STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Skilled Nursing and Rehabilitation	3537 12th Street, NW Canton, OH 44708

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, interviews with staff and family, review of facility investigative information and review of the facility policies titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, and Abuse, Neglect, Exploitation and Misappropriation Prevention Program the facility failed to ensure all residents were free from incidents of resident-to-resident sexual abuse. This resulted in Immediate Jeopardy and the potential for actual physical and psychosocial harm beginning on 03/26/24 at approximately 3:00 P.M. when Resident #61 (a female resident), who was severely cognitively impaired was found naked in the facility spa room with Resident #4 (a male resident), who was dressed. On 03/26/24 at approximately 8:00 P.M. State tested Nursing Assistant (STNA) #505 again found Resident #61 in the spa room with Resident #4. Resident #4 was observed with his pants down holding on to Resident #61's hip from behind as the resident was bent over. Resident #4 was observed making a pumping motion with an erect penis indicative of sexual activity. There was no evidence Resident #61 had consented or was able to consent to the sexual interaction with Resident #4. The facility failed to implement effective and individualized interventions to prevent these incidents of sexual abuse from occurring, to protect Resident #61 and other residents from Resident #4 and to address the safety and/or supervisory needs of the residents. On 04/09/24 Resident #51 was observed being sexually abused by Resident #4, when Resident #4 was observed grabbing the resident's breast without her consent. This affected two residents (#61 and #51) of five residents reviewed for abuse. The facility census was 60. On 05/23/24 at 1:10 P.M., the Administrator and Regional Director of Operations (RDO) #510 were notified Immediate Jeopardy began on 03/26/24 at approximately 3:00 P.M. when the facility failed to prevent and identify an incident of potential sexual abuse involving Resident #61. No interventions were implemented by the facility following this incident. On 03/26/24 STNA #505 observed Resident #61 being sexually assaulted/abused by Resident #4. The facility failed to ensure adequate and effective interventions were in place to prevent this incident or to ensure additional incidents of sexual abuse did not occur. On 04/09/24 Resident #51 was identified to be sexually abused by Resident #4 in a common area in the facility. Resident #4's care plan had not been updated to include his sexual behaviors until 04/10/24 and an intervention to redirect (the resident) with an activity was not initiated until 04/16/24. The Immediate Jeopardy was removed on 05/23/24 when the facility implemented the following corrective actions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/26/24 at 8:00 P.M. Resident #4 and Resident #61 were immediately separated. Resident #4 and Resident #61 were placed on 1:1 supervision. On 04/09/24 at 2:48 P.M. Resident #4 and Resident #51 were immediately separated, and Resident #4 was placed back on 1:1 supervision with staff. On 05/23/24 from 8:00 A.M. to 8:30 A.M. Regional Quality Assurance Registered Nurse (RQARN) #800 reviewed the progress notes of Resident #4 since his admission to the facility to ensure there were no other documented occurrences of like behaviors. On 05/23/24 from 9:45 A.M. to 11:00 A.M. Facility Assistant Administrator (FAA) #801 completed interviews with 28 of 28 alert and oriented residents with Brief Interview of Mental Status (BIMS) scores of 12 and higher. All 28 residents denied any like concerns and denied abuse and mistreatment by staff and/or other residents. On 05/23/24 from 9:50 A.M. to 2:30 P.M. Unit Manager Licensed Practical Nurses (UMLPN) #802 and #803 performed skin sweeps on 33 of 33 residents with BIMS scores less than 12. No new or unidentified skin impairments, psychosocial distress or signs of abuse or mistreatment were noted for these 33 residents. On 05/23/24 from 11:00 A.M. to 11:30 A.M. Regional Director of Operations (RDO) #501 educated 18 of 18 administrative staff including the Administrator, FAA #801, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #403, UMLPN #802, UMLPN #803, Food Service Director (FSD) #400, Director of Rehabilitation (DOR) #804, Administrative Assistant (AA) #805, Medical Records Clerk (MRC) #806, Maintenance Director (MD) #807 , Activities Director (AD) #808, Social Services Designee (SSD) #809, Business Office Manager (BOM) #810, Admissions Director #811, Housekeeping Supervisor (HS) #812, Administrative Assistant #814 and Scheduler #815 on the facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, the Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and re-educated on 1:1 supervision requirements including but not limited to remaining with the resident at all times during the assignment. 18 of 18 staff confirmed understanding of the provided education. On 05/23/24 from 11:30 A.M. to 7:49 P.M. the Administrator, FAA #801, the DON, ADON #403, UMLPN #802 and #803, FSD #400, DOR #804, AA #805, MRC #806, MD #807, AD #808, SSD #809, BOM #810 Admissions Director #811, HS #812, AA #814 and Scheduler #815 re-educated 98 of 99 facility staff on the facility Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating policy, the Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy and re-educated on 1:1 supervision requirements including but not limited to remaining with the resident at all times during the assignment. 98 of 99 staff confirmed understanding of the provided education. One staff member could not be reached by call, text or at her home on this date. The facility implemented a plan for this employee to receive education on the facility Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating policy, the Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and re-education on 1:1 supervision requirement including but not limited to always remaining with the resident during the assignment prior to her next shift worked. During this time frame 98 of 99 staff were also interviewed and all reported they were not aware of any other instances of abuse, neglect, or mistreatment of any resident. The one staff member who could not be reached at this time would be interviewed to ensure she was not aware of any other instances of abuse, neglect, or mistreatment of any resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/24 at 1:14 P.M. RDO #510 visually confirmed Resident #4 to be on 1:1 supervision. Resident #4 would remain on 1:1 with staff indefinitely and would continue to be seen by psych services for behavior and medication management until such time the resident had a change of location to another facility or a change in physical capability/abilities. On 05/23/24 from 1:25 P.M. to 1:50 P.M. RDO #510 educated the Administrator, Assistant Administrator #801, the DON, the ADON, and UMLPNs #802 and #803 on federal regulation F609: Reporting of Alleged Violations and F610: Response to Alleged Violations. Additionally, education was provided regarding ensuring proper interventions were in place, including timely psychiatric services, as appropriate, with notable changes in behavior. All confirmed their understanding of the federal regulation requirements. On 05/23/24 at 1:59 P.M. the care plan of Resident #4 that was originally initiated on 02/01/2023 by LPN #816 was updated to include the 1:1 supervision. On 05/23/24 at 2:25 P.M. RDO #510 notified the Medical Director via phone of the Immediate Jeopardy and abatement plan. On 05/23/24 at 2:44 P.M. SSD #809 performed a psychosocial assessment on Resident #51 who showed no signs of psychosocial distress at this time. Resident #51 would continue to be followed by the facility's counseling services provider. On 05/23/24 from 2:50 P.M. to 3:50 P.M. RQARN #800 reviewed progress notes for the last 90 days for all current facility residents for any related sexually inappropriate behaviors and the review showed no variances. On 05/23/24 at 5:15 P.M. Stated tested Nursing Assistant (STNA) #817, who was assigned to Resident #4's 1:1 supervision on 05/21/24, was terminated from employment at the facility by the Administrator due to her stating she chose to walk away to complete another task instead of maintaining the 1:1 supervision with Resident #4. On 05/23/24 at 7:49 P.M. an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the facility Immediate Jeopardy and removal plan. Attendees included RDO #510, the Medical Director, FAA #801, the DON, the ADON, UMLPNs #802 and #803, DOR #804, MD #807, BOM #810, Admissions Director #811, MRC #806, FSD #400, AD #808, SSD #809, HS #812, AA #814, and Administrative Assistant #805. The removal plan was approved by the committee and ongoing compliance would be monitored as follows: The DON or designee would verify 1:1 was in place (for Resident #4) and the staff person assigned to the 1:1 had full understanding of the requirement for providing 1:1, including but not limited to remaining with the resident at all times, each shift seven days a week for a period of one week and each shift five times a week for a period of three weeks thereafter. All variances would be corrected upon discovery and additional education and follow-up will be provided as deemed necessary. The DON or designee would interview eight staff members five times weekly for a period of four weeks to ensure understanding of the 1:1 education provided and confirm their understanding that 1:1 entails always remaining with the resident during the assignment. All variances would be corrected upon discovery and additional education and follow-up will be provided as deemed necessary. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON or designee would review progress notes of current residents five times a week for a period of four weeks to ensure any notable changes in sexual behavior had an appropriate and timely intervention, including but not limited to psychiatric services, as appropriate, as well as to ensure care plans are updated appropriately to reflect changes as needed related to the noted behavior changes and interventions. All variances would be corrected upon discovery and additional education/follow-up would be provided as deemed necessary. The Administrator or designee would interview 10 residents weekly, for a period of four weeks regarding abuse and mistreatment to ensure residents remain free of abuse and/or mistreatment and feel comfortable reporting any concerns. Any variances would be corrected immediately upon discovery and additional follow-up and education would be provided as deemed necessary. The DON or designee would assess 10 non-interviewable residents weekly for a period of four weeks to ensure residents remain free of signs of unknown skin impairment and abuse and/or mistreatment. Any variances would be corrected immediately upon discovery and additional follow-up and education will be provided as deemed necessary. RDO #510 or designee would review all allegations of abuse three times a week, for a period of four weeks to ensure timely follow-up, completion of full investigation, documentation of allegation, reporting, and appropriate intervention implementation with review of resident progress notes, any self-reported incidents, and review of resident concern forms. All variances would be corrected immediately upon discovery and additional follow-up and education will be provided as deemed necessary. The Administrator would audit 100% of new hires five times a week for four weeks for education on the facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating Policy, the Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, as well as re-education on 1:1 supervision requirement including but not limited to remaining with the resident at all times during the assignment prior to her next shift worked. All variances would be corrected immediately upon discovery and additional follow-up and education will be provided as deemed necessary. RDO #510 would review all audits weekly for a period of four weeks to ensure completion and compliance. All variances would be corrected immediately upon discovery and additional follow-up and education would be provided as deemed necessary. Results would be reported to the facility QAPI committee and additional ongoing compliance would be maintained through the facility quality assurance program, review of progress notes in the clinical operations meeting, and random audits as directed by the facility. Additional follow-up/education would be provided as directed by the committee. Although the Immediate Jeopardy was removed, the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings Include: 1. Review of Resident #61's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including anemia, history of falling, hypertension, hearing loss, dysthymic disorder, protein-calorie malnutrition, dementia, Alzheimer's disease, depression, and anxiety. The resident was discharged to another facility on 04/05/24 at the request of her family. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #61 had severely impaired cognition. Review of the plan of care dated 03/05/24 revealed Resident #61 had alterations in mood and behaviors related to anxiety, depression and wandering. She had no documentation of sexually inappropriate behaviors or of behaviors that included disrobing. Review of the progress note dated 03/26/24 at 9:10 P.M and authored by the DON revealed Resident #61 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. The note indicated Resident #61 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note also indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #61's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. Record review revealed Resident #61 was discharged from the facility on 04/05/24 per family request. Review of the medical record for Resident #4 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, psychotic disturbances and mood disturbances, Parkinson's disease, mild protein calorie malnutrition, hypertension, osteoarthritis, generalized anxiety disorder, essential tremor, depression, altered mental status, hearing loss, and cognitive communication deficit. Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #4 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. Resident #4 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #4's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. Review of the progress note dated 03/28/24 at 5:09 P.M. revealed Resident #4 was no longer 1:1 with staff. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #4 had severely impaired cognition and physical behaviors directed towards others for at least one to three days in the seven-day review period. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the psychiatric note dated 04/09/24 revealed Resident #4 was being seen by the request of the facility for an initial psychiatric assessment related to the chief complaint of hypersexual behaviors related to dementia and generalized anxiety disorder. Staff reported he had grabbed a resident's breast today and was also found in the bathroom with his pants down with another resident. Throughout the assessment the resident had limited verbal engagement and would respond yeah to all questions. The note revealed staff placed him on 1:1 to protect other residents. Mental health nursing for ongoing symptom monitoring and management of anxiety and dementia was recommended. Review of the physician orders for March 2024 and April 2024 revealed Resident #4 had an order for Cimetidine 200 milligrams once daily for inappropriate sexual behavior dated 04/10/24. There were no orders for 1:1 supervision. Review of the plan of care, date revised 04/16/24, revealed Resident #4 had mood problems related to generalized anxiety disorder, inappropriate sexual behaviors (added 04/10/24), and depression. Interventions included administering medications as ordered, behavioral health consults as needed, monitor and record mood, report any change to the physician, and redirection offer activity and provide privacy (added 04/16/24). Review of a facility investigation dated 03/26/24 (no time noted) revealed Residents #4 and #61 were noted to be in the East Side Spa Room at the same time. Resident #4 had a Brief Interview for Mental Status (BIMS) score of one (severe cognitive impairment) out of 15 and Resident #61 was unable to complete the BIMS assessment (due to cognitive impairment). Both residents resided on the East side of the building and were known to use the spa room restroom regularly on their own. Resident #61 was noted to have her pants down attempting to use the commode and Resident #4 was zipping his pants up. The facility written investigation included there was no skin-to-skin contact witnessed and neither resident appeared to be in distress. Resident #4 was assisted from the spa room and Resident #61 assisted with toileting and assisted from the spa room. One-on-one supervision was initiated to prevent reoccurrence of wandering in at the same time. Review of a signed witness statement from the DON dated 03/26/24 at 8:49 P.M. revealed RN #411 had notified her that there was an incident with Resident #4 and #61. She stated both residents were in the spa room and staff observed Resident #4 standing behind Resident #61 as she was pulling her pants up. Both the residents were re-directed out of the spa room, and they were immediately separated. Resident #4 was placed on 1:1 to prevent unintended wandering. Review of a statement from the DON dated 03/26/24 at 9:15 P.M. revealed the DON and Administrator spoke to STNA #505 and she re-iterated the pants of Resident #61 were down by her thighs, and she was in the spa room and Resident #4 was also present. Both residents were using the spa room for toileting. However, there was no written statement from STNA #505 who witnessed the incident in the facility investigation provided to the surveyor for review. Observation on 05/21/24 at 9:38 A.M. revealed Resident #4 was in bed sleeping and he did not have a staff member providing 1:1 supervision at this time. On 05/21/24 at 11:00 A.M. an interview with Licensed Practical Nurse (LPN) #472 revealed on 03/26/24 she had still been at the facility working over. She stated she was getting ready to leave around 8:00 P.M. when the nurse on duty stated Resident #4 had Resident #61 in the spa room and they both had their pants own and Resident #4 had his penis out. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/21/24 at 12:35 P.M. an interview with Family Member #700 (family of Resident #61) revealed she and her brother had been visiting the facility on 03/26/24 around 3:00 P.M. for a care plan meeting for the resident. She stated when they got there, they could not find Resident #61 anywhere and after about 15 minutes of searching, staff found her mother in the spa room with Resident #4. She stated she had not gone into the spa room however the Director (later identified as Director of Marketing #710) had gone in. She stated Director of Marketing #710 told her that her mother was completely naked in the spa room with Resident #4. She stated her clothes were in the spa room and she was told Resident #4 was attempting to help her mother. She stated later that evening around 10:00 P.M. she received a call stating they had found her mother and Resident #4 in the spa room again except this time Resident #4 had his pants down, his penis out and he was touching her mother inappropriately. She stated the facility decided to place both residents with an aide 24 hours a day until they could get her mother moved to another facility. She stated Resident #4 would seek her mother out and stared at her every time they were there. She stated it was creepy. On 05/21/24 at 1:20 P.M. an interview with STNA #503 revealed Resident #4 usually had an aide with him to provide 1:1 supervision, but he did not have anyone with him today. Observation on 05/21/24 at 1:25 P.M. revealed Resident #4 was sitting in the dining room. He did not have staff sitting with him 1:1; however, staff were walking around the dining room and nurse's station. On 05/21/24 at 4:45 P.M. an interview with the Administrator revealed the facility had not completed a Self-Reported Incident (SRI) related to the incidents between Resident #61 and Resident #4 (on 03/26/24) because the facility did not believe it was abuse, but rather just Resident #4 and Resident #61 trying to use the bathroom at the same time. The Administrator verified he had not completed any type of facility self-reported incident for any incidents involving Resident #4. On 05/22/24 at 9:45 A.M. an interview was attempted with Resident #4; however, he was not able to answer questions appropriately. The resident just kept saying yes and smiling. On 05/22/24 at 12:10 P.M. an interview with the DON revealed they had placed both Resident #4 and #61 on 1:1 supervision after the second time they were found wandering in the spa room together (on 03/26/24) and then Resident #61 was moved to another facility with a locked unit on 04/05/24. On 05/22/24 at 2:50 P.M. an interview with STNA #501 revealed he had just come on duty at 7:00 P.M. on 03/26/24. He stated he did not witness Resident #4 touch Resident #61 in the spa room; however, about 15 to 20 minutes after the incident had happened, he had to redirect Resident #4 from trying to take Resident #61 back into the spa room again. He stated the nurse was on the phone with the DON at the time Resident #4 tried to take Resident #61 back into the spa room. He stated he had not seen Resident #4 act like this before and had never seen him have sexual behaviors prior to that day. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 03/26/24 around 3:00 P.M. when Resident #61's family was in the building, they were looking for the resident and Director of Marketing #710 (who was no longer employed) found her in the spa room. The Administrator said he was told by Director of Marketing #710 Resident #61was getting up off the toilet with her pants down and Resident #4 was just standing in there. He stated Resident #4 did not have his pants down and he was not touching her. The Administrator indicated there was not an investigation completed related to this incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/22/24 at 4:33 P.M. an interview Director of Marketing #710 revealed she had only worked at the facility for about four months. She stated on 03/26/24 Resident #61's family was at the facility for a care conference, and they were trying to find Resident #61 but were unable to. She stated they started looking for her. She stated she found Resident #61 in the spa room sitting on the toilet completely naked. She said Resident #4 had his hand on her arm attempting to get her to stand up. She stated she immediately asked Resident #4 to come out of the spa room with her, she went out, and told the nursing staff to go in the spa room and help Resident #61 get dressed. On 05/23/24 at 5:15 A.M. an interview with STNA #508 revealed Resident #4 was to have 1:1 supervision; however, they do not always have an extra aide working to sit with him. She stated staff would sit outside his room until it was time to do rounds or until someone needed help with something then they would leave his room to help and then they would go back to his room again. She stated this scenario happened three to four times a week. On 05/22/24 at 5:25 A.M. an interview with RN #411 revealed on 03/26/24 around 8:00 P.M. STNA #505 came to her, and stated Resident #4 was in the spa room with Resident #61 doing inappropriate things with her. She stated by the time she got into the spa room Resident #4 had his pants up and he was attempting to pull Resident #61's pants up. She stated Resident #4 seemed really embarrassed, he was fumbling around and quickly trying to pull Resident #61's pants up. She stated Resident #61 was clueless as to what was going on. On 05/22/24 at 5:51 P.M. an interview with STNA #505 revealed she had been working on 03/26/24. She stated around 8:00 P.M. she had gone into the spa room to get the Hoyer lift and when she walked in, she saw Resident #4 had Resident #61 bent over with both his hands on her hips making a pumping movement with his hips and both of the resident's pants were down. She stated she yelled at him that he could not be doing that to her, and she scared him, he jumped back, and let go of Resident #61. She stated Resident #4's penis was out and erect. She stated she ran out of the spa room to get Registered Nurse #411, who was at the nurse's station, about 15 feet away from the spa room. When they got back into the spa room Resident #4 had his pants pulled up and he was trying to help Resident #61 get her pants back up. She stated she wrote out a witness statement about what happened and made three copies of the statement. She stated she placed one copy under the doors of the office of Human Resources, provided a copy to the DON and also a copy to the Administrator. However, STNA #505 stated all of the copies of her written statements were now missing. She stated she purposefully made three copies because the last time she had filled out a report concerning an unrelated incident, that report also ended up being missing. She stated the administrative staff never asked her to complete another written witness statement. On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a telehealth visit for Resident #4 on 04/09/24 due to increase in inappropriate sexual behaviors. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/28/24 at 2:40 P.M. an interview with the DON verified Resident #4 was taken off 1:1 supervision on 03/28/24 and then placed back on 1:1 supervision following an incident with Resident #51 on 04/09/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Astoria Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3537 12th Street, NW Canton, OH 44708	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/29/24 at 8:50 A.M. an interview with the DON and Administrator revealed they denied having a written statement from STNA #505. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, revealed residents have the right to be free from abuse. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/22 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. 2. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including traumatic brain injury, traumatic hemorrhage of the right cerebrum, insomnia, transient cerebral ischemic attack, schizoaffective disorder, epilepsy, chronic kidney disease, aphasia, panic disorder, anxiety disorder, polyneuropathy, left hemiplegia, dysphagia, ileus, fibromyalgia, and placement of cardiac defibrillator. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #51 had moderately impaired cognition. Review of the plan of care initiated 07/14/22 with a revision date of 02/16/24 revealed Resident #51 had alterations in mood and behavior related to anxiety, depression, insomnia, panic disorder, and schizoaffective disorder. She would at times manipulate staff. She had hallucinations and delusions at times. There was no indication she had any sexual behavior. Review of the progress notes from 04/01/24 through 04/10/24 revealed no documentation of any type of sexual abuse occurring. There was no note related to the resident being sexually abused by Resident #4 on 04/09/24, when Resident #4 grabbed the breast of Resident #51. Review of an undated witness statement authored by the Administrator revealed while doing daily rounds on the East side of the building he came up the 400 hall and Resident #4 and #51 were both in the TV lounge watching TV and they were seated on opposite sides of the room. He entered the spa room to check it and heard Resident #51 yell. He immediately came out of the spa room and saw Resident #4 walking away from Resident #51. He asked Resident #51 what was wrong, and she stated Resident #4 had tried to kiss and touch her. The Administrator asked her if he actually kissed or touched her, and she stated no. The statement noted out of an abundance of caution Resident #4 was placed on 1:1 with a referral made to the psychiatric group to address his behaviors. On 05/21/24 at 3:40 P.M. an interview with Resident #51 revealed (on 04/09/24) Resident #4 had grabbed her breast and tried to kiss her. Resident #51 stated she told him to get away from her. She stated that was not the first time he had tried anything. She stated he was always coming up to her and she would just tell him to get away from her. She stated she thought he had a crush on her. She stated the staff were right there when it happened and saw him do it, so she did not have to report it to anyone. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/22/24 at 12:10 P.M. an interview with DON revealed they had placed Resident #4 on 1:1 supervision after the second time (on 03/26/24) he was found wandering in the spa room with Resident #61. She stated she was not aware of an incident with Resident #51, and stated she would have to look into why the psychiatric note said she was called into visit (Resident #4) due to hypersexual activity and it was reported he was touching another resident's breast and was caught with his pants down with another (resident). On 05/22/24 at 2:15 P.M. an interview with STNA #500 revealed she had witnessed the incident between Resident #4 and #51 (on 04/09/24). She stated Resident #51 was in her wheelchair sitting in the TV lounge when Resident #4 walked up to her and bent down towards Resident #51. She stated Resident #4 was hard of hearing so she though he was bending down to hear something Resident #51 was saying but then Resident #51 yelled out to stop and when she looked over Resident #4 had Resident #51's whole breast in his hand, he had picked her breast up and let [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the facility's investigation, interviews with staff and family, and review of facility policy, the facility failed implement their abuse policy to thoroughly investigate and report all allegations of resident-to-resident abuse. This affected two residents (#51, and #61) of five reviewed for abuse. The facility census was 60. Findings Include: 1. Review of Resident #61's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including anemia, history of falling, hypertension, hearing loss, dysthymic disorder, protein-calorie malnutrition, dementia, Alzheimer's disease, depression, and anxiety. The resident was discharged to another facility on 04/05/24 at the request of her family. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #61 had severely impaired cognition. Review of the plan of care dated 03/05/24 revealed Resident #61 had alterations in mood and behaviors related to anxiety, depression and wandering. She had no documentation of sexually inappropriate behaviors or of behaviors that included disrobing. Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #61 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. The note indicated Resident #61 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note also indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #61's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. Record review revealed Resident #61 was discharged from the facility on 04/05/24 per family request. Review of the medical record for Resident #4 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, psychotic disturbances and mood disturbances, Parkinson's disease, mild protein calorie malnutrition, hypertension, osteoarthritis, generalized anxiety disorder, essential tremor, depression, altered mental status, hearing loss, and cognitive communication deficit. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #4 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. Resident #4 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #4's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. Review of the progress note dated 03/28/24 at 5:09 P.M. revealed Resident #4 was no longer 1:1 with staff. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #4 had severely impaired cognition and physical behaviors directed towards others for at least one to three days in the seven-day review period. Review of the psychiatric note dated 04/09/24 revealed Resident #4 was being seen by the request of the facility for an initial psychiatric assessment related to the chief complaint of hypersexual behaviors related to dementia and generalized anxiety disorder. Staff reported he had grabbed a resident's breast today and was also found in the bathroom with his pants down with another resident. Throughout the assessment the resident had limited verbal engagement and would respond yeah to all questions. The note revealed staff placed him on 1:1 to protect other residents. Mental health nursing for ongoing symptom monitoring and management of anxiety and dementia was recommended. Review of the physician orders for March 2024 and April 2024 revealed Resident #4 had an order for Cimetidine 200 milligrams once daily for inappropriate sexual behavior dated 04/10/24. There were no orders for 1:1 supervision. Review of the plan of care, date revised 04/16/24, revealed Resident #4 had mood problems related to generalized anxiety disorder, inappropriate sexual behaviors (added 04/10/24), and depression. Interventions included administering medications as ordered, behavioral health consults as needed, monitor and record mood, report any change to the physician, and redirection offer activity and provide privacy (added 04/16/24). Review of a facility investigation dated 03/26/24 (no time noted) revealed Residents #4 and #61 were noted to be in the East Side Spa Room at the same time. Resident #4 had a Brief Interview for Mental Status (BIMS) score of one (severe cognitive impairment) out of 15 and Resident #61 was unable to complete the BIMS assessment (due to cognitive impairment). Both residents resided on the East side of the building and were known to use the spa room restroom regularly on their own. Resident #61 was noted to have her pants down attempting to use the commode and Resident #4 was zipping his pants up. The facility written investigation included there was no skin-to-skin contact witnessed and neither resident appeared to be in distress. Resident #4 was assisted from the spa room and Resident #61 assisted with toileting and assisted from the spa room. One-on-one supervision was initiated to prevent reoccurrence of wandering in at the same time. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a signed witness statement from the DON dated 03/26/24 at 8:49 P.M. revealed RN #411 had notified her that there was an incident with Resident #4 and #61. She stated both residents were in the spa room and staff observed Resident #4 standing behind Resident #61 as she was pulling her pants up. Both the residents were re-directed out of the spa room, and they were immediately separated. Resident #4 was placed on 1:1 to prevent unintended wandering. Review of a statement from the DON dated 03/26/24 at 9:15 P.M. revealed the DON and Administrator spoke to STNA #505 and she re-iterated the pants of Resident #61 were down by her thighs, and she was in the spa room and Resident #4 was also present. Both residents were using the spa room for toileting. However, there was no written statement from STNA #505 who witnessed the incident in the facility investigation provided to the surveyor for review. Observation on 05/21/24 at 9:38 A.M. revealed Resident #4 was in bed sleeping and he did not have a staff member providing 1:1 supervision at this time. On 05/21/24 at 11:00 A.M. an interview with Licensed Practical Nurse (LPN) #472 revealed on 03/26/24 she had still been at the facility working over. She stated she was getting ready to leave around 8:00 P.M. when the nurse on duty stated Resident #4 had Resident #61 in the spa room and they both had their pants own and Resident #4 had his penis out. On 05/21/24 at 12:35 P.M. an interview with Family Member #700 (family of Resident #61) revealed she and her brother had been visiting the facility on 03/26/24 around 3:00 P.M. for a care plan meeting for the resident. She stated when they got there, they could not find Resident #61 anywhere and after about 15 minutes of searching, staff found her mother in the spa room with Resident #4. She stated she had not gone into the spa room however the Director (later identified as Director of Marketing #710) had gone in. She stated Director of Marketing #710 told her that her mother was completely naked in the spa room with Resident #4. She stated her clothes were in the spa room and she was told Resident #4 was attempting to help her mother. She stated later that evening around 10:00 P.M. she received a call stating they had found her mother and Resident #4 in the spa room again except this time Resident #4 had his pants down, his penis out and he was touching her mother inappropriately. She stated the facility decided to place both residents with an aide 24 hours a day until they could get her mother moved to another facility. She stated Resident #4 would seek her mother out and stared at her every time they were there. She stated it was creepy. On 05/21/24 at 1:20 P.M. an interview with STNA #503 revealed Resident #4 usually had an aide with him to provide 1:1 supervision, but he did not have anyone with him today. Observation on 05/21/24 at 1:25 P.M. revealed Resident #4 was sitting in the dining room. He did not have staff sitting with him 1:1; however, staff were walking around the dining room and nurse's station. On 05/21/24 at 4:45 P.M. an interview with the Administrator revealed the facility had not completed a Self-Reported Incident (SRI) related to the incidents between Resident #61 and Resident #4 (on 03/26/24) because the facility did not believe it was abuse, but rather just Resident #4 and Resident #61 trying to use the bathroom at the same time. The Administrator verified he had not completed any type of facility self-reported incident for any incidents involving Resident #4. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 9:45 A.M. an interview was attempted with Resident #4; however, he was not able to answer questions appropriately. The resident just kept saying yes and smiling. On 05/22/24 at 12:10 P.M. an interview with the DON revealed they had placed both Resident #4 and #61 on 1:1 supervision after the second time they were found wandering in the spa room together (on 03/26/24) and then Resident #61 was moved to another facility with a locked unit on 04/05/24. On 05/22/24 at 2:50 P.M. an interview with STNA #501 revealed he had just come on duty at 7:00 P.M. on 03/26/24. He stated he did not witness Resident #4 touch Resident #61 in the spa room; however, about 15 to 20 minutes after the incident had happened, he had to redirect Resident #4 from trying to take Resident #61 back into the spa room again. He stated the nurse was on the phone with the DON at the time Resident #4 tried to take Resident #61 back into the spa room. He stated he had not seen Resident #4 act like this before and had never seen him have sexual behaviors prior to that day. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 03/26/24 around 3:00 P.M. when Resident #61's family was in the building, they were looking for the resident and Director of Marketing #710 (who was no longer employed) found her in the spa room. The Administrator said he was told by Director of Marketing #710 Resident #61 was getting up off the toilet with her pants down and Resident #4 was just standing in there. He stated Resident #4 did not have his pants down and he was not touching her. The Administrator indicated there was not an investigation completed related to this incident. On 05/22/24 at 4:33 P.M. an interview Director of Marketing #710 revealed she had only worked at the facility for about four months. She stated on 03/26/24 Resident #61's family was at the facility for a care conference, and they were trying to find Resident #61 but were unable to. She stated they started looking for her. She stated she found Resident #61 in the spa room sitting on the toilet completely naked. She said Resident #4 had his hand on her arm attempting to get her to stand up. She stated she immediately asked Resident #4 to come out of the spa room with her, she went out, and told the nursing staff to go in the spa room and help Resident #61 get dressed. On 05/23/24 at 5:15 A.M. an interview with STNA #508 revealed Resident #4 was to have 1:1 supervision; however, they do not always have an extra aide working to sit with him. She stated staff would sit outside his room until it was time to do rounds or until someone needed help with something then they would leave his room to help and then they would go back to his room again. She stated this scenario happened three to four times a week. On 05/22/24 at 5:25 A.M. an interview with RN #411 revealed on 03/26/24 around 8:00 P.M. STNA #505 came to her, and stated Resident #4 was in the spa room with Resident #61 doing inappropriate things with her. She stated by the time she got into the spa room Resident #4 had his pants up and he was attempting to pull Resident #61's pants up. She stated Resident #4 seemed really embarrassed, he was fumbling around and quickly trying to pull Resident #61's pants up. She stated Resident #61 was clueless as to what was going on. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 5:51 P.M. an interview with STNA #505 revealed she had been working on 03/26/24. She stated around 8:00 P.M. she had gone into the spa room to get the Hoyer lift and when she walked in, she saw Resident #4 had Resident #61 bent over with both his hands on her hips making a pumping movement with his hips and both of the resident's pants were down. She stated she yelled at him that he could not be doing that to her, and she scared him, he jumped back, and let go of Resident #61. She stated Resident #4's penis was out and erect. She stated she ran out of the spa room to get Registered Nurse #411, who was at the nurse's station, about 15 feet away from the spa room. When they got back into the spa room Resident #4 had his pants pulled up and he was trying to help Resident #61 get her pants back up. She stated she wrote out a witness statement about what happened and made three copies of the statement. She stated she placed one copy under the doors of the office of Human Resources, provided a copy to the DON and also a copy to the Administrator. However, STNA #505 stated all of the copies of her written statements were now missing. She stated she purposefully made three copies because the last time she had filled out a report concerning an unrelated incident, that report also ended up being missing. She stated the administrative staff never asked her to complete another written witness statement. On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a telehealth visit for Resident #4 on 04/09/24 due to increase in inappropriate sexual behaviors. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/28/24 at 2:40 P.M. an interview with the DON verified Resident #4 was taken off 1:1 supervision on 03/28/24 and then placed back on 1:1 supervision following an incident with Resident #51 on 04/09/24. On 05/29/24 at 8:50 A.M. an interview with the DON and Administrator revealed they denied having a written statement from STNA #505. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/2022 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. 2. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including traumatic brain injury, traumatic hemorrhage of the right cerebrum, insomnia, transient cerebral ischemic attack, schizoaffective disorder, epilepsy, chronic kidney disease, aphasia, panic disorder, anxiety disorder, polyneuropathy, left hemiplegia, dysphagia, ileus, fibromyalgia, and placement of cardiac defibrillator. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #51 had moderately impaired cognition. Review of the plan of care initiated 07/14/22 with a revision date of 02/16/24 revealed Resident #51 had alterations in mood and behavior related to anxiety, depression, insomnia, panic disorder, and schizoaffective disorder. She would at times manipulate staff. She had hallucinations and delusions at times. There was no indication she had any sexual behavior. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from 04/01/24 through 04/10/24 revealed no documentation of any type of sexual abuse occurring. There was no note related to the resident being sexually abused by Resident #4 on 04/09/24, when Resident #4 grabbed the breast of Resident #51. Review of an undated witness statement authored by the Administrator revealed while doing daily rounds on the East side of the building he came up the 400 hall and Resident #4 and #51 were both in the TV lounge watching TV and they were seated on opposite sides of the room. He entered the spa room to check it and heard Resident #51 yell. He immediately came out of the spa room and saw Resident #4 walking away from Resident #51. He asked Resident #51 what was wrong, and she stated Resident #4 had tried to kiss and touch her. The Administrator asked her if he actually kissed or touched her, and she stated no. The statement noted out of an abundance of caution Resident #4 was placed on 1:1 with a referral made to the psychiatric group to address his behaviors. The facility wsa unable to provide any further investigation into the incident. On 05/21/24 at 3:40 P.M. an interview with Resident #51 revealed (on 04/09/24) Resident #4 had grabbed her breast and tried to kiss her. Resident #51 stated she told him to get away from her. She stated that was not the first time he had tried anything. She stated he was always coming up to her and she would just tell him to get away from her. She stated she thought he had a crush on her. She stated the staff were right there when it happened and saw him do it, so she did not have to report it to anyone. On 05/22/24 at 12:10 P.M. an interview with DON revealed they had placed Resident #4 on 1:1 supervision after the second time (on 03/26/24) he was found wandering in the spa room with Resident #61. She stated she was not aware of an incident with Resident #51, and stated she would have to look into why the psychiatric note said she was called into visit (Resident #4) due to hypersexual activity and it was reported he was touching another resident's breast and was caught with his pants down with another (resident). On 05/22/24 at 2:15 P.M. an interview with STNA #500 revealed she had witnessed the incident between Resident #4 and #51 (on 04/09/24). She stated Resident #51 was in her wheelchair sitting in the TV lounge when Resident #4 walked up to her and bent down towards Resident #51. She stated Resident #4 was hard of hearing so she though he was bending down to hear something Resident #51 was saying but then Resident #51 yelled out to stop and when she looked over Resident #4 had Resident #51's whole breast in his hand, he had picked her breast up and let it drop back down. She stated she went over and immediately removed Resident #4 from the TV room. She stated the Administrator was out on the unit doing rounds, so she went to tell him what had happened. She stated Resident #4 was placed on 1:1 supervision after that incident. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 04/09/24 he was out on the units' doing rounds when he heard Resident #51 yell and when he came out of the spa room both Resident #4 and #51 were in the TV lounge. He stated he asked Resident #51 what had happened, she stated Resident #4 had tried to kiss her. He stated Resident #51 never stated to him Resident #4 had touched her breast. He stated the staff were sitting at the nurse's station so he didn't know how they could have seen him touch her breast. The Administrator indicated he did not believe there were any witnesses to the incident. The Administrator also denied conducting a thorough investigation of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Astoria Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3537 12th Street, NW Canton, OH 44708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a telehealth visit for Resident #4 on 04/09/24 due to an increase in inappropriate sexual behavior. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/29/24 at 8:50 A.M. an interview with the DON and Administrator revealed they made an error on the date of the incident between Resident #4 and Resident #51, and they believed it occurred on 04/02/24 and not 04/09/24. However, they did not provide any written documentation to support the incident had occurred on 04/02/24 instead of 04/09/24. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/22 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. This deficiency represents non-compliance identified during the investigation of Master Complaint Number OH00154325 and Complaint Number OH00153999.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on record review, interview, and review of the facility policy, the facility failed to ensure an allegation of sexual abuse was reported to the State Agency. This affected two resident (Resident #51, and #61) of five reviewed for abuse. The facility census was 60. Findings included: 1. Review of Resident #61's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including anemia, history of falling, hypertension, hearing loss, dysthymic disorder, protein-calorie malnutrition, dementia, Alzheimer's disease, depression, and anxiety. The resident was discharged to another facility on 04/05/24 at the request of her family. Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #61 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. The note indicated Resident #61 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note also indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #61's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. Record review revealed Resident #61 was discharged from the facility on 04/05/24 per family request. Review of the medical record for Resident #4 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, psychotic disturbances and mood disturbances, Parkinson's disease, mild protein calorie malnutrition, hypertension, osteoarthritis, generalized anxiety disorder, essential tremor, depression, altered mental status, hearing loss, and cognitive communication deficit. Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #4 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. Resident #4 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #4's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024

