STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365291	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hall of Fame Rehabilitation and Nursing Center	2714 13th Street NW Canton, OH 44708

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on medical record review, staff interview and policy review the facility failed to ensure advanced directives were present in the electronic chart. This affected one (Resident #37) of 16 (Residents #3, #4, #5, #10, #15, #19, #20, #23, #25, #26, #30, #35, #37, #38, #191, and #192) reviewed for advanced directives. The facility census was 38. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included but were not limited to type II diabetes with ketoacidosis, dementia, cardiomyopathy, congestive heart failure, and Alzheimer's dementia. Review of the physician's orders located in the electronic medical record for Resident #37 revealed no evidence of an order for advance directives. Review of the admission packet which included the baseline care plan dated 6/20/24 for Resident #37 revealed the code status was Do Not Resuscitate Comfort Care Arrest (DNR CCA). Interview on 08/13/24 at 8:50 A.M. with the Director of Nursing (DON) confirmed the DNR CCA was signed and in a pile of unfiled papers and was not in the medical record as required. Review of the 2024 facility policy Residents' Rights Regarding Treatment and Advance Directives revealed it was the policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate and advance directive. Upon admission, the resident would have an advance directive and copies would be made and placed in the chart as well as communicated to the staff.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43063 Based on record review, observation and interview, the facility failed to ensure smoking assessments were completed. This affected four (Residents #15, #35, #38 and #192) of 12 residents who smoked at the facility. The facility census was 38. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including vascular dementia, history of traumatic brain injury and nicotine dependence. Review of Resident #15's assessments revealed his last smoking safety screen was completed on 05/23/23. At that time, Resident #15 was safe to smoke with supervision. Review of Resident #15's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was moderately cognitively impaired. Observation on 08/12/24 at 10:00 A.M. revealed Resident #15 smoking in the designated smoking area with staff. Interview on 08/14/24 at 12:15 P.M. with Licensed Practical Nurse (LPN) #523 verified a smoking assessment had not been completed quarterly and was last completed on 05/23/23. LPN #523 stated smoking assessments should be completed with the MDS assessment every quarter. Review of the facility policy titled, Resident Smoking, dated 08/01/20, revealed a smoking evaluation would be completed on each resident who chose to smoke and would be re-evaluated quarterly and with a change of condition. 2. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including muscle weakness, abnormalities of gait and mobility, need for assistance with personal care and repeated falls. Review of Resident #35's assessments revealed his last smoking safety screen was completed on 05/24/23. At that time, Resident #35 was safe to smoke with supervision. Observation on 08/12/24 at 10:00 A.M. revealed Resident #35 smoking in the designated smoking area with staff. Interview on 08/14/24 at 12:15 P.M. with Licensed Practical Nurse (LPN) #523 verified a smoking assessment had not been completed quarterly and was last completed on 05/24/23. LPN #533 stated the smoking assessment should be completed with the MDS assessment every quarter. Review of the facility policy titled, Resident Smoking, dated 08/01/20, revealed a smoking evaluation would be completed on each resident who chose to smoke and would be re-evaluated quarterly and with a change of condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including chronic kidney disease, muscle weakness, abnormalities of gait and mobility and need for assistance with personal care. Review of Resident #38's assessments revealed she did not have a smoking assessment since she was admitted . Observation on 08/12/24 at 10:00 A.M. revealed Resident #38 smoking in the designated smoking area with staff. Interview on 08/14/24 at 12:15 P.M. with Licensed Practical Nurse (LPN) #523 verified a smoking assessment had not been completed since Resident #38 was admitted . Review of the facility policy titled, Resident Smoking, dated 08/01/20, revealed a smoking evaluation would be completed on each resident who chose to smoke and would be re-evaluated quarterly and with a change of condition. 4. Review of the medical record for Resident #192 revealed an admitted [DATE] with diagnoses including psychoactive substance abuse, bipolar disorder and anxiety. Review of Resident #192's assessments revealed he did not have a smoking assessment since he was admitted . Observation on 08/12/24 at 10:00 A.M. revealed Resident #192 smoking in the designated smoking area with staff. Interview on 08/14/24 at 12:15 P.M. with Licensed Practical Nurse (LPN) #523 verified a smoking assessment had not been completed since Resident #192 was admitted . Review of the facility policy titled, Resident Smoking, dated 08/01/20, revealed a smoking evaluation would be completed on each resident who chose to smoke and would be re-evaluated quarterly and with a change of condition.