STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366078	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, family interview, staff interview and policy review, the facility failed to ensure Resident #49 was always treated with respect and dignity. This affected one resident (Resident #49) of 32 residents reviewed in the initial sample. Findings include: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had moderately impaired cognition and required supervision after being set-up for eating. Interview on 03/02/20 at 4:29 P.M. with Resident #49 and Family Member #500 revealed, the staff was not very nice at times. Resident #49 indicated a couple weeks ago she had an incident with a State tested Nursing Assistant (STNA) who brought her breakfast tray in and set it down on her over the bed table. The resident stated she had attempted to pull the table over to her but she could not move it so she asked the STNA who was walking out of her room if she could move it closer for her, and the STNA told her, you have two hands you can do it yourself, and left the room. Resident #49 stated she had reported it and was told in a care conference meeting, you are not going to let that ruin your day are you. Family Member #500 verified what was said in the care conference meeting because she attended the meeting on 02/18/20. The resident did not think the incident was abuse, and the resident felt safe in the facility. Review of the care conference notes dated 02/18/20 revealed Resident #49 and her daughter attended. Interview on 03/05/20 at 1:38 P.M. the Administrator indicated she had gone and spoken to Resident #49, and the resident indicated a couple weeks ago she had an incident with a STNA who brought her breakfast tray in and set it down on her over the bed table. The resident stated she had attempted to pull the table over to her but she could not move it so she asked the STNA who was walking out of her room if she could move it closer for her, and the STNA told her, you have two hands you can do it yourself, and left the room. Resident #49 stated she had reported in and was told in a care conference meeting, you are not going to let that ruin your day are you. The Administrator indicated they had started an investigation and submitted a Self-Reported Incident for verbal abuse. The Administrator indicated she had narrowed it down to the aides that normally work on that unit and was able to find out who was working that day. She indicated STNA #412 stated she was at the door when Resident #49 had asked her to move the table closer to her, but the resident had her hands on the table moving it closer to herself, so she just left the room. STNA #412 indicated to the Administrator she never said anything to the resident. However, STNA #412 was suspended pending the investigation outcome. She indicated she was still investigation the care conference concern. The Administrator indicated she spoke with Family Member #500 and she confirmed what was said in the care conference meeting, but no staff members could remember what had been said at the meeting. Interview on 03/05/20 at 2:11 P.M. the Administrator indicated Resident #49 had told the nurse working the floor the day of the incident. Licensed Practical Nurse (LPN) #406 verified Resident #49 indicated to her she had asked STNA #412 to move the tray table closer to her, and STNA #412 told her she had two hands, she could do it herself. The Administrator stated LPN #406 had taken STNA #412 aside and asked her what had happened, and STNA #412 stated to her Resident #49 had both her hands on the tray table when she asked her to move the table, so she thought she could get it herself and left the room. The nurse told STNA #412 if a resident asked you to do something you just do it. The Administrator verified LPN #406 was aware of the incident and should have reported the incident, but she had not reported the incident to any one to be investigated because she did not think there was an issue. The Administrator indicated when she spoke to the resident and her daughter, they both did not think the incident was abuse, and the resident felt safe in the facility. Review of the facility policy, Abuse Prohibitions, Investigation, and Reporting, dated 07/19, revealed it was the facility policy to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/resident property or resources. The facility would not allow verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, or exploitation and all facility personnel would promptly report any incident or suspected incident of guest mistreatment, injuries of unknown source or misappropriation of property/resources. Reports of alleged abuse and/or misappropriation would be immediately reported to the Administrator and thoroughly investigated. Allegations of abuse/misappropriation and the investigative conclusion would be reported to the appropriate State regulatory agency, Law Enforcement agency, licensing, and/or certification board as required by State and Federal law.
