

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  12/09/2024
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)
<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> 43063</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review and interviews, the facility failed to provide adequate supervision to prevent the elopement of a resident. This affected one (Resident #131) of three residents reviewed for elopement. The facility census was 130.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #131 revealed an admitted [DATE] with diagnoses including traumatic brain injury, depression and hypertension. Resident #131 was discharged to the hospital on 07/27/24.</p> <p>Review of the physician's orders for Resident #131 revealed orders dated 07/26/24 to check the wanderguard placement on his right lower extremity, send him to the emergency room if he became violent, psychiatric referral and Lorazepam 0.5 milligrams to be given one time at bedtime as needed for agitation.</p> <p>Review of the care plan dated 07/26/24 for Resident #131 revealed he was at risk for exit seeking and wandering related to cognitive dysfunction, impulsivity and traumatic brain injury. Interventions included to apply a wanderguard per the physician's order, observe wandering behaviors, attempt diversional interventions, provide structured activities and redirect resident as needed.</p> <p>(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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress notes dated from 07/26/24 through 07/27/24 for Resident #131 revealed he arrived at the facility on 07/26/24 at 12:10 P.M. He became agitated and began making verbal insults at his wife requiring de-escalating interventions by the nurse. On 07/26/24 at 1:50 P.M., he was assessed by the nurse practitioner and an order for a wanderguard was given due to his confusion and wandering. On 07/26/24 at 7:31 P.M. Resident #131 was noted to have one-on-one supervision and was in his room. He was noted to be agitated with the staff and visitors. His wife was updated on his behaviors and the need for him to transition to another facility due to his needs for a locked unit. On 07/26/24 at 8:19 P.M. the nurse updated the nurse practitioner on Resident #131's agitation and exit seeking. A return call was received at 8:45 P.M. and new orders for as needed anxiety medication was provided as well as an order to send him to the emergency for evaluation and treatment if he became violent. On 07/26/24 at 9:33 P.M. he was provided with the as needed anxiety medication. It was noted he was sexually inappropriate with staff and slamming his door. He would not allow the one-on-one male caregiver in his room. On 07/27/24 at 1:05 A.M. Resident #131's nursing progress note stated he returned to the facility with a nurse aid and nurse. A full head to toe assessment was performed and he had no injuries. The crisis center and police escorted Resident #131 to the hospital and his wife was present during this transfer.</p> <p>Review of the Elopement Incident Report dated 07/26/24 at 11:19 P.M. for Resident #131 revealed the floor nurse notified the Director of Nursing (DON) that he was not observed in his room and the screen was removed and his window was hyper extended. The staff began to search for the resident and called the local police department. Resident #131 was found at a local business by the nurse and aide. The local police were also present. The resident was then returned to the facility and assessed. He was alert, oriented to person and place. There were no injuries. Per the wife's statement, she stated he had called her and asked her to come get him.</p> <p>Review of the document Guest Location Visual Check dated 07/26/24 revealed Resident #131 was started on 15 minute checks at 6:15 P.M. These checks were completed every 15 minutes by Receptionist #210 until 11:00 P.M.</p> <p>Review of the facility investigative timeline performed by the DON of Resident #131's elopement on 07/26/24 revealed:</p> <p>On 07/26/24 at 11:00 P.M. was the last documented resident check for the one-on-one by Receptionist #210.</p> <p>On 07/26/24 at 11:19 P.M. Registered Nurse (RN) #209 updated the DON and stated during Resident #131's one-on-one checks he was not in his room and the window was open. DON instructed RN #209 to start the elopement policy and notify police.</p> <p>On 07/26/24 at 11:21 P.M. the Administrator was informed.</p> <p>On 07/26/24 at 11:24 P.M. the Regional office was updated on the elopement and the elopement policy being implemented.</p> <p>On 07/26/24 at 11:29 P.M. a photo of Resident #131 was obtained for the search.</p> <p>On 07/26/24 between 11:30 ad 11:35 P.M. the DON arrived and staff were searching outside and throughout the local area.</p> <p>(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>On 07/26/24 at approximately 11:34 P.M. facility staff located Resident #131 at a local business with the police department present.</p> <p>On 07/26/24 at 11:37 P.M. facility staff arrived with Resident #131 back to the facility. A full assessment was completed and he had no injuries.</p> <p>On 07/26/24 at 11:50 P.M. the local police department called the crisis center for assistance with Resident #131.</p> <p>On 07/27/24 at 12:20 A.M. the local crisis center personnel arrived and assessed Resident #131. They recommended to send him to the local emergency room .</p> <p>On 07/27/24 at 12:56 A.M. Resident #131's wife arrived at the facility.</p> <p>On 07/27/24 at 1:05 A.M. the local police as well as the crisis center escorted Resident #131 to the emergency room .</p> <p>Review of the police report #24-180202 dated 07/26/24 at 11:33 P.M. revealed they had received the call from the facility stating that Resident #131 eloped. He was described as a male who could be confrontational if approached. It stated that he had crawled out of his window, had a traumatic brain injury and the facility was holding him until he could get into a locked unit. The police report stated Resident #131 was found with staff at a local business and returned back to the facility at 11:53 P.M.