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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to ensure certified nursing assistants (CNA) had yearly performance evaluations. This had the potential to affect all residents residing in the facility. The facility census was 151. Findings include:Review of the employee files for Certified Nursing Assistant (CNA) #325, CNA #386 and CNA #425 revealed they had not received yearly performance evaluations. CNA #325 was hired on 03/13/25, CNA #386 was hired on 01/15/25 and CNA #425 was hired on 03/04/25. Interview on 04/28/26 at 1:15 P.M. with Human Resources Director (HR) #307 verified yearly performance evaluations had not been completed as required. HR #307 acknowledged the delay and stated they were behind on evaluations but were working to get caught up.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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. Based on resident interviews, lunch meal observations, staff interview, and review of diet spreadsheets, resident council minutes and facility policy, the facility failed to ensure appropriate portion sizes were served and all components of the meal were served to meet resident needs and preferences. This affected all residents receiving meals from the kitchen. The facility identified no residents with a nothing by mouth (NPO) diet. The facility census was 151.Findings include:1. Interview on 04/19/26 at 9:30 A.M. with Resident #75 revealed the menus were not always posted in common areas and the aides were not taking down alternate choices to the kitchen. Resident #75 reported the portion sizes are child-like and he was not receiving enough food. Interview on 04/19/26 at 10:09 A.M. with Resident #99 revealed there were no food substitutions available. Interview on 04/19/26 at 10:12 A.M. with Resident #124 revealed there were no food substitutions available. Interview on 04/19/26 at 12:47 P.M. with Resident #51 revealed he was not receiving enough food at each meal. Interview on 04/19/26 at 1:54 P.M. with Resident #94 revealed the dietary staff or nursing staff do not come to ask residents what they would like to eat for meals. Resident #94 stated the menus posted were old. Resident #94 stated she had offered to post menus each week on every unit for the kitchen. Observation on 04/22/26 at 12:06 P.M. with [NAME] #462 revealed for regular texture ham and beans the residents were served with a six-ounce ladle. There was no mechanical soft texture available to be served. The scoop sizes were confirmed by [NAME] #462. Interview on 04/22/26 at 12:15 P.M. with Dietary Manager (DM) #458 revealed there was an alternative menu item listed on the menu and spreadsheets. DM #458 indicated they were not serving the alternate menu in addition to the main menu. DM #458 stated many of the residents were confused by this. DM #458 stated they send menus every week to each unit and nurse aides were expected to ask residents if they would like a substitution. DM #458 stated resident orders needed to be submitted by 10:00 A.M. for lunch and 3:00 P.M. for dinner. DM #458 stated only two units returned their list of alternates on 04/22/26 for lunch. DM #458 was unable to provide a list of always available/alterative menu items upon request. Observations on 04/22/26 from 12:27 P.M. to 2:13 P.M. of the lunch meal service revealed there was no pureed cornbread or pureed fruit cobbler dessert available for puree diets. The fruit cobbler was substituted for pudding. There was no substitute for cornbread. At 1:43 P.M. the kitchen staff ran out of fruit cobbler for all other textures or diet modifications. Applesauce was served as a substitute. There were three units out of 6 units who did not receive fruit cobbler. The alternates served were observed to be hamburgers or hot dogs. Interview on 04/22/26 at 2:40 P.M. with DM #458 confirmed the kitchen had run out of fruit cobbler and served applesauce or pudding. DM #458 confirmed there was no puree cornbread served to residents on puree diet. Follow up interview on 04/22/26 at 3:02 P.M. with DM #458 confirmed the ham and beans portion size served to regular and mechanical soft textures was inadequate and did not follow the spreadsheet recommendations. DM #458 stated resident food preferences were mostly obtained if something was reported to therapy or nursing staff. DM #458 stated there are forms for food preferences but the last one she could locate was completed by the former DM. DM #458 was unable to describe a system for maintaining current food preferences to meet each resident's needs. Interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she was only at the facility every other week for one day. Dietitian #468 stated the rest of her work was completed offsite. Dietitian #468 stated she had minimal oversight in the kitchen and generally just completed a monthly sanitation audit. Dietitian #468 stated she was unaware of the issues identified in the kitchen. Review of Diet Spreadsheet for Spring/Summer menu dated 2024 revealed for a regular texture diet and mechanical soft diet residents would be served with an 8-ounce ladle. The spreadsheet revealed all residents were to receive meal components of the appropriate texture for ham and beans, seasoned spinach, cornbread with a fruit cobbler dessert. Review of Resident Council Meeting minutes from 11/25/25 revealed residents complained nurse (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	aides were not asking them if they wanted an alternate menu item. Review of facility policy titled Resident Food Preferences Policy undated revealed nutrition assessments would include an evaluation of individual food preferences. The dietitian was expected to complete initial food preferencing within 72 hours of admission and periodically to determine if revisions were needed. The food service department would offer a limited number of food substitutes for individuals who do not want to eat the primary meal. The facility's Quality Assessment and Assurance (QAA) program would periodically review issues related to food preferences and meals to identify widespread concerns. This deficiency represents non-compliance investigated under Complaint Number 2593029.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and review of food committee minutes, the facility failed to serve appealing meals at palatable temperatures. This had potential to affect all residents receiving meals from the kitchen. The facility identified no residents with a nothing by mouth (NPO) diet order. The facility census was 151.Findings include:Review of the food committee meeting minutes from 11/25/25, 02/24/26, and 03/31/26 revealed residents complaining of cold food.An interview on 04/19/26 at 11:25 A.M. with Resident #12 revealed the food was not served hot enough and was not appealing. An interview on 04/19/26 at 12:26 P.M. with Resident #91 revealed the food was never hot. An interview on 04/19/26 at 1:16 P.M. with Resident #117 revealed the food was not hot. An observation on 04/22/26 at 12:06 P.M. revealed temperatures taken with [NAME] #462 prior to lunch service using a facility digital thermometer revealed the ham and beans were 187 degrees Fahrenheit (F), turnip greens were 190 degrees F, and cornbread was at room temperature. Observations on 04/22/26 of lunch meal service revealed the service began at 12:27 P.M. through 2:13 P.M. Nurse aides completed passing trays at 2:38 P.M. It was noted the facility had run out of insulated dome lids, and insulated plastic bowls. There was no use of heated or insulated bases. Lunch service ended 38 minutes after the scheduled mealtime and the last residents received their lunch trays one hour and three minutes after the scheduled mealtime. Observation on 04/22/26 at 2:38 P.M. of a test tray with Dietary Manager (DM) #458 revealed temperatures were taken using the facility's digital thermometer. The ham and beans were in a ceramic bowl, and the temperature was 115 degrees F. The turnip greens were 125 degrees F and were on a plate with a piece of cornbread. The juices from the turnip greens were pooled on the plate and soaking in to the cornbread. Taste test of the ham and beans revealed a lukewarm temperature and food was not palatable due to temperature. An interview on 04/22/26 at 2:40 P.M. with DM #458 confirmed the ham and beans were not at a palatable temperature. DM #458 confirmed the cornbread was soggy. DM #458 confirmed they had run out of the plastic insulated bowls and dome lids. An interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she was only at the facility every other week for one day. Dietitian #468 stated the rest of her work was completed offsite. Dietitian #468 stated she had minimal oversight in the kitchen and generally just completed a monthly sanitation audit. Dietitian #468 stated she was unaware of the issues identified in the kitchen. This deficiency represents non-compliance investigated under complaint number 2677432.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure meals were served at regularly scheduled times. This affected all residents receiving meals from the kitchen. The facility identified no residents with a nothing by mouth (NPO) diet order. The facility census was 151.Findings include:Review of the Resident Meal Times, undated, revealed breakfast was from 8:15 A.M. to 9:20 A.M., lunch was from 12:30 P.M. to 1:35 P.M., and Dinner was from 5:15 P.M. to 6:20 P.M. Service order was [NAME] Unit, Grant Unit, [NAME] Unit, Presidential Unit, Taft Unit, and [NAME] Unit. Review of Food Committee Meeting minutes from 02/24/26 revealed residents complaining of late lunches and trays being left to sit for 15 minutes after arriving to the unit before staff passed them out. The meeting minutes from 11/25/25 revealed meals were not on time. Observation on 04/19/26 from 1:40 P.M. to 2:37 P.M. revealed the lunch meal was delivered late to each of the six units as followed: Observation at 1:40 P.M. revealed a nurse aide was passing trays on Grant Unit. Observation at 1:43 P.M. revealed nurse aide staff were passing lunch trays on [NAME] Unit. Observation at 1:45 P.M. revealed Certified Nursing Assistant (CNA) #418 was picking up finished lunch trays. An interview on 04/19/26 at 1:45 P.M. with CNA #418 confirmed [NAME] Unit lunch trays were over an hour late. CNA #418 indicated it was hit or miss on if meals were on time. An interview on 04/19/26 at 1:47 P.M. with CNA #383 confirmed lunch trays were late on Grant Unit. CNA #383 stated it varied if the lunch meal was on time from day to day. An interview on 04/19/26 at 1:53 P.M. with Medical Records #344 confirmed the [NAME] Unit had not received lunch trays. An interview on 04/19/26 at 1:56 P.M. with CNA #301 confirmed Presidential Unit had not received lunch trays. An interview on 04/19/26 at 1:58 P.M. with Licensed Practical Nurse (LPN) #437 confirmed Taft Unit had not received lunch trays. LPN #437 did not answer if late meals were a normal occurrence. Observation on 04/19/26 at 1:59 P.M. revealed Resident #36 commented to staff that the food was late, and staff told him it would be coming. Resident #120 asked when she would be able to have a smoke break and was told she needed to wait until lunch was over. Observation at 2:19 P.M. revealed lunch trays arrived at Taft Unit. An interview on 04/19/26 at 2:07 P.M. with Resident #28, #45, and #54 complained lunch was late. Residents #28, #45, and #54 were sitting in the dining room on [NAME] Unit. An observation on 04/19/26 at 2:22 P.M. revealed lunch trays arrived at Presidential Unit. Follow up interview on 04/19/26 at 2:21 P.M. with Medical Records #344 revealed the dietary director had come to [NAME] Unit. Medical Records #344 reported the lunch trays were late because the dietary director reported that the cooler had broke and all the prepped food for the lunch meal had to be thrown away. Interview on 04/19/26 at 2:29 P.M. with Resident #119 revealed the food was always delivered late. An observation on 04/19/26 at 2:35 P.M. in the [NAME] Unit dining room revealed Resident #141 stated he had not had lunch yet. An observation on 04/19/26 at 2:37 P.M. revealed lunch trays arrived at [NAME] Unit. An observation on 04/22/26 from 12:06 P.M. to 2:38 P.M. of lunch tray service revealed [NAME] Unit lunch trays left the kitchen at 12:47 P.M., Grant Unit lunch trays left kitchen at 1:08 P.M., [NAME] Unit lunch trays left kitchen at 1:20 P.M., Presidential Unit lunch trays left kitchen at 1:43 P.M., Taft Unit lunch trays left kitchen at 1:59 P.M., and [NAME] Unit lunch trays left kitchen at 2:13 P.M. Lunch tray pass was not completed until 2:38 P.M. An interview on 04/22/26 at 2:40 P.M. with Dietary Manager (DM) #458 confirmed lunch meals were late on 04/19/26 and 04/22/26. An interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she was only at the facility every other week for one day. Dietitian #468 stated the rest of her work was completed offsite. Dietitian #468 stated she had minimal oversight in the kitchen and generally just completed a monthly sanitation audit. Dietitian #468 stated she was unaware of the issues identified in the kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and review of facility policy, the facility failed to ensure food was stored, prepared and served under sanitary conditions. This had the potential to affect all residents receiving meals from the kitchen. The facility identified no residents with a nothing by mouth (NPO) diet order. The facility census was 151.Findings include:Observation on 04/19/26 from 8:24 A.M. to 9:05 A.M. of the facility kitchen revealed upon entering the kitchen it was observed that the walk-in refrigerator's temperature gauge was at 60 degrees Fahrenheit (F). Food stored inside was warm to touch.Observation of the dish machine area revealed the floors and walls had dried splatter and debris. There were four rubber floor mats that were sticky with various debris stuck to them. There was noted dust on the walls and ceiling by air vents and lights. There were three fans with dust covering the fans. The dish machine had dried splatters and a white colored build up. There was a dried, soiled rag sitting on top of dish machine. There was a notable sour, spoiled odor in the dish machine area. Observation of the main kitchen area revealed there was a stove with six burners. The stove had burnt food debris and dark grease build-up on it. The wall across from the stove and prep table had dried food splatter. The prep table holding the juice machine had dried red juice on shelves and splattered on the ground in front of the table. There was a dried spill on the floor in front of the three-compartment sink. Observation of a deep fryer revealed the frying oil was empty with significant amounts of dried yellow grease in the frying well. There were dried grease drips down the front and sides of the fryer. Observation of a reach-in refrigerator by the tray line revealed there was a container of peanut butter mixed with grape jelly with no date or label. There was a plastic wrapped partial package of sliced deli ham without label or date. There was a plastic wrapped chunk of deli turkey without label or date. There was a cut cucumber covered with plastic wrap with no label or date. There was a container of hard-boiled eggs with no label or date. There was a container of sliced tomatoes with no label or date. There was a container of mixed fruit cocktail with no label or date. There was a fan across from tray line that was over a prep area table that was coated with dust. Observation of the walk-in freezer revealed significant ice buildup from the condenser. The ice was built up on the food storage rack below with ice in two empty metal trays. There was also ice on a covered tray of beef tips and a tray of pineapple crisp. There was ice built up on the ceiling and the door. Observation of the dry storage room revealed an open box of powdered sugar that was not sealed. There was various debris on floors throughout the dry storage area. The floors and walls throughout the kitchen had various food debris/splatters and the floors were sticky. An interview on 04/19/26 at 8:26 A.M. with Dietary Aide (DA) #326 confirmed the walk-in cooler was at 60 degrees F. Dietary Aide #326 stated the staff were not using anything from the cooler because all the food was warm. DA #326 stated she was in the kitchen until about 8:00 P.M. last night and it was working fine. DA #326 stated when she came in this morning it was warm. DA #326 stated Dietary Manager (DM) #458 was aware. An interview on 04/19/26 at 8:35 A.M. with [NAME] #462 confirmed findings in the reach-in refrigerator. [NAME] #462 reported leftovers were kept for seven days. [NAME] #462 confirmed findings related to cleanliness in the kitchen area. [NAME] #462 stated they have not used the fryer since she started in January 2026. An interview on 04/22/26 at 8:45 AM DM #458 revealed DM #458 had arrived and completed a tour. DM #458 reported she had become the manager about two months ago. DM #458 confirmed findings in the walk-in freezer and cooler. DM #458 stated the ice had been building up for a while in the freezer. DM #458 stated her staff were supposed to clean the floors everyday including sweeping and mopping. DM #458 stated maintenance was aware of the fryer, and they needed to remove it and cap off the gas line. DM #458 stated the deep fryer had not been used in over a year. DM #458 confirmed findings in the stove area and prep areas. DM #458 confirmed findings in the dish machine area. Observations on 04/22/26 from 12:06 P.M. to 2:38 P.M. of lunch tray service revealed DA #934 had picked up spilled plastic lids off the floor with bare hands and disposed of them (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	in a trash can in the dish machine area. DA #934 touched the lid of the trash can and returned to tray line without performing hand hygiene. DA #934 was observed to drink out of a cup and continue assisting on tray line without performing hand hygiene. DA #934 was observed to adjust his hair net and clothing without performing hand hygiene before continuing to assist on tray line. DA #934 was observed to have facial hair that was not secured with a beard net. Certified Nursing Assistant (CNA) #433 entered the kitchen area to fill an ice cooler from the ice machine. CNA #433 was not wearing a hair net or perform hand hygiene. DA #349 was fixing desserts on trays and dropped a dessert in a plastic cup with lid on the floor and it did not break open so DA #349 picked the dessert up and put it on a lunch tray. DA #349 took dirty trays to the dish machine area and returned to tray line without performing hand hygiene. [NAME] #368 was preparing desserts and was observed to rinse hands in a preparation sink without using soap and dried her hands on her pants. [NAME] #368 was observed to prepare three different desserts without performing hand hygiene between tasks or when leaving her preparation area. [NAME] #368 was observed to handle her cellphone and return to her task without performing hand hygiene. [NAME] #368 returned to the kitchen area from the breakroom to remove cakes from the oven. [NAME] #368 did not perform hand hygiene. [NAME] #368 was observed to cough without covering her mouth and did not perform hand hygiene. An interview on 04/22/26 at 2:40 P.M. with DM #458 revealed concerns with hand hygiene and hair net/beard guard use were reviewed and confirmed by DM #458. An interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she was only at the facility every other week for one day. Dietitian #468 stated the rest of her work was completed offsite. Dietitian #468 stated she had minimal oversight in the kitchen and generally just completed a monthly sanitation audit. Dietitian #468 stated she was unaware of the issues identified in the kitchen. Review of the facility policy titled Kitchen Sanitation and Cleanliness Policy, undated,j revealed all kitchen equipment would be kept clean and in working condition, floors would be cleaned regularly, and refrigeration/freezers would be monitored daily. Review of facility policy titled Proper Food Storage dated 10/22/03 revealed all ready-to-eat foods stored should be discarded if not consumed within seven days. Proper storage included a label including the contents, a date, and initials. Foods stored should be covered and secured with plastic wrap or foil. Review of facility policy titled Hand Washing Policy undated revealed staff must wash hands with soap and water when hands were visibly dirty, after using restroom, before and after eating or handling food, and after removing gloves. Review of facility policy titled Why the Hairnet? undated revealed a hair restraint was part of the dress code. Hair restraints should be worn by anyone in the kitchen including guests and staff. Hands should be washed following handling of the hair restraint. Hair restraints included a hat that covers all hair, a fine net, a beard or facial hair covering, or a piece of clothing that covers body hair.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Dispose of garbage and refuse properly. Based on observation, staff interview, and policy review, the facility failed to properly dispose of garbage and refuse. This had the potential to affect all residents residing in the facility. The facility census was 151. Findings include:Observation on 04/19/26 at 9:00 A.M. with Dietary Manager (DM) #458 revealed there were multiple dumpsters in an enclosed, indoor space. There was a very strong, pervasive, foul odor in the room. There were various debris including plastic gloves, dried leaves, and a tied black trash bag on the floor. In the dumpster area there was also various equipment including two floor cleaners and a plastic wrapped recliner on a wooden pallet. An interview on 04/19/26 at 9:00 A.M. with DM #458 confirmed the pervasive foul odor and garbage and refuse not being properly disposed. DM #458 stated all staff were responsible for keeping the area clean and free of debris. An interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she was only at the facility every other week for one day. Dietitian #468 stated the rest of her work was completed offsite. Dietitian #468 stated she had minimal oversight in the kitchen and generally just completed a monthly sanitation audit. Dietitian #468 stated she was unaware of the issues identified in the kitchen. Review of the facility policy titled Policy for Dumpster Area/Refuse undated revealed the dumpster area must be kept clean, secure, and accessible for waste removal services. The policy stated the dumpster area would be inspected daily for cleanliness and loose trash or spills would be cleaned. The area would be pressure washed periodically to control odor.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, review of facility job descriptions and interview the facility failed to ensure effective administration to manage the facility and identify care concerns, implement appropriate and sustainable corrective actions to prevent reoccurrence and attain or maintain the highest practicable physical, mental and psychosocial well-being of all 151 residents residing in the facility.Findings include: Review of the Administrator job description, signed by the Administrator but not dated, revealed the position would establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet resident's needs in compliance with state and local requirements. The administrator would develop a monitoring system to assure compliance with federal, state and local requirements. The administrator would establish systems to enforce facility policies and procedures, establish operating procedures for physician responsibilities, participate in the scheduling, planning and procuring of materials and information of staff meetings and in-service education programs, observe all infection control policies and procedures, assume responsibility for implementation of an effective quality assurance program, assume responsibility for notifying appropriate state and local agencies of the transfer, temporary or permanent discharge or death of any resident receiving medicaid funds, consistently work cooperatively with residents, resident's representatives, facility staff, physicians, consultants and ancillary service providers, observe all facility safety policies and procedures and remain positive and caring and act in the best interest of the residents.Review of the Director of Nursing (DON) job description signed by the DON on 11/14/01 revealed the DON was responsible for organizing and directing activities in the nursing department to ensure proper resident care. The DON attends various meetings to initiate a collaborative working environment in the organization. Investigates possible neglect and abuse incidents. Resolves operational issues throughout the day regarding nursing care application. Maintains open communication with the administrator, medical director, quality assurance committee and related departmental heads to ensure proper operation of nursing department.Interview on 05/05/26 at 9:13 A.M. with the Administrator, DON and Regional Director (RDI) #449 revealed the Administrator had assumed his position on 12/08/25.During the onsite investigation, the following concerns were identified related to a lack of comprehensive and effective administrative oversight:1. Review of personnel files revealed a lack of a Licensed Social Worker (LSW) since LSW #360 had been terminated on 01/09/26. Social Service Designee (SSD) #373 remained the only current employee in the social services department and was not a LSW. The facility had brief LSW coverage from LSW #451 from 02/12/26 until she separated from the facility on 02/27/26. Review of census data revealed the facility census remained over 120 residents, with a census of 151 residents upon survey entry on 04/19/26.Interviews with Human Resource Director (HRD) #307, LSW #360, SSD #373 and the Administrator verified the social service concerns identified during the survey.2. Review of multiple self-reported incidents (SRIs) in conjunction with medical record, Medication Administration Record (MAR), controlled substance administration record and controlled medication shift change log review revealed misappropriation of controlled medications between November 2025 and April 2026 affecting Resident #1, Resident #3, Resident #47 and Resident #154. Not all instances of the medication misappropriation were reported to the state agency as required and staff were not re-educated on medication administration or narcotic handling in response to the misappropriation events.Interviews with Registered Nurse (RN) #457, the DON and Licensed Practical Nurse (LPN) #431 verified the medication misappropriation concerns identified during the survey.3. Observations of the kitchen environment and meal service on 04/19/26 and 04/22/26 revealed concerns with kitchen sanitation, disposal of garbage, following the menu (items and portion sizes), appropriate food temperatures, appropriate food consistencies and delays in meal service to the resident units. While the facility had taken dietary concerns to Quality Assurance and Performance Improvement (QAPI) during their meetings on 04/24/25, September 2025, 12/18/25 and 03/19/26, the issues continued to (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	recur without resolution. Interviews with the Administrator, Dietary Manager (DM) #458, Dietary Aide (DA) #326, [NAME] #462 and Registered Dietitian (RD) #468 verified the dietary service concerns identified during the survey.4. Review of the facility's infection control program documentation revealed a lack of a comprehensive legionella water management program. Observations during the survey indicated additional infection control concerns were identified relative to handwashing, contact isolation and the provision of personal care.Interviews with the Administrator, DON and Infection Preventionist (IP)/LPN #445 verified the infection control concerns identified during the survey.5. Review of QAPI meeting minutes dated 04/24/25 revealed action plans for the physical environment/pest control, care plan revisions, falls, leave of absence and dietary services. The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to the physical environment, care plan revisions, falls, inappropriate discharge and dietary services.6. Review of QAPI meeting minutes dated 06/26/25 revealed action plans for leave of absence, therapy/equipment, falls, smoking policy, dietitian services and dietary department staffing. The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to inappropriate discharge, falls and nutrition.7. Review of QAPI meeting minutes dated September 2025 (date not specified) revealed action plans for pharmacy services, dietitian services, infection control, wound care, discharge documentation, dietary services, physical environment and Minimum Data Set (MDS) 3.0 assessments. The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to pharmacy services, nutrition, infection control, wound care for pressure and non-pressure wounds, discharge documentation, dietary services, physical environment and MDS assessments.8. Review of QAPI meeting minutes dated 12/18/25 revealed an action plan in place for workplace culture change. There was no evidence that previous QAPI action items (pharmacy services, nutrition, infection control, wound care for pressure and non-pressure wounds, discharge documentation, dietary services, physical environment and MDS assessments) were revisited, followed up with if needed or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to pharmacy services, nutrition, infection control, wound care for pressure and non-pressure wounds, discharge documentation, dietary services, physical environment and MDS assessments. 9. Review of QAPI meeting minutes dated 03/19/26 revealed action plans for falls with major injury, MDS assessments, nursing point of care documentation, dietary services, abuse reporting and prevention, laundry services and Preadmission Screening and Resident Review (PASRR). The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to falls, MDS assessments, dietary services, abuse reporting and investigation and PASSR.During an interview on 05/05/26 at 9:13 A.M. the Administrator was made aware none of the QAPI meeting minutes had a full PIP developed including dates and a point person to ensure follow-through, evidence of auditing, (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	education or other corrective measures completed to address the facility-identified concerns or for ongoing monitoring to prevent reoccurrence. The Administrator verified during the interview he was unaware the PIPs were not completed from any of the QAPI meetings prior to his start of employment in December 2025. This deficiency represents noncompliance investigated under Complaint Number 2992799, Complaint Number 2668600 and Complaint Number 2593029.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, the facility failed to ensure the facility assessment was accurately completed. This had the potential to affect all 151 residents residing in the facility. The facility census was 151. Findings include:Review of the facility assessment revised 08/01/25 revealed Former Administrator (FA) #448 was listed as the current administrator for the facility.Additional review of the facility assessment revealed under the section for ?Staffing Plan,' there was a table listing positions including licensed nurses providing direct care, nurse aides, other nursing personnel, other staff needed for behavioral healthcare and services, dietitian or other clinically qualified nutrition professional, food and nutrition services staff and respiratory care services staff. Under the adjacent column ?Total Number Needed or Average or Range' the area was blank. A second table in this section listed staff including licensed nurses, direct care staff and other staff with a notation ?refer to Centers for Medicare and Medicaid Services (CMS) minimum staffing rule.' Both sections did not specify numbers or ranges of staff required to meet resident needs.Interview on 04/27/26 at 9:23 A.M. with the current Administrator revealed he had looked at the facility assessment twice since starting his employment with the facility on 12/08/25 and indicated the assessment was due to be reviewed again in August 2026. When asked about the ?CMS minimum staffing rule' written in the staffing plan section, the Administrator stated he could not speak to that and acknowledged the assessment was not done how he would do it. The Administrator shared staffing levels for Certified Nursing Assistants (CNAs) were 14 CNAs for first and second shift, with nine on third shift and staffing levels for Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) together were six on first and second shift and four on third shift and confirmed this information was not located within the facility assessment and should have been.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on personnel record review, review of the job description for social services, and staff interview, the facility failed to employ a full-time Licensed Social Worker (LSW). This had the potential to affect all residents residing in the facility. The facility census was 151.Findings include:Review of the personnel file for Social Services Director (SSD) #373 revealed a hire date of 03/11/25. Review of her employee application as well as her resume revealed she did not have a degree in social services.Review of the personnel file for LSW #360 revealed a progressive discipline action form dated 01/09/26 which revealed he had been terminated on 01/09/26. Review of the personnel file for LSW #451 revealed she was hired by the facility on 02/12/26 and separated from the facility on 02/27/26. Interview on 04/20/26 at 9:39 A.M. with Human Resources Director (HR) #307 verified SSD #373 was the only employee in the social services department. She stated SSD #373 was not a Licensed Social Worker (LSW) nor held a bachelor's degree in a human services field.Interview on 04/20/26 at 10:36 A.M. with SSD #373 verified she was not a LSW nor held a bachelor's degree in a human services field. She stated she had been the Social Services Director since LSW #360 was fired on 01/09/26.Interview on 04/20/26 at 11:17 A.M. with the Administrator verified the facility did not have a LSW and had not had one in the social services department since 02/27/26. He stated they were interviewing candidates for the position, but had not completed the hiring process yet.Review of the facility document titled Job Description for social services, undated, revealed the purpose of the position was to provide services to meet the social and/or emotional needs that affected the residents' abilities to achieve their highest level of function. There was no verbiage included in the job description that the Social Services Director would be required to be a Licensed Social Worker if the facility census was over 120 residents as required.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, interview, and review of the facility policy and procedure, the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) committee was in place to identify and address concerns timely and effectively. This had the potential to affect all 151 residents in the facility. The facility census was 151. Findings include: Review of the facility QAPI minutes and Performance Improvement Plan (PIP) documentation revealed the following plans without continued corrective action or evidence the plan was revised when necessary or changed once identified to be ineffective:1. Review of QAPI meeting minutes dated 04/24/25 revealed action plans for the physical environment/pest control, care plan revisions, falls, leave of absence and dietary services. The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to the physical environment, care plan revisions, falls, inappropriate discharge, and dietary services.2. Review of QAPI meeting minutes dated 06/26/25 revealed action plans for leave of absence, therapy/equipment, falls, smoking policy, dietitian services, and dietary department staffing. The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to inappropriate discharge, falls and nutrition.3. Review of QAPI meeting minutes dated September 2025 (date not specified) revealed action plans for pharmacy services, dietitian services, infection control, wound care, discharge documentation, dietary services, physical environment, and Minimum Data Set (MDS) 3.0 assessments. The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to pharmacy services, nutrition, infection control, wound care for pressure and non-pressure wounds, discharge documentation, dietary services, physical environment and MDS assessments.4. Review of QAPI meeting minutes dated 12/18/25 revealed an action plan in place for workplace culture change. There was no evidence that previous QAPI action items (pharmacy services, nutrition, infection control, wound care for pressure and non-pressure wounds, discharge documentation, dietary services, physical environment and MDS assessments) were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to pharmacy services, nutrition, infection control, wound care for pressure and non-pressure wounds, discharge documentation, dietary services, physical environment and MDS assessments. 