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	06/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the closed medical record, interviews, and review of facility policies and procedures, the facility failed to ensure the physician was notified of a change in condition for Resident #60. This affected one resident (Resident #60) of three reviewed for change in condition. Findings included: Review of the closed medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses including respiratory failure, pneumonia, encephalopathy, protein-calorie malnutrition, thyrotoxicosis, asthma, epilepsy, pacemaker status, transient ischemic attacks, tracheostomy, anxiety disorder, depression, acute kidney failure, adult failure to thrive, and diabetes. Resident #60 passed away at the hospital on [DATE]. Review of a plan of care dated [DATE] revealed Resident #60 was a full code. Interventions included (Cardiopulmonary Resuscitation) CPR to be initiated in the event of cardiac arrest and to notify the physician of a change in condition. Review of hospital discharge paperwork for Resident #60 revealed she was admitted to the hospital on [DATE] and was discharged back to the facility on [DATE]. The hospital discharge information noted the resident was still a full code, her transfer of care prognosis was poor, and they submitted education material related to community-acquired pneumonia (including instructions to contact the healthcare provider for worsening shortness of breath) with new orders for the antibiotic, Doxycycline 100 milligrams twice daily (with no specified length of time), and no new orders for oxygen therapy. There were no medical notes related to radiologic studies, laboratory services, specific diagnoses, or physician/nurses notes available to review from the resident's hospital stay. Review of the Respiratory Therapy (RT) progress note dated [DATE] at 12:36 A.M. revealed Resident #60 arrived at the facility at approximately 9:45 P.M. [indicating the night before, on [DATE]]. The resident's saturation of peripheral oxygen (SpO2) was 92 percent (%) to 93% on five liters of oxygen (via tracheostomy). The note included the resident was suctioned four times with a small amount of thick white secretions obtained. The RT suggested the nurse's suction the resident about every two to three hours to keep the resident's airway clear. The RT checked the resident's inner cannula for patency, placed it back in and changed the gauze under the tracheostomy. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated [DATE] at 5:43 P.M. revealed the physician was in for a visit and ordered the antibiotic Doxycycline 100 milligrams twice daily for 10 days for pneumonia, clarifying the length of time the resident was to be on the antibiotic. The resident's responsible party (RP) was notified. Review of the Five-Day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had severely impaired cognition and was dependent on staff for all activities of daily living (ADL). The MDS included Resident #60 was on continuous oxygen therapy, required intermittent suctioning, had a tracheostomy and was admitted with an invasive mechanical ventilator. Review of Resident #60's [DATE] physicians orders revealed the resident was a full code (indicating CPR was to be performed if someone's heart stopped beating or their breathing stopped), tracheostomy to be changed every three months, tracheostomy care twice daily, vital signs twice daily, change tracheostomy dressing every night shift and as needed, droplet isolation precautions due to COVID-19, monitor for signs and symptoms of aspiration pneumonia and notify the physician or nurse practitioner of any abnormal findings. Medication orders included Budesonide suspension 0.5 milligrams per two milliliters inhalation every 12 hours for shortness of breath, Doxycycline 100 milligram tablets twice daily via percutaneous endoscopic gastrostomy (PEG) tube for 10 days, and Ipratropium-albuterol solution 0.5 milligrams per three milliliter inhalation four times daily for pneumonia. Resident #60 did not have an order for mechanical ventilation in [DATE], contrary to the MDS assessment on [DATE]. Review of Resident #60's [DATE] Medication Administration Record (MAR) and TAR revealed her vital signs for day shift on [DATE] included blood pressure 141/64 millimeters of mercury(mmHg)(normal range being around 120/80), pulse 86 beats per minute (bpm)(normal range being around 60 to 100 bpm), temperature 98.1 degrees Fahrenheit (F)(normal range being from 97.8 degrees F to 99.1 degrees F), respirations were 18 breaths per minute (normal range being around 12 to 20), and a SpO2 98%. During the night shift vital sign documentation included blood pressure 108/58, pulse 86 bpm, temperature 98.8 degrees F, respirations 21 breaths