STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365747	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Waterville	555 Anthony Wayne Trail Waterville, OH 43566

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observation, resident and staff interview, and review of facility policy, the facility failed to ensure dependent residents received adequate nail care. This affected two (#40 and #45) of three residents reviewed for activities of daily living. The facility census was 74.Findings include: 1. Review of the medical record revealed Resident #40 was admitted on [DATE]. Diagnoses included unspecified dementia with psychotic disturbance, major depressive disorder recurrent severe with psychotic symptoms, anxiety disorder, Alzheimer's disease, and cognitive communication dysfunctions.Review of the Minimum Data Set (MDS) assessment, dated 06/16/25, revealed Resident #40 was unable to complete the assessment interview. Review of the care plan, revised 01/04/24, revealed Resident #40 had a behavior problem including playing in her own feces. Review of the care plan, revised on 11/11/24, revealed Resident #40 had an activities of daily living (ADL) self-care performance deficit. Interventions includes to check nail length, trim, and clean on bath day and as necessary. Observation on 08/04/25 at 12:02 P.M. revealed Resident #40 had dirty fingerprints with a dark brown substance under all nails on both hands.Observation on 08/05/25 at 3:03 P.M. revealed Resident #40 had dirty fingerprints with a dark brown substance under all nails on both hands. Interview on 08/06/25 at 8:09 A.M. with Registered Nurse (RN) #368 verified Resident #40 does put her hands in her feces. It was reported the resident had a bowel movement three times yesterday and the staff had provided care to the resident immediately. Observation on 08/06/25 at 8:12 A.M. revealed Resident #40 eating breakfast in the dining room. Resident #40 was eating breakfast with her right hand, scooping the food directly into her mouth. Resident #40's fingernails were observed to remain dirty with the left hand fingernails more heavily soiled than the right. Interview on 08/06/25 at 8:14 A.M. with Registered Nurse (RN) #368 verified Resident #40's fingernails were dirty with a dark brown substance and was using her hands to eat breakfast. 2. Review of the medical record revealed Resident #45 was initially admitted on [DATE]. Diagnoses included bipolar disorder, type two diabetes mellitus, hypothyroidism, hyperlipidemia, major depressive disorder, essential hypertension, acute ischemic heart disease, and chronic kidney disease stage three. Review of the MDS assessment, dated 06/09/25, revealed Resident #45 was moderately cognitively impaired and required set-up/clean-up assistance with personal hygiene. Review of the care plan, revised 06/17/25, verified Resident #45 had an ADL self care performance deficit with interventions including to check nail length, trim, and clean on bath day and as necessary. Interview on 08/04/25 at 11:04 A.M. with Resident #45 revealed he would like his fingernails trimmed. Subsequent observation revealed Resident #45's fingernails were longer than typical but clean and not jagged. Observation on 08/07/25 at 2:43 P.M. revealed Resident #45's nails remained long. Subsequent interview with the resident revealed he did not like his nails as long as they were and stated he would like them to be trimmed.Interview on 08/07/25 at 2:46 P. M. with Certified Nurse Aide (CNA) #305 acknowledged Resident #45's fingernails were long and verified Resident #45 indicated he wanted them trimmed. CNA #305 stated it was unknown who normally trimmed Resident #45's nails. Review of the policy titled, Activities of Daily Living, revised January 2022, verified staff will carryout the ADL care tasks following the resident's ADL care plan. This deficiency represents non-compliance investigated under Complaint Number 2562969.

