

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review, observation, and interview, the facility failed to maintain proper food storage in the kitchen to prevent potential contamination and spoilage. This had the potential to affect all residents who receive food from the kitchen. The facility identified three residents (Resident #9, Resident #6, and Resident #5) as NPO (Nothing by mouth), who were not affected. The facility census was 42. Findings include: On 09/02/2025 at 8:50 A.M., an observation of the kitchen revealed a 16-ounce (oz) box of Barley which was opened and uncovered in the dry pantry. This was verified at that time by DM #165. On 09/02/2025 at 8:52 A.M., an observation of the kitchen revealed a dented 50 oz can of Campbell's Chicken Noodle Soup on the dry pantry shelf. This was verified at that time by DM #165. On 09/02/2025 at 9:00 A.M., an observation of the stand-up freezer revealed a package of approximately 25 frozen hot dogs, which was opened and unsealed, exposing the hot dogs to the freezer air. This was verified at the time of observation by the DM #165. On 09/02/2025 at 9:01 A.M., an observation of the kitchen revealed a large box of frozen seasoned beef patties, which was approximately 3/4 full, to be open and unsealed in the stand-up freezer. This was verified at the time of the observation by the DM #165. On 09/02/2025 at 9:06 A.M., an observation of the kitchen revealed white, crusted debris around the outer aspects of the ice machine and on the inside of the lid, which was flakey and would fall off when touched. An interview at that time with the DM #165 revealed this happened often and would run down the sides of the machine as well. On 09/03/25 at 10:55 A.M., an observation of the kitchen revealed a large box of frozen seasoned beef patties, which was approximately 3/4 full, to be open and unsealed in the stand-up freezer. This observation was verified by DM #165 on 09/03/25 at 11:00 A.M. A review of the facility policy titled, Food Receiving and Storage, revised October of 2017, revealed food services, or other designated staff, will maintain clean food storage areas at all times. It further revealed all foods stored in the refrigerator or freezer would be covered, labeled and dated.		

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, observation, interview, review of the Centers for Disease Control and Prevention (CDC) Guideline for Isolation Precautions, and review of facility policy, the facility failed to timely implement orders for contact isolation for Resident #9 and ensure staff donned adequate personal protective equipment (PPE) when entering isolation rooms. This affected one resident (#9) of five reviewed for infection control. In addition, the facility failed to ensure staff performed appropriate hand hygiene during medication administration. This affected four residents (#7, #16, #21 and #27) of 10 observed for medication administration. The facility census was 42. Findings include: 1. Review of the medical record for Resident #9 revealed an admission date of 08/01/25 with diagnoses including dementia, atrial fibrillation, and dysphagia. Review of the progress note dated 08/13/25 at 12:56 A.M. revealed Resident #9 had a loose stool or diarrhea and the physician was notified. The note dated 08/14/25 at 10:36 P.M. revealed Resident #9's lab results indicated a positive result for clostridium difficile (c. diff). The note dated 08/15/25 at 1:28 P.M. revealed Resident #9 was placed on precautions (unspecified what kind of precautions) until further notice due to testing positive for c. diff and the resident's son was notified. The note dated 08/18/25 at 10:05 A.M. revealed Resident #9 was receiving antibiotics due to c. diff and remained on isolation. The note dated 08/22/25 at 3:37 P.M. revealed Resident #9 was receiving antibiotics due to c. diff and remained on isolation. On 09/02/25 at 10:07 A.M., an observation of Resident #9's room revealed a bin of personal protective equipment (PPE) outside the door, a red sign with EP on the door frame, and a red sign indicating to see the nurse prior to entering the room. There was no sign indicating contact precautions were in place. On 09/02/25 at 10:08 A.M., an interview with Registered Nurse (RN) #105 stated Resident #9 was on full contact precautions for c. diff. Review of the physician's orders revealed an order for contact isolation was created on 09/02/25 at 10:46 A.M. by the Director of Nursing (DON) with an effective date of 08/14/25. There was no evidence of prior orders for transmission-based precautions or isolation. On 09/02/25 at 5:30 P.M., an interview with the DON verified Resident #9's order for contact precautions was not added until 09/02/25 and the progress notes written prior to the order did not specify what type of transmission-based precautions were implemented. On 09/04/25 at 9:35 A.M., an observation of Resident #9's room revealed Housekeeper #163 was cleaning the room without wearing a gown. At this time, Resident #9 was sitting in a chair in the room. On 09/04/25 at 9:39 A.M., an interview with Housekeeper #163 confirmed no gown was worn while cleaning Resident #9's room. Housekeeper #163 stated she did not have to gown up because she was not providing direct care to Resident #9. On 09/04/25 at 10:10 A.M., an interview with Assistant Director