5. Review of QAPI meeting minutes dated 03/19/26 revealed action plans for falls with major injury, MDS assessments, nursing point of care documentation, dietary services, abuse reporting and prevention, laundry services and Preadmission Screening and Resident Review (PASRR). The plans indicated the department responsible for the corrective action but did not specify a point person on most of the plans. The columns under monthly progress were blank for most of the plans and if not blank, did not contain dates or other information to show when the plan would be completed by. There was no additional information provided to verify the correction plan was completed.During the current annual survey, deficiencies were identified related to falls, MDS assessments, dietary services, abuse reporting and (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	investigation and PASRR.Interview on 05/05/26 at 9:13 A.M. with the Administrator, Director of Nursing (DON), and Regional Director (RDI) #449 revealed QAPI was a mechanism in place to identify and resolve issues. During the interview, the Administrator was made aware none of the QAPI meeting minutes had a full PIP developed and there was no evidence of auditing or education or other corrective measures completed to address the facility-identified concerns or for ongoing monitoring to prevent reoccurrence. The Administrator verified during the interview he was unaware the PIPs were not completed from any of the QAPI meetings prior to his start of employment in December 2025. The Administrator also verified during the interview there was not yet a mechanism in place for residents and staff to report issues to the facility's QAPI program and hoped to have related education out to staff within the next 30 days.Review of the undated policy, Quality Assurance and Performance Improvement (QAPI) Policy, revealed the QAPI program would ensure the delivery of safe, effective and high-quality care to all residents. This program provides a systematic, data-driven approach to maintaining and improving resident outcomes, care processes and organizational performance. The facility is committed to ongoing quality assessment and performance improvement, identifying opportunities for improvement through data analysis and implementing corrective actions and monitoring outcomes. The QAPI committee was responsible for reviewing performance data and trends, overseeing performance improvement projects (PIPs), ensuring compliance with regulatory standards and reporting findings to leadership. Leadership was responsible for fostering a non-punitive culture that encourages reporting and improvement. PIPs are initiated based on identified areas needing improvement. All QAPI activities should be documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure infection control standards were maintained during medication administration for Resident #50 and during incontinence care for Resident #24. The facility failed to ensure contact precautions were in place for Resident #1. The facility failed to ensure the infection control policy was reviewed annually. Additionally, the facility failed to ensure the Legionella water management program comprehensively assessed risk measures for their elderly population. This had the potential to affect all residents residing in the facility. The facility census was 151.Findings include: 1.Review of the facility's Legionella risk assessment, undated, revealed the facility had a municipal water source. The assessment evaluated the risk of Legionnaires' disease associated with the facility's water systems and supports compliance with the Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, and American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE). The assessment did not reveal any resident risk profile or the overall risk level. Based on system condition, population, and control measures revealed no overall risk determination. There were no control measures or monitoring plan in place per the assessment. There was no attached water management diagram. The assessment revealed the program was not reviewed annually nor were monitoring logs reviewed. Review of the facility's water temperature logs for April 2026 and May 2026 revealed water temperatures and call light functioning were measured in rooms. Interview on 04/28/26 at 11:15 A.M. with Maintenance Director (MD) #399 revealed the facility does not do water flushing but does take water temperatures. He indicated the city tests the water for Legionella. Interview on 05/04/26 at 12:48 P.M. with Maintenance Director #399 revealed information on risk assessment was what was available. There was no water schematic map. Per Maintenance Director #399, he was new to the maintenance role. Review of the facility's Legionella policy, undated, revealed the facility would establish a comprehensive water management program that reduced the risk of growth and transmission of Legionella bacteria within the facility's water systems. The facility would implement and maintain a water management program consistent with industry standards. The team would identify high-risk populations and routine flushing faucets at least weekly. If control limits were not met: there would be immediate investigation of cause, system flushing or thermal disinfection, and documentation of all corrective action. Review of the Center for Disease Control's Legionella Control Toolkit, dated 02/17/26, revealed developing and maintaining a water management program was a multi-step process that required continuous review including establishing a team, describing building water systems, identifying areas or devices where Legionella might grow or spread to people, determining control measures, monitoring control measures, establishing remediation activities and interventions when control measures are not met, ensuring the program was running as designed and was effective, and documenting all program activities. Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures regularly as needed to maintain water quality parameters within control limits. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	2. Review of Resident #1's medical record revealed an admission date of 01/20/22 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease, bacteremia, pseudomonas, methicillin resistant staphylococcus aureus, chronic bronchitis, and congestive heart failure. Review of Resident #1's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/09/26, revealed intact cognition and the presence of a multi-drug-resistant organism (MDRO). Review of Resident #1's physician orders revealed an order for contact isolation for Carbapenem-resistant Acinetobacter baumannii (CRAB, an infectious MDRO) that started on 03/31/26. Review of Resident #1's comprehensive care plan did not indicate the resident required contact isolation. This was verified in an interview with the Director of Nursing (DON) on 05/04/26 at 2:51 P.M. Observation on 04/20/26 at 10:20 A.M. of Resident #1's room revealed no isolation supplies outside of room. At the time of observation, confirmation with Licensed Practical Nurse (LPN) #456 revealed Resident #1 should be on contact isolation for CRAB in his blood, but there was no signage indicating isolation was required and there was no personal protective equipment (PPE) available outside of the room. Interview on 04/27/26 at 11:44 A.M. with Assistant Director of Nursing (ADON) #445 revealed the facility used a gown and gloves for residents on contact isolation. For a resident on contact isolation, there were red barrels in their room, carts outside their rooms for personal protective equipment, and a sign on the door which showed what kind of isolation the resident was on for staff notification. Observation on 04/29/26 at 9:38 A.M. revealed staff donned gown and gloves prior to going into Resident #1's room with contact isolation in place. Review of the facility's Isolation Categories and Transmission-Based Precautions Policy, undated, to prevent and control the transmission of infectious organisms within the facility by implementing standard precautions, transmission-based precautions, and enhanced barrier precautions when indicated. Contact precaution indications for MDROs private room preferred or cohorting. Gloves and gowns were to be worn upon room entry. Dedicated or disposable equipment was to be used. The policy noted to limit resident movement unless necessary. 3. Interview on 04/27/2026 at 11:44 A.M. with ADON #445 revealed their infection control policy was last reviewed in 2020 and had not been reviewed annually. Review of the facility's Infection Prevention and Control and Stewardship Program Policy, revised date 01/15/20, revealed the facility had established an infection control program which addressed all phases of the organization's operation to reduce or prevent the risks of nosocomial infections in residents and healthcare workers. All infection control policies and procedures would be reviewed annually by the Quality Assurance Committee and revised as needed. 4. Review of the medical record for Resident #24 revealed an admission date of 08/30/22 with diagnoses including dementia, chronic kidney disease, repeated falls and need for assistance with personal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 had severely impaired cognition and was dependent on staff for toileting. Observation on 04/27/26 at 9:46 A.M. of incontinence care to Resident #24 by Certified Nursing Assistant (CNA) #426 revealed concerns with infection control. CNA #426 assisted the resident to her bed, removed her shoes, and placed them on the floor by the foot of the bed and started providing perineal care. When CNA #426 removed Resident #24's brief, she placed it on the ground by Resident #24's shoes. She then utilized disposable wipes to wash the resident and after wipes were soiled, including with bowel movement, she attempted to place them on top of the soiled brief on the floor with some landing directly on the floor. During the observation, it was noted a trash can was by the resident's head of the bed but there was no trash bag in it. CNA #426 stated there was usually a bag in the can and she stated she should have opened a bag before started providing care. CNA #426 stated she had trash bags in her pocket. Review of the facility policy titled, Perineal Care, revised August 2008, revealed staff were to throw disposable items into a designated container. 5. Review of the medical record for Resident #50 revealed an admission date of 10/28/25 with diagnoses including schizophrenia, anxiety, depression and hypertension. Review of the physician's orders for April 2026 revealed Resident #50 received Aspirin 81 milligrams (mg), calcium carbonate (supplement), Coenzyme Q10 (supplement) 30 mg, Effexor (anti-depressant) 37.5 mg, Magnesium (supplement) 200 mg, Omeprazole (antacid) 40 mg, Oxybutynin (medication for over-active bladder) 2.5 mg, Potassium Chloride (supplement) 20 milliequivalents (meq), Seroquel (anti-psychotic) 25 mg, Thiamine (supplement) 100 mg, Zestoretic (medication for high blood pressure) 20-12.5 mg, Aso D Mannose (medication for urinary tract infections) 500 mg, Tylenol extra strength (pain medication) 500 mg, and Carbidopa-Levodopa (medication for Parkinson's Disease) 25-100 mg every morning. Observation on 04/27/26 at 9:28 A.M. of LPN #406 revealed she was performing medication administration for Resident #50. She was observed to be popping the resident's medications out of the medication card into her ungloved hand and then into a medication cup. There was a total of 17 pills in the medication cups on her medication cart when she had completed gathering Resident #50's medications. LPN #406 stated she was in a hurry and did not notice she was popping the pills into her hands first and then placing them into the medication cups. Review of the facility policy titled, Medication Dispensing System, revised August 2008, revealed staff were not to touch the medication when opening a bottle or unit dose package.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on personnel file review, review of the facility assessment, and interviews, the facility failed to conduct mandatory training to all staff on the facility's quality assurance and performance improvement (QAPI) program. This affected five out of 11 personnel files reviewed and had the potential to affect all 151 residents residing in the facility. The facility census was 151. Findings include: Review of Certified Nursing Assistant (CNA) #464's personnel file revealed a hire date of 12/23/25. There was no documented evidence that CNA #464 had received QAPI training as required.Review of CNA #465's personnel file revealed a hire date of 01/06/26. There was no documented evidence that CNA #465 had received QAPI training as required.Review of CNA #466's personnel file revealed a hire date of 02/26/26. There was no documented evidence that CNA #466 had received QAPI training as required.Review of Licensed Practical Nurse (LPN) #338's personnel file revealed a hire date of 09/16/25. There was no documented evidence that LPN #338 had received QAPI training as required.Review of Human Resource Director (HRD) #307's personnel file revealed a hire date of 04/21/25. There was no documented evidence that HRD #307 had received QAPI training as required.Interview on 04/30/26 at 10:23 A.M. with HRD #307 revealed the facility had not provided any QAPI training or in-services to staff since she started her employment with the facility in April 2025. HRD #307 stated she believed the Administrator would handle that area and confirmed he had not provided any QAPI in-servicing to staff, including herself.Interview on 04/30/26 at 11:05 A.M. with the Administrator verified the facility needed to complete QAPI training and it had not been completed yet since he started his employment with the facility on 12/08/25.Review of the facility assessment revised 08/01/25 revealed the facility would train its staff on communications, residents' rights, abuse, infection control, culture change, identification of changes in condition and cultural competency. The assessment did not include education for staff on QAPI as required.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure Certified Nursing Assistants (CNA) had at least 12 hours of in-service training annually as required. This had the potential to affect all residents residing in the facility. The facility census was 151.Findings include:Review of the employee file for Certified Nursing Assistant (CNA) #325 revealed a hire date of 03/13/25. Continued review of the employee file revealed CNA #325 had not received 12 hours of in-service training annually as required. Review of the employee file for CNA #386 revealed a hire date of 01/15/25. Continued review of the employee file revealed CNA #386 had not received 12 hours of in-service training annually as required. Review of the employee file for CNA #425 revealed a hire date of 03/04/25. Continued review of the employee file revealed CNA #425 had not received 12 hours of in-service training annually as required. Interview on 04/29/26 at 2:26 P.M. with Human Resources Director (HR) #307 verified the CNA's had not completed the 12 hours of in-service training annually as required. She stated the facility was in the process of setting up an online education system.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to conduct care conferences at least quarterly as required. This affected nine residents (#6, #62, #65, #66, #74, #75, #119, #138, and #139) of nine residents reviewed for care planning. Facility census was 151. Findings include: 1. Review of Resident #139's medical record revealed an admission date of 09/05/24 and diagnoses including dementia with other behavioral disturbance, depression, anxiety, hypertension, and osteoarthritis. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #139 was cognitively impaired. Further review of Resident #139's medical record for the last twelve months revealed one care conference completed on 07/31/25. Telephone interview on 04/19/26 at 11:20 A.M. with Resident #139's guardian revealed she was concerned Resident #139 had not had a care conference since July 2025. Interview on 04/21/26 at 2:45 P.M. with MDS/Licensed Practical Nurse (LPN) #379 during review of Resident #139's chart revealed the last care conference conducted for Resident #139 was during July 2025. MDS/LPN #379 confirmed this was the last care conference done for Resident #139 and verified the facility was to be completing care conferences at least quarterly for all residents. 2. Review of the medical record for Resident #119 revealed an admission date of 11/22/19 and diagnoses including chronic respiratory failure, anxiety disorder, diabetes mellitus, and recurrent major depressive disorder. Review of quarterly MDS assessment dated [DATE] revealed Resident #119 was cognitively intact. Review of plan of care meeting notes from 10/02/25 revealed the care plan meeting was held however Resident #119 did not attend the meeting. Further review of the medical record for Resident #119 revealed there was no evidence of additional care plan meeting held since 10/02/25. Interview on 05/05/26 at 8:10 A.M. with Director of Nursing (DON) confirmed she was unable to locate any additional care plan meetings for Resident #119 held since 10/02/25. Review of facility policy Care Conference Resident/Family Participation undated revealed each resident and their family members were encouraged to participate in the development of the resident's comprehensive assessment and care plan. The social services director or designee was responsible for arranging care planning conferences. The policy did not address requirements for frequency of care planning conferences. 3. Review of the medical record for Resident #138 revealed an admission date of 11/25/24 and (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	diagnoses including dementia with mood disturbance, chronic kidney disease, generalized anxiety disorder, hyperlipidemia, osteoarthritis, and essential hypertension. Review of plan of care meeting notes from 07/31/25 revealed the meeting needed to be re-scheduled. Review of MDS assessment dated [DATE] revealed Resident #138 had short- and long-term memory problems and severely impaired decision-making ability. Resident #138 was noted to have delusions. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #138 was unable to participate in interview resulting in score of 99. Further review of the medical record for Resident #138 revealed there was no evidence of a care plan meeting held since 04/10/25. There was no evidence the care plan meeting on 07/31/25 was re-scheduled as indicated. Interview on 04/27/26 at 3:17 P.M. with Social Services Designee (SSD) #373 confirmed Resident #138 had not had a care plan meeting since April of 2025. Review of facility policy Care Conference Resident/Family Participation undated revealed each resident and their family members were encouraged to participate in the development of the resident's comprehensive assessment and care plan. The social services director or designee was responsible for arranging care planning conferences. The policy did not address requirements for frequency of care planning conferences. 4. Review of Resident #62's medical record revealed an admission date of 09/05/24 with diagnoses including cerebral infarction, seizures, depression, anxiety, chronic kidney disease, neurocognitive disorder, insomnia, and alcohol-induced dementia. Review of Resident #62's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/13/26, revealed Resident #62 was cognitively impaired. Review of the weekly schedules of plan of care meetings dated back to 01/22/26 revealed Resident #62 had no scheduled care plan meetings. Interview on 04/21/26 at 12:00 P.M. with Resident #62 revealed the facility does not include her in care plan meetings or follow any preferences or wishes she had. Interviews on 04/21/26 at 2:44 P.M. with the Resident Council revealed residents were invited to care plan meetings but there have not been any care plan meetings lately. Interview on 04/21/26 at 2:55 P.M. with the DON revealed residents were involved with their plan of care. There was a meeting schedule and the staff would bring residents to the meetings if they wished to attend. Interview on 04/22/26 10:22 A.M. with the DON revealed care plan meetings were currently not being done. Review of the facility's care conference policy, undated, revealed the resident and family are invited to attend and participate in the residents assessment and care planning conference. Advance notice of the care planning conference was provided to the resident and authorized representative. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	5. Review of Resident #6's medical record revealed he was admitted on [DATE] and his diagnoses Included but were not limited to personal history of traumatic brain injury acute and chronic respiratory failure, tracheostomy, unspecified kidney failure, and cerebral vascular disease. Review of Resident #6's quarterly MDS 3.0 assessment dated [DATE] revealed he had a Brief Interview Mental status score of 15 indicating he was intact cognition and he was his own responsible party. Review of Resident #6's progress notes revealed the last Plan of Care Care Conference was dated 09/21/25. Progress notes from 09/22/25 to 05/01/26 /22 did not reveal any documented evidence that a quarterly care conference was completed. Interview on 04/22/26 at 2:03 P.M. with SSD #373 revealed many of the care conferences were missed/not done recently including Resident #6's care conference. 6. Review of Resident #65's medical record revealed he was admitted on [DATE] and his diagnoses included but were not limited to Schizoaffective disease, major depressive disorder, anxiety disorder, chronic kidney disease, and peripheral vascular disease Review of Resident #65's quarterly MDS 3.0 assessment dated [DATE] revealed he had a Brief Interview Mental status score of five indicating he was severely cognitively impaired. The medical record revealed Resident #65 had a legally appointed Guardian. Review of Resident #65's progress notes revealed the last Plan of Care Conference was dated 10/30/25. Resident #65's Care Plan documentation and his medical record Progress notes from 10/30/25 to 05/01/26 did not reveal any documented evidence that a quarterly care conference was completed. Interview on 04/22/26 at 2:03 P.M. with SSD #373 revealed many of the care conferences were missed/not done recently including Resident #65's care conference. 7. Review of Resident #66's medical record revealed he was admitted on [DATE] and his diagnoses included but were not limited to Schizoaffective disease, major depressive disorder, anxiety disorder, chronic kidney disease, and peripheral vascular disease Review of Resident #66's quarterly MDS 3.0 assessment dated [DATE] revealed he had a Brief Interview Mental status score of five indicating he was severely cognitively impaired. The medical record revealed Resident #66 had a legally appointed Guardian. Review of Resident #66's progress notes revealed the last Plan of Care Conference was dated 10/30/25. Resident #66's Care Plan documentation and his medical record Progress notes from 01/01/25 to 05/01/26 did not reveal any documented evidence that a quarterly care conference was completed. Interview on 04/22/26 at 2:03 P.M. with SSD #373 revealed many of the care conferences were missed/not done recently including Resident #66's care conference. 8. Review of Resident #74's medical record revealed he was admitted on [DATE] and his diagnoses included but were not limited to Parkinson's disease, chronic respiratory failure, chronic obstructive (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	pulmonary disease, hypertensive chronic kidney disease, and generalized weakness. Review of Resident #74's quarterly MDS 3.0 assessment dated [DATE] revealed he had a Brief Interview Mental status score of eight indicating he was severely cognitively impaired. The medical record revealed Resident #74's brother was responsible party. Review of Resident #74's progress notes revealed the last Plan of Care Conference was dated 10/30/25. Resident #74's Care Plan documentation and his medical record Progress notes from 10/31/25 to 05/01/26 did not reveal any documented evidence that a quarterly care conference was completed. Interview on 04/22/26 at 2:03 P.M. with SSD #373 revealed many of the care conferences were missed/not done recently including Resident #74's care conference. 9. Resident #75 was admitted to the facility on [DATE] with diagnosis motor and sensory neuropathy schizoaffective disorder type 2 diabetes Mellitus, varicose veins of left lower extremity with ulcer on other part of lower leg, non pressure chronic ulcer on right heel, and major depressive disorder. Review of Resident #75's annual MDS assessment dated [DATE] revealed the resident had a brief interview mental status score of 12, indicating mild to moderate cognitive impairment. Review of Resident #75's progress notes revealed the last Plan of Care Conference was dated 10/08/25. Resident #75's Care Plan documentation and his medical record Progress notes from 10/09/25 to 05/01/26 did not reveal any documented evidence that a quarterly care conference was completed. Interview on 04/22/26 at 2:03 P.M. with SSD #373 revealed many of the care conferences were missed/not done recently including Resident #75's care conference. Review of the undated policy, Care Conference Resident/Family Participation, revealed the resident and his/her family members are encouraged to participate in the development of the resident's assessment and care planning conference. A baseline care plan is completed within 48 hours of admission and a summary of the baseline care plan will be provided to the resident and/or representative upon request. Advance notice of the care planning conference is provided to the resident and authorized representative. The Social Service director/designee is responsible for contacting the resident's family and/or maintaining records for such notices. A comprehensive care plan is developed within seven days of completing the resident assessment by the interdisciplinary team. This deficiency represents non-compliance investigated under Complaint Number 2593029.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy the facility failed to timely notify the responsible party and physician of changes. This affected four residents (#2, #56, #138 and #153) of five residents reviewed for notification of change. Facility census was 151. Findings include:1.Review of Resident #56's medical record revealed an admission date of 01/30/24 and diagnoses including schizoaffective disorder bipolar type, generalized anxiety disorder, depression, type two diabetes, dementia with mood disturbance and chronic kidney disease stage three. Review of an annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 had severe cognitive impairment and had two or more falls since the previous assessment without injury. Review of a fall investigation dated 12/31/25 at 2:45 A.M. revealed Resident #56 tried to transfer herself from her wheelchair to her toilet and fell to the floor. The report indicated the nurse practitioner (NP) was notified. Under the report section, 'Agencies/People Notified,' Resident #56's family member was documented as having been notified regarding her fall on 01/02/26 at 1:57 P.M. Review of a hand-written investigation follow-up form included with the fall investigation dated 12/31/25 revealed Licensed Practical Nurse (LPN) #327 notified Resident #56's family regarding her fall on 01/02/26 at 1:50 P.M. Review of a progress note dated 01/07/26 at 6:56 A.M. revealed NP and [Resident #56's] family updated on resident's fall with no new orders. Family updated on room change recommendations. Interview on 04/30/26 at 2:40 P.M. with the Director of Nursing (DON) revealed if a fall occurred after hours, she expected staff to notify the family and physician within the shift the incident occurred in. During the interview the DON verified that notification to Resident #56's family two days after she fell was not timely notification as required. 2. Review of Resident #153's closed medical record revealed an admission date of 04/23/25 and diagnoses including dementia with other behavioral disturbance, unspecified protein-calorie malnutrition, type two diabetes, unspecified psychosis, hypertension, delusional disorders, altered mental status and depression. Resident #153 discharged to the hospital and then on to another facility on 09/19/25. Review of a quarterly MDS 3.0 assessment dated [DATE] revealed Resident #153 was cognitively impaired and displayed other behaviors one to three days over the seven day look-back period. Review of a progress note dated 05/11/25 at 9:31 A.M. revealed Resident #153 continued to remove his wanderguard (device used to alert staff of unauthorized leave of absence). Wanderguard replaced this morning. Resident #153 became upset and speaking Spanish when replaced to left ankle. Review of a progress note dated 05/14/25 at 11:11 A.M. revealed Resident #153 removed his wanderguard again. New one replaced to left extremity. Review of a progress note dated 05/14/25 at 2:00 P.M. revealed despite much encouragement, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	explanation of need and possible adverse effects given, [Resident #153] refused Depakote (medication) three times stating, I am not a child, I know what you are doing. Review of a progress note dated 05/24/25 at 1:53 P.M. revealed Resident #153 was without his wanderguard to left lower extremity. When asked, Resident #153 stated he was unsure where the wanderguard was. New wanderguard was placed. Review of an electronic Medication Administration Record (e-MAR) note dated 05/27/25 at 2:23 P.M. revealed there was no wanderguard present on Resident #153. Review of an e-MAR note dated 05/31/25 at 2:04 P.M. revealed there was no wanderguard present on Resident #153 and the supervisor was made aware. Review of an e-MAR note dated 06/01/25 at 2:30 P.M. revealed Resident #153 keeps removing [the wanderguard] and cannot find it in his room. Review of a progress note dated 06/27/25 at 1:54 P.M. revealed despite much encouragement and explanation of need given, refused shower three times. Resident #153 repeatedly stated 'no.' Further review of Resident #153's medical record revealed no evidence the physician and Resident #153's family member were notified regarding Resident #153's above refusals of his wanderguard, showers and medications. Interview on 04/29/26 at 4:20 P.M. with the DON verified there was no evidence the facility notified the physician or Resident #153's family member regarding Resident #153 removing his wanderguard on 05/11/25, 05/24/25, 05/27/25, 05/31/25 and 06/01/25, refusing medications on 05/14/25 and refusing showers on 06/27/25. 3. Review of the medical record for Resident #2 revealed an admission date of 03/02/26 and diagnoses including dementia, fracture of first lumbar vertebra, multiple fractures of ribs on left side, repeated falls, contusion of scalp, unsteadiness on feet, generalized muscle weakness, adult failure to thrive, and need for assistance with personal care. Review of Weight Summary revealed Resident #2 had an admission weight on 03/02/26 of 184.0 pounds. Additional weights were obtained: on 03/12/26 at 175.0 pounds, on 03/13/26 at 173.0 pounds, on 03/19/26 at 173.0 pounds, on 03/27/26 at 172.0 pounds, on 04/10/26 at 172.2 pounds, on 04/17/26 at 128.5 pounds, and on 04/22/26 at 129.6 pounds. Review of a Medicare MDS admission assessment dated [DATE] revealed Resident #2 had a brief interview for mental status (BIMS) score of 03 indicating severe cognitive impairment. Resident #2 had significant weight loss not on prescribed weight loss regimen. Further review of the medical record for Resident #2 revealed no evidence Resident #2's son who was identified as an emergency contact was notified of the weight changes including significant weight loss. Interview on 04/30/26 at 7:39 A.M. with DON confirmed there was no evidence Resident #2's family was notified of significant weight changes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of facility policy Nutrition (Impaired)/Unplanned Weight Loss – Clinical Protocol dated August 2008 revealed staff would notify the resident's family of significant weight losses, weight gains, decline of appetite, or decline in food intake. 4. Review of the medical record for Resident #138 revealed an admission date of 11/25/24 and diagnoses including dementia with mood disturbance, chronic kidney disease, generalized anxiety disorder, hyperlipidemia, osteoarthritis, and essential hypertension. Review of Medicare MDS assessment dated [DATE] revealed Resident #138 required substantial/maximal assistance from staff for personal hygiene, bathing, and upper body dressing and was dependent on staff assistance for lower body dressing and toileting hygiene. Resident #138 had short- and long-term memory problems and severely impaired decision-making ability. Resident #138 was noted to have delusions. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #138 was unable to participate in interview resulting in score of 99. Review of progress note dated 03/27/26 at 2:20 P.M. revealed Resident #138's right wrist was red and swollen. Resident #138 complained of pain when moving the wrist. NP was notified and gave new orders for x-ray and two tablets of Tylenol 500 milligrams twice daily for three days for pain. There were no noted accidents or events related to the redness, swelling, and pain. Review of NP progress note dated 03/27/26 revealed Resident #138 was seen for evaluation of right wrist pain. There was noted redness and swelling. There were no related falls and resident was unable provide details other than the area was painful. Resident #138 noted to be an irritated mood. Noted right forearm bruising on physical exam. New orders for an x-ray and addition of 1000 milligrams of Tylenol twice daily for three days. Review of radiology result dated 03/28/26 at 12:00 A.M. revealed x-ray resulted with no evidence of acute fracture or dislocation of right wrist. Review of NP progress note dated 03/30/26 revealed the NP was unable to determine an underlying reason for swelling, redness, and pain. A new order for Voltaren one percent two grams applied twice daily for seven days. Review of progress note dated 03/30/26 at 12:11 P.M. revealed Resident #138's son who was identified as her resident representative was notified of redness, swelling, and pain to Resident #138's right wrist and results of an x-ray. Interview on 04/30/26 at 7:39 A.M. with Director of Nursing (DON) confirmed there was no evidence Resident #138's resident representative was notified of the redness, swelling, and pain to Resident #138's right wrist, need for x-ray, and medication change until 03/30/26. Review of facility policy titled Notification of Resident Change in Condition Policy dated August 2015 revealed a licensed nurse would promptly inform the resident's legal representative of a significant change in the resident's physical, mental, or psychosocial status, need to alter treatment significantly or begin a new treatment, and any injury/accident that could require nursing or medical intervention. This deficiency represents non-compliance investigated under Complaint Number 2626558.

