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	03/27/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, observation, interview, review of Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to ensure staff performed hand hygiene to prevent possible cross contamination of germs during Resident #1's wound care and Resident #29's incontinence care. This affected one resident (#1) out of two residents reviewed for wound care and one resident (#29) out of three residents reviewed for incontinence care. The facility census was 89. Findings include: 1. Review of the medical record revealed Resident #1 was admitted on [DATE] and readmitted on [DATE] with diagnoses including Multiple Sclerosis (MS), anxiety, psychosis, depression, quadriplegia, neuromuscular bladder, gastroesophageal reflux disease (GERD), esophagitis, vitamin B deficiency, joint contracture and osteoporosis. A review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had an indwelling urinary catheter and was incontinent of bowel. A review of Resident #1's medical record revealed a skin/wound note dated 03/24/24 of an assessment of a Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.), located on the left posterior thigh/ischium and measuring 9.0 centimeters (cm) long by 8.5 cm wide by 1.1 cm deep. Undermining was present at the 12 o'clock position measuring 2.0 cm. The measured area was 20 percent intact and tissue was within normal limits with 50 percent granular tissue and 10 percent slough. Edges were well defined and irregular in shape with no odor present. The skin/wound note indicated a Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling.), located on the right posterior thigh measuring 1.5 cm long by 3.0 cm wide by 0.1 cm deep with 30 percent granular tissue, and 70 percent epithelial tissue. The wound edges were well defined, attached to the wound base, area irregular in shape. A small amount of serosanguinous exudate was noted when the dressing was removed from the wound. A third area of skin breakdown located on the right gluteal area was classified as moisture associated skin damage (MASD) measuring 3.5 cm long by 5.0 cm wide by 0.1 cm deep. The measured area had 60 percent partial thickness skin loss and 40 percent epithelial tissue present. The wound had irregular edges and shape with a small amount of serosanguinous exudate noted when the dressing was removed from the wound. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 03/25/25 at 1:50 P.M. of Licensed Practical Nurse (LPN) #525 perform Resident #1's wound treatment with the assistance of Certified Nurse Aide (CNA) #563 revealed a failure to perform hand hygiene to prevent cross contamination of germs. Both staff entered Resident #1's room and did not perform hand hygiene and donned a pair of gloves. Both staff assisted Resident #1 to roll on her right side, and LPN #525 removed the soiled wound treatments from the three wounds on her sacral area and right/left gluteal areas. The wounds had open areas which had a small amount of serosanguinous drainage present and appeared very red with a tunneling area on the left ischium. LPN #525 cleansed the wounds with wound cleanser and gauze and discarded the soiled supplies in a plastic bag. LPN #525 did not remove her gloves or perform hand hygiene and applied the calcium alginate with silver dressing (a specialized wound care product the merges the absorbent qualities of alginate with the antimicrobial properties of silver) to the left and right gluteal wounds and border foam dressing to the sacral wound. Without removing her gloves, LPN #522 proceeded to assist Resident #1 to reposition using a foam wedge cushion, handling multiple items in the room including Resident #1's call light button and bed remote and moved the over-the bed table close to Resident #1. LPN #525 then removed her gloves and applied another pair of gloves and did not perform hand hygiene and picked up the unused clean wound treatment supplies and exited the room. CNA #563 assisted LPN #525 with repositioning Resident #1 during the wound treatment and used the same gloved hands to place Resident #1's personal items on the over-the-bed table and then exited to room and placed her gown in the soiled utility room. On 03/25/25 at 2:20 P.M. an interview with LPN #525 and CNA #563 verified they failed to perform hand hygiene to prevent the spread of germs during Resident #1's wound treatment. 2. Review of the medical record revealed Resident #29 was admitted n 01/01/25 with diagnoses including nutritional marasmus, bipolar disorder, atrial fibrillation, high cholesterol, lymphedema, high blood pressure, cognitive communication deficit, and left pelvic fracture. A review of Resident #29's MDS assessment dated [DATE] indicated she had bowel and bladder incontinence and needed maximum assistance with toileting. An observation on 03/24/25 at 9:54 A.M. of LPN #522 assist Resident #29 with incontinence care revealed a failure to perform hand hygiene to prevent cross contamination of germs. LPN #522 entered Resident #29's room and did not wash her hands, donned a pair of gloves and proceeded to clean Resident #29's buttock and perineal area of a large amount of feces. Upon completion of the incontinence care, LPN #522 removed her gloves and did not perform hand hygiene. LPN #522 proceeded to touch various surfaces and items in the room including the call light button, bed remote, bedside drawer and other surfaces. LPN #522 was waiting for