F 0565 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to organize and participate in resident/family groups in the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure Resident #43's concerns regarding missing property were resolved timely. This affected one (Resident #43) of one residents reviewed for missing property. Findings include: Resident #43 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #43's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed her cognition was intact. Interview on 03/03/20 at 2:31 P.M. with Resident #43 revealed she was missing cell phone accessories and a gift care around Christmas time. Resident #43 revealed the concern was reported, and she had not hear anything back. Review of the facility grievance log for the last six months revealed no evidence Resident #43 had a concern regarding missing items. Review of Resident #43's Guest Satisfaction Concern/ Suggestion form dated 02/06/20, revealed the resident was missing one USB cable, a screen protector, and a 25 dollar gift card. The concern was reviewed by the Administrator and referred to Registered Nurse (RN) #413. The investigation and findings portion of the the form was blank. Review of the form that was rewritten on 03/03/19 revealed under investigations and findings revealed on 02/07/20 RN #413 spoke to Resident #43 and her family, and the resident had asked her daughter-in-law to take boxes home and the inside of the box was the screen protector and USB cable. Under the resolution portion of the form, RN #413 indicated the family stated the boxes were empty, and Resident #43 was upset the boxes were thrown out. Resident #43's family indicated they had not gone to the store to use the gift cart yet, and the family was afraid the resident may have thrown the gift card away on accident, as the resident had a room full of stuff. The form indicated a replacement was offered and declined. The resolution portion of the form was not signed by the Administrator. Interview on 03/04/20 at 7:46 A.M. with Administrator revealed there was a concern form for Resident #43, but they could not locate the original copy of the concern form, so RN #413 rewrote the concern form to indicate what happened with the concern Resident #43 had. Interview on 03/04/20 with RN #413 revealed on 02/06/20 it was reported to one of the nurses that Resident #43 was missing the phone items and a gift card. RN #413 confirmed the above details in the concern form and revealed the resident was mad her daughter took the box out of her room, but the family indicated there was nothing in the box. RN #413 revealed the family indicated Resident #43 could have misplaced the items, and they continued to look in other

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident rooms and medication rooms for the gift card in case anyone secured the gift card. RN #413 revealed Resident #43's family indicated the resident may have thrown the gift card away, as she has many items throughout her room. Although the concern form did not indicate any discussion with Resident #43, RN #413 indicated on 02/07/20 she spoke with Resident #43 and her family to notify her they could not find the items, and both parties declined replacement of the items. Interview on 03/04/20 at 8:06 A.M. with Administrator revealed when a resident had a concern she delegated who should address the concern, and the Administrator signed off on the resolution. The Administrator confirmed there was no evidence she signed off on Resident #43's concern as they lost the original concern form. Review of the facility policy and procedure titled, Guest Satisfaction Concern/Suggestion Form revealed the facility will thoroughly investigate all concerns and apply correctively measures to resolve issue in a timely manner. The procedure includes the guest, family, or staff member is to complete the guest satisfaction concern/suggestion form. The Administrator will review the nature of the concern, and sign and date that he/she has reviewed it. The Administrator will then either complete the investigation or refer to concern to the appropriate employee for follow-up during the next business day. The Social Service Director will receive the yellow copy of the form to record the concern on the guest satisfaction concern/suggestion tracking log. The appointed employee will investigate and review his/her findings with the Administrator. Follow-up with the family member and/or guest will be done in writing by the employee within seven days, pending approval of the action plan by the Administrator. Upon resolution or the concern, to the satisfaction of the guest and/or family member who initiated the process, the Administrator will sign the form to signify completion/resolution. It will then go to Social Services to complete the necessary information for the guest satisfaction/concern tracking log, designed as part of the quality assurance program. A copy of the completed form with resolution will be given to the guest or responsible party.