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review, interviews and facility policy review, the facility failed to ensure a comprehensive care plan was created related to behavioral health needs. This affected one (Resident #192) of nineteen residents reviewed for care plans. The facility census was 38. Findings include: Review of the medical record for Resident #192 revealed an admitted [DATE]. Diagnoses included but were not limited to rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood) acute kidney failure, anxiety disorder, other psychoactive substance abuse and bipolar disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #192 revealed he was cognitively intact, was noted to be feeling down, depressed, little interest in doing things, trouble falling asleep, tired, and had little energy seven to eleven days of the last fourteen days during the assessment period. Resident #192's Patient Health Questionnaire (PHQ-9) score of 10 indicated moderate depression. Review of the baseline care plan dated 07/31/24 for Resident #192 revealed under Psychosocial Wellbeing-Care there were no identified problems. Interventions were to monitor medication: side effect and effectiveness, provide comfort and safe environment and assess and monitor for cause/notify physician of changes. Review of the care plan dated 07/31/24 for Resident #192 revealed no evidence of a psychosocial care plan was developed or interventions related to his diagnosis of schizophrenia and bipolar disorder. Review of the Psychiatric Nurse Practitioner's (Psychiatric NP #566) progress note dated 08/08/24 for Resident #192 revealed diagnoses including schizoaffective disorder bipolar type, anxiety, depression and insomnia. Resident #192's past medical history revealed he was diagnosed at the age of 18 with schizophrenia and bipolar disorder. Resident #192 stated he had current stressors including being at the facility and his health. Psychiatric NP #566 indicated Resident #192 had a history of panic attacks, anxiety, delusions, substance abuse, and had attempted suicide twice via overdose. Psychiatric NP #566 also indicated staff were to monitor for side effects of medication, monitor for mood/behavioral changes and encourage him to participate in group and activities. Interview on 8/15/24 at 10:29 A.M. with Registered Nurse (RN) #543 confirmed a psychosocial care plan had not been developed for Resident #192. Interview on 08/15/24 at 10:41 A.M. with the Assistant Director of Nursing (ADON) confirmed there was not a care plan to address Resident #192's psychosocial needs. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 2024 facility policy Behavioral Health Services revealed the facility utilized the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan would include goals that were person-centered care. The assessment and care plan would include goals that were person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff would: assess and develop a person-centered care plan for concerns identified in the resident's assessment. Review of the 2023 facility policy Comprehensive Care Plans revealed the comprehensive care plan would be developed within seven days after the completion of the comprehensive MDS assessment. The comprehensive care plan would describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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** 38522 Based on record review, interview and review of the facility policy, the facility failed to adequately monitor residents on anti-anxiety medications. This affected one resident (#10) of five residents reviewed for unnecessary medications. The facility census was 38. Findings include: Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses including anxiety, schizoaffective disorder bipolar type, depression, falls, hypertension and suicidal ideations. Review of Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 was cognitively intact and received anti-psychotic, anti-depressant and anti-anxiety medications as well as a diuretic. Review of Resident #10's physician's orders as of 08/15/24 revealed an order dated 11/09/23 for Ativan (anti-anxiety medication) oral tablet 0.5 milligrams (mg) give by mouth twice a day for anxiety. No orders were in place to monitor side effects relative to Resident #10's anti-anxiety medication. An interview on 08/15/24 at 1:00 P.M. with Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #524 and the Director of Nursing (DON) revealed Certified Nurse Practitioner (CNP) #566 monitored resident medications and side effects and confirmed there was nothing in place for facility nursing staff to monitor for potential side effects related to Resident #10's anti-anxiety medications. Interview on 08/15/24 at 1:12 P.M. with Chief Operating Officer (COO)/Registered Nurse (RN) #577 verified the lack of anti-anxiety medication monitoring in place for Resident #10. Review of the policy, Use of Psychotropic Medication, undated, revealed the effects of the psychotropic medications on a resident's physical, mental and psychosocial well-being would be evaluated on an ongoing basis, such as: upon physician evaluation (routine and as needed), during the pharmacist's monthly medication review, during the MDS review (quarterly, annually and significant change) and in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications and the resident's comprehensive plan of care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on observation, interview and policy review, the facility failed to ensure proper sanitation for resident refrigerators for two residents (Residents #9 and #17) of eight (Residents #9, #14, #15, #16, #17, #28, #34 and #36) reviewed for in room refrigerators. The facility census was 38. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic congestive heart failure, encephalopathy, chronic obstructive pulmonary disorder, type II diabetes mellitus with neuropathy, and dementia with behaviors. Review of the 07/01/24 Minimum Data Set (MDS) 3.0 assessment revealed Resident #9 had severe cognitive impairment. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic and mild intellectual disabilities. Review of the 05/29/24 MDS 3.0 assessment revealed Resident #17 had severe cognitive impairment. Observations or resident room refrigerators on 08/14/24 at 3:19 P.M. with Registered Dietitian (RD) #564 revealed the following concerns: -Resident #9's refrigerator had two hamburgers on a Styrofoam plate which were not labeled or undated. -Resident #17's refrigerator had a 15 ounce (oz) container of Lays smooth ranch dip in which the expiration date was unable to be determined but had been opened and had a visible black thick layer of mold on top of dip, a 23 oz glass container of Lays French onion dip with an expiration of 04/30/24, a 15 oz glass container of Lays smooth ranch dip with an expiration date of 09/15/23, and a 15 oz jar of Lays smooth ranch dip with an expiration date of 12/18/23. RD #564 confirmed the above findings at the time of the observation and stated they have previously had concerns related to resident refrigerators not being monitored and she developed a list of resident refrigerators and monitored them monthly but was unable to provide evidence of the last review of the resident refrigerators. Interview on 08/15/24 at 9:27 A.M. with Housekeeper #505 and Housekeeper #518 revealed when they cleaned resident rooms, they did not clean the inside of the refrigerators, just the top and sides and they thought the aides were responsible for monitoring the resident refrigerators. Interview on 08/15/24 at 9:33 A.M. with State tested Nurse Aide (STNA) #549 revealed STNAs did not monitor resident refrigerators and she thought the housekeepers cleaned them. Review of the 2024 facility policy Use of Storage of Food Brought in by Family or Visitors revealed the facility staff would assist residents in accessing and consuming food that was brought in by resident and family or visitors if the resident was not able to do so on their own.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview and review of the facility policy, the facility failed to maintain a complete and accurate record. This affected one resident (#10) of 19 resident records reviewed. The facility census was 38. Findings include: Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses including anxiety, schizoaffective disorder bipolar type, depression, falls, hypertension and suicidal ideations. Review of Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 was cognitively intact and received routine antipsychotic medications. Review of a pharmacy recommendation dated 12/01/23 revealed Resident #10 received Abilify (antipsychotic) which could cause involuntary movements but an Abnormal Involuntary Movement Scale (AIMS) or other appropriate assessment was not documented in the medical record within the previous six months. Review of a pharmacy recommendation dated 06/03/24 revealed Resident #10 received Geodon (antipsychotic) which could cause involuntary movements but an AIMS or other appropriate assessment was not documented in the medical record within the previous six months. Review of a pharmacy recommendation dated 07/01/24 revealed Resident #10 received Geodon which could cause involuntary movements but an AIMS or other appropriate assessment was not documented in the medical record within the previous six months. Review of Resident #10's electronic medical record revealed the last AIMS assessment completed was on 04/28/23. During an interview on 08/15/24 at 12:21 P.M. Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #524 was asked to provide any additional AIMS assessments for Resident #10. During a follow-up interview on 08/15/24 at 1:00 P.M. with LPN/ADON #524 and the Director of Nursing (DON) no additional AIMS assessments for Resident #10 were provided. Interview on 08/15/24 at 1:49 P.M. with Chief Operating Officer (COO)/Registered Nurse (RN) #577 revealed she had obtained AIMS assessments from Certified Nurse Practitioner (CNP) #566 but confirmed these were not from or part of the facility's medical records. Review of provided documentation indicated Resident #10 had AIMS assessments completed on 03/21/24 and 07/11/24 by CNP #566 outside of the facility medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview on 08/15/24 at 2:17 P.M. with LPN/ADON #524 verified CNP #566 had documented Resident #10's AIMS outside of the facility's medical record and confirmed Resident #10's medical record was not complete and accurate as such. Review of the undated facility policy, Documentation in Medical Record, revealed licensed staff and interdisciplinary team members were to document all assessments, observations and services provided in the resident's medical record. Documentation was to be completed at the time of service but no later than the shift in which the assessment, care or service occurred. Documentation was to be accurate, relevant and complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on observation, interview, record review, review of the facility policy and review of Centers for Disease Control (CDC) guidance, the facility failed to develop and implement a water management program to prevent the potential growth of legionella as required. Additionally, the facility failed to maintain infection control during medication administration for one resident (Resident #31) out of two residents observed for medication administration. The facility census was 38. Findings include: 1. Review of available facility documentation relative to legionella revealed the CDC toolkit titled, Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, dated 06/05/17. The documentation included a section, Identifying Buildings at Increased Risk, which instructed staff to survey the building or property to determine if they needed a water management program to reduce the risk of Legionella growth and spread and this section was blank and not filled out. There was no attached water management diagram and no water management plan written for the facility identifying components of the facility's water system, addressing testing the water for legionella or listing routine measures the facility would take to monitor the water system. Review of additional documentation relative to legionella provided