STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366078	A. Building B. Wing	05/14/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to ensure nutritional interventions were implemented for nutrition status maintenance for Resident #148. This affected one resident (#148) of four residents reviewed for nutrition. The facility census was 134. Findings include: Review of the closed medical record for Resident #148 revealed an admission date of 09/09/25 with diagnoses including moderate protein calorie malnutrition, chronic obstructive pulmonary disease, wedge compression fracture first lumbar vertebra, and displaced fracture of medial malleolus of left tibia. Resident #148 discharged from the facility to home on [DATE]. Review of the physician orders for Resident #148 identified orders for a regular diet with regular texture and regular consistency liquids effective 09/10/25. Review of Resident #148's admission weight revealed on 09/10/25 Resident #148 weighed 152.0 pounds. Review of the nurse's progress note dated 09/10/25 at 3:23 P.M. revealed Resident #148 had trace edema to bilateral lower extremities. Review of the skilled care note dated 09/11/25 revealed Resident #148 had no edema. Review of the nutritional risk screening dated 09/12/25, completed by Dietary Technician (DT) #633, revealed Resident #148 weighed 152 pounds, had a moderate decrease in food intake, and had moderate protein calorie malnutrition. Review of the nutritional risk screening dated 09/15/25, completed by DT #633, revealed Resident #148 weighed 152 pounds, had a moderate decrease in food intake, and had moderate protein calorie malnutrition. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #148 had no cognitive impairment, no swallowing concerns, and no therapeutic diet. Review of the initial nutritional evaluation dated 09/16/25, completed by DT #633, revealed Resident #148 had moderate protein calorie malnutrition, varied intakes at meals, and a recommendation was made for a house supplement 120 milliliters (ml) twice daily for nutrition and weight maintenance. Review of the physician orders for Resident #148 revealed there were no orders added for a nutritional supplement after this recommendation was made by DT #633 on 09/16/25 for a house supplement 120 ml twice a day. Review of the weekly weight dated 09/17/25 revealed Resident #148 weighed 142.6 pounds, which indicated a significant weight loss of 6.2 percent in seven days. Review of the physician orders for Resident #148 identified an order to obtain a re-weight effective 09/18/25. Review of the re-weight dated 09/18/25 revealed Resident #148 weighed 144.3 pounds, which indicated a significant weight loss of 5.1 percent in eight days. Further review of the medical record for Resident #148 including review of nurse's notes, physician's notes, nurse practitioner's notes, dietary notes, and dietary assessments revealed no evidence the physician or nurse practitioner were notified of the re-weight, the confirmed weight loss and there was no evidence of a nutritional intervention in response to the weight loss confirmed on 09/18/25 prior to Resident #148 being discharged from the facility to home on [DATE]. Review of the dietary progress note dated 09/28/25 at 12:54 P.M., which was written by Registered Dietitian (RD) #671 six days after Resident #148 discharged from the facility, indicated Resident #148 experienced a significant weight loss of 5.15 percent, had discharged from the facility, and would be re-evaluated if she re-admitted . On 05/13/26 at 9:20 A.M., an interview with DT #633 verified Resident #148 experienced a significant weight loss and there was no evidence the nutritional supplement DT #633 had recommended was ever ordered by (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician. DT #633 stated she went on vacation after the weight loss occurred so did not know why the RD who was covering for her did not follow up on the weight loss timely. On 05/13/26 at 2:44 P.M., an interview with the Director of Nursing confirmed there were no physician orders for a nutritional supplement, so it was not implemented for Resident #148 as recommended by DT #633. Review of the facility policy titled Weight Management, dated 07/30/25, revealed residents would be monitored for significant weight changes on a regular basis and the evaluation of a significant weight change of a specific time period was important. The policy indicated any resident with unintended weight loss would be evaluated by the interdisciplinary team (IDT) and interventions would be implemented to prevent further weight loss. The dietary manager, unit manager, or RD were responsible for communicating weight changes to the IDT, practitioner, and the resident's responsible party and notification documented in the medical record. Review of the facility policy titled Nutritional Supplementation, dated 03/11/26, revealed it was the facility's policy to provide nutritional supplements when clinically necessary to maintain weight, health, and hydration of residents. Nutritional interventions and potential oral supplements would be utilized to prevent the onset and progression of significant weight loss, which would be three percent in one week, five percent in one month, seven and a half percent in three months, and 10 percent in six months. All supplements would be ordered by the physician.This deficiency represents noncompliance investigated under Complaint Number 2690307.