's misappropriation allegation was reported eight days after the initial report to them was made. Also, he confirmed Resident #101's allegation was reported five days after the initial report to them was made. He confirmed the elder abuse act was not specified in their abuse policy regarding reporting timelines to law enforcement. Review of facility Abuse Prohibition Policy, dated 10/14/22, revealed each residents shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the administrator and reported to the appropriate state agencies, physician, families, and/or representative. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or (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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. Review of Elder Abuse Act regulation review revealed each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility. If the events that cause the suspicion: (A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and (B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion. This deficiency represents non-compliance investigated regarding complaint number 3040495.

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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 medical record review, facility investigative document review, staff interview and facility policy review, the facility failed to complete a thorough investigation regarding an allegation of misappropriation. This affected one (Resident #101) of three residents reviewed for misappropriation allegations. The census was 98. Findings Include:Resident #101 was admitted to the facility on [DATE]. His diagnoses were pleural effusion, congestive heart failure, acute and chronic respiratory failure, muscle weakness, lack of coordination, cognitive communication deficit, atherosclerotic heart disease, atrioventricular block, chronic kidney disease, atrial fibrillation, chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease, Type II Diabetes, major depressive disorder, hyperlipidemia, ischemic cardiomyopathy, and dependence on supplemental oxygen. Review of his minimum data set (MDS) assessment, dated 04/20/26, revealed he was cognitively intact. Review of Resident #101's SRI investigation documentation found that his family made an allegation of misappropriation to the facility on [DATE]. They reported all of the resident's personal belongings were missing. This included Resident #101's wallet with two credit cards, two blank checks, two quarters, cell phone, watch, jewelry and all his clothing. The investigation reveaeld Resident #101 was sent to the hospital via Emergency Medical Services (EMS) on 05/07/26 and his belongings were in the room at the facility then. The findings from the investigation determined the facility concluded the report to be unsubstantiated since none of the items have been located, the credit cards/checks have not been used, and all items appear to have been together and the box is either missing or was accidentally disposed. Facility staff continue to search for his belongings. Interview with Administrator on 06/22/26 at 2:30 P.M. and 2:50 P.M. confirmed they completed the investigation, but he was not certain how they came to the conclusion that the housekeeping staff put Resident #101's personal belongings in a box and removed them from his room. He confirmed their typical policy was for housekeeping staff to put all resident personal items in a box, and place it in a secure location until the resident came back to the facility or the resident/representatives came to pick them up. He confirmed at the time the investigation was completed, he could not confirm that the personal items were actually placed in a box and secured for Resident #101's family. He confirmed the facility did an investigation and determined the misappropriation allegation was unsubstantiated due to the facility's inability to find the personal items and there was no evidence that the bank accounts associated with the credit cards and blank checks had been used. He confirmed after the surveyor requested to speak with the housekeeping supervisor about the room cleaning and removal of resident personal items process, that on this day Resident #101's items had been located as staff looked in a location they had not looked in prior. He also confirmed as part of the investigation, he could not find Resident #101 personal inventory log to identify what personal items he had in the facility. Interview with Housekeeping Supervisor #105 on 06/22/26 at 3:10 P.M. revealed his staff had cleaned out Resident #101's room and placed his personal items in a box for safe keeping. He confirmed when Resident #101's family came to the facility to collect the items, they could not find them. He confirmed his staff took possession of them for safekeeping. He confirmed he looked in one of the locked closets that they place resident personal items in when ta resident is discharged , and he either overlooked it or it had been covered by other items in that closet, but he found them this day. Review of facility Abuse Prohibition Policy, dated 10/14/22, revealed each residents shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the administrator and reported to the appropriate state agencies, physician, families, and/or representative. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. All new employees will have criminal background (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reference checks completed prior to starting employment. All employees will receive resident rights and abuse training at the time of hire and at least annually thereafter. Allegations by anyone who becomes aware of misappropriation of resident property must immediately report it to his/her administrator. An incident report will be completed. A preliminary, on-site investigation will be initiated within 24 hours of any report. The administrator or director of nursing/designee shall initiate the Incident and Accident Investigation form and take the following actions to ensure that the investigation is conducted effectively. The investigation may consist of a review of the completed incident report, an interview with the person reporting the incident, interviews with any witnesses to the incident, an interview with the resident (if possible), a review of the resident's medical record, an interview with staff members having contact with the resident during the period/shift of the alleged incident, interviews with the resident's roommate, family members, and visitors, and a review of all circumstances surrounding the incident. The administrator or the director of nursing/designee will keep the resident or his/her representative informed of the progress of the investigation. The Administrator, Director of Nursing/designee will compile a final summary of all investigations and report the finding at the quality assurance performance improvement committee meeting. This deficiency represents non-compliance investigated regarding complaint number 3040495.