per minute, and SpO2 at 98%. Review of the nursing progress note dated [DATE] at 7:34 P.M. revealed Resident #60 was currently on Doxycycline for pneumonia. She had increased yellowish secretions noted during suctioning and coughing. She had no signs of respiratory distress or discomfort. The resident's lung sounds were noted to have rhonchi (lung sounds characterized as a low-pitched continuous sound that resembles snoring or gurgling) when auscultated. The head of the resident's bed was elevated to a 60-degree angle for lung expansion. Her temperature was 97.3 degrees F. Review of the late entry progress notes dated [DATE] at 7:50 P.M., created on [DATE] at 2:06 P.M. by Regional Nurse #600, revealed the physician was in the facility earlier in the day and was aware of Resident #60's continued yellow secretions, and no new orders were noted. However, there was no physician progress note from this date. Review of the SpO2 documentation in the resident's medical record revealed on [DATE] the SpO2 for Resident #60 was 79% at 7:59 A.M. on room air. Oxygen was administered at three liters and her oxygen level came up to 90%. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the late entry progress note dated [DATE] at 7:54 A.M., created on [DATE] at 7:55 A.M. by Unit Manager #513, revealed Resident #60 was tested for COVID-19 and was positive. The note included the physician and the resident's responsible party were notified. There were no other nursing progress notes entered on [DATE] related to the resident's condition/status. Review of the plan of care dated [DATE] revealed Resident #60 was at risk for complications related to COVID-19. Interventions included notifying the physician of a worsening condition and to complete a respiratory assessment per facility protocol. Review of the plan of care dated [DATE] revealed Resident #60 was at risk for respiratory complications related to tracheostomy status and was at risk for dislodgement due to her removing her tracheostomy (nursing progress notes included incidents of resident removal on [DATE], [DATE] and [DATE]). Interventions included administering humidified oxygen as prescribed, assessing respiratory rate, depth and quality every shift, assessing tracheostomy incision for redness, warmth, tenderness and exudate, ensuring tracheostomy ties were secured, and suction as necessary. Record review revealed there was no documented evidence of a respiratory/tracheostomy care plan prior to [DATE]. Review of the nursing progress note (authored by LPN #500) dated [DATE] at 7:11 A.M. revealed Resident #60 was having labored breathing when LPN #500 arrived for her shift [the LPN worked on [DATE] at 7:00 P. M. through [DATE] at 7:00 A.M.]. In shift report, the off going nurse stated Resident #60 was positive for COVID-19. LPN #500 noted at 7:00 P.M. [on [DATE]] she administered night medications and checked the resident's SpO2 which was 92%. Resident #60 was suctioned and very little mucous came out. At around 11:00 P.M. [on [DATE]] while the nursing assistants were doing rounds the nurse checked on Resident #60 and she was still having labored breathing and at that time she called the RT [RT #700] to check and see what the resident's baseline (condition) was. The RT informed her that this was the resident's normal. She suctioned her and the resident's SpO2 was 98%. The nursing assistants did rounds at 1:30 A.M. [on [DATE]] with no change in the resident status. Resident #60 was suctioned at 3:30 A.M. with a small amount of mucous obtained. The note included the nurse visually laid eyes on the resident around 4:45 A.M. At approximately 5:10 A.M. the nurse headed down the hall and noticed Resident #60 did not seem to be breathing. She checked for a pulse, called for help, had the aide get a second nurse, and the crash cart. The second nurse called the EMS, a board was placed under the resident, a third nurse began CPR, and the writer/nurse gave breaths through an Ambu-bag. The second nurse took over for this nurse and she went to the nurse's station to print out her face sheet and medication list. EMS arrived and took over performing CPR. The daughter was notified immediately, and the physician was called to inform her of the situation, but she did not answer. It was noted also that at some point between 11:00 P.M. and midnight, the resident's daughter had called the facility for an update and the nurse informed her of what the RT told her about the resident being at her baseline. Review of the nursing progress note dated [DATE] at 5:31 A.M. revealed Resident #60 was transported to the hospital via EMS with CPR in progress to the hospital. Review of the nursing progress note dated [DATE] at 7:57 A.M. revealed the facility received a call from the hospital indicating Resident #60 had passed