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	365655	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of self-reported incidents (SRI) and review of the facility policy, the facility failed to ensure residents were free of misappropriation of controlled medications. This affected four residents (Residents #1, #3, #47 and #154) of five residents reviewed for controlled substances. The facility census was 151. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 01/20/22 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease, heart failure and arthritis. Review of the physician's orders for Resident #1 revealed an order for Oxycodone (opioid medication for pain) 10 milligrams (mg) every four hours dated 03/27/26. The medication was to be administered at 1:00 A.M., 5:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M. and 9:00 P.M. daily. Review of the Medication Administration Record (MAR) for April 2026 for Resident #1 revealed Oxycodone 10 mg was administered on 04/27/26 at 1:00 A.M., 5:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M. and 9:00 P.M. Review of the Patient Controlled Substance Administration Record for Resident #1's Oxycodone 10 mg revealed nursing staff had administered the medication on 04/27/26 at 1:00 A.M., 5:00 A.M., 10:00 A.M., 4:52 P.M., 4:00 P.M. and 10:00 P.M. The record revealed medication times were out of order and did not match the MAR. It was also noted there was an extra dose of medication signed out of the record but not administered to the resident. Interview on 04/29/26 at 11:13 A.M. with the Director of Nursing (DON) revealed she was alerted on 04/28/26 there were discrepancies with Resident #1's Oxycodone administration for 04/27/26. She stated Licensed Practical Nurse (LPN) #338 had documented on the patient controlled substance administration record that she administered Resident #1's Oxycodone 10 mg at 4:00 P.M. However, LPN #338 was not working at that time. She stated LPN #338 did not clock into work until 6:46 P.M. The DON stated the facility initiated an investigation and filed a self-report incident with the State Agency. She stated LPN #338 and LPN #456, who was the nurse on duty on 04/27/26 at 4:52 P.M., were both sent for drug tests which were negative. Interview on 04/29/26 at 11:45 A.M. with Registered Nurse (RN) #457, who is the Assistant Director of Nursing, stated she identified an inconsistency on Resident #1's patient controlled substance administration record on 04/28/26. She stated LPN #456 was working the 7:00 A.M.–7:00 P.M. shift on 04/27/26 and had correctly administered Resident #1's scheduled 5:00 P.M. dose of Oxycodone 10 mg at 4:52 P.M., which matched the MAR. RN #457 reported that the next entry on the controlled substance record showed an additional administration of Oxycodone at 4:00 P.M., documented and signed by LPN #338, who was not working at that time. She confirmed the signature on the 4:00 P.M. entry matched LPN #338's other signatures on the page. RN #457 verified that Resident #1 did not receive an extra dose of Oxycodone on 04/27/26. However, she was unable to account for the medication associated with the incorrect 4:00 P.M. entry. Interviews were attempted on 04/29/26 at 1:33 P.M. and at 3:34 P.M. with LPN #338 without success. Messages were left with no return contact made. Interview on 04/29/26 at 2:20 P.M. with Resident #1 revealed he was concerned about getting his pain medications timely. He stated he was worried that he would not be able to remember if he got his (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	medications as ordered. Review of the facility policy titled, Medication Dispensing System, undated, revealed nursing staff were to verify each medication preparation that the medication was the right drug, right dose, right route, right rate, right time and for the right customer. Review of the facility policy titled, Abuse Prevention Program, dated February 2017, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings without the resident's consent. The facility was to ensure the residents were free from abuse, neglect, exploitation, misappropriation of property or mistreatment. 2. Review of the medical record for Resident #154 revealed an admission date 05/13/25 with diagnoses including malignant neoplasm of the lung (cancer), chronic obstructive pulmonary disease, diabetes mellitus and back pain. She was discharged home on [DATE]. Review of the physician's orders for Resident #154 revealed she had an order for Oxycodone (opioid medication for pain) 5 milligrams (mg) every eight hours as needed for pain dated 12/01/25. Review of the Patient Controlled Substance Administration Record for Resident #154's Oxycodone 5 mg Rx #206039493 revealed 30 tablets had been received on 12/02/25. The first dose was administered on 12/13/25 at 8:15 P.M. and the last dose on the card was administered on 12/25/25 at 8:30 P.M. There were 23 tablets remaining on the card. Review of the Controlled Medication Shift Change Log dated 12/26/25 revealed Registered Nurse (RN) #452, the Assistant Director of Nursing, had removed Resident #154's card of Oxycodone 5 mg Rx #206039493 with 23 remaining tablets from the medication cart. Her signature was the only one noted with the removal of the medication. Review of the witness statement by Licensed Practical Nurse (LPN) #327 revealed on 12/26/25 RN #452 had come to her medication cart to check the narcotic book. She stated RN #452 stated there were errors on Resident #154's Oxycodone card so she removed the signature sheet along with the card of remaining pills. LPN #327 asked if she wanted her to assist in destroying the medication with RN #452, but RN #452 had responded she could only do it with another department head. Review of the witness statement dated 12/29/25 by LPN #317, Assistant Director of Nursing, revealed she was doing audits on 12/29/25 of the narcotic count sheets and noted Oxycodone for Resident #154 was removed from the medication cart on 12/26/25. She stated she could not find the patient controlled substance administration record or the reason it was removed. LPN #317 stated she interviewed LPN #327 who stated RN #452 removed Resident #152's Oxycodone card with the medications stating there were discrepancies on the card. LPN #327 stated RN #452 did not want her to waste the remaining narcotics with her. LPN #317 stated she then interviewed RN #452 about the discrepancy and she became nervous and flustered and her hands were shaking. RN #452 stated she had wasted the Oxycodone with LPN #327. LPN #317 stated she had spoken to LPN #327 who denied wasting the medication with her. RN #452 then began to pull papers out of her personal back pack and then wanted to go to her car to look for the narcotic card. RN #452 could not explain why she had removed the card and was unable to produce the medication. RN #452 provided the patient controlled substance administration record to LPN #317 for Resident #154's Oxycodone 5 mg which revealed there were 23 tablets remaining. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the emailed statement dated 12/30/25 by RN #452 revealed she was notified by the floor nurse there was an error on the patient controlled substance administration record for Resident #154's Oxycodone. She stated she reviewed the record and updated pharmacy who stated they were sending a new card of Oxycodone to the facility. RN #452 stated she took the card of medication out of the medication cart and placed it in her office. She stated before she left the facility for the day she destroyed the medication prior to leaving because she did not want them in her office over the weekend. She did not identify any other staff having assisted her in destroying the Oxycodone for Resident #154. Interview on 04/22/26 at 9:11 A.M. with the DON verified the facility had not filed a self-reported incident (SRI) incident for misappropriation with the State Agency related to Resident #154's Oxycodone 5 mg. The DON verified RN #452 was unable to produce the Oxycodone 5 mg with the 23 remaining tablets. Interview on 05/04/26 at 8:35 A.M. with the DON revealed nursing staff were not re-educated on medication administration or narcotic handling since their orientation on hire to the facility. Review of the facility policy titled, Schedule II Controlled Substance Medication, undated, revealed all controlled dangerous substances would be stored under double lock. If the controlled medication could not be accounted for, the DON should be notified immediately and a report of theft or loss of controlled form would be forwarded to the appropriate authorities. All medication destruction in the facility should be witnessed by at least two persons (an RN, LPN or pharmacist consultant). A record of each instance of the drug destruction should be maintained. Review of the facility policy titled, Abuse Prevention Program, dated February 2017, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings without the resident's consent. The facility was to ensure the residents were free from abuse, neglect, exploitation, misappropriation of property or mistreatment. 3. Review of the medical record for Resident #47 revealed an admission date of 05/15/25 with diagnoses including schizoaffective disorder, depression, anxiety, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 had impaired cognition. Review of Resident #47's physician orders revealed an order for Lyrica (anticonvulsant controlled substance) 100 milligrams twice a day that started on 06/06/25. Review of Resident #47's medication administration record (MAR) for November 2025 revealed the morning dose on 11/12/25 was not administered since it was not available. Review of Resident #47's Lyrica count sheets revealed no doses were signed out on 11/12/25. Review of SRI tracking number 267482 dated 11/12/25 revealed the facility staff reported that Resident #47's Lyrica was misplaced. A new order of Lyrica was ordered from the pharmacy. The facility immediately initiated an investigation. The physician and police were notified. The facility unsubstantiated the SRI stating evidence was inconclusive that misappropriation occurred. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility investigation for SRI tracking number 267482 revealed Resident #47 was not interviewed. There were no interviews with like residents related to the SRI. Resident #47's family was not notified. The Alleged Perpetrator, a witness, and other staff were interviewed regarding the SRI. Interview on 05/04/26 at 8:35 A.M. with the DON revealed the nurses has had no additional competencies for medication administration since hire even though there were concerns with misappropriation and possible narcotic diversion. The DON stated the in-services provided were the competencies the nurses were set up to complete. Interview on 05/04/26 at 11:01 A.M. with the DON revealed a previous administrator handled the SRI and indicated the SRI was unsubstantiated due to the Alleged Perpetrator not having the intent to steal the medication. The DON indicated she was notified of the missing medication and assisted in trying to locate the medication. The Alleged Perpetrator that misplaced the medication was training and it was lost due to being busy with the nurse trainee. The Alleged Perpetrator was drug tested on [DATE] with a negative result. The DON confirmed Resident #47 was not interviewed nor were other residents since it was a missing medication card. The DON confirmed Resident #47's family was not notified of the misplaced medication. Also, there was no education provided to the facility staff in regard to misappropriation. Interview on 05/04/2026 at 12:30 PM with the DON revealed Resident #47 did not receive Lyrica on 11/12/25 even though a dose was marked on the MAR as given for the evening dose. Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. Review of the facility's controlled substance medication policy, undated, revealed when the licensed staff member/nurse receives a controlled dangerous substance medication from the pharmacy, he/she will verify the contents with the label and will note the date received and quantity on the declining inventory form. 4. Resident #3 was admitted to the facility at 01/12/26, with diagnosis including cellulitis, non-pressure chronic ulcer of unspecified part of right lower leg , type two diabetes mellitus with diabetic neuropathy, and peripheral vascular disease. Resident #3 Quarterly Minimum Data Set, dated [DATE] revealed the resident had a Brief Mental Status of 15, revealing the resident was mentally intact. Resident was independent on bed mobility, independent with upper and lower dressing, independent on transfers, could ambulate with a walker for 150 feet independently. Review of Resident #3's care plan dated revised 04/18/26 revealed Resident #3 can be resistant of care including physical therapies, goes out for long leave of absences, (LOA), refuses to elevate leg than complains of pain, and can be verbally aggressive. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #3's physician orders for April 2026 revealed orders for Oxycodone HCl tablet five milligrams orally on wound care day, assess for pain, Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) give one tablet by mouth every 24 hours as needed for pain on wound care days one hour prior to appointment, do not give as needed (PRN) dose within one hour other PRN dose. All Oxycodone orders had been discontinued by 04/09/26. Review of the Resident#3's MAR and Resident #3's Narcotic Medication Administration Log revealed on 04/01/26 LPN #393 signed the controlled substance administration sheet stating she gave Oxycodone to resident but did not document in electronic MAR. On 04/05/26 LPN #425 signed the controlled substance administration sheet stating she gave Oxycodone to Resident #3 but did not document in electronic MAR. Interview on 04/30/26 at 11:58 A.M. with DON regarding Resident #3 Oxycodone not being administered on 04/01/26 and 04/05/26 but the medication being removed revealed on 04/01/26 the nurse was LPN #393 and nurse on 04/05/26 was LPN #425. DON revealed they would begin an investigation and submit a SRI Interview on 04/30/26 at 1:32 P.M. with Resident #3 revealed he was received Oxycodone medication when his wound was worse, but feel his wound was better, his pain was no longer as intense, his Oxycodone was no longer needed and he did not recall if he received his Oxycodone on 04/01/26 and 04/05/26. Review of the facility's SRI dated 04/30/26 revealed on 04/01/26 LPN #425 signed the controlled substance administration sheet stating she gave Oxycodone to Resident #3 but did not document in electronic MAR. On 04/05/26 LPN #393 signed the controlled substance administration sheet stating she gave Oxycodone to same resident but did not document in electronic MAR. The nurse practitioner and the resident's family were notified. Both LPNs were suspended pending investigation. Resident #3 was at his normal baseline; no ill effects were noted. The Ohio Department of Health surveyor and the Ohio Attorney General were aware. Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. Review of the facility's controlled substance medication policy, undated, revealed when the licensed staff member/nurse receives a controlled dangerous substance medication from the pharmacy, he/she will verify the contents with the label and will note the date received and quantity on the declining inventory form. This deficiency represents non-compliance investigated under Complaint Number 2668600 and 2990856.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of self-reported incidents (SRI) and review of the facility policy, the facility failed to implement and follow their policy for allegations of abuse for residents. This affected four residents (Residents #47, #98, #138, #154) of fifteen residents reviewed for abuse. The facility census was 151. Findings include:1. Review of the medical record for Resident #154 revealed an admission date 05/13/25 with diagnoses including malignant neoplasm of the lung (cancer), chronic obstructive pulmonary disease, diabetes mellitus and back pain. She was discharged home on [DATE]. Review of the physician's orders for Resident #154 revealed she had an order for Oxycodone (opioid medication for pain) 5 milligrams (mg) every eight hours as needed for pain dated 12/01/25. Review of the Patient Controlled Substance Administration Record for Resident #154's Oxycodone 5 mg Rx #206039493 revealed 30 tablets had been received on 12/02/25. The first dose was administered on 12/13/25 at 8:15 P.M. and the last dose on the card was administered on 12/25/25 at 8:30 P.M. There were 23 tablets remaining on the card. Review of the Controlled Medication Shift Change Log dated 12/26/25 revealed Registered Nurse (RN) #452, the Assistant Director of Nursing, had removed Resident #154's card of Oxycodone 5 mg Rx #206039493 with 23 remaining tablets from the medication cart. Her signature was the only one noted with the removal of the medication. Review of the witness statement by Licensed Practical Nurse (LPN) #327 revealed on 12/26/25 RN #452 had come to her medication cart to check the narcotic book. She stated RN #452 stated there were errors on Resident #154's Oxycodone card so she removed the signature sheet along with the card of remaining pills. LPN #327 asked if she wanted her to assist in destroying the medication with RN #452, but RN #452 had responded she could only do it with another department head. Review of the witness statement dated 12/29/25 by LPN #317, Assistant Director of Nursing, revealed she was doing audits on 12/29/25 of the narcotic count sheets and noted Oxycodone for Resident #154 was removed from the medication cart on 12/26/25. She stated she could not find the patient controlled substance administration record or the reason it was removed. LPN #317 stated she interviewed LPN #327 who stated RN #452 removed Resident #152's Oxycodone card with the medications stating there were discrepancies on the card. LPN #327 stated RN #452 did not want her to waste the remaining narcotics with her. LPN #317 stated she then interviewed RN #452 about the discrepancy and she became nervous and flustered and her hands were shaking. RN #452 stated she had wasted the Oxycodone with LPN #327. LPN #317 stated she had spoken to LPN #327 who denied wasting the medication with her. RN #452 then began to pull papers out of her personal back pack and then wanted to go to her car to look for the narcotic card. RN #452 could not explain why she had removed the card and was unable to produce the medication. RN #452 provided the patient controlled substance administration record to LPN #317 for Resident #154's Oxycodone 5 mg which revealed there were 23 tablets remaining. Review of the emailed statement dated 12/30/25 by RN #452 revealed she was notified by the floor nurse there was an error on the patient controlled substance administration record for Resident #154's Oxycodone. She stated she reviewed the record and updated pharmacy who stated they were sending a new card of Oxycodone to the facility. RN #452 stated she took the card of medication out (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	of the medication cart and placed it in her office. She stated before she left the facility for the day she destroyed the medication prior to leaving because she did not want them in her office over the weekend. She did not identify any other staff having assisted her in destroying the Oxycodone for Resident #154. Interview on 04/22/26 at 9:11 A.M. with the Director of Nursing (DON) verified the facility had not filed a self-reported incident (SRI) incident for misappropriation with the State Agency related to Resident #154's Oxycodone 5 mg. She verified a thorough investigation was not completed and the facility did not follow their policy. Review of the facility policy titled, Abuse Prevention Program, dated February 2017, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings without the resident's consent. The facility stated it was to report immediately or no later than 24 hours to the State Agency, local law enforcement and the resident's representative. The facility policy stated upon learning of the allegation of misappropriation of resident properly it would initiate an incident and investigation. 2. Review of the medical record for Resident #138 revealed an admission date of 11/25/24 and diagnoses including dementia with mood disturbance, chronic kidney disease, generalized anxiety disorder, hyperlipidemia, osteoarthritis, and essential hypertension. Review of progress note dated 11/22/25 at 8:15 A.M. revealed Resident #138 had grayish black ecchymosis areas to left outer upper arm, left outer wrist area, and right inner arm. Resident #138 did not complain of any pain. Resident #138 was noted to have fragile skin and was on a daily aspirin. Resident #138 was noted to ambulate independently. There were no noted accidents or events related to bruising. Review of Self-Reported Incident (SRI) Form number 267836 dated 11/22/25 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted bruising on Resident #138's left upper outer arm, left outer wrist, and right inner wrist. Resident #138 was unable to report what had happened. It was noted the facility did not suspect abuse due to location and shape of bruising. It was noted Resident #138 can be combative with care and independently ambulates on the unit. The facility was unable to determine the origin of bruising. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 267836 revealed no identification of root cause. There was no evidence of any environmental inspection. There was no evidence of staff re-training related to the occurrence and investigation of an injury of unknown origin. Review of Nurse Practitioner (NP) progress note dated 11/24/25 revealed Resident #138 seen for evaluation for contusion to the arm. NP ordered long sleeves to protect skin. Resident #138 noted to be poor historian and pleasantly confused. Nursing staff reported Resident #138 had intermittent bruising. Plan to continue monitoring for ongoing occurrences and monitor for symptoms suggestive of anemia. Review of progress note dated 01/23/26 at 10:00 P.M. revealed Resident #138 had a lump with bruising on right forearm. There was also bruising noted to inner right forearm. Resident #138 denied pain. Resident #138 was unable to report what had happened. Resident #138 was noted to have a history of being combative with care. There were no noted accidents or events related to bruising or a (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	lump. Review of progress note dated 01/23/26 at 10:30 P.M. revealed Resident #138 had order for x-ray to the right forearm and new order for antibiotics. Review of Self-Reported Incident (SRI) Form number 270153 dated 01/23/26 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted a lump with bruising on Resident #138's lateral right forearm and bruising on medial forearm. Resident #138's family and NP were notified. The facility initiated 15-minute checks. Resident #138 was unable to provide a description of what had happened to her arm. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 270153 revealed no identification of root cause. There was no evidence of any environmental inspection. There was no evidence of additional residents being evaluated for bruising. There was no evidence of staff re-training related to the occurrence and investigation of an injury of unknown origin. Review of radiology result dated 01/24/26 at 11:57 A.M. revealed no evidence of acute fracture. There was noted soft tissue swelling over the latera aspect of proximal shaft of the radius consistent with hematoma. Review of progress note dated 01/24/26 at 12:45 P.M. revealed a new order to elevate and ice area on right forearm. Staff were to monitor area and call NP if the area had additional spread. Review of NP progress note dated 01/26/26 revealed Resident #138 seen for evaluation of bruise to right forearm. The bruise was of unknown etiology per nursing and Resident #138. There was no noted trauma or injury. New orders for Doxycycline 100 mg twice daily for seven days, elevate and ice area, and x-ray. Physical exam revealed poor strength, range of motion was normal to right arm and wrist, and there was no erythema. Resident #138 remained pleasantly confused. NP unable to identify etiology of bruising. Review of progress note dated 01/28/26 at 10:19 P.M. revealed Resident #138 had a doppler test completed to the bruised and swollen right forearm area. There was no evidence of deep vein thrombosis. Review of radiology result dated 01/28/26 at 8:48 P.M. revealed a doppler scan resulted with no evidence of deep venous thrombosis in right upper extremity veins. Review of Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #138 required substantial/maximal assistance from staff for personal hygiene, bathing, and upper body dressing and was dependent on staff assistance for lower body dressing and toileting hygiene. Resident #138 had short- and long-term memory problems and severely impaired decision-making ability. Resident #138 was noted to have delusions. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #138 was unable to participate in interview resulting in score of 99. Review of progress note dated 03/27/26 at 2:20 P.M. revealed Resident #138's right wrist was red and swollen. Resident #138 complained of pain when moving the wrist. NP was notified and gave new (continued on next page)

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	365655	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	orders for x-ray and two tablets of Tylenol 500 milligrams twice daily for three days for pain. There were no noted accidents or events related to the redness, swelling, and pain. Review of facility's SRIs revealed no evidence an SRI was reported to the State Agency on or around 03/27/26 for an injury of unknown origin for Resident #138. There was no evidence of investigation to determine root cause of redness, swelling, and pain to Resident #138's wrist. Review of NP progress note dated 03/27/26 revealed Resident #138 was seen for evaluation of right wrist pain. There was noted redness and swelling. There were no related falls and resident was unable provide details other than the area was painful. Resident #138 noted to be an irritated mood. Noted right forearm bruising on physical exam. New orders for an x-ray and addition of 1000 milligrams of Tylenol twice daily for three days. Review of radiology result dated 03/28/26 at 12:00 A.M. revealed x-ray resulted with no evidence of acute fracture or dislocation of right wrist. Review of NP progress note dated 03/30/26 revealed the NP was unable to determine an underlying reason for swelling, redness, and pain. A new order for Voltaren one percent two grams applied twice daily for seven days. Interview on 04/30/26 at 7:39 A.M. with Director of Nursing (DON) revealed Resident #138 was supposed to walk with assistance from staff, however, did not always remember to ask for help. Resident #138 was not known to get into altercations with other residents. Resident #138 had impaired cognition. SRIs #267836 and #270153 were reviewed and the DON confirmed she was unable to locate evidence to support a root cause was identified to sufficiently rule out abuse. DON confirmed an SRI was not filed Resident #138's wrist presenting with redness, swelling, and pain despite history with injuries of unknown origin presenting in a similar manner. DON reported there was no bruise, so an SRI was not filed. Review of facility policy titled Abuse Prevention Program dated February 2017 revealed an appointed investigator would at a minimum interview the person reporting the incident, interview anyone with direct knowledge of the incident, obtain written statements, and gather any pertinent medical records. An injury would be classified as an injury of unknown source when both conditions were met: the source of injury was not observed or could not be explained and the injury is suspicious due to location, extent, or incidence of injuries over time. The injury would be reported to the State Agency and investigated following the abuse policy. 3. Review of the medical record for Resident #47 revealed an admission date of 05/15/25 with diagnoses including schizoaffective disorder, depression, anxiety, and bipolar disorder. Review of Resident #47's physician orders revealed an order for Lyrica (anticonvulsant controlled substance) 100 milligrams twice a day that started on 06/06/25. Review of Resident #47's medication administration record (MAR) for November 2025 revealed the morning dose on 11/12/25 was not administered since it was not available. Review of Resident #47's Lyrica count sheets revealed no doses were signed out on 11/12/25. Review of SRI tracking number 267482 dated 11/12/25 revealed the facility staff reported that (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #47's Lyrica was misplaced. A new order of Lyrica was ordered from the pharmacy. The facility immediately initiated an investigation. The physician and police were notified. The facility unsubstantiated the SRI stating evidence was inconclusive that misappropriation occurred. Review of the facility investigation for SRI tracking number 267482 revealed Resident #47 was not interviewed. There were no interviews with like residents related to the SRI. Resident #47's family was not notified. Interview on 05/04/26 at 11:01 A.M. with the DON revealed a previous administrator handled the SRI and indicated the SRI was unsubstantiated due to the Alleged Perpetrator not having the intent to steal the medication. The DON indicated she was notified of the missing medication and assisted in trying to locate the medication. The Alleged Perpetrator that misplaced the medication was training and it was lost due to being busy with the nurse trainee. The Alleged Perpetrator was drug tested on [DATE] with a negative result. The DON confirmed Resident #47 was not interviewed nor were other residents since it was a missing medication card. The DON confirmed Resident #47's family was not notified of the misplaced medication. Also, there was no education provided to the facility staff in regard to misappropriation. Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. 4. Review of the medical record for Resident #98 revealed an admission date of 05/21/25 with diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, anxiety, depression, and chronic kidney disease. Review of SRI tracking number 271768 dated 03/05/26 revealed Resident #98 alleged a certified nurse assistant spoke to her in an unfriendly way and cursed at her. The certified nurse assistant was suspended pending investigation. No known witnesses noted. Resident questioned with no known issues noted. Staff questioned with no known issues noted. Based on the facility's investigation the allegation was unsubstantiated. Evidence indicated abuse, neglect or misappropriation did not occur. Review of the facility investigation for SRI tracking number 267482 revealed Resident #98 was interviewed but no statement provided. There were interviews with residents but they were not dated and did not cover all the resident in the area of the alleged incident. There was no assessment completed on Resident #98 following the allegation. There were staff interviews but it was not specific to the allegation and not dated. Also there was no education provided to the staff regarding abuse. Interview on 04/30/26 at 12:26 P.M. with the Administrator revealed resident statements were obtained but not dated and not all residents from the area of the alleged incident. There was no resident assessment completed. There was no abuse training completed for the staff. Staff statements were included in the investigation but they were not specific to the allegation and no dates listed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. This deficiency represents non-compliance investigation under Complaint Number 2668600, 2990856, and 2992799.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of self-reported incident (SRI) and review of the facility policy, the facility failed to thoroughly investigate an allegation of abuse, misappropriation and injury of unknown origin for residents. This affected four (Residents #47, #98, #138, #154) of fifteen residents reviewed for abuse. The facility census was 151. Findings include: 1. Review of the medical record for Resident #154 revealed an admission date 05/13/25 with diagnoses including malignant neoplasm of the lung (cancer), chronic obstructive pulmonary disease, diabetes mellitus and back pain. She was discharged home on [DATE]. Review of the physician's orders for Resident #154 revealed she had an order for Oxycodone (opioid medication for pain) 5 milligrams (mg) every eight hours as needed for pain dated 12/01/25. Review of the Patient Controlled Substance Administration Record for Resident #154's Oxycodone 5 mg Rx #206039493 revealed 30 tablets had been received on 12/02/25. The first dose was administered on 12/13/25 at 8:15 P.M. and the last dose on the card was administered on 12/25/25 at 8:30 P.M. There were 23 tablets remaining on the card. Review of the Controlled Medication Shift Change Log dated 12/26/25 revealed Registered Nurse (RN) #452, the Assistant Director of Nursing, had removed Resident #154's card of Oxycodone 5 mg Rx #206039493 with 23 remaining tablets from the medication cart. Her signature was the only one noted with the removal of the medication. Review of the witness statement by Licensed Practical Nurse (LPN) #327 revealed on 12/26/25 RN #452 had come to her medication cart to check the narcotic book. She stated RN #452 stated there were errors on Resident #154's Oxycodone card so she removed the signature sheet along with the card of remaining pills. LPN #327 asked if she wanted her to assist in destroying the medication with RN #452, but RN #452 had responded she could only do it with another department head. Review of the witness statement dated 12/29/25 by LPN #317, Assistant Director of Nursing, revealed she was doing audits on 12/29/25 of the narcotic count sheets and noted Oxycodone for Resident #154 was removed from the medication cart on 12/26/25. She stated she could not find the patient controlled substance administration record or the reason it was removed. LPN #317 stated she interviewed LPN #327 who stated RN #452 removed Resident #152's Oxycodone card with the medications stating there were discrepancies on the card. LPN #327 stated RN #452 did not want her to waste the remaining narcotics with her. LPN #317 stated she then interviewed RN #452 about the discrepancy and she became nervous and flustered and her hands were shaking. RN #452 stated she had wasted the Oxycodone with LPN #327. LPN #317 stated she had spoken to LPN #327 who denied wasting the medication with her. RN #452 then began to pull papers out of her personal back pack and then wanted to go to her car to look for the narcotic card. RN #452 could not explain why she had removed the card and was unable to produce the medication. RN #452 provided the patient controlled substance administration record to LPN #317 for Resident #154's Oxycodone 5 mg which revealed there were 23 tablets remaining. Review of the emailed statement dated 12/30/25 by RN #452 revealed she was notified by the floor nurse there was an error on the patient controlled substance administration record for Resident #154's Oxycodone. She stated she reviewed the record and updated pharmacy who stated they were sending a new card of Oxycodone to the facility. RN #452 stated she took the card of medication out (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	of the medication cart and placed it in her office. She stated before she left the facility for the day she destroyed the medication prior to leaving because she did not want them in her office over the weekend. She did not identify any other staff having assisted her in destroying the Oxycodone for Resident #154. Interview on 04/22/26 at 9:11 A.M. with the Director of Nursing (DON) verified the facility had not filed a self-reported incident (SRI) incident for misappropriation with the State Agency related to Resident #154's Oxycodone 5 mg. She verified a thorough investigation was not completed. Review of the facility policy titled, Abuse Prevention Program, dated February 2017, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings without the resident's consent. The facility stated it was to report immediately or no later than 24 hours to the State Agency, local law enforcement and the resident's representative. The facility policy stated upon learning of the allegation of misappropriation of resident properly it would initiate an incident and investigation. 2. Review of the medical record for Resident #138 revealed an admission date of 11/25/24 and diagnoses including dementia with mood disturbance, chronic kidney disease, generalized anxiety disorder, hyperlipidemia, osteoarthritis, and essential hypertension. Review of progress note dated 11/22/25 at 8:15 A.M. revealed Resident #138 had grayish black ecchymosis areas to left outer upper arm, left outer wrist area, and right inner arm. Resident #138 did not complain of any pain. Resident #138 was noted to have fragile skin and was on a daily aspirin. Resident #138 was noted to ambulate independently. There were no noted accidents or events related to bruising. Review of SRI Form number 267836 dated 11/22/25 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted bruising on Resident #138's left upper outer arm, left outer wrist, and right inner wrist. Resident #138 was unable to report what had happened. It was noted the facility did not suspect abuse due to location and shape of bruising. It was noted Resident #138 can be combative with care and independently ambulates on the unit. The facility was unable to determine the origin of bruising. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 267836 revealed no identification of root cause. There was no evidence of any environmental inspection. There was no evidence of staff re-training related to the occurrence and investigation of an injury of unknown origin. Review of Nurse Practitioner (NP) progress note dated 11/24/25 revealed Resident #138 seen for evaluation for contusion to the arm. NP ordered long sleeves to protect skin. Resident #138 noted to be poor historian and pleasantly confused. Nursing staff reported Resident #138 had intermittent bruising. Plan to continue monitoring for ongoing occurrences and monitor for symptoms suggestive of anemia. Review of progress note dated 01/23/26 at 10:00 P.M. revealed Resident #138 had a lump with bruising on right forearm. There was also bruising noted to inner right forearm. Resident #138 denied pain. Resident #138 was unable to report what had happened. Resident #138 was noted to have a history of being combative with care. There were no noted accidents or events related to bruising or a lump. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of progress note dated 01/23/26 at 10:30 P.M. revealed Resident #138 had order for x-ray to the right forearm and new order for antibiotics. Review of Self-Reported Incident (SRI) Form number 270153 dated 01/23/26 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted a lump with bruising on Resident #138's lateral right forearm and bruising on medial forearm. Resident #138's family and NP were notified. The facility initiated 15-minute checks. Resident #138 was unable to provide a description of what had happened to her arm. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 270153 revealed no identification of root cause. There was no evidence of any environmental inspection. There was no evidence of additional residents being evaluated for bruising. There was no evidence of staff re-training related to the occurrence and investigation of an injury of unknown origin. Review of radiology result dated 01/24/26 at 11:57 A.M. revealed no evidence of acute fracture. There was noted soft tissue swelling over the latera aspect of proximal shaft of the radius consistent with hematoma. Review of progress note dated 01/24/26 at 12:45 P.M. revealed a new order to elevate and ice area on right forearm. Staff were to monitor area and call NP if the area had additional spread. Review of NP progress note dated 01/26/26 revealed Resident #138 seen for evaluation of bruise to right forearm. The bruise was of unknown etiology per nursing and Resident #138. There was no noted trauma or injury. New orders for Doxycycline 100 mg twice daily for seven days, elevate and ice area, and x-ray. Physical exam revealed poor strength, range of motion was normal to right arm and wrist, and there was no erythema. Resident #138 remained pleasantly confused. NP unable to identify etiology of bruising. Review of progress note dated 01/28/26 at 10:19 P.M. revealed Resident #138 had a doppler test completed to the bruised and swollen right forearm area. There was no evidence of deep vein thrombosis. Review of radiology result dated 01/28/26 at 8:48 P.M. revealed a doppler scan resulted with no evidence of deep venous thrombosis in right upper extremity veins. Review of Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #138 required substantial/maximal assistance from staff for personal hygiene, bathing, and upper body dressing and was dependent on staff assistance for lower body dressing and toileting hygiene. Resident #138 had short- and long-term memory problems and severely impaired decision-making ability. Resident #138 was noted to have delusions. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #138 was unable to participate in interview resulting in score of 99. Review of progress note dated 03/27/26 at 2:20 P.M. revealed Resident #138's right wrist was red and swollen. Resident #138 complained of pain when moving the wrist. NP was notified and gave new orders for x-ray and two tablets of Tylenol 500 milligrams twice daily for three days for pain. There were no noted accidents or events related to the redness, swelling, and pain. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of facility's SRIs revealed no evidence an SRI was reported to the State Agency on or around 03/27/26 for an injury of unknown origin for Resident #138. There was no evidence of investigation to determine root cause of redness, swelling, and pain to Resident #138's wrist. Review of NP progress note dated 03/27/26 revealed Resident #138 was seen for evaluation of right wrist pain. There was noted redness and swelling. There were no related falls and resident was unable provide details other than the area was painful. Resident #138 noted to be an irritated mood. Noted right forearm bruising on physical exam. New orders for an x-ray and addition of 1000 milligrams of Tylenol twice daily for three days. Review of radiology result dated 03/28/26 at 12:00 A.M. revealed x-ray resulted with no evidence of acute fracture or dislocation of right wrist. Review of NP progress note dated 03/30/26 revealed the NP was unable to determine an underlying reason for swelling, redness, and pain. A new order for Voltaren one percent two grams applied twice daily for seven days. Interview on 04/30/26 at 7:39 A.M. with DON revealed Resident #138 was supposed to walk with assistance from staff, however, did not always remember to ask for help. Resident #138 was not known to get into altercations with other residents. Resident #138 had impaired cognition. SRIs #267836 and #270153 were reviewed and the DON confirmed she was unable to locate evidence to support a root cause was identified to sufficiently rule out abuse. DON confirmed an SRI was not filed Resident #138's wrist presenting with redness, swelling, and pain despite history with injuries of unknown origin presenting in a similar manner. DON reported there was no bruise, so an SRI was not filed. Review of facility policy titled Abuse Prevention Program dated February 2017 revealed an appointed investigator would at a minimum interview the person reporting the incident, interview anyone with direct knowledge of the incident, obtain written statements, and gather any pertinent medical records. An injury would be classified as an injury of unknown source when both conditions were met: the source of injury was not observed or could not be explained and the injury is suspicious due to location, extent, or incidence of injuries over time. The injury would be reported to the State Agency and investigated following the abuse policy. 3. Review of the medical record for Resident #47 revealed an admission date of 05/15/25 with diagnoses including schizoaffective disorder, depression, anxiety, and bipolar disorder. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #47 had impaired cognition. Review of SRI tracking number 267482 dated 11/12/25 revealed the facility staff reported that Resident #47's Lyrica was misplaced. A new order of Lyrica (anticonvulsant controlled substance) was ordered from the pharmacy. The facility immediately initiated an investigation. The physician and police were notified. The facility unsubstantiated the SRI stating evidence was inconclusive that misappropriation occurred. Review of the facility investigation for SRI tracking number 267482 revealed Resident #47 was not interviewed. There were no interviews with like residents related to the SRI. Resident #47's family was not notified. The Alleged Perpetrator, a witness, and other staff were interviewed regarding the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	SRI. Interview on 05/04/26 at 8:35 A.M. with the DON revealed the nurses have had no additional competencies for medication administration since hire even though there were concerns with misappropriation and possible narcotic diversion. The DON stated the in-services provided were the competencies the nurses were set up to complete. Interview on 05/04/26 at 11:01 A.M. with the DON revealed a previous administrator handled the SRI and indicated the SRI was unsubstantiated due to the Alleged Perpetrator not having the intent to steal the medication. The DON indicated she was notified of the missing medication and assisted in trying to locate the medication. The Alleged Perpetrator that misplaced the medication was training and it was lost due to being busy with the nurse trainee. The Alleged Perpetrator was drug tested on [DATE] with a negative result. The DON confirmed Resident #47 was not interviewed nor were other residents since it was a missing medication card. The DON confirmed Resident #47's family was not notified of the misplaced medication. Also, there was no education provided to the facility staff in regard to misappropriation. Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. 4. Review of the medical record for Resident #98 revealed an admission date of 05/21/25 with diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, anxiety, depression, and chronic kidney disease. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #98 had intact cognition. Review of SRI tracking number 271768 dated 03/05/26 revealed Resident #98 alleged a certified nurse assistant spoke to her in an unfriendly way and cursed at her. The certified nurse assistant was suspended pending investigation. No known witnesses noted. Resident questioned with no known issues noted. Staff questioned with no known issues noted. Based on the facility's investigation the allegation was unsubstantiated. Evidence indicated abuse, neglect or misappropriation did not occur. Review of the facility investigation for SRI tracking number 267482 revealed Resident #98 was interviewed but no statement provided. There were interviews with residents but they were not dated and did not cover all the resident in the area of the alleged incident. There was no assessment completed on Resident #98 following the allegation. There were staff interviews but it was not specific to the allegation and not dated. Also there was no education provided to the staff regarding abuse. Interview on 04/30/26 at 12:26 P.M. with the Administrator revealed resident statements were obtained but not dated and not all residents from the area of the alleged incident. There was no resident assessment completed. There was no abuse training completed for the staff. Staff statements were included in the investigation but they were not specific to the allegation and no (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	dates listed. Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. This deficiency represents non-compliance investigated under Complaint Number 2668600, 2990856, and 2992799.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure assessments were accurately completed. This affected five (Residents #5, #9, #15, #35 and #107) of 48 residents reviewed for Minimum Data Set (MDS) 3.0 assessments. The facility census was 151. Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 06/25/25 with diagnoses including multiple sclerosis, dementia and obstructive reflux uropathy (a blockage in the urinary tract that stops urine from flowing). Review of Resident #5's physician's orders from March of 2026 revealed she had an indwelling catheter related to obstructive reflux uropathy dated 12/02/25. Review of the nursing progress notes from 03/01/26 through 03/31/26 revealed Resident #5 had a foley catheter. There was no evidence she had any other indwelling devices. Review of the quarterly modified Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed under section H that Resident #5 had an indwelling catheter. It was also documented she had an ostomy (a surgical opening in the abdomen that would allow waste or urine to exit the body). Interview on 05/04/26 at 1:40 P.M. with Licensed Practical Nurse (LPN) #304 verified Resident #5 did not have an ostomy and the MDS was inaccurate. 2. Review of the medical record for Resident #15 revealed an admission date of 02/11/26 with diagnoses including Alzheimer's Disease, hypertension and depression. Review of Resident #15's physician's orders from February of 2026 revealed he had no orders for restraints. Review of the nursing progress notes from 02/11/26 through 02/24/26 revealed Resident #15 had no restraints in place. Review of the quarterly modified Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed under section P that Resident #15 had other restraint used in bed daily. Interview on 04/22/26 at 9:16 A.M. with LPN #379 verified Resident #15 did not have restraints and the MDS was inaccurate. 3. Review of the medical record for Resident #35 revealed an admission date of 06/23/17 with diagnoses including Schizoaffective disorder, hypertension and unsteadiness on feet. Review of the fall investigation follow-up dated 10/29/25 revealed Resident #35 was pushed by another resident and fell to the ground. She had no injuries. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed under section J that Resident #35 had not had any falls since the prior assessment which was 09/29/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 04/30/26 at 8:50 A.M. with LPN #379 verified Resident #35's MDS dated [DATE] was inaccurate as she had a fall on 10/29/25. 4. Review of the medical for Resident #107 revealed an admission date of 03/06/26 and diagnoses including chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia, heart failure, shortness of breath, and dependence on supplemental oxygen. Review of physician order dated 03/08/26 revealed Resident #107 received continuous oxygen therapy at two liters per minute via nasal canula. Review of Treatment Administration Record (TAR) for March 2026 revealed Resident #107 was evaluated for oxygen therapy use three times per day and was documented as receiving as ordered. Review of Medicare Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #107 was coded to not be receiving oxygen therapy. Interview on 04/22/26 at 9:26 A.M. with LPN #379 confirmed Resident #107's admission MDS assessment on 03/12/26 was coded incorrectly for oxygen therapy. 5. Review of the medical record for Resident #9 revealed an admission date of 04/13/23 with diagnoses including Type 2 Diabetes Mellitus. Review of Resident #9's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #9 was taking hypoglycemic medication. Review of Resident #9's physician orders revealed no active anti-diabetic medications. Interview on 04/22/26 at 3:17 P.M. with LPN #379 revealed Resident #9 last received Metformin on 03/14/26 and the assessment reference date (ARD) was 03/25/26 so no diabetic medications were received seven days prior to 03/25/26.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to formulate a complete baseline care plan timely after admission. This affected 22 residents (#2, #3, #4, #9, #12, #15, #48, #50, #53, #56, #62, #81, #91, #95, #98, #100, #107, #113, #117, #139, #154 and #160) of 62 residents reviewed for care plans. Facility census was 151.Findings include:1. Review of Resident #53's medical record revealed an admission date of 08/29/25 and diagnoses including Alzheimer's disease, dementia, depression anxiety and Crohn's disease. Review of a significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had severe cognitive impairment. Further review of Resident #53's medical record revealed no baseline care plan could be found. Interviews on 04/22/26 at 9:16 A.M. and on 04/27/26 at 9:28 A.M. with MDS/Licensed Practical Nurse (LPN) #379 revealed she was not responsible for the baseline care plan as floor nurses created this. MDS/LPN #379 verified she was unable to locate a baseline care plan for Resident #53. 2. Review of Resident #56's medical record revealed an admission date of 01/30/24 and diagnoses including schizoaffective disorder bipolar type, generalized anxiety disorder, depression, type two diabetes, dementia with mood disturbance and chronic kidney disease stage three. Review of an annual MDS 3.0 assessment dated [DATE] revealed Resident #56 had severe cognitive impairment and had two or more falls since the previous assessment without injury. Further review of Resident #56's medical record revealed no baseline care plan could be found. Interviews on 04/22/26 at 9:16 A.M. and on 04/27/26 at 9:28 A.M. with MDS/LPN #379 revealed she was unable to locate a baseline care plan for Resident #56. 3. Review of Resident #81's medical record revealed an admission date of 09/26/24 and diagnoses including dementia with other behavioral disturbance, anxiety, depression, hypertension and hyperlipidemia. Review of a quarterly MDS 3.0 assessment dated [DATE] revealed Resident #81 had moderate cognitive impairment and displayed disorganized thinking. Review of the interim care plan for Resident #81 dated 11/30/24 revealed the document was in assessment form and did not identify interventions. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #81 looked like an assessment and confirmed it did not have interventions as it should. 4. Review of Resident #139's medical record revealed an admission date of 09/05/24 and diagnoses including dementia with other behavioral disturbance, depression, anxiety, hypertension, and osteoarthritis. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #139 was cognitively impaired. Review of the interim care plan for Resident #139 dated 09/05/24 revealed the document was in assessment form and did not identify interventions. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #139 looked like an assessment and confirmed it did not have interventions as it should. 5. Review of Resident #160's medical record revealed an admission date of 04/17/26 and diagnoses including end stage renal disease, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, dementia and Alzheimer's disease. Review of the interim care plan for Resident #160 dated 04/17/26 revealed the document was in assessment form and did not identify interventions. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 revealed the baseline care plan for Resident #160 looked like an assessment and confirmed it did not have interventions as it should. 6. Review of the medical record for Resident #4 revealed an admission date of 10/05/25 with diagnoses including paraplegia, chronic obstructive pulmonary disease, diabetes mellitus, and schizophrenia. Review of the quarterly modified MDS 3.0 assessment dated [DATE] for Resident #4 revealed he had depression and a suprapubic catheter (a tube inserted through the lower abdomen into the bladder to drain urine). Further review of Resident #4's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #4 looked like an assessment and confirmed it did not have interventions as it should. 7. Review of the medical record for Resident #12 revealed an admission date of 02/07/26 with diagnoses including malignant neoplasm of endometrium (cancer), diabetes mellitus and hypertension. Review of the admission MDS 3.0 assessment dated [DATE] for Resident #12 revealed she had depression, had obvious or likely cavity or broken natural teeth, was on a mechanical diet and had pain. Further review of Resident #12's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #12 looked like an assessment and confirmed it did not have interventions as it should. 8. Review of the medical record for Resident #15 revealed an admission date of 02/11/26 with diagnoses including Alzheimer's disease, dementia, depression, anxiety and hypertension. Review of the quarterly modified MDS 3.0 assessment dated [DATE] for Resident #15 revealed he had impaired cognition, inattention and disorganized thinking that comes and goes, depression, was (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	occasionally incontinent of bowel and bladder and utilized a walker. Further review of Resident #15's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #15 looked like an assessment and confirmed it did not have interventions as it should. 9. Review of the medical record for Resident #117 revealed an admission date of 09/17/25 with diagnoses including chronic obstructive pulmonary disease, pain, depression, hypertension and edema. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #117 revealed he had depression and pain. Further review of Resident #117's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #117 looked like an assessment and confirmed it did not have interventions as it should. 10. Review of the medical record for Resident #154 revealed an admission date of 05/13/25 with diagnoses including malignant neoplasm of the lung (cancer), chronic obstructive pulmonary disease, back pain and depression. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #154 revealed she had impaired cognition, rejected care, was dependent for most activities of daily living and had frequent pain. Further review of Resident #154's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #154 looked like an assessment and confirmed it did not have interventions as it should. 11. Review of the medical record for Resident #2 revealed an admission date of 03/02/26 and diagnoses including dementia, fracture of first lumbar vertebra, multiple fractures of ribs on left side, repeated falls, contusion of scalp, unsteadiness on feet, generalized muscle weakness, and need for assistance with personal care. Review of Interim Care Plan dated 03/12/26 revealed at admission Resident #2 had impaired skin integrity, was cognitively impaired, required assistance with bed mobility, transfers, eating, was dependent on staff for assistance with ambulation, locomotion, dressing, personal hygiene, toileting use, and bathing, was incontinent of bowel and bladder, used an assistive device for mobility, and used anti-psychotic/psychotropic medications. The assessment indicated once completed the staff member should navigate to the care plan and add triggers identified on the assessment to build the interim care plan. Review of Medicare MDS admission assessment dated [DATE] revealed Resident #2 had brief interview for mental status (BIMS) score of 03 indicating severe cognitive impairment. Resident #2 was experiencing hallucinations, inattention, and disorganized thinking. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the care plan for Resident #2 revealed no evidence baseline care plan was initiated. Further review of the medical record for Resident #2 revealed no evidence a baseline care plan was developed and was provided to the resident and their representative as required. Interview on 04/21/26 at 11:21 A.M. with Director of Nursing (DON) revealed the MDS staff complete the baseline care plans. Interview on 04/22/26 at 9:16 A.M. with MDS Licensed Practical Nurse (LPN) #379 reported nursing staff completed the baseline care plans upon admission. MDS LPN #379 stated she was responsible for the comprehensive care plan. MDS LPN #379 confirmed she was unable to locate a baseline care plan for Resident #2. Interview on 04/22/26 at 10:22 A.M. with DON confirmed the baseline care plans were not being completed appropriately and residents were not provided with a copy of the baseline care plan. 12. Review of the medical for Resident #107 revealed an admission date of 03/06/26 and diagnoses including chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia, heart failure, shortness of breath, and dependence on supplemental oxygen. Review of Medicare MDS admission assessment dated [DATE] revealed Resident #107 was cognitively intact. Review of the care plan initiated on 03/06/26 revealed at admission Resident #107 was a smoker, desired to be a full code, was admitted for short term rehab, was independent for meeting emotional/social needs, required assistance for activities of daily living, was at risk for falls, had nutritional problems, was at risk for pain, had skin impairments, was on oxygen therapy, experienced shortness of breath. There were goals and interventions initiated for each area of concern. Further review of the medical record for Resident #107 revealed no evidence Resident #107 was provided with a copy of the baseline care plan developed. Interview on 04/22/26 at 9:16 A.M. with MDS LPN #379 confirmed she was unable to locate evidence Resident #107 was provided with a copy of baseline care planning. 13. Review of the medical record for Resident #9 revealed an admission date of 04/13/23 with diagnoses including type 2 diabetes mellitus, bipolar disorder, dementia, depression, and schizoaffective disorder. Review of Resident #9's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed impaired cognition and non-traumatic brain dysfunction. Further review of Resident #9's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #9 looked like an assessment and confirmed it did not have interventions as it should. 14. Review of the medical record for Resident #48 revealed an admission date of 09/02/25 with diagnoses including benign neoplasm of meninges, chronic obstructive pulmonary disease, depression, (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	heart failure, anxiety, and chronic kidney disease. Review of Resident #48's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed intact cognition and mood issues noted. Further review of Resident #48's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #37 stated the baseline care plan for Resident #48 looked like an assessment and confirmed it did not have interventions as it should. 15. Review of Resident #62's medical record revealed an admission date of 09/05/24 with diagnoses including cerebral infarction, seizures, depression, anxiety, chronic kidney disease, neurocognitive disorder, insomnia, and alcohol-induced dementia. Review of Resident #62's quarterly MDS 3.0 assessment, dated 03/13/26, revealed Resident #62 was cognitively impaired and mood issues present. Further review of Resident #62's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #62 looked like an assessment and confirmed it did not have interventions as it should. 16. Review of Resident #91's medical record revealed an admission date of 04/17/25 with diagnoses of right femur fracture, type 2 diabetes mellitus, weakness, chronic kidney disease, anxiety, heart failure, and major depression. Review of Resident #91's annual MDS 3.0 assessment, dated 04/01/26, revealed intact cognition. For activities of daily living, Resident #91 was dependent for toileting hygiene and substantial assistance for transfers. Also, pain noted that affected sleep occasionally. Further review of Resident #91's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #91 looked like an assessment and confirmed it did not have interventions as it should. 17. Review of the medical record for Resident #95 revealed an admission date of 04/13/23 with diagnoses including type 2 diabetes mellitus, bipolar disorder, dementia, depression, and schizoaffective disorder. Review of Resident #95's quarterly MDS 3.0 assessment dated [DATE] revealed impaired cognition and was dependent on staff for toileting and transfers. Also required substantial assistance for showering. Further review of Resident #95's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #95 looked like an assessment and confirmed it did not have interventions as it should. 18. Review of the medical record for Resident #98 revealed an admission date of 05/21/25 with (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, anxiety, depression, and chronic kidney disease. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #98 had intact cognition and required hypoglycemic medication for diabetes management. Further review of Resident #98's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #98 looked like an assessment and confirmed it did not have interventions as it should. 19. Review of Resident #100's medical record revealed an admission date of 01/07/25 with diagnoses of malnutrition, cellulitis of the bilateral lower extremities (BLE), type 2 diabetes mellitus, peripheral vascular disease, failure to thrive, and chronic ulcers of the BLE. Review of Resident #100's five-day MDS 3.0 assessment, dated 03/13/26 revealed impaired cognition. Also, Resident #100 had two deep tissue injuries and six vascular ulcers. Further review of Resident #100's medical record revealed no baseline care plan could be found. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #100 looked like an assessment and confirmed it did not have interventions as it should. Interview on 04/22/26 at 10:22 A.M. with the Director of Nursing (DON) verified baseline care plans were not being done appropriately and no interventions were in place until the comprehensive care plan. The DON also verified residents were not being given a copy of the baseline care plan as required. 20. Review of Resident #50's medical record revealed resident was admitted to the facility on [DATE] with admitting diagnoses that included Schizophrenia, bipolar disorder, anxiety disorder, Parkinson's disease, and hypertension. Review of Baseline/Interim Care Plan dated 10/28/25 had no care plan interventions. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #50 looked like an assessment and confirmed it did not have interventions as it should. 21. Review of Resident #3's medical record revealed resident was admitted to the facility at 01/12/26, with diagnosis including cellulitis, non-pressure chronic ulcer of unspecified part of right lower leg , type two diabetes mellitus with diabetic neuropathy, and peripheral vascular disease. Review of the medical record revealed no evidence of an appropriate Baseline Care Plan with care plan interventions. Interview on 04/22/26 at 9:16 A.M. with MDS/LPN #379 stated the baseline care plan for Resident #3 looked like an assessment and confirmed it did not have interventions as it should. 22. Resident #113 was admitted to the facility at 02/27/26, with diagnosis including schizoaffective disorder, generalized weakness, type two diabetes, and generalized anxiety disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 review of the facility policy, the facility failed to formulate an accurate and comprehensive care plan as required. This affected five residents (#2, #38, #47, #91 and #139) of 62 residents reviewed for care plans. Facility census was 151.Findings include:1. Review of Resident #139's medical record revealed an admission date of 09/05/24 and diagnoses including dementia with other behavioral disturbance, depression, anxiety, hypertension, and osteoarthritis. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #139 was cognitively impaired and received medications including opioids. Review of Resident #139's physician's orders revealed an order dated 07/22/25 for morphine sulfate solution 20 milligrams (mg)/milliLiter (mL), give five mg by mouth every four hours as needed for pain one to 10 and/or dyspnea and an order dated 03/14/26 for admission to hospice services. Review of Resident #139's care plans revealed no care plan was in place regarding pain or opioid medication use. Interview on 04/22/26 at 11:09 A.M. with the Director of Nursing (DON) verified Resident #139 did not have a care plan in place for pain and/or opioid medication use and should have as she had current orders for morphine sulfate. 2. Review of the medical record for Resident #2 revealed an admission date of 03/02/26 and diagnoses including dementia, fracture of first lumbar vertebra, multiple fractures of ribs on left side, repeated falls, contusion of scalp, unsteadiness on feet, generalized muscle weakness, and need for assistance with personal care. Review of progress note dated 03/04/26 at 3:50 P.M. revealed Resident #2 was observed lying on his back on the bathroom floor. Resident #2 was sent to hospital and found to have left sided rib fracture and fracture of first lumbar vertebra. Review of the physician's order dated 03/12/26 revealed Resident #2 was ordered 2 milligrams (mg) Alprazolam (Xanax) three times per day for recurrent major depressive disorder and generalized anxiety disorder. This medication order was adjusted on 04/22/26 to 2 mg Xanax two times per day for anxiety and 1 mg Xanax at bedtime for anxiety. Review of Medicare Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #2 had severe cognitive impairment. Resident #2 was experiencing hallucinations, inattention, and disorganized thinking. Resident #2 required partial/moderate assistance for bathing, toileting hygiene, dressing, personal hygiene, and transfers. Resident #2 had falls in last month prior to admission and falls in last 6 months prior to admission resulting in fracture. Review of progress note dated 03/17/26 at 10:30 A.M. revealed Resident #2 was observed lying on the floor near foot of bed in his room. Interventions initiated included to reinforce call light use and room change closer to a nursing station. Review of the physician's order dated 03/19/26 revealed Resident #2 was ordered 50 (mg) Zoloft in (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the morning for depression. Review of the physician's order dated 03/23/26 revealed Resident #2 was ordered 125 mg Depakote for two capsules two times per day for recurrent major depressive disorder. Review of progress note dated 03/27/26 at 8:30 P.M. revealed Resident #2 was observed lying on the floor by the roommate's bed. Interventions initiated included use gripper socks and keep room free of debris and obstacles. Review of progress note dated 03/30/26 at 5:00 A.M. revealed Resident #2 had fall during incontinence care due to combativeness with a staff member. Interventions included modification of bed. Review of the plan of care initiated on 03/30/26 revealed Resident #2 was at risk for falls. Interventions included anticipate and meet resident needs, ensure call light within reach, encourage use of call light, educate resident/family on safety reminders, ensure resident wearing appropriate footwear, follow fall protocol, therapy evaluation as ordered, and resident needed a safe environment. The plan of care was revised on 04/22/26 to reflect a comprehensive care plan for falls. Review of the plan of care initiated on 03/30/26 revealed Resident #2 had an actual fall with serious injury of fracture of lumbar spine and ribs. There were no interventions implemented to address actual falls. The care plan was resolved on 04/22/26. Review of the physician's order dated 04/01/26 revealed Resident #2 was ordered 22.5 mg Remeron at bedtime for poor caloric intake, depression, and insomnia. Review of the physician's order dated 04/15/26 revealed Resident #2 was ordered 50 mg Trazodone at bedtime for insomnia. This medication order was increased on 04/22/26 to 100 mg Trazodone at bedtime. This medication order was again increased on 04/23/26 to include an additional 25 mg dose of Trazodone once per day. Review of plan of care initiated on 04/22/26 revealed Resident #2 uses anti-anxiety medications and anti-depressant medications. Interventions included educate the resident/family/caregivers of the risks, benefits, and side effects/toxic symptoms of the drug regimen being given. Interview on 04/30/26 at 9:24 A.M. with MDS Licensed Practical Nurse (LPN) #304 confirmed care planning was not initiated until 03/30/26 and was not revised until 04/22/26 to comprehensively address falls for Resident #2. MDS LPN #304 confirmed care planning was not initiated until 04/22/26 to address psychotropic medication use. MDS LPN #304 stated it was better late than never. MDS LPN #304 indicated they had 21 days following admission to complete comprehensive care planning. 3. Review of the medical record for Resident #91 revealed an admission date of 04/17/25 and diagnoses including type two diabetes mellitus, diabetic neuropathy, diabetic chronic kidney disease, chronic kidney disease, anemia, generalized anxiety disorder, right femur fracture, weakness, heart failure, and major depression. Review of the plan of care dated 4/25/25, revealed Resident #91 was at risk for falls. Interventions included a safe environment, walker usage, footwear, follow fall protocol, call light usage, and to move fridge to a better height. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the physician's order dated 12/31/25 revealed Resident #91 was ordered Lantus 100 unit per milliliter (mL) for 20 units twice per day for diabetes mellitus. Review of the Medication Administration Record (MAR) for February 2026 to April 2026 revealed Resident #91 regularly refused insulin coverage. In April 2026 Resident #91 accepted insulin coverage on 04/04/26 at 5:00 P.M., 04/06/26 at 8:00 A.M., 04/07/26 at 8:00 A.M., 04/09/26 at 5:00 P.M., 04/10/26 at 5:00 P.M., 04/14/26 at 5:00 P.M., 04/16/26 at 5:00 P.M., 04/17/26 at 5:00 P.M., 04/19/26 at 5:00 P.M., 04/20/26 at 5:00 P.M., 04/21/26 at 5:00 P.M., 04/22/26 at 5:00 P.M., and on 04/26/26 8:00 A.M. All other administration times were marked refused. Review of Resident #91's progress note on 03/10/26 at 11:00 A.M. revealed while passing medications, the nurse heard the resident calling for help. Upon entering the resident's room, the resident was observed lying on the floor. The resident complained of pain in her right leg. Resident denied hitting her head. The resident was not moved at this time. Resident stated her rollator slipped from underneath her while trying to sit down on it. Vital signs within normal range. Resident sent to Mercy Medical Center for evaluation and treatment. Nurse practitioner, assistant nursing director, and family notified. Review of Resident #91's progress note on 03/11/26 at 2:55 P.M. revealed the interdisciplinary team reviewed intervention to move refrigerator to more accessible area. Review of Resident 91's annual Minimum Data Set (MDS) 3.0 assessment, dated 04/01/26, revealed intact cognition. For activities of daily living, Resident #91 was dependent for toileting hygiene and substantial assistance for transfers. Resident #91 had behavior of rejection of care for four to six days in the last seven days. Review of the current comprehensive care plan revealed there was no care plan developed to address Resident #91's refusals of insulin coverage. Observation on 04/29/2026 at 12:11 P.M. of Resident #91's room revealed a small fridge under the sink on the floor. Interview on 04/29/2026 at 12:11 P.M. with Resident #91 revealed the fridge has always been under the sink and it has never been moved. Interview on 04/29/2026 at 12:26 P.M. with Assistant Director of Nursing (ADON) #457 revealed in March 2026 Resident #91 had a fall that resulted in a right femur fracture. She was sitting on her rollator trying to get a pop out of her fridge and slid off onto the floor. The interdisciplinary team intervention was to move the fridge to a more accessible area. ADON #457 indicated not sure why the fridge had not been moved but would notify maintenance. Interview on 04/29/26 at 12:20 P.M. with LPN #306 revealed the fridge has always been in the same place. It has never moved. Interview on 05/04/26 at 11:53 A.M. with MDS LPN #304 confirmed there was no comprehensive care plan developed to address Resident #91's refusals of insulin coverage. 