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Astoria Skilled Nursing and Rehabilitation	3537 12th Street, NW Canton, OH 44708

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the psychiatric note dated 04/09/24 revealed Resident #4 was being seen by the request of the facility for an initial psychiatric assessment related to the chief complaint of hypersexual behaviors related to dementia and generalized anxiety disorder. Staff reported he had grabbed a resident's breast today and was also found in the bathroom with his pants down with another resident. Throughout the assessment the resident had limited verbal engagement and would respond yeah to all questions. The note revealed staff placed him on 1:1 to protect other residents. Mental health nursing for ongoing symptom monitoring and management of anxiety and dementia was recommended. Review of the physician orders for March 2024 and April 2024 revealed Resident #4 had an order for Cimetidine 200 milligrams once daily for inappropriate sexual behavior dated 04/10/24. There were no orders for 1:1 supervision. Review of the plan of care, date revised 04/16/24, revealed Resident #4 had mood problems related to generalized anxiety disorder, inappropriate sexual behaviors (added 04/10/24), and depression. Interventions included administering medications as ordered, behavioral health consults as needed, monitor and record mood, report any change to the physician, and redirection offer activity and provide privacy (added 04/16/24). Review of a facility investigation dated 03/26/24 (no time noted) revealed Residents #4 and #61 were noted to be in the East Side Spa Room at the same time. Resident #4 had a Brief Interview for Mental Status (BIMS) score of one (severe cognitive impairment) out of 15 and Resident #61 was unable to complete the BIMS assessment (due to cognitive impairment). Both residents resided on the East side of the building and were known to use the spa room restroom regularly on their own. Resident #61 was noted to have her pants down attempting to use the commode and Resident #4 was zipping his pants up. The facility written investigation included there was no skin-to-skin contact witnessed and neither resident appeared to be in distress. Resident #4 was assisted from the spa room and Resident #61 assisted with toileting and assisted from the spa room. One-on-one supervision was initiated to prevent reoccurrence of wandering in at the same time. Review of a signed witness statement from the DON dated 03/26/24 at 8:49 P.M. revealed RN #411 had notified her that there was an incident with Resident #4 and #61. She stated both residents were in the spa room and staff observed Resident #4 standing behind Resident #61 as she was pulling her pants up. Both the residents were re-directed out of the spa room, and they were immediately separated. Resident #4 was placed on 1:1 to prevent unintended wandering. Review of a statement from the DON dated 03/26/24 at 9:15 P.M. revealed the DON and Administrator spoke to STNA #505 and she re-iterated the pants of Resident #61 were down by her thighs, and she was in the spa room and Resident #4 was also present. Both residents were using the spa room for toileting. However, there was no written statement from STNA #505 who witnessed the incident in the facility investigation provided to the surveyor for review. Review of the facility history of Self-Reported Incidents revealed an allegation of sexual abuse between Resident #4 and Resident #6 was not reported to the State Agency. Observation on 05/21/24 at 9:38 A.M. revealed Resident #4 was in bed sleeping and he did not have a staff member providing 1:1 supervision at this time. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 11:00 A.M. an interview with Licensed Practical Nurse (LPN) #472 revealed on 03/26/24 she had still been at the facility working over. She stated she was getting ready to leave around 8:00 P.M. when the nurse on duty stated Resident #4 had Resident #61 in the spa room and they both had their pants own and Resident #4 had his penis out. On 05/21/24 at 12:35 P.M. an interview with Family Member #700 (family of Resident #61) revealed she and her brother had been visiting the facility on 03/26/24 around 3:00 P.M. for a care plan meeting for the resident. She stated when they got there, they could not find Resident #61 anywhere and after about 15 minutes of searching, staff found her mother in the spa room with Resident #4. She stated she had not gone into the spa room however the Director (later identified as Director of Marketing #710) had gone in. She stated Director of Marketing #710 told her that her mother was completely naked in the spa room with Resident #4. She stated her clothes were in the spa room and she was told Resident #4 was attempting to help her mother. She stated later that evening around 10:00 P.M. she received a call stating they had found her mother and Resident #4 in the spa room again except this time Resident #4 had his pants down, his penis out and he was touching her mother inappropriately. She stated the facility decided to place both residents with an aide 24 hours a day until they could get her mother moved to another facility. She stated Resident #4 would seek her mother out and stared at her every time they were there. She stated it was creepy. On 05/21/24 at 4:45 P.M. an interview with the Administrator revealed the facility had not completed a Self-Reported Incident (SRI) related to the incidents between Resident #61 and Resident #4 (on 03/26/24) because the facility did not believe it was abuse, but rather just Resident #4 and Resident #61 trying to use the bathroom at the same time. The Administrator verified he had not completed any type of facility SRI for any incidents involving Resident #4. On 05/22/24 at 2:50 P.M. an interview with STNA #501 revealed he had just come on duty at 7:00 P.M. on 03/26/24. He stated he did not witness Resident #4 touch Resident #61 in the spa room; however, about 15 to 20 minutes after the incident had happened, he had to redirect Resident #4 from trying to take Resident #61 back into the spa room again. He stated the nurse was on the phone with the DON at the time Resident #4 tried to take Resident #61 back into the spa room. He stated he had not seen Resident #4 act like this before and had never seen him have sexual behaviors prior to that day. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 03/26/24 around 3:00 P.M. when Resident #61's family was in the building, they were looking for the resident and Director of Marketing #710 (who was no longer employed) found her in the spa room. The Administrator said he was told by Director of Marketing #710 Resident #61 was getting up off the toilet with her pants down and Resident #4 was just standing in there. He stated Resident #4 did not have his pants down and he was not touching her. The Administrator indicated there was not an investigation completed related to this incident. On 05/22/24 at 4:33 P.M. an interview Director of Marketing #710 revealed she had only worked at the facility for about four months. She stated on 03/26/24 Resident #61's family was at the facility for a care conference, and they were trying to find Resident #61 but were unable to. She stated they started looking for her. She stated she found Resident #61 in the spa room sitting on the toilet completely naked. She said Resident #4 had his hand on her arm attempting to get her to stand up. She stated she immediately asked Resident #4 to come out of the spa room with her, she went out, and told the nursing staff to go in the spa room and help Resident #61 get dressed. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 5:15 A.M. an interview with STNA #508 revealed Resident #4 was to have 1:1 supervision; however, they do not always have an extra aide working to sit with him. She stated staff would sit outside his room until it was time to do rounds or until someone needed help with something then they would leave his room to help and then they would go back to his room again. She stated this scenario happened three to four times a week. On 05/22/24 at 5:25 A.M. an interview with RN #411 revealed on 03/26/24 around 8:00 P.M. STNA #505 came to her, and stated Resident #4 was in the spa room with Resident #61 doing inappropriate things with her. She stated by the time she got into the spa room Resident #4 had his pants up and he was attempting to pull Resident #61's pants up. She stated Resident #4 seemed really embarrassed, he was fumbling around and quickly trying to pull Resident #61's pants up. She stated Resident #61 was clueless as to what was going on. On 05/22/24 at 5:51 P.M. an interview with STNA #505 revealed she had been working on 03/26/24. She stated around 8:00 P.M. she had gone into the spa room to get the Hoyer lift and when she walked in, she saw Resident #4 had Resident #61 bent over with both his hands on her hips making a pumping movement with his hips and both of the resident's pants were down. She stated she yelled at him that he could not be doing that to her, and she scared him, he jumped back, and let go of Resident #61. She stated Resident #4's penis was out and erect. She stated she ran out of the spa room to get Registered Nurse #411, who was at the nurse's station, about 15 feet away from the spa room. When they got back into the spa room Resident #4 had his pants pulled up and he was trying to help Resident #61 get her pants back up. She stated she wrote out a witness statement about what happened and made three copies of the statement. She stated she placed one copy under the doors of the office of Human Resources, provided a copy to the DON and also a copy to the Administrator. However, STNA #505 stated all of the copies of her written statements were now missing. She stated she purposefully made three copies because the last time she had filled out a report concerning an unrelated incident, that report also ended up being missing. She stated the administrative staff never asked her to complete another written witness statement. On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a Telehealth visit for Resident #4 on 04/09/24 due to increase in inappropriate sexual behaviors. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/28/24 at 2:40 P.M. an interview with the DON verified Resident #4 was taken off 1:1 supervision on 03/28/24 and then placed back on 1:1 supervision following an incident with Resident #51 on 04/09/24. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, revealed residents have the right to be free from abuse. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/22 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. 2. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including traumatic brain injury, traumatic hemorrhage of the right cerebrum, insomnia, transient cerebral ischemic attack, schizoaffective disorder, epilepsy, chronic kidney disease, aphasia, panic disorder, anxiety disorder, polyneuropathy, left hemiplegia, dysphagia, ileus, fibromyalgia, and placement of cardiac defibrillator. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #51 had moderately impaired cognition. Review of the plan of care initiated 07/14/22 with a revision date of 02/16/24 revealed Resident #51 had alterations in mood and behavior related to anxiety, depression, insomnia, panic disorder, and schizoaffective disorder. She would at times manipulate staff. She had hallucinations and delusions at times. There was no indication she had any sexual behavior. Review of the progress notes from 04/01/24 through 04/10/24 revealed no documentation of any type of sexual abuse occurring. There was no note related to the resident being sexually abused by Resident #4 on 04/09/24, when Resident #4 grabbed the breast of Resident #51. Review of an undated witness statement authored by the Administrator revealed while doing daily rounds on the East side of the building he came up the 400 hall and Resident #4 and #51 were both in the TV lounge watching TV and they were seated on opposite sides of the room. He entered the spa room to check it and heard Resident #51 yell. He immediately came out of the spa room and saw Resident #4 walking away from Resident #51. He asked Resident #51 what was wrong, and she stated Resident #4 had tried to kiss and touch her. The Administrator asked her if he actually kissed or touched her, and she stated no. The statement noted out of an abundance of caution Resident #4 was placed on 1:1 with a referral made to the psychiatric group to address his behaviors. On 05/21/24 at 3:40 P.M. an interview with Resident #51 revealed (on 04/09/24) Resident #4 had grabbed her breast and tried to kiss her. Resident #51 stated she told him to get away from her. She stated that was not the first time he had tried anything. She stated he was always coming up to her and she would just tell him to get away from her. She stated she thought he had a crush on her. She stated the staff were right there when it happened and saw him do it, so she did not have to report it to anyone. On 05/22/24 at 12:10 P.M. an interview with DON revealed they had placed Resident #4 on 1:1 supervision after the second time (on 03/26/24) he was found wandering in the spa room with Resident #61. She stated she was not aware of an incident with Resident #51, and stated she would have to look into why the psychiatric note said she was called into visit (Resident #4) due to hypersexual activity and it was reported he was touching another resident's breast and was caught with his pants down with another (resident). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 2:15 P.M. an interview with STNA #500 revealed she had witnessed the incident between Resident #4 and #51 (on 04/09/24). She stated Resident #51 was in her wheelchair sitting in the TV lounge when Resident #4 walked up to her and bent down towards Resident #51. She stated Resident #4 was hard of hearing so she though he was bending down to hear something Resident #51 was saying but then Resident #51 yelled out to stop and when she looked over Resident #4 had Resident #51's whole breast in his hand, he had picked her breast up and let it drop back down. She stated she went over and immediately removed Resident #4 from the TV room. She stated the Administrator was out on the unit doing rounds, so she went to tell him what had happened. She stated Resident #4 was placed on 1:1 supervision after that incident. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 04/09/24 he was out on the units' doing rounds when he heard Resident #51 yell and when he came out of the spa room both Resident #4 and #51 were in the TV lounge. He stated he asked Resident #51 what had happened, she stated Resident #4 had tried to kiss her. He stated Resident #51 never stated to him Resident #4 had touched her breast. He stated the staff were sitting at the nurse's station so he didn't know how they could have seen him touch her breast. The Administrator indicated he did not believe there were any witnesses to the incident and confirmed not reporting the incident to the State agency. On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a Telehealth visit for Resident #4 on 04/09/24 due to an increase in inappropriate sexual behavior. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/29/24 at 8:50 A.M. an interview with the DON and Administrator revealed they made an error on the date of the incident between Resident #4 and Resident #51, and they believed it occurred on 04/02/24 and not 04/09/24. However, they did not provide any written documentation to support the incident had occurred on 04/02/24 instead of 04/09/24. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/2022 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, revealed residents have the right to be free from abuse. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. This deficiency represents non-compliance identified during the investigation Master Complaint Number OH00154325 and Complaint Number OH00153999.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024

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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 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35765

Based on review of the medical record, review of the facility's investigation, interviews with staff and family, and review of facility policy, the facility failed to thoroughly investigate all allegations of resident-to-resident sexual abuse. This affected two residents (#51, and #61) of five reviewed for abuse. The facility census was 60.

Findings Include:

1. Review of Resident #61's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including anemia, history of falling, hypertension, hearing loss, dysthymic disorder, protein-calorie malnutrition, dementia, Alzheimer's disease, depression, and anxiety. The resident was discharged to another facility on 04/05/24 at the request of her family.

Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #61 had severely impaired cognition.

Review of the plan of care dated 03/05/24 revealed Resident #61 had alterations in mood and behaviors related to anxiety, depression and wandering. She had no documentation of sexually inappropriate behaviors or of behaviors that included disrobing.

Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #61 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. The note indicated Resident #61 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note also indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified.

Review of Resident #61's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date.

Record review revealed Resident #61 was discharged from the facility on 04/05/24 per family request.