included the undated facility policy, Water Management Program, the facility policy, Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated June 2017, the undated facility policy, Legionella Surveillance, and a Centers for Medicare and Medicaid Services (CMS) Survey & Certification Group memo dated 06/02/17 titled, Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD). There was no attached water management diagram and no water management plan written for the facility identifying components of the facility's water system, addressing testing the water for legionella or listing routine measures the facility would take to monitor the water system. Interview on 08/15/24 at 11:54 A.M. with Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON)/Infection Preventionist (IP) #524 revealed she called the old maintenance staff who stated they tested for Legionella in February 2024 and no concerns were found. LPN/ADON/IP #524 stated the facility did water flushes weekly on the new unit that was unoccupied at this time. During an interview on 08/15/24 at 12:21 P.M. LPN/ADON/IP #524 and the Director of Nursing (DON) were made aware the provided information relative to legionella included three policies, a CMS memo and a blank copy of the Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, toolkit written by the CDC and the provided information lacked a water management plan and information specific to the facility relative to monitoring the water supply to prevent the growth of legionella to which LPN/ADON/IP #524 and the DON did not disagree. Interview on 08/15/24 at 1:12 P.M. with Chief Operating Officer (COO)/Registered Nurse (RN) #577 verified the facility did not have a legionella water management plan available for review. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Water Management Program, undated, revealed the facility would establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens in the facility's water systems based on nationally accepted standards. A water management team had been established to develop and implement the facility's water management program including the facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff and Director of Nursing .the Maintenance Director maintained documentation that described the facility's water system. A copy was kept in the water management program binder. A risk assessment would be conducted by the water management team annually to identify where Legionella could grow and spread in the facility's water systems. This risk assessment would consider the following elements: precise plumbing, clinical equipment and at-risk populations. The entire facility's population was at risk. High risk areas would be identified through the risk assessment process. Supporting documentation of any areas or resident population that exhibited greater risk than the general population would be kept in the water management program binder. Data to be used for completing the risk assessment could include but was not limited to: water system schematic/description; legionella environmental assessment; resident infection control surveillance data, environmental culture results; rounding observation data; water temperature logs; water quality reports from drinking water provider and community infection control surveillance data. Based on the risk assessment, control points would be identified and the list of the identified points would be kept in the water management program binder. Control measures would be applied to address potential hazards at each control point. Testing protocols and control limits would be established for each control measure. The water management team would regularly verify that the water management program was being implemented as designed. The facility would conduct an annual review of the water management program as part of the annual review of the infection prevention and control program and as needed. Documentation of all the activities related to the water management program would be maintained with the water management program and would be maintained with the water management program binder for a minimum of three years. Review of the CDC webpage updated 03/15/24 revealed guidance under the title of, Overview of Water Management Programs, and revealed water management programs identified hazardous conditions and outlined steps to minimize the health impact of waterborne pathogens. Developing and maintaining a water management program was a multi-step process that required continuous review. Further review of the webpage under the subsection titled, Steps, revealed the step of a legionella water management program which included: establish a water management program team, describe the building water systems, identify areas where legionella could grow and spread, decide where control measures should be applied and how to monitor them, establish interventions when control limits were not met, make sure the program was running as designed and was effective, and document and communicate all the activities. 43063 2. Review of medical record for Resident #31 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, diabetes mellitus and chronic kidney disease. Observation on 08/13/24 at 8:10 A.M. of the medication administration to Resident #31 with Licensed Practical Nurse (LPN) #522 revealed she pushed the medication out of the card and the pill fell into the narcotic drawer. LPN #522 then picked the pill up with her bare hand and placed it into the medication cup. LPN #522 then continued to get other medications from the medication cart for Resident #31. Interview with LPN #522 at the time of the observation verified she had touched the pill with her bare hand. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Medication Administration, undated, revealed when medication was removed from the source (medication card or bottle), staff should not touch medication with their bare hands.