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehensive assessments were accurate for Resident #13's wounds and Resident #104's discharge location. This affected two residents (Resident #13 and Resident #104) of 25 residents reviewed for comprehensive assessments. Facility census was 111. Findings include: 1. Review of Resident #13's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of an admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #13 had three stage two pressure ulcers (partial-thickness skin loss), two unstageable pressure ulcers and two deep tissue injuries (DTI), a pressure-related injury to subcutaneous tissues under intact skin. Review of a quarterly MDS 3.0 assessment dated [DATE] indicated Resident #13 had one stage two pressure ulcer and five unstageable pressure ulcers. Review of a discharge/return anticipated MDS 3.0 assessment dated [DATE] indicated Resident #13 had two unstageable pressure ulcers. Review of a significant change MDS 3.0 assessment dated [DATE] indicated Resident #13 had two unstageable pressure ulcers. Review of a quarterly MDS 3.0 assessment dated [DATE] indicated Resident #13 had one unstageable pressure ulcer and one vascular ulcer. Review of a quarterly MDS assessment dated [DATE] indicated Resident #13 had one unstageable pressure ulcer and two vascular ulcers (chronic or long term breaches in the skin caused by problems with the vascular system). Review of facility skin and wound evaluations dated 11/25/19, 12/02/19, 12/09/19, 12/16/19, 12/30/19, 01/06/20, 01/14/20, 01/20/20, 01/28/20, 02/03/20, 02/11/20, 02/17/20, 0[DATE] and 03/02/20 revealed Resident #13 had an unstageable pressure area to right heel. Review of an outside wound consultant note dated 02/20/20 revealed Resident #13 had unstageable pressure ulcers to right heel and right calf and a surgical incision at his left above knee amputation site. The right heel measured five centimeters by three centimeters with no depth and was 100 percent (%) eschar (dead or necrotic tissue). The right calf measured 10 centimeters by four centimeters with no depth and was 40 % slough (dead tissue coming to the surface) and 60 % eschar. Review of a care plan for impairment to skin integrity, revised 0[DATE], revealed Resident #13 had unstageable vascular areas to right heel and right calf and a below-knee amputation incision. Vascular areas were noted to right lower extremity. Listed interventions included the wound nurse practitioner following in-house. Interviews on 03/03/20 at 11:16 A.M. and 12:56 P.M. with Registered Nurse (RN) #401, who served as the facility's wound nurse, revealed Resident #13's wounds were not pressure areas but were vascular. RN #401 explained the areas started out as pressure areas but then became vascular. RN #401 looked through Resident #13's nurses notes with the surveyor and could not determine when the wound changed classification from pressure to vascular in nature. RN #401 also shared the facility utilized a cellular phone to measure wounds; when an wound was put into the phone, any subsequent entries would be pre-populated with the wound type, which in this case was pressure. A follow-up interview on 03/03/20 at 3:20 P.M. with RN #401 provided the surveyor with a nurse practitioner note dated 11/24/19 which revealed Resident #13 had severe and significant [MEDICAL CONDITIONS]. An interview on 03/03/20 at 4:21 P.M. with RN #401 and RN #400, who also completed MDS assessments, revealed she used nursing notes and facility skin and wound assessments to complete MDS assessments. RN #400 stated if RN #401's notes classified a wound as a pressure area, she coded that area as pressure. RN #401 confirmed Resident #13's wounds were vascular after 11/24/19 and were not pressure areas which made Resident #13's MDS assessments on 12/10/19 and 02/19/20 incorrect. 2. Resident #104 was admitted on [DATE] and discharged on [DATE]. Review of Resident #104's Social Services Note dated 12/31/19 revealed the resident was discharged home. Review of Resident #104's Discharge Return Not Anticipated MDS 3.0 assessment dated [DATE] revealed the assessment identified he was discharged to an acute hospital. Interview on 03/03/20 at 4:37 P.M. with the Director of Nursing revealed Resident #104 was not hospitalized and was discharged home and confirmed the MDS was coded inaccurately.