</p> <p>Review of the Incident and Accident Investigation Report dated 07/27/24, by the Administrator, stated the resident had manipulated the window to meet his wife at a pre-determined location. It was noted prior to the elopement and eluding one-on-one supervision, the resident was aggressive and inappropriate with staff.</p> <p>Interview on 12/04/24 at 2:29 P.M. with the Administrator revealed Resident #131 was admitted on [DATE]. He stated what the facility had received on paper about Resident #131 did not match the resident they had received. He stated Resident #131 was having behaviors such as urinating in flower pots, saying sexually inappropriate statements and becoming aggressive with staff. He was also wandering and stating he was going to leave the facility. The Administrator stated they updated the wife at approximately 5:00 P.M. that he would need a different facility due to his risk of eloping. The Administrator stated on 07/26/24 at approximately 6:00 P.M. he initiated one-on-one supervision with Resident #131 with Receptionist #210 who had been educated on elopement, dementia, behaviors and communication. He stated that during the one-on-one supervision, Resident #131 became aggressive with staff, slamming the door in their faces and swearing. The Administrator stated RN #209 made the decision to allow Resident #131 to shut his door as he was becoming more agitated by being watched and felt he could calm down if the room was quiet. He stated staff performed 15-minute checks. The Administrator stated at approximately 11:19 P.M. the staff went to check on Resident #131 and his room was observed to be unoccupied and the window had been opened and the screen removed. The Administrator stated the wife of Resident #131 stated he had previously been a carpenter and knew how to take things apart. He stated the resident only opened approximately four inches but if you took the screw out, removed the locking mechanism and slid out the bracket mechanism, you could open the window all of the way.</p> <p>(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>Interview on 12/09/24 at 8:35 A.M. with the Maintenance Director #208 verified he had performed elopement drills monthly. He stated he also assessed all doors daily to ensure they were working for the wanderguards. He stated he had worked at the facility for [AGE] years and never had a resident take the window apart like Resident #131 did. He stated the window has a vent lock on the side that kept the window from opening more than four inches. He stated Resident #131 had to remove the screen, open the window and remove the crank, take the crank apart and then utilize the handle to push the vent lock and pull it down. He stated Resident #131 broke the handle on the window to utilize it to move the vent lock.</p> <p>Attempted interviews of RN #209 and Receptionist #210 were not able to be held as calls on 12/09/24 were not returned.</p> <p>Review of the facility policy titled, Elopement Policy, dated 05/01/22, revealed the facility would prevent, to the extent reasonably possible, the elopement of residents from the facility.</p> <p>The deficient practice was corrected on 07/31/2024 when the facility implemented the following corrective actions:</p> <p>On 07/27/24, an entire facility audit was completed by the DON of all residents for the risk of elopement. All residents who were at risk were assessed and interventions were placed if needed.</p> <p>On 07/27/24, all staff were educated by the Director of Nursing on the elopement policy, one-on-one supervision and resident behaviors.</p> <p>On 07/27/24 the facility identified the window mechanisms/function could be manipulated to open further than the regulation allowed. The windows were all observed and modified to ensure they were unable to be opened by the Administrator and maintenance department.</p> <p>On 07/28/24, Maintenance Director #208 emailed corporate maintenance and reviewed all windows and the mechanisms/function to ensure residents were safe at the facility. It was recommended that he remove the cranks so the windows would be inoperable.</p> <p>On 07/30/24 an emergency quality assurance meeting was held to discuss Resident #131's elopement. A new intervention was put into place of having staff go on-site to accept new admissions to ensure the facility was able to manage the resident's condition.</p> <p>Audits were performed to ensure window modification was intact and effective, twice a week with a total of 14 rooms, from 08/07/24 through 08/29/24 by the Director of Nursing for a total of four weeks.</p> <p>This deficiency represents non-compliance investigation under Master Complaint Number OH00160053 and Complaint Number OH00159580.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43063</p> <p>Based on record review and interview, the facility failed to ensure residents were screened for tuberculosis on admission. This affected one (Resident #63) out of three residents reviewed for tuberculosis screening. The facility census was 130.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses including anxiety, depression and hypertension.</p> <p>Review of Resident #63's physician's orders for August 2024 revealed there were no physician's orders for tuberculosis screening.</p> <p>Review of Resident #63's medication administration record for August 2024 revealed staff never administered tuberculosis screening after admission.</p> <p>Interview on 12/09/24 at 9:45 A.M. with the Director of Nursing (DON) verified Resident #63's tuberculosis screening was not completed after her admission in August 2024. She verified Resident #63 did not have tuberculosis screening until after a readmission in October of 2024.</p> <p>Review of the facility policy titled, Tuberculosis Control Plan, dated 01/03/23, revealed all first-time residents would be screened for tuberculosis on admission. The screening would consist of a Mantoux testing using five units of tuberculin (liquid solution used to test for tuberculosis through skin reaction). This test would be done twice with the second test occurring one to three weeks after the first test was performed and read.</p> <p>This deficiency represents non-compliance investigation under Complaint Number OH00160053.</p>		