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	11/17/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that medications and showers were accurately documented. This affected two residents (#24, #31) of two residents reviewed for accurate and complete medical records. The facility census was 156. Findings include: 1. Review of the medical record for Resident #24, revealed an admission date of 06/13/25. Diagnoses included: other fracture of upper and lower end of left fibula sequela, diabetes, morbid obesity, hypertension, attention-deficit hyperactivity disorder, anxiety disorder, major depressive disorder, diabetic ulcer, methicillin resistant staphylococcus aureus infection, and idiopathic neuropathy. Review of Resident #24's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. No behaviors were observed during the look back period. The resident was assessed to require a wheelchair for mobility and to be independent with all activities of daily living. Review of Resident #24's physicians orders revealed an order dated 07/03/25 for cefepime (8an medication used to treat infection) 2 grams to be give every eight hours intravenously (IV) for a surgical wound infection. This order was discontinued on 07/16/25. Further review revealed an order dated 07/16/25 cefepime 2 grams to be give every eight hours intravenously (IV) for a surgical wound infection until 08/13/25. Review of Resident #24's medication administration record revealed the entry for cefepime 2 grams to be give every eight hours intravenously (IV) for a surgical wound infection was not signed off on 07/04/25 at 10:00 P.M., 07/0/25 at 10:00 P.M., 07/14/25 at 10:00 P.M., 07/15/25 at 6:00 A.M. and at 10:00 P.M., 07/19/25 at 10:00 P.M., and 07/21/25 at 10:00 P.M. Review of Resident #24's nursing progress notes revealed nothing regarding the entry for cefepime 2 grams to be give every eight hours intravenously (IV) for a surgical wound infection not being signed off on 07/04/25 at 10:00 P.M., 07/0/25 at 10:00 P.M., 07/14/25 at 10:00 P.M., 07/15/25 at 6:00 A.M. and at 10:00 P.M., 07/19/25 at 10:00 P.M., and 07/21/25 at 10:00 P.M. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on11/06/25 at 11:25 A.M. the Director of Nursing (DON) verified the medication administration record entry for cefepime 2 grams to be give every eight hours intravenously (IV) for a surgical wound infection was not signed off on 07/04/25 at 10:00 P.M., 07/0/25 at 10:00 P.M., 07/14/25 at 10:00 P.M., 07/15/25 at 6:00 A.M. and at 10:00 P.M., 07/19/25 at 10:00 P.M., and 07/21/25 at 10:00 P.M. The DON stated that she did not always have an IV certified nurse on that unit and would have to designate a nurse from another unit to do the IV. In an interview on 11/06/25 at 12:30 P.M. the DON stated she spoke with the supervisor who was working some of the days that were not signed off as given. The supervisor was supposed to do IV when no IV certified nurse was working that unit and stated to the DON that she would have done IV but might have missed signing off. The DON state that her expectation was that medications would be signed off if given. 2. Review of Resident #31's medical record revealed diagnoses including dementia with behavioral disturbance and agitation, depression, and history of transient ischemic attacks (mini strokes) and stroke. July 2025 bathing records revealed no documentation on evening shift on 07/01/25, 07/05/25, 07/17/25, and 07/22/25 or on night shift on 07/02/25, 07/08/25, 07/09/25, 07/13/25, 07/14/25, 07/16/25, 07/18/25, 07/21/25, 07/23/25, 07/26/25, 07/28/25 and 07/31/25 revealing whether a shower/bath was offered and/or provided. Review of August 2025 bathing records revealed no documentation on day shift on 08/06/25 or 08/19/25, evening shift on 08/01/25, 08/02/25, 08/24/25, or 08/31/25 or night shift on 08/01/25, 08/02/25, 08/06/25, 08/20/25, 08/27/25, 08/28/25, or 08/31/25. Review of September 2025 bathing records through 09/19/25 revealed no documentation on day shift on 09/06/25, 09/07/25 or 09/13/25 or on evening shift on 09/06/25, 09/11/25, or 09/13/25 or on night shift on 09/02/25, 09/04/25, 09/05/25, 09/08/25, 09/13/25, 09/15/25, 09/16/25, or 09/18/25. On 11/06/25 at 12:40 P.M., the Director of Nursing (DON) verified bathing records were incomplete. This deficiency represents incidental findings of non-compliance investigated under Complaint Number 2659263.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to ensure call lights were accessible. This affected one resident (#25) of 156 residents residing in the facility. The facility census was 156. Findings Include:Review of the medical record for Resident #25 revealed admission to facility on 09/06/24 with diagnoses including unspecified dementia, anxiety, depression, schizophrenia, morbid obesity, and left lower leg Tri malleolar (ankle) fracture. The most recent Minimum Data Set (MDS) quarterly assessment completed on 09/23/25 revealed Resident #25 had delusional and disorganized thinking, used a walker to navigate facility, and required supervision or light touching with activities of daily living and grooming or bathing. A Brief Interview for Mental Status (BIMS) assessment completed on 09/23/25 revealed Resident #25 had moderate cognitive deficit (forgetful and distractable). Further record review revealed Resident #25 was a high fall risk and had two recent falls at the facility on 10/28/25 and 09/23/25. Observation and interview on 11/05/25 between 1:40 P.M. and 1:55 PM with Resident #25 revealed Resident sitting on side of bed in her room with her over the bed table in front of her. Observed bed positioned against wall. Further observation revealed the call light hanging from the wall and on the floor in between the bed and the wall. Resident #25 reported she could not reach it and attempted to demonstrate reaching for the light. Observation of the demonstration revealed Resident #25 could not in fact reach her call light. Interview and observation on 11/05/25 at 1:58 P.M. with Licensed Practical Nurse (LPN) #32 revealed verbal confirmation that the call light was stuck between the bed and wall and Resident #25 could not reach it. Then observed LPN #25 crawl over bed, putting one knee on bed to stretch and reach over to call light and pull it up from floor and to make accessible to Resident #25. This deficiency represents incidental findings of non-compliance investigated under Complaint Number 2659263.