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	03/26/2026

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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure the Director of Nursing (DON) duties were completed by the registered nurse (RN). This had the potential to affect all 48 residents residing in the facility.Findings include:Review of the key personnel list indicated the Director of Nursing (DON) as Registered Nurse (RN) #419. The list indicated Licensed Practical Nurse (LPN) #423 as the Assistant Director of Nursing (ADON). Review of the personnel file for ADON LPN #423 revealed an employee action form dated 10/21/22 indicating a salary increase effective 10/09/22. Under the comments sections was a handwritten note effective 10/09/22 currently acting DON and all clinical lead, approved by the Administrator. Interview on 03/25/26 at 5:03 P.M. with the Administrator verified he had written the note and stated that it was effective as of 10/09/22 ADON LPN #423 was the acting DON with all clinical leads. The Administrator stated the DON RN #419 was only by title, and ADON LPN #423 did all the DON duties.

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of the Resident Council minutes, observation, staff interview, resident interview and review of the mealtime policy, the facility failed to ensure meals were served in a timely manner. This affected five residents (#13, #31, #47, #48, and #56) of five residents reviewed for frequency of meals and had the potential to affect all 47 residents who received meals from the kitchen. The facility identified one resident (Resident #4) as receiving nothing by mouth (NPO). The facility census was 48.Findings include:Review of the Resident Council minutes dated 01/08/26 revealed meals were often late.Review of the Resident Council minutes dated 02/05/26 revealed meals were often late.Review of the undated facility mealtimes posted at the second-floor nurses' station revealed the second floor was the second cart and should be delivered to the floor at 11:50 A.M.Observation and interview on 03/23/26 at 12:45 P.M. revealed that lunch trays came to the second floor. Licensed Practical Nurse (LPN) #433 verified that the lunch trays for the residents on second floor were 55 minutes late and confirmed the posted mealtime delivery of 11:50 A.M.Interview on 03/24/26 at 8:17 A.M. with Dietary Manager (DM) #449 stated that the times that were posted were when they started tray line for the food cart. When questioned, DM #449 verified the posted mealtimes stated the trays were to be delivered to the second floor at 11:50 A.M.Interviews on 03/24/26 at 1:46 P.M. with Residents #13, #31, #47, #48, and #56 during a resident council meeting for the recertification survey revealed that late meals were a concern. Review of the mealtime policy dated 2023 titled, Frequency of meals, revealed that the facility scheduled three regular mealtimes comparable to normal mealtimes in the community. This deficiency represents non-compliance investigated under Complaint Number 2693841.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility policy review, the facility failed to maintain the kitchen in a clean and sanitary manner and failed to ensure foods were stored in a manner to prevent contamination and spoilage. This had the potential to affect 47 of 48 residents that received food from the facility. The facility identified one resident (Resident #4) as receiving nothing by mouth (NPO). The facility census was 48.Findings include:Tour of the kitchen on 03/23/26 from 8:10A.M. through 8:40 A.M. revealed [NAME] #451 and Dietary Aide (DA) #452 were serving breakfast. [NAME] #451 and DA #452 had full beards with no beard covering on. The mixer on a floor stand had food splatter on the back splash, white mix on the top of the mixer, and there was dried food splatter on the stand. In the dry storeroom, there was a bag of vanilla wafers that were not labeled and dated. The walk-in refrigerator's gasket was ripped and had mold on it. In the cooking area, the shelf on the stove had grease, dust, and food residue on it. The wall near the microwave had food splatter on it. There were grease drippings on the stove. In the dish area, there were missing tiles on the floor.Interview on 03/23/26 at 8:40 A.M. with [NAME] #451 verified the above findings.Review of the kitchen sanitation policy dated 05/14 and revised on 06/25 titled, Environment revealed that all food preparation areas, food service areas and dining areas will be maintained in a clean and sanitary condition.This deficiency represents non-compliance investigated under Complaint Number 2693841.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, interview and facility policy review, the facility failed to ensure all required committee members attended the quality assurance and performance improvement (QAPI) and quality assessment and assurance (QAA) meetings at least quarterly. This had the potential to affect all residents. The facility census was 48.Findings include:Review of the sign-in sheets for the QAPI/QAA meetings dated 03/20/25 through 02/19/26 revealed the committee met monthly, and there was no documented evidence that the Director of Nursing (DON) attended any of the meetings. Interview of 03/26/26 at 3:37 P.M. with Assistant Director of Nursing (ADON) #423 stated the DON had attended some but not all of the QAA/QAPI meetings. ADON #423 verified the DON's signatures were not on any of the sign-in sheets and stated she could not say which meetings the DON had attended. Review of the undated policy Quality Assurance and Performance Improvement, revealed the QAA committee shall be interdisciplinary and shall consist of the minimum of the DON the medical director or his/her designee, and at three other members of the facility staff at least of which be the administrator, owner, a board member or other individual in a leadership role; and the infection preventionist.