Review of the medical record for Resident #4 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, psychotic disturbances and mood disturbances, Parkinson's disease, mild protein calorie malnutrition, hypertension, osteoarthritis, generalized anxiety disorder, essential tremor, depression, altered mental status, hearing loss, and cognitive communication deficit.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Astoria Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3537 12th Street, NW Canton, OH 44708	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 03/26/24 at 9:10 P.M. and authored by the DON revealed Resident #4 was in the bathroom with another resident (#61), both residents were noted with their pants down. They were immediately separated and placed on one-on-one (1:1) supervision with staff. Resident #4 was assessed with no signs of physical interaction, no new or unknown skin issues and no psychosocial distress. The note indicated the responsible party was notified and was okay with and understands but prefers residents remain separated. Resident remains 1:1 with staff. The physician was notified. Review of Resident #4's medical record revealed there was no documentation related to an incident occurring between Resident #61 and Resident #4 earlier on this same date. Review of the progress note dated 03/28/24 at 5:09 P.M. revealed Resident #4 was no longer 1:1 with staff. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #4 had severely impaired cognition and physical behaviors directed towards others for at least one to three days in the seven-day review period. Review of the psychiatric note dated 04/09/24 revealed Resident #4 was being seen by the request of the facility for an initial psychiatric assessment related to the chief complaint of hypersexual behaviors related to dementia and generalized anxiety disorder. Staff reported he had grabbed a resident's breast today and was also found in the bathroom with his pants down with another resident. Throughout the assessment the resident had limited verbal engagement and would respond yeah to all questions. The note revealed staff placed him on 1:1 to protect other residents. Mental health nursing for ongoing symptom monitoring and management of anxiety and dementia was recommended. Review of the physician orders for March 2024 and April 2024 revealed Resident #4 had an order for Cimetidine 200 milligrams once daily for inappropriate sexual behavior dated 04/10/24. There were no orders for 1:1 supervision. Review of the plan of care, date revised 04/16/24, revealed Resident #4 had mood problems related to generalized anxiety disorder, inappropriate sexual behaviors (added 04/10/24), and depression. Interventions included administering medications as ordered, behavioral health consults as needed, monitor and record mood, report any change to the physician, and redirection offer activity and provide privacy (added 04/16/24). Review of a facility investigation dated 03/26/24 (no time noted) revealed Residents #4 and #61 were noted to be in the East Side Spa Room at the same time. Resident #4 had a Brief Interview for Mental Status (BIMS) score of one (severe cognitive impairment) out of 15 and Resident #61 was unable to complete the BIMS assessment (due to cognitive impairment). Both residents resided on the East side of the building and were known to use the spa room restroom regularly on their own. Resident #61 was noted to have her pants down attempting to use the commode and Resident #4 was zipping his pants up. The facility written investigation included there was no skin-to-skin contact witnessed and neither resident appeared to be in distress. Resident #4 was assisted from the spa room and Resident #61 assisted with toileting and assisted from the spa room. One-on-one supervision was initiated to prevent reoccurrence of wandering in at the same time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a signed witness statement from the DON dated 03/26/24 at 8:49 P.M. revealed RN #411 had notified her that there was an incident with Resident #4 and #61. She stated both residents were in the spa room and staff observed Resident #4 standing behind Resident #61 as she was pulling her pants up. Both the residents were re-directed out of the spa room, and they were immediately separated. Resident #4 was placed on 1:1 to prevent unintended wandering. Review of a statement from the DON dated 03/26/24 at 9:15 P.M. revealed the DON and Administrator spoke to STNA #505 and she re-iterated the pants of Resident #61 were down by her thighs, and she was in the spa room and Resident #4 was also present. Both residents were using the spa room for toileting. However, there was no written statement from STNA #505 who witnessed the incident in the facility investigation provided to the surveyor for review. Observation on 05/21/24 at 9:38 A.M. revealed Resident #4 was in bed sleeping and he did not have a staff member providing 1:1 supervision at this time. On 05/21/24 at 11:00 A.M. an interview with Licensed Practical Nurse (LPN) #472 revealed on 03/26/24 she had still been at the facility working over. She stated she was getting ready to leave around 8:00 P.M. when the nurse on duty stated Resident #4 had Resident #61 in the spa room and they both had their pants own and Resident #4 had his penis out. On 05/21/24 at 12:35 P.M. an interview with Family Member #700 (family of Resident #61) revealed she and her brother had been visiting the facility on 03/26/24 around 3:00 P.M. for a care plan meeting for the resident. She stated when they got there, they could not find Resident #61 anywhere and after about 15 minutes of searching, staff found her mother in the spa room with Resident #4. She stated she had not gone into the spa room however the Director (later identified as Director of Marketing #710) had gone in. She stated Director of Marketing #710 told her that her mother was completely naked in the spa room with Resident #4. She stated her clothes were in the spa room and she was told Resident #4 was attempting to help her mother. She stated later that evening around 10:00 P.M. she received a call stating they had found her mother and Resident #4 in the spa room again except this time Resident #4 had his pants down, his penis out and he was touching her mother inappropriately. She stated the facility decided to place both residents with an aide 24 hours a day until they could get her mother moved to another facility. She stated Resident #4 would seek her mother out and stared at her every time they were there. She stated it was creepy. On 05/21/24 at 1:20 P.M. an interview with STNA #503 revealed Resident #4 usually had an aide with him to provide 1:1 supervision, but he did not have anyone with him today. Observation on 05/21/24 at 1:25 P.M. revealed Resident #4 was sitting in the dining room. He did not have staff sitting with him 1:1; however, staff were walking around the dining room and nurse's station. On 05/21/24 at 4:45 P.M. an interview with the Administrator revealed the facility had not completed a Self-Reported Incident (SRI) related to the incidents between Resident #61 and Resident #4 (on 03/26/24) because the facility did not believe it was abuse, but rather just Resident #4 and Resident #61 trying to use the bathroom at the same time. The Administrator verified he had not completed any type of facility self-reported incident for any incidents involving Resident #4. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 9:45 A.M. an interview was attempted with Resident #4; however, he was not able to answer questions appropriately. The resident just kept saying yes and smiling. On 05/22/24 at 12:10 P.M. an interview with the DON revealed they had placed both Resident #4 and #61 on 1:1 supervision after the second time they were found wandering in the spa room together (on 03/26/24) and then Resident #61 was moved to another facility with a locked unit on 04/05/24. On 05/22/24 at 2:50 P.M. an interview with STNA #501 revealed he had just come on duty at 7:00 P.M. on 03/26/24. He stated he did not witness Resident #4 touch Resident #61 in the spa room; however, about 15 to 20 minutes after the incident had happened, he had to redirect Resident #4 from trying to take Resident #61 back into the spa room again. He stated the nurse was on the phone with the DON at the time Resident #4 tried to take Resident #61 back into the spa room. He stated he had not seen Resident #4 act like this before and had never seen him have sexual behaviors prior to that day. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 03/26/24 around 3:00 P.M. when Resident #61's family was in the building, they were looking for the resident and Director of Marketing #710 (who was no longer employed) found her in the spa room. The Administrator said he was told by Director of Marketing #710 Resident #61 was getting up off the toilet with her pants down and Resident #4 was just standing in there. He stated Resident #4 did not have his pants down and he was not touching her. The Administrator indicated there was not an investigation completed related to this incident. On 05/22/24 at 4:33 P.M. an interview Director of Marketing #710 revealed she had only worked at the facility for about four months. She stated on 03/26/24 Resident #61's family was at the facility for a care conference, and they were trying to find Resident #61 but were unable to. She stated they started looking for her. She stated she found Resident #61 in the spa room sitting on the toilet completely naked. She said Resident #4 had his hand on her arm attempting to get her to stand up. She stated she immediately asked Resident #4 to come out of the spa room with her, she went out, and told the nursing staff to go in the spa room and help Resident #61 get dressed. On 05/23/24 at 5:15 A.M. an interview with STNA #508 revealed Resident #4 was to have 1:1 supervision; however, they do not always have an extra aide working to sit with him. She stated staff would sit outside his room until it was time to do rounds or until someone needed help with something then they would leave his room to help and then they would go back to his room again. She stated this scenario happened three to four times a week. On 05/22/24 at 5:25 A.M. an interview with RN #411 revealed on 03/26/24 around 8:00 P.M. STNA #505 came to her, and stated Resident #4 was in the spa room with Resident #61 doing inappropriate things with her. She stated by the time she got into the spa room Resident #4 had his pants up and he was attempting to pull Resident #61's pants up. She stated Resident #4 seemed really embarrassed, he was fumbling around and quickly trying to pull Resident #61's pants up. She stated Resident #61 was clueless as to what was going on. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 5:51 P.M. an interview with STNA #505 revealed she had been working on 03/26/24. She stated around 8:00 P.M. she had gone into the spa room to get the Hoyer lift and when she walked in, she saw Resident #4 had Resident #61 bent over with both his hands on her hips making a pumping movement with his hips and both of the resident's pants were down. She stated she yelled at him that he could not be doing that to her, and she scared him, he jumped back, and let go of Resident #61. She stated Resident #4's penis was out and erect. She stated she ran out of the spa room to get Registered Nurse #411, who was at the nurse's station, about 15 feet away from the spa room. When they got back into the spa room Resident #4 had his pants pulled up and he was trying to help Resident #61 get her pants back up. She stated she wrote out a witness statement about what happened and made three copies of the statement. She stated she placed one copy under the doors of the office of Human Resources, provided a copy to the DON and also a copy to the Administrator. However, STNA #505 stated all of the copies of her written statements were now missing. She stated she purposefully made three copies because the last time she had filled out a report concerning an unrelated incident, that report also ended up being missing. She stated the administrative staff never asked her to complete another written witness statement. On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a Telehealth visit for Resident #4 on 04/09/24 due to increase in inappropriate sexual behaviors. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/28/24 at 2:40 P.M. an interview with the DON verified Resident #4 was taken off 1:1 supervision on 03/28/24 and then placed back on 1:1 supervision following an incident with Resident #51 on 04/09/24. On 05/29/24 at 8:50 A.M. an interview with the DON and Administrator revealed they denied having a written statement from STNA #505. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/2022 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. 2. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including traumatic brain injury, traumatic hemorrhage of the right cerebrum, insomnia, transient cerebral ischemic attack, schizoaffective disorder, epilepsy, chronic kidney disease, aphasia, panic disorder, anxiety disorder, polyneuropathy, left hemiplegia, dysphagia, ileus, fibromyalgia, and placement of cardiac defibrillator. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #51 had moderately impaired cognition. Review of the plan of care initiated 07/14/22 with a revision date of 02/16/24 revealed Resident #51 had alterations in mood and behavior related to anxiety, depression, insomnia, panic disorder, and schizoaffective disorder. She would at times manipulate staff. She had hallucinations and delusions at times. There was no indication she had any sexual behavior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from 04/01/24 through 04/10/24 revealed no documentation of any type of sexual abuse occurring. There was no note related to the resident being sexually abused by Resident #4 on 04/09/24, when Resident #4 grabbed the breast of Resident #51. Review of an undated witness statement authored by the Administrator revealed while doing daily rounds on the East side of the building he came up the 400 hall and Resident #4 and #51 were both in the TV lounge watching TV and they were seated on opposite sides of the room. He entered the spa room to check it and heard Resident #51 yell. He immediately came out of the spa room and saw Resident #4 walking away from Resident #51. He asked Resident #51 what was wrong, and she stated Resident #4 had tried to kiss and touch her. The Administrator asked her if he actually kissed or touched her, and she stated no. The statement noted out of an abundance of caution Resident #4 was placed on 1:1 with a referral made to the psychiatric group to address his behaviors. The facility was unable to provide any further investigation into the incident. On 05/21/24 at 3:40 P.M. an interview with Resident #51 revealed (on 04/09/24) Resident #4 had grabbed her breast and tried to kiss her. Resident #51 stated she told him to get away from her. She stated that was not the first time he had tried anything. She stated he was always coming up to her and she would just tell him to get away from her. She stated she thought he had a crush on her. She stated the staff were right there when it happened and saw him do it, so she did not have to report it to anyone. On 05/22/24 at 12:10 P.M. an interview with DON revealed they had placed Resident #4 on 1:1 supervision after the second time (on 03/26/24) he was found wandering in the spa room with Resident #61. She stated she was not aware of an incident with Resident #51, and stated she would have to look into why the psychiatric note said she was called into visit (Resident #4) due to hypersexual activity and it was reported he was touching another resident's breast and was caught with his pants down with another (resident). On 05/22/24 at 2:15 P.M. an interview with STNA #500 revealed she had witnessed the incident between Resident #4 and #51 (on 04/09/24). She stated Resident #51 was in her wheelchair sitting in the TV lounge when Resident #4 walked up to her and bent down towards Resident #51. She stated Resident #4 was hard of hearing so she though he was bending down to hear something Resident #51 was saying but then Resident #51 yelled out to stop and when she looked over Resident #4 had Resident #51's whole breast in his hand, he had picked her breast up and let it drop back down. She stated she went over and immediately removed Resident #4 from the TV room. She stated the Administrator was out on the unit doing rounds, so she went to tell him what had happened. She stated Resident #4 was placed on 1:1 supervision after that incident. On 05/22/24 at 3:54 P.M. an interview with the Administrator revealed on 04/09/24 he was out on the units' doing rounds when he heard Resident #51 yell and when he came out of the spa room both Resident #4 and #51 were in the TV lounge. He stated he asked Resident #51 what had happened, she stated Resident #4 had tried to kiss her. He stated Resident #51 never stated to him Resident #4 had touched her breast. He stated the staff were sitting at the nurse's station so he didn't know how they could have seen him touch her breast. The Administrator indicated he did not believe there were any witnesses to the incident. The Administrator also denied conducting a thorough investigation of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 12:19 P.M. an interview with Psychiatric Nurse Practitioner #600 revealed the psychiatric service she worked for was called by the facility to do a Telehealth visit for Resident #4 on 04/09/24 due to an increase in inappropriate sexual behavior. She stated she was told he grabbed the breast of a female resident and had previously been found with another resident, both having their pants down. On 05/29/24 at 8:50 A.M. an interview with the DON and Administrator revealed they made an error on the date of the incident between Resident #4 and Resident #51, and they believed it occurred on 04/02/24 and not 04/09/24. However, they did not provide any written documentation to support the incident had occurred on 04/02/24 instead of 04/09/24. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/2022 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property were reported to the local, state, and federal agencies and thoroughly investigated by facility management. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, revealed residents have the right to be free from abuse. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The policy did not include a definition of sexual abuse nor any information on what constituted consent to sexual activity. This deficiency represents non-compliance identified during the investigation of Master Complaint Number OH00154325 and Complaint Number OH00153999.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and staff interviews, the facility failed to ensure Resident #63 had an adequate supply of narcotic medications to ensure a safe discharge until her post-discharge physician appointment. This affected one resident (Resident #63) of three residents reviewed for safe discharge. Findings included: Review of the medical record revealed Resident #63 was admitted to the facility on [DATE] with diagnoses including attention deficit hyperactivity disorder, generalized anxiety disorder, arthritis, history of transient ischemic attack, major depressive disorder, intervertebral disc degeneration, fibromyalgia, hypertension, restless leg syndrome, malignant neoplasm of ovary, insomnia, and migraines. She was discharged to home on 04/04/24. Review of the Admission Minimum Data Set assessment dated [DATE] revealed Resident #63 had moderately impaired cognition. Review of the April 2024 Physician's orders revealed Resident #63 had narcotic order for Adderall 10 milligrams every morning for Attention-Deficit/Hyperactivity Disorder and Hydrocodone-acetaminophen 5/325 milligrams one tablet every six hours for pain as needed and one tablet every 24 hours as needed for pain. Review of the Social Service note dated 04/01/24 at 4:00 P.M. revealed Resident #63 did not have a primary care physician in the community. A clinic was discussed with the resident and she gave her approval to set up and post discharge appointment with the clinic. Resident #63 also stated who her pharmacy of choice was for her medication to be called in. Review of the Social Service Note dated 04/03/24 at 1:54 P.M. revealed Resident #63 was scheduled to be discharged on [DATE] at 2:00 P.M. Home health care (HHC) was discussed with the resident and she decided to all HHC services and no durable medical equipment was needed. Her primary care physician post discharge appointment was set up with a clinic on 04/08/24 at 11:00 A.M. Review of the progress note dated 04/04/24 at 3:28 P.M. revealed the discharge packet was reviewed with Resident #63 and her fiance. The resident had no concerns regarding the discharge instructions. She was aware of home health care and post discharge appointment with her primary care physician. Review of the discharge summary dated 04/04/24 signed by Resident #63 revealed her medications were reviewed by Registered Nurse #410 and the prescriptions were called into the pharmacy. There was no documentation it was discussed if she had medications at home to last until the post discharge clinician appointment on 04/08/24. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 11:00 A.M. an interview with Social Services #500 revealed at discharge she would print a list of the resident's medication out and attached it to the discharge instructions. She stated she does not go over the medications with the resident however the nurse would do that at discharge and the nurse would call the medications into the resident's pharmacy of choice. She stated the nurse goes over the medications and activities of daily living and does the skin assessment and she did the rest of the discharge form. She stated the facility does not send medication home with any of the skilled Medicare residents but they do call in a 10-day to two-week supply to the pharmacy of choice. She stated that was their policy. She stated residents are not offered to take any medication home with them. She stated they only send medication home with Medicaid residents. She stated the resident was not asked if they wanted to take them home per the facility policy. On 06/03/24 at 11:30 A.M. an interview with the Director of Nursing revealed all resident who were being discharged to home had their medication called into their pharmacy of choice. She stated no medication went home with the resident unless the physician orders the medication to be sent home with them. On 06/03/24 at 12:17 P.M. an interview with Registered Nurse #412 revealed she had called in the medication to Resident #63's pharmacy however the boyfriend of the resident was upset because the physician would not write a prescription for her narcotics. She stated she even called the physician to ask him if she could send the medication they had at the facility home with them and the physician stated absolutely not. On 06/03/24 at 1:15 P.M. an interview with Social Service Director #500 revealed she does not remember if anyone asked Resident #63 if she had narcotics at home to last until her appointment on 04/08/24. She stated that was usually a question that was asked however she could not remember. She stated Resident #63 had issues with being able to keep a PCP due to her boyfriend canceling or not taking her to appointments so they physician would not keep her as a patient which was why she did not have a PCP at the tie of discharge. Review of the facility policy titled, Discharge Medications, dated 12/2016 revealed a physician must be contacted for an order to discharge a resident with mediation before they will be dispensed. The charge nurse shall verify that the medications are labeled consistent with current physician orders including instructions for use. Controlled substances shall not be released upon discharge of the resident unless permitted by current state law governing the release of controlled substances and as authorized in writing by the resident's attending physician. The nurse will reconcile pre-discharge medications with the resident's post-discharge medications. The medication reconciliation will be documented. The nurse shall review medication instructions with the resident, family member or representative before the resident leaves the facility. This deficiency represents non-compliance investigated under Complaint Number OH00153699.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 35765 Based on closed medical record review, interviews with staff and family, review of a local Fire Department Patient Care Record, review of hospital records, review of facility investigation information, and review of facility policy and procedures, the facility failed to ensure all residents received adequate and timely care and treatment to meet their total care needs. This resulted in Immediate Jeopardy and subsequent actual harm/death beginning at [DATE] at approximately 4:30 A.M. when Resident #42, who was dependent on staff for transfers, incontinence care, management of insulin dependent diabetes and who was physically impaired due to Huntington's disease (an incurable neurological disorder that damages brain cells impacting movement, behavior and cognition) and a fall risk related to unstable medical condition, seizures, debility, weakness and tardive dyskinesia (a condition affecting the nervous system causing repetitive, involuntary movements) was found unresponsive in his room, absent of pulse, slumped over in his chair with blood on his face, clothing and on the floor. The resident had last been seen by staff (Licensed Practical Nurse (LPN) #433) on [DATE] at approximately 10:00 P.M. sitting in his wheelchair in his room. LPN #433 checked the resident's blood glucose level at that time which was 400 milligrams per deciliter (mg/dl) (elevated/hyperglycemic) and administered 40 units of scheduled Glargine insulin at that time. There was no evidence the nurse went back to reassess the resident's blood glucose level or monitor the resident after giving the routine insulin. Resident #42 remained in his wheelchair in his room throughout the night and was not checked again all night until State tested Nursing Assistant #501 went into the resident's room at 4:30 A. M. and found the resident unresponsive. The resident required cardiopulmonary resuscitation and when the local fire department arrived to take over the code/care, Resident #42's blood glucose was 509 mg/dl. The resident was transported to the emergency room where his blood sugar was noted to be 607 mg/dl. The resident was admitted to the intensive care unit and subsequently passed away on [DATE]. This affected one resident (#42) of six residents reviewed for change of condition. The facility census was 60. On [DATE] at 3:45 P.M. the Administrator, [NAME] President of Operations #81 and Regional Director of Operations #510 were notified Immediate Jeopardy occurred on [DATE] at 4:30 A.M. when Resident #42 was found unresponsive in his room. Prior to this time, the resident had not been checked or provided care by staff since [DATE] at 10:00 P.M. when LPN #433 checked the resident's blood sugar and administered routine insulin. Resident #42 was not checked or provided care by staff for approximately six and a half hours overnight until 4:30 A.M. despite having hyperglycemia (high blood sugar) of 400 identified by the facility nurse at 10:00 P.M., despite being at risk for falls and care planned to be in out in a common area when in his wheelchair and despite being care planned for every two-hour check/change for incontinence care. The resident was found unresponsive, required cardiopulmonary resuscitation (CPR) and was sent to the hospital where he subsequently passed away on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions. On [DATE] from 5:30 P.M. to 7:24 P.M. Regional Quality Assurance Registered Nurse (RQARN) #800 audited ,d+[DATE] residents with physician orders for blood sugar checks to ensure residents with physician orders for blood sugar checks had parameters that included when to notify the physician. Variances were corrected on discovery. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Astoria Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3537 12th Street, NW Canton, OH 44708	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] from 5:40 P.M. to 8:05 P.M. Assistant Director of Nursing (ADON) #403 audited ,d+[DATE] residents with physician orders for blood sugar checks for the last 24 hours to ensure the physician's order was followed, notifications were complete as needed, and appropriate follow up was completed as needed with appropriate interventions as necessary. No variances identified. On [DATE] from 4:00 P.M. to 4:30 P.M. Regional Director of Operations (RDO) #510 educated the Administrator, Facility Assistant Administrator (FAA) #801, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #403, Unit Manager Licensed Practical Nurse (UMLPN) #802, UMLPN #803, Food Service Director (FSD) #400, Director of Rehab (DOR) #804, Administrative Assistant (AA) #805, Medical Records Clerk (MRC) #806, Maintenance Director (MD) #807, Activities Director (AD) #808, Social Services Designee (SSD) #809, Business Office Manager (BOM) #810, Admissions Director #811, Administrative Assistant (AA) #814 and Scheduler #815 on following individualized care plans related to incontinence checks and resident monitoring. ,d+[DATE] staff educated confirm understanding. On [DATE] from 4:30 P.M. to 5:00 P.M. RQARN #800 educated the DON, ADON #403, UMLPN #802 and #803 on the facility policy Nursing Care of the Resident with Diabetes Mellitus including obtaining follow up blood sugar checks if indicated. ,d+[DATE] staff educated confirm understanding. On [DATE] at 5:26 P.M. the facility Medical Director was notified of the Immediate Jeopardy related to quality of care and treatment. On [DATE] from 5:30 P.M. to 8:24 P.M. Facility Administrator, FAA #801, the DON, ADON #403, UNLPN #802 and #803, FSD #400, DOR #804, AA #805, MRC #806, MD #807, AD #808, SSD #809, BOM #810, AD #811, Housekeeping Supervisor (HK) #817, AA #814 and Scheduler #815 educated all nursing staff on following individualized care plans related to incontinence checks and resident monitoring. ,d+[DATE] of staff educated confirm understanding. On [DATE] from 5:30 P.M. to 8:12 P.M. RQARN #800, the DON, ADON #403 and UMLPNs #802 and 803 educated all licensed nursing staff on the facility policy Nursing Care of the Resident with Diabetes Mellitus including obtaining follow up blood sugar checks as appropriate. ,d+[DATE] of staff educated confirm understanding. On [DATE] from 5:30 P.M. to 6:45 P.M. Clinical Resource Specialist LPN #816 audited all current resident care plans to ensure resident care plans for fall interventions reflect resident preferences and that refusals to follow care planned intervention to be in common areas when up in wheelchair are addressed in the care plan. Audit revealed ,d+[DATE] resident care plans reviewed had fall interventions for placement in common area when up in wheelchair. No variances identified. On [DATE] from 6:45 P.M. to 8:15 P.M. Clinical Resource Specialist LPN #816, audited all current resident care plans to ensure residents with an incontinence care plan to check every two hours include resident preferences and refusals to follow care planned checks. Audit revealed ,d+[DATE] care plans reviewed had like intervention to check every two hours. No variances identified. On [DATE] at 6:30 P.M. RDO #510 added facility education for Following individualized Care Plans related to incontinence checks and resident monitoring and the facility policy Nursing Care of the Resident with Diabetes Mellitus to facility General Orientation manual. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] 5:30 P.M. to 7:30 P.M. Clinical Operations Specialist RN #992 completed an audit of 90 days of progress notes for active residents with physician's orders for blood sugar checks to ensure any patterns of hyperglycemia or hypoglycemia were addressed appropriately with appropriate follow up and/or physician notification. No variances noted. On [DATE] at 8:25 P.M. Ad hoc Quality Assurance Performance Improvement (QAPI) meeting held to discuss the plan of action. Attendees included: RDO #510, the facility Administrator, the Medical Director, FAA #801, the DON, ADON #403, UMLPNs #802 and #803, DOR #804, MD #807, BOM #810, AD #811, MRC #806, FSD #400, AD #808, SSD #809, and AAs #805 and #814. The facility implemented a plan for the Regional Quality Assurance RN/Designee to review all residents with physician's orders for blood sugar checks five times a week, for a period of four weeks to ensure physician order was followed, notifications complete as needed, and follow up completed as needed with appropriate interventions as necessary. The facility implemented a plan for the DON/designee to interview eight staff members five times weekly for a period of four weeks to ensure understanding of following individualized care plans related to incontinence checks and resident monitoring. The facility implemented a plan for the DON/Designee to review progress notes of current residents with physician orders for blood sugar checks five times a week for a period of four weeks to ensure any patterns of hyperglycemia or hypoglycemia are addressed as appropriate with appropriate intervention and/or physician notification as appropriate. The facility implemented a plan for the DON or Designee to audit 100% of new hires five times a week for four weeks to ensure new hire staff receive education on facility policy for Following Care Plans related to incontinence checks and resident monitoring and the facility policy Nursing Care of the Resident with Diabetes Mellitus including obtaining follow up blood sugar checks as appropriate. The facility implemented a plan for the DON or designee to audit all residents with physician orders for blood sugar checks five times a week for four weeks to ensure all blood sugar check orders include parameters that include when to notify the physician. The facility implemented a plan for the DON or designee to audit all residents with fall care plans five times a week for four weeks to ensure interventions are in place as appropriate, reflect resident preference and refusals, and are being followed by interdisciplinary care team with communication on care card as appropriate. The facility implemented a plan for the DON or designee to audit all residents with incontinence care plans five times a week for four weeks to ensure check and changes follow standard of care, reflect resident preference and refusals, and are being followed by interdisciplinary care team with communication on care card as appropriate. The facility implemented a plan for RDO #510 to review all audits weekly for a period of four weeks to ensure completion and compliance. The QA Committee will monitor the results of all audits and monitoring and follow-up as needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance Findings included: Review of the closed medical record for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure, dysphagia, gastrostomy, peptic ulcer disease, Huntington's disease, diabetes, epilepsy, benign prostatic hyperplasia, dyskinesia, hypothyroidism, malignant neoplasm of the thyroid, hypertension, metabolic encephalopathy, severe protein calorie malnutrition, kidney failure, and cystitis with hematuria. Resident #42 was discharged to the hospital on [DATE] and subsequently passed away on [DATE]. Review of the plan of care dated [DATE] and revised on [DATE] revealed Resident #42 was at risk for falls and potential injury related to unstable medical conditions, debilitation, weakness, seizures, Vitamin D deficiency, tardive dyskinesia and he attempted to be independent beyond ability. Interventions included placing Resident #42 in the common area when the resident was up in his wheelchair. Review of the plan of care dated [DATE] and revised on [DATE] revealed Resident #42 was incontinent of bowel which made him at risk for urinary tract infections and skin breakdown. Interventions included changing resident every two hours and as needed. Review of the plan of care dated [DATE] and revised on [DATE] revealed Resident #42 was at risk for hypo/hyperglycemic episodes related diabetes, requiring insulin. Interventions included to be alert to medication which cause a change in blood sugars, diet as orders, insulin as orders, monitor blood sugars as ordered, monitor for signs and symptoms of hyperglycemia: flushed, dry skin, nausea and vomiting, abdominal pain, decreased blood pressure, acetone breath and increased respirations, and sliding scale as ordered. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had moderately impaired cognition. The assessment revealed the resident required moderate assistance for rolling in bed, sit to stand transfers and chair to bed transfers. Review of the physician medication orders revealed an order for Glargine insulin, dated [DATE] to administer 40 units twice daily. The medication was scheduled to be administered at 9:00 A.M. and 9:00 P.M. Review of the physician orders revealed an order for Lispro insulin, dated [DATE]. The order revealed the medication was to be administered per sliding scale before meals: if blood sugar 180 to 200 give two units, if 201 to 250 give three units, if 251 to 300 give four units, if 301 to 350 give five units, if 351 to 400 give six units, if 401 to 450 give seven units and if above 450 call the physician. The hours of administration were listed as rise, lunch and after. Review of a telephone order dated [DATE] revealed Resident #42 had an order to discontinue Trulicity (a medication used to treat type 2 diabetes) and check blood sugars with meals and at bedtime. The order did not include any changes to the resident's Lispro or Glargine insulin orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility Transfer and Lift Data Form dated [DATE] revealed Resident #42 required assistance with transfers. The form identified the resident required at least one staff assist to transfer. Review of the facility document Resident Temporary Leave of Absence for Resident #42 revealed the resident's wife signed the resident out of the facility on [DATE]. Review of the facility document Resident Temporary Leave of Absence for Resident #42 revealed the resident's wife brought the resident back on [DATE] at 4:00 P.M. Review of the [DATE] medication administration record (MAR) revealed on [DATE] staff documented a 1 (one) meaning the resident was away from home with medications and there was no blood glucose level recorded for the dinner meal even though the resident had returned to the facility at 4:00 P.M. on [DATE]. Review of the nursing progress notes revealed an entry on [DATE] at 4:09 P.M. Resident returned from LOA with wife. In addition, review of the MAR for the [DATE] 9:00 P.M. administration time revealed LPN #433 documented on the MAR that Resident #42 had a blood sugar of 400 mg/dl and was given 40 units of insulin Glargine. Record review revealed there was no follow up documentation regarding the blood sugar of 400 mg/dl in the resident's medical record after this entry. Review of facility documentation provided by RDO #510 and titled Insulin Glargine Subcutaneous Solution Pen-Injector 100 units per milliliter (u/ml) (Insulin Glargine) dated [DATE] revealed on [DATE] at 10:22 P.M. 40 units of Insulin Glargine was administered in Resident #42's right upper quadrant of the abdomen by LPN #433. The next narrative nursing progress note, dated [DATE] at 7:09 A.M. and authored by LPN #433 revealed at 4:35 A.M. the nursing assistant notified the nurse Resident #42 was unresponsive in his room. The nurse checked his code status and went into his room, as she was going to the room, she had the nursing assistant (STNA #506) go get the other nurses, crash cart and had the other nursing assistant, who was in the room with the resident when she entered, call 911. Upon entering, the nurse observed Resident #42 slumped over in his chair in front of his dresser and noted dark fluid coming from his nose, mouth and on the floor in front of him. The nurse called his name and gave him a sternal rub before checking for pulse. When the nurse did not feel a pulse and he did not respond, the nursing assistant (STNA #501) helped her get Resident #42 on the floor and on the back board before calling 911 while she started CPR. She switched back and forth with the other nurse (LPN #472) doing cardiopulmonary resuscitation (CPR) for 10 minutes until Emergency Medical Service (EMS) arrived at 4:42 A.M. and took over CPR. At 5:05 A.M. EMS stated they had obtained a pulse and left facility at 5:10 A.M. transporting Resident #42 to the hospital. The note indicated at approximately 10:00 P.M. on [DATE] this nurse gave Resident #42 his medications and he was alert, oriented and responsive. He took his medications and the nurse indicated she told the resident the nursing assistant would be in soon to lay him down. She notified STNA #542, the STNA on duty, that Resident #42 still needed to be laid down before she left shift at 11:00 P.M. STNA #501 had come to work early to help STNA #542 put the remaining residents in bed. STNA #542 failed to report to STNA #501 Resident #42 was still up in his chair. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the local Fire Department Patient Care Record, dated [DATE], revealed the fire department was dispatched to the facility for an unresponsive male. They arrived on scene at 4:46 A.M. and when the crew entered the room, the resident was laying supine on the floor of his room with the lights out. There was coffee ground emesis all over the floor and the staff were doing chest compressions. The resident was pulled out into the hallway by the fire department staff and compressions continued. They departed the facility at 5:12 A.M. The fire department record noted Resident #42 was last known/seen at 9:00 P.M. on [DATE] by facility staff. Per EMS, Resident #42's blood sugar was 509 mg/dl at 5:03 A.M. Review of the hospital emergency room report dated [DATE] revealed emergency medical services (EMS) were called to the facility for an unresponsive resident. They reported the nursing staff stated Resident #42 was last seen at 9:00 P.M. and then when they went to check on him in the morning, he was found unresponsive. EMS stated when they got to the facility CPR had already been initiated and Resident #42 was on the ground. Resident #42 had a return of spontaneous circulation and was transported to the emergency room . Resident #42 was unresponsive, his pupils were four millimeters and fixed, breath sounds were present, he had an indentation in his chest from the [NAME] (chest compression machine) and he was tachycardic (rapid heart rate). The resident's blood glucose was 607 mg/dl with normal being 70 to 100 mg/dl. The resident was admitted to the intensive care unit. Review of the staff assignment sheet dated [DATE] revealed STNA #542 and #505 were scheduled on the [NAME] unit from 3:00 P.M. to 11:00 P.M. and STNA #578 and #575 were scheduled on the East wing from 3:00 P.M. to 11:00 P.M. with STNA # 501 coming in at 9:00 P.M. to float both the [NAME] and East units. However, STNA #575 had reported off. Resident #42 resided on the [NAME] unit. The normal staff assignment was two aides on each unit with an aide floating between both sides. Review of the staff time punches from [DATE] revealed STNA #501 worked 9:15 P.M. to 8:15 A.M., STNA #575 had not worked (called off), STNA #542 worked 2:45 P.M. to 11:30 P.M., STNA #578 had not worked, and STNA #505 worked 4:25 P.M. to 7:00 A.M. Review of a facility investigation revealed the facility had witness statements that were typed and not handwritten by the following staff who signed the witness statements: The witness statement signed by STNA #506 dated [DATE] revealed on [DATE] at around 4:32 A.M., STNA #506 was walking down the 100 hallway, and he noticed Resident #42's door was open. He looked into the room and observed Resident #42 leaning over in the wheelchair. He went to get LPN #433 and STNA #501. LPN #433 instructed him to go get Registered Nurse (RN) #411. He went to get her then waited at the front of the building for the EMS. The witness statement signed by STNA #501 dated [DATE] revealed on [DATE] at 4:33 A.M., STNA #501 was notified by STNA #506 that Resident #42's door was open and the resident was unresponsive in the wheelchair. He went into the room and observed the resident sitting in his wheelchair by his dresser. He had dark brown emesis on his mouth and on the floor. STNA #501 instructed STNA #506 to go get LPN #433. LPN #433 checked the resident's code status and stated the resident was a full code. She arrived at the room and they placed the resident on the floor. LPN #433 instructed STNA #501 to call 911. EMS arrived and they placed the resident in the hallway and continued CPR. STNA #501 spoke to RN #413 on the telephone. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The witness statement dated [DATE] and signed by LPN #433 revealed on [DATE] at 4:35 A.M. LPN #433 was notified by STNA #506 that when he was walking by Resident #42's room he was unresponsive sitting in the wheelchair. She checked his code status in the computer and verified in his chart that he was a full code. She then went to his room and observed resident slumped over in his by his dresser with dark brown coffee ground emesis on his nose, mouth and front of shirt and on the ground. She performed sternal rub and the resident did not respond. She felt for pulse and no pulse was noted. STNA #501 assisted her in placing resident on the floor. She initiated CPR and instructed STNA #506 to go get RN #411 from the other unit. As she was performing CPR, she instructed STNA #501 to call 911. RN #411 took over CPR and the both rotated chest compressions and breaths with ambu bag until EMS arrived. EMS arrived at 4:46 A.M. and took over CPR. EMS performed CPR with chest compressions and then moved the resident to the hallway and hooked the resident up to the [NAME] Chest compression system. EMS placed an AED on the resident and resident did not have a heart rhythm, EMS shocked the resident. After the resident was shocked, he got a heart rhythm. EMS stopped compressions and were bagging (ventilation) the resident while placing him on the stretcher. EMS transported the resident to the hospital at 5:10 A.M. As the resident was leaving the facility, EMS stated he had a pulse and a heart rhythm. LPN #433 called the physician at 5:35 A.M. and left her a voice mail. She then called the resident's wife at 5:38 A.M. and notified her of the incident and that EMS transported resident to the hospital. Additional investigative information (dated [DATE]), contained on different papers also typed and signed by staff were provided as noted below: a. STNA #501 had clocked in around 9:15 P.M. on [DATE] and was assisting on the East unit then around 10:30 to 10:40 P.M., he went to [NAME] unit to help Hoyer (mechanical lift) and clean up two residents. Around 11:10 P.M., STNA #542 told STNA #501 she had stayed over to clean up a resident on 200 Hall. Around 1:30 A.M. STNA #501 was doing rounds and noted Resident #42's bedroom door to be closed as normal. Around 3:40 A.M., a resident in the 100 Hall had put his call light on and when STNA #501 was walking back down hall, he noted (Resident #42's) bedroom door was still closed. Around 4:30 A.M. STNA #501 was at the nurse's station when STNA #506, yelled for him to come to Resident #42's room because the resident was up in his chair. b. STNA #506 came into work on [DATE] at around 10:45 P.M. and STNA #542 told him she had stayed longer to help and that a resident on the 100 Hall still needed to be Hoyered into bed. At around 3:30 A.M., two residents had turned on their call lights on the 100 Hall so he responded to both. When he was coming back down the hall, he noted Resident #42's door was closed as usual then a little after 4:00 A.M STNA #501 remarked that Resident #42 must be sleeping good because he had not turned his call light on, which was not abnormal after returning from LOA visits. He stated when disturbed overnight in the past by STNAs the resident would become aggressive and combative and per resident demands, they were not to go into his room without permission and he would ring when he was wet. Both the STNAs prepared to do their final rounds and check and changes. At around 4:30 A.M. STNA #506 was going down the 100 Hall after caring for a resident when he noted Resident #42's bedroom door and bathroom door were both open, which was abnormal. From hallway, STNA #506 could see Resident #42 slouched over in his wheelchair and immediately yelled for other STNA #501, to come to room and then he ran to get his nurse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. STNA #542 stated Resident #42 had returned to his room shortly after 7:00 P.M. and she went into his room to toilet and change him and at that time she had offered to lay him down in bed. Resident #42 refused stating no, you have things to do, I'll stay up a while. She explained to him she had time to lay him down if he wanted and he stated no, I'll sit up a while; I'm fine. At around 10:30 P.M. she went to check on the resident again and he was clean and dry, sitting in wheelchair, watching television. She again offered to lay him down and he said, I'm alright. Get everyone else to bed I'll wait. She told him if he waited then midnights would have to put him to bed. He said that was fine as long as that one girl doesn't do it.'' At around that time STNA #501 came over to the [NAME] unit to help STNA #542 finish up for the night; they had to lay down two residents who required the Hoyer and provided care to these residents. At that time, STNA #542 went over the [NAME] side resident's needs, explaining that on the 300 Hall one resident was still up, on the 200 Hall two residents still needed changed, and on the 100 Hall, one resident's catheter needed emptied and one resident needed laid down. STNA #501 stated he would change the one resident on 200 hall while STNA #542 changed the other. Shortly after 11:00 P.M. STNA #542 went to the two STNAs at the nurse's station and updated them on one resident who returned from the hospital now needed a two assist, told them Resident #42 still needed laid down, and told them the resident she changed was having a bowel movement and would need cleaned up when she was finished. STNA #542 clocked out around 11:30 P.M. d. LPN #433 was assigned to Resident #42 the night of [DATE], at around 10:00 P.M. she gave him his nighttime medications and told STNA #542 Resident #42 had received his medication and she need to have STNA #501 assist her in laying him down prior to leaving. LPN #433 had finished her medication pass in that hall at approximately 10:20 P.M. before going to her next hall. She finished her med pass around 11:30 P.M. and came to the nurse's station where STNA #542 was speaking to the other two STNAs but had not informed them of Resident #42's refusal to lay down. Shortly after 4:30 A.M. LPN #433 was at the computer working through her morning medication pass when STNA #506 came and told her about Resident #42's condition. She was on his computer chart and saw he was a full code which she verified in the resident's paper chart and ran to the room. STNA #501 was already in resident's room. On [DATE] at 11:00 A.M. an interview with STNA #542 revealed she had worked 3:00 P.M. to 11:00 P.M. on [DATE]. She stated Resident #42 was out with his wife until around supper time. She stated she was the only aide working on the [NAME] unit. She stated the last time she checked on Resident #42 was between 9:00 P. M. and 10:00 P.M. She stated he was fine. She stated he was a really sweet guy, and he knew she was working by herself so he told her he would wait until she got time to put him to bed. She stated he normally went to bed between 7:00 P.M. and 9:00 P.M. She stated STNA #501 came over to the [NAME] unit at around 10:30 P.M. to help her put another resident to bed. She stated she told STNA #501 and #506 that Resident #42, Resident #7 and Resident #43 were still up and she had not changed Resident #16 or Resident #32 yet. She confirmed the other staff knew Resident #42 was still up in his wheelchair. Further interview on [DATE] at 11:00 A.M. with STNA #542 revealed she had not been working on the [NAME] unit, as the staff assignment dated [DATE] indicated, she had been working on the East unit and STNA #505 had worked on the [NAME] unit. She stated she was the only staff member on the East unit from 7:00 P.M. to 10:30 P.M. At 9:15 P.M. STNA #501 was to assist her, however he did not come over to the East unit until around 10:30 P.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Skilled Nursing and Rehabilitation	3537 12th Street, NW Canton, OH 44708