of Nursing (ADON) #160 confirmed Resident #9 was still on contact precautions and housekeeping staff should wear gowns. Further review of the physician's orders revealed the order for contact isolation was active until (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9 discharged on 09/08/25. Review of the facility ' s policy titled Isolation - Initiating Transmission-Based Precautions, revised August 2019, revealed transmission-based precautions, including contact precautions, droplet precautions, and airborne precautions, were initiated when a resident developed signs and symptoms of a transmissible infection, arrived for admission with symptoms of an infection, or had a laboratory confirmed infection and was at risk of transmitting the infection to other residents. Transmission-based precautions remained in effect until the attending physician or infection preventionist discontinued them after criteria for discontinuation had been met. Review of the facility ' s policy titled Isolation - Categories of Transmission-Based Precautions, revised September 2022, revealed transmission-based precautions (TBP) were initiated when a resident developed signs and symptoms of a transmissible infection, arrived for admission with symptoms of an infection, or had a laboratory confirmed infection and was at risk of transmitting the infection to other residents. The policy indicated contact precautions were implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident ' s environment. Contact precautions included use of gloves and gown when entering the room and removing both before leaving the room, with hand hygiene performed after removing gloves. Review of the CDC's 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, revised September 2024, revealed contact precautions were intended to prevent transmission of infectious agents which were spread by direct or indirect contact with the patient or the patient's environment. The guidelines included that contact precautions would be used when there was a possibility of unintentional contact with contaminated environmental surfaces. Healthcare personnel caring for patients on contact precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment, and donning PPE upon room entry and discarding PPE before exiting the room was done to contain pathogens that had been implicated in transmission through environmental contamination, such as c. diff. Appendix A, included in the guidelines, indicated c. diff required contact and standard precautions for the duration of the illness. 2. Observation of medication administration on 09/04/25 at 10:38 A.M. with Licensed Practical Nurse (LPN) #138 revealed no hand hygiene was completed prior to preparing Resident #27's medications. LPN #138 administered Residents #27's medications and walked back to her cart. No hand hygiene was completed. LPN #138 began prepared Resident #21's medications. LPN #138 walked into Resident #21's room and administered the medication and walked back to her cart. No hand hygiene was completed. LPN #138 prepared Resident #7's medications, walked into his room and administered the medications. LPN #138 walked back to the cart. No hand hygiene was completed. LPN #138 began preparing Resident #16's medications. LPN #138 placed the medications in a drawer, in Resident #16's room, for Resident #16 to self administer with lunch. LPN #138 walked out of the room and did not perform hand hygiene. Interview on 09/04/24 at 11:00 A.M. with LPN #138 verified she did not perform hand hygiene prior or between residents. LPN #138 stated she was required to sanitize after providing care to three residents. Interview on 09/04/25 at 11:05 A.M. with the Director of Nursing (DON) stated hand washing or sanitizing must be completed prior to preparing medications. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Handwashing Hand Hygiene revised August 2019 revealed the use of an alcohol-based hand rub or an approved non-alcohol-based hand sanitizer or soap and water is used before preparing or handling medications.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 with the light cords. She further confirmed Resident #12's recliner in her room was too difficult for a resident post knee surgery to operate safely. Review of facility policy titled Call System, Resident, dated September 2022, revealed residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The policy further revealed each resident would be provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure residents had access to paper towels. This affected one (Resident #8) of three residents reviewed for environment. The facility census was 42. Findings include: Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including collapsed vertebra of the thoracic region, diabetes mellitus, concussion, depression, morbid obesity, and asthma. Review of the 5-Day Minimum Data Set (MDS) assessment, dated 08/25/25, revealed Resident #8 had intact cognition. The MDS further revealed Resident #8 required staff assistance with activities of daily living (ADLs). Review of the Care Plan, dated 08/25/25, revealed Resident #8 had the potential for an alteration in activities with interventions including to allow the resident the opportunity to express opinions of activities of choice and to interview the resident quarterly and as needed for