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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 record review, observations, interviews and facility policy review, the facility failed to maintain infection control by not wearing appropriate personal protection equipment (PPE) when care was being provided to Residents #1, #47, #63 and failed to ensure Resident #65 had contact precautions when admitted to the facility. The facility identified eight residents (#1, #4, #15, #19, #21, #56, #63 and #65) on either enhanced barrier precautions (EBP) or contact precautions. The facility census was 48.Findings include:1. Review of Resident #47's medical record revealed an admission date of 02/16/23 with diagnoses including osteomyelitis of the vertebra. Review of Resident #47's Minimum Data Set (MDS) assessment, dated 02/11/26, revealed Resident #47 had no intravenous (IV) medications listed however IV medications had an order date of 03/04/26. Review of Resident #47's physician's orders revealed an order for EBP due to a peripherally inserted central line (PICC) each shift. Review of Resident #47's comprehensive care plan, dated 02/16/23, revealed there were no revisions that added EBP as an intervention for IV medication administration. Observation on 03/25/2026 at 8:57 A.M. of Resident #47's medication administration with Registered Nurse (RN) #400 revealed EBP were not used during medication administration via PICC line. RN #400 confirmed EBP were not used immediately following the observation. Interview on 03/26/26 at 11:11 A.M. Infection Preventionist Licensed Practical Nurse (LPN) #422 revealed EBP were to be used with wounds, Foley catheters, IVs, and other invasive medical devices. Review of the facility policy for EBP, dated 2025, revealed initiation of EBP for wounds and indwelling medical devices for the prevention of transmission of multi-drug resistant organisms (MDRO). 2. Review of Resident #63's medical record revealed a facility admission date of 03/18/26 with a diagnosis of pyelonephritis. Resident #63's admission MDS assessment was in progress. Review of Resident #63's physician's orders revealed an order for EBP due to a Foley catheter each shift. Review of Resident #63's comprehensive care plan, dated 03/18/26, revealed there were not EBP listed as an intervention for the Foley catheter. Observation on 03/25/2026 at 12:41 P.M. of Resident #63's catheter care with Certified Nurse Assistant (CNA) #442 revealed EBP were not used during catheter care. CNA #442 confirmed EBP were not used immediately following the observation. Interview on 03/26/26 at 11:11 A.M. Infection Preventionist LPN #422 revealed EBP were to be used with wounds, Foley catheters, IVs, and other invasive medical devices. Review of the facility policy for EBP, dated 2025, revealed initiation of EBP for wounds and indwelling medical devices for the prevention of transmission of MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #65 revealed an admission date of 03/20/26 with diagnoses including fracture of shaft of the left femur, conjunctivitis, and diabetes mellitus. Resident #65's admission MDS assessment was in progress. Review of Resident #65's physician orders for March 2026 revealed that Resident #65 was on contact precautions and had a Foley catheter. Observation and interview on 03/23/26 at 11:40 A.M. revealed that Resident #65 was lying in bed and had a Foley catheter. Resident #65 stated that her eye was sewed shut because she had an eye infection. Interview on 03/23/26 at 11:42 A.M. with LPN #433 stated that Resident #65 should at least be on EBP, and she was not. LPN #433 stated probably because she was admitted on Friday, 03/20/26. 4. Review of the medical record for Resident #1 revealed an admission date of 01/05/26 with diagnoses including chronic obstructive pulmonary disease (COPD), generalized anxiety disorder, and emphysema. Resident #1 was diagnosed with sepsis due to other specified staphylococcus on 03/23/26. Review of Resident #1's MDS admission assessment dated [DATE] revealed Resident #1 was cognitively intact and required moderate assistance for activities of daily living. Review of Resident #1's physician orders dated 03/23/26 revealed that Resident #1 was on contact precautions. Observation on 03/23/26 at 4:34 P.M. revealed that Resident #1's door had a contact precaution signage on the door that stated gowns and gloves must be worn. Rehabilitation Director #500 was sitting next to Resident #1 with no PPE on. RD #500 stated that she was not providing actual care and was there for therapy. Interview on 03/23/26 at 4:45 P.M. with Assistant Director of Nursing (ADON) #423 verified that staff should wear PPE when a resident was on contact precautions. Review of the facility policy dated 2025 titled, Transmission-Based (Isolation) Precautions, revealed that contact precautions is intended to prevent transmission of pathogens that are spread by direct contact with the resident or resident's environment. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve direct contact with the resident or potentially contaminated areas in the resident's environment.

