STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365289	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Lane Nursing and Rehabilitation	5425 High Mill Avenue NW 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interviews, observation and resident handbook the facility failed ensure a clean homelike environment. This affected three residents (Resident #51, #172, and #178) out of five residents reviewed for physical environment. The facility census was 162. Findings Include:1. On 01/27/26 at 10:44 AM Resident #178 room revealed the bedside commode (BSC) had a small amount of urine and bowel movement (BM) in it dried and when the bathroom door was opened there was BM all around the toilet riser, toilet base and on the floor by the toilet. Resident #178 was not in the room at that time. At 10:53A.M. Resident #178 came back from getting her hair done At10:55 A.M. with Register Nurse #821unit manager and Licensed Practical Nurse (LPN) #902 stated Resident #178 takes herself to bathroom. Resident #178 stated yes, she does take herself to the bathroom and it has been a few days ago that she used her BSC. At 10:59 A.M. RN #821 cleaned up the bathroom. Observation at 1:50 P.M. of the BSC in Resident #178's room revealed it still had not been cleaned. No housekeeping has been seen on the hall.Interview on 1/28/26 at 7:53 A.M. with Housekeeper (HK) #860 revealed she worked over the weekend but did not work yesterday. HK #860 revealed on Saturday they worked the 700 and 800 hall and Sunday 200 hall. Resident rooms get cleaned everyday if there is a housekeeper on the hall and usually they have a housekeeper on each hall but on the weekends there may not be. On 01/28/26 at 11:29 A.M. RN #821 verified the BSC in Resident #178 had dried urine and BM in the bottom of the tub. RN #821 stated it should have been cleaned during housekeeping or by the Certified Nurses Assistant (CNA) that was working on the hall.2. On 01/27/2026 at 11:11 A.M. of Resident #51's room revealed the bed sheets and covers have dried brown spots, appear to be dried blood. Resident #51 stated he does not know when they change his sheets he is not in the room.On 1/29/26 at 2:39 P.M. interview with CNA #921 revealed she had been in Resident #51's room and asked him if he needs anything, but he will ring if he needs anything. CNA #921 stated linens get changed on bath days and when needed.On 01/28/2026 at 2:47 P.M. observation of Resident #51 bed sheets with CNA #920 verified small amount of smeared BM on the chuck, and multiple blood spots from Resident #51 scratching himself, also other brown areas on his flat sheet, top sheet and covers. CNA #920 stated his sheet did need to be changed and she had not noticed it during her shift.3. Interview on 01/27/2026 at10:22 A.M. with Resident #172 revealed he had been in the room for about a week. Observation of his room at that time revealed the night light on wall is loose and the electric baseboard was in disarray. The front panel of the electric heater was off at one end, and the coils appeared to be bent. Observation on 01/29/2026 at 8:40 A.M. of Resident #172's room with Maintenance Assistance #874 verified the night light on the wall was loose and the baseboard heater beside the bed was in disarray. The front panel was coming off the front of the heater and was caught on Resident #172's rollator and the coils were bent. Review of the facility Resident Handbook on page 47 revealed resident has a right to a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interior and clean bed and bath linens that are in good condition.This deficiency represents non-compliance invsetigated under Complaint 2685934.

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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 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 reviews, interviews and observations the facility failed to assist Resident #32 with his meal per his care plan. This affected one resident (Resident #32) of one residents reviewed for meal assistance. The census was 162.Findings include: Review of the medical record for Resident #32 revealed an admission date of 09/12/24. Diagnoses included dementia, depression, anxiety, hypertension, need for assistance with personal care and muscle weakness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 was cognitively impaired. He required set-up or clean-up assistance with eating. He was dependent for all other activities of daily living. Review of the medical nutritional assessment dated [DATE] revealed Resident #32 weighed 169.8 pounds. He ate 50-100% of meals. He was ordered a house supplement BID. Review of January 2026 orders revealed Resident #32 had an order for regular diet and thin liquids and a 4 ounce house supplement twice a day. Review of monthly weights revealed Resident #32 weighed 167.9 pounds on 11/07/25 and 161.4 on 01/06/26. Review of the care plan initiated on 09/13/24 revealed Resident #32 was at risk for decreased nutritional status and dehydration. Interventions included assisting him with meals and feeding as necessary which was initiated on 09/13/24 and revised on 01/28/26 during the survey after observations by surveyor. Other interventions included monitoring intakes and weight. Interview on 01/27/26 at 3:03 P.M. with Resident #32's daughter revealed the resident needed cued for eating. She stated when she was there for meals, she would put food in his hand and he would eat every time. She was concerned about weight loss. She believed the facility had a plan in place after she mentioned issue to them recently. Observation on 01/28/26 at 12:04 P.M. of the Memory Care Unit (MCU) dining room, where Resident #32 resided, revealed two certified nursing assistants (CNAs) #912 and #937, Activity Director (AD) #817 and Human Resources (HR) #819 passing lunch. Observation on 01/28/26 at 12:06 P.M. revealed Resident #32 was seated at the table. AD #817 was assisting Resident #83 across the table. At 12:10 P.M. AD #817 and HR #819 were speaking across the table to each other while Resident #32's meal was placed in front of him. HR #819 stated she thought that he would eat it if staff handed him the food or utensil AD #817 responded I don't think so stating he would eat it if placed in front of him. HR #819 did hand him a sandwich and he started eating it. HR #819 left the dining room and did not return. AD #817 continued to help Resident #83 across the table from Resident #32. At 12:15 P.M. Resident #32 tried to open up his packet of crackers including biting the wrapper which took him five minutes to do. At 12:21 P.M. Resident #32 was done eating his crackers. He still had a bowl of soup, potato salad and fruit, all of which were untouched. AD #817 gave a verbal cue to him from across the table however he did not attempt to pick up spoon or fork. AD #817 was still assisting other resident. At 12:28 P.M. Resident #32 closed his eyes. At 12:35 P.M., with his eyes still closed, he tried to push back from the table but the front of the chair just lifted in the air then back down. Resident #32's nose was dripping. At 12:36 P.M., CNA #912 asked him if he was done and he mumbled something. CNA #912 gathered his untouched food and removed it from the table. Interview on 01/28/26 at 12:50 P.M. with CNA #912 revealed Resident #32 usually ate independently, they monitored his meal intakes, did not write the meal intake down, but documented what she remembered. CNA #912 revealed Resident #32 ate 50% of his meal today. Interview on 01/29/26 at 9:34 A.M. with AD #817 revealed nursing staff kept her well-informed on who needed assistance. She revealed Resident #32 needed verbal cues but said it depended on the day. AD #817 revealed the resident was not a big eater but could not rule out that he was not eating as a result of not remembering to eat. Interview on 01/29/26 at 10:27 A.M. with Registered Nursing (RN) #950 revealed Resident #32's daughter was active in his care. She stated he (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ate well on some days but other days he did not. She stated her expectation was to allow him to try to eat on his own and assist him before taking away food. Interview on 01/29/26 at 2:34 P.M. with Director of Nursing (DON) revealed there was no specific policy for activities of daily living. She also verified Resident #32's care plan had an intervention of assisting with meals and to feed resident as needed which was initiated on 09/13/24 and then had a revision date of 01/28/26. Interview on 01/29/26 at 3:30 P.M. with HR #819 revealed she helped pass trays at least once a week as part of facility program. She was a CNA for 25 years. She had seen a CNA place food in Resident #32's hand and saw that it worked for him to start eating. She also stated she knew from experience to try different cues with residents with cognitive impairment. This deficiency represents non-compliance investigated under Complaint 2653004.