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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Massillon, The	2000 Sherman Circle NE Massillon, OH 44646

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide a comprehensive, resident centered treatment plan to accommodate Resident #5's identified physical and communication needs to assist the resident in achieving and/or maintaining her highest level of well-being and dignity. This affected one resident (#5) of three residents reviewed for accommodation of needs. The facility census was 130. Findings include: Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included encephalopathy, type 2 diabetes, aphasia, generalized anxiety disorder, chronic pain syndrome, cerebral infarction, dysphagia, hemiplegia affecting the right side, and major depressive disorder. a. An occupational therapy treatment encounter note dated 11/20/24 revealed Resident #5 was referred for treatment for the ability to achieve increased active participation with basic activities of daily living, provide the most appropriate seating system, and for staff education. An occupational therapy treatment encounter note dated 11/21/24 revealed therapeutic activities included facilitation of postural control and wheelchair management. Wheelchair management included measurement/design of new wheelchair to enable functional independence, assessment of current seating system for appropriate modifications, and safe and efficient wheelchair mobility over various surfaces. An occupational therapy treatment encounter note dated 12/12/24 revealed Resident #5 was sitting in wheelchair with bilateral lower extremities propped on step for increased support. An occupational therapy treatment encounter note dated 12/18/24 revealed Resident #5 was provided with a facility wheelchair with bilateral lower extremity leg rests. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. The assessment also identified Resident #5 had impairment to one side of upper and lower extremity and used a wheelchair. An interview on 06/05/25 at 8:59 A.M. with Resident #5 revealed she did not get out of bed. Resident #5 pointed to a customized wheelchair located in her room and indicated she was afraid of falling from the wheelchair (to explain why she didn't get out of bed). (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/05/25 at 1:26 P.M. with Rehabilitation Director (RD) #219 revealed Resident #5 did not like to get out of bed or participate in therapy. However, during the interview the RD did not know what wheelchair the resident used or if the wheelchair was appropriate for the resident. An additional interview of 06/09/25 at 7:58 A.M. revealed occupational therapy (OT) would have used the wheelchair when treating Resident #5 and RD #219 denied awareness of any concerns Resident #5 had with the wheelchair. An interview on 06/05/25 at 2:51 P.M. with Certified Nursing Assistant (CNA) #585 revealed Resident #5 was afraid of sitting in her wheelchair. CNA #585 stated the wheelchair for Resident #5 had elevated footrests but Resident #5's legs did not fit appropriately and would fall through the footrests unless pillows were placed under Resident #5's legs. CNA #585 shared Resident #5 had previously reported the wheelchair did not fit her properly. An interview on 06/05/25 at 2:59 P.M. with Unit Manager/Registered Nurse (RN) #513 revealed Resident #5 did not like the wheelchair in her room but the UM/RN was unsure if the wheelchair was property of the resident or if the wheelchair had been provided by the facility. The UM/RN stated she would have to ask therapy if the wheelchair used by Resident #5 fit her correctly. An observation on 06/09/25 at 12:18 P.M. revealed Resident #5 was seated in her wheelchair in her room. Pillows were placed under Resident #5's legs and a wheelchair footbox (a padded unit designed to provide support, comfort, and assistance to the occupant of a wheelchair) was lying on Resident #5's bed. Resident #5 pointed to the footbox and indicated it was to be on her wheelchair but she was unsure why it was not. An interview on 06/09/25 at 12:23 P.M. with Occupational Therapist, Registered (OTR) #217 revealed Resident #5 needed a bariatric size footbox to her wheelchair. The footbox in Resident #5's room was not the correct size and Resident #5 had the same wheelchair since November or December 2024 and a footbox had not been used and a bariatric footbox had not been provided to the resident. b. Review of Resident #5's speech therapy evaluation and plan of treatment note dated 11/25/24 included treatment of speech, language, voice, communication and/or auditory processing. A speech therapy Discharge summary dated [DATE] revealed discharge recommendations for Resident #5 included to facilitate optimal cognitive-communicative performance. The following strategies recommended included training in use of concrete, one step directions by the speaker to increase comprehension, training in the use of short, direct comments to facilitate follow-through, training in use of consistent words/verbal directions to increase comprehension, caregiver instruction with emphasis in the use of visual aids to increase orientation and decrease wandering, and caregiver instruction with emphasis on the use of familiar visual stimuli to facilitate reminiscing. Resident #5 and caregivers were to be trained on communication techniques to facilitate improved follow-through instruction, as well as word finding strategies for Resident #5 to express wants and needs. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. The assessment revealed Resident #5 had unclear speech and was usually understood but had difficulty communicating some words and finishing thoughts but was able to if prompted or given time. Resident #5 was usually able to understand others but missed some part/intent of the message but comprehended most of the conversation. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 02/28/25 revealed Resident #5 had impaired communication and usually understood and was usually understood by others. Interventions included to encourage Resident #5 to continue stating thoughts even if having difficulty, focusing on a word or phrase that made sense, or respond to the feeling Resident #5 was trying to express, observe for non-verbal indicators of attempts to express herself such as tears, furrowing of the brown, pursing of the lips, yelling, grabbing, reaching, gestures, et cetera. Resident #5 was to be referred to speech therapy as needed to evaluate Resident #5's dexterity and ability to use a communication board, writing, using a computer or use of sign language as an alternate communication to speech. When communicating with Resident #5, the person should speak clearly and distinctly, adjusting the volume and tone as needed. Communication techniques to enhance interaction included allowing adequate time for Resident #5 to respond, repeat as necessary, not to rush Resident #5, request feedback/clarification from Resident #5 to ensure understanding, face Resident #5 when speaking and to make eye contact, turn off the TV/radio as needed to reduce environmental noise, ask Resident #5 yes and no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures, and validate Resident #5's message by repeating aloud. An interview on 06/05/25 at 8:59 A.M. with Resident #5 revealed she had difficulty saying the right words. Resident #5 revealed she would become frustrated with not being able to communicate clearly with family and caregivers. Resident #5 revealed additional speech therapy was needed to help her communicate appropriately. An observation of Resident #5 during the interview revealed Resident #5 would become frustrated when she was unable to convey clearly what she was trying to say. Resident #5 was not aware of any communication tools being available to use when she had difficulty expressing herself. An interview on 06/05/25 at 1:26 P.M. with RD #219 revealed Resident #5 was discharged from speech therapy on 01/04/25 and stated training provided to caregivers as indicated in the discharge summary was done with the nursing staff during Resident #5's treatment days. However, RD #219 was unable to say what training was provided and which caregivers had actually been trained. RD #219 was also unable to verify if any visual aids or communication tools had been provided to Resident #5. RD #219 stated a referral could be made again if Resident #5 required speech therapy services. An interview on 06/09/25 at 5:25 A.M. with Licensed Practical Nurse (LPN) #531 revealed staff were not aware of training on how to communicate effectively with Resident #5. On 06/09/25 at 5:28 A.M. an interview with Certified Nursing Assistant (CNA) #570 revealed they sometimes understood Resident #5 and did not rush Resident #5 when she talked. On 06/09/25 at 5:31 A.M. an interview with CNA #341 revealed they had not received any training on how to communicate with Resident #5. CNA #341 stated they were just patient with Resident #5. An additional interview on 06/09/25 at 9:08 A.M. with Resident #5 revealed speech therapy had just started again (after surveyor intervention). Resident #5 had a laminated picture communication form to use to communicate wants and needs. Resident #5 indicated this would help when she had trouble communicating. This deficiency represents non-compliance investigated under Complaint Number OH00166176.