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:10 P.M. an interview with STNA #506 revealed he came in on [DATE] at 10:45 P.M., got report from STNA #542 who stated she only had Resident #48 left to do. So, he went to clock in and her and STNA #501 went to put Resident #48 in bed. He stated he did not know Resident #42 was still up until he went past his room at around 4:30 A.M. doing last rounds. He stated the resident's door had been closed all night until they did last rounds and it was open which was weird. He stated he does not take care of Resident #42 because the resident's wife does not allow him in his room. He stated he could honestly say he never checked on him all night. He stated he could not speak for anyone else. He stated STNA #575 had called off, and he saw STNA #501, STNA# 542 and STNA #578 were working that night when he came in. He stated he never saw STNA #505 but he never went over to her side. On [DATE] at 10:45 A.M. an interview with Family Member #622 revealed she had taken Resident #42 out overnight on [DATE] and brought him back to the facility at 4:00 P.M. on [DATE]. She stated the resident was fine the whole time he was out with her. She stated he usually liked to get ready for bed around 6:, d+[DATE]:00 P.M. because it was easier for him to use his urinal with a gown on so he does not have to call the aides to help him. She stated he gets his Keppra (medication) at 9:00 P.M. and it completely wipes him out so he needs to be in bed when he gets it. She stated she spoke to LPN #433 about what had happened. She stated LPN #433 told her she gave him the resident his Keppra and insulin around 10:00 P.M. that night then Resident #42 had asked her to be put to bed. She stated LPN #433 told her no one put him to bed or checked on him until 4:30 A.M. She stated the resident was to be checked on every two hours and they did not do it. She stated they left him up all night and nobody checked on him. She stated the Director of Nursing was saying the resident refused to go to bed and she charted he had refused. She stated how would she know she was not even there. She stated Resident #42 never refused to go to bed plus he told LPN #433 he had wanted to go to bed at 10:00 P.M. The family member then started crying and apologized for crying indicating this was all still so upsetting to her. She again stated the resident had been fine when he was at home. She stated she wished she would have gotten him out (discharged to home) of the facility sooner. She stated the plan was for the resident to be discharged home with her on [DATE]. She stated the resident (her husband) and STNA #506 did not get along, so she did not want STNA #506 taking care of him. On [DATE] at 3:00 P.M. an interview with Regional Quality Assurance RN # 800 confirmed NA meant not applicable on the [DATE] MARS on [DATE] at 9:00 P.M. for his Glargine insulin. On [DATE] at 8:45 P.M. an interview with LPN #433 revealed on the morning of [DATE] the aides working came and got her around 4:45 A.M. stating Resident #42 was slumped over in his wheelchair. She went to Resident #42's room and told STNA #506 to go get the other nurse working and the crash cart. She stated STNA #501 was standing beside Resident #42, she called out his name, did a sternal rub and checked his pulse. She stated she could not feel a pulse so her and STNA #501 place him on the floor and she started CPR until the EMS came. She stated RN # 411 assisted her with CPR. She stated the last time she saw Resid [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, record review and interview the facility failed to maintain sufficient levels of staff to meet the total care needs of all residents. This affected one resident (Resident #42) of three reviewed for staffing however it had the potential to affect all 60 residents residing in the facility. Findings included: Review of the closed medical record for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure, dysphagia, gastrostomy, peptic ulcer disease, Huntington's disease, diabetes, epilepsy, benign prostatic hyperplasia, dyskinesia, hypothyroidism, malignant neoplasm of the thyroid, hypertension, metabolic encephalopathy, severe protein calorie malnutrition, kidney failure, and cystitis with hematuria. Resident #42 was discharged to the hospital on [DATE] and subsequently passed away on [DATE]. Review of the plan of care dated [DATE] and revised on [DATE] revealed Resident #42 was at risk for falls and potential injury related to unstable medical conditions, debilitation, weakness, seizures, Vitamin D deficiency, tardive dyskinesia and he attempted to be independent beyond ability. Interventions included placing Resident #42 in the common area when the resident was up in his wheelchair. Review of the plan of care dated [DATE] and revised on [DATE] revealed Resident #42 was incontinent of bowel which made him at risk for urinary tract infections and skin breakdown. Interventions included changing resident every two hours and as needed. Review of the plan of care dated [DATE] and revised on [DATE] revealed Resident #42 was at risk for hypo/hyperglycemic episodes related diabetes, requiring insulin. Interventions included to be alert to medication which cause a change in blood sugars, diet as orders, insulin as orders, monitor blood sugars as ordered, monitor for signs and symptoms of hyperglycemia: flushed, dry skin, nausea and vomiting, abdominal pain, decreased blood pressure, acetone breath and increased respirations, and sliding scale as ordered. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had moderately impaired cognition. The assessment revealed the resident required moderate assistance for rolling in bed, sit to stand transfers and chair to bed transfers. Review of the facility Transfer and Lift Data Form dated [DATE] revealed Resident #42 required assistance with transfers. The form identified the resident required at least one staff assist to transfer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:35 A.M. an interview with State tested Nursing Assistant #523 stated staffing was terrible. She stated she had to work the whole East unit by herself yesterday ([DATE]). She stated there was supposed to be two aides on each unit and an aide floating between them but the other aide on her unit called off. She stated the Unit Manager was supposed to come out and help her but she never did. She stated finally the new scheduler came out to help her answer call lights. On [DATE] at 5:51 P.M. an interview with STNA # 505 revealed she worked by herself all the time from 7:00 P.M. to 3:00 A.M. Review of the progress note dated [DATE] at 7:09 A.M. and authored by LPN #433 revealed at 4:35 A.M. the nursing assistant notified the nurse Resident #42 was unresponsive in his room. The nurse checked his code status and went into his room, as she was going to the room, she had the nursing assistant (STNA #506) go get the other nurses, crash cart and had the other nursing assistant, who was in the room with the resident when she entered, call 911. Upon entering, the nurse observed Resident #42 slumped over in his chair in front of his dresser and noted dark fluid coming from his nose, mouth and on the floor in front of him. The nurse called his name and gave him a sternal rub before checking for pulse. When the nurse did not feel a pulse and he did not respond, the nursing assistant (STNA #501) helped her get Resident #42 on the floor and on the back board before calling 911 while she started CPR. She switched back and forth with the other nurse (LPN #472) doing cardiopulmonary resuscitation (CPR) for 10 minutes until Emergency Medical Service (EMS) arrived at 4:42 A.M. and took over CPR. At 5:05 A.M. EMS stated they had obtained a pulse and left facility at 5:10 A.M. transporting Resident #42 to the hospital. The note indicated at approximately 10:00 P.M. on [DATE] this nurse gave Resident #42 his medications and he was alert, oriented and responsive. He took his medications and the nurse indicated she told the resident the nursing assistant would be in soon to lay him down. She notified STNA #542, the STNA on duty, that Resident #42 still needed to be laid down before she left shift at 11:00 P.M. STNA #501 had come to work early to help STNA #542 put the remaining residents in bed. STNA #542 failed to report to STNA #501 Resident #42 was still up in his chair. Review of the staff assignment sheet dated [DATE] revealed STNA #542 and #505 were scheduled on the [NAME] unit from 3:00 P.M. to 11:00 P.M. and STNA #578 and #575 were scheduled on the East wing from 3:00 P.M. to 11:00 P.M. with STNA # 501 coming in at 9:00 P.M. to float both the [NAME] and East units. However, STNA #575 had reported off. Resident #42 resided on the [NAME] unit. The normal staff assignment was two aides on each unit with an aide floating between both sides. Review of the staff time punches from [DATE] revealed STNA #501 worked 9:15 P.M. to 8:15 A.M., STNA #575 had not worked (called off), STNA #542 worked 2:45 P.M. to 11:30 P.M., STNA #578 had not worked, and STNA #505 worked 4:25 P.M. to 7:00 A.M. On [DATE] at 11:00 A.M. an interview with STNA #542 revealed she had worked 3:00 P.M. to 11:00 P.M. on [DATE]. She stated Resident #42 was out with his wife until around supper time. She stated she was the only aide working on the [NAME] unit. She stated the last time she checked on Resident #42 was between 9:00 P.M. and 10:00 P.M. She stated he was fine. She stated he was a really sweet guy, and he knew she was working by herself so he told her he would wait until she got time to put him to bed. She stated he normally went to bed between 7:00 P.M. and 9:00 P.M. She stated STNA #501 came over to the [NAME] unit at around 10:30 P.M. to help her put another resident to bed. She stated she told STNA #501 and #506 that Resident #42, Resident #7 and Resident #43 were still up and she had not changed Resident #16 or Resident #32 yet. She confirmed the other staff knew Resident #42 was still up in his wheelchair. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further interview on [DATE] at 11:00 A.M. with STNA #542 revealed she had not been working on the [NAME] unit, as the staff assignment dated [DATE] indicated, she had been working on the East unit and STNA #505 had worked on the [NAME] unit. She stated she was the only staff member on the East unit from 7:00 P.M. to 10:30 P.M. At 9:15 P.M. STNA #501 was to assist her, however he did not come over to the East unit until around 10:30 P.M. On [DATE] at 3:30 P.M. an interview with LPN#419 revealed on [DATE] from 3:00 P.M. to 11:100 P.M. the staff present was her, Agency LPN #579 who was doing one on one with Resident #4 until 6;00 P.M. STNA # 505 and STNA #578 were on the East unit and STNA #542 was on the [NAME] Unit and STNA #575 had called off that night. This deficiency represents non-compliance identified during the investigation of Complaint Number OH00154262 and OH00153699.