activities of choice. Interview on 09/02/25 at 11:56 A.M. with Resident #8 revealed she did not have any paper towels in her bathroom and had told nursing staff early yesterday that she was out and needed more, however, the dispenser was still empty. Observation on 09/02/25 at 11:59 A.M. of Resident #8's bathroom revealed the paper towel dispenser was empty. Interview on 09/02/25 at 12:05 P.M. with Certified Nursing Assistant (CNA) #157 revealed Resident #8's paper towel dispenser was empty and she would notify housekeeping to refill it. Interview on 09/08/25 at 1:52 P.M. with Housekeeping Supervisor #163 revealed it was housekeeping's responsibility to check the paper towels located in the resident's bathroom daily. Review of the facility policy titled, Quality of Life-Homelike Environment, dated May 2017, revealed the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to complete an activities assessment timely to ensure residents participated in group activities and/or preferred activities. This affected one (Resident #8) of one resident reviewed for activities. The facility census was 42. Findings include: Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including collapsed vertebra of the thoracic region, diabetes mellitus, concussion, depression, morbid obesity, and asthma. Review of the 5-Day Minimum Data Set (MDS) assessment, dated 08/25/25, revealed Resident #8 had intact cognition. The MDS further revealed Resident #8 required staff assistance with activities of daily living (ADLs). Review of the Care Plan, dated 08/25/25, revealed Resident #8 had the potential for an alteration in activities with interventions including to allow the resident the opportunity to express opinions of activities of choice and to interview the resident quarterly and as needed for activities of choice. Interview on 09/02/25 at 11:52 A.M. with Resident #8 revealed she had not attended any activities since her most recent admission and that she was bored and would like to go to an activity. Interview on 09/03/25 at 10:28 A.M. with Activities Director (AD) #106 revealed activities assessments are documented in the electronic medical record (EMR) and confirmed Resident #8's EMR did not contain an activities assessment. AD #106 further confirmed although she had spoken to the resident and knew her likes and dislikes, she had not yet completed an activities assessment following the resident's recent admission. When asked whether the resident had attended any activities, she stated yes, the resident always attended activities. Review of Resident #8's written Activities Individual Participation Record (documented on paper) and not located in the EMR and provided by AD #106 revealed the resident's activities were primarily individual activities and not group activities. Review of the facility policy titled, Activities Documentation, dated 2018, revealed the AD is responsible for maintaining appropriate departmental documentation. The following records are maintained by the AD personnel: Activity assessment, attendance records, activity progress notes.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to address pharmacy recommendations for medication dosage adjustments for three of five Residents (Resident #04, #25, #1) reviewed for gradual dose reduction (GDR) monitoring. The facility census was 42. Findings include: 1. Review of the medical record for Resident #25 revealed admission to facility on 02/25/25 with diagnosis including heart attack, dementia with moderate agitation, protein malnutrition, repeated falls, high blood pressure, cancer of abdomen, heart failure, anxiety. Review of Resident #25's most recent quarterly Minimum Data Set 3.0 (MDS 3.0) completed on 07/02/25 revealed the brief interview of mental status (BIMS) score of 5 out of 15 indicating severe impairment. Further review of Resident #25's medical record revealed a pharmacist note dated 05/19/25 which recommended a gradual dose reduction for Trazodone (antidepressant) 50 milligrams (mg) by mouth once daily at bedtime for sleep. Further record review revealed a physician note by the primary care provider dated 05/30/25 stating to see Via [NAME] (contracted psychiatric services at the facility) for GDR recommendations. Via [NAME] first initial psychiatric evaluation to address GDR was completed on 07/02/25. Trazadone was increased to 100 mg by mouth daily at bedtime for sleep on 07/02/25. Interview on 09/08/25 at 11:42 A.M. with Psychiatric Nurse Practitioner (Psych NP) #171 stated she did not get GDR requisitions for the facility because the primary care physician handled all of that. She also stated she did not review any pharmacy recommendations. Psych NP #171 further stated the notes template she used included a section on GDR contraindications that was included on all notes as part of the standard template. 