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review the facility failed to provide privacy during care for Resident #92. This affected one resident (#92) of two residents reviewed for privacy. The facility census was 130. Findings include: Review of the medical record revealed Resident #92 was admitted on [DATE] with diagnoses that included congestive heart failure and morbid obesity. The annual Minimum Data Set assessment dated [DATE] revealed Resident #92 was cognitively intact. A physician order dated 05/06/25 revealed Resident #92's coccyx was to be cleansed with wound cleanser, patted dry, Triad paste (hydrophilic paste for light-to-moderate exudate to help maintain a moist healing environment) applied to the wound bed, and covered with a foam dressing every day and as needed. On 06/05/25 at 12:10 P.M. Registered Nurse (RN) #512 and Licensed Practical Nurse (LPN) #572 were observed completing wound care for Resident #92. At the time of the observation, Resident #92 was wearing a hospital style gown and the head of the resident's bed was against the wall to the right as you entered the room. RN #512 and LPN #572 assisted Resident #92 with removing her incontinence brief and turned Resident #92 on her left side. When Resident #92 was turned on their left side, Resident #92 was exposed from the upper back to the ankles. Resident #92 had a roommate, and the head of the roommate's bed was against the left side of the room. The roommate, Resident #70 was lying in bed and was able to see Resident #92's exposed back, buttocks, and legs. This surveyor asked if the curtain should be pulled between Resident #70 and Resident #92 to provide for Resident #92's privacy. RN #512 then verified via interview that the curtain should be pulled to provide Resident #92 privacy while treatment was being completed. Review of the Clean Dressing Change policy revised 09/18/23 revealed to provide privacy (after gathering and setting up supplies in the resident area and prior to beginning the procedure). This is an incidental finding discovered during the complaint investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for Resident #5. This affected one resident (#5) of three residents reviewed for care plans. The facility census was 130. Findings include: Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included encephalopathy, type 2 diabetes, aphasia, generalized anxiety disorder, chronic pain syndrome, cerebral infarction, dysphagia, hemiplegia affecting the right side, and major depressive disorder. a. The plan of care dated 11/20/24 and revised on 06/06/25 revealed Resident #5 had a functional ability deficit and required assistance with self care/mobility. Interventions included reporting refusals of activities of daily living care, personal hygiene, nail care, bathing, and showers to the nurse. Resident #5 preferred a shower and liked to sleep in. The plan of care dated 11/21/24 revealed Resident #5 required 24-hour care/long term placement. Interventions included to observe and report changes in mood/behavior to social worker and/or physician as needed such as refusals of medications or care, being withdrawn or tearfulness. The plan of care dated 12/06/24 revealed Resident #5 was incontinent with bowel and bladder. Interventions included the use of disposable briefs, incontinence brief to be changed every two hours and as needed, and to be checked every two hours and as needed for incontinence. The plan of care dated 12/06/24 revealed Resident #5 had an alteration in neurological status. Interventions included a bowel and bladder program to improve or maintain continence as needed. A progress note dated 01/03/25 at 9:55 A.M. revealed Resident #5 refused to have incontinence care completed at 12:00 A.M., 6:45 A.M., and 8:45 A.M. Additional progress notes dated 01/13/25 at 4:46 P.M. and 01/18/25 at 2:29 P.M. revealed Resident #5 refused incontinence care. A progress note dated 01/24/25 at 6:48 A.M. revealed Resident #5 refused incontinence care and stated she did not like any of the staff and that it always hurt. A social service note dated 02/06/25 at 11:14 A.M. revealed Resident #5 tended to gravitate towards certain staff for care and would refuse the staff Resident #5 did not like. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. No behaviors were identified. The assessment revealed Resident #5 was dependent for toileting and was always incontinent of bowel and bladder. Review of behavior monitoring with interventions date 05/11/25 through 06/09/25 revealed Resident #5 had a behavior/refused on 05/15/25 at 9:04 P.M., on 05/18/25 at 9:41 P.M., 05/26/25 at 10:09 P.M. and on 06/04/25 at 4:21 A.M. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/05/25 at 8:59 A.M. with Resident #5 revealed she had concerns with staff turning on the lights at night to provide care and the light hurt her eyes. Resident #5 stated she did not like to be woken up early in the morning. An interview on 06/05/25 at 2:51 P.M. Certified Nursing Assistant (CNA) #585 verified Resident #5 would refuse to allow some CNAs to provide care and Resident #5 often refused to allow incontinence care to be provided at night. CNA #585 stated that when she worked, she would change Resident #5 first thing at the start of her shift because Resident #5 probably had not had incontinence care provided all night. An interview on 06/09/25 at 5:25 A.M. with Licensed Practical Nurse (LPN) #531 revealed Resident #5 sometimes refused care. LPN #531 stated Resident #5 wanted only female caregivers, so the staff tried to accommodate the request. An interview on 06/09/25 at 5:28 A.M. CNA #341 revealed Resident #5 permitted incontinence care to be provided around 4:40 A.M. CNA #341 verified Resident #5 the resident sometimes refused care because she wanted to sleep. An interview on 06/09/25 at 6:12 A.M. with the Director of Nursing (DON) revealed she removed the light that shined down on Resident #5 when lying in bed. The DON stated Resident #5 would notify her spouse of the staff Resident #5 did not want to provide care and the facility would try to ensure there was someone available to provide care to Resident #5. The DON stated the CNAs documented Resident #5's refusals of care under behavior monitoring. On 06/10/25 at 9:23 A.M. during an interview with the DON, the DON revealed the care plan for 24-hour care/long term placement addressed Resident #5's refusal of care. An intervention was in place for the social worker or physician to be notified of the refusals. The DON verified there was not a care plan or intervention in place to address Resident #5's refusal of incontinence care, light bothering Resident #5's eyes, only wanting certain staff to provide care, or choosing to not have incontinence care provided if sleeping. The DON also verified the plan of care dated 12/06/24 for alteration in neurological status had an incorrect intervention for Resident #5 to have a bowel and bladder program. The DON verified Resident #5 had never been on a bowel and bladder program. b. In addition, an occupational therapy treatment encounter note dated 11/20/24 revealed Resident #5 was referred for treatment for the ability to achieve increased active participation with basic activities of daily living, provide the most appropriate seating system, and for staff education. An occupational therapy treatment encounter note dated 11/21/24 revealed therapeutic activities included facilitation of postural control and wheelchair management. Wheelchair management included measurement/design of new wheelchair to enable functional independence, assessment of current seating system for appropriate modifications, and safe and efficient wheelchair mobility over various surfaces. An occupational therapy treatment encounter note dated 12/12/24 revealed Resident #5 was sitting in wheelchair with bilateral lower extremities propped on step for increased support. An occupational therapy treatment encounter note dated 12/18/24 revealed Resident #5 was provided with a facility wheelchair with bilateral lower extremity leg rests. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. Resident #5 had impairment to one side of upper and lower extremity and used a wheelchair. An interview on 06/05/25 at 8:59 A.M. Resident #5 revealed she did not get out of bed. Resident #5 pointed to customized wheelchair. Resident #5 indicated she was afraid of falling. An interview on 06/05/25 at 1:26 P.M. with Rehabilitation Director #219 revealed Resident #5 did not like to get out of bed or participate in therapy. Rehabilitation Director #219 was not aware of what wheelchair Resident #5 used or if it fit her properly. An interview on 06/05/25 at 2:51 P.M. with Certified Nursing Assistant (CNA) #585 revealed Resident #5 was afraid of sitting in her wheelchair. CNA #585 stated the wheelchair for Resident #5 had elevated footrests but Resident #5's legs did not fit appropriately and would fall through the footrests unless pillows were placed under Resident #5's legs. CNA #585 revealed Resident #5 stated the wheelchair did not fit properly. An interview on 06/05/25 at 2:59 P.M. Unit Manager/Registered Nurse (RN) #513 revealed Resident #5 did not like the wheelchair in her room. Unit Manager/RN #513 was unsure if the wheelchair was Resident #5's or had been provided by the facility. Unit Manager/RN #513 stated she would have to ask the therapy department if the wheelchair fit Resident #513 correctly. An additional interview on 06/09/25 at 7:58 A.M. Rehabilitation Director #219 verified occupational would have used the wheelchair for Resident #5. Rehabilitation Director #219 was unsure if there were any concerns with the wheelchair Resident #5 had. On 06/10/25 at 9:23 A.M. with the DON verified there was not a plan of care in place addressing Resident #5 not wanting to sit in the wheelchair due to feeling unsafe. This is an incidental finding discovered during the complaint investigation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interview the facility failed to ensure Resident #5, who