4. Review of Resident #47's medical record revealed an admission date of 05/15/25 with diagnoses of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	malignant carcinoid tumor of the ileum, liver, and intrahepatic bile duct, schizoaffective disorder, fibromyalgia, and adult failure to thrive. Review of Resident #47's quarterly MDS 3.0 assessment dated [DATE] revealed impaired cognition. Review of Resident #47's physician orders revealed a do not resuscitate-comfort care (DNR-CC) order dated 06/20/25. Review of Resident #47's DNR order form revealed DNR-CC was elected on 06/20/25. Review of Resident #47's code status care plan, dated 09/21/25 revealed the resident desired to be a full code. Interview on 05/04/26 at 8:46 A.M. with the Director of Nursing verified the code status order and care plan did not match. 5. Review of Resident #38's medical record revealed an admission date of 10/29/12 with diagnoses of chronic obstructive pulmonary disease, heart failure, atrial fibrillation, asthma, bipolar disorder, pulmonary hypertension, rheumatoid arthritis, weakness, edema, repeated falls, depression, anxiety, spondulopathies, lack of coordination, and plantar fascial fibromatosis. Review of Resident #38's quarterly MDS 3.0 assessment dated [DATE] revealed impaired cognition. Review of Resident #38's physician orders revealed a DNR-CC order dated 06/06/25. Review of Resident #38's DNR order form revealed DNR-CC was elected on 04/23/25. Review of Resident #38's code status care plan, dated 04/07/25, revealed the resident desired to be a do not resuscitate-comfort care arrest (DNR-CCA). Interview on 04/27/26 at 11:15 A.M. with the Director of Nursing verified the code status order and code status care plan did not match. Review of the facility policy Care Plan Review and Revision Policy undated revealed the facility would review and update each resident's comprehensive care plan at least quarterly, after each comprehensive assessment, or whenever there was a change in the resident's condition, needs, or preferences.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 observation, interview, record review and review of the facility policy, the facility failed to implement effective fall interventions and post fall assessments including neurological checks to ensure resident safety. This affected four residents (Resident #2, #42, #56 and #91) of six residents reviewed for falls. Facility census was 151.Findings include:1. Review of Resident #42's medical record revealed an admission date of 10/28/22 and diagnoses including acute and chronic respiratory failure, type two diabetes, peripheral vascular disease, anxiety and schizoaffective disorder. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had moderate cognitive impairment and rejected care one to three days in the seven day look-back period. Review of a fall risk assessment dated [DATE] revealed Resident #42 was up at lib and at risk for falls. Review of a fall investigation for 08/05/25 at 2:56 P.M. revealed Resident #42 was heard yelling out in her room. Upon entering the room, Resident #42 was sitting upright in her chair and claimed she fell on the floor and got herself up already. Singular neurological checks were documented on 08/06/25 and 08/07/25. There was no fall risk assessment for this fall with the investigation. Review of a fall investigation for 08/06/25 at 11:55 P.M. revealed Resident #42's roommate yelled out and stated Resident #42 had fallen out of the bed. Resident #42 was found laying on the floor beside her bed, shaky, unable to speak and unable to stand. Singular neurological checks were documented on 08/06/25 and 08/07/25. There was no fall risk assessment for this fall until 08/16/25. Review of a fall risk assessment dated [DATE] revealed Resident #42 was confined to chair and at risk for falls. Review of a fall investigation for 09/24/25 at 1:02 P.M. revealed Resident #42 told the nurse practitioner she had a fall the previous evening/early this morning when she was self-transferring back to bed from her wheelchair. There was no fall risk assessment for this fall with the investigation and no neurological checks completed. Review of a fall investigation for 10/08/25 at 11:30 A.M. revealed Resident #42 stated she fell in the bathroom and the incident was not witnessed. Therapy staff found Resident #42 squatting on the bathroom handle bar at the time of discovery. There was no fall risk assessment for this fall with the investigation and no neurological checks completed. Review of a fall investigation for 10/28/25 at 6:20 P.M. revealed Resident #42 had put on her call light and when staff entered the room, Resident #42 stated she fell on the floor on her knees in front of the heater. There was no fall risk assessment for this fall until 11/05/25 and no neurological checks were completed. Review of a fall investigation for 02/21/26 at 2:00 P.M. revealed Resident #42 told the nurse after she walked to her room from the dining room, her legs gave out and she had fallen on her back by her bed. There was no fall risk assessment for this fall with the investigation and no neurological checks completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interviews on 04/28/26 at 12:20 P.M., 1:56 P.M. and 3:56 P.M. with the Director of Nursing (DON) revealed fall risk assessments were to be completed on admission, quarterly and after each fall. The DON stated that neurological checks were to be done for unwitnessed falls for 72 hours. The DON verified the above falls for Resident #42 were missing post-fall risk re-assessment and complete sets of neurological checks as required. 2. Review of Resident #56's medical record revealed an admission date of 01/30/24 and diagnoses including schizoaffective disorder bipolar type, generalized anxiety disorder, depression, type two diabetes, dementia with mood disturbance and chronic kidney disease stage three. Review of an annual MDS 3.0 assessment dated [DATE] revealed Resident #56 had severe cognitive impairment and had two or more falls since the previous assessment without injury. a. Review of Resident #56's physician's orders revealed an order dated 07/11/25 for non-slip strips to the floor in front of the toilet and an order dated 01/20/26 for non-slip strips to the floor in front of the recliner chair. Observation on 05/04/26 at 11:16 A.M. with the DON revealed Resident #56 did not have non-skid strips in front of her toilet or her recliner as ordered. Interview with the DON at the time of observation verified the fall interventions were not in place as ordered for Resident #56. b. Review of a fall investigation dated 06/17/25 at 1:15 A.M. revealed staff heard Resident #56 yelling 'help' and was found laying on the floor on her left side next to her wheelchair. Resident #56 stated her wheelchair moved when she went to get into it. A singular neurological check was documented on 06/17/25. Review of a fall investigation dated 07/24/25 at 5:13 A.M. revealed staff answered Resident #56's call light and noted she was sitting on the edge of her recliner and slowly sliding off of it. Staff attempted to stop Resident #56 from sitting on the floor but were not successful. There was no fall risk assessment for this fall with the investigation. Review of a fall investigation dated 08/04/25 at 10:15 A.M. revealed staff found Resident #56 in her bathroom between the wheelchair and toilet. Singular neurological checks were documented on 08/05/25 (two) and 08/06/25. Review of a fall investigation dated 09/24/25 at 2:05 P.M. revealed staff found Resident #56 laying in her bathroom on her right side without pants on. Resident #56 stated she was trying to change her clothes and fell. Singular neurological checks were documented on 09/25/25 and 09/26/25. There was no fall risk assessment for this fall with the investigation. Review of a fall investigation dated 10/11/25 at 2:35 P.M. revealed staff found Resident #56 in front of her recliner laying of her left side with the wheelchair in front of her. Resident #56 stated she was trying to transfer herself from the recliner to the wheelchair when she fell onto the floor and that she did not have the wheelchair's brakes locked. There was no fall risk assessment for this fall with the investigation and no neurological checks completed. Review of a fall investigation dated 12/31/25 at 2:45 A.M. revealed Resident #56 tried to transfer herself from the wheelchair to the toilet and fell to the floor. There was no fall risk assessment for this fall with the investigation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a fall investigation dated 01/16/26 at 3:30 P.M. revealed Resident #56 was found on the floor in front of her recliner and told staff she was trying to reposition herself comfortably in the chair and slid to the floor. There was no fall risk assessment for this fall with the investigation and no neurological checks completed. Interview on 04/30/26 at 2:40 P.M. with the DON verified neurological checks were to be done for unwitnessed falls for 72 hours. The DON verified the above falls for Resident #56 were missing post-fall risk re-assessment and complete sets of neurological checks as required. 3. Review of the medical record for Resident #2 revealed an admission date of 03/02/26 and diagnoses including dementia, fracture of first lumbar vertebra, multiple fractures of ribs on left side, repeated falls, contusion of scalp, unsteadiness on feet, generalized muscle weakness, and need for assistance with personal care. Review of Fall Risk Observation assessment dated [DATE] revealed Resident #2 was alert and oriented. Resident #2 had balance problem while standing and while walking. Resident #2 required use of assistive devices. Resident #2 required assistance with toileting. Resident #2 used medications including antipsychotics and anxiolytics. Resident #2 was a new admission. Resident #2 had psychiatric or cognitive factors contributing to fall risk. The assessment identified a risk score of 15.0 however there was no indication as to what the score meant. Review of progress note dated 03/04/26 at 3:50 P.M. revealed Resident #2 was observed lying on his back on the bathroom floor. Resident #2's wheelchair was in a locked position outside the bathroom door. Resident #2 was sent to hospital. Review of Fall Incident Report dated 03/04/26 at 3:50 P.M. revealed Resident #2 had unwitnessed fall in bathroom. Resident #2 was unable to state what he was attempting to do. There was a contusion to left side of Resident #2's forehead. Resident #2 reported four out of 10 pain. Resident #2 was noted to be taking Apixaban and was sent to the emergency room for observation. Review of physician's order dated 03/04/26 revealed to send Resident #2 to the hospital for evaluation and treatment. Review of progress note dated 03/04/26 at 4:51 P.M. revealed Resident #2's son was notified of fall. Review of progress note dated 03/05/26 at 9:45 A.M. revealed Resident #2 was found to have left sided rib fracture and fracture of first lumbar vertebra related to fall on 03/04/26. Review of progress noted dated 03/12/26 at 6:05 P.M. revealed Resident #2 returned from the hospital. Resident #2 returned to the facility following hospitalization for first lumbar fracture and left ribs four through seven fractures. Resident #2 was repeatedly explained how to use the call light for assistance. Resident #2 to wear a lumbar sacral orthosis (LSO) brace while out of bed related to fractures. Review of Fall Risk Observation assessment dated [DATE] revealed Resident #2 was alert and oriented. Resident #2 had balance problem while standing. Resident #2 required use of assistive devices. Resident #2 required assistance with toileting. Resident #2 used medications including antipsychotics and anxiolytics. Resident #2 was a new admission. Resident #2 had psychiatric or cognitive factors contributing to fall risk. The assessment identified a risk score of 14.0 however (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	there was no indication as to what the score meant. Review of physician's order dated 03/13/26 revealed LSO brace as tolerated when out of bed. Review of Medicare MDS admission assessment dated [DATE] revealed Resident #2 had brief interview for mental status (BIMS) score of 03 indicating severe cognitive impairment. Resident #2 was experiencing hallucinations, inattention, and disorganized thinking. Resident #2 required partial/moderate assistance for bathing, toileting hygiene, dressing, personal hygiene, and transfers. Resident #2 had falls in the last month prior to admission and falls in last 6 months prior to admission resulting in fracture. Review of progress note dated 03/17/26 at 10:30 A.M. revealed Resident #2 was observed lying on the floor near foot of bed in his room. Interventions initiated included to reinforce call light use. Review of Fall Incident Report dated 03/17/26 at 10:30 A.M. revealed Resident #2 had unwitnessed fall in room. Resident #2 stated he did not know what had happened. Resident #2's wheelchair was nearby with the wheels locked. There were no visible injuries, range of motion (ROM) was within normal limits (WNL), and neurological checks were WNL. Review of Neurological Check dated 03/17/26 at 10:30 A.M. revealed Resident #2 was alert and oriented to person. Resident #2's pupils were equal in size and reactive to light. Resident #2 was responding to simple verbal commands. No pain was reported. ROM to extremities WNL. Review of progress note dated 03/18/26 at 9:45 P.M. revealed neurological check was WNL. Review of Neurological Checks dated 03/19/26 at 7:00 A.M., 11:00 A.M., and 3:00 P.M. revealed Resident #2 was alert and oriented to person. Resident #2's pupils were equal in size and reactive to light. Resident #2 was responding to simple verbal commands. No pain was reported. ROM to extremities WNL. There were no additional neurological checks on this day. Review of Neurological Checks dated 03/20/26 at 7:00 A.M. and 11:00 A.M. revealed Resident #2 was alert and oriented to person. Resident #2's pupils were equal in size and reactive to light. Resident #2 was responding to simple verbal commands. No pain was reported. ROM to extremities WNL. There were no additional neurological checks on this day. Review of progress note dated 03/17/26 at 5:06 P.M. revealed Resident #2's son was notified of fall. Review of progress note dated 03/18/26 at 1:51 P.M. revealed the interdisciplinary team (IDT) reviewed Resident #2's fall on 03/17/26 and determined a room move closer a nursing station was necessary. Review of physician's order dated 03/26/26 revealed order for anti-roll backs to wheelchair. Review of progress note dated 03/27/26 at 8:30 P.M. revealed Resident #2 was observed lying on the floor by the roommate's bed. Review of Fall Incident Report dated 03/27/26 at 8:30 P.M. revealed Resident #2 had unwitnessed fall in room. Resident #2 was found on the other side of the room by his roommate's bed. Resident #2 was calling out for his wife. There were no injuries noted. Resident #2 reported he hit his head. Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	#2 was transferred to his wheelchair and brought to the nursing station. Review of Fall Risk Observation assessment dated [DATE] revealed Resident #2 had intermittent confusion. Resident #2 exhibited jerking or unstable movements when making turns. Resident #2 was up Ad Lib. Resident #2 required assistance with toileting. Resident #2 utilized medications including narcotics. Resident #2 had history of falls in the past three months. The assessment identified a risk score of 12.0 however there was no indication as to what the score meant. Review of Investigation Follow-Up form dated 03/27/26 revealed gripper socks were given and Resident #2 placed in wheelchair and brought to nursing station. Following an IDT review it was recommended to keep room clean and clear of debris and obstacles. Review of Neurological Checks dated 03/28/26 at 7:15 A.M., 9:15 A.M., 11:15 A.M., 1:15 P.M., 3:15 P.M., and 5:15 P.M. revealed Resident #2 was alert and oriented to person. Resident #2's pupils were equal in size and reactive to light. Resident #2 was responding to simple verbal commands. No pain was reported. ROM to extremities WNL. Review of Neurological Check dated 03/29/26 at 5:15 P.M. revealed Resident #2 was alert and oriented to person. Resident #2's pupils were equal in size and reactive to light. Resident #2 was responding to simple verbal commands. No pain was reported. ROM to extremities WNL. There were no additional neurological checks on this day. Review of progress note dated 03/30/26 at 5:00 A.M. revealed Resident #2 had fall during incontinence care due to combativeness with a staff member. Interventions included modification of bed. Review of Fall Incident Report dated 03/30/26 at 5:00 A.M. revealed Resident #2 had witnessed fall in room. Resident #2 was receiving incontinence care and became combative with the staff member causing him to roll out of the other side of the bed. The bed was in a low position however there was noted slant to the left side. Resident #2 stated he thought someone was trying to attack him. Resident #2 denied pain. There was a small reddened area to Resident #2's forehead. ROM and neurological checks were WNL. An order was placed to complete a bed modification to address slant. Review of Fall Risk Observation assessment dated [DATE] revealed Resident #2 had intermittent confusion. Resident #2 exhibited jerking or unstable movements when making turns. Resident #2 required assistance with toileting. Resident #2 utilized medications including narcotics, antihypertensives, and diuretics. Resident #2 had history of falls in past three months. Resident #2 had psychiatric or cognitive, neurological or functional, and orthopedic factors contributing to fall risk. The assessment identified a risk score of 21.0 however there was no indication as to what the score meant. Review of progress note dated 03/30/26 at 9:44 P.M. revealed neurological check was WNL. Review of progress note dated 03/31/26 at 5:59 A.M. revealed neurological check was WNL. Review of physician's order dated 03/30/26 revealed order for perimeter mattress. Review of progress note dated 03/31/26 at 8:43 A.M. revealed IDT reviewed Resident #2's 03/30/26 fall and determined need to place a perimeter mattress to bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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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 Note: The nursing home is disputing this citation.	Review of Neurological Checks dated 04/01/26 at 9:45 A.M., 1:45 P.M., 5:45 P.M. revealed Resident #2 was alert and oriented to person. Resident #2's pupils were equal in size and reactive to light. Resident #2 was responding to simple verbal commands. No pain was reported. ROM to extremities WNL. Review of the plan of care initiated on 03/30/26 revealed Resident #2 was at risk for falls. Interventions included anticipate and meet resident needs, ensure call light within reach, encourage use of call light, educate resident/family on safety reminders, ensure resident wearing appropriate footwear, follow fall protocol, therapy evaluation as ordered, and resident needed a safe environment. The plan of care was revised on 04/22/26 to reflect a comprehensive care plan for falls and include interventions initiated following actual falls. Review of the plan of care initiated on 03/30/26 revealed Resident #2 had an actual fall with serious injury of fracture of lumbar spine and ribs. There were no interventions implemented to address actual falls. The care plan was resolved on 04/22/26. Interview on 04/28/26 at 10:06 A.M. with Licensed Practical Nurse (LPN) Assistant Director of Nursing (ADON) #317 revealed Resident #2 needed a significant amount of assistance for activities of daily living. LPN ADON #317 stated it had been difficult preventing falls for Resident #2. LPN ADON #317 stated Resident #2 was not able to use the call light reliably due to his cognition. LPN ADON #317 stated Resident #2 experienced delusions and other behaviors so education was ineffective. LPN ADON #317 confirmed there were no additional fall risk assessments or neurological checks following falls for Resident #2. LPN ADON #317 stated she had created a falls packet that included the issues identified however it was not widely used across the whole building. Interview on 04/28/26 at 12:20 P.M. with Director of Nursing (DON) confirmed fall risk assessments were not completed post falls. DON indicated fall risk assessments were completed on admission and quarterly thereafter. DON confirmed she was unable to locate additional neurological checks related to Resident #2's falls on 03/17/26, 03/27/26, and 03/30/26 Interview on 04/30/26 at 7:39 A.M. with DON revealed Resident #2 was awake frequently during the nighttime hours. Resident #2 was noted to be restless, agitated, and to yell out. DON indicated Resident #2 was being followed by psychology services. DON indicated it was likely they would not be able to prevent falls for Resident #2 however they should anticipate falls and place interventions for safety. Review of facility policy titled Falls – Clinical Protocol dated August 2008 revealed fall risk would be identified as part of the initial assessment. Risk factors of falls would be documented in the resident's record. Staff would evaluate and document when falls occur and attempt to identify possible causes. Staff would then identify pertinent interventions to prevent subsequent falls and to address risk for serious consequences. If the resident continues to fall the staff would re-evaluate the situation and consider other possible reasons for falls. Review of facility policy titled Neurological Assessment dated August 2008 revealed neurological assessments should be performed for a 72-hour period as follows every 15 minutes for four checks, every hour for four checks, every two hours for eight checks, and every four hours until the 72 hour period is completed. 4. Review of Resident 91's medical record revealed an admission date of 04/17/25 with diagnoses of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	right femur fracture, type 2 diabetes mellitus, weakness, chronic kidney disease, anxiety, heart failure, and major depression. Review of Resident 91's annual MDS 3.0 assessment, dated 04/01/26, revealed intact cognition. For activities of daily living, Resident #91 was dependent for toileting hygiene and substantial assistance for transfers. Also, pain noted that affected sleep occasionally. Review of Resident #91's fall care plan, dated 04/25/25, revealed interventions that included a safe environment, walker usage, footwear, follow fall protocol, call light usage, and to move fridge to a better height. Review of Resident #91's fall risk assessments revealed an assessment was completed on 07/17/25 and 03/13/26. Interview on 04/29/26 at 12:20 P.M. with Licensed Practical Nurse (LPN) #306 revealed that normally Resident #91 does not stand and bend over to get into her fridge but previously she did have a fall trying to get something out of her fridge. Interview on 04/29/26 at 1:48 P.M. with the Director of Nursing (DON) revealed fall risk assessment were to be completed on admission, quarterly, annually, and as needed. The DON verified the fall risk assessments for Resident #91 were completed 07/17/25 and 03/13/26. Review of the facility's fall policy, revision date August 2008, revealed the staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. This deficiency represents non-compliance investigated under Complaint Number 2668600.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician visits were provided as required. This affected five residents (#5, #35, #42, #44, and #53) of 62 residents reviewed for physician visits. Facility census was 151.Findings include: 1. Review of Resident #42's medical record revealed an admission date of 10/28/22 and diagnoses including acute and chronic respiratory failure, type two diabetes, peripheral vascular disease, anxiety and schizoaffective disorder. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had moderate cognitive impairment and rejected care one to three days in the seven day look-back period. Review of the last 12 months of physician visit documentation revealed Resident #42 was seen on 04/24/25, 08/07/25, 09/11/25, 09/25/25 and 03/05/26. Interview on 05/04/26 at 1:55 P.M. with the Director of Nursing (DON) verified there were no other visits to provide regarding Resident #42 and confirmed she was not seen by the physician as required between 09/25/25 and 03/05/26. 2. Review of Resident #44's medical record revealed an admission date of 09/07/21 and diagnoses including dementia with behavioral disturbance, psychosis, anxiety, type two diabetes and schizophrenia. Review of an annual MDS 3.0 assessment dated [DATE] revealed Resident #44 had moderate cognitive impairment and exhibited inattention and disorganized thinking. Review of the last 12 months of physician visit documentation revealed Resident #44 was seen on 07/03/25, 07/10/25, 08/21/25, 02/19/26 and 03/19/26. Interview on 05/04/26 at 1:55 P.M. with the DON verified there were no other visits to provide regarding Resident #44 and confirmed she was not seen by the physician as required between 08/21/25 and 02/19/26. 3. Review of Resident #53's medical record revealed an admission date of 08/29/25 and diagnoses including Alzheimer's disease, dementia, depression anxiety and Crohn's disease. Review of a significant change MDS 3.0 assessment dated [DATE] revealed Resident #53 had severe cognitive impairment. Review of the last 12 months of physician visit documentation revealed Resident #53 was seen on 09/04/25. Interview on 05/04/26 at 1:48 P.M. with the DON verified there were no other visits to provide regarding Resident #53 and confirmed he was not seen by the physician as required since 09/04/25. 4. Review of the medical record for Resident #5 revealed an admission date of 06/25/25 with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, dementia, and chronic kidney disease. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the physician visits from 09/11/25 through 05/04/26 for Resident #5 revealed she was seen by the physician on 09/11/25 and 01/22/26. Review of the modified quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #5 revealed she had severe cognitive impairment. She rejected care four to six days out of the review. Resident #5 was dependent for most activities of living. Interview on 05/04/26 at 1:58 P.M. with the DON verified Resident #5 was seen by the physician on 09/11/25 and 01/22/26. She stated there were no other visits by the physician, only the nurse practitioner. 5. Review of the medical record for Resident #35 revealed an admission date of 06/23/17 with diagnoses including schizoaffective disorder, dementia, anxiety, hypertension and chronic obstructive pulmonary disease. Review of the physician visits from 04/17/25 through 04/30/26 for Resident #35 revealed she was seen by the physician on 07/10/25 and 11/20/25. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #35 revealed she had impaired cognition. Resident #35 was noted to have moderate depression and disorganized thinking that fluctuated. Interview on 04/30/26 at 2:20 P.M. with the DON verified Resident #35 had not seen the physician since 11/20/25, only the nurse practitioner.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were free of significant medication errors. This affected four (Residents #1, #4, #47 and #117) of 13 residents reviewed for significant medication errors. The facility census was 151. Findings include:1. Review of the medical record for Resident #1 revealed an admission date of 01/20/22 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease, heart failure and arthritis. Review of the physician's orders for Resident #1 revealed an order for Oxycodone (opioid medication for pain) 10 milligrams (mg) every four hours dated 03/27/26. The medication was to be administered at 1:00 A.M., 5:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M. and 9:00 P.M. daily. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1's cognition was intact. Review of the Medication Administration Record (MAR) for April 2026 for Resident #1 revealed Oxycodone 10 mg was administered as ordered except for 04/18/26 at 1:00 P.M. when there was no documentation noted. Review of the Patient Controlled Substance Administration Record for Resident #1's Oxycodone 10 mg revealed nursing staff had administered his medication incorrectly and not every four hours as the physician ordered on: -04/01/26 at 4:00 P.M. and then again at 10:00 P.M. which was a six hour gap. -04/05/26 at 4:00 P.M. and then again at 10:00 P.M. which was a six hour gap. -04/07/26 at 4:00 P.M. and then again at 10:00 P.M. which was a six hour gap. -04/08/26 at 4:00 P.M. and then again at 10:00 P.M. which was a six hour gap. -04/17/26 at 9:21 P.M., 8:00 P.M. and then on 04/18/26 at 5:00 A.M. -04/20/26 at 4:00 P.M. and then on 04/21/26 at 12:00 A.M. which was an eight hour gap. -04/26/26 at 12:00 A.M. and then again at 6:00 A.M. which was a six hour gap. Interview on 04/29/26 at 2:14 P.M. with the Director of Nursing (DON) verified Resident #1's Oxycodone was not administered every four hours as ordered by the physician. Interview on 04/29/26 at 2:20 P.M. with Resident #1 revealed he was concerned about getting his pain medications timely. He stated he was worried that he would not be able to remember if he got his medications as ordered. Review of the facility policy titled, Medication Dispensing System, undated, revealed nursing staff were to verify each medication preparation that the medication was the right drug, right dose, right route, right rate, right time and for the right customer. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	2. Review of the medical record for Resident #4 revealed an admission date of 10/05/25 with diagnoses including paraplegia, chronic obstructive pulmonary disease, diabetes mellitus and urinary tract infection. Review of the modified quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4's cognition was intact. He had no behaviors and did not reject care. Review of the physician's orders for Resident #4 revealed he had an order for Meropenem Intravenous Solution 1 gram three times a day (6:00 A.M., 2:00 P.M. and 10:00 P.M.) for infection for seven days dated 04/12/26. Review of the Medication Administration Record (MAR) for April 2026 for Resident #4 revealed Meropenem was not administered on 04/17/26 at 6:00 A.M., 2:00 P.M. and 10:00 P.M. and on 04/18/26 at 6:00 A.M. and 2:00 P.M. Review of the nursing progress notes for Resident #4 revealed he did not receive his antibiotics as ordered. On 04/15/26 at 12:44 A.M. the progress note stated a message was left for the pharmacy to send refills of Meropenem intravenous balls as the pharmacy had sent the antibiotic without an intravenous pump. There was no indication the physician was updated. On 04/17/26 at 1:06 P.M. Meropenem was not administered stating they were waiting on the pharmacy to deliver antibiotic. There was no indication the physician was updated. On 04/20/26 at 5:40 P.M. there was a progress note that stated the nurse practitioner was aware of the delay of Resident #4 not receiving antibiotics as ordered. A verbal order was given to add the missed doses to the end of the order and to resume antibiotic therapy when the antibiotic arrived. Interview on 04/20/26 at 8:01 A.M. with Resident #4 revealed he was concerned because he was not receiving his intravenous antibiotics as ordered. Interview on 04/21/26 at 9:58 A.M. with Licensed Practical Nurse (LPN) #317 verified Resident #4's antibiotics were not administered as ordered by the physician. She also verified nursing did not administer the two additional days, the missed doses, as ordered by the nurse practitioner on 04/20/26. Review of the facility policy titled, Medication Dispensing System, undated, revealed nursing staff were to verify each medication preparation that the medication was the right drug, right dose, right route, right rate, right time and for the right customer. 3. Review of the medical record for Resident #117 revealed an admission date of 09/17/25 with diagnoses including encounter for orthopedic aftercare following surgical amputation (03/13/26), acute pain due to trauma and osteoarthritis. Review of the physician's orders for Resident #117 revealed an order for Oxycodone with Acetaminophen (APAP) (opioid medication for pain) 5-325 milligrams (mg) dated 04/03/26 and discontinued 04/13/26. The medication was to be administered every eight hours as needed for pain. Review of the Medication Administration Record (MAR) for April 2026 for Resident #117 revealed Oxycodone/Apap 5-325 mg was administered on 04/09/26 at 9:09 A.M., 5:10 P.M. and 8:02 P.M. Review of the Patient Controlled Substance Administration Record for Resident #117's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Oxycodone/APAP 5-325 mg on 04/09/26 revealed nursing staff had administered his medication at 9:17 A.M., 5:10 P.M. and at 8:00 P.M., which was not every eight hours as ordered. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #117's cognition was intact. He was noted to have pain frequently. Interview on 04/27/26 at 8:29 A.M. with Registered Nurse (RN) #457 verified Resident #117's medication was administered too soon, five hours too early. She stated on 04/09/26 Licensed Practical Nurse (LPN) #456 had not signed off the MAR indicating she had administered Resident #117's Oxycodone/APAP 5-325 at 5:10 P.M. but had documented on the patient controlled substance administration record. RN #457 stated Resident #117 had requested pain medication when LPN #338 was on duty and she administered Oxycodone/Apap 5-325 mg at 8:00 P.M. and was able to sign off the MAR due to the error by the previous nurse. RN #457 stated LPN #338 should have noted the previous nurse had administered the medication at 5:10 P.M. when she looked at the patient controlled substance administration record, however, she did not. Review of the facility policy titled, Medication Dispensing System, undated, revealed nursing staff were to verify each medication preparation that the medication was the right drug, right dose, right route, right rate, right time and for the right customer. 4. Review of the medical record for Resident #47 revealed an admission date of 05/15/25 with diagnoses including fibromyalgia and dorsalgia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #47 had impaired cognition. Review of Resident #47's comprehensive care plan, dated 06/02/25, revealed pain risk related to dorsalgia and fibromyalgia with an intervention to administer pain medications as ordered. Review of Resident #47's physician orders revealed an order for Lyrica (anticonvulsant controlled substance) 100 milligrams twice a day that started on 06/06/25. Review of Resident #47's medication administration record (MAR) for November 2025 revealed the morning dose on 11/12/25 was not administered since it was not available. Review of Resident #47's Lyrica count sheets revealed no doses were signed out on 11/12/25. Review of Resident #47's progress notes on 11/12/25 revealed Pregabalin 100 milligrams unavailable and reordered this shift. Interview on 05/04/2026 at 12:30 PM with the DON revealed Resident #47 did not receive Lyrica on 11/12/25 even though a dose was marked on the MAR as given for the evening dose. The physician was not notified. Review of the facility's medication dispensing system policy, undated, revealed prior to medication administration verify that the medication administration record reflects the most recent medication order. Medications are administered in a timely fashion as specified by policy. As specified by federal and state regulations, controlled substances are documented as given at the time of administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	This deficiency represents non-compliance investigated under Complaint Number 2593029 and 2990856.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, record review and review of facility policy, the facility failed to ensure a mechanical soft diet texture was prepared in a form to meet individual resident needs. This affected 29 Residents (#5, #11, #12, #19, #21, #22, #31, #38, #44, #46, #54, #58, #68, #79, #81, #82, #95, #100, #105, #109, #110, #122, #123, #132, #135, #137, #140, #141, and #147) identified as receiving a mechanical soft diet. The facility census was 151.Findings include:Review of the Diet Spreadsheet for the Spring/Summer menu, dated 2024, revealed a mechanical soft diet would receive ground ham and beans, soft chopped greens, cornbread with margarine, and soft chopped fruit cobbler.Review of the recipe for Ground Ham and Beans, dated 2026, revealed ham would be ground before adding it to the recipe.Observations on 04/22/26 from 12:06 P.M. to 2:38 P.M. of lunch tray service revealed there was no ground, mechanical soft ham and beans prepared for the mechanical soft diets. The residents identified during tray line as receiving a mechanical soft texture received the regular texture ham and beans, greens, and cornbread. An interview on 04/22/26 at 3:02 P.M. with Dietary Manager (DM) #458 confirmed there was not a mechanical soft texture ham and beans available for the lunch meal on 04/22/26 and it was not served to residents who required the texture modification. An interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she was only at the facility every other week for one day. Dietitian #468 stated the rest of her work was completed offsite. Dietitian #468 stated she had minimal oversight in the kitchen and generally just completed a monthly sanitation audit. Dietitian #468 stated she was unaware of the issues identified in the kitchen. Review of the facility policy titled Mechanical Soft Diet dated June 2023 revealed a mechanical soft diet consists of foods that are easy to chew. The regular diet menu items should be mechanically altered, chopped or ground. The food items should be able to be mashed or broken down with the pressure from a fork or spoon.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on record review, interview, and review of the facility policy, the facility failed to ensure medical records were complete and accurate. This affected four residents (#5, #47, #56, and #100) out of 62 records reviewed. The facility census was 151.Findings include: 1. Review of Resident #56's medical record revealed an admission date of 01/30/24 and diagnoses including schizoaffective disorder bipolar type, generalized anxiety disorder, depression, type two diabetes, dementia with mood disturbance and chronic kidney disease stage three. Review of an annual minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 had severe cognitive impairment and had two or more falls since the previous assessment without injury. Review of Resident #56's physician's orders as of 05/04/26 revealed an order dated 04/11/24 for five nursing observations: bowel, bladder, full body, Braden (skin), and fall every evening shift every three months starting on the first [of the month] for one day. Review of Resident #56's Treatment Administration Record (TAR) for November 2025 revealed the nursing assessments including fall assessment were signed off as completed on 11/01/25. Review of Resident #56's TAR for February 2026 revealed the nursing assessments including fall assessment were signed off as completed on 02/01/26. Further review of Resident #56's medical record revealed no evidence of a fall risk assessment completed on 11/01/25 or 02/01/26. The only documented fall risk assessment completed for Resident #56 from November 2025 through April 2026 was completed on 04/04/26. Interview on 05/04/26 at 11:21 A.M. with the Director of Nursing (DON) verified staff signed off as completing the fall risk assessments for Resident #56 on 11/01/25 and 02/01/26 although the assessments were not actually completed and indicated this was not documented accurately within Resident #56's record. 2. Review of the medical record for Resident #5 revealed an admission date of 06/25/25 with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease and dementia. Review of the physician's orders for April 2026 for Resident #5 revealed she had orders to monitor behaviors on dayshift, afternoons and nightshift dated 06/26/25; cleanse catheter site with soap and water and empty urine drainage bag on dayshift, afternoons and nightshift dated 07/15/25; enhanced barrier precautions on dayshift, afternoons and nightshift for foley catheter on dayshift, afternoons and nightshift dated 07/28/25; and cleanse bilateral buttocks with soap and water and apply a combination of antifungal cream and zinc barrier at 9:00 A.M. and 9:00 P.M. which was dated 12/05/25. Review of the Medication Administration Record (MAR) and TAR for April 2026 revealed Resident #5 has missing documentation for behavior monitoring on afternoons on 04/13/26, 04/23/26 and 04/27/26 and on dayshift on 04/29/26; for catheter care on afternoons on 04/13/26, 04/23/26 and 04/27/26 and on dayshift on 04/29/26; for enhanced barrier precautions on afternoons on 04/13/26, (continued on next page)