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident #33 and Resident #68 was offered activities to meet their activity needs and interests. This affected two (Resident #33 and Resident #68) of four residents reviewed for activities. Findings include: 1. Resident #33 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #33's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed her cognition was severely impaired. Observation on 03/02/20 at 9:06 A.M., 03/02/20 at 2:31 P.M., 03/03/20 at 10:19 A.M., and on 03/03/10 at 2:51 P.M. revealed the resident was sitting in the common area far from being able to view the television. Resident #33 was not engaged in television or socializing with staff or residents. Resident #33's back was towards any staff walking by, and residents in her area were not conversing. Review of Resident #33's quarterly Activity Re-evaluation, dated 01/06/20, revealed the resident initiated independent activities daily, including prayer, television and with encouragement may attend group activities including religion, entertainment and bingo. Resident #33's active comprehensive care plan revealed she had the potential for decreased leisure lifestyle with rehabilitation stay due to focus on therapy and goal of returning home. Resident #33 preferred independence in pursuit of leisure. Staff were to encourage self-initiated activities of interest including prayer, music, and television. Resident #33 would be encouraged to socialize and would be invited and escorted to activities including religion, entertainment, and bingo. Review of Resident #33's Documentation Survey Report for January 2020 activities, revealed the resident participated in 14 self prayer activities, one community event, one music/radio activity, and two room visits. There was no evidence the resident was offered additional music, entertainment, or bingo activities. Review of Resident #33's Documentation Survey Report for February 2020 activities, revealed the resident had eight self prayer activities, one social activity on 02/07/20, one room visit on 02/20/20, and 02/27/20 (two within seven days). There was no evidence the resident was offered bingo or other entertainment activities. Interview on 03/04/20 at 9:33 A.M. with Activities Director (AD) #414 revealed Resident #33 sits in the social area to socialize with peers, and her family comes in often. AD #414 revealed the resident comes to entertainment, enjoys variety of music, and she is seen two times a month on a one on one , and there are volunteers that may see her weekly on Thursdays. AD #414 confirmed there was no evidence of volunteer visits weekly on Thursdays. AD #414 revealed Resident #33's care plan for leisure activities needed updated as she does not play bingo. AD #414 revealed she was unsure how it was determined that the residents is initiating self prayer as staff are not involved with the residents self prayer activity. AD #414 confirmed the lack of evidence of Resident #33 had additional music activities in January 2020. 2. Resident #68 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #68's quarterly MDS 3.0 assessment dated [DATE] revealed the resident's cognition was intact. Resident #68's quarterly Activities Re-evaluation dated 0[DATE] revealed the resident self initiates independent activities and may attend group activities, such as bingo. Resident #68's active comprehensive care plan for leisure activity revealed she preferred independent activities but may show interest in bingo Review of the facility January 2020 and February 2020 Activities Schedule revealed bingo was offered two to three times a week. Review of Resident #68's

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F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Documentation Survey Report for activities, for January 2020 and February 2020 revealed no evidence the resident was offered bingo as an activity. Interview on 03/04/20 at 9:24 A.M. with AD #414 confirmed there was no evidence Resident #68 was offered bingo as an activity. Interview on 03/05/20 at 7:07 A.M. with Resident #68 revealed she would need help to play bingo, but if she had the help she would like to play.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and policy review, the facility failed to ensure pressure injuries were accurately assessed, measured and documented for Residents #13, #33, #92, and #94. This affected four residents (Residents #13, #33, #92, and #94) of five residents reviewed for pressure injuries. Findings include: 1. Review of the medical record revealed Resident #92 was admitted to the facility 10/02/15 with the [DIAGNOSES REDACTED]. Review of the five-day Medicare Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #92 had moderately impaired cognition and had one unstageable pressure ulcer (obscured full-thickness and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). Review of the Skin assessment dated [DATE] revealed Resident #92 had an unstageable sacral pressure ulcer measuring 1.6 centimeters (cm) in length by 1.7 cm in width. Observation of the dressing change on 03/03/20 at 1:40 P.M. Registered Nurse (RN) #401 performed a dressing change to the sacrum of Resident #92. RN #401 measured the sacrum wound of Resident #92, which measured 3.5 centimeters (cm) in length by 2.0 cm in width. Interview on 03/03/20 at 1:40 P.M. RN #401 indicated she had taken the measurements on 03/02/20 with her telephone. She indicated it was the facility policy to measure all wound with the program on her telephone. She verified the measures were different from the telephone and manually measuring the wound. The wound was twice the size manually than with the telephone, and she did not understand why it was measuring differently. Review of the facility policy Skin Management, dated 10/19, revealed the facility policy the facility should identify implement interventions to prevent development of clinically unavoidable pressure injuries. Photographs may be taken of the pressure injury and vascular wounds. 