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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. Based on record review, interview and facility policy review, the facility failed to ensure Resident #63's code status was accurately reflected in both the hard medical record and the electronic medical record. This affected one of 29 residents reviewed for Advanced Directives. The facility census was 48.Findings include:A review of the medical record for Resident #63 revealed an admission date of 03/8/26 with diagnoses of pyelonephritis, diabetes mellitus, and major depressive disorder.Review of the physician's orders for March 2026 revealed Resident #63's revealed code status of Do Not Resuscitate-Comfort Care Arrest (DNR-CCA). A DNR-CCA means a person would receive all emergency and medical care up until the time he or she experiences a cardiac or respiratory arrest, then all lifesaving measures would be stopped. A document on green paper with the words Full Code, was in the hard medical chart on the first page. A full code status means all emergency life saving measures will be provided in the event of respiratory arrest or cardiac arrest. Interview on 03/24/26 at 9:59 A.M. with Assistant Director of Nursing (ADON) #423 brought a copy of Resident #63's signed DNR-CCA and verified that it should have been in the hard chart.Review of the facility policy dated 2026 titled, Residents' Rights Regarding Treatment and Advance Directives, revealed that it is policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical treatment and to formulate advance directives.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review, policy review and interview, the facility failed to ensure Resident #7 and Resident #63's antipsychotic medications had appropriate diagnoses/rationale for use. This affected two residents (#7 and #63) of five residents reviewed for unnecessary medications. The facility census was 48.Findings include:1. Review of the medical record for Resident #7 revealed an admission date of 09/19/25 with diagnoses of dementia, protein-calorie malnutrition, and diverticulosis.Review of the pharmacy recommendations to the attending physician dated 09/20/25 revealed the pharmacist made a recommendation to evaluate Quetiapine Fumarate (commonly known as Seroquel) for an appropriate diagnosis. The physician addressed the pharmacist recommendations that the benefits outweigh the risks and would cause distress.Review of the pharmacy recommendations to the attending physician dated 12/14/25 revealed the pharmacist made a recommendation to evaluate Seroquel for an appropriate diagnosis and a gradual dose reduction (GDR). The physician addressed the pharmacist recommendations that the benefits outweigh the risks and would increase behaviors.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/06/26, revealed Resident #7 had severely impaired cognition and needed partial assistance for activities of daily living (ADL). Further review of the MDS revealed that Resident #7 received antipsychotic medication routinely.Review of the physician's orders for March 2026 revealed Resident #7 was prescribed Quetiapine Fumarate (antipsychotic) 25 milligrams (mg) and give 0.5 tablet by mouth at bedtime for insomnia (ordered 09/19/25).Interview on 03/26/26 at 10:30 A.M. with Assistant Director of Nursing (ADON) #423 verified that insomnia was not an appropriate diagnosis for Resident #7's Quetiapine Fumarate.Interview on 03/26/26 at 10:53 A.M. with Certified Psych Nurse Practitioner #502 stated that she saw Resident #7 twice and did not catch the diagnosis for Seroquel, and she did not attempt a GDR because the resident was new to her. Interview on 03/26/2026 at 12:14 P.M. with ADON #422 verified the pharmacy recommendations dated 09/20/25 and 12/14/25 regarding the physician did not accurately address the recommendation. 2. A review of the medical record for Resident #63 revealed an admission date of 03/08/26 with diagnoses of pyelonephritis, diabetes mellitus, and major depressive disorder. Review of the admission MDS revealed that it was still in progress.Review of the physician's orders for March 2026 revealed Resident #63 was prescribed Vraylar oral capsule (antipsychotic) 1.5 mg by mouth at bedtime for major depressive disorder.Review of the nurses note dated 03/18/26 at 6:24 P.M. revealed that Resident #63 was admitted to the facility from the hospital. Resident #63 was assessed with no concerns and resting. Physician (MD) was called to review medications and orders. MD stated not to order Vraylar due to the resident stated that it is a new medication that was prescribed in the community, and she only had one dose before ending up in the hospital and had not taken it since. Per the MD, have psych see Resident #63 and then let them determine if the resident needs placed on Vraylar since she truly had not started medication at this time. Resident #63 was in agreement at this time. Psych services have been notified, and Resident #63 was added to the list to be seen.Review of the psych consult consent signed 