was dependent on staff assistance for activities of daily living, was bathed per preference and as scheduled to promote optimal hygiene and resident well-being. This affected one resident (#5) of three residents reviewed for bathing. The facility census was 130. Findings include: Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included encephalopathy, type 2 diabetes, aphasia, generalized anxiety disorder, chronic pain syndrome, cerebral infarction, dysphagia, hemiplegia affecting the right side, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. The assessment revealed Resident #5 required substantial to maximal assistance for bathing and personal hygiene. Review of the plan of care dated 02/28/25 revealed Resident #5 had functional ability deficits and required assistance with self-care. Interventions included refusals for activities of daily living care such as personal hygiene, bathing and showers were to be reported to the nurse. The plan of care also revealed Resident #5 preferred showers and required substantial to maximal (staff) assistance with bathing. The care plan did not address the resident's use of a shower chair or the resident's fear of the shower chair. Review of the facility bathing schedule revealed Resident #5 was scheduled to be bathed/showered twice a week on Tuesday and Saturday evening. Review of bathing documentation from 05/12/25 through 06/05/25 revealed Resident #5 received a shower/bath/bed bath. However, the documentation did not specify which type of bathing was provided, whether the resident received a shower, bath, or bed bath. Resident #5 was bathed on 05/12/25. Resident #5 was not bathed on 05/17/25. Review of the behavior monitoring for Resident #5 refusing care and peri care was marked yes on 05/18/25. The behavior monitoring did not indicate the type of care that was refused. The bathing documentation revealed Resident #5 was bathed on 05/19/25 and 05/22/25. The behavior monitoring for Resident #5 refusing care and peri care was marked yes on 05/26/25. The behavior monitoring did not indicate the type of care that was refused. The bathing documentation revealed Resident #5 was not bathed on the scheduled days of 05/27/25, 05/31/25, or 06/03/25 which revealed Resident #5 was not bathed from 05/22/25 until 06/05/25. The behavior monitoring for Resident #5 refusing care and peri care was marked refused on 06/04/25. The behavior monitoring did not indicate the type of care that was refused. Interview on 06/05/25 at 8:59 A.M. with Resident #5 revealed it was her preference to receive a shower. During the interview, the resident reported she had received maybe one shower at the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 2:51 P.M. with Certified Nursing Assistant (CNA) #585 revealed Resident #5 was afraid to use the shower chair so bed baths were provided for the resident. During the interview, CNA #585 verified bathing documentation did not support Resident #5 had been bathed at least twice a week (as scheduled). Interview on 06/05/25 at 2:59 P.M. with Unit Manager/Registered Nurse (RN) #513 revealed she audited the bathing documentation. RN #513 revealed she was not aware Resident #5 had not been bathed twice a week as scheduled. RN #513 stated if a resident refused to be bathed, the CNA was to notify the nurse. The nurse would then talk with the resident about the refusal and would document the refusal. An additional interview on 06/09/25 at 9:08 A.M. with Resident #5 revealed it hurt her to sit in the shower chair. Resident #5 was unable to comment further about why it hurt. An additional interview on 06/09/25 at 1:12 P.M. Unit Manager/RN #513 revealed showers were reviewed every day in the morning meeting. Unit Manager/RN #513 stated she reviewed the shower schedules with room changes and management staff assigned to residents as guardian angels, would ask residents if there were any concerns with showers. Unit Manager/RN #513 stated adjustments to the day and time of showers could be changed if a resident requested. Unit Manager/RN #513 revealed she was unaware Resident #5 was not comfortable in the shower chair and because Resident #5 had a stroke, the shower bed would not be appropriate due to weakness on Resident #5's right side. On 06/09/25 at 10:17 A.M. an interview with the Director of Nursing (DON) revealed CNA #585 reported a bed bath was actually provided to Resident #5 on 05/15/25 even though the electronic record showed documentation of Resident #5 not being bathed. Review of the Routine Resident Care policy revised 03/12/25 revealed showers, tub baths, and/or shampoos were scheduled according to person centered care or state specific guidelines. This deficiency represents non-compliance investigated under Complaint Number OH00166176.