

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
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 05/14/2026
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, and interview, the facility failed to ensure residents received appetizing food served at palatable temperatures. This affected seven residents (#1, #31, #50, #53, #68, #89 and #117) of 37 residents interviewed for food and nutrition services. The facility census was 134. Findings include: An interview on 05/11/26 at 10:13 A.M. with Resident #53 revealed the food was undercooked especially on weekends. An interview on 05/11/26 at 10:18 A.M. with Resident #1 revealed the food was bland, tasteless and he had to order food out because of it. An interview on 05/11/26 at 10:41 A.M. with Resident #89 revealed he ordered take-out food a lot because the facility food was tasteless and undercooked. An interview on 05/11/26 at 11:39 A.M. with Resident #117 revealed she did not get fresh fruits to eat except banana; the vegetables were served mushy and sometimes the hot foods were served cold. An interview on 05/12/26 at 8:13 A.M. with Resident #68 revealed the food had no flavor and hot foods were served cold. An interview on 05/12/26 at 8:32 A.M. with Resident #50 revealed the food was bland and unappealing. An interview on 05/12/26 at 10:27 A.M. with Resident #31 revealed vegetables at meals were served overcooked and mushy. On 05/14/26 at 11:18 A.M., an observation of the lunch tray line revealed the temperature of the chicken patties were 189 degrees Fahrenheit (F), roasted potatoes were 169 degrees F, and the green beans were 181 degrees F. These temperature measurements were taken and verified by Dietary [NAME] (DC) #534 at the time of observation. On 05/14/26 at 12:37 P.M., a new pan of roasted potatoes was taken out of oven with a temperature reading of 167 degrees F and placed for lunch tray line service. On 05/14/26 at 12:58 P.M., the test tray started on tray line and was taken out of the kitchen directly into the dining room on an open cart. On 05/14/26 at 1:00 P.M., the test tray arrived in the dining room on an open cart. On 05/14/26 at 1:10 P.M., an observation of the test tray with Dietary Manager (DM) #539 revealed DM #539 taking the following food temperatures using a calibrated facility thermometer: the temperature of the chicken patty was 107 degrees F and was luke warm upon tasting, the roasted potatoes were 92 degrees F and luke warm upon tasting, and the green beans were 123 degrees F and warm upon tasting. An interview at the time of observation with DM #539 verified the findings of the test tray. DM #539 stated ideally hot foods would be served to residents at a temperature between 120 and 130 degrees F.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review, the facility failed to ensure infection control practices were implemented correctly during medication administration and urinary catheter care. This affected three Residents (#42, #60, and #89) of eight residents observed for medication administration and one (Resident #57) of one resident observed for urinary catheter care. The facility census was 134. Findings include: 1. An observation on 05/14/26 from 8:02 A.M. to 8:20 A.M. with Registered Nurse (RN) #688 revealed the following: at 8:02 A.M. RN #688 was observed exiting Resident #89's room and hand hygiene was not observed prior to dispensing Resident #89's medication. RN #688 then donned personal protective equipment (PPE) which included a gown and gloves. RN #688 then administered Resident #89's medications. RN #688 then removed the PPE, and exited the room without performing hand hygiene; RN #688 then immediately moved the medication cart down the hall, and dispensed medications for Resident #42. RN #688 then entered Resident #42's room, put on gloves, completed a finger stick and glucometer (a machine that measures blood glucose levels) reading, administered the other medications, and exited the room. RN #688 removed their gloves at the medication cart, set the contaminated glucometer on top of the medication cart without cleaning it, and then immediately started to dispense the medications for Resident #60 without hand hygiene being completed. During the process of dispensing the medications for Resident #60, RN #688 dropped a pill on the top of the medication cart. RN #688 then used a glove to pick up the pill and add it to the cup of pills to be crushed prior to administration. RN #688 proceeded to crush the medications. RN #688 then placed the contaminated glucometer back into the medication cart, and then administered Resident #60's medications. An interview on 05/14/26 at 8:25 A.M. with RN #688 verified the above findings. A review of the facility policy titled Hand hygiene, dated 04/30/26 revealed that hand hygiene was considered the most important procedure for preventing infections, hand hygiene was to be performed before and after resident contact, hand hygiene was to be performed after contact with objects in resident rooms, hand hygiene was to be completed after removing PPE, and hand hygiene was to be performed after direct resident contact even if gloves are used. A review of the facility policy titled Medication Administration, dated 10/17/2023 revealed medications were to be dispensed in a sanitary manner, hand hygiene was to be performed prior to medication preparation, hand hygiene was to be performed after direct resident contact, and if a medication came into contact with the medication cart it was to be disposed of and not administered to the resident. A review of the facility policy titled Cleaning and Disinfecting Multi-Use Resident Equipment, dated 03/11/2026 revealed cleaning and disinfection of multi-use items was essential to not transmit germs to residents, multi-use items included glucometers, and multi-use items were to be cleaned or disinfected when they are visibly soiled, and on a regular schedule such as after each use. 2. Review of the medical record for Resident #57 revealed they were admitted to the facility on [DATE] with diagnoses including Amyotrophic Lateral Sclerosis (a progressive disease of the nervous system), obstructive and reflux uropathy, urine retention, and prostate cancer. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact, did not reject care, was dependent on staff for toileting hygiene, and had an indwelling urinary catheter (a tube in the bladder which is left in place that allows for continuous drainage of urine). Review of the physician orders for Resident #57 revealed an order to cleanse the urinary catheter insertion site with soap and water, rinse, and pat dry every shift dated 02/13/26. A review of the care plan revealed Resident #57 was at risk for urinary tract infection related to an (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indwelling urinary catheter with a goal to be free from urinary tract infections dated 02/13/26. Interventions included cleanse peri-area front to back and provide catheter care per policy. An observation on 05/14/26 at 9:56 A.M. with Certified Nurse Assistant (CNA) #516 of urinary catheter care for Resident #57 revealed the following: CNA #516 donned PPE and entered Resident #57's room; CNA #516 then gathered supplies for catheter care and placed a basin and linens directly on the bedside table without a barrier; CNA #516 completed catheter care and external genitalia cleansing; CNA #516 then used the towel which was in direct contact with the bedside table to dry the catheter site and external genitalia; CNA #516 then removed her gloves and put on new gloves without hand hygiene performed; CNA #516 then continued with perineal care and used the brief which was in direct contact with the bedside table; CNA #516 then changed gloves without hand hygiene being performed; CNA #516 then retrieved a graduate (a container with markings used to measure the amount of urine emptied from a urinary catheter drainage bag) from the bathroom, placed it on a barrier, and emptied the urinary catheter drainage bag; CNA #516 then walked into the bathroom, emptied the graduate into the toilet, without changing gloves retrieved the basin of water from the bedside table, emptied it, grabbed the sink faucet handles to turn on the water, rinsed the basin, grabbed the sink faucet handles to turn off the water, and then used paper towels to dry the basin; CNA #516 then removed her PPE and completed hand hygiene. An interview on 05/14/26 at 10:10 A.M. with CNA #516 revealed the bedside table was not cleansed or disinfected prior to setting down the basin or linens and she was unaware hand hygiene was to be utilized after removing contaminated gloves before putting on new ones. During the interview CNA #516 verified the above findings. A review of the company policy titled Hand hygiene, dated 04/30/26 revealed that hand hygiene was considered the most important procedure for preventing infections, hand hygiene was to be performed before and after resident contact, hand hygiene was to be performed after contact with objects in resident rooms, hand hygiene was to be completed after removing PPE, and hand hygiene was to be performed after direct resident contact even if gloves are used.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to maintain the ceiling on the 100-hall in good repair and failed to ensure Resident #154's room furniture was in good repair. This affected 43 residents including all 42 residents (#4, #6, #10, #11, #12, #16, #21, #25, #28, #39, #43, #44, #45, #48, #49, #53, #54, #55, #64, #66, #68, #69, #71, #76, #79, #82, #83, #91, #95, #96, #102, #112, #114, #116, #122, #123, #126, #130, #132, #137, #139, and #142) residing on the 100 hall and Resident #154 of 134 residents observed for physical environment. The facility census was 134. Findings include: 1. Review of the service invoice dated 05/08/26 revealed a repair was scheduled on 04/14/26 for a leaking pipe on the 100- hall and the repair was completed on 05/08/26. On 05/11/26 at 2:02 P.M., an observation of the 100-hall revealed a large hole cut out of the ceiling in the resident common area. On 05/12/26 at 9:52 A.M., an observation of the 100-hall revealed a 12-inch by 18-inch section of drywall was cut out of the ceiling in the 100-hall day room common area. On 05/12/26 at 9:52 A.M., an interview at the time of observation with Maintenance Director #540 verified the drywall had been cut out of the ceiling on the 100-hall for a pipe repair and not been repaired yet. 2. Review of the medical record revealed Resident #154 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, diabetes mellitus type two, chronic kidney disease, and need for assistance with personal care. An interview on 05/11/26 at 2:55 P.M. with Resident #154 revealed she was alert and able to answer questions appropriately. Resident #154 revealed the facility supplied a recliner and the outer material covering on the front of the chair arms was peeling. Observation of the recliner revealed there was substantial peeling of the material covering the back head rest area and also the front of the chair arms. An observation on 05/14/2026 at 1:14 P.M. of Resident #154's recliner revealed it was in the same condition as observed on 05/11/26. An interview on 05/14/26 at 1:14 P.M. at the same time of observation with Resident #154 revealed the recliner had been in that condition since she was admitted the week prior and she was concerned with the condition of the recliner. An interview on 05/14/26 at 1:50 P.M. with Maintenance Director #540 verified the recliner had substantial peeling. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/14/26 at 1:52 P.M. with the Administrator revealed the facility was responsible for inspecting and replacing the facility supplied recliners. The Administrator noted staff were to let the administrative team know of any issues regarding the recliners. The Administrator verified Resident #154 should not have been supplied a recliner with peeling material on it.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on observation, interview and review of facility policy, the facility failed to ensure the smoking policy was developed and being implemented to promote smoking safety in designated smoking areas. This affected four residents (#3, #61, #132 and #139) of four residents the facility identified as smokers. The facility census was 134. Findings include: On 05/12/26 at 10:07 A.M., an observation of the designated outdoor smoking area revealed more than 10 cigarette butts were disposed of inside a non-flame resistant trash can with combustible trash. An interview at the time of the observation with Maintenance Director #540 verified more than 10 cigarette butts were disposed of in a non-flame resistant trash can with combustible trash instead of into non-combustible containers. Review of the facility policy titled Smoking Policy, revised 06/16/25, revealed smoking should occur in designated outdoor areas only and ashtrays would be available in the designated smoking area for resident use. The policy indicated staff members could empty ashtrays as needed. The policy did not specify the use of non-combustible containers.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to notify the physician or nurse practitioner of Resident #148's significant weight loss. 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 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, indicated 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 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 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 there was no documentation to evidence the physician, or nurse practitioner was notified of the results of the re-weight from 09/18/25 and confirmed significant weight loss of 5.1 percent in eight days. There was also no evidence of any physician ordered interventions related to this re-weight and significant weight loss. 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%, had discharged from the facility, and would be re-evaluated if she re-admitted. On 05/13/26 at 2:44 P.M., an interview with Director of Nursing confirmed there was no evidence that the physician or nurse practitioner was notified of Resident #148's re-weight on 09/18/25 and confirmed significant weight loss. 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. This deficiency represents noncompliance investigated under Complaint Number 2690307.		

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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 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. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review, interview, and policy review the facility failed to ensure Resident #48 was vaccinated for COVID-19 after consenting to the vaccine. This affected one (Resident #48) out of five residents reviewed for vaccinations. The facility census was 134. Findings include: Review of the medical record for Resident #48 revealed an admission date of 01/20/2025. Diagnoses included but were not limited to diabetes mellitus with diabetic chronic kidney disease, major depressive disorder, paroxysmal atrial fibrillation, and hypertension. Review of the residents' annual Minimum Data Set 3.0 revealed her cognition was intact. Review of the Consent/Declination of COVID-19 Vaccination form revealed Resident #48 consented to be vaccinated against COVID-19 on 11/26/25. Review of Resident #48's Physician orders from November 2025 until May 2026 revealed the COVID-19 vaccine was not ordered. Additional review of her Medication Administration Record through this period revealed the vaccine had not been administered to the resident. An interview on 05/12/26 at 2:55 P.M. with Assistant Director of Nursing #625 verified the facility failed to order and administer Resident #48's COVID-19 vaccine after she consented to receive the vaccine in 11/2025. Review of the facility policy titled COVID-19 Vaccination Policy dated 05/14/24 revealed the facility will obtain a signed consent form for the administration of the COVID-19 vaccine from the resident or the resident's designated health care representative(s). A copy of the consent form will be provided to the pharmacy, if required. The resident's Primary Physician/Practitioner will provide an order for COVID-19 vaccination following review of allergies, medications, and plan of care to determine if there are any.		