STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365654	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austinwoods Rehab Health Care	4780 Kirk Rd Austintown, OH 44515

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, observation, interview and review of the facility policy, the facility failed to ensure Resident #85's pain was timely and appropriately addressed. This affected one resident (Resident #85) of four residents observed for timely and appropriate medication administration. The facility census was 83. Findings include:Review of the medical record for Resident #85 revealed an admission date of 11/13/25 with diagnoses including unspecified dislocation of the right hip, unspecified complication of internal orthopedic prosthetic device, implant, and graft, gastroesophageal reflux disease (GERD), hyperlipidemia, primary hypertension, and unspecified glaucoma.Review of the orders revealed a medication order dated 11/13/25 for Resident #85 to have Tylenol 650 milligrams (mg) (analgesic) by mouth every four hours as needed for discomfort or pain. Review of the baseline care plan initiated on 11/13/25 revealed Resident #85 had a right hip injury which resulted in an open reduction internal fixation (ORIF) of the right hip (a surgical procedure to repair a severe hip fracture by surgically realigning the broken bone and then stabilizing it with hardware like screws, plates, or rods) and a recent emergency room visit for a right hip reduction (a medical procedure to realign the hip joint, most commonly following a dislocation). The baseline care plan did not include interventions related to the potential for pain in the right hip or leg secondary from the hip injury or procedures.Review of the Brief Interview for Mental Status (BIMS) summary score from the BIMS completed on 11/14/25 revealed Resident #85 had moderately impaired cognition. Review of the Skilled Charting dated 11/14/25 revealed Resident #85 was alert to person, place, time, and situation. The assessment further revealed Resident #85 was admitted to the facility for post-surgical services, including physical therapy (PT) and occupational therapy (OT), and that medication orders had been received. The assessment did not contain any documentation in the pain evaluation section. Review of the Pain Tool completed on 11/14/25, 11/15/25, and 11/16/25 revealed Resident #85 had right knee pain, rated as hurting a little more on the Faces Pain Scale. Further review of the pain assessment revealed movement made Resident #85's pain worse while the use of rest, ice, and Tylenol helped to make it hurt a little less. Review of the weights and vital signs tab in the electronic medical record (EMR) viewed at 4:59 P.M. revealed Resident #85 had a total of 17 pain assessments documented between 11/13/25 at 10:56 P.M. and 11/17/25 at 9:01 A.M. Further review if the pain assessments revealed the pain was rated using a numerical rating scale from zero to ten, with zero meaning no pain and 10 being the worst pain possible. Of the 17 pain assessments, Resident #85 reported no pain on four occasions, mild pain (rated as one or two) on eight occasions, moderate pain on three occasions (rated as six on 11/13/25 at 10:56 P.M. and five on 11/14/25 at 9:14 P.M. and on 11/16/25 at 11:59 P.M.), and severe pain twice (on 11/17/25 at 8:53 A.M. and at 9:01 A.M.).Review of the Medication Administration Record (MAR) revealed documentation that Resident #85 received Tylenol 650 mg,by mouth on 11/13/25 at 10:56 P.M. for moderate pain, 11/15/25 at 9:14 P.M. for moderate pain, on 11/15/25 at 5:44 A.M. for no pain, and on 11/16/25 at 11:59 P.M. for moderate pain. Further review of the MAR revealed no Tylenol was administered to Resident #85 after reporting severe pain on 11/17/25 at 8:53 A.M. and at 9:01 A.M. Observation on 11/17/25 from 9:00 A.M. to 9:07 A.M. revealed Licensed Practical Nurse (LPN) #313 obtained vital signs from Resident #85, prepared scheduled morning medications, and administered the prepared medications to Resident #85. At 9:01 A.M., Resident #85 was heard telling LPN #313 that her right leg hurt a lot and she then rated the pain level as an eight on a one to 10 numerical rating scale. Further observation revealed Tylenol was not included in the medication cup that was prepared and handed to Resident #85, although LPN #313 informed Resident #85 that there was a little something for her leg pain with the medications that were handed to Resident #85. At the time of the medication observation, two staff from the therapy department were in the room and waiting to take Resident #85 for prescribed therapy. Interview on 11/17/25 at 9:07 A.M. with LPN #313 confirmed that when telling Resident #85 that there was something for her leg pain in the medicine cup, LPN #313 was referring to the meloxicam 15 mg that was ordered daily for arthritis. During the interview, LPN #313 also stated that Resident #85 also had on a patch for pain that was not yet due to be removed (review of the medication orders and the MAR revealed Resident #85 had no orders for, or applications of, topical analgesics or pain patches). Interview on 11/17/25 at 11:48 A.M. with Resident #85 confirmed she usually took Tylenol to help with her right leg pain. During the interview, Resident #85 was uncertain whether she received the Tylenol with her morning medications because there were so many pills and she did not know what all was in the medicine cup, but she thought the nurse told her she gave her something extra for pain. At the time of the interview, Resident #85 stated