03/18/26 revealed that Resident #63 agreed to psych services.Review of the nurses' notes dated 03/20/26 at 7:29 P.M. revealed new orders for Vraylar oral capsule 1.5 mg by mouth at bedtime for major depressive disorder as well as a sliding scale for insulin.Further review of progress notes from 03/18/26 through 03/22/26 revealed no behaviors noted.Interview on 03/24/26 at 2:02 P.M. with ADON #423 revealed that she was the nurse who wrote the progress note that MD wanted psych to see Resident #63 first, and she signed the psych consultation.Interview on 03/26/26 at 10:30 A.M. with ADON #423 stated that she talked to the Registered Nurse (RN) about the Resident #63's Vraylar and asked why she had the MD put her on Vraylar when it was supposed to be on hold until psych saw the resident. ADON #423 stated that the RN stated that Resident #63 wanted the medication, and she called the physician. ADON #423 verified that the progress note had no documented evidence the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was asking for a certain medication. Interview on 03/26/26 at 10:53 with psych Nurse Practitioner #502 revealed she was to see Resident #63 on Friday, 03/27/26.Review of the facility policy dated 2025 titled, Use of Psychotropic Medications, revealed that it is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, the facility failed to ensure discharge Minimum Data Set (MDS) assessments were created in a timely manner for Residents #5 and #6. This affected two residents (#5 and #6) of three residents reviewed for discharge. The facility census was 48.Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 10/31/25. Diagnoses included end stage renal disease, acute pulmonary edema, bipolar disorder, morbid obesity, and immunodeficiency. Review of the progress notes dated 03/15/26 at 9:50 A.M. revealed a nurse's note that the nurse contacted the hospital, and Resident #5 had been admitted to the intensive care unit (ICU) with sepsis. Further review of Resident #5's chart revealed there was no MDS assessment for discharge with return anticipated. Interview on 03/23/26 at 3:52 P.M. with MDS Coordinator (MDSC) #429 verified Resident #5 went to the hospital last week, and she did not create a discharge return anticipated MDS assessment. 2. Review of the medical record for Resident #6 revealed an admission date of 10/31/25 and a discharge date of 01/16/26. Diagnoses included multiple fractures of left side ribs, fall, and type two diabetes mellitus. Review of the nurse's notes dated 01/16/26 at 12:15 P.M. revealed Resident #6 discharged home. Vital signs obtained at time of discharge. All paperwork was reviewed with the resident. The resident voiced understanding and was in good spirits and happy to go home.Further review of Resident #6's medical record revealed there was no discharge no return anticipated MDS assessment.Interview on 03/25/26 at 10:53 A.M. with MDSC #429 verified she recalled Resident #6 and that he had discharged on 01/16/26. MDSC #429 verified there was no discharge no return anticipated MDS assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure contact isolation was included in the care plans for Resident #01 and #15. This affected two residents (#01 and #15) of 23 resident records reviewed for care plans. The facility census was 48.Findings include:1. Review of the medical record for Resident #01 revealed an admission date of 01/05/26 with the diagnosis of sepsis.Review of Resident #01's care plan, dated 01/05/26, revealed no care plan for contact isolation.Review of Resident #01's March 2026 physician orders revealed an order for contact isolation due to a Foley catheter each shift.Review of Resident #01's Minimum Data Set (MDS), dated [DATE], revealed a re-entry assessment was in progress.Interview on 03/26/26 at 4:10 P.M. with Licensed Practical Nurse (LPN) #422 confirmed contact isolation was not included in Resident #01's care plan.Review of the facility's policy for comprehensive care plans, dated 2025, revealed the policy of the facility was to develop and implement a comprehensive person-center care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical and nursing needs. 2. Review of the medical record for Resident #15 revealed an admission date of 03/03/26 with the diagnosis of osteomyelitis to left ankle/foot with methicillin-resistant staphylococcus aureus (MRSA).Review of Resident #15's March 2026 physician orders revealed an order for contact isolation each shift.Review of Resident #15's care plan, date 03/04/26, revealed no care plan for contact isolation.Review of Resident #15's MDS, dated [DATE], revealed a multi-drug-resistant organism (MRDO) infection, intravenous medication, and isolation.Interview on 03/26/26 at 4:10 P.M. with LPN #422 confirmed contact isolation was not included in Resident #15's care plan.Review of the facility's policy for comprehensive care plans, dated 2025, revealed the policy of the facility was to develop and implement a comprehensive person-center care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical and nursing needs.