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NAME OF PROVIDER OR SUPPLIER Astoria Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3537 12th Street, NW Canton, OH 44708	

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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. 39333 Based on observations, interview and record review, the facility failed to ensure the kitchen was clean and sanitary. This had the potential to affect 58 residents that received meals from the facility. Two residents (Resident #3 and #5) were identified as receiving nothing by mouth. The facility census was 60. Findings include: Observation of the kitchen on 05/21/24 at 2:15 P.M. with Dietary Manger (DM) #400 revealed underneath the sink the extra dish racks were stored on top of four old milk crates. When Dietary aide #402 pulled the dish racks and milk crates out many gnats flew out from under the sink. There were approximately five feet of missing tile along the baseboard for water damage, the drywall was crumbling, and water damaged with a large hole in the wall. The gnats were coming from the hole in the wall. An interview at this time with the Dietary Manger #400 confirmed there was a hole in a wall and there were many gnats. He was not sure how long the wall had been like that since he had just started a couple months ago. DM #400 verified finds at time of observation. Interview on 05/21/24 at 2:10 P.M. an interview with Dietary Aide #402 confirmed the wall had been like that for a while and sometimes water would leak into the private dining room on the other side of the wall. A revisit to the kitchen on 06/03/24 from 7:45 A.M. through 8:05 A.M. with Dietary Manager (DM) # 400 revealed the tile was replaced but the wall behind the tile had food splatter on it. The pipe that was directly above the tile had chunks of food on it and there were several gnats flying around the dish machine. The walk-in refrigerator revealed that three shelves in the walk-in refrigerator had mold on the shelves. The floor in the walk-in refrigerator had food residue, pieces of paper and a broken egg on the floor. In the dry storage area, a box of thickener was not wrapped, labeled or dated properly. The walk-in freezer had water sitting outside of it on the floor. DM # 400 stated that it started leaking last week and the walk-in freezer and refrigerator are a year old, and the company has been out to look at it. DM #400 verified finds at time of observation. Review of a facility list of resident diets revealed Resident #3 and Resident #5 did not receive food by mouth. Review of the facility policy dated 10/2008 titled, Sanitation revealed that all kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from pests, flies and other insects. Review of the facility policy titled, Pest Control, dated 05/2008 revealed the facility would maintain an effective pet control program and maintain an ongoing pest control program to ensure that the building was kept free of insects and rodents. This deficiency represents non-compliance identified during the investigation of Complaint Number OH00154262, OH00153699 and OH00152023.