Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365655	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Health Care Ctr LLC	800 Market Avenue North Canton, OH 44702

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, interview, and policy review, the facility failed to ensure a timely discharge/transfer and failed to provide the resident or resident representative with required documentation upon discharge. This affected one (Resident #1) of three residents reviewed for discharge/transfer. The facility census was 150. Findings include: Review of Resident #1's closed medical record revealed an admitted [DATE] with diagnoses that included schizoaffective disorder, anxiety, heart failure, atrial fibrillation, asthma, and the use of anticoagulant therapy. The resident was discharged to another nursing facility on 03/06/24. Review of the Minimum Data Set (MDS) quarterly assessment, dated 01/01/24, revealed the resident had intact cognition with delusions, physical and verbal behaviors, and rejection of care noted. a. Review of the medical record revealed the resident's Discharge Planning form, dated 03/06/24 and completed by Social Services Designee #301, revealed there was no resident or resident representative signature. During interview on 03/26/24 at 11:56 A.M., Resident #1's power of attorney (POA) stated that at the time of her mother's discharge from the facility, there were no discharge instructions or paperwork provided and there was no assistance with transporting the resident's belongings from the resident's room. The POA stated this was very unprofessional. The POA further stated the receiving facility continued to ask for the MDS assessment, however, the facility continued to delay sending the information and her mother had to wait until the next week to be admitted to the new facility. During interview on 03/27/24 at 10:39 A.M., the Director of Nursing (DON) confirmed Resident #1's Discharge Planning form was not signed by the resident or resident representative. b. Review of email communication, dated 02/22/24 at 2:24 P.M., from Social Services Designee (SSD) #300 to Admissions Coordinator #400 (employee at the facility the resident was being transferred to) revealed the receiving facility had an open spot for Resident #1 the following week. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of email communication, dated 02/28/24 at 2:47 P.M., from Admissions Coordinator #400 to Social Services Designee (SSD) #300 revealed a request for Level II Pre-Admission Screening and Resident Review (PASARR) (a screening to ensure residents are not inapropriately placed in a nursing home) results and sections C and GG from the current MDS. Review of email communication, dated 02/29/24 at 9:59 A.M., from Admissions Coordinator #400 to Social Services Designee (SSD) #300 revealed an additional request for section C and GG from the MDS. Review of email communication, dated 02/29/24 at 12:30 P.M., from Social Services Designee (SSD) #300 to Admissions Coordinator #400 revealed, I have been told that we do not send that information out. Review of email communication, dated 02/29/24 at 1:59 P.M., Admissions Coordinator #400 to Social Services Designee (SSD) #300 revealed, these are needed by the insurance provider to do the transfer desktop level of care. I am not sure why this is an issue as it's part of what's needed for the level of care which needs done before she can transfer. I am confused by this, let me forward you the email from the insurance provider requesting it. Interview on 03/27/24 at 10:23 A.M., Social Services Designee (SSD) #300 confirmed he was asked for MDS assessment on 2/28/24, however he was told by Business Office Manager (BOM) #302 that he was not required to send the MDS data because Resident #1's insurance did not require this for admission. SSD #300 confirmed the MDS data was not sent to the receiving facility until 03/04/24. Interview on 03/28/24 at 10:45 A.M., Admissions Coordinator #400 confirmed that the facility did have an open spot for the resident during the week of 02/25/24; however, there was a delay in the transfer because of continued requests for the MDS assessment and the resident could not be admitted until the following week. Admissions Coordinator #400 stated this information was required before the facility could admit the resident. Interview on 03/28/24 at 12:05 P.M., the Administrator confirmed the MDS assessment data is part of Resident #1's medical record. Review of the facility's policy, Discharging the Resident, dated August 2008, revealed the purpose of this procedure is to provide guidelines for the discharge process. Collect the resident's personal effects. Put them in a cart for transporting to the pickup area. Assist the family in loading the resident's personal effects. Say goodbye to the resident and family. This deficiency represents non-compliance investigated under Complaint Number OH00151767.