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews, observations, interviews and review of the facility policy, the facility failed to ensure a medication error rate of less than five percent (%) during medication administration on 11/17/25 with four errors of 25 medication administration opportunities resulted in a 16% medication error rate. This affected two residents (Residents #85 and #86) of four residents observed during medication administration. The facility census was 83.Findings include:1. Review of the medical record for Resident #85 revealed an admission date of 11/13/25 with diagnoses including unspecified dislocation of the right hip, unspecified complication of internal orthopedic prosthetic device, implant, and graft, gastroesophageal reflux disease (GERD), hyperlipidemia, primary hypertension, and unspecified glaucoma. Review of the Brief Interview for Mental Status (BIMS) summary score completed on 11/14/25 revealed Resident #85 had moderately impaired cognition. Review of the Skilled Charting dated 11/14/25 revealed Resident #85 was alert to person, place, time, and situation. The assessment further revealed Resident #85 was admitted to the facility for post-surgical services, including physical therapy (PT) and occupational therapy (OT), and that medication orders had been received. Review of the physician orders revealed Resident #85 had one medication scheduled for administration at 8:00 A.M. and a total of twelve medications scheduled for administration at 9:00 A.M. These medications included:1) Cefadroxil oral capsule, 500 milligrams (mg), (antibiotic) give one capsule by mouth two times a day for prophylaxis for seven days, dated 11/14/25, with the morning dose scheduled for 8:00 A.M.2) Amlodipine besylate oral tablet, five milligrams, give one tablet by mouth one time a day for primary hypertension, dated 11/13/25, scheduled at 9:00 A.M.3) Aspirin 81 mg oral delayed release (DR) tablet, give one tablet by mouth two times a day for deep vein thrombosis (DVT) prophylaxis, dated 11/13/25, with the morning dose scheduled at 9:00 A.M.4) Biotin oral tablet, 10,000 mcg, give one tablet by mouth one time a day for supplementation, ordered 11/13/25, scheduled at 9:00 A.M.5) Vitamin D oral tablet 50 micrograms (mcg), give one tablet by mouth once daily for supplement, dated 11/13/25, scheduled at 9:00 A.M.6) Valsartan oral tablet 320 mg, five one tablet by mouth one time a day for hypertension, dated 11/13/25, scheduled at 9:00 A.M.7) Niacin oral tablet, 100 mg, give one tablet by mouth one time a day for anemia, dated 11/13/25, scheduled at 9:00 A.M.8) Meloxicam 15 mg tablet, give one tablet by mouth one time a day for arthritis, dated 11/13/25, scheduled at 9:00 A.M.9) Folic acid 1 mg tablet, give one tablet by mouth one time a day for anemia, dated 11/13/25, scheduled at 9:00 A.M.10) Vitamin E 15 mg oral tablet, one tablet once daily as a supplement, dated 11/14/25, scheduled at 9:00 A.M.11) Culturelle Immunity Support 15B Cell capsule, give one capsule by mouth one time a day for supplement, ordered 11/14/25, scheduled at 9:00 A.M.12) Cranberry juice powder capsule, 425 mg, give one capsule by mouth one time a day for supplementation, dated 11/14/25, scheduled at 9:00 A.M.13) Prevagen oral capsule, 10 mg, give 10 mg my mouth one time a day for supplement, dated 11/14/25, scheduled at 9:00 A.M. Observation on 11/17/25 from 9:00 A.M. to 9:07 A.M. revealed Licensed Practical Nurse (LPN) #313 obtained vital signs from Resident #85, prepared morning medications, and administered the prepared medications to Resident #85. During the observation, LPN #313 confirmed there were nine pills in the medication cup, which included a 5 mg amlodipine tablet, an 81 mg aspirin tablet, a 425 mg cranberry juice powder capsule, a 1,000-mcg folic acid tablet, a 10,000-mcg biotin tablet, a 10 mg prevagen capsule, a 320 mg valsartan tablet, a 50-mcg vitamin D tablet, and a 50 mg meloxicam tablet. During medication preparation, LPN #313 confirmed that there was no Vitamin E available to give to Resident #85 because it was on order. Continued observation revealed Resident #85 took the nine pills that were provided in the medication cup at 9:05 A.M.After the medication administration observation, at 9:49 A.M., review of the medication administration record (MAR) revealed Resident #85 had 11 of the 13 morning medications signed as given by LPN #313 and one morning medication (Vitamin E, 15 mg) signed by LPN #313 with the MAR code 3 for Hold/See Progress Notes (only nine medications were observed as administered. Medications signed as given that were not prepared and administered during the observation included Culturelle Immunity Support 15B Cell capsule (scheduled to be given at 9:00 A.M.), Niacin 100 mg oral tablet (scheduled to be given at 9:00 A.M.), and cefadroxil 500 mg oral capsule (scheduled to be given at 8:00 A.M.). Review of the Medication Administration Audit Report (MAAR) revealed LPN #313 documented administration of the 100 mg of Niacin and 500 mg of cefadroxil at the same time as signing for the nine medications that were observed as administered (between 9:06 A.M. and 9:07 A.M.), directly after the medication was observed being administered to Resident #85. Interview on 11/17/25 at 12:08 P.M. with LPN