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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** Based on record review, observation, facility policy review and interview, the facility failed to ensure safe smoking practices affecting Resident #26 and timely smoke breaks affecting Residents #26, #51, #53, #56, and #69. This affected one resident (#26) of one resident reviewed for safe smoking and five residents (#26, #51, #53, #56, and #69) of five residents observed for smoking schedules. The facility census was 48.Findings include:1. Review of the medical record for Resident #26 revealed an initial admission date of 06/23/24. Diagnoses included hypertension, type two diabetes mellitus, muscles weakness, morbid obesity, and chronic systolic congestive heart failure. Review of the smoking safety screen dated 11/05/25 revealed Resident #26 was safe to smoke with supervision and needed the facility to store lighter and cigarettes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition.Review of the current plan of care revealed Resident #26 was a smoker. Interventions included instructing the resident about the facility policy on smoking, locations, times, and safety concerns. Interview on 03/23/26 at 10:37 A.M. with Resident #26 stated she was a smoker and that smoke breaks were not timely, especially at 7:00 hours because of shift change. Observation at this time revealed a cigarette lighter on the resident's tray table. Resident #26 stated she was able to keep her smoking materials. Observation on 03/25/26 at 12:58 P.M. of Resident #26 in her power wheelchair in the hall on her cellphone with a cigarette lighter in her hand. At 1:02 P.M., she was observed going outside into the courtyard with the other smokers. Resident #26 was then observed pulling out her own cigarettes from her jacket and observed lighting it. Interview on 03/25/26 at 1:05 P.M. with Housekeeper (HSK) #420 revealed smoking materials were kept in a clear tote that was kept behind nurse's station. HSK #420 verified Resident #26 kept her own smoking materials and stated she was an independent smoker. HSK #420 stated independent smokers were allowed to hold onto their smoking materials, and some of the staff will let them know who the independent smokers were. Interview on 03/25/26 at 3:25 P.M. with Assistant Director of Nursing (ADON) #423 verified Resident #26's smoking assessment stated she required supervision, and smoking materials were to be stored by the facility. ADON #423 stated all smoking materials were to be kept in a tote behind the nurse's station. 2. Observation on 03/26/26 at 7:30 A.M. of Residents #26, #51, #53, #56, and #69 waiting by the door to the courtyard complaining staff were late for smoke break. Interview on 03/26/26 at 7:34 A.M. with Licensed Practical Nurse (LPN) #422 verified the late time and stated the aides usually take residents to smoke, but they were giving report. LPN #422 stated she was extra today. Review of the policy Resident Smoking, updated 03/19/20, revealed residents are not permitted to maintain smoking materials on their person or in their rooms. Designated smoking times- smoking is permitted only during posted smoke times (7:00 A.M, 10:00 A.M., 1:00 P.M., 4:00pm, 7:00 P.M., and 9:00 P.M.) and only under staff supervision. Smoking time shall last for fifteen (15) minutes, and the number of cigarettes may be limited to ensure that residents smoke within that time frame.