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	365655	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	04/23/26 and 04/27/26 and on dayshift on 04/29/26; and treatment to her buttocks at 9:00 P.M. on 04/13/26, 04/23/26 and 04/27/26 and at 9:00 A.M. on 04/29/26. Interview on 05/04/26 at 12:30 P.M. with the Director of Nursing (DON) verified there was no documentation on the MAR and TAR on the dates listed above. Review of the facility policy titled, Medication Dispensing System, undated, nursing staff were to document necessary medication administration/treatment information on appropriate forms. 3. Review of the medical record for Resident #47 revealed an admission date of 05/15/25 with diagnoses including schizoaffective disorder, depression, anxiety, and bipolar disorder, fibromyalgia, and dorsalgia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 had impaired cognition. Review of Resident #47's physician orders revealed an order for Lyrica 100 milligrams twice a day that started on 06/06/25. Review of Resident #47's MAR for November 2025 revealed the evening dose on 11/12/25 was administered. Review of Resident #47's Lyrica count sheets revealed no doses were signed out on 11/12/25. Interview on 05/04/2026 at 12:30 P.M. with the Director of Nursing (DON) revealed Resident #47 did not receive Lyrica on 11/12/25 even though a dose was marked on the medication administration record as given for the evening dose. Review of the facility's documentation policy, revised August 2006, revealed all observations, medications administered, services performed, etc. must be documented in the resident's clinical record. 4. Review of Resident #100's medical record revealed an admission date of 01/07/25 with diagnoses of malnutrition, cellulitis of the bilateral lower extremities (BLE), type 2 diabetes mellitus, peripheral vascular disease, failure to thrive, and chronic ulcers of the BLE. Review of Resident #100's five-day Minimal Data Set (MDS) 3.0 assessment, dated 03/13/26 revealed impaired cognition. Also, Resident #100 had two deep tissue injuries and six vascular ulcers. Review of Resident #100's physician orders revealed treatment orders for multiple areas to the BLE to be changed nightly, behavior monitoring orders for every shift, enhanced barrier precaution orders for every shift, hoyer lift transfer orders for every shift, and oxygen orders for every shift. Review of Resident #100's medication administration record for April 2026 revealed BLE treatments were signed off as completed 04/16/26, 04/17/26, 04/21/26, 04/22/26, 04/23/26, 04/25/26, and 04/26/26. Behavior monitoring was not signed off on the evening of 04/10/26, 04/16/26, 04/17/26, 04/18/26, 04/20/26, and 04/24/26. Enhanced barrier precautions were not signed off on the evening of 04/10/26, 04/16/26, 04/17/26, 04/18/26, 04/20/26, and 04/24/26. Hoyer lift transfers were not signed off on the evening of 04/10/26, 04/16/26, 04/17/26, 04/18/26, 04/20/26, and 04/24/26. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Oxygen was not signed off on the evening of 04/10/26, 04/16/26, 04/17/26, 04/18/26, 04/20/26, and 04/24/26. Observation on 04/20/26 at 9:20 A.M. revealed BLE dressings were dated 04/16/26. This was confirmed at the time of observation in an interview with Licensed Practical Nurse (LPN) #456. Observation on 04/22/26 at 11:15 A.M. revealed Resident #100's BLE dressings were dated 04/16/26. Observation on 04/28/26 at 10:14 A.M. revealed Resident #100's BLE dressings were dated 04/23/26. This was verified at the time of observation with Assistant Director of Nursing (ADON) #445. Interview 04/28/2026 1:18 P.M. with the DON confirmed the inaccurate documentation on Resident #100's April 2026 TAR. The DON indicated the tasks were completed, but the nurses were not signing off the orders within the electronic medical record system. Review of the facility's documentation policy, revised August 2006, revealed all observations, medications administered, services performed, etc. must be documented in the resident's clinical record. This deficiency represents non-compliance investigated under Complaint Number 2668600.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review, the facility failed ensure a clean, sanitary and homelike environment. This affected six residents (#20, #24, #29, #62, #65, and #75) out of 23 residents reviewed for physical environment. The facility census was 151.Findings include: Observation of the facility on 04/21/26 from 2:45 P.M. to 3:55 P.M. with Director of Maintenance (DOM) #399 and Housekeeping Director (HD) #450 revealed the following areas of concern: In Resident #20's room, debris was all over the floor. Resident #20, who was in bed at the time of the observation, stated he could not recall when the floor was last vacuumed. In Resident #24's side of her room, debris including personal care wipes were noted under the resident's bed. In Resident #65's part of the room, a pervasive urine odor was noted. In Resident #75's room, the carpeting had large stained areas and debris was scattered all over the floor. In Resident #29's room, the carpeting had large stained areas that were yellow and red and debris was noted on the floor. Resident #29, who was in the room at the time of observation, stated it had been two weeks since housekeeping had vacuumed her floor. Resident #29 denied refusing housekeeping services. In Resident #62's bathroom, no soap was present in the dispenser.HD #450 verified the above findings at the time of observation. HD #450 stated floors were to be cleaned seven days a week and staff should be cleaning under the bed each time. HD #450 shared they just received a new chemical that addressed urine odors and agreed they needed to mitigate the urine odor in Resident #65's room. HD #450 also confirmed staff were to be checking and replacing the soap dispensers daily if they were empty.Review of the facility policy, Housekeeping and Cleaning Policy, no date revealed the facility would maintain, sanitary and safe environment for residents, staff and visitors by following standardized housekeeping and infection prevention practices. The facility will ensure routine and thorough cleaning of all areas. Housekeeping staff will perform daily and terminal cleaning. In resident rooms, daily cleaning included high touch surfaces (bed rails, call buttons, bedside tables), bathroom fixtures, floors (sweep and wet mop). Review of the facility policy, Housekeeping/Custodial Policy/Procedure Removing Flooring Stains, no date revealed routine cleaning will be done on hallways and in resident rooms. If there are any spots that needed to be extracted immediately, there must be a staff member in the area.This deficiency represents non-compliance investigated under Complaint Numbers 2677432, 2668600 and 2593029.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure consent of psychotropic medications were in place for Resident #2. This affected one Resident (#2) of five reviewed for unnecessary medications. The facility census was 151. Review of the medical record for Resident #2 revealed an admission date of 03/02/26 and diagnoses including dementia, generalized anxiety disorder, recurrent major depressive disorder, restlessness and agitation, and suicidal ideations. Review of the physician's order dated 03/12/26 revealed Resident #2 was ordered 2 milligrams (mg) Alprazolam (Xanax) three times per day for recurrent major depressive disorder and generalized anxiety disorder. This medication order was adjusted on 04/22/26 to 2 mg Xanax two times per day for anxiety and 1 mg Xanax at bedtime for anxiety. Review of Consent for Psychotropic Medications assessment dated [DATE] revealed Resident #2 was on 25 mg Zoloft in the morning and 2 mg Xanax three time per day. The assessment indicated the resident was informed of the benefits of medication use, potential side effects, right to refuse treatment, need for continued use would be evaluated quarterly, consent could be withdrawn at any time, and questions could be directed to the physician or facility staff. The assessment indicated Resident #2 gave verbal consent for use of the medications listed. Review of Medicare Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #2 had brief interview for mental status (BIMS) score of 03 indicating severe cognitive impairment. Resident #2 was experiencing hallucinations, inattention, and disorganized thinking. Review of Psychiatry Initial Consult dated 03/18/26 revealed Resident #2 was forgetful and at times confused. Resident #2 had moderately impaired insight and comprehension. Review of the physician's order dated 03/19/26 revealed Resident #2 was ordered 50 (mg) Zoloft in the morning for depression. Review of the physician's order dated 03/23/26 revealed Resident #2 was ordered 125 mg Depakote for two capsules two times per day for recurrent major depressive disorder. Review of the physician's order dated 04/01/26 revealed Resident #2 was ordered 22.5 mg Remeron at bedtime for poor caloric intake, depression, and insomnia. Review of Psychiatry Progress note dated 04/01/26 revealed Resident #2 had impaired insight and moderate impairment of comprehension. Resident #2 was forgetful and confused. Review of the physician's order dated 04/15/26 revealed Resident #2 was ordered 50 mg Trazodone at bedtime for insomnia. This medication order was increased on 04/22/26 to 100 mg Trazodone at bedtime. This medication order was again increased on 04/23/26 to include an additional 25 mg dose of Trazodone once per day. Review of Psychiatry Progress note dated 04/15/26 revealed Resident #2 had moderate impairment of comprehension and insight. There were noted symptoms of depression, insomnia, and poor appetite in context of advanced dementia. Resident #2 was alert to self upon assessment. Review of plan of care initiated on 04/22/26 revealed Resident #2 uses anti-anxiety medications and anti-depressant medications. Interventions included educate the resident/family/caregivers of the risks, benefits, and side effects/toxic symptoms of the drug regimen being given. Further review of the medical record revealed no evidence Resident #2's representative was notified of and assisted with consent for use of psychotropic medications. There were no updates identified to the 03/12/26 consent for psychotropic medications with the addition of Depakote, Remeron, or Trazodone. Interview on 04/30/26 at 7:39 A.M. with Director of Nursing (DON) confirmed the consent for psychotropic medication use on 03/12/26 was issued to Resident #2 despite cognitive impairments. DON indicated she was unsure if Resident #2's son was notified. DON confirmed there was not an updated consent form to address addition of medications Depakote, Remeron, and Trazodone. There was no facility policy provided to address consents for psychotropic medication use.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to manage his or her financial affairs. Based on record review and interview, the facility failed to ensure resident account management authorization's were signed and witnessed when setting up accounts managed by the facility for residents. This affected three (Residents #56, #62 and #154) of five residents reviewed for personal funds. The facility census was 151. Findings include: 1. Review of the medical record for Resident #56 revealed an admission date of 01/30/24 with diagnoses including schizoaffective disorder, dementia, anxiety and depression. Review of the Resident Fund Manage Service authorization and agreement to handle resident funds dated 05/08/24 revealed the facility signed the authorization as they were Resident #56's representative payee. There was no witness to this authorization. Interview on 04/22/26 at 3:22 P.M. with Business Office Manager (BOM) #413 verified the authorization was not witnessed. 2. Review of the medical record for Resident #62 revealed an admission date of 09/05/24 with diagnoses including cerebral infarction (stroke), alcohol induced persisting dementia, anxiety and depression. Review of the Resident Fund Manage Service authorization and agreement to handle resident funds dated 03/07/25 revealed the facility signed the authorization as they were Resident #56's representative payee. There was no witness to this authorization. Interview on 04/22/26 at 3:22 P.M. with BOM #413 verified the authorization was not witnessed. 3. Review of the medical record for Resident #154 revealed an admission date of 05/13/25 with diagnoses of malignant neoplasm of the lung (cancer), anxiety and depression. Review of the Resident Fund Manage Service authorization and agreement to handle resident funds dated 08/08/25 revealed the resident's power of attorney signed. There was no witness to this authorization. Interview on 04/22/26 at 3:22 P.M. with BOM #413 verified the authorization was not witnessed. This deficiency represents non-compliance investigated under Complaint Number 2668600 and 2593029.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of self-reported incidents (SRI) and review of the facility policy, the facility failed to report an allegation of abuse and/or misappropriation to the State Agency as required. This affected three (Residents #62, #138 and #154) of fifteen residents reviewed for abuse and misappropriation. The facility census was 151. Findings include:1. Review of the medical record for Resident #154 revealed an admission date 05/13/25 with diagnoses including malignant neoplasm of the lung (cancer), chronic obstructive pulmonary disease, diabetes mellitus and back pain. She was discharged home on [DATE]. Review of the physician's orders for Resident #154 revealed she had an order for Oxycodone (opioid medication for pain) 5 milligrams (mg) every eight hours as needed for pain dated 12/01/25. Review of the Patient Controlled Substance Administration Record for Resident #154's Oxycodone 5 mg Rx #206039493 revealed 30 tablets had been received on 12/02/25. The first dose was administered on 12/13/25 at 8:15 P.M. and the last dose on the card was administered on 12/25/25 at 8:30 P.M. There were 23 tablets remaining on the card. Review of the Controlled Medication Shift Change Log dated 12/26/25 revealed Registered Nurse (RN) #452, the Assistant Director of Nursing, had removed Resident #154's card of Oxycodone 5 mg Rx #206039493 with 23 remaining tablets from the medication cart. Her signature was the only one noted with the removal of the medication. Review of the witness statement by Licensed Practical Nurse (LPN) #327 revealed on 12/26/25 RN #452 had come to her medication cart to check the narcotic book. She stated RN #452 stated there were errors on Resident #154's Oxycodone card so she removed the signature sheet along with the card of remaining pills. LPN #327 asked if she wanted her to assist in destroying the medication with RN #452, but RN #452 had responded she could only do it with another department head. Review of the witness statement dated 12/29/25 by LPN #317, Assistant Director of Nursing, revealed she was doing audits on 12/29/25 of the narcotic count sheets and noted Oxycodone for Resident #154 was removed from the medication cart on 12/26/25. She stated she could not find the patient controlled substance administration record or the reason it was removed. LPN #317 stated she interviewed LPN #327 who stated RN #452 removed Resident #152's Oxycodone card with the medications stating there were discrepancies on the card. LPN #327 stated RN #452 did not want her to waste the remaining narcotics with her. LPN #317 stated she then interviewed RN #452 about the discrepancy and she became nervous and flustered and her hands were shaking. RN #452 stated she had wasted the Oxycodone with LPN #327. LPN #317 stated she had spoken to LPN #327 who denied wasting the medication with her. RN #452 then began to pull papers out of her personal back pack and then wanted to go to her car to look for the narcotic card. RN #452 could not explain why she had removed the card and was unable to produce the medication. RN #452 provided the patient controlled substance administration record to LPN #317 for Resident #154's Oxycodone 5 mg which revealed there were 23 tablets remaining. Review of the emailed statement dated 12/30/25 by RN #452 revealed she was notified by the floor nurse there was an error on the patient controlled substance administration record for Resident #154's Oxycodone. She stated she reviewed the record and updated pharmacy who stated they were (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	sending a new card of Oxycodone to the facility. RN #452 stated she took the card of medication out of the medication cart and placed it in her office. She stated before she left the facility for the day she destroyed the medication prior to leaving because she did not want them in her office over the weekend. She did not identify any other staff having assisted her in destroying the Oxycodone for Resident #154. Interview on 04/22/26 at 9:11 A.M. with the Director of Nursing (DON) verified the facility had not filed a self-reported incident (SRI) incident for misappropriation with the State Agency related to Resident #154's Oxycodone 5 mg. The DON verified RN #452 was unable to produce the Oxycodone 5 mg with the 23 remaining tablets. Review of the facility policy titled, Abuse Prevention Program, dated February 2017, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings without the resident's consent. The facility stated it was to report immediately or no later than 24 hours to the State Agency, local law enforcement and the resident's representative. The facility was to ensure the residents were free from abuse, neglect, exploitation, misappropriation of property or mistreatment. 2. Review of the medical record for Resident #138 revealed an admission date of 11/25/24 and diagnoses including dementia with mood disturbance, chronic kidney disease, generalized anxiety disorder, hyperlipidemia, osteoarthritis, and essential hypertension. Review of progress note dated 11/22/25 at 8:15 A.M. revealed Resident #138 had grayish black ecchymosis areas to left outer upper arm, left outer wrist area, and right inner arm. Resident #138 did not complain of any pain. Resident #138 was noted to have fragile skin and was on a daily aspirin. Resident #138 was noted to ambulate independently. There were no noted accidents or events related to bruising. Review of Self-Reported Incident (SRI) Form number 267836 dated 11/22/25 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted bruising on Resident #138's left upper outer arm, left outer wrist, and right inner wrist. Resident #138 was unable to report what had happened. It was noted the facility did not suspect abuse due to location and shape of bruising. It was noted Resident #138 can be combative with care and independently ambulates on the unit. The facility was unable to determine the origin of bruising. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 267836 revealed no identification of root cause. There was no evidence of any environmental inspection. There was no evidence of staff re-training related to the occurrence and investigation of an injury of unknown origin. Review of Nurse Practitioner (NP) progress note dated 11/24/25 revealed Resident #138 seen for evaluation for contusion to the arm. NP ordered long sleeves to protect skin. Resident #138 noted to be poor historian and pleasantly confused. Nursing staff reported Resident #138 had intermittent bruising. Plan to continue monitoring for ongoing occurrences and monitor for symptoms suggestive of anemia. Review of progress note dated 01/23/26 at 10:00 P.M. revealed Resident #138 had a lump with bruising on right forearm. There was also bruising noted to inner right forearm. Resident #138 denied pain. Resident #138 was unable to report what had happened. Resident #138 was noted to have a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	history of being combative with care. There were no noted accidents or events related to bruising or a lump. Review of progress note dated 01/23/26 at 10:30 P.M. revealed Resident #138 had order for x-ray to the right forearm and new order for antibiotics. Review of Self-Reported Incident (SRI) Form number 270153 dated 01/23/26 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted a lump with bruising on Resident #138's lateral right forearm and bruising on medial forearm. Resident #138's family and NP were notified. The facility initiated 15-minute checks. Resident #138 was unable to provide a description of what had happened to her arm. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 270153 revealed no identification of root cause. There was no evidence of any environmental inspection. There was no evidence of additional residents being evaluated for bruising. There was no evidence of staff re-training related to the occurrence and investigation of an injury of unknown origin. Review of radiology result dated 01/24/26 at 11:57 A.M. revealed no evidence of acute fracture. There was noted soft tissue swelling over the latera aspect of proximal shaft of the radius consistent with hematoma. Review of progress note dated 01/24/26 at 12:45 P.M. revealed a new order to elevate and ice area on right forearm. Staff were to monitor area and call NP if the area had additional spread. Review of NP progress note dated 01/26/26 revealed Resident #138 seen for evaluation of bruise to right forearm. The bruise was of unknown etiology per nursing and Resident #138. There was no noted trauma or injury. New orders for Doxycycline 100 mg twice daily for seven days, elevate and ice area, and x-ray. Physical exam revealed poor strength, range of motion was normal to right arm and wrist, and there was no erythema. Resident #138 remained pleasantly confused. NP unable to identify etiology of bruising. Review of progress note dated 01/28/26 at 10:19 P.M. revealed Resident #138 had a doppler test completed to the bruised and swollen right forearm area. There was no evidence of deep vein thrombosis. Review of radiology result dated 01/28/26 at 8:48 P.M. revealed a doppler scan resulted with no evidence of deep venous thrombosis in right upper extremity veins. Review of Medicare MDS assessment dated [DATE] revealed Resident #138 required substantial/maximal assistance from staff for personal hygiene, bathing, and upper body dressing and was dependent on staff assistance for lower body dressing and toileting hygiene. Resident #138 had short- and long-term memory problems and severely impaired decision-making ability. Resident #138 was noted to have delusions. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #138 was unable to participate in interview resulting in score of 99. Review of progress note dated 03/27/26 at 2:20 P.M. revealed Resident #138's right wrist was red (continued on next page)

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McKinley Nursing	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and swollen. Resident #138 complained of pain when moving the wrist. NP was notified and gave new orders for x-ray and two tablets of Tylenol 500 milligrams twice daily for three days for pain. There were no noted accidents or events related to the redness, swelling, and pain. Review of facility's SRIs revealed no evidence an SRI was reported to the State Agency on or around 03/27/26 for an injury of unknown origin for Resident #138. There was no evidence of investigation to determine root cause of redness, swelling, and pain to Resident #138's wrist. Review of NP progress note dated 03/27/26 revealed Resident #138 was seen for evaluation of right wrist pain. There was noted redness and swelling. There were no related falls and resident was unable provide details other than the area was painful. Resident #138 noted to be an irritated mood. Noted right forearm bruising on physical exam. New orders for an x-ray and addition of 1000 milligrams of Tylenol twice daily for three days. Review of radiology result dated 03/28/26 at 12:00 A.M. revealed x-ray resulted with no evidence of acute fracture or dislocation of right wrist. Review of NP progress note dated 03/30/26 revealed the NP was unable to determine an underlying reason for swelling, redness, and pain. A new order for Voltaren one percent two grams applied twice daily for seven days. Interview on 04/30/26 at 7:39 A.M. with DON revealed Resident #138 was supposed to walk with assistance from staff, however, did not always remember to ask for help. Resident #138 was not known to get into altercations with other residents. Resident #138 had impaired cognition. SRIs #267836 and #270153 were reviewed and the DON confirmed she was unable to locate evidence to support a root cause was identified to sufficiently rule out abuse. DON confirmed an SRI was not filed Resident #138's wrist presenting with redness, swelling, and pain despite history with injuries of unknown origin presenting in a similar manner. DON reported there was no bruise, so an SRI was not filed. Review of facility policy titled Abuse Prevention Program dated February 2017 revealed an appointed investigator would at a minimum interview the person reporting the incident, interview anyone with direct knowledge of the incident, obtain written statements, and gather any pertinent medical records. An injury would be classified as an injury of unknown source when both conditions were met: the source of injury was not observed or could not be explained and the injury is suspicious due to location, extent, or incidence of injuries over time. The injury would be reported to the State Agency and investigated following the abuse policy. 3. Review of Resident #62's medical record revealed an admission date of 09/05/24 with diagnoses including cerebral infarction, seizures, depression, anxiety, chronic kidney disease, neurocognitive disorder, insomnia, and alcohol-induced dementia. Review of Resident #62's quarterly MDS 3.0 assessment, dated 03/13/26, revealed Resident #62 was cognitively impaired, mood issues present, and no behaviors. Review of Resident #62's behavior care plan, dated 06/26/25, revealed interventions to explore underlying causes with the interdisciplinary team and address coping mechanisms and communication strategies. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #62's mood care plan, dated 09/13/24, revealed interventions to meet one-on-one and encourage resident to verbalize feelings, concerns, and fears. Review of Resident #62's progress notes revealed on 03/05/26 at 11:00 P.M. Resident #62 was separated from her roommate. Resident #62 denied any pain, and states she feels safe. There was no physical harm, pain or, mental anguish noted. Review of Resident #62's progress notes revealed on 03/05/26 at 11:30 P.M. a message was left with Resident #62's guardian in regard to complaints with her roommate. Review of Resident #62's progress notes revealed on 03/06/26 at 2:08 P.M. the nurse practitioner and family was notified. A skin check was completed and there was no physical harm, marks, or bruises. Her roommate was immediately removed from the room and placed on 15-minute checks. Also, a room change was completed. Interview on 04/21/26 at 12:00 P.M. with Resident #62 revealed she didn't feel safe in the facility. Resident #62 stated her previous roommate squeezed her butt and said I like that. Also, she doesn't feel like the facility was trying to help her. Interview on 04/21/26 4:26 P.M. with the DON revealed there was no self-reported incident (SRI) completed for Resident #62 for the incident on 03/05/26. The DON indicated an SRI did not need completed due to no mental anguish noted to Resident #62. The DON indicated they would talk to Resident #62 to get further details of the alleged incident with her previous roommate. Review of the facility's abuse policy, dated 02/07/17, revealed any incident involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. Within five working days after the report of the occurrence, a complete report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. This deficiency represents non-compliance investigated under Complaint Number 2668600, 2990856, and 2992799.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure a safe and appropriate discharge for Resident #165. This affected one Resident (#165) of five reviewed for discharge. The facility census was 151. Findings include:Review of the medical record for Resident #165 revealed an admission date of 02/26/25 and discharge date of 07/01/25. Diagnoses include human immunodeficiency virus (HIV) disease, psoriasis, anemia, homelessness, anxiety disorder, recurrent major depressive disorder, and patient's noncompliance with medical treatment and regimen due to financial hardship. Review of Discharge Planning assessment dated [DATE] revealed an anticipated length of stay of three months. Barriers to returning home included health, finances, housing, and lack of support. It was noted Resident #165 had numerous health needs with no finances, support system or housing so discharge would not be considered safe. Review of Social Service History and Initial assessment dated [DATE] revealed Resident #165 was currently homeless and unemployed. Resident #165 was able to make needs known and was alert and oriented to person, place, time, and situation. Resident #165 had a brief interview for mental status (BIMS) score of 14 indicating intact cognition. Review of activities progress note dated 03/18/25 at 11:09 A.M. revealed Resident #165 was not in the facility most of the time due to Resident #165 working in the community to hang dry wall. Review of social service progress note dated 03/24/25 at 12:07 P.M. revealed the social worker attempted to talk with Resident #165 about his last cover date however Resident #165 was on a leave of absence (LOA). Review of expedited appeal request determination letter dated 04/02/25 revealed Resident #165 did not meet the criteria for an expedited review. An appeal would be resolved within 10 days. Review of Final Adverse Benefit Determination letter dated 04/09/25 revealed Resident #165 was denied a continued stay in a skilled nursing facility from 03/22/25 through discharge. Review of progress note dated 05/24/25 at 9:35 A.M. revealed Resident #165 went on LOA. Review of progress note dated 05/25/25 at 12:20 A.M. revealed Resident #165 returned from LOA and left again and had not returned. Review of progress note dated 05/25/25 at 5:25 P.M. revealed Resident #165 remained on LOA. Review of progress note dated 05/25/25 at 9:28 P.M. revealed Resident #165 had been on a LOA. Facility staff attempted to call the cellphone number listed on file however the number was disconnected. The facility staff also attempted to contact the listed emergency contact however the name on the voicemail was different than the name provided. Review of progress note dated 05/25/25 at 10:38 P.M. revealed Resident #165 remained on LOA for almost 24-hours. The facility called local hospitals and the county jail without successfully locating Resident #165. Review of progress note dated 05/26/25 at 6:34 A.M. revealed Resident #165 remained absent from facility. Review of progress note dated 05/26/25 at 10:16 P.M. revealed Resident #165 remained absent from facility all of shift. Review of progress note dated 05/27/25 at 3:37 A.M. revealed Resident #165 returned to the facility from LOA. Review of progress note dated 06/04/25 at 10:46 P.M. revealed Resident #165 reported concerns of where he was going to live when discharged . The nurse encouraged him to speak with the social services department to discuss housing options. Review of social service progress note dated 06/06/25 at 9:06 A.M. revealed Resident #165 discussed discharge plans with the social worker. Resident #165 was provided with community resources to help with housing. The social worker advised Resident #165 to start calling. Review of Discharge Notice dated 06/06/25 revealed Resident #165 was given a 30-day discharge notice for failure to pay or have Medicare or Medicaid programs pay for care provided. The discharge location was listed as another nursing facility with planned date of 07/07/25. Review of progress note dated 06/08/25 at 4:20 P.M. revealed Resident #165 went on LOA. Review of progress note dated 06/09/25 at 1:25 P.M. revealed Resident #165 remained on LOA. There was no evidence of any contact made with Resident #165. Review of progress note dated 06/10/25 at 6:52 A.M. revealed (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #165 returned from LOA. Review of progress note dated 06/12/25 at 2:25 P.M. revealed Resident #165 went on LOA. Review of progress note dated 06/13/25 at 2:27 P.M. revealed Resident #165 remained on LOA. The supervisor was notified. There was no evidence of any contact made with Resident #165. Review of progress note dated 06/14/25 at 1:53 A.M. revealed Resident #165 returned from LOA. Resident #165 requested towels for a shower. Review of social service progress note dated 06/27/25 at 7:58 A.M. revealed Resident #165 was reminded of a proposed discharge date of 07/07/25 by social worker. The social worker offered contact numbers for services and Resident #165 declined. The social worker stated definitive plans needed to be made and Resident #165 cannot keep putting this off. Review of progress note dated 06/29/25 at 1:09 A.M. revealed Resident #165 requested to be moved to a room with a bathtub. Resident #165 was offered to use bath on the unit which he declined. Resident #165 had a large footlocker in room. Around 12:30 A.M. Resident #165 packed up his belongings and left unit with the footlocker. Review of progress note dated 06/29/25 at 2:50 A.M. revealed Resident #165 returned to the facility. Review of social service progress note dated 06/29/25 at 8:43 A.M. revealed the social worker left message for another nursing facility to address discharge planning for Resident #165. Review of progress note dated 07/02/25 at 6:05 A.M. revealed Resident #165 was gone at start of shift at 7:00 A.M. and had been gone entire shift. Resident #165 had not returned to the unit as of 6:08 P.M. Review of progress note dated 07/04/25 at 7:04 P.M. revealed Resident #165 was gone the entire shift. Review of progress note dated 07/05/25 at 2:59 P.M. revealed Resident #165 was not in the building the entire shift from 6:30 A.M. to 3:00 P.M. Review of Discharge Planning assessment dated [DATE] revealed Resident #165 expects discharge to the community. The care planning team had determined discharge was feasible. Resident #165 was marked as living alone but having concerns with housing. The assessment indicated Resident #165 needed housing and had limited to no community support. Review of social service progress note dated 07/07/25 at 11:26 A.M. revealed the social worker attempted to call the emergency contact listed for Resident #165. This was unsuccessful as the person was not someone affiliated with Resident #165. Review of social service progress note dated 07/07/25 at 12:47 P.M. revealed Resident #165's son came to building and told staff Resident #165 was safe and staying with his brother. The son was unable to provide an address or phone number. The son was encouraged to have Resident #165 contact the facility for discharge information and community resources. Review of progress note dated 07/08/25 at 7:25 A.M. revealed Resident #165 was currently on LOA. Review of social services progress note dated 07/09/25 at 11:25 A.M. revealed the social worker attempted to contact Resident #165 via phone, however, was unsuccessful. Review of social services progress note dated 07/10/25 at 4:06 P.M. revealed the social worker attempted to contact Resident #165 via phone, however, was unsuccessful. This was the last progress note recorded in Resident #165's medical record. Review of Order Summary Report for Resident #165 revealed there was no order for LOAs. Review of plan of care for Resident #165 revealed no care planning to address discharge planning or frequent use of LOAs. Interview on 04/27/26 at 3:17 P.M. with Social Services Designee (SSD) #373 revealed Resident #165 was cut by his insurance for continued stay. SSD #373 stated Resident #165 treated the facility as a shelter (homeless). SSD #373 stated Resident #165 was issued a 30-day discharge however he did not properly discharge. SSD #373 stated Resident #165 often went on LOA and confirmed she was unable to locate an order for LOAs. SSD #373 stated there were no services arranged for Resident #165 and no reports made when he did not return from LOA on 07/02/25. SSD #373 stated Resident #165 did not sign against medical advice paperwork to acknowledge his risks. Interview on 04/30/26 at 7:39 A.M. with Director of Nursing (DON) confirmed residents should have an order for LOAs. The resident was expected to sign out and tell staff where they are going and when they will return. There are LOA books at each nursing station where residents leave contact information. DON stated Resident #165 was often non-compliant with LOA procedures. DON stated Resident #165 was often on LOA and was working various jobs in the community. Review of facility policy titled Discharging the Resident dated August 2008 revealed (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	residents should be consulted about the discharge including location of discharge and why discharge was necessary. The facility should ensure the resident and the receiving location were sufficiently prepared. The facility should document the date and time of discharge, name and title of those assisting with discharge, all assessment data obtained as applicable, how resident tolerated, and signature of person completing discharge. Reporting of other information related to discharge would be completed based on professional standards of practice. Review of facility policy titled Discharging a Resident Without a Physician's Approval dated April 2007 revealed should a resident insist on a discharge without the approval of the attending physician, the resident or representative must sign a release of responsibility form. Review of facility policy titled Leave of Absence (LOA) Policy undated revealed residents have the right to leave the facility temporarily for therapeutic visits, family visits, medical appointments, personal reasons, or hospitalization provided such leave does not compromise resident safety, violate physician orders, or violate regulatory requirements. Residents requesting leave should notify the nursing staff in as far advance as possible. Nursing staff would assess condition and stability, safety concerns, medication needs, mobility and transfer requirements, cognitive status, and infection control precautions. Prior to departure staff would document date and time, expected return date and time, destination, name and contact for accompanying party, resident condition at departure, medications or supplies sent with resident, physician notification or orders, and educated provided. Upon return staff would document date and time of return, condition of resident, skin assessment as indicated, medication reconciliation, and note any incidents or injuries during leave. This deficiency represents non-compliance investigated under complaint number 2609973.