

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER McKinley Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Market Avenue North Suite 1560 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on observation, interview, and record review the facility failed to ensure a clean, sanitary, and homelike environment for residents. This affected one resident (Resident #72) out of three residents reviewed for quality of care and treatment. The facility census was 154.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #72 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type one, acquired absence of the left leg below the knee, major depressive disorder, and noninfectious gastroenteritis.</p> <p>Review of Resident #72's care plan dated 01/07/25 revealed the resident displayed behavioral symptoms not directed toward others as evidenced by defecating on the floor and in the trash can instead of utilizing the bedside commode that was provided for him.</p> <p>Review of Resident #72's Minimum Data Set assessment dated [DATE] revealed the resident required supervision and touch assistance for toileting hygiene and showering and bathing. The assessment indicated the resident utilized a motorized wheelchair.</p> <p>Observation on 01/13/25 at 11:25 A.M. of Resident #72 and his room revealed upon entering the room a strong sour smell of vomit and feces was present. On the floor was a full urinal filled with urine, a basin full to the top of vomit, applesauce cups open and scattered on the floor, old food laying on the floor, dishes in his sink with old food still present, a large bin filled to the top with bags of trash, disposable bed pads covered in feces placed into a pile next to the residents bed, and a dead cockroach stuck to a glue trap behind the residents refrigerator. The resident who was a partial amputee was noted to be in the fetal position on his bed. He was calm and pleasant but reported he had been ill since the night before. Licensed Practical Nurse (LPN) #201 entered the resident's room during the observation and confirmed the findings.</p> <p>Interview with LPN #201 on 01/13/25 at 11:30 A.M. revealed Resident #72's room was commonly a mess. She reported if he did not smoke, he got sick and he threw up frequently. She stated he was ill a lot and would not clean up after himself. She reported the resident was compliant with care, and she was going to give him medication to assist with his nausea. LPN #201 did not attempt clean up before leaving the room.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow up interview and observation of Resident #72's room on 01/13/25 at 12:45 P.M. revealed the residents room was in the same condition it was at 11:25 A.M. the basin of vomit remained full and sitting on the floor, the residents urinal was not emptied, the food and trash remained on the floor, and the disposable incontinence briefs were not placed in the trash or removed from the room. Interview with the resident during the observation revealed he had a chronic gastrointestinal (GI) issue that caused stomach upset, nausea, vomiting, and diarrhea. He reported he was too ill and needed assistance with keeping his room clean. He stated no one had come in to clean his room on this day, but he would like for it to be cleaned.</p> <p>Interview on 01/13/25 at 12:51 P.M. with Certified Nurse Assistant (CNA) #205 reported she was one of the CNA's on Resident #72's hall. She stated that the resident was sick often and his room was usually a mess. She stated housekeeping was usually the one who went in and cleaned his room. She stated she had not been in his room on this day.</p> <p>Interview on 01/13/25 at 1:00 P.M., Housekeeper #207 reported she was told by her manager that they would go into Resident #72's room after lunch to clean it up. She reported it was usually a mess and took more than one person to clean it up. She reported, at times, the resident did refuse to let them clean up, but she had not attempted to clean the room on this day.</p> <p>Interview on 01/14/25 at 1:35 P.M., Housekeeping Supervisor #208 reported that she attempted to clean Resident #72's room on 01/13/24 in the morning, but he refused. She stated she went back in around 1:00 P. M. and was able to clean it. She stated she reported his refusal to Licensed Social Worker (LSW) #304.</p> <p>Interview on 01/14/25 at 2:35 P.M. with LSW #304 revealed Housekeeping Supervisor #208 did not report to her on 01/13/25 that Resident #72 refused to allow staff to clean his room. She continued that yesterday (01/13/25) she reported to housekeeping that they needed to go in and clean Resident #72's after observing what it looked like at 9:00 A.M. that morning.</p> <p>Interview on 01/14/25 at 10:22 A.M. the Director of Nursing verified it would be her expectation that if facility staff observed issues related to infection control/sanitation issues they should be addressed timely by facility staff if the resident was being complaint with treatment. She confirmed this was not done.