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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 - Few	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, medical record review, and staff interview, the facility failed to adequately assess a resident following an unwitnessed fall and failed to ensure adequate supervision to prevent a resident from consuming food not in their diet. This affected two (#56 and #38) of two residents reviewed for accidents. The facility census was 74.Findings include: 1. Review of the medical record for Resident #56 revealed an admission on [DATE] with diagnoses of paranoid schizophrenia, major depressive disorder, and pseudobulbar affect. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact. Further review of the MDS assessment revealed Resident #56 used a walker to ambulate and required supervision for activities of daily living (ADLs). Review of the care plan dated 07/15/25 revealed Resident #56 was at risk for falls and potential injury related to psychoactive drug use, and staff were to minimize the potential risk factors related to falls. Additional review of the care plan revealed Resident #56 used psychotropic medications related to paranoid schizophrenia, major depressive disorder, and anxiety disorder. Resident #56 was to remain free of drug related complications including gait disturbances. Staff were to report any adverse reactions, including unsteady gait or shuffling gate. Observation on 08/12/25 at 10:03 A.M. at the Connections nurses station revealed Resident #56 approximately ten feet from the nurse’s station lying on the ground with her walker next to her yelling for help. Licensed Practical Nurse (LPN) #381 was behind the nurse’s station at this time. At 10:05 A. M., Housekeeper #376 came out of a resident room stated to Resident #56, Come on get up, and helped Resident #56 off the floor. Housekeeper #376 then went back into room [ROOM NUMBER] without reporting the incident. Interview on 08/12/25 at 10:07 A.M. with LPN #381 revealed she was unaware Resident #56 was on the floor. LPN #381 heard Resident #56 yelling out but stated she was preoccupied with charting. LPN #381 stated she was unsure where the nurse aides were during this time. Further interview with LPN #381 revealed if a resident was on the floor and it was not witnessed the nurse should complete a head-to-toe assessment, neurological checks, call the doctor and resident representative, tell management, and complete a fall packet. LPN #381 confirmed Housekeeper #376 did not report that Resident #56 was on the ground and was only aware due to being told by this surveyor. Review of the progress note for Resident #56 on 08/12/25 at 10:16 A.M. revealed Resident #56 put herself on the floor in the hallway and housekeeping helped Resident #56 up. Interview on 08/12/25 at 10:48 with Housekeeper #376 revealed she did not see Resident #56 fall and came out of the resident room on 08/12/25 due to hearing Resident #56 yelling. Housekeeper #376 confirmed she did not report it to the nurse. Interview on 08/12/25 at 10:57 A.M. with Chief Nursing Officer #401 confirmed the nurse should complete a fall assessment when a resident has an unwitnessed fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #38 revealed an admission date of 12/28/23 with diagnoses of Alzheimer's disease, dementia, oropharyngeal dysphagia, and schizoaffective disorder. Review of the quarterly MDS assessment, dated 07/07/25, revealed Resident #38 had mildly impaired cognition, used a walker and wheelchair for mobility, was able to eat with supervision or touching assistance, and was able to wheel 50 feet with two turns once seated in her wheelchair. Further review revealed Resident #38 was on a texture modified diet. Review of the physician order dated 01/16/25 revealed Resident #38 was on a regular diet with pureed textures and thin liquids. Review of the care plan, updated 06/05/25, revealed Resident #38 displayed behavioral symptoms, including taking food off other resident trays. Interventions included verbal redirection and intervening when Resident #38 displayed inappropriate behavior. Review of a progress note dated 05/16/25 revealed Resident #38 was at the food cart stealing regular texture food off other residents’ trays. Resident #38 was educated and redirected. Review of a progress note dated 05/27/25 revealed Resident #38 was eating regular food. Resident #38 was educated twice but refused to give the food back to staff. Review of a progress note dated 06/14/25 revealed Resident #38 was caught eating steak out of the trash. Resident #38 was redirected. Review of a progress note dated 07/04/25 revealed Resident #38 took a hamburger off a discharged