

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2025
NAME OF PROVIDER OR SUPPLIER  Auburn Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  451 Valley Road Salem, OH 44460	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, policy review, and staff/Resident interviews, the facility failed to maintain the dignity and privacy of one resident (Resident #07) of five residents reviewed for dignity and privacy. The facility census was 42. Findings Include: Review of medical record of Resident #07 revealed initial admission to facility on 04/22/25 for diagnosis including metabolic encephalopathy, pneumonia, chronic respiratory failure, high blood pressure, major depression and anxiety, spinal cord injury, and chronic lung disease. Review of the medical record for Resident #07 revealed the Minimum Data Set 3.0 (MDS 3.0) indicated Resident #07 required moderate to substantial assistance with personal care and was dependent on wheelchair for mobility. Observation on 09/02/25 at 9:50 A.M. revealed Resident #07 in bed with bilateral heel boots on and flannel pajama pants noted to be pulled down to below the resident's knees, above the boots and a sheet laying across the resident's midsection. Resident #07 reported that they do this at night in case I have an accident, and I need changed, it makes it easier. Resident #07 then adjusted his sheet to cover up the pulled down flannel pants. Observation on 09/03/25 at 8:24 A.M. revealed Resident #07 lying in bed covered with a linen sheet with heel boots on bilaterally. Observation of Resident #07 revealed he was wearing flannel pajama pants pulled down to below the knees and above the boots. Resident #07 reported this was done at night to make it easier to change him if he had an accident since he was wearing heel boots while in bed. Interview on 09/03/05 at 8:26 A.M. with Assistant Director of Nursing (ADON) #160 confirmed Resident #07 pajamas being pulled down below knees and above boots. ADON #160 was not able to explain reason for this and stated the aides must be doing it. Review of facility policy titled Quality of Life-Dignity revised August 2009 revealed all residents will be treated with dignity and respect at all times including, providing for bodily privacy during assistance with personal care and during treatments procedures. This deficiency represents non-compliance investigated under Complaint Number 2578619.</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observation and interview, the facility failed to ensure the call light was within reach, and failed to provide functional furniture to accommodate resident needs. This affected two (Resident #12 and Resident #16) of two residents reviewed for accommodation of needs. The facility census was 42. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 12/02/23. Diagnoses included but were not limited to alopecia; cognitive communication deficit; unsteadiness on feet; hyperlipidemia; generalized anxiety disorder; essential hypertension; glaucoma; and cataracts. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 out of a possible 15, indicating intact cognition. Section B of the MDS indicated the resident had moderate difficulty hearing with a device, her speech was unclear, and her vision was moderately impaired with no corrective lenses. On 09/02/2025 at 9:00 A.M., an observation of Resident #16's room revealed her call light was not in reach. The call light with a cord connected to a round orange object was lying on the floor behind her nightstand, out of reach of the resident. There was noted to be a long string, with a blue circle attached to the end, on the arm of her recliner. On 09/02/2025 at 11:50 A.M., observation revealed Resident #16 was in recliner in her room. Her call light was out of reach. When asked how she would call for help, the resident picked up a blue round object that was connected to a cord for the light, pulled it, and the light turned off. The cord for the call light was connected to an orange round object and out of reach of the resident. On 09/02/2025 2:02 P.M., interview with Registered Nurse (RN) #105 confirmed the resident could not reach her call light. The cord she indicated to be her call light was the light switch/cord. On 09/04/25 at 9:28 A.M., an interview with the Director of Nursing (DON) revealed the cord for Resident #16's call light and the cord for the overhead light were difficult to distinguish and the call light was out of reach for the resident. 2. Review of the medical record for Resident #12 revealed an admission date of 08/13/25. Diagnoses included but were not limited to bilateral primary osteoarthritis of knee, presence of left artificial knee joint, other unilateral secondary osteoarthritis of knee, post-traumatic osteoarthritis left shoulder, pulmonary embolism, aortic aneurysm of unspecified site, depression, benign neoplasm of brain, anxiety disorder, and aftercare following joint replacement surgery. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of a total score of 15 which indicated intact cognition. Further review of the MDS revealed the resident had no behavioral issues. The resident indicated in Section F of the MDS that choices for personal care were very important to her. Section GG of the MDS indicated the resident used a walker for mobility and needed substantial/maximal assistance for upper and lower body dressing as well as toileting hygiene. She required partial/moderate assistance to shower or bathe, and to put on and take off footwear. Resident #12 also was assessed to have occasional pain, which she rated a five on a 0-10 scale, with zero being no pain and ten as the worst pain one could imagine. Review of a care plan for Resident #12, dated 08/19/25, revealed the resident was identified as having an alteration in musculoskeletal status following her joint replacement. One intervention read, anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Interventions also included changing the surgical incision dressing per order and PRN (as needed) and modifying the environment to meet the resident's needs. On 09/02/2025 at 11:43 A.M., observation revealed the call light was observed under the covers of Resident #12's bed. The resident was in a recliner and not able to reach the call light from where she was sitting. There was a string for another call light on the floor out of the resident's reach. She indicated if she needed assistance, she would pull the string which was on the arm of the recliner. This string was for the room light. On 09/02/25 at 1:59 P.M., an observation of Resident #12's room revealed the string for the light was on the recliner and the recliner was in the reclined position. The other call light for the room was under the bed covers. Resident #12 was observed in a wheelchair. Her recliner was in the reclined position, and she reported she had issues getting out of the chair and could not get out without the assistance of her son. The footrest of the recliner would not close without significant force. On 09/02/2025 at 2:03 P.M., an observation and interview with RN #105 confirmed Resident #12's call lights were on the floor and on the bed and they were out of reach of the resident. RN #105 also confirmed Resident #12's recliner was too difficult for the resident to close and a resident who had knee surgery should have a functional chair for safety. On 09/04/2025 at 9:01 A.M., an interview with the DON revealed Resident #12 and Resident #16 had call lights which were easily confused</p>		