away. Review of Resident #60's nurse's notes and RT notes from [DATE] through [DATE] revealed no documented evidence that the resident had previously had labored breathing or that it was normal for the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:35 A.M. an interview with Regional Registered Nurse #522 revealed Physician #511 was not actually in the building as charted on [DATE] at 7:50 P.M. However, Resident #60 was being treated for pneumonia and yellow secretions at that time. Regional Registered Nurse #522 stated she was not with the company in [DATE]; Additionally, the nurse who wrote the late entry note (Regional Nurse #600) no longer worked for the company. On [DATE] at 11:50 A.M. an interview with Physician #511 revealed Resident #60 was aphasic (unable to speak) after a stroke, she had a tracheostomy and had several re-hospitalizations due to respiratory failure and sepsis. She stated she had spoken to the family several times about updating the resident's code status from full code to do-not-resuscitate (DNR), but they would not change it. She verified she was never called on the night Resident #60 expired. She stated with this resident; she would have had her transferred to the hospital if she was having labored breathing. She stated the only thing she could think of as to why they did not call her or send her out was because there had been times when she was having trouble breathing and she had a mucous plug. She stated the nurses were usually able to suction it out and the resident would be fine afterwards. She stated that she could not speak for the nurse on duty regarding why the nurse did not call her. On [DATE] at 3:56 P.M. an interview with LPN #500 revealed she had not worked at the facility in a while, and this day [[DATE] into [DATE]] was her first time working with Resident #60. She stated she received report from the previous nurse, but she was unsure of the nurse's name. She stated the only thing the previous nurse told her was that Resident #60 had COVID-19, she was pretty much okay, and she was in isolation. She stated she received a call from the resident's daughter around 11:00 P.M. calling to check up on her mom. She stated when she went in to give Resident #60 her medication, she was having trouble breathing so she asked the nursing assistant if it was normal and the nursing assistant stated sometimes the resident had trouble breathing. She stated she called the RT [RT #700] on Facetime and turned the camera around to ask her if her breathing was normal and she also asked the RT if the resident was on hospice. The LPN revealed the resident did not talk, but was awake. She stated the RT told her the resident was like that [indicating her breathing was normal], and the RT never told her Resident #60 might have a mucous plug. She stated she attempted to suction her three times and did not get hardly any mucous out. She stated if she would have known about the mucus plug, she would have done something, but stated she was not told this until after the resident had passed away. She stated other staff told her that she needed to put saline in the resident's tracheostomy to loosen up secretions. She stated Resident #60 was completely dry when she suctioned her. LPN #500 stated she had never had to put saline down a tracheostomy before so she would have had to have someone show her how to do that. She stated she did not go get the other nurse for assistance with the resident until she found the resident not breathing. She stated she called a code [indicating an emergency code for staff to respond as a resident needed immediate medical attention, usually due to cardiac or respiratory arrest], and the other two nurses came over and started CPR. The squad got to the facility fast and took over CPR. She stated she called the daughter and the physician to notify them of what had happened. She stated the doctor did not seem surprised. She stated she never thought to call the doctor earlier in the night because the RT told her this was normal for the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 5:10 P.M. an interview with RT #700 revealed she had been the RT for the facility since 2000. She stated the nurses would Facetime her after hours (when she wasn't working onsite) if they needed to. She was knowledgeable about Resident #60 and stated Resident #60 would get a mucous plug quite often and they would have to suction her very vigorously to get the mucous plug out. She stated when she had a mucus plug, her oxygen saturations would drop, but she would be fine after they removed the mucous plug. She stated it was a little hard to tell with the resident if she had mucous because staff could not always tell when the resident needed suctioned. She stated with most people you could automatically tell if they