staff to answer the call light and touched the underside bandage on Resident #29's right temple, Resident #29's bed linens, and repositioned Resident #29. LPN #522 then picked up the package of incontinence wipes which had feces on the outside of the package and set the package on top of Resident #29's clean clothing on top of her bedside table. LPN #522 asked CNA #567 to assist her with turning and repositioning Resident #29 for the incontinence care. CNA #567 entered the room and donned a pair of gloves without performing hand hygiene and proceeded to assist LPN #522 with turning and repositioning Resident #29. LPN #522 then placed Resident #29's call light in reach, picked up the soiled bag of incontinence supplies and soiled linen and exited the room. LPN #522 placed the bag of soiled linen and bag of soiled incontinence supplies in the soiled utility room. LPN #522 removed her gloves and performed hand hygiene. LPN #522 proceeded to obtain a cup, straw and lid and filled the cup with lemonade, walked back to Resident #29's room and assisted her with drinking from the cup of lemonade while holding the straw for her. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/24/25 between 10:00 A.M. and 10:30 A.M. an interview with LPN #522 and CNA #567 verified the above findings and agreed they didn't perform hand hygiene to prevent the spread of germs during Resident #29's incontinence care. The facility policy and procedure titled Handwashing revised July 2015 indicated the purpose of the policy was to maintain medical asepsis, for infection control, to reduce transferal of microorganisms from resident to resident, to reduce transferal of microorganisms between staff and residents. The policy indicated proper handwashing technique would be used by all employees to maintain optimal infection control. The Centers for Disease Control and Prevention (CDC) hand hygiene guidance dated 01/30/20 indicated to perform hand hygiene immediately before touching a resident, before performing an aseptic task, before moving from a soiled body site to a clean body site on the same resident, after touching a resident, after contact with blood, body fluids, or contaminated surfaces, after touching a resident's immediate environment. Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. Ensure healthcare personnel wash their hands with soap and water when hands were visibly soiled.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on record review, observation, interview and facility policy review, the facility failed to ensure resident #22 had a physician's order for oxygen use. This affected one resident (#22) of four residents reviewed for oxygen therapy. The facility identified 15 residents (#4, #16, #23, #30, #44, #52, #65, #70, #131, #284, #285, #289, #290, #291, and #294) that required oxygen. The facility census was 89. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included hypertensive heart disease with chronic kidney disease, dementia, type two diabetes mellitus, and asthma. Review of the physician's orders for Resident #22 revealed no orders for oxygen. Review of the care plan dated 03/11/25 revealed Resident #22 had a respiratory diagnosis. Interventions included administering oxygen as ordered by the physician and monitoring the resident's pulse oximetry (a non-invasive medical procedure that measures the oxygen saturation of the blood). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had mild cognitive impairment and required extensive assistance for all activities of daily living. Resident #22 was receiving oxygen therapy. Observations on 03/24/25 from 9:00 A.M. to 10:50 A.M. revealed Residents #22 had and oxygen concentrator and was utilizing the oxygen. Interview on 03/25/25 at 10:53 with Registered Nurse (RN) #504 confirmed Resident #22 did not have a physician's order for oxygen therapy. Review of the facility policy Oxygen Tubing and Nasal Cannula Care, effective 08/01/19, stated to verify physician's order for oxygen.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on record review, observation, interview and facility policy review, the facility failed to ensure nasal sprays for Resident #41, who did not have an order to self-administer medications, were not left at the bedside. In addition, the nasal sprays left at the bedside were discontinued by the physician. This affected one resident (#41) of three residents reviewed for medication administration. The facility census was 89. Findings include: Review of the medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, major depressive disorder, and hypertension. Review of the physician's orders for Resident #41 revealed an order for ipratropium bromide nasal solution 0.03% (reduces the amount of mucus produced in the nose) two sprays in each nostril every six hours as needed dated 01/24/25 and discontinued on 03/13/25 and an order for Flonase allergy relief nasal suspension 50 micrograms (mcg) (corticosteroid) two sprays in both nostrils as needed for allergies one time a day dated 04/21/24 and discontinued 03/13/25. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had intact cognition. Resident #41 required standby to moderate assistance for all activities of daily living. Review of the care plan dated 03/11/25 for Resident #41 revealed no focus that Resident #41 was able to self-administer medications or keep them at her bedside. Interview and observation on 03/24/25 at 9:38 A.M. with Resident #41 revealed Flonase nasal spray and ipratropium bromide nasal spray on her bedside table. Resident #41 confirmed the staff let her keep them there and give them to herself when needed. Interview on 03/25/25 at 8:03 A.M. with Registered Nurse (RN) #504 revealed that Resident #41 does keep her nasal sprays at her bedside and administers them to herself. She reported they are trying to keep Resident #41 as independent as possible. Subsequent interview on 03/25/25 at 10:45 A.M. with RN #504 revealed that Resident #41 had no physician's order to self-administer the nasal sprays, and she had brought them back from her bedside table to the medication cart for storage. RN #504 also confirmed that the order for both nasal sprays were discontinued by the physician on 03/13/25 for Resident #41. Review of the facility policy titled Self-Administration of Medication, effective 06/02/15, revealed a decision to permit self-administration is made in the interdisciplinary care plan conference. An order must be received from a physician and placed in the medication administration record. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Storage in the facility, effective 06/02/15, revealed the medication supply is assessable only to licensed personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, interview and facility policy review, the facility failed to obtain physician ordered laboratory testing for Resident #283. This affected one resident (#283) of five residents reviewed for unnecessary medications. The facility census was 89. Findings include: Review of Residents #283's medical record revealed an admitted [DATE] with diagnoses including infection and inflammatory reaction due to internal left knee prosthesis, atrial fibrillation, peripheral vascular disease, rhabdomyolysis, venous thrombosis, and cognitive deficit. Review of the physician orders start date 02/25/25 end date of 04/03/25 revealed Resident #283 was to receive Cefepime HCL (antibiotic) Intravenous Solution two grams use 2000 milligrams intravenously three times a day for prosthetic infection for 37 days. Review of the physician order dated 02/24/25 revealed an order for C-Reactive Protein (CRP), a protein produced by the liver in response to inflammation) and erythrocyte sedimentation rate (SED Rate), measured the rate to detect inflammation in the body, every Monday and fax to infectious disease. Review of Resident #283 Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive deficit. Resident #283 had received anticoagulant medication and antibiotic medications in the seven days prior to 03/02/25 and had intravenous access. Review of facility document titled Specimen Collected dated 03/03/24 revealed CRP level of 29.7 (high) and SED Rate of 47 (high). Review of facility document titled Specimen Collected dated 03/17/24 revealed CRP level of 8.0 (normal) and SED Rate of 38 (high). Lab results for Monday 03/10/25 were not available to review. Interview on 03/26/25 at 7:58 A.M., the Director of Nursing (DON) confirmed the facility did not have the 03/10/25 specimen results for Resident #283 and verified no lab was drawn on 03/10/25. Review of the facility policy titled Following Physician Order dated February 2022 revealed licensed nursing professionals were to be aware of and follow all physician orders as written.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, interview and Centers for Disease Control and Prevention guidelines the facility failed to ensure staff performed hand hygiene to prevent possible cross contamination of germs during Resident #1's wound care and Resident #29's incontinence care. This affected one out of three residents reviewed for incontinence care. The facility census was 89. Findings include: Resident #1 was admitted on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis, anxiety, psychosis, depression, quadriplegia, neuromuscular bladder, gastroesophageal reflux disease, esophagitis, vitamin B deficiency, joint contracture and osteoporosis. A review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had an indwelling urinary catheter and was incontinent of bowel. A review of Resident #1's clinical record revealed a skin/wound note dated 03/24/24 of an assessment of a stage IV pressure ulcer (Sores that extend below the subcutaneous fat into your deep tissues, including muscle, tendons, and ligaments.), located on the left posterior thigh/ischium and measuring 9 centimeters (cm) long by 8.5 cm wide by 1.1 cm deep. Undermining present at the 12 o'clock position measuring 2 cm. The measured area had 20 percent intact and tissue within normal limits with 50 percent granular tissue and 10 percent slough. Edges were well defined and irregular in shape with no odor present. The skin/wound note indicated a stage III pressure ulcer (Sores that have broken completely through the top two layers of the skin and into the fatty tissue below.) located on the right posterior thigh measuring 1.5 cm long by 3 cm wide by 0.1 cm deep with 30 percent granular tissue, and 70 percent epithelial tissue. The wound edges were well defined, attached to the wound base and the area was irregular in shape. A small amount of serosanguinous exudate was noted when the dressing was removed from the wound. A third area of skin breakdown located on the right gluteal area was classified as moisture associated skin damage measuring 3.5 cm long by 5 cm wide by 0.1 cm deep. The measured area had 60 percent partial thickness skin loss and 40 percent epithelial