resident’s food tray. Resident #38 was educated and refused to return the hamburger. Resident #38 consumed the hamburger without issue. Observation on 08/11/25 at approximately 9:05 A.M. revealed [NAME] President of Clinical Services (VPCS) #400 in the nurses station at the medication cart with her back to Resident #38. Further observation revealed Resident #38 opened the tray cart in the hallway and reaching inside, lifting the lid off another resident’s tray, and pulling out two pieces of bacon. Resident #38 then turned in her wheelchair and began to wheel away from the area while eating a piece of the bacon. Interview on 08/11/25 at approximately 9:07 A.M. with VPCS #400 confirmed Resident #38 had bacon. Concurrent observation revealed VPCS #400 removed the bacon from Resident #38’s hands and provided education. Interview on 08/11/25 at 9:08 A.M. with Certified Nurse Aide (CNA) #404 confirmed Resident #38 regularly took food from other residents’ plates. Staff had to monitor Resident #38 closely because of this behavior. Further interview revealed CNA #404 was in the dining room during the observation at approximately 9:05 A.M. when Resident #38 removed bacon from the tray cart. CNA #404 confirmed Resident #38 was on a pureed diet. Further, CNA #404 confirmed the tray Resident #38 removed the bacon from was an untouched tray for a resident who was hospitalized . Interviews on 08/12/25 at 9:51 A.M. with LPN #405 and CNA #371 revealed they were familiar with Resident #38 and her behavior of taking food from other residents’ trays. LPN #405 and CNA #371 stated the expectation was staff would monitor Resident #38 and redirect her when needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/12/25 at 9:56 A.M. with VPCS #400 and Chief Nursing Officer #401 revealed they were unable to provide any additional interventions developed by the facility to prevent Resident #38, who was on a pureed diet, from obtaining and consuming regular texture foods from other residents’ trays. This deficiency represents non-compliance investigated under Complaint Number OH00166789 (1260025).

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, county coroner interview, review of the Emergency Medical Services (EMS) run report, review of the death certificate, and review of the facility self-imposed action plan, including in-service records and audits, the facility failed to provide residents food in the correct texture to meet individual needs, failed to ensure residents were provided feeding assistance/supervision as required, and failed to put monitoring systems in place to prevent the same actions, situations, and/or practices from reoccurring. This resulted in Immediate Jeopardy for one (#83) resident who experienced serious life-threatening harm and negative health outcomes resulting in death when served the incorrect food item at snack time, subsequently choked, lost consciousness, and collapsed, requiring staff intervention to perform cardiopulmonary resuscitation (CPR), and an emergency medical service response in an effort to remove the food bolus from the trachea where it was preventing air flow to and from the lungs. Additionally, a second resident (#07) was placed at risk for potential serious life-threatening adverse outcomes when Resident #07 who was observed eating alone in his room, coughing with urgency, with a purple/red discoloration to his face, requiring facility staff to be alerted by a surveyor, and staff intervention to dislodge food. This affected one (#83) of three residents reviewed for mechanically altered diets and one (#07) of three residents reviewed for activities of daily living who required assistance/supervision with eating. The facility identified 17 residents (#14, #20, #46, #03, #49, #53, #55, #56, #57, #01, #07, #62, #79, #82, #64, #65, and #72) who were ordered mechanically altered diets, and seven residents (#05, #07, #33, #41, #53, #64 and #78) who required feeding assistance/supervision. The facility census 74. On 08/06/25 at 4:02 P.M., Corporate Chief Nursing Officer (CCNO) #401, [NAME] President of Clinical (VPC) #400, Regional Director of Operations (RDO) #402, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 09/30/24 at 9:26 P.M. when Resident #83 was served a peanut butter sandwich, sometime around 8:00 P.M. , as an evening snack by Certified Nursing Assistant (CNA) #320, contrary to the resident's physician order for a regular diet, mechanical soft, thin consistency, no bread, and no straws. Sometime later, CNA #320 responded to Resident #83's roommates call light and found Resident #83 on the floor, and unresponsive. CNA #320 summoned Registered Nurse (RN) #366 for help. RN #366 began CPR as Resident #83 had no pulse