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure Resident #16 was provided a written transfer notice and failed to ensure the Long-Term Care Ombudsman was notified of resident discharges for Residents #16 and #165. This affected two Residents (#16 and #165) of five reviewed for discharge. The facility census was 151. Findings include:1. Review of the closed medical record for Resident #165 revealed an admission date of 02/26/25 and discharge date of 07/01/25. Diagnoses include human immunodeficiency virus (HIV) disease, psoriasis, anemia, homelessness, anxiety disorder, recurrent major depressive disorder, and patient's noncompliance with medical treatment and regimen due to financial hardship. Review of Discharge Planning assessment dated [DATE] revealed an anticipated length of stay of three months. Barriers to returning home included health, finances, housing, and lack of support. It was noted Resident #165 had numerous health needs with no finances, support system or housing so discharge would not be considered safe. Review of Social Service History and Initial assessment dated [DATE] revealed Resident #165 was currently homeless and unemployed. Resident #165 was able to make needs known and was alert and oriented to person, place, time, and situation. Resident #165 had a brief interview for mental status (BIMS) score of 14 indicating intact cognition. Review of social service progress note dated 03/24/25 at 12:07 P.M. revealed the social worker attempted to talk with Resident #165 about his last cover date however Resident #165 was on a leave of absence (LOA). Review of expedited appeal request determination letter dated 04/02/25 revealed Resident #165 did not [NAME] the criteria for an expedited review. An appeal would be resolved within 10 days. Review of Final Adverse Benefit Determination letter dated 04/09/25 revealed Resident #165 was denied a continued stay in a skilled nursing facility from 03/22/25 through discharge. Review of Discharge Planning assessment dated [DATE] revealed Resident #165 expects discharge to the community. The care planning team had determined discharge was feasible. Resident #165 was marked as living alone but having concerns with housing. The assessment indicated Resident #165 needed housing and had limited to no community support. Review of social service progress note dated 07/07/25 at 11:26 A.M. revealed the social worker attempted to call the emergency contact listed for Resident #165. This was unsuccessful as the person was not someone affiliated with Resident #165. Review of social service progress note dated 07/07/25 at 12:47 P.M. revealed Resident #165's son came to building and told staff Resident #165 was safe and staying with his brother. The son was unable to provide an address or phone number. The son was encouraged to have Resident #165 contact the facility for discharge information and community resources. Interview on 04/30/26 at 1:01 P.M. with DON confirmed the Long Term Care (LTC) Ombudsman was not notified of Resident #165's discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of facility policy titled Discharging the Resident dated August 2008 revealed residents should be consulted about the discharge including location of discharge and why discharge was necessary. The facility should ensure the resident and the receiving location were sufficiently prepared. The facility should document the date and time of discharge, name and title of those assisting with discharge, all assessment data obtained as applicable, how resident tolerated, and signature of person completing discharge. Reporting of other information related to discharge would be completed based on professional standards of practice. 2. Resident #16 was admitted to the facility on [DATE] with diagnosis of Parkinson's acute and chronic respiratory failure dysphagia and history of cerebral infarction. Minimum Data Set (MDS) dated [DATE] revealed Resident #16 was severely cognitively impaired and was Dependent on staff for most Activities of Daily Living (ADLs). Review of the census records revealed Resident #16 was discharged to an acute care hospital on [DATE] and returned to the facility on [DATE], discharged to an acute care hospital on [DATE] and returned to the facility on [DATE]; and discharged to an acute care hospital on [DATE] and returned to the facility on [DATE]. Review of both the electronic and paper charts revealed no evidence of the Resident #16 or the Residents Representative receiving a written transfer notice or the office of the State and local ombudsman were notified of Residents #16's discharge to the hospital. Interview on 04/28/26 at 4:02 P.M. with the Social Service Designee #373 confirmed a transfer notice was not provided to Resident #16 and Ombudsman notifications were not made due to whose responsibility it was after the former social worker left the facility. This deficiency represents non-compliance investigated under complaint number 2609973.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) was completed when residents had a significant change. This affected one (Resident #41) of one resident reviewed for PASARR. The facility census was 151. Findings include:Review of the medical record for Resident #41 revealed an admission date of 03/27/25 with diagnoses including dementia with behavioral disturbance, schizophrenia, depression and anxiety. Review of the nursing progress notes for Resident #41 revealed on 10/29/25 at 4:00 P.M. she was in another resident's room pushing the television and pushing the other resident on the ground. The physician was updated and nursing had received a new order to send her for psychiatric assessment. On 10/30/25 at 9:30 P.M. she was discharged to a psychiatric facility. Further review of the medical record revealed no indication a new PASARR was completed with the significant change in mental status for Resident #41. Interview on 04/21/26 at 9:49 A.M. with Social Services Director (SSD) #373 verified a PASARR was not completed on a significant change for Resident #41 when she had a psychiatric hospital admission and change in mental status.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to revise care plans as needed. This affected three residents (#1, #56 and #81) of 62 residents reviewed for care plans. Facility census was 151.Findings include: 1. Review of Resident #56's medical record revealed an admission date of 01/30/24 and diagnoses including schizoaffective disorder bipolar type, generalized anxiety disorder, depression, type two diabetes, dementia with mood disturbance and chronic kidney disease stage three. Review of an annual minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 had severe cognitive impairment and had two or more falls since the previous assessment without injury. Review of a physician's order dated 01/20/26 revealed an order for non-slip strips applied to the floor in front of Resident #56's recliner chair. Review of a progress note dated 04/06/26 at 10:43 A.M. revealed the interdisciplinary team met and reviewed the recommendation to encourage [Resident #56] to wear proper footwear/gripper socks and to add non-skid strips in front of her recliner. Review of Resident #56's care plans for fall risk initiated 05/16/24 and 09/26/24 did not include non-skid strips in front of her recliner as an intervention. Interview on 05/04/26 at 11:21 A.M. with the Director of Nursing (DON) verified Resident #56's fall care plans did not include non-skid strips in front of her recliner as an intervention and should have. 2. Review of Resident #81's medical record revealed an admission date of 09/26/24 and diagnoses including dementia with other behavioral disturbance, anxiety, depression, hypertension and hyperlipidemia. Review of a quarterly MDS 3.0 assessment dated [DATE] revealed Resident #81 had moderate cognitive impairment and displayed disorganized thinking. Review of a physician's order dated 02/17/26 revealed an order for aripiprazole tablet (antipsychotic medication) two milligrams, give one tablet by mouth one time a day for schizophrenia. Review of a care plan initiated 09/17/24 revealed Resident #81 used psychotropic medication. Listed interventions included: administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness each shift; monitor the resident for safety as the resident is taking anti-anxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance and cognitive impairment that looks like dementia; monitor/document/report as needed (PRN) any adverse reactions to anti-anxiety therapy including drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion, disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset and blurred or double vision; provide diversional activities and non-pharmacological relief interventions and refer to psychiatrist/psychologist as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/23/26 at 12:00 P.M. with the DON revealed she did not see a care plan specific to Resident #81's antipsychotic in her medical record. Interview on 04/23/26 at 12:34 P.M. with MDS/Licensed Practical Nurse (LPN) #304 revealed she did Resident #81's care planning and stated they had pre-made templates in the electronic medical record based on the different drug classes residents had medications in. MDS/LPN #304 indicated the plan of care in place for Resident #81 for psychotropic medications was the available option for antipsychotic medications and shared she did not have access to write the care plan templates in the record herself. MDS/LPN #304 verified Resident #81's plan of care for psychotropic medications was not specific to her antipsychotic especially as many of the interventions addressed anti-anxiety medication and Resident #81 already had a care plan in place addressing antianxiety medication. 3. Review of the medical record for Resident #1 revealed an admission date of 01/20/22 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease, congestive heart failure and chronic pain. Review of the care plan dated 04/05/24 for Resident #1 revealed it had not been updated to reflect he was receiving hospice services or end of life care. Review of the hospice enrollment form dated 03/31/26 revealed Resident #1 was admitted to hospice for chronic respiratory failure. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was receiving hospice services. Interview on 04/30/26 at 8:50 A.M. with MDS/Licensed Practical Nurs (LPN) #379 verified Resident #1 did not have a care plan for end of life care or hospice services. Review of the facility policy, Care Plan and Revision Policy, no date, revealed the facility will review and update each resident's comprehensive care plan at least quarterly and whenever there is a change in the resident's condition, needs or preferences.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure blood pressure medications were monitored for safety and effectiveness. This affected one (Resident #35) of seven residents reviewed for monitoring of medications. The facility also failed to ensure to treat resident skin conditions per the physician's order. This affected two (Residents #75 and #100) of three residents reviewed for general skin conditions. The facility census was 151. Findings include:1. Review of the medical record for Resident #35 revealed an admission date of 06/23/17 with diagnoses including schizoaffective disorder, dementia, anxiety, hypertension and chronic obstructive pulmonary disease. Review of the physician's orders for Resident #35 revealed she had orders for blood pressure medications without parameters for monitoring the blood pressure. Resident #35 had an order for Propanolol 10 milligrams (mg) one time a day dated 03/13/24 and Clonidine 0.1 mg one time a day dated 03/13/24. She also had an order for monthly vitals to be obtained, including blood pressure, on dayshift on the fourth day of every month dated 03/13/24. Review of the Medication Administration Record (MAR) dated from April 2025 through April 2026 for Resident #35 revealed Propanolol and Clonidine did not have blood pressure monitoring. On further review, it was noted the monthly vital signs were not obtained on 12/04/25 and 04/04/26 as ordered. Review of the vitals section in the electronic health record for Resident #35 dated from 04/04/25 through 03/04/26 revealed blood pressure was not obtained from 04/04/25 through 09/04/25 as well as in the months of December 2025, February 2026 and April 2026. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #35 revealed she had impaired cognition. Review of the nurse practitioner progress note dated 04/07/26 for Resident #35 stated she had hypertension and the nursing staff would continue to monitor her blood pressure. Interview on 04/29/26 at 9:04 A.M. with Licensed Practical Nurse (LPN) #317, also the Assistant Director of Nursing (ADON), verified Resident #35's monthly vital signs were not taken in December 2025 and April 2026. She also verified there were no blood pressures obtained from 04/04/25 through 09/04/25. LPN #317 stated Resident #35's blood pressure should have been monitored as she was on two blood pressure medications. She stated there were usually parameters attached to the physician's order for blood pressure medications but the above listed medications had none. Review of the facility policy titled, Medication Dispensing System, revised August 2006, revealed if the medication required vital signs, they should be obtained prior to the medication administration. 2. Resident #75 was admitted to the facility on [DATE] with diagnosis Motor and sensory neuropathy schizoaffective disorder type 2 diabetes Mellitus, varicose veins of left lower extremity with ulcer on other part of lower leg, non-pressure chronic ulcer on right heel, and major depressive disorder. Review of the comprehensive annual MDS dated [DATE] revealed the resident had a mild to moderate cognitive impairment. The resident was independent in personal hygiene, upper and lower body dressing, eating, and ambulation. Resident # 75 needed supervision only for toileting and bathing or showering. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #75's Care Plan revealed the resident had care plans for moderate impairment in decision making, fluctuations in mood, and potential and actual impairment to his skin integrity, Physician orders for April 2026 included to treat abrasion to right knee and left lower extremity (leg) cleanse with wound cleanser, apply triple antibiotic ointment (TAO) and dressing every evening shift with a start date of 04/17/26 at 3:00 P.M. Observation on 04/20/26 at 4:28 P.M. revealed Resident#75 had a wound bandage on lower left extremity dated 04/16/26, Resident# 75 had a greenish brown discharge stained on the bandage. LPN #338 verified the bandage date and looked up the orders, she stated the resident was seen by the wound team on the previous Thursday, 04/16/26; and the resident's order were supposed to start Friday 04/17/26 but must have been missed by the nurses on duty, The LPN confirmed the bandage had not been changed since 04/16/26, went to clean and change the dressing immediately. Interview with the Wound Nurse #445 on 04/29/26 at 5:08 P.M. confirmed the resident's lower leg wound was not addressed, the bandage was not changed from 04/16/26 to 04/20/26 due to an oversite; but has taken measures to ensure it will not reoccur in the future. Review of the facility policy titled Care of Skin Alterations dated August 2008 reveal procedure to verify that there is a physician's order for this procedure and check the treatment record. For the residents skin alterations. 3. Review of Resident #100's medical record revealed an admission date of 01/07/25 with diagnoses of malnutrition, cellulitis of the bilateral lower extremities (BLE), type 2 diabetes mellitus, peripheral vascular disease, failure to thrive, and chronic ulcers of the BLE. Review of Resident #100's five-day Minimal Data Set (MDS) 3.0 assessment, dated 03/13/26, revealed impaired cognition. Also, Resident #100 had two deep tissue injuries and six vascular ulcers. Review of Resident #100's care plan, dated 07/28/25, revealed actual impairment due to cellulitis, fragile skin, diabetes, and venous areas with interventions in place to complete treatments as ordered. Review of Resident #100's physician orders revealed treatment orders for multiple areas to the BLE to be changed nightly. Review of Resident #100's medication administration record for April 2026 revealed BLE treatments were signed off as completed 04/16/26, 04/17/26, 04/21/26, 04/22/26, 04/23/26, 04/25/26, and 04/26/26. Interview on 04/20/26 at 8:57 A.M. with Resident #100 revealed he was unsure how often staff were changing his dressings. Observation on 04/20/26 at 9:20 A.M. revealed BLE dressings were dated 04/16/26 and wounds on the toes were not covered by a dressing. Confirmed with Licensed Practical Nurse (LPN) #456. Observation on 04/22/26 at 11:15 A.M. revealed Resident #100's BLE dressings were dated 04/16/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 04/28/26 at 10:14 A.M. revealed Resident #100's BLE dressings were dated 04/23/26. Verified with Assistant Director of Nursing (ADON) #445. Review of the facility's policy for measurement, assessment of pressure ulcers, wounds, and other skin problems, undated, revealed at first observation of any skin condition, the charge nurse or treatment nurse was responsible to measure and describe skin condition in the clinical record. All ulcers will be measured weekly and results recorded. Identify the type of ulcer present. The clinical record should clearly support the clinical basis for the determination of the etiology of the ulcer. Assess the wound. Describe any problems and additional wound descriptions. Describe any problems with adherence to treatment or wounds and/or prevention interventions. This deficiency represents non-compliance investigated under Complaint Number 2668600.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and policy review, the facility failed to ensure skin was assessed appropriately and pressure ulcers were treated timely for residents. This affected one (Resident #41) of three residents reviewed for wounds. The facility census was 151. Findings include:Review of the medical record for Resident #41 revealed an admission date of 03/27/25 with diagnoses including Alzheimer's Disease, dementia, heart failure, hypertension and adult failure to thrive. Review of the braden scale assessment dated [DATE] for Resident #41 revealed she was at moderate risk for skin breakdown. Review of the shower sheet for Resident #41 dated 02/13/26 revealed her skin was intact. Review of the skilled nursing assessment dated [DATE] by Licensed Practical Nurse (LPN) #406 revealed Resident #41 did not have any changes in skin integrity and there was no wound care being performed. Review of the nurse practitioner progress note dated 02/16/26 for Resident #41 revealed there was a right lower extremity pressure ulcer to her right ankle. The nurse practitioner ordered triple antibiotic ointment and a pad and protective dressing to the area with an offloading boot. She also ordered for Resident #41's right ankle to be seen by the wound physician. Review of the physician's orders for Resident #41 for 02/16/26 and 02/17/26 revealed nursing staff had not entered the nurse practitioner's orders for her right ankle pressure ulcer for the dressing and offloading boot. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #41 had severe cognitive impairment. She was dependent on staff for activities of daily living. There were no noted pressure areas, foot ulcers or open lesions to the foot. Review of the progress note dated 02/17/26 by Wound Physician #467 revealed Resident #41 had a stage III pressure injury (full-thickness skin loss potentially extending into the subcutaneous tissue layer) to her right lateral ankle. Wound Physician #467 classified this pressure injury as a stage III due to the location. He ordered a new treatment and heel boots to be on while in bed. Interview on 04/27/26 at 1:21 P.M. with LPN #445 revealed she was the facility's wound nurse. She verified the nurse's skilled assessment dated [DATE] stated there were no new skin issues to Resident #41. She also verified the nurse practitioner's treatment orders on 02/16/26 for Resident #41 were not entered into the computer. Interview on 04/28/26 at 2:35 P.M. with LPN #406 verified she had not assessed Resident #41 on 02/16/26. She stated the certified nursing assistants would alert her if there were skin changes and they had not updated her on new concerns with Resident #41's skin. Review of the facility policy titled, Measurement, Assessments of Pressure Ulcers, Wounds and Other Skin Problems, undated, stated at first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and describe the skin condition in the clinical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure sufficient interventions were in place to maintain resident nutritional status. This affected three Residents (#2, #41, and #110) of seven reviewed for nutrition services. The facility census was 151. Findings include:1. Review of the medical record for Resident #2 revealed an admission date of 03/02/26 and diagnoses including dementia, adult failure to thrive, generalized anxiety disorder, heart failure, need for assistance with personal care, and suicidal ideations. Review of weight dated 03/02/26 revealed Resident #2 weighed 184.0 pounds and was weighed in a wheelchair. Review of weight dated 03/12/26 revealed Resident #2 weighed 175.0 pounds and was weighed while standing. Review of weight dated 03/13/26 revealed Resident #2 weighed 173.0 pounds and was weighed while standing. Review of physician's order dated 03/13/26 revealed order for regular diet with regular texture and thin liquids. Review of progress note dated 03/18/26 at 10:36 A.M. revealed Resident #2 was evaluated for clinical nutrition admission. Dietitian notes Resident #2 consuming 75-100 percent (%) of meals. Resident #2 had significant weight loss of 6.0 % in one month following return from hospitalization. Plan to provide house supplement twice per day for variable oral intake. There was no evidence Resident #2's food preferences were reviewed. Review of weight dated 03/19/26 revealed Resident #2 weighed 173.0 pounds and was weighed using a mechanical lift (sit to stand). Review of physician's order dated 03/20/26 revealed an order for weekly weights for four weeks on Fridays. Review of nurse practitioner (NP) progress note dated 03/23/26 revealed Resident #2 complained about the food. NP gave order to add Ensure supplement and consult the dietitian. There was no evidence Resident #2's food preferences were reviewed. Review of progress note dated 03/23/25 at 2:28 P.M. revealed Resident #2 refused Hi-cal and Ensure supplements. Resident #2 stated they were nasty. There was no evidence Resident #2's food preferences were reviewed. Review of meal intake recorded from 03/23/26 to 04/20/26 revealed Resident #2 refused meals on 03/27/26 at dinner, on 04/01/26 at breakfast and lunch, on 04/06/26 at breakfast and lunch, 04/10/26 at lunch, on 04/13/26 at breakfast and lunch, on 04/14/26 at dinner, on 04/15/26 at breakfast, lunch and dinner, on 04/16/26 at lunch, on 04/18/26 at breakfast, on 04/19/26 at breakfast, lunch and dinner, and on 04/20/26 at breakfast, lunch and dinner. Review of progress note dated 03/24/26 at 12:40 P.M. revealed Resident #2 refused Hi-cal and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure supplements. Review of NP progress note dated 03/25/26 revealed Resident #2 presented with nine-pound weight loss since 03/02/26. NP questioned if the weight was accurate due to method used. Review of weight dated 03/27/26 revealed Resident #2 weighed 172.0 pounds and was weighed using a mechanical lift (sit to stand). Review of progress note dated 03/27/26 at 11:26 A.M. revealed Resident #2 refused ensure supplement. Review of progress note dated 04/01/26 at 10:28 A.M. revealed Resident #2 had significant weight loss of over 30 days. Resident #2 has had a 12-pound weight change from admission. Dietitian questioned accuracy of weights and noted differing methods for weighing including wheelchair, standing, and mechanical lift. Dietitian noted Resident #2 had been refusing meals and supplements. Plan to trial Magic Cup twice daily. There was no evidence Resident #2's food preferences were reviewed. Review of physician's order dated 04/02/26 revealed order for Magic Cup twice per day for nutritional supplement. Review of weight dated 04/03/26 revealed the weight was struck out as incorrect documentation. There was no reweight recorded for accuracy of weights. Review of weight dated 04/07/26 revealed the weight was struck out as incorrect documentation. There was no reweight recorded for accuracy of weights. Review of progress note dated 04/08/26 at 9:11 A.M. revealed Resident #2 had significant weight loss over 30 days. Resident #2 had a 12-pound weight change from admission. Dietitian indicated the weight was stable from 03/27/26 weight. Plan to continue weekly weights. There was no evidence Resident #2's food preferences were reviewed. Review of weight dated 04/10/26 revealed Resident #2 weighed 172.2 pounds and was weighed using a mechanical lift (sit to stand). Review of NP progress note dated 04/13/26 revealed Resident #2's acute weight loss may be secondary to multiple variations of weighing. Continue to monitor closely. Review of weight dated 04/17/26 revealed Resident #2 weighed 128.5 pounds and was weighted using a mechanical lift (sit to stand). Review of progress note dated 04/20/26 at 4:17 P.M. revealed Resident #2 had significant weight loss over 30 days. Resident #2 has had 55-pound weight change from admission. Dietitian noted the weight was likely inaccurate and requested a reweight. There was no evidence Resident #2's food preferences were reviewed. Review of progress note dated 04/22/26 at 5:55 P.M. revealed Resident #2 had refused all meals. Nurse was encouraging small bites of food. Resident #2 refused and stated he wanted to see his doctor for poor appetite. Review of weight dated 04/22/26 revealed Resident #2 weighed 129.6 pounds and was weighed in a wheelchair. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/22/26 at 3:02 P.M. with Dietary Manager (DM) #458 revealed resident food preferences were mostly obtained if something was reported to therapy or nursing staff. DM #458 stated there are forms for food preferences but the last one she could locate was completed by the former DM. DM #458 was unable to describe a system for maintaining current food preferences to meet each resident's needs. Review of progress note dated 04/28/26 at 1:49 P.M. revealed a re-weight indicated a possible weight loss from admission. Dietitian noted possible inaccuracy in the significance of weight loss. Resident #2 had been refusing multiple meals with poor appetite. Resident #2 had order for Magic Cup supplement twice per day. Remeron was ordered on 04/01/26 to promote appetite. Resident #2 working with speech therapy starting on 04/13/26 for dysphagia management and to encourage intake. Resident #2 was requesting a physician consultation due to poor appetite. There was no evidence Resident #2's food preferences were reviewed. Interview on 04/28/26 at 10:06 A.M. with Licensed Practical Nurse (LPN) Assistant Director of Nursing (ADON) #317 revealed Resident #2 was not eating or drinking well here and reported he felt like a burden. LPN ADON #317 reviewed Resident #2's weights and confirmed there were discrepancies in his weights. LPN ADON #317 indicated she observed Resident #2 be weighed herself on 04/22/26 and confirmed this weight was accurate. LPN ADON #317 indicated accurate weights had been an ongoing issue and about three months ago they had started a weight program. LPN ADON #317 indicated they had arranged for a single nurse aid to obtain all the monthly weights. LPN ADON #317 indicated they still were having issues and noted scale calibration issues, so they had a company come in and calibrate scales. LPN ADON #317 indicated they were still having weight issues and noted the aide was not using the same method to weigh residents each time. LPN ADON #317 indicated she also noted nursing staff who entered weights were not checking if there were weight discrepancies. Interview on 04/28/26 at 10:52 A.M. with Certified Nursing Aide (CNA) #330 revealed Resident #2 refused all meals she had attempted to give him. CNA #330 stated Resident #2 threw his breakfast tray on her. Interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she made a visit to the building every other week and completed the rest of her time offsite. Dietitian #468 confirmed Resident #2 was being monitored for significant weight loss and poor appetite. Dietitian #468 reported Resident #2 was refusing meals and supplements. Dietitian #468 indicated she suspected Resident #2's weight discrepancies were related to the scale. Dietitian #468 reported she often has to request reweighs and had discussed discrepancies with the facility. Review of progress note dated 04/28/26 at 4:09 P.M. revealed the nurse practitioner assessed Resident #2's poor appetite. Interview on 05/04/26 at 12:03 P.M. with CNA #325 revealed she was the designated staff member completing monthly weights. CNA #325 stated there was an issue with the mechanical sit to stand lift not being calibrated a few months ago. CNA #325 stated she does not obtain the daily or weekly weights ordered by the dietitian. CNA #325 stated the floor staff manage those. CNA #325 stated staff should be going a reweight automatically if they notice a five-pound difference from the last weight. Review of facility policy Weight Assessment and Intervention dated August 2008 revealed nursing staff would measure resident weights upon admission and would not use hospital weights as (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	admission weight. Resident weights would be taken for four weeks following admission. Any weight changes greater than five pounds within 30 days would be taken for confirmation. If the weight change was verified the dietitian would be notified. Review of facility policy titled Resident Food Preferences Policy undated revealed nutrition assessments would include an evaluation of individual food preferences. The dietitian was expected to complete initial food preferencing within 72 hours of admission and periodically to determine if revisions were needed. The food service department would offer a limited number of food substitutes for individuals who do not want to eat the primary meal. The facility's Quality Assessment and Assurance (QAA) program would periodically review issues related to food preferences and meals to identify widespread concerns. 2. Review of the medical record for Resident #110 revealed an admission date of 04/11/25 and diagnoses including abnormal weight loss, oral phase dysphagia, hypokalemia, secondary parkinsonism, generalized anxiety disorder, and paranoid schizophrenia. Review of weight dated 04/12/25 revealed Resident #110 weighed 204.0 pounds and was weighed using a mechanical lift. Review of physician's order dated 05/08/25 revealed order for regular diet with mechanical soft texture and thin liquids. Review of weight dated 10/01/25 revealed Resident #110 weighed 176.0 pounds and was weighed in a wheelchair. Review of physician's order dated 10/09/25 revealed order for four ounces of two-calorie med pass supplement three times per day. Review of weight dated 11/01/25 revealed Resident #110 weighed 174.0 pounds and was weighed in a wheelchair. Review of weight summary revealed there was not a weight for December 2025 available for review. Review of weight dated 01/05/26 revealed Resident #110 weighed 175.2 pounds and was weighed in a wheelchair Review of weight dated 02/01/26 revealed Resident #110 weighed 156.0 pounds and was weighed while standing. Review of progress note dated 02/02/26 revealed Resident #110 had significant weight loss over last 30 days with loss of 19 pounds. A reweigh was requested to verify significance of weight loss. Resident #110 had no changes in appetite. Plan for Resident #110 to be evaluated by speech therapy. There was no evidence Resident #110's food preferences were reviewed. Review of weight dated 02/03/26 revealed Resident #110 weighed 158.0 pounds and was weighed while standing. Review of progress note dated 02/18/26 revealed Resident #110 had significant weight loss over 30 days with loss of 17 pounds. Plan to continue monitoring Resident #110's weights. There was no (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	evidence Resident #110's food preferences were reviewed. Review of physician's order dated 02/20/26 revealed an order for weekly weights for four weeks on Fridays. Review of weight dated 02/20/26 revealed Resident #110 weighed 152.0 pounds and was weighed while standing. Review of weights revealed there was no weight available for 02/27/26 weekly weight as ordered. Review of weight dated 03/04/26 revealed Resident #110 weighed 158.0 pounds and was weighed using a mechanical lift (sit to stand). Review of weight dated 03/13/26 revealed Resident #110 weighed 154.0 pounds and was weighed in a wheelchair. Review of progress note dated 03/13/26 revealed Resident #110 was reviewed for quarterly nutrition assessment. There were no changes to nutritional plan of care. There was no evidence Resident #110's food preferences were reviewed. Review of physician's order dated 04/07/26 revealed an order for weekly weights for four weeks on Wednesdays. Review of weight dated 04/07/26 revealed Resident #110 weighed 152.0 pounds and was weighed while standing. Review of Nurse Practitioner (NP) progress note dated 04/07/26 revealed Resident #110 had progressive weight loss since admission. Resident #110 reported poor appetite. NP noted weight loss to be chronic and concerning. NP reported significant weight loss of about 50 pounds in the last year. Resident #110 reported he does not like the food. Plan to add fortified ice cream at every meal and to continue to monitor weekly weights. Review of physician's order dated 04/07/26 revealed order for magic cup supplement three times per day with meals. Review of weights revealed there was no weight available for 04/15/26 weekly weight as ordered. Review of progress note dated 04/18/26 revealed Resident #110 was reviewed for annual nutritional assessment. There were no changes to nutritional plan of care. There was no evidence Resident #110's food preferences were reviewed. Review of weight dated 04/22/26 revealed Resident #110 weighed 140.0 pounds and was weighed while standing. Interview on 04/22/26 at 3:02 P.M. with Dietary Manager (DM) #458 revealed resident food preferences were mostly obtained if something was reported to therapy or nursing staff. DM #458 stated there are forms for food preferences but the last one she could locate was completed by the former DM. DM #458 was unable to describe a system for maintaining current food preferences to meet each resident's needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of meal intake for April 2026 revealed Resident #110 refused meals on 04/03/26 at lunch, on 04/06/26 at breakfast and lunch, on 04/07/26 at breakfast and lunch, on 04/08/26 at breakfast, on 04/11/26 at breakfast and lunch, on 04/15/26 at breakfast and lunch, on 04/17/26 at breakfast, on 04/20/26 at breakfast, lunch and dinner, on 04/21/26 at breakfast and lunch, on 04/22/26 at breakfast, on 04/24/26 at lunch, on 04/25/26 at breakfast and lunch, on 04/26/26 at breakfast and lunch, on 04/27/26 at lunch, on 04/28/26 at breakfast, and on 04/29/26 at breakfast. Interview on 04/28/26 at 10:06 A.M. with Licensed Practical Nurse (LPN) Assistant Director of Nursing (ADON) #317 revealed accurate weights had been an ongoing issue and about three months ago they had started a weight program. LPN ADON #317 indicated they had arranged for a single nurse aid to obtain all the monthly weights. LPN ADON #317 indicated they still were having issues and noted scale calibration issues, so they had a company come in and calibrate scales. LPN ADON #317 indicated they were still having weight issues and noted the weights aide was not using the same method to weigh residents each time. LPN ADON #317 indicated she also noted nursing staff who entered weights were not checking if there were weight discrepancies. Interview on 04/28/26 at 12:51 P.M. with Certified Nursing Assistant (CNA) #425 revealed Resident #110 does not like the food and will generally only eat a couple bites at meals. CNA #425 reported she had noticed Resident #110 appeared to have lost weight in the past few months. Interview on 04/28/26 at 1:07 P.M. with Dietitian #468 revealed she made a visit to the building every other week and completed the rest of her time offsite. Dietitian #468 confirmed Resident #110 was being monitored for significant weight loss and poor appetite. Dietitian #468 indicated Resident #110 had lost additional weight between 04/07/26 to 04/22/26 so she had requested a reweight however there was not a reweigh for review at this time. Dietitian #468 reported she often has to request reweighs and had discussed discrepancies in weights with the facility. Interview on 04/29/26 at 11:25 A.M. with Registered Nurse (RN) Unit Manager (UM) #457 revealed if the dietitian felt a weight was inaccurate they would ask for a reweigh on their recommendation sheets. RN UM #457 stated CNA #325 obtained monthly weights. RN UM #457 stated she knew of some issues with scales being calibrated and stated the last time she knew the scales were calibrated was in January 2026. RN UM #457 stated she did not have concerns with weight discrepancies. RN UM #457 reviewed Resident #110's weights and confirmed weight changes. RN UM #457 stated Resident #110 had recently been having diarrhea and he did not like the mechanical soft texture. Interview on 05/04/26 at 12:03 P.M. with CNA #325 revealed she was the designated staff member completing monthly weights. CNA #325 stated there was an issue with the mechanical sit to stand lift not being calibrated a few months ago. CNA #325 stated she does not obtain the daily or weekly weights ordered by the dietitian. CNA #325 stated the floor staff manage those. CNA #325 stated staff should be going a reweight automatically if they notice a five-pound difference from the last weight. Review of facility policy Weight Assessment and Intervention dated August 2008 revealed nursing staff would measure resident weights upon admission and would not use hospital weights as admission weight. Resident weights would be taken for four weeks following admission. Any weight changes greater than five pounds within 30 days would be taken for confirmation. If the weight change was verified the dietitian would be notified. Review of facility policy titled Resident Food Preferences Policy undated revealed nutrition (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	assessments would include an evaluation of individual food preferences. The dietitian was expected to complete initial food preferencing within 72 hours of admission and periodically to determine if revisions were needed. The food service department would offer a limited number of food substitutes for individuals who do not want to eat the primary meal. The facility's Quality Assessment and Assurance (QAA) program would periodically review issues related to food preferences and meals to identify widespread concerns. 