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to provide Resident #5 with speech therapy services as indicated in the plan of treatment and discharge summary. This affected one resident (#5) of three reviewed for therapy services. The facility census was 130. Findings include: Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included encephalopathy, type 2 diabetes, aphasia, generalized anxiety disorder, chronic pain syndrome, cerebral infarction, dysphagia, hemiplegia affecting the right side, and major depressive disorder. Resident #5's speech therapy evaluation and plan of treatment dated 11/25/24 included treatment of speech, language, voice, communication and/or auditory processing. Resident #5 was referred to speech therapy due to a history of aphasia and dysarthria. The plan of treatment revealed Resident #5 was to receive speech therapy five times a week for six weeks. Review of the speech therapy treatment encounter notes from 11/25/24 to 01/04/25 revealed Resident #5 was evaluated and received treatment four days the week of 11/24/24. Resident #5 received treatment one day out of the five days as indicated in the plan of treatment during the week of 12/01/24. Resident #5 received treatment five days the week on 12/08/24 and four days the week of 12/15/24. Resident #5 received treatment three days, instead of the five days indicated in the plan of treatment, the weeks of 12/22/24 and 12/29/24. The speech therapy Discharge summary dated [DATE] revealed discharge recommendations for Resident #5 included to facilitate optimal cognitive-communicative performance. The following strategies recommended included training in use of concrete, one step directions by the speaker to increase comprehension, training in the use of short direct comments to facilitate follow-through, training in use of consistent words/verbal directions to increase comprehension, caregiver instruction with emphasis in the use of visual aids to increase orientation and decrease wandering, and caregiver instruction with emphasis on the use of familiar visual stimuli to facilitate reminiscing. Resident #5 and caregivers were to be trained on communication techniques to facilitate improved follow-through instruction, as well as word finding strategies for Resident #5 to express wants and needs. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. The assessment revealed Resident #5 had unclear speech and was usually understood but had difficulty communicating some words and finishing thoughts but was able to if prompted or given time. Resident #5 was usually able to understand others but missed some part/intent of the message but comprehended most of the conversation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Massillon, The	2000 Sherman Circle NE Massillon, OH 44646

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 02/28/25 revealed Resident #5 had impaired communication and usually understood and was usually understood by others. Interventions included to encourage Resident #5 to continue stating thoughts even if having difficulty, focusing on a word or phrase that made sense, or respond to the feeling Resident #5 was trying to express, observe for non-verbal indicators of attempts to express herself such as tears, furrowing of the brown, pursing of the lips, yelling, grabbing, reaching, gestures, et cetera. Resident #5 was to be referred to speech therapy as needed to evaluate Resident #5's dexterity and ability to use a communication board, writing, using a computer or use of sign language as an alternate communication to speech. When communicating with Resident #5, the person should speak clearly and distinctly, adjusting the volume and tone as needed. Communication techniques to enhance interaction included allowing adequate time for Resident #5 to respond, repeat as necessary, not to rush Resident #5, request feedback/clarification from Resident #5 to ensure understanding, face Resident #5 when speaking and to make eye contact, turn off the TV/radio as needed to reduce environmental noise, ask Resident #5 yes and no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures, and validate Resident #5's message by repeating aloud. An interview on 06/05/25 at 8:59 A.M. with Resident #5 revealed she had difficulty saying the right words. Resident #5 revealed she would become frustrated with not being able to communicate clearly with family and caregivers. Resident #5 revealed additional speech therapy was needed to help her communicate appropriately. An observation of Resident #5 during the interview revealed Resident #5 would become frustrated when she was unable to convey clearly what she was trying to say. An interview on 06/05/25 at 1:26 P.M. with Rehabilitation Director #219 revealed Resident #5 was discharged from speech therapy on 01/04/25. Rehabilitation Director #219 stated the reason for discharge from services was due to Resident #5 meeting maximum potential. Rehabilitation Director #219 revealed