2. Review of the medical record for Resident #4 revealed an admission date of 02/05/21 and re-admission date of 10/10/23. Diagnoses included suicidal ideations, schizoaffective disorder bipolar type, depression, post-traumatic stress disorder, anxiety, insomnia, cerebral infarction, dementia, and brief psychotic disorder. Review of the pharmacy monthly medication regimen reviews revealed the following: On 10/21/24, the pharmacy identified there was no gradual dose reduction (GDR) attempt for Depakote (Divalproex) and Topiramate. A GDR was recommended unless clinically contraindicated, in which case documentation was needed to indicate such. The provider response, dated 11/20/24, was disagree due to followed by psychiatric services for GDR. On 01/21/25, the pharmacy identified there was no GDR attempt for Aripiprazole. A GDR was recommended unless clinically contraindicated, in which case documentation was needed to indicate such. The provider response, dated 01/29/25, was other due to the resident was followed by psychiatric services for GDR and there was no indication as to whether they agreed or disagreed with the recommendation. On 05/19/25, the pharmacy identified Venlafaxine was due for a GDR attempt unless clinically contraindicated, in which case documentation was needed to indicate such. The provider response, dated 05/30/25, was see ViaQuest notes with no indication as to whether they agreed or disagreed with the recommendation. On 05/19/25, the pharmacy identified there was no GDR attempt for Divalproex. A GDR was recommended unless clinically contraindicated, in which case documentation was needed to indicate such. The provider response, dated 05/30/25, was see ViaQuest notes with no indication as to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Auburn Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 451 Valley Road Salem, OH 44460	
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whether they agreed or disagreed with the recommendation. Review of the psychiatric services notes for Resident #4 revealed there was no indication that pharmacy recommendations were reviewed or addressed. Review of the annual Minimum Data Set (MDS) assessment, dated 07/28/25, revealed Resident #4 was cognitively intact and had indicators of moderately severe depression. The assessment indicated Resident #4 received medications including antipsychotic, antidepressant, and anticonvulsant with no gradual dose reduction (GDR) attempted. Review of the physician's orders for September 2025 identified orders for Topiramate oral tablet 50 milligrams (mg) to give one tablet once daily for schizoaffective disorder bipolar type (06/21/25), Prazosin Hydrochloride (HCl) oral capsule 1.0 mg to give one capsule daily at bedtime for schizoaffective disorder bipolar type (07/10/25), Aripiprazole oral tablet 10 mg to give one tablet daily for schizophrenia (07/16/25), Divalproex Sodium oral tablet delayed release 250 mg to give one tablet three times daily for depression (08/20/25), and Venlafaxine HCl oral tablet 75 mg to give 150 mg once daily for depression (08/21/25). On 09/08/25 at 11:42 A.M., an interview with Psychiatric Nurse Practitioner (Psych NP) #171 stated she did not get GDR requisitions for the facility because the primary care physician handled all of that. She also stated she did not review any pharmacy recommendations. Psych NP #171 further stated the notes template she used included a section on GDR contraindications that was included on all notes as part of the standard template. On 09/08/25 at 2:21 P.M., an interview with the Director of Nursing (DON) confirmed the provider responses to the pharmacy recommendations for Resident #4 indicated to see the psychiatric services notes for GDR documentation. The DON said Psych NP #171 reviewed medications and GDRs on all visits to the facility however, there was no documentation to support the review. 3. Review of the medical record for Resident #1 revealed an admission date 04/04/24 with diagnoses including depression, anxiety, type II diabetes, chronic obstructive pulmonary disease, respiratory failure, malnutrition and cerebral infraction a stroke. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had impaired cognition and was dependent on staff for activities of daily living. The resident had a Patient Health Questionnaire (PHQ) score of 15, a mood assessment indicating a high severity of symptoms. Please evaluate for worsening depression. The recommendation on 08/01/25. Review of the pharmacy recommendation dated 07/31/25 stated the resident was receiving antidepressant therapy with Cymbalta 60 milligram and had a recent PHQ score that was elevated indicating a significant risk of depression symptom. The form did not indicate if the provider agreed disagreed or other. There was a note stating that was deferred to psychiatric service and was signed on 08/01/25. There was no documentation that the recommendation was addressed. Interview with the Director of Nursing (DON) on 09/04/25 at 3:32 P.M. stated the physician did not want to be responsible for the pharmacy recommendation and referred it to psychiatric services. On 09/08/25 at 11:42 A.M., an interview with Psychiatric Nurse Practitioner (Psych NP) #171 stated she did not get GDR requisitions for the facility because the primary care physician handled all of that. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She also stated she did not review any pharmacy recommendations. Psych NP #171 further stated the notes template she used included a section on GDR contraindications that was included on all notes as part of the standard template. Review of the facility policy titled Medication Regimen Reviews revised May 2019 revealed The pharmacists ' recommendations will be addressed timely by the physician. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record.		