2. Review of the medical record revealed Resident #94 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #94 had moderately impaired cognition, two unstageable pressure ulcers present upon admission and two deep tissue injuries (pressure-related injury to subcutaneous tissues under intact skin) present upon admission. Review of the skin assessment dated [DATE] revealed the sacral wound for Resident #94 measured 4.5 cm in length by 5.1 cm in width by 4 cm deep, the left heel measured 1.6 cm in length by 4.0 in width, the left foot, first digit measured 0.3 cm in length by 0.6 cm in width, and the right heel measured 0.9 cm in length by 2.0 cm in length. Observation of a dressing change and measurements on 03/03/20 at 2:00 P.M. RN #401 manually measured the pressure wounds of Resident #94, which revealed: The sacral wound measured 6.0 cm in length by 4.0 cm in width by 4.0 cm deep, the left heel measured 2.0 cm in length by 5.2 cm in width, the left foot, first digit measured 2.0 cm in length by 0.2 cm in width, the right heel measured 3.0 cm in length by 2.0 cm in width. Interview on 03/03/20 at 2:30 P.M. RN #401 verified the measurement from 03/02/20 and during the dressing change were not the same and were measuring worse than previously documented. Review of the facility policy Skin Management, dated 10/19, revealed the facility policy the facility should identify implement interventions to prevent development of clinically unavoidable pressure injuries. Photographs may be taken of the pressure injury and vascular wounds. 3. Resident #33 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #33's quarterly MDS 3.0 assessment dated [DATE] revealed her cognition was severely impaired, she required two person extensive assistance with bed mobility, transfers, and one person extensive assistance with dressing. Resident #33's Skin and Wound Evaluation dated 07/19/20 revealed she had an unstageable pressure ulcer to her right heel, measuring 1.1 cm long by 0.8 cm long. Resident #33's physician orders dated 08/23/20 through 09/12/20 revealed orders to cleanse the right heel with normal saline, apply nickel thick Santyl ointment (debridement ointment), cover with dry dressing, and change daily and as needed. Review of Resident #33's August Treatment Administration Record (TAR) and medical record revealed no evidence the treatment was completed 08/24/19 through 08/28/29, 08/30/19, and 08/31/19. Review of Resident #33's September TAR and medical record revealed no evidence the treatment was completed 09/01/19 through 09/05/19, 09/07/19, 09/08/19, 09/10/19, and 0[DATE]. Review of Resident #33's physician orders revealed from 09/21/19 through 12/05/19 it was ordered to cleanse the resident's right heel with normal saline, apply Theraworks, Santyl nickel thick, cover with foam dressing until exhausted then use super absorbent dressing, and changed daily and as needed. Review of Resident #33's October 2019 TAR revealed no evidence the treatment was completed 10/02/19, 10/09/19, 10/11/19, 10/16/19, 10/19/29, 10/23/19, and 10/30/19. Review of Resident #33's November 2019 TAR revealed no evidence the treatment was completed 11/02/19 and 11/03/19. Review of Resident #33's Skin and Wound Evaluation, dated 03/02/20 revealed Resident #33 still had the unstageable pressure ulcer to her right heel. Interview on 03/04/20 at 5:05 P.M. with Director of Nursing confirmed there was no evidence Resident #33's treatments were completed on the above dates. 4. Review of Resident #13's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of an admission MDS 3.0 assessment dated [DATE] indicated Resident #13 had three stage two pressure ulcers (partial-thickness skin loss), two unstageable pressure ulcers and two deep tissue injuries (DTI). Review of a quarterly MDS assessment dated [DATE] indicated Resident #13 had one stage two pressure ulcer and five unstageable pressure ulcers. Review of a discharge/return anticipated MDS 3.0 assessment dated [DATE] indicated Resident #13 had two unstageable pressure ulcers. Review of a significant change MDS 3.0 assessment dated [DATE] indicated Resident #13 had two unstageable pressure ulcers. Review of a quarterly MDS 3.0 assessment dated [DATE] indicated Resident #13 had one unstageable pressure ulcer and one vascular ulcer. Review of a quarterly MDS 3.0 assessment dated [DATE] indicated Resident #13 had one unstageable pressure ulcer and two vascular