or respirations. Emergency Medical Services (EMS) were called and arrived at 8:47 P.M., EMS took over CPR. Resident #83 remained without a pulse or respirations. At 8:53 P.M., EMS attempted to place a breathing tube, and a foreign body was noted in Resident #83's mouth, the foreign body appeared to be chewed food. Resident #83 was suctioned and about five milliliters (ml) of product was removed. Continued efforts to resuscitate Resident #83 were unsuccessful and Resident #83's death was pronounced at 9:26 P. M.The Immediate Jeopardy was removed on 08/07/25 at 2:12 P.M. when the facility implemented the following corrective actions: On 08/06/25 at 4:30 P.M., a root cause analysis was conducted by the following team members: the Administrator, DON, RDO #402, and CCNO #401 and VPC #400 to determine why residents were not provided with food prepared in a form designed to meet individual needs and why residents were not provided the level of supervision when eating as ordered. On 08/06/25 at 4:45 P.M., a Quality Assurance Assessment (QAA) meeting was held which included the Administrator, Executive Director, DON, RDO #402, and the Medical Director. The team discussed a plan to mitigate resident choking incidents. The plan outlined included the following: - Identifying on the resident's meal ticket, the diet ordered, and the resident's required level of assistance with eating, including supervision. Resident diet orders and level of assistance with eating will be managed by the clinical team, with any changes to the diet order or a resident's level of assistance communicated to the Dietary Manager by the clinical team at the time of the change. - The Dietary Manager, on a daily basis, will ensure resident meal tickets are up to date with the resident's current diet and level assistance or need for supervision with eating. The Dietary Manager will also place a list of resident diet orders, including diet texture, level of assistance or supervision needed on the snack carts, and all snacks will be labeled to identify the diet texture type. On 08/06/25 at 5:00 P.M., the Department Managers initiated education with the staff on-duty; five Registered Nurses (RN), 15 Licensed Practical Nurses (LPN), three laundry aides, five housekeepers, nine dietary staff, four activities staff, one Executive Director (ED), one DON, one Assistant Director of Nursing (ADON), five therapy staff, one receptionist, one social service employee, 23 CNAs, and one transportation person, on the meal ticket containing the resident's diet ordered, and the required level of assistance with eating, including supervision

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of a job description, and policy review, the facility failed to provide adequate administration over the facility when a resident died from a choking incident as a result of being provided unapproved food items. The facility subsequently put a corrective action plan into place that was not fully followed to prevent further episodes of resident's choking and prevent residents from receiving restricted food and drinks. This had the potential to affect all 74 residents residing in the facility. The facility census was 74.Findings Include:Interview on 08/12/25 at 1:47 P.M. with the Administrator, Chief Nursing Officer (CNO) #401, and [NAME] President of Clinical Services (VPCS) #400 revealed after a choking incident on 09/30/24 that resulted in a resident's (#83) death when the resident was give food items that were restricted, the facility immediately implemented a self-imposed action plan (SIAP) to correct the deficiencies that contributed to the event. Part of the SAIP included an entry dated 10/01/24, that the Dietary Manager (DM) would put a diet list on each snack tray so staff are aware of the current diet order prior to offering a snack. Additionally, the SAIP included on 10/01/24 staff education on the diet list would be completed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) #370/Clinical Manager (CM) with audits being done to observe staff were utilizing the cards. The SIAP also indicated the results of the audits will be reported to the Quality Assurance (QA) committee.Random observations made throughout the survey revealed staff not utilizing diet order cards on snack trays during snack pass times; and additional observations made throughout the annual survey revealed on 08/06/25 at 10:27 A.M. Resident #7 was choking on food while eating in bed and staff came to assist with the resident ultimately coughing up food into a towel. Resident #7 was eating alone at the time of the choking incident and review of a nutritional assessment dated [DATE] revealed the resident was to be supervised while eating. Interview