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, interview, and policy review, the facility failed to ensure a discharge summary which included a recapitulation (concise summary) of the resident's stay at the facility, was completed. This affected one (Resident #1) of three residents reviewed for discharge. The facility census was 150. Findings include: Review of Resident #1's closed medical record revealed an admitted [DATE] with diagnoses that included schizoaffective disorder, anxiety, heart failure, atrial fibrillation, asthma, and the use of anticoagulant therapy. The resident was discharged to another nursing facility on 03/06/24. Review of the Minimum Data Set (MDS) quarterly assessment, dated 01/01/24, revealed the resident had intact cognition with delusions, physical and verbal behaviors, and rejection of care noted. Review of the medical record revealed no evidence that the discharge summary was completed at the time of Resident #1's discharge on 03/06/24. During interview on 03/27/24 at 10:39 A.M., the DON confirmed she could not find evidence that a discharge summary was completed for Resident #1 at the time of discharge. Review of facility policy titled, Discharge Summary and Plan, dated August 2006, revealed when a resident's discharge is anticipated, a discharge summary and post discharge plan will be developed to assist the resident to adjust to his/her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. This deficiency represents non-compliance investigated under Complaint Number OH00151767.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33019 Based on observation and staff and resident interviews, the facility failed to ensure cinnamon rolls were properly prepared to ensure palatability and an appetizing appearance. This had the potential to affect all residents residing in the facility. The facility census was 150. Findings include: Observation on 03/27/24 at 12:28 P.M. with State tested Nursing Assistant (STNA) #303 revealed Resident #6 had eaten approximately 10% of his lunch tray. Observation of the uneaten cinnamon roll revealed the roll, still covered with clear plastic, was approximately the size of a 50-cent piece in diameter and the texture was hard and crunchy. During interview on 03/27/24 at 12:29 P.M., STNA #303 revealed residents had complained that they were unable to eat the cinnamon rolls because they were too hard and appeared overcooked. STNA #303 verified Resident #6's cinnamon roll appeared overcooked and was hard throughout. During interview on 03/27/24 at 12:31 P.M. Resident #6 stated he didn't eat his cinnamon roll because it was hard. During interview on 03/27/24 at 12:34 P.M., Registered Nurse (RN) #304 stated residents had complained to her that the cinnamon rolls were too hard to eat. During interview and observation on 03/27/24 at 12:38 P.M., Resident #7 was sitting at a table in the dining room, and stated his cinnamon roll was very hard and gross. Observation revealed the cinnamon roll was approximately the size of a 50-cent piece in diameter and the texture appeared to be hard and overcooked. Interview on 03/28/24 at 11:17 A.M. with Dietary Manager (DM) #304 revealed she was made aware of the concern regarding the cinnamon rolls served on 03/27/24. DM #304 confirmed all the cinnamon rolls served for lunch were not properly prepared. DM #304 stated a dietary cook did not place the tray of cinnamon rolls over a steam table to allow the dough to rise before baking, which resulted in the very small size and texture. DM #304 confirmed the cinnamon rolls were not palatable nor appetizing in their appearance and should not have been served to the residents. DM #304 stated the dietary cook who prepared the cinnamon rolls, had been educated on the proper preparation of the cinnamon rolls. This deficiency represents non-compliance investigated under Complaint Number OH00151976 and Complaint Number OH00151767.

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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** 33019 Based on observation, interview, and policy review, the facility failed to maintain appropriate infection control precautions when Licensed Practical Nurse (LPN) #320 did not properly dispose of a used insulin syringe with needle. This had the potential to affect 31 residents (#3, #7, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40) of 31 residents residing on [NAME] Hall. The facility census was 150. Findings include: Observation on 03/27/24 at 12:40 P.M. revealed a used insulin syringe, with the sheath pulled over the needle, lying on the floor approximately five feet from the nursing station. This surveyor continued observation. At 12:45 P.M., the Director of Nursing (DON) confirmed the needle was lying on the floor and then retrieved it, without donning gloves, and walked approximately 20 feet to the location of the medication cart and placed the syringe into the sharps disposal container (rigid, puncture-resistant plastic or metal with leak-resistant sides and bottom, and a tight-fitting, puncture-resistant lid with an opening to accommodate depositing a sharp but not large enough for a hand to enter). Interview on 03/28/24 at 12:46 P.M. with LPN #320 revealed she was certain the insulin syringe was used to administer insulin to Resident #3. LPN #320 stated that she must have missed the sharps disposal container and apologized. The DON and LPN #302 confirmed Resident #3 did not have any communicable diseases. Interview on 03/28/24 at 12:50 P.M., the DON confirmed all needles and sharps should be properly disposed of after use. Review of the facility's policy titled, Insulin Administration, dated April 2007, revealed the purpose of the policy to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the procedure include to dispose of the needle in the designated container. This deficiency is an incidental finding discovered during the complaint investigation.