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews, observations, interviews, review of facility policies, and review of manufacturer instructions for the facility's blood glucose meter, the facility failed to ensure the blood glucose meter was properly cleaned after use with Resident #86. This affected one (Resident#86) and had the potential to affect three additional (Residents #70 #73, and #81) identified by the facility as having blood sugar level checked with a glucometer. In addition, the facility did not ensure enhanced barrier precautions (EBP) were maintained during medication administration through an enteral feeding tube, affecting Resident #67. The facility identified nine residents who had enteral feeding tubes (Residents #6, #26, #45, #64, #66, #67, #69, #77, and #83). The facility census was 83.Findings include:1. Review of the medical record for Resident #86 revealed an admission date of 10/22/25 and a re-entry date of 11/03/25. Diagnoses included acute respiratory failure with hypoxia, transfusion-related acute lung injury, anemia, peripheral vascular disease, end stage renal disease, dependence on renal dialysis, and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 10/27/25 revealed Resident #86 had moderately impaired cognition and received insulin injections, antidepressant, antiplatelet, anticonvulsant, and hypoglycemic medications. Further review of the MDS revealed Resident #86 had complex medical conditions which included diabetes mellitus and dependence on renal dialysis.Review of the physician's orders revealed an order dated 11/14/25 for Resident #86 to have a blood sugar level checked twice a day. Further review of the order revealed the blood sugar checks were scheduled for 6:00 A.M. and 4:00 P.M. Observation on 11/17/25 from 9:10 A.M. to 9:13 A.M. revealed Licensed Practical Nurse (LPN) #313 used a hand-held, multi-use, blood glucose meter (BGM) to check the blood sugar of Resident #86. Further observation revealed LPN #313 removed the soiled gloves, disposed of the lancet and soiled gloves into the sharps container and trash receptacle on the medication cart, respectively, then removed one standard sized alcohol wipe from the top drawer of the medication cart, opened the wipe, and used the wipe to briskly wipe down the front of the BGM before placing the BGM back into the top drawer of the medication cart and performing hand hygiene. At the end of the observation, LPN #313 stated Resident #87 did not get insulin per sliding scale and did not need the additional fingerstick for blood sugar monitoring that was just performed, but LPN #313 expressed it was her process to check all resident's blood sugars if they were on insulin. Interview on 11/17/25 at 9:25 A.M. with LPN #313 revealed a lack of knowledge of the facility's specific policy for cleaning BGM's between resident use and confirmed the use of one standard alcohol swab to clean the BGM before placing it back into the drawer of the medication cart. Interview on 11/17/25 at 10:05 A.M. with the Director of Nursing (DON) confirmed that use of an alcohol swab to wipe the front of the BGM was not the correct procedure to ensure the device was properly cleaned and disinfected. During the interview, the DON confirmed that the facility used Sani-Cloth Disposable Wipes to clean and disinfect the BGM. During a follow-up interview on 11/17/25 at 10:20 A.M., the DON confirmed the Sani-Cloth Disposable Wipes required a two-minute dry time before the BGM would be considered properly disinfected before drying and placing the BGM back into the drawer of the medication cart.Review of the undated policy titled Performing a Blood Glucose Test revealed the facility was to always ensure that the blood glucose monitoring device was cleaned and disinfected between resident use following manufacturer's instructions. Review of the Assure Prism Multi Blood Glucose Monitoring System Manufacturer's Instructions revealed the device was required to be cleaned prior to disinfection and then disinfected using only specified products with approved Environmental Protection Agency (EPA) registration numbers, which included the following products: Clorox Germicidal Wipes, Super Sani-Cloth Germicidal Disposable Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, and CaviWipes1. The instructions further revealed two of the approved wipes were required, one to clean, and one to disinfect the device. Further review of the manufacturer's instructions revealed the device was to remain wet for the specified amount of time per the wipe manufacturer's instructions in order to be considered properly disinfected. 2. Review of the medical record for Resident #67 revealed an admission date of 04/08/25 and a re-entry date of 09/16/25. Pertinent diagnoses included acute and chronic respiratory failure, spastic quadriplegic cerebral palsy, dysphagia, neuromuscular dysfunction of the bladder, seizures, attention to tracheostomy, dependence on respirator (ventilator) status, tracheostomy status, pressure ulcer of the sacral region, and gastrostomy status. Review of the quarterly MDS 3.0 assessment completed on 10/29/25 revealed Resident #67 had severely impaired cognition. Further review of the MDS revealed Resident #67 had a feeding tube and received more than 51