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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** Based on observation, record review and interview the facility failed to ensure medications were properly stored for residents identified as being able to self-administer medications. This affected one resident (Resident #16) of one residents reviewed for secured medication. The census was 42. Findings include: 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. A BIMS score of 13 to 15 points would suggest cognitive intactness. 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. Record review of a hard chart for Resident #16 provided by the facility revealed a form titled Self-Administration Skills Assessment, dated 04/16/2025. This assessment indicated Resident #16 demonstrated correct technique for administering all medications, knew the name, strength, and frequency of all medications, was able to recognize the color and shape of medications, could state the side effects of her medications, could correctly secure (open and close medication containers) medications, and had demonstrated the ability to self-administer medications safely. The assessment indicated the resident did not have any topicals, creams, transdermal patches, ear drops, suppositories, inhalers, or injections. An observation on 09/05/25 at 10:45 A.M. of Resident #16 's lunch time medication administration revealed Licensed Practical Nurse (LPN) #138 prepared pills and placed them in a small medication cup. LPN #138 went into Resident #16 room and asked if she wanted her pills. Resident #16 stated to place the medications in the nightstand, and she would take them with her lunch. LPN #138 opened the nightstand drawer, placed the white cup of pills in the drawer, closed the drawer and walked out of the room. On 09/08/25 at 11:40 A.M., an interview with Resident #16 revealed she took her medications that were left in a white medication cup after each meal. She reported she could not identify what the pills were. Resident #16 also reported the cabinet drawer was never locked or she would not be able to access her medications. On 09/08/25 at 11:48 A.M., an observation of Resident #16's room revealed an unlocked cabinet beside her recliner. The cabinet contained a white cup with seven pills; a bottle of eye drops and several pill bottles which held cough drops. This was confirmed by LPN #138. On 09/08/25 at 11:42 A.M., an interview with Nurse Manager #160 revealed Resident #16 ' s medications were placed in her top drawer by the medication nurse. The drawer had a lock on it; however, he confirmed the drawer was not locked throughout the day when the medications were in it allowing unauthorized access to the medications.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview the facility failed to accurately document influenza, pneumococcal, and Covid-19 vaccination consents for three residents (Residents #07, #12 and #15) of the five residents reviewed for vaccinations. The facility census was 42 Findings Include: 1. Review of medical record of Resident #07 revealed initial admission to facility on 04/22/25 with diagnoses including metabolic encephalopathy, pneumonia, chronic respiratory failure, high blood pressure, major depression and anxiety, spinal cord injury, and chronic lung disease. Review of Resident #07's influenza/pneumococcal vaccination consent signed on 04/23/25 revealed a question asking if Resident #07 had received the influenza/pneumococcal vaccine prior. There was a check marked by the word No after this question. No dates were entered for prior pneumococcal vaccinations. Resident #07 declined the pneumococcal vaccine. Further review of the consent revealed the Vaccine Information Sheet (VIS) was provided on 04/23/25 for the pneumococcal vaccine and 04/23/25 for the influenza vaccine. Review of a second influenza/pneumococcal vaccination consent signed on 09/02/25 revealed a question asking if Resident #07 had received the influenza/pneumococcal prior. There was a check marked by the word Yes. There was a date for the Pneumovac vaccine received on 04/09/25 and the Prevnar 20 vaccine received 05/21/25. Further review of the consent reveal the Vaccine Information Sheet (VIS) was provided on 05/29/25 for the pneumococcal vaccine and 1/31/25 for the influenza vaccine. 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 Resident #12 influenza/pneumococcal vaccination consent signed on 08/13/25 revealed no answer marked the question if the resident received the pneumococcal vaccine prior. The VIS was provided on 05/29/25 for the pneumococcal vaccine and 01/31/25 for the influenza vaccine. 3. Review of the medical record for Resident #15 revealed an admission date of 07/14/25. Diagnoses included but were not limited to osteoarthritis of knee, muscle weakness, repeated falls, chronic pain, anemia, depression, age-related physical debility; atherosclerotic heart disease of native coronary artery with angina pectoris, occlusion and stenosis of unspecified carotid artery, pure hypercholesterolemia, malaise and fatigue, osteoarthritis of hip. Review of Resident #15's influenza/pneumococcal vaccination consent signed on 07/09/25 revealed the VIS was provided on 05/29/25 for the pneumococcal vaccine and 1/31/25 for the influenza vaccine. Interview on 09/08/25 at 9:50 A.M. with Assistant Director of Nursing (ADON) #160 revealed verification that the above documentation for vaccination consents for Residents #07, #12, and #15. ADON #160 further verified discrepancies with duplicate copies on pneumococcal/influenza consents signed and dated by Resident #07 on 04/23/25 and 09/02/25.		