tissue present. The wound had irregular edges and shape with a small amount of serosanguinous exudate noted when the dressing was removed from the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 03/25/25 at 1:50 P.M. of Licensed Practical Nurse (LPN) #525 perform Resident #1's wound treatment with the assistance of Certified Nurse Aide (CNA) #563 revealed a failure to perform hand hygiene to prevent cross contamination of germs. Both staff entered Resident #1's room and did not perform hand hygiene and donned a pair of gloves. Both staff assisted Resident #1 to roll on her right side and LPN #525 removed the soiled wound treatments from the three wounds on her sacral area and right/left gluteal areas. The wounds had open areas which had a small amount of serosanguinous drainage present and appeared very red with a tunneling area on the left ischium. LPN #525 cleaned the wounds with wound cleanser and gauze and discarded the soiled supplies in a plastic bag. LPN #525 did not remove her gloves or perform hand hygiene and applied the calcium alginate with silver dressing to the left and right gluteal wounds and border foam dressing to the sacral wound. Without removing her gloves LPN #522 proceeded to assist Resident #1 to reposition using a foam wedge cushion, handling multiple items in the room including Resident #1's call light button and bed remote and moved the over-the bed table close to Resident #1. LPN #525 then removed her gloves and applied another pair of gloves and did not perform hand hygiene and picked up the unused clean wound treatment supplies and exited the room. CNA #563 assisted LPN #525 with repositioning Resident #1 during the wound treatment and used the same gloved hands to place Resident #1's personal items on the over-the-bed table and then exited to room and placed her gown in the soiled utility room. On 03/25/25 at 2:20 P.M. an interview with LPN #525 and CNA #563 verified they failed to perform hand hygiene to prevent the spread of germs during Resident #1's wound treatment. 2. Resident #29 was admitted n 01/01/25 with diagnoses including nutritional marasmus, bipolar disorder, atrial fibrillation, high cholesterol, lymphedema, high blood pressure, cognitive communication deficit, and left pelvic fracture. A review of Resident #29's MDS assessment dated [DATE] indicated she bowel and bladder incontinence and needed maximum assistance with toileting. An observation on 03/24/25 at 9:54 A.M. of Licensed Practical Nurse (LPN) #522 assist Resident #29 with incontinence care revealed a failure to perform hand hygiene to prevent cross contamination of germs. LPN #522 entered Resident #29's room and did not wash her hands, donned a pair of gloves and proceeded to clean Resident #29's buttock and perineal area of a large amount of feces. Upon completion of the incontinence care, LPN #522 removed her gloves and did not perform hand hygiene. LPN #522 proceeded to touch various surfaces and items in the room including the call light button, bed remote, bed side drawer and other surfaces. LPN #522 was waiting for staff to answer the call light and touched the underside bandage on Resident #29's right temple, Resident #29's bed linens, and repositioned Resident #29. LPN #522 then picked up the package of incontinence wipes which had feces on the outside of the package and set the package on top of Resident #29's clean clothing on top of her bed side table. LPN #522 asked CNA #567 to assist her with turning and repositioning Resident #29 for the incontinence care. CNA #567 entered the room and donned a pair of gloves without performing hand hygiene and proceeded to assist LPN #522 with turning and repositioning Resident #29. LPN #522 then placed Resident #29's call light in reach, picked up the soiled bag of incontinence supplies and soiled linen and exited the room. LPN #522 placed the bag of soiled linen and bag of soiled incontinence supplies in the soiled utility room. LPN #522 removed her gloves and did perform hand hygiene. LPN #522 proceeded to obtain a cup, straw and lid and filled the cup with lemonade, walked back to Resident #29's room and assisted her with drinking from the cup of lemonade while holding the straw for her. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/24/25 between 10:00 A.M. and 10:30 A.M. interview with LPN #522 and CNA #567 verified the above findings and agreed they didn't perform hand hygiene to prevent the spread of germs during Resident #29's incontinence care. The facility policy and procedure titled Handwashing revised July 2015 indicated the purpose of the policy was to maintain medical asepsis, for infection control, to reduce transferal of microorganisms from resident to resident, to reduce transferal of microorganisms between staff and residents. The policy indicated proper handwashing technique would be used by all employees to maintain optimal infection control. The Centers for Disease Control and Prevention (CDC) hand hygiene guidance dated 01/30/20 indicated to perform hand hygiene immediately before touching a resident, before performing an aseptic task, before moving from a soiled body site to a clean body site on the same resident, after touching a resident, after contact with blood, body fluids, or contaminated surfaces, after touching a resident's immediate environment. Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. Ensure healthcare personnel wash their hands with soap and water when hands were visibly soiled.