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161141.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>42015</p> <p>Based on review of the facility menu, review of resident council meeting minutes, observation, staff interview and resident interview, the facility failed to ensure menus were prepared in advance and updated periodically and failed to ensure residents received the correct portion sizes based on the menus. This had the potential to affect all 154 residents who resided in the facility.</p> <p>Findings include:</p> <p>Review of the Resident Council Meeting Minutes dated 12/31/24 revealed the food committee meeting was not held on this day due to the absence of the Dietary Manager. The council voted to reschedule the food committee meeting as soon as possible.</p> <p>Review of the facility menu (in January 2025) revealed the facility was utilizing the menu for spring and summer 2024. The date on the top of the menu for 01/13/25, revealed the menu was to be used for 07/22/24. It was also noted that residents were supposed to receive eight ounces of spaghetti and meat sauce.</p> <p>Observation on 01/13/25 at 12:00 P.M. revealed Dietary Aide (DA) #202 had utilized a regular-non measurable serving spoon to place one spoonful of spaghetti onto each resident's plate.</p> <p>Interview on 01/13/25 at 12:25 P.M. Assistant Dietary Manager #200 stated the facility was supposed to switch over to the fall/winter menu, but that had not happened yet. She reported due to ordering errors or issues with the trucks coming in timely the menu had changed several times over the last month. She confirmed at this time that the facility did not keep a substitution log or have a way to track what meal had been served. Assistant Dietary Manager #200 also confirmed DA #202 utilized a non-measurable serving spoon to plate the residents spaghetti.</p> <p>Interview on 01/14/25 at 10:17 A.M. with the Administrator revealed dietary concerns were discussed in the monthly food committee meeting held by the Dietary Manager, who had recently been off work. He revealed he was unable to find the minutes from recent food committee meetings. He stated no one had made him aware of the dietary concerns so he had not done any investigation into resident concerns.</p> <p>Interview on 01/14/25 at 10:22 A.M. the Director of Nursing stated she had heard from residents that the portion sizes were small, but she was not sure if the facility had looked into the concerns.</p> <p>Interview on 01/14/25 at 10:25 A.M. with Resident #73 revealed he was often served food that was not on the menu and portion sizes were too small. He reported the concern had been brought up in resident council, but nothing had been done.</p> <p>Interview on 01/14/25 at 10:35 A.M. with Resident #74, who identified himself as the resident council president, reported residents had repeatedly brought up in resident council and at the food committee meeting that residents were not being served the correct meals and portions were too small. He reported he did not believe the Dietary Manager was taking their concerns seriously.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 01/14/25 at 10:49 A.M., Activity Director (AD) #300 revealed he was usually present for the food committee meetings and the resident council meetings. He continued that dietary issues were usually discussed in the food committee and the Dietary Manager was responsible for addressing those concerns. He went on to say he had witnessed residents having concerns related to the menu and portion sizes in the facility. AD #300 confirmed the facility had not yet rescheduled a time for the food committee meeting that was canceled in December 2024.</p> <p>Interview on 01/14/25 at 2:25 P.M. Resident #67 reported she was often served meals that were not what she had chosen and often times the portion sizes were too small.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161141 and OH00161383.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42015</p> <p>Based on observation and staff interviews, the facility failed maintain a sanitary kitchen and food storage areas and failed to ensure infection control was maintained while serving the lunch meal. This affected all residents who resided in the facility, as the facility identified all residents as receiving kitchen services. The facility census was 154.</p> <p>Findings Include:</p> <p>1. Observation of the facility kitchen on 01/13/25 from 9:20 A.M. through 9:40 A.M. revealed the facility kitchen floors were scattered with torn sugar packets, pieces of old discarded food, crumbs, and dark sticky substances were covering parts of the floor. Several walls were noted to have dried up liquids that were previously splashed from food or drinks. Observation of the facility's chemical dishwasher revealed the top to be covered with dust, an abundance of what appeared to be crumbs from food, two dirty wash cloths, and a dried-up dirty sponge. The kitchen also had a large light with the name echo lab used to kill gnats and directly under the echo lab light, the facility was noted to have soup bowls on a drying cart.