needed suctioned, but not with Resident #60, so she always told the nurses to make sure they went in and suctioned her even if she did not look like she needed suctioned. She stated the night Resident #60 passed away, LPN #500 called her and asked her if Resident #60 always looked like she was distressed and RT #700 told her yes, she always looked a little bit distressed. She stated her oxygen saturation was up and down, but stated she did not believe the resident's oxygen saturations would be up in the 92% and 98% range if she had a mucous plug. She stated LPN #500 called her around 11:30 P.M. and at that time she did not believe Resident #60 needed to be transferred to the hospital. She stated she had been off that day, so she didn't treat Resident #60 that day. She stated her schedule was to work four days per week from 3:00 P.M. through 11:00 P.M. and that she was the only RT on staff for the facility so she was on-call at all other times. On [DATE] at 10:40 A.M. an interview with Vital Statistics Staff #400 revealed Resident #60's death certificate indicated she expired from respiratory failure. On [DATE] at 11:15 A.M. an interview with Family Member #817 revealed she called the nursing home for an update every couple hours for Resident #60. She stated on [DATE] the last time she had called the nursing home to check on her mother was around 2:30 A.M. She stated it was LPN #500's first night working with her mother and the nurse told her she had called the RT to get Resident #60's baseline. She stated LPN #500 never told her that her mother was having trouble breathing or had labored breathing. She stated the only time her mother had trouble breathing was when she got junky and needed to be suctioned, then she would be fine. She stated her mother was fidgety and would grab at her tracheostomy and feeding tube, but she had brought in fidget toys for her to play with and they did help with her grabbing at stuff. Review of the facility policy titled, Change in Residents Condition or Status, dated [DATE] revealed the facility would promptly notify the resident, his or her attending physician, and the RP of changes in the resident's medical or mental condition and/or status. The nurse would notify the resident's physician or physician on-call when there had been an incident involving the resident, significant change in the resident physical or mental condition, and the need to transfer the resident to the hospital. This deficiency represents non-compliance investigated under Complaint Number OH00165463.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview with residents and staff, the facility failed to ensure the linens were free from stains. This affected one resident (Resident #39) and had the potential to affect all the residents in the facility who utilized the facility linens. The facility census was 60. Findings included: Review of the medical record revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, diabetes, obstructive sleep apnea, schizoaffective disorder, personality disorder, lymphedema, paranoid personality, kidney disease, congestive heart failure, edema, hypertension, depression, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #39 had moderately impaired cognition and had no behaviors. On 05/20/25 at 3:00 P.M. an interview with Resident #39 revealed the washcloths and towels in the facility were stained and dingy. He stated they were not white at all and they want you to wash your face with them. Observation of linen closets on 05/21/25 at 3:00 P.M. with Certified Nursing Assistant (CNA) #316 revealed the wash clothes, hand towels and bath towels were light brown in color with several larger brown stains on them. She stated they are all like that. She stated they did not have incontinence wipes anymore, so they had to use wash cloths and towels to clean up bowel movements (BM). She stated the stains did not come out of them in the wash. On 05/22/25 at 8:45 A.M. an interview with Laundry Manager #710 revealed all the wash cloths and towels in both linen closets (a total of 15 bath towels, two hand towels and eight wash cloths) were light brown in color, some with larger stains, and some of the wash cloths and towels were worn and thin. She stated this was all she had, and she had been washing the same ones for a while. She stated they ordered more a few weeks ago, but they had not been delivered. She stated the nursing assistants would clean up resident's BM with the washcloths and just throw them away. She stated they stopped purchasing incontinence wipes and they had been having problems with running out of wash cloths and towels ever since. She stated they had been looking dingy because the same ones are getting used over and over.