ulcers (chronic or long term breaches in the skin caused by problems with the vascular system). Review of facility skin and wound evaluations dated 11/25/19, 12/02/19, 12/09/19, 12/16/19, 12/30/19, 01/06/20, 01/14/20, 01/20/20, 01/28/20, 02/03/20, 02/11/20, 02/17/20, 0[DATE] and 03/02/20 revealed Resident #13 had an unstageable pressure area to right heel. Review of an outside wound consultant note dated 02/20/20 revealed Resident #13 had unstageable pressure ulcers to right heel and right calf and a surgical incision at his left above knee amputation site. The right heel measured 5.0 cm by 3.0 cm with no depth and was 100 percent (%) eschar (dead or necrotic tissue). The right calf measured 10 cm by 4.0 cm with no depth and was 40% slough (dead tissue coming to the surface) and 60% eschar. Review of a care plan for impairment to skin integrity revised 0[DATE] revealed Resident #13 had unstageable vascular areas to right heel and right calf and a below-knee amputation incision. Vascular areas were noted to right lower extremity. Listed interventions included the wound nurse practitioner following in-house. Interviews on 03/03/20 at 11:16 A.M. and 12:56 P.M. with RN #401, who served as the facility's wound nurse, revealed Resident #13's wounds were not pressure areas but were vascular. RN #401 explained the areas started out as pressure areas but then became vascular. RN #401 looked through Resident #13's nurses notes with the surveyor and could not determine when the wound changed classification from pressure to vascular in nature. RN #401 also shared the facility utilized a cellular phone to measure wounds; when an wound was put into the phone, any subsequent entries would be pre-populated with the wound type which in this case was pressure. A follow-up interview on 03/03/20 at 3:20 P.M. with RN #401 provided the surveyor with a nurse practitioner note dated 11/24/19 which revealed Resident #13 had severe and significant [MEDICAL CONDITIONS]. An interview on 03/03/20 at 4:21 P.M. with RN #401 and RN #400, who also completed MDS assessments, revealed she used nursing notes and facility skin and wound assessments to complete MDS assessments. RN #400 stated if RN #401's notes classified a wound as a pressure area, she coded that area as pressure. RN #401 confirmed Resident #13's wounds were vascular after 11/24/19 and were not pressure areas which made Resident #13's MDS assessments on 12/10/19 and 02/19/20 incorrect. Review of the facility policy Skin Management, revised October 2019, revealed residents with wounds and/or pressure injury and those at risk for skin compromise were identified, evaluated and provided appropriate treatment to promote prevention and healing. In electronic health record (EHR) facilities the nurse would document on the skin and wound evaluation for pressure injuries and vascular ulcers on a weekly basis until resolved.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Based on observation, interview and record review, the facility failed to ensure Resident #33's fall precaution interventions were in place at all times. This affected one (Resident #33) of three residents reviewed for falls. Findings include: Resident #33 was admitted on with [DIAGNOSES REDACTED]. Resident #33's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed her cognition was severely impaired, she required two person extensive assistance with bed mobility, transfers, and one person extensive assistance with dressing. Resident #33's comprehensive care plan related to being at risk for falls, revised 06/24/19, revealed the resident should wear non-skid foot wear when out of bed, and to encourage the resident to wear appropriate footwear as needed. Observation on 03/02/20 at 9:06 A.M. revealed Resident #33 was sitting in her wheelchair in a common area with socks that were not non-skid. Interview on 03/02/20 at 11:09 A.M. with Registered Nurse (RN) #413 confirmed Resident #33 should be wearing non-skid socks and she was not wearing them at the time.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record and staff interview the facility failed to implement non-pharmacological intervention prior to administering as needed anti-anxiety medication, [MEDICATION NAME], for Resident #49. This affected one resident (Resident #49) of five residents reviewed for unnecessary medications. Findings include: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had moderately impaired cognition and received an anti-anxiety medication for seven days. Review of the March 2020 physician's orders [REDACTED]. Review of the January 2020 Medication Administration Record [REDACTED]. Review of the February 2020 MAR indicated [REDACTED]. Review of the March 2020 MAR indicated [REDACTED]. Interview on 03/05/20 at 2:06 P.M. the Director of Nursing verified there was no documentation of non-pharmacological interventions attempted prior to the administration of [MEDICATION NAME].