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	03/26/2026

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on record review, observation and interview, the facility failed to ensure resident food allergies were honored. This affected one resident (#63) of one resident reviewed for food preferences. This had the potential to affect 47 residents out of 48 who received meals from the facility kitchen. The facility identified one resident (#4) as receiving nothing by mouth (NPO). The facility census was 48.Findings include:A review of the medical record for Resident #63 revealed an admission date of 03/8/26 with diagnoses of pyelonephritis, diabetes mellitus, and major depressive disorder.Review of the physician's orders for March 2026 revealed Resident #63 received a regular diet.Review of Resident #63's diet ticket revealed that she was on a regular diet had onion, peanut butter and strawberry allergies.Interview on 03/23/26 at 9:45 A.M. with Resident #63 revealed that the kitchen does not honor her preferences.Observation and interview of lunch tray line service on 03/25/26 at 12:31 P.M. revealed that [NAME] #451 portioned beef tips over noodles for Resident #63. The lid was placed on top of the plate and put into the food cart. The tray was asked to be looked at. Resident #63 was noted to have an onion allergen. [NAME] #451 stated that there were onions in the beef tips. Corporate District Manager (CDM) # 447 asked Dietary Manager (DM) #449 if Resident #63's onion allergen was an actual allergy or just a dislike. DM #449 stated that he just talked to her, and Resident #63 stated that onions make her break out.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on record review, observation and interview, the facility failed to ensure Residents #35 and #68 received therapeutic diets as ordered by the physician. This affected two residents (#35 and #63) of three residents (#35, #63, and #68) reviewed therapeutic diets. The facility census was 48.Findings include:1. Review of the medical record for Resident #35 revealed an admission date on 07/13/21 with diagnoses to schizophrenia, bipolar, and diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/02/26, revealed Resident #35 had severely impaired cognition and was dependent on staff for activities of daily living (ADL) except for eating, Resident #35 required set up assistance only.Review of the physician's orders for March 2026 revealed Resident #35 received a regular diet, dysphagia mechanical soft (Dys Mech) texture and regular fluid consistency diet.Observation of lunch tray line service on 03/25/26 at 12:00 P.M. revealed [NAME] #451 portioned regular textured beef tips over noodles for Resident #35. The lid was placed on top of the plate and put into the food cart. The tray was asked to be looked at. Resident #35 was noted to be on a regular diet, dysphagia mechanical soft texture and regular fluid consistency diet. [NAME] #451 served Resident #35 regular meat instead of ground neat. Dietary Aide (DA) #452 stated that he missed it. Corporate District Manager (CDM) # 447 told DA #452 that he should read the tickets louder to communicate better to the cook, and then she stated that [NAME] #451 should read the tickets before putting the plate on the tray.Review of the spreadsheets for the lunch meal on 03/25/26 revealed that Dys Mech diets were to get ground meat.2. Review of the medical record for Resident #68 revealed an admission date on 03/23/26 with diagnoses to hypertension and diabetes mellitusReview of the admission MDS assessment revealed it was in progress.Review of the physician's orders for March 2026 revealed Resident #68 received a consistent carbohydrate diet (CCD) with regular texture and regular fluid consistency. Observation of lunch tray line service on 03/25/26 at 12:09 P.M. revealed that [NAME] #451 portioned Resident #68's meal. The lid was placed on top of the plate and put into the food cart. The tray was asked to be looked at. Resident #68 was noted to be on a CCD with regular texture and regular fluid consistency. [NAME] #451 did not portion Resident #68's baked apples for dessert. [NAME] #451 stated that he missed the CCD dessert because he does not usually put desserts on resident's trays. CDM #447 verified that a CCD should have gotten baked apples according to the spreadsheet.Review of the spreadsheets for the lunch meal on 03/25/26 revealed that CCD were to have baked apples.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interview and review of the facility policy and procedure, the facility failed to ensure a homelike environment. This affected three residents (#9, #10, and #15) of six residents reviewed for physical environment. The facility census was 48.Findings include:1. Observation on 03/23/36 at 10:42 A.M. of Resident #9's room revealed a hole in the bathroom door. Interview at this time with Housekeeper (HSK) #429 verified the observation. 2. Observation on 03/23/26 at 11:19 A.M. of Resident #15's room revealed a urinal and a pair of scissors were observed on the floor. Interview at this time with Licensed Practical Nurse (LPN) #422 verified the observation. 3. Observation on 03/23/26 at 2:08 P.M. of Resident #10's room revealed long deep gash in the lower part of the bathroom door, and there was a large missing chunk on the rim on trash bin. Interview on 03/23/26 at 3:39 P.M. of Resident #10's room with Director of Maintenance (DOM) #428 verified the observation. Review of the undated policy titled Safe and Homelike Environment revealed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure the daily nursing staff information was posted. This had the potential to affect all 48 residents residing in the facility.Findings include:Observations on 03/24/26 revealed the daily nursing staff information was not posted. Interview on 03/24/26 at 10:01 A.M. with Assistant Director of Nursing (ADON) #423 stated the posted daily nursing information was usually kept at the receptionist desk and verified she had not put it up.