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on review of the medical record and interview with staff the facility failed to ensure transportation was set up for a postoperative appointment for Resident #52. This affected one resident (#52) of three reviewed for appointments. Findings included: Review of the medical record revealed Resident #52 was admitted to the facility on [DATE]. Diagnoses included cervical disc disorder, spinal stenosis, diabetes, hypertension, chronic obstructive pulmonary disease, obstructive sleep apnea, osteoarthritis of the hip, injury to the cauda equina, benign prostatic hyperplasia, sleep apnea, depression, asthma, anxiety disorder, alcohol abuse, gout, fracture of the cervical vertebrae, fusion of the spine and fluid overload. Review of the hospital discharge paperwork provided to the facility dated 03/28/25 revealed Resident #52 had a post operative appointment with the surgeon on 04/07/25 at 9:30 A.M. Review of the physician's order dated 03/28/25 revealed Resident #52 had a post operative appointment with the surgeon on 04/07/25 at 9:30 A.M. The order did not specify anything related to obtaining an X-ray prior to the appointment. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #52 had moderately impaired cognition. He was frequently incontinent of bladder and always continent of bowel. Review of the physician's order dated 03/28/25 revealed Resident #52 had a new post operative appointment with the surgeon on 04/15/25 at 11:15 A.M. The order stated that transportation wound need set up prior to the appointment and the resident was to go first to radiology at the main hospital, and to the medical office building immediately after. On 05/21/25 at 11:50 A.M. an interview with Neurosurgery Medical Assistant #100 revealed the office was having issues with the lack of communication with the facility regarding the follow-up care for Resident #52. She stated the resident never showed up for his follow up appointment on 04/07/25 so it had to be rescheduled for 04/15/25. She stated he was 30 minutes late for his appointment on 04/15/25 and they never took him to have his X-rays completed prior to his appointment, like the order stated to do. She stated they went ahead and saw him and then sent him down after his appointment to have the X-rays completed. On 05/21/25 at 4:01 P.M. an interview with Regional Registered Nurse #522 revealed she was not sure what happened on the 04/07/25 appointment for Resident #52, but she believed it was due to transportation not being available. She stated the appointment was rescheduled for 04/15/25 and his son took him to that appointment. She stated she did not know anything about an X-ray prior to the appointment or if it was completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/25 at 4:25 P.M. an interview with Resident #52 revealed he never went to his appointment with the surgeon on 04/07/25 because the facility never set up the transportation. He stated he had rescheduled the appointment for 04/15/25. He stated his family did not take him to that appointment, he went there with a transport company and his family met him there. He stated the transport driver gave him a business card to call him when he was done with his appointment, but he did not want to wait for them, so his family brought him back to the facility. He stated he was never told he had to go to radiology prior to his appointment, but he did go afterwards. On 05/22/25 at 11:50 A.M. an interview with Regional Registered Nurse #522 confirmed Resident #52 had missed his appointment because transportation had not been set up. This deficiency represents non-compliance investigated under Complaint Number OH00164926 and OH00163019.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interview, and review of facility policy, the facility failed to implement individualized and effective pressure ulcer interventions timely. This affected one resident (Resident #42) out of three reviewed for pressure ulcers. Findings included: Review of the medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included hemiplegia of the left side after cerebrovascular disease, contractures of the left arm, major depressive disorder, bipolar disorder, hypertension, pressure ulcers to the left and right heel, hypertensive retinopathy, insomnia, age related cataract, drusen of the left eye, and xerosis cutis. Review of the admission Braden Scale (pressure ulcer risk assessment) dated 04/11/25 revealed Resident #42 was at a high risk for the development of pressure injuries. Review of the admission assessment dated [DATE] revealed Resident #42 had an unstageable (full thickness tissue loss where the base of the ulcer was obscured by slough (a yellowish, tan or green, moist, loose and stringy tissue that was present in the wound bed) and/or eschar (dead tissue)) pressure ulcer to