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based observation, staff interview and policy review, the facility failed to ensure pureed food was the proper consistency. This affected one resident (Resident #92) but had the potential to affect all 13 residents (Resident #5, #9, #14, #15, #27, #31, #33, #34, #47, #77, #78, #92 and #154) who received pureed diets. Finding include: Observation on 03/02/20 at 11:51 A.M. staff gave Resident #92 a meal tray. The pureed food was on a regular plate, the food had a very thin consistency and was running all over the plate mixing into each other. An interview at this time State tested Nursing Assistant (STNA) #409 verified the pureed food was too runny and looked terrible on the plate. An interview on 03/02/20 at 11:57 A.M. Dietary Manger #410 verified the pureed food for Resident #92 was too runny, and she went to get him a new plate of purred food. Review of the facility policy Mechanically Altered Diet, dated 04/10, revealed mechanically altered diets would be prepared and served as prescribed by the physician. Guests would be provided with the least restrictive diet to optimize nutritional status and to promote overall satisfaction with meals. All guests with a physician's order for a pureed diet would receive pureed, homogenous, and cohesive foods. Foods would be pudding-like. No coarse textures, raw fruits, or vegetables, nuts are allowed. Any food that requires bolus formation, controlled manipulation, or mastication. Review of the facility policy National Dysphagia Diet, Level 1: Pureed Diet, dated 04/10, revealed the NDD1 diet consists of pureed, homogenous, and cohesive foods in pudding like consistency. Any foods that require bolus formation, controlled manipulation, or mastication are excluded. This diet was designed for people who have moderate to severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. Close or complete supervision and alternated feeding methods may be required on an individual basis.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and staff interview the facility failed to ensure food service carts were maintained in a sanitary manner. This affected all 69 residents (Resident #1, #3, #4, #5, #6, #7, #8, #10, #16, #18, #19, #20, #21, #22, #24, #28, #29, #31, #32 #40, #41, #42, #44, #45, #47, #49, #51, #52, #54, #55, #56, #57, #60, #61, #62, #63, #64, #65, #66, #67, #69, #70, #71, #76, #77, #80, #82, #87, #88, #89, #91, #92, #93, #94, #95, #98, #100, #102, #154, #155, #156, #157, #158, #159, #160, #161, #162, #164, and #308) who were served from the metal meal storage carts on the 100, 200 and 300 hallways. Findings include: Observation on 03/02/20 at 12:20 P.M. revealed the metal food storage cart on the 100 hallway with the residents meals was soiled with food and dried liquid. The cart had a red substance spilled on the outside of the cart, a white substance spilled on the inside of the cart on the door, and a brown sticky substance on the outside of the cart by the handle. An interview at this time State tested Nursing Assistant (STNA) #408 verified the carts were soiled Observation on 03/02/20 at 12:25 P.M. revealed the metal food storage cart on the 300 hallway with the residents meals was soiled with food and dried liquid. The cart had a white dried liquid substance spilled on the inside on the cart, a white dried liquid spilled on the outside of the cart, the rail along outside bottom of the cart had a moderate amount of food debris laying along it. Observation on 03/02/20 at 12:27 P.M. revealed the metal food storage cart on the 200 hallway with the resident's meals was soiled with food and dried liquid. The cart had white and brown substance spilled on the inside and outside, the rail along outside bottom of the cart had a moderate amount of food debris laying along it, and the handle had a brown sticky substance on it. An interview on 03/02/20 at 12:30 P.M. STNA #600 verified the meal carts were dirty and indicated they were always dirty. She stated sometimes they were so dirty the doors stick shut.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews and policy review, the facility failed to maintain standard infection control practices when Resident #1's food tray was delivered to the room without proper implementation of contact isolation precautions and during Resident #33's dressing change. This affected one resident (Resident #1) and had the potential to affect three additional residents (Resident #41, #51, and #93) residing on the hall who received lunch trays, and affected one resident (Resident #33) of two residents observed during dressing changes. Findings include: 1. Medical record review revealed Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 03/02/20 at 11:57 A.M., observation revealed a contact isolation sign posted on Resident #1's room door and personal protective equipment (PPE) located outside of the room's doorway. Observation of the lunch tray service revealed State-tested Nursing Assistant (STNA) #420 