training provided to caregivers as indicated in the discharge summary was done with the nursing staff during Resident #5's treatment days. However, Rehabilitation Director #219 was unable to say what training was provided and which caregivers had actually been trained. Rehabilitation Director #219 was also unable to verify if any visual aids or communication tools had been provided to Resident #5. Rehabilitation Director #219 stated a referral could be made again if Resident #5 required speech therapy services. An additional interview on 06/09/25 at 7:58 A.M. with Rehabilitation Director #219 revealed Resident #5 did not receive speech therapy five times a week from 11/25/24 through 01/04/25, because there was not a full-time speech therapist at that time. Rehabilitation Director #219 revealed they just pieced in the speech therapy treatment to Resident #5 whenever a speech therapist was available. Rehabilitation Director #219 then indicated they had started speech therapy again on 06/06/25 for the resident (following surveyor intervention). An additional interview on 06/09/25 at 9:08 A.M. with Resident #5 verified speech therapy had started again. On 06/09/25 at 12:18 P.M. during an interview with Resident #5, the resident was tearful and stated she wanted to return home but did not feel she had made the progress necessary. Resident #5 stated sometimes she was unable to think clearly but became frustrated when she was unable to communicate clearly, especially with her spouse. This deficiency represents non-compliance investigated under Complaint Number OH00166176.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Laurels of Massillon, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Sherman Circle NE Massillon, OH 44646	

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interview, the facility failed to ensure Resident #5 was ordered the appropriate antibiotic to treat a urinary tract infection. This affected one resident (#5) of three reviewed for urinary tract infections. The facility census was 130. Findings include: Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included encephalopathy, type 2 diabetes, aphasia, generalized anxiety disorder, chronic pain syndrome, cerebral infarction, dysphagia, hemiplegia affecting the right side, and major depressive disorder. A situation brief assessment recommendation (SBAR) dated 12/18/24 at 8:55 P.M. revealed Resident #5 had a change in condition. Urinalysis results were pulled from the system and revealed Resident #5's results were abnormal. The on-call physician was notified, and a verbal order was received for Macrobid (antibiotic) 100 milligram by mouth twice a day for seven days. The medication administration record (MAR) revealed Resident #5 received the 8:00 A.M. dose of Macrobid on 12/19/24. A certified nurse practitioner (CNP) note date 12/19/24 revealed Resident #5 was started on Macrobid, which did not cover any of the organisms listed on the urinalysis report. On 12/19/24 an order was received to discontinue Macrobid and start Rocephin (antibiotic) two grams intramuscularly one time and the Rocephin one gram intravenously daily for seven days. Review of the Urine Culture and Sensitivity Antibiotic Sensitivity Testing results collected 12/14/24 and reported 12/19/24 revealed the resident's urine contained the bacteria, Klebsiella pneumoniae. Macrobid was not on the sensitivity list to treat the bacteria. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had cognitive impairment. The assessment revealed Resident #5 was dependent on staff for toileting and was always incontinent of bowel and bladder. An interview on 06/09/25 at 6:11 A.M. with Assistant Director of Nursing (ADON) #514 verified Macrobid was ordered and administered to Resident #5. ADON #514 verified Macrobid did not meet the criteria for administration. Review of the facility Infection Control Antibiotic Stewardship and Multi-Drug Resistant Organism policy revised 04/17/25 revealed the antibiotic stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials, by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration. The program would encourage appropriate prescribing; and reduce adverse effects which often include gastrointestinal problems, clotridoides difficile diarrhea, yeast infections and antibiotic resistance in aging adults. The medical director and director of nursing would use their influence as medical and nursing leaders to help ensure antibiotics are prescribed only when appropriate. When a urine culture was positive, antibiograms and lab results would be utilized to help prescribers select the best antibiotic for each resident based on the guidelines for prescribing protocols. (continued on next page)

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	366078	A. Building B. Wing	06/12/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00166176.