</p> <p>Interview on 01/13/25 at 9:40 A.M. Assistant Dietary Manager (ADM) #200 confirmed the sanitation findings and reported that due to recent staff changes, the facility's kitchen staff had fallen behind on some of the cleaning. She continued that the facility had a cleaning schedule and that the kitchen should have been cleaned at least two times a day. She reported the kitchen staff had not been signing off that the cleaning had been completed and she was unable to find the cleaning schedule.</p> <p>2. Observation on 01/13/25 at 12:00 P.M. revealed Dietary Aide (DA) #202 washed her hands and begin plating food for the entire facility. She was observed grabbing plates from the cart and placing food on the plates. DA #202 was observed with ungloved hands, adjusting her hair net, and then she grabbed a bread stick with her ungloved hand and placed it on a resident's plate. She continued to use her ungloved hands to open the refrigerator and obtain a storage container of cheese, grab the cheese with her ungloved hand and place it on a hamburger. She then continued to plate resident food using her ungloved hand to grab breadsticks and place them on various resident's plates. During the observation, DA #202 was observed dropping spaghetti onto the tray line and using her ungloved hand to pick it up and place it on residents' plate and then wiping her hand off on her clothing.</p> <p>Interview on 01/13/25 at 12:25 P.M. with Assistant Dietary Manager (ADM) #200 confirmed the kitchen sanitation issues observed with DA #202.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161141 and OH00161383.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on observation, resident interview, staff interview, and review of pest control customer service reports, the facility failed to eradicate cockroaches from Resident #72's room. This affected one resident (#72) out of three residents reviewed for pest control. The facility census was 154.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #72 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type one, acquired absence of the left leg below the knee, major depressive disorder, and noninfectious gastroenteritis.</p> <p>Review of Resident #72's care plan dated 01/07/25 revealed the resident displayed behavioral symptoms not directed toward others as evidenced by defecating on the floor and in the trash can instead of utilizing the bedside commode that was provided for him.</p> <p>Review of Resident #72's Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact required supervision and touch assistance for tilting hygiene and showering and bathing. The assessment indicated the resident utilized a motorized wheelchair.</p> <p>Interview and observation on 01/13/25 at 11:25 A.M. of Resident #72 and his room revealed upon entering the room a strong sour smell of vomit and feces was present. On the floor was a full urinal filled with urine, a basin full to the top of vomit, applesauce cups open and scattered on the floor, old food laying on the floor, dishes in his sink with old food still present, a large bin filled to the top with bags of trash, disposable bed pads covered in feces placed into a pile next to the residents bed, and a dead cockroach stuck to a glue trap behind the residents refrigerator. Licensed Practical Nurse (LPN) #201 entered the resident's room during the observation and confirmed the findings.</p> <p>Interview on 01/13/25 at 12:45 P.M. with Resident #72 revealed the resident was aware of cockroaches being in his room. He stated the facility had put traps in his room to catch them and on two occasion he left his room while the exterminator came in.</p> <p>Review of the pest control company customer service report dated 11/30/24 revealed Resident #72's room was inspected and treated for cockroaches on this date. Review of the service report dated 12/18/24 revealed the resident's room was treated again. Review of the 12/27/24 service report revealed the resident's room was difficult to do a thorough service because so much personal items and clothing were thrown throughout the room. The action section stated for the facility to please address the sanitation issue. Continued review of the service reports revealed the pest control company had not reassessed the room.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/14/25 at 2:50 PM with the Administrator revealed Resident #72 was admitted on [DATE]. A couple days after admission, staff reported seeing cockroaches in the resident's room. He reported they contacted their pest control company who came in and treated the room on 11/30/24, 12/18/24, and 12/27/24. He stated the company came in monthly and checked the preventative traps. He confirmed the resident's sanitation issues were a reason why the cockroaches had not completely been eradicated from Resident #72's room.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161141.</p>		