removed Resident #1's tray from the service cart, entered the resident's room, and delivered the tray without wearing gloves or other PPE. STNA #420 then exited the room and removed Resident #41's tray from the service cart and carried it to the common area dining table. During interview on 03/02/20 at 12:00 P.M., STNA #420 confirmed that [MEDICAL CONDITION] contact isolation precautions were being implemented for Resident #1 and stated she did touch the resident's bedside table while delivering the the lunch tray. STNA #420 further confirmed she should have been wearing gloves and the designated PPE. During interview at 03/02/20 at 12:02 P.M., Registered Nurse (RN) #421 confirmed STNA #420 should have worn proper PPE while delivering Resident #1's tray. Review of the facility's policy Infection Prevention Program Overview, revision date September 2019, stated when the infection control program identifies that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. 2. Resident #33 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #33's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed her cognition was severely impaired, she required two person extensive assistance with bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366078	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) mobility, transfers, and one person extensive assistance with dressing. Resident #33's physician orders [REDACTED]. Resident #33's Skin and Wound Evaluation dated 03/02/20 revealed she had an unstageable pressure ulcer to her right heel (obscured full-thickness and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). Observation on 03/02/20 10:50 A.M. of RN #401 completing Resident #33's right heel pressure ulcer dressing revealed she placed all of the dressing change supplies on a clean field on the resident's bed side table. The dressings were in unopened packages. After RN #401 discarded the resident's old heel protector, she washed her hands and applied new clean gloves. RN #401 than opened up the foam dressing packaging with her clean gloves, grabbed a permanent marker that was lying on a blanket on the residents bed, and dated the dressing with her clean gloves on. RN #401 then placed her thumb in the middle of the foam dressing before applying the collagen ointment to the foam dressing. RN #401 than applied the collagen to the foam heel protector and placed the dressing on the right heel wound. Interview on 03/02/20 at 11:10 A.M. with RN #401 revealed she did not sanitize the marker before the dressing change and opened the dressings with clean gloves on. Review of the facility procedure for Clean Dressing Change, printed 03/02/20, revealed the staff are to gather and set up supplies in the resident area, including establishing a clean field, open supplies onto clean field, and to pour solution into clean container, prepare ointments, and medications. Upon completion of informing the resident of what they are doing and provide privacy, they are to wash hands and apply clean gloves and remove and discard old dressing. Staff are then to remove gloves, wash hands and apply new closed, and then cleanse and dress the wound as ordered. The procedure did not provide steps on how to use a marker to date the dressing.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure two residents (Resident #19 and #99) of five residents reviewed for pneumococcal and influenza vaccines received the education addressing the benefits and risks of the pneumococcal and influenza vaccines or the date when re-offered the vaccines. The facility census was 111. Findings include: Review of Resident #19's Acknowledgement of Receipt of Vaccine Information Sheet (VIS), revealed the resident declined the pneumonia [MEDICATION NAME] vaccine and the influenza vaccine; however, the medical record failed to include a date confirming when Resident #19 received the education addressing the benefits and risks or the date when the resident was re-offered the vaccines. Review of Resident #99's Acknowledgement of Receipt of Vaccine Information Sheet (VIS), revealed the resident declined the pneumonia [MEDICATION NAME] vaccine and the influenza vaccine; however, the medical record failed to include a date confirming when Resident #99 received the education addressing the benefits and risks or the date when the resident was re-offered the vaccine. During an interview on 03/05/20 at 2:32 P.M., the Director of Nursing confirmed that Resident #19 and Resident #99's Vaccine Information Sheets did not provide evidence of the date when the residents received education or were re-offered the pneumococcal and influenza vaccinations. Review of the facility's policy titled, Influenza and Pneumococcal Vaccine Policy, revised September 2019, stated informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination. Vaccination refusal should be documented by the facility. If the resident chooses to decline the vaccination, it will be re-evaluated annually.