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	09/30/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the facility investigation, review of emergency medical service (EMS) and police reports, review of the county coroner case documentation, and review of facility policy, the facility failed to prevent resident to resident abuse. Actual harm occurred on 09/23/25 when Resident #29 was discovered in a resident room behind a closed door and Resident #53 was discovered in the same room behind a drawn privacy curtain laying supine on a sheet on the floor with towels secured tightly around the neck. Resident #53's head was purple in color, skin was cool to touch, with blood in her mouth, petechia to her skin, and no respirations or pulse were present. Resident #29 later admitted strangling Resident #53. The county coroner case documentation listed the cause of Resident #53's death as a homicide by means of strangulation. This affected one (#53) of three residents reviewed for abuse in a facility census of 71. Findings include:1. Review of the medical record revealed Resident #29 admitted to the facility on [DATE]. Diagnoses included schizophrenia, chronic obstructive pulmonary disease, hypertension, and brief psychotic disorder. Review of the resident census revealed Resident #29 was initially admitted to the secured dementia unit and then moved to the secured second floor behavior unit on 07/17/25. Review of the Minimum Data Set (MDS) assessment dated [DATE] the resident was assessed with clear speech, usually understood and understands others, moderate cognitive impairment, no recorded behaviors, no range of motion impairment, and independent with ambulation. Review of the resident's care plan dated 07/25/25 revealed a the nursing plan of care was revised to address Resident #29's cognitive loss/disorientation/impaired judgement related to diagnosis of schizophrenia. Interventions included: Follow doctor's orders for appropriate treatment, review the medication regimen with the physician to assess and rule out possible side effects or contraindications related to medications or food products, verbalize you will help him/her Stay in control, assure the resident he is protected, safe, and secure and in a protected environment. On 08/21/25 Resident #29 was evaluated by psychiatry services. Resident #29 was documented to be pleasant, calm and engaged throughout the entire evaluation. Psychoactive medications were reviewed and no behaviors were documented. Review of Resident #29 medical record lacked documentation indicated he exhibited aggressive behaviors towards staff or residents while residing at the facility. Review of the resident census revealed Resident #29 was returned to the dementia unit on 09/05/25. 2. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included major depression, bipolar disorder, muscle weakness, cognitive communication deficit, insomnia, anxiety disorder, polyneuropathy, and anemia. Resident #53 resided on the secured dementia unit since 01/24/25. Review of the MDS assessment dated [DATE] revealed Resident #53 had clear speech, usually understood and understands, severe cognitive impairment, no recorded behaviors, and was independently ambulatory. On 08/28/25 a quarterly secure unit admission assessment noted Resident #53 to be appropriate for the dementia unit due to a mental health condition. The unit would benefit the resident due to a smaller unit that allowed for staff interventions Review of a facility investigation revealed on 09/23/25 at approximately 9:30 P.M. Registered Nurse (RN) #400 attempted to locate Resident #29 for medication administration. RN #400 was unable to locate Resident #29 in his room or common area and requested Certified Nurse Aide (CNA) #301 to assist in finding him. RN #400 and CNA #301 proceeded to walk down the unit corridor and discovered Resident #55's room door closed. CNA #301 opened the door. Resident #29 was observed standing inside the door rocking from side to side with perspiration on his forehead. CNA #301 observed the curtain pulled around the first bed in the room and proceeded to open the curtain. Resident #53 was observed lying on the floor placed on a sheet in the supine position. Her face was deep purple with blood coming from her mouth. A bath towel and pillowcase were wrapped tightly around her neck. RN #400 yelled for help and Licensed Practical Nurse (LPN) #500 responded to the room. CNA #302 was located at the nursing station and responded to the room. Once CNA #302 observed Resident #53 on the floor she immediately returned to the nurses' station and called Emergency Medical Services (EMS). LPN #500 directed staff to stay with Resident #29 and take him to the unit dining room. LPN #500 assessed Resident #53 and checked her for a radial pulse with no pulse palpable. Resident #53's skin was noted to be cold and clammy, and no respirations were detected. LPN #500 and RN #400 determined the room was a crime scene. LPN #500 stood outside the room until EMS and Police arrived while RN #400 contacted the Director of Nursing (DON) to inform her of the incident. EMS assessed Resident #53, pronounced the resident