on 08/06/25 at 10:28 A.M. with ADON #370 revealed Resident #07 coughed up his food and spit it in a towel. ADON #307 confirmed that the most recent nutritional assessment on 07/17/25 stated Resident #07 was to be supervised while eating. Further observation on 08/11/25 at approximately 9:05 A.M. revealed Resident #38 eating bacon from another resident's meal tray off the unattended hallway cart, and review of Resident #38's physician order dated 01/16/25 revealed the resident a regular diet with pureed texture and thin liquids. Interview on 08/11/25 at approximately 9:07 A.M. with VPCS #400 confirmed Resident #38 had bacon. Interview on 08/11/25 at 9:08 A.M. with Certified Nurse Aide (CNA) #404 confirmed Resident #38 regularly took food from other residents' plates. Staff had to monitor Resident #38 closely because of this behavior. Further interview revealed CNA #404 was in the dining room during the observation at approximately 9:05 A. M. when Resident #38 removed bacon from the tray cart. CNA #404 confirmed Resident #38 was on a pureed diet. Further, CNA #404 confirmed the tray Resident #38 removed the bacon from was an untouched tray for a resident who was hospitalized .Review of the undated Executive Director (Administrator) job description listed essential job functions and responsibilities included to develop and maintain written policies and procedures that govern the operation of the facility, and assume the administrative authority, responsibility, and accountability of directing the activities and programs of the facility. Additionally, the primary purpose of job description was to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to our residents at all times.Review of the Quality Assurance Performance Improvement (QAPI) policy, dated 03/2023, revealed governance and leadership will operate under the direction of the QAPI Governing Chairpersons who are considered subject matter experts; Executive Director, Director of Nursing, Medical Director, and Infection Preventionist. Further, the policy revealed the object of the QAPI Governing was to develop a continuous pro-active approach to self-discovery to decrease the likelihood of issues/concerns and test new approaches to correct underlying potential causes of those issues/concerns.This deficiency represents non-compliance investigated under Complaint Number 2562969.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to ensure the facility maintained a homelike environment. This affected eight (#35, #82, #22, #36, #12, #81, #7, and #29) of eight residents reviewed for environment. The facility census was 74.Findings include:1. Observation on 08/05/25 at 1:43 P.M. behind Resident #12's bedroom door revealed a large hole in the drywall at the door handle height. Also noted in the coinciding area behind the door right below the ceiling was a small hole in the drywall. In Resident #12's shared bathroom there was a waste basket under the sink, approximately one-quarter full of water.2. Observation on 08/05/25 at 1:43 P.M. of Resident #81's bedroom revealed a light above his bed with no cord to turn the light on. Resident #81 shared a bathroom with Resident #12 which had a waste basket under the sink, approximately one-quarter full of water.3. Observation on 08/05/25 at 1:49 P.M. of Resident #7 and Resident #35's room revealed large brown-colored areas of a substance throughout the entire ceiling.4. Observation on 08/05/25 at 1:51 P.M. of Resident #29's bedroom revealed a light above the bed with no pull cord.5. Observation on 08/05/25 at 1:52 P.M. of Resident #36 and Resident #22's room revealed large brown-colored areas of a substance throughout the entire ceiling.6. Observation on 08/05/25 at 1:53 P.M. of Resident #82's bedroom revealed a light above the bed with a broken cover that was hanging from the light. Interview and observation on 08/06/25 at 8:07 A.M. with Regional Director of Maintenance (RDM) #403 confirmed Resident #12 had two holes behind the door and a waste basket under the bathroom sink shared by Resident #12 and Resident #81 that was approximately one-quarter full of water. RDM #403 stated he was going to get a part to fix the sink. RDM #403 also confirmed Resident #81 and Resident #29 did not have pull cords for their lights over their bed. RDM #403 confirmed the ceilings in the room shared by Resident #7 and Resident #35 and the room shared by Resident #36 and Resident #22 had water pipes that burst and were fixed; however, the brown-colored spots on the ceiling were not. Additionally, RDM #403 confirmed Resident #82's light was broken.This deficiency represents non-compliance investigated under Complaint Number 2562969 and Complaint Number OH00166789 (1260025).