STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366391	A. Building B. Wing	02/13/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, record review, interview, and manufacturer guidance review the facility failed to ensure distilled water was replaced as required to prevent infection associated with respiratory therapy tasks and equipment. This affected one out of one resident reviewed for the use of bilevel positive airway pressure (BiPAP) (A mechanical breathing device with a mask that is used to treat sleep apnea and other health conditions that affect breathing.). The facility census was 63. Findings include: Medical record review revealed Resident #40 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease with chronic respiratory failure, morbid obesity with alveolar hypoventilation, diabetes mellitus, obstructive sleep apnea, schizoeffective disorder, paranoid personality disorder, lymphedema, high cholesterol, anemia, chronic kidney disease, heart failure, high blood pressure, gastroesophageal reflux disease, and depression, Review of Resident #40's physician order dated 01/29/25 revealed an order to administer BIPAP 24/8 centimeters (cm) water pressure (machine delivers pressure with exhalation cm water pressure /inhalation cm water pressure) with a backup respiratory rate of 16 breaths per minute and three liters of oxygen every night shift for obstructive sleep apnea. A physician order dated 02/03/25 indicated to change the oxygen/aerosol tubing (when in use) every night shift every Monday. An interview with Resident #40 on 02/11/25 at 10:45 A.M. revealed he had complained to the Respiratory Therapist (RT) (RT #67) and direct care staff (unnamed) regarding the taste of the distilled water that was used when he was using his BiPAP equipment. Resident #40 stated the water tasted bad and was making him feel sick with nausea and affected his ability to breathe. Resident #40 stated RT #67 and the staff refused to replace the distilled water every day as he had requested. An observation of Resident #40's room on 02/11/25 at 11:00 A.M. revealed a plastic gallon jug of distilled water located beside the bed on the floor. The gallon jug of distilled water was dated as opened on 02/10/25. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RT #67 on 02/12/25 at 11:39 A.M. revealed she had set-up Resident #40's BiPAP machine and supplied the distilled water for Resident #40 to use with his BiPAP machine. RT #67 stated Resident #40 had complained about the taste of the distilled water and wanted the water changed every day. RT #67 felt it was wasteful and the distilled water jug was changed once a week on Mondays. RT #67 was unaware of the facility policy regarding the use of distilled water for respiratory equipment in the facility. RT #67 stated she felt the distilled water should be changed when the gallon jug was empty or once a week. RT #67 had informed the Administrator and Director of Nursing (DON) of Resident #40's request to have the distilled water changed every day and they informed her once a week was sufficient to replace the gallon of distilled water after it was opened. RT #67 stated she had to store the gallon jugs of the distilled water in her locked office to prevent the staff from changing the distilled water every day. An interview with the Administrator on 02/13/25 at 12:00 P.M. revealed RT #67 had informed him of Resident #40's wish to have his distilled water changed daily and he told RT #67 to change the distilled water according to Resident #40's wishes. An interview with the DON on 02/13/25 at 12:05 P.M. revealed she had a discussion with RT #67 regarding Resident #40's complaints that the distilled water was making him sick and he thought the facility was poisoning him. The DON stated the distilled water was supposed to be changed every 24 hours and she had instructed RT #67 to change Resident #40's distilled water every day. Review of the facility policy titled Departmental (Respiratory Therapy) - Prevention of Infection revised October 2021 indicated the purpose of the procedure was to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. General guidelines included: 1. Distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after twenty-four (24) hours if not using prefilled reservoirs/humidifier bottles. 2. Transport respiratory therapy equipment to designated soiled utility area for decontamination. A review of the manufacturer's guidance indicated to change the distilled water when the distilled water had an unusual or unpleasant taste. The distilled water could taste musty, or it could have a faint taste of the container it was stored in (such as a plastic or metallic taste). This suggested that the water had been contaminated by the container materials. This deficiency represents non-compliance investigated under Complaint Number OH00162097.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, record review, interview, and policy review the facility failed to ensure a medication error rate of less than five percent. Two errors were made within 25 opportunities for error resulting in a medication error rate of eight percent. This affected two (Residents #3 and #50) of three residents observed during medication administration. Facility census was 63. Findings include: 1. Medical record review revealed Resident #50 was readmitted on [DATE] with diagnoses including colitis with irritable bowel syndrome, methicillin susceptible staphylococcus aureus infection, fractured left ischium, quadriplegia, cervical disc myelopathy (Severe compression of the spinal cord.), gastroesophageal reflux disease, ovarian cysts, sacral pressure ulcer, sepsis, and rhabdomyolysis (Disorder of skeletal muscle breakdown [necrosis] caused by muscle injury or myocyte membrane damage that leads to the release of myocyte contents into the bloodstream.) Resident #50's physician orders dated 02/01/25 to 02/28/25 indicated to administer the following medications scheduled in the morning: - polyethylene glycol 17 grams dissolved in 240 milliliters of water orally - Gabapentin 600 milligrams (mg) orally - potassium chloride 20 milliequivalents (mEq) orally - Flonase 50 micrograms (mcg) one spray in each nostril An observation of Licensed Practical Nurse (LPN) #66 administer the above listed medication to Resident #50 on 02/11/25 at 7:00 A.M. revealed a failure to measure the polyethylene glycol medication accurately. LPN #66 obtained a bottle of polyethylene glycol powder and measured the polyethylene glycol powder in the cap from the bottle of polyethylene glycol powder. LPN #66 filled the cap with polyethylene glycol powder below the white line on the cap. LPN #66 then emptied the cap of powder in a cup. LPN #66 was asked to read the directions on the polyethylene glycol powder bottle which indicated to fill the cap to the white line on the cap to administer 17 grams of the polyethylene glycol. An interview with LPN #66 on 02/11/25 at 7:10 A.M. verified she had not measured the Ethylene Glycol medication accurately to administer 17 grams of the medication as ordered by the physician. 2. Medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including hypertensive heart disease with heart failure, high cholesterol, anxiety , hypothyroidism, depression, gout and diabetes mellitus. Resident #3's physician orders dated 02/01/25 to 02/28/25 indicated to administer the following medications in the morning: - Acetaminophen 500 mg orally (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Gabapentin 600 mg orally - Diphenhydramine 25 mg orally - Allopurinol 300 mg orally - Allopurinol 100 mg orally - Aripiprazole 10 mg orally - Aspirin 81 mg chewable orally - Buspirone Hydrochloride 10 mg orally - Duloxetine 60 mg orally - Levothyroxine 100 mcg orally - Magnesium Oxide 400 mg orally - Montelukast 10 mg orally - Pantoprazole Delayed Release 40 mg orally - Potassium chloride 20 mEq orally - Ropinirole 0.25 mg orally - Torsemide 20 mg administer four tablets orally - Lispro Insulin 100 units/ml administer 4 units subcutaneous - Azelastine Hydrochloride 137 mcg/spray one spray in each nostril An observation on 02/11/25 at 7:22 A.M. of Registered Nurse (RN) #65 administer the above listed medications to Resident #3 revealed she failed to administer the Azelastine Hydrochloride nasal spray at the time of the observation. On 02/11/25 at 10:42 A.M. RN #65 verified she had forgot to administer Resident #3 the Azelastine Hydrochloride nasal spray. Review of the facility policy titled Administering Medications revised April 2019 revealed medications would be administered in a safe and timely manner, and as prescribed. The policy interpretation and implementation included: - Only persons licensed or permitted by the state to prepare, administer and document the administration of medications could do so. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Director of Nursing Services supervised and directed all personnel who administered medications and/or had related functions. - Staffing schedules were to be arranged to ensure that medications were administered without unnecessary interruptions. - Medications were to be administered in accordance with prescriber orders, including any required time frame. - Medications errors were to be documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. - Medications were to be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). - The individual administering the medication would verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. This deficiency represents non-compliance investigated under Complaint Number OH00162097 and Complaint Number OH00161623.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, interview, policy review and Center for Disease Control guidance for hand hygiene, the facility failed to ensure staff performed hand hygiene to prevent cross contamination of germs during Resident #3's and Resident #31's medication administration and failed to ensure staff disinfected the glucometer prior to obtaining Resident #3's and Resident #31's blood sugar. This affected two out of three residents observed for medication administration. The facility census was 63. Findings include: Medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including hypertensive heart disease with heart failure, high cholesterol, anxiety , hypothyroidism, depression, gout and diabetes mellitus. Medical record review revealed Resident #31 was admitted on [DATE] with diagnoses including progressive neurological conditions, anemia, coronary artery disease, high blood pressure, and kidney disease. An observation on 02/11/25 at 7:22 A.M. of Registered Nurse (RN) #65 administer medications to Resident #3 revealed a failure to perform hand hygiene to prevent cross contamination of germs. RN #65 opened the medication cart and tucked her hair behind her ear. RN #65 proceeded to dispense Resident #3's medications into a medication cup. RN #65 then donned a pair of disposable gloves and removed a glucometer from her pocket and proceeded to obtain Resident #3's blood sugar level. RN #65 did not disinfect/sanitize the glucometer prior to obtaining Resident #3's blood sugar. RN #65 then removed her disposable gloves and exited Resident #3's room without performing hand hygiene. RN #65 obtained Resident #3's Lispro insulin pen from the medication cart and applied the insulin needle to the pen and walked back to Resident #3's room. RN #65 did not perform hand hygiene and donned a pair of disposable gloves and administered the Lispro insulin to Resident #3. RN #65 then placed the glucometer in her pocket and did not disinfect/sanitize the glucometer. RN #65 removed her gloves and did not perform hand hygiene and exited Resident #3's room. RN #65 proceeded to enter Resident # 31's room and did not perform hand hygiene and donned a pair of disposable gloves. RN #65 proceeded to remove the glucometer from her pocket and obtained Resident #31's blood sugar level. RN #65 did not disinfect/sanitize the glucometer prior to or after obtaining Resident #31's blood sugar. An interview with RN #65 on 02/11/25 at 7:55 A.M. verified she failed to perform hand hygiene before and after removing her gloves during Resident #3's medication administration and verified she had not disinfected the glucometer prior to obtaining Resident #3's and Resident #31's blood sugar level. Review of the facility policy titled Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. The policy interpretation and implementation included for staff to follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Blood Sampling- Capillary (Finger Sticks) revised September 2014 indicated the purpose of the procedure was to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodbome diseases to residents and employees. General guidelines included always ensure that blood glucose meters intended for reuse were cleaned and disinfected between uses. The lancets and platforms must always be changed after use on each resident. Handle the lancet as a used needle. Review of the Centers for Disease Control guidance for hand hygiene in healthcare settings dated 01/30/20 indicated the Healthcare Infection Control Advisory Committee (HICPAC) included healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following indications: - Immediately before touching a patient/resident. - Before performing an aspetic task. - Before moving from work on a soiled body site to a clean body site on the same patient/resident. - After touching a patient/resident or the patient's/resident's immediate environment. - After contact with blood, body fluids, or contaminated surfaces. - Immediately upon removal of gloves.