3. Review of the medical record for Resident #41 revealed an admission date of 03/27/25 with diagnoses including Alzheimer's Disease, dementia, dysphagia (difficulty swallowing), hypertension and adult failure to thrive. Resident #41 was noted to be discharged to a psychiatric facility on 10/30/25 and was readmitted to the facility on [DATE]. Review of the care plan dated 03/28/25 revealed Resident #41 was at increased risk of malnutrition as evidenced by mechanically altered diet, depression and medications. Interventions included to monitor weights as provided and to monitor changes in weight and notify the dietitian. Review of Resident #41's weights from 10/03/26 through 01/03/26 revealed:-10/03/25 158.6 pounds via wheelchair-11/13/25 184.0 pounds via wheelchair-11/20/25 172.2 pounds via mechanical lift-11/28/25 174.1 pounds via mechanical lift-11/30/25 174.1 pounds via wheelchair-12/04/25 180.2 pounds via wheelchair, weighed at 7:09 A.M.-12/04/25 160.0 pounds via wheelchair, weighed at 5:16 P.M.-12/15/25 162.2 pounds via mechanical; lift-12/30/25 156.0 pounds via wheelchair-01/03/26 162.0 Pounds via wheelchair Review of the nursing admission assessment dated [DATE] revealed Resident #41 was admitted from the hospital. Nursing staff had utilized Resident #41's weight from 10/03/25 of 158.6 as her admission weight. Review of the physician's orders for Resident #41 revealed orders for weekly weights for four weeks dated 11/06/25, monthly weights dated 12/03/25 and weekly weights must be done dated 12/30/25. Review of the modified quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #41 revealed she had severe cognitive impairment. Resident #41 was documented as having no weight loss, however, she had a weight gain noted of five percent or more in the last month or gain in the last six months. Interview on 04/28/26 at 10:06 A.M. with Licensed Practical Nurse (LPN) Assistant Director of Nursing (ADON) #317 indicated inaccurate weights had been an ongoing issue and about three months ago they had started a weight program. LPN ADON #317 indicated they had arranged for a single nurse aid to obtain all the monthly weights. LPN ADON #317 indicated they still were having issues and noted scale calibration issues, so they had a company come in and calibrate scales. LPN ADON #317 indicated they were still having weight issues and noted the weights aide was not using the same method to weigh residents each time. LPN ADON #317 indicated she also noted nursing staff who entered weights were not checking if there were weight discrepancies. Interview on 04/28/26 at 10:31 A.M. with the Director of Nursing (DON) verified Resident #41's weight was not obtained on admission on [DATE]. She also verified that weekly weights were not done as ordered in December 2025. Interview on 04/28/26 at 1:31 P.M. with Dietitian #468 revealed the expectation was the staff were to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	obtain resident weights on admission. She felt Resident #41 was at her baseline weight and some of her listed weights were errors. Interview on 05/04/26 at 12:03 P.M. with CNA #325 revealed she was the designated staff member completing monthly weights. CNA #325 stated there was an issue with the mechanical sit to stand lift not being calibrated a few months ago. CNA #325 stated she does not obtain the daily or weekly weights ordered by the dietitian. CNA #325 stated the floor staff manage those. CNA #325 stated staff should be going a reweight automatically if they notice a five-pound difference from the last weight. Review of facility policy Weight Assessment and Intervention dated August 2008 revealed nursing staff would measure resident weights upon admission and would not use hospital weights as admission weight. Resident weights would be taken for four weeks following admission. Any weight changes greater than five pounds within 30 days would be taken for confirmation. If the weight change was verified the dietitian would be notified.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to maintain oxygen tubing in a hygienic manner and per standards of practice. This affected three residents (Resident #11, #32 and #42) of four residents reviewed for respiratory care. Facility census was 151.Findings include:1. Review of Resident #11's medical record revealed an admission date of 03/07/14 and diagnoses including lupus, chronic respiratory failure, type two diabetes, depression, dementia with other behavioral disturbance and anxiety. Review of an annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had moderate cognitive impairment and displayed inattention and disorganized thinking. Review of Resident #11's physician's orders revealed an order dated 02/25/26 for oxygen at two liters as needed to maintain oxygen saturation above 88. Call nurse practitioner if oxygen saturation is below 88. Observation on 04/19/26 at 5:20 P.M. with the Director of Nursing (DON) revealed Resident #11's oxygen tubing was dated 03/16/26. Interview with the DON at the time of observation verified the tubing needed to be changed as it was due to be changed weekly which had not been completed. 2. Review of Resident #42's medical record revealed an admission date of 10/28/22 and diagnoses including acute and chronic respiratory failure, type two diabetes, peripheral vascular disease, anxiety and schizoaffective disorder. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had moderate cognitive impairment and rejected care one to three days in the seven day look-back period. Review of Resident #42's physician orders as of 04/19/26 revealed there were no current orders for oxygen. Observation on 04/19/26 at 10:28 A.M. with Registered Nurse (RN) #446 revealed Resident #42's oxygen tubing was not dated. Interview with RN #446 at the time of observation verified the tubing was not dated and needed to be changed. Follow-up interview on 04/21/26 at 11:13 A.M. with the DON verified Resident #42's last order for oxygen was discontinued on 08/18/25 and confirmed Resident #42 needed an order for oxygen administration so she would be contacting the nurse practitioner right now to obtain one. 3. Review of the medical record for Resident #32 revealed an admission date of 02/15/26 with diagnoses including hemiplegia, heart failure, dementia, and chronic obstructive pulmonary disease. Review of the care plan dated 03/26/24 for Resident #32 revealed she had respiratory distress and interventions included to administer oxygen at 2 liters per the nasal canula. Review of the physician's orders for Resident #32 revealed she had an order for oxygen at 2 liters via nasal canula to maintain oxygen saturation at 92% or greater dated 09/11/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 04/19/26 at 2:03 P.M. revealed Resident #32's oxygen concentrator was set at 4.5 liters. Certified Nursing Assistant (CNA) #418 verified the oxygen concentrator was set at 4.5 liters. She stated she will update the nurse the oxygen settings were incorrect. She also verified the oxygen tubing was not dated when it had been changed by nursing staff. Observation on 04/21/26 at 7:45 A.M. revealed Resident #32's oxygen concentrator was set at 4.5 liters. Licensed Practical Nurse (LPN) #374 verified the oxygen setting was incorrect and should have been on 2 liters. Review of the facility policy titled, Oxygen Tubing, undated, revealed residents were to have their nasal cannulas and tubing changed every seven days and as needed. Staff were to label with a piece of tape and mark the date on the tubing.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to provide comprehensive pre and post dialysis monitoring. This affected one resident (#160) of one resident receiving dialysis at the facility. Facility census was 151. Findings include: Review of Resident #160's medical record revealed an admission date of 04/17/26 and diagnoses including end stage renal disease, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, dementia and Alzheimer's disease.Review of Resident #160's physician orders as of 04/21/26 revealed an order dated 04/17/26 for dialysis: length of treatment time 3.25 hours, type of dialyzer (blank), parameters of dialysis delivery system: electrolyte composition of dialysate (blank), blood flow rate (blank), dialysate flow rate (blank), anticoagulation (blank) target weight (blank); an order dated 04/17/26 for dialysis: check access site for bruit and thrill, record/report abnormalities immediately every shift record + or = and notify physician if absent; an order dated 04/17/26 for dialysis: check permacath site daily and upon return from dialysis and check that caps are secure one time a day every Monday, Wednesday and Friday; an order dated 04/17/16 for if bleeding noted at dialysis site apply direct pressure to site and transfer to emergency room; an order dated 04/17/26 for dialysis: may reinforce dressing to dialysis site as needed; and an order dated 04/17/26 for dialysis: renal dialysis at (blank) organization/location, frequency (blank) and transported by (blank).Review of Resident #160's assessments did not include pre and post dialysis monitoring.Review of Resident #160's nurses' notes from 04/17/26 to 04/21/26 did not mention dialysis care and service.Review of Resident #160's care plan for hemodialysis due to renal failure dated 04/19/26 revealed interventions including check and change dressing to right upper extremity (permacath) at access site and document; check for bruit and thrill per order; do not draw blood or take blood pressure in arm with graft; encourage resident to go to the scheduled dialysis appointments that resident receives Monday, Wednesday and Friday; if bleeding occurs, hold pressure and send to emergency room; monitor for dry skin and apply lotion as needed; monitor/document/report to physician signs and symptoms of depression and obtain order for mental health consult if needed; monitor/document/report as needed (PRN) any signs or symptoms of infection to access site including redness, swelling, warmth or drainage; monitor/document/report PRN any signs or symptoms of renal insufficiency including changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds; monitor/document/report PRN for signs and symptoms of bleeding, hemorrhage, bactremia and septic shock; montiro/document/report PRN new/worsening peripheral edeam; work with resident to relieve discomfort for side effects of disease and treatment including cramping, fatigue, headaches, itching, anemia, bone demineralization, body image change and role disruption. The care plan did not include pre and post dialysis monitoring.Review of a dialysis report for Resident #160 dated 04/21/26 revealed she had dialysis offsite on 04/20/26 from 7:19 A.M. to 10:17 A.M. Phone interview on 04/21/26 at 8:12 A.M. with Resident #160's guardian revealed Resident #160 had been receiving renal dialysis the last two years that she was her guardian. Resident #160's guardian stated Resident #160 had received dialysis yesterday, 04/20/26 and was supposed to be receiving dialysis Mondays, Wednesdays and Fridays off-site. Interview on 04/21/26 at 8:34 A.M. with Licensed Practical Nurse (LPN) #425 revealed she had gotten report from midnight shift staff Resident #160 had received dialysis off-site on 04/20/26 and that Assistant Director of Nursing (ADON)/LPN #317 would have the paperwork.Interview on 04/21/26 at 8:38 A.M. with ADON/LPN #317 revealed Resident #160 had went for her first dialysis treatment on 04/20/26 since she was admitted to the facility on [DATE]. ADON/LPN #317 stated medical records staff would have set up Resident #160's hemodialysis and Resident #160 would come back to the facility with a pre and post dialysis document. ADON/LPN #317 reviewed Resident #160's record with the surveyor and stated Resident #160 should have her blood pressure checked before and after dialysis treatments and confirmed this information could not (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	be found within her record. ADON/LPN #317 also confirmed there was not an order pertaining to when Resident #160 was to receive dialysis and there was no progress note saying that Resident #160 went to dialysis on 04/20/26 and stated if Resident #160 came back to the facility from dialysis then this should have also been documented in the record.Interview on 04/21/26 at 8:46 A.M. with the Director of Nursing (DON) revealed there was a dialysis communication form that was to go to dialysis treatment with the resident and staff were to obtain vitals including blood pressure, weight and bruit and thrill at the dialysis site both before and after the dialysis treatment. The DON verified there were no dialysis pre or post assessments located in Resident #160's record as of the time of the interview and could not provide the dialysis communication form for surveyor review. The DON also verified no blood pressure was recorded for Resident #160 on 04/20/26.Review of the undated policy, Pre-Dialysis Monitoring and Observation, revealed all residents scheduled for dialysis shall receive a pre-dialysis assessment to identify clinical instability. Assess a resident within 2-4 hours prior to scheduled dialysis transport. Required clinical assessments included vital signs blood pressure, heart rate, respiratory rate, temperature and weight. Review of the undated policy, Post Dialysis Monitoring and Observation with Implanted A-V Shunt, revealed monitoring and an after observation will be conducted by the charge nurse post dialysis. Documentation was to include blood pressure and vital signs, clinical information notes from observation and monitoring and blood pressure to be done on unaffected arm.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of facility policy and job descriptions, the facility failed to ensure residents received sufficient and appropriate social services to meet the residents psychosocial and emotional needs. This affected one resident (Resident #138) of 21 reviewed for social services needs. The facility census was 151. Findings include:Review of the medical record for Resident #138 revealed an admission date of 11/25/24 and diagnoses including dementia with mood disturbance, chronic kidney disease, generalized anxiety disorder, hyperlipidemia, osteoarthritis, and essential hypertension. Resident #138's son was listed as a resident representative. Review of the plan of care dated 12/03/24 revealed Resident #138 had mood problem related to dementia with agitation. Interventions included administer medications as ordered, encourage resident involvement with activities of interest as tolerated, meet with resident one on one to encourage resident to verbalize feelings, concerns and fears, monitor and report to physician any changes in mood, and refer to psych services as needed. Review of the plan of care dated 02/07/25 revealed Resident #138 experienced delirium, hallucinations, and delusions. Interventions included ensure resident safety, provide diversional activities, and staff would maintain food items on tray to differentiate from food of others. Review of psychiatric note dated 03/07/25 revealed Resident #138 was anxious and irritable. Resident #138 had delusions and was experiencing a mild degree of psychomotor retardation. Resident #138 had poor concentration, insight, and judgement. Review of progress note dated 06/13/25 at 1:01 P.M. revealed Resident #138 did not participate in activities. Review of plan of care meeting notes from 07/31/25 revealed the meeting needed to be re-scheduled. Further review of the medical record for Resident #138 revealed there was no evidence of a care plan meeting held since 04/10/25. There was no evidence the care plan meeting on 07/31/25 was re-scheduled as indicated. Review of physician's order dated 08/01/25 revealed Resident #138 was admitted to a secured unit to promote safety and quality of life. Review of the plan of care dated 08/05/25 revealed Resident #138 had impaired cognitive functioning and impaired thought process. Interventions included ask yes/no questions to determine needs and communicate with the resident, family or caregivers regarding capabilities and needs. Review of progress note dated 11/22/25 at 8:15 A.M. revealed Resident #138 had grayish black ecchymosis areas to left outer upper arm, left outer wrist area, and right inner arm. Resident #138 did not complain of any pain. Resident #138 was noted to have fragile skin and was on a daily aspirin. Resident #138 was noted to ambulate independently. There were no noted accidents or events related to bruising. Review of Self-Reported Incident (SRI) Form number 267836 dated 11/22/25 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted bruising on Resident #138's left upper outer arm, left outer wrist, and right inner wrist. Resident #138 was unable to report what had happened. It was noted the facility did not suspect abuse due to location and shape of bruising. It was noted Resident #138 can be combative with care and independently ambulates on the unit. The facility was unable to determine the origin of bruising. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 267836 revealed no identification of root cause. There was no evidence to suggest emotional or social services support was provided. Review of progress note dated 11/24/25 at 6:38 A.M. revealed Resident #138 became agitated during blood draw. Review of Nurse Practitioner (NP) progress note dated 11/24/25 revealed Resident #138 seen for evaluation for contusion to the arm. NP ordered long sleeves to protect skin. Resident #138 noted to be poor historian and pleasantly confused. Resident #138 with nonsensical conversation. Review of progress note dated 12/01/25 at 4:58 P.M. revealed Resident #138 had increase wandering and was attempting to push others in their wheelchairs causing agitation. Review of progress note dated 12/02/25 at 3:32 P.M. revealed Nurse Practitioner (NP) recommended Resident #138 be seen by (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	psychological services. Review of progress note dated 12/04/25 at 4:07 P.M. revealed Resident #138 tested positive for COVID-19 and required isolation until 12/15/25. Review of psychiatric note dated 12/05/25 revealed Resident #138 was pleasantly confused and it was unclear if she could comprehend what was being asked of her. Resident #138 was tearful during the assessment. It was noted Resident #138's husband had passed away a few months prior and it was unclear if Resident #138 was aware of his passing. Review of progress note dated 12/11/25 at 10:25 P.M. revealed Resident #138 was combative with care. Review of psychiatric note dated 12/23/25 revealed Resident #138 was unable to comprehend and respond appropriately. Resident #138's speech was nonsensical, remained delusional, and had poor concentration, insight, and impulse control. Review of progress note dated 01/23/26 at 10:00 P.M. revealed Resident #138 had a lump with bruising on right forearm. There was also bruising noted to inner right forearm. Resident #138 denied pain. Resident #138 was unable to report what had happened. Resident #138 was noted to have a history of being combative with care. There were no noted accidents or events related to bruising or a lump. Review of progress note dated 01/23/26 at 10:30 P.M. revealed Resident #138 had order for x-ray to the right forearm and new order for antibiotics. Review of Self-Reported Incident (SRI) Form number 270153 dated 01/23/26 revealed the facility reported to the State Agency an injury of unknown origin for Resident #138. Staff noted a lump with bruising on Resident #138's lateral right forearm and bruising on medial forearm. Resident #138's family and NP were notified. The facility initiated 15-minute checks. Resident #138 was unable to provide a description of what had happened to her arm. The SRI was unsubstantiated as evidence indicates abuse, neglect, or misappropriation did not occur. Review of the facility's investigation for SRI number 270153 revealed no identification of root cause. There was no evidence to suggest emotional or social services support was provided. Review of radiology result dated 01/24/26 at 11:57 A.M. revealed no evidence of acute fracture. There was noted soft tissue swelling over the latera aspect of proximal shaft of the radius consistent with hematoma. Review of NP progress note dated 01/26/26 revealed Resident #138 seen for evaluation of bruise to right forearm. The bruise was of unknown etiology per nursing and Resident #138. There was no noted trauma or injury. Resident #138 remained pleasantly confused. NP unable to identify etiology of bruising. Review of psychiatric note dated 02/04/26 revealed Resident #138 continued to have poor social cognition and safety awareness. Unable to rule out Resident #138 experiencing delusions. Continue with Buspar, Aricept, and Namenda. Review of Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #138 was unable to participate in brief interview for mental status (BIMS) assessment as Resident #138 was rarely or never understood. Resident #138 had short- and long-term memory problems and severely impaired decision-making ability. Resident #138 scored 12 on mood assessment indicating moderate depression. Resident #138 was noted to have delusions. Resident #138 required substantial/maximal assistance from staff for personal hygiene, bathing, and upper body dressing and was dependent on staff assistance for lower body dressing and toileting hygiene. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #138 was unable to participate in interview resulting in score of 99. Review of psychiatric note dated 03/20/26 revealed Resident #138 extremely difficult to hear and was unable to volunteer much information. Resident #138 exhibiting psychomotor retardation. Resident #138 was alert to self, had an angry mood, and irritable affect. Resident #138 remained guarded and suspicious. Resident #138 had poor concentration, insight, and judgement. Resident #138 on 28 milligrams (mg) of Namenda, 10 mg Aricept, and 5 mg Buspar twice daily. Resident #138 required supportive therapy. Review of progress note dated 03/27/26 at 2:20 P.M. revealed Resident #138's right wrist was red and swollen. Resident #138 complained of pain when moving the wrist. NP was notified and gave new orders for x-ray and two tablets of Tylenol 500 milligrams twice daily for three days for pain. There were no noted accidents or events related to the redness, swelling, and pain. Review of facility's SRIs revealed no evidence an SRI was reported to the State Agency on or around 03/27/26 for an injury of unknown origin for Resident #138. There was no evidence of (continued on next page)

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	365655	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Nursing	800 Market Avenue North Suite 1560 Canton, OH 44702

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	investigation to determine root cause of redness, swelling, and pain to Resident #138's wrist. Review of NP progress note dated 03/27/26 revealed Resident #138 was seen for evaluation of right wrist pain. There was noted redness and swelling. There were no related falls and resident was unable provide details other than the area was painful. Resident #138 noted to be an irritated mood. Noted right forearm bruising on physical exam. Review of radiology result dated 03/28/26 at 12:00 A.M. revealed x-ray resulted with no evidence of acute fracture or dislocation of right wrist. Review of NP progress note dated 03/30/26 revealed the NP was unable to determine an underlying reason for swelling, redness, and pain. Review of progress note dated 03/30/26 at 12:11 P.M. revealed Resident #138's son who was identified as her resident representative was notified of redness, swelling, and pain to Resident #138's right wrist and results of an x-ray. Review the plan of care dated 04/17/26 revealed Resident #138 had a communication problem related to fear and shyness. Interventions included anticipate and meet needs, promote proper communication with others, use simple questions or cues, discuss concerns with resident and family, monitor for and record communication problems, use alternative methods of communication, and refer to therapy or audiology as needed. Review of the plan of care dated 04/17/26 revealed Resident #138 had psychosocial wellbeing concerns related to little to no activity involvement and disinterest. Interventions included establish record of involvement and interests, explain to the resident importance of social interaction, encourage participation in activities of choice as tolerated, encourage family participation, and modify resident's daily schedule to accommodate participation in activities. Further review of the medical record for Resident #138 revealed no evidence of social service assessments to address psychosocial and emotional needs since 12/02/24. Interview on 04/27/26 at 3:17 P.M. with Social Services Designee (SSD) #373 revealed Resident #138's husband had passed away in the last year. SSD #373 stated Resident #138's son had taken over as resident representative however he worked midnight shift so communication with him was poor. SSD #373 confirmed Resident #138 had not had a care plan meeting since April of 2025. SSD #373 confirmed there had been issues with timing and completion of assessments. SSD #373 indicated this was recognized when the last social worker left. SSD #373 stated Resident #138 does not communicate well, does not get involved with activities on her unit, and typically could be found sitting at a table in the common area. Interview on 04/30/26 at 7:39 A.M. with Director of Nursing (DON) revealed Resident #138 was supposed to walk with assistance from staff, however, did not always remember to ask for help. Resident #138 was not known to get into altercations with other residents. Resident #138 had impaired cognition. SRIs #267836 and #270153 were reviewed and the DON confirmed she was unable to locate evidence to support a root cause was identified to sufficiently rule out abuse. DON confirmed an SRI was not filed Resident #138's wrist presenting with redness, swelling, and pain despite history with injuries of unknown origin presenting in a similar manner. DON confirmed there was no evidence Resident #138's resident representative was notified of the redness, swelling, and pain to Resident #138's right wrist, need for x-ray, and medication change until 03/30/26. DON reported she was unsure of the current family involvement for Resident #138. DON stated Resident #138's husband would come to the facility daily and help take care of her however Resident #138's husband had passed away. Review of Social Services Job Description undated revealed the purpose of the social services was to meet the social and emotional needs that affect the resident's ability to achieve their highest level of functioning. The social services employee was to participate in development of resident comprehensive care planning and develop procedures to provide social services. Responsibilities included to develop one on one professional relationships with residents and families, coordinate and participate in activities designed to promote social interaction, and document the psychosocial needs of a resident. Review of facility policy Care Conference Resident/Family Participation undated revealed each resident and their family members were encouraged to participate in the development of the resident's comprehensive assessment and care plan. The social services director or designee was responsible for arranging care planning conferences. The policy did not address requirements for frequency of care planning conferences. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of facility policy titled Notification of Resident Change in Condition Policy dated August 2015 revealed a licensed nurse would promptly inform the resident's legal representative of a significant change in the resident's physical, mental, or psychosocial status, need to alter treatment significantly or begin a new treatment, and any injury/accident that could require nursing or medical intervention.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were available to administer to residents per the physicians' orders. This affected one (Resident #35) of 13 residents reviewed for medications. The facility census was 151. Findings include: Review of the medical record for Resident #35 revealed an admission date of 06/23/17 with diagnoses including schizoaffective disorder, dementia, anxiety, hypertension and chronic obstructive pulmonary disease. Review of the physician's orders for Resident #35 revealed she had orders for Latanoprost eye drops for glaucoma, one drop in both eyes at bedtime dated 03/13/24; Quetiapine 300 milligrams (mg) at bedtime for schizoaffective disorder dated 03/13/24; Restoril 7.5 mg at bedtime for insomnia dated 03/19/25; and Artificial Tears eye drops three times a day for irritated eyes dated 01/12/25. Review of the Medication Administration Record (MAR) dated from October 2025 through April 2026 for Resident #35 revealed Latanoprost eye drops were not administered on 10/28/25 and 02/01/26, Quetiapine 300 mgs was not administered on 03/05/26, Restoril was not administered on 10/04/25, 10/05/25 and 02/05/26, and Artificial Tears were not administered on 12/22/25 and 12/23/25 and from 04/10/26 through 04/12/26 for all three administration daily. Review of the nursing progress notes for Resident #35 revealed medications were held without the physician being updated on: -10/04/25 at 7:28 P.M. Restoril was documented as on hold. -10/05/25 at 8:45 P.M. Restoril was documented as waiting on arrival from the pharmacy.-10/28/25 at 10:38 P.M. Lantanoprost eye drops were unavailable.-12/22/25 at 3:16 P.M. Artificial Tears were on order.-12/23/25 at 2:58 P.M. Artificial Tears were on order.-02/01/26 at 8:47 P.M. Lantanoprost eyes drops were awaiting prescription refill from the pharmacy.-02/05/25 at 9:19 P.M. Restoril was documented as waiting on prescription refill.-03/05/26 at 9:01 P.M. Quetiapine 300 mg was documented as the drug was on order.-04/10/26 at 3:13 P.M. Artificial Tears were recalled.-04/12/26 at 10:24 A.M. Artificial Tears were recalled. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #35 revealed she had impaired cognition. Interview on 04/29/26 at 9:04 A.M. with Licensed Practical Nurse (LPN) #317, also the assistant director of nursing, verified Resident #35's medications were not administered as ordered. She stated they had over the counter medications in the storage rooms as well as an emergency kit of medications the nursing staff were able to utilize if needed. LPN #317 also verified the Artificial Tears the facility had in stock were not on a recall list. Review of the facility policy titled, Medication Dispensing System, revised August 2006, revealed medications were to be administered as ordered. This deficiency represents non-compliance investigated under Complaint Number 2593029.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure dental services were provided timely for residents. This affected one (Resident #12) of six residents reviewed for dental services. The facility census was 151. Findings include: Review of the medical record for Resident #12 revealed an admission date of 02/07/26 with diagnoses including diabetes mellitus, hypertension, chronic pain and unspecified protein-calorie malnutrition. Review of the dental visits dated from 04/20/25 through 04/20/26 revealed Resident #12 had not been seen by the dentist including visits dated 02/19/26 and 04/07/26. Review of the physician's orders for Resident #12 revealed an order to be seen by the dentist dated 02/09/26. Resident #12 also had an order for Orajel 2x Toothache and Gum Mouth/Throat dated 03/20/26. The nursing staff were to apply to affected tooth every eight hours as needed for tooth pain. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had impaired cognition. It was documented she had obvious or likely cavities or broken natural teeth. Interview on 04/19/26 at 11:25 A.M. with Resident #12 revealed she needed to see the dentist. She stated she had a lose tooth and had pain at times. She stated she had to have a special diet due to her dental status. Resident #12 stated she had not seen a dentist since she was admitted to the facility. Interview on 04/21/26 at 10:38 A.M. with Medical Records Coordinator #344 verified she was in charge of ancillary services including dental. She verified Resident #12 had not been seen by the dentist since her admission. She stated their dental service did not do emergency services. Review of the facility policy titled, Dental Services, undated, stated routine and emergency dental services were available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. The policy also stated social services personnel would be responsible for assisting the resident/family in making dental appointments.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure coordination of care with hospice services for residents to ensure safe and person-centered care. This affected one (Resident #1) of two residents reviewed for hospice services. The facility census was 151.Findings include:Review of the medical record for Resident #1 revealed an admission date of 01/20/22 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease, congestive heart failure and chronic pain. Review of the care plan dated 04/05/24 for Resident #1 revealed the care plan had not been updated to reflect he was receiving hospice services or end of life care.Review of the hospice enrollment form dated 03/31/26 revealed Resident #1 was admitted to hospice for chronic respiratory failure.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was receiving hospice services.Review of the facility's general hospice binder revealed Resident #1 had a plan of care update report from his hospice company which was dated 04/18/26 and included his diagnoses, his orders and care plan.Further record review of Resident #1's medical revealed there was no documentation related to hospice staff visits including weekly nursing visits or three times weekly aide visits. Interview on 04/29/26 at 3:21 P.M. with Hospice Registered Nurse (RN) #469 revealed she came to the facility one time per week. She stated they do internal notes for visits and she did not provide the facility documentation related to her visits. She was unsure if the notes were sent to the facility or where they would be located. Interview on 04/29/26 at 3:30 P.M. with Hospice Health Aide (HHA) #470 revealed she came to the facility three times per week. She stated she did not provide the facility documentation related to her visits.Interview on 04/29/26 at 3:40 P.M. with the Director of Nursing (DON) verified the only hospice documentation in Resident #1's medical record and hospice binder was his plan of care and enrollment form. Review of the facility policy titled, Hospice Program, revised August 2006, revealed the policy did not include to ensure coordination of care between hospice and themselves related to hospice staff visit summaries.