the right heel which measured 4.5 centimeters (cm) by 4.3 cm by undetermined depth and a Stage III pressure ulcer to the left heel which measured 7.0 cm by 11.4 cm by an unable to determine (UTD) depth. Review of the admission Skin Grid dated 04/11/25 revealed Resident #42 was admitted to the facility with an unstageable right heel pressure ulcer which measured 6.0 cm by 6.0 cm with 80 percent necrotic tissue and 20 percent slough tissue. There was heavy serous drainage. It also noted that Resident #42 was also admitted with a Stage III left heel pressure ulcer which measured 8.0 cm by 16 cm with heavy serous drainage. Review of the Plan of Care dated 04/15/25 revealed Resident #42 was at risk for skin breakdown related to bowel and bladder incontinence, decreased bed mobility, and previous pressure ulcer. Interventions included treatments and preventative skin care as ordered, pressure relieving device or mattress to the bed to promote comfort and prevent skin breakdown, supplements as ordered, apply house moisture barrier as needed, assist with cleaning the perineal area, assistance with transfers and bed mobility, avoid friction and shearing, encourage and assist with turning and repositioning with routine rounds, encourage the resident to lay down after meals, encourage the resident to not stay up in the chair too long and change positions frequently, encourage to float heels, and a pressure relieving cushion to the chair. Further review of the Plan of Care dated 04/15/25, and revised on 05/20/25, revealed Resident #42 had an actual skin integrity alteration/pressure areas to the right heel, left heel, right axillary and left great toe. Interventions included assessing pain, encourage and assist with turning and repositioning, resident to be followed by the in-facility wound team, initiate wound treatments, keeping skin clean and dry, notify the physician as needed of worsening wound conditions, pressure reliving device to the chair, supplements as ordered, and treatments as ordered. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #42 had intact cognition, was dependent for all activities of daily living, was always incontinent of bladder, was frequently incontinent of bowel, received a scheduled pain medication and as needed pain medication, and a non-medication intervention for pain management. Resident #42 was admitted with three Stage III pressure ulcers. Review of the Wound Nurse Practitioner (WNP) note dated 04/16/25 revealed it was the initial consultation for wound care services for Resident #42. The right heel was an unstageable pressure ulcer which was present on admission. The right heel measured 3.9 cm by 2.9 cm by UTD depth with 60 percent (%) granulation (new tissue) and 40% slough and moderate serosanguinous drainage. The left heel was an unstageable pressure ulcer which was present on admission. The left heel measured 6.7 cm by 10.8 cm by UTD depth with 40% granulation, 10% slough, 40% eschar and 10% epithelial tissue, and moderate serosanguinous drainage. Debridement was postponed due to the residents high discomfort or pain concerns. The plan of care was off loading heels, proper nutrition, protein supplements to promote wound healing, and a pressure reduction mattress per facility protocol. Review of the WNP note dated 04/23/25 revealed the right heel of Resident #42 was an unstageable pressure ulcer which was present on admission. The right heel measured 4.5 cm by 4.3 cm by UTD depth with 70% granulation and 30% slough and moderate serosanguinous drainage. The wound was documented as unchanged. The left heel was an unstageable pressure ulcer which was present on admission. The left heel measured 7.0 cm by 11.4 cm by UTD depth with 30% granulation, 10% slough, 40% eschar and 20% epithelial tissue and moderate serosanguinous drainage. The wound was documented as unchanged. The resident refused debridement. The plan of care was off loading heels, proper nutrition, protein supplements to promote wound healing, noting the importance of good hygiene, and a pressure reduction mattress per facility protocol. It noted that the wounds became larger. Review of the WNP note dated 04/30/25 revealed the right heel of Resident #42 was an unstageable pressure ulcer which was present on admission. The right heel measured 3.9 cm by 3.9 cm by UTD depth with 80% granulation and 20% slough and moderate serosanguinous drainage. The wound bed was filling in granulation tissue and decreased in overall size. The wound was debrided and was improving. The left heel was an unstageable pressure ulcer which was present on admission. The left heel measured 5.9 cm by 9.4 cm by UTD depth with 30% granulation, 50% eschar and 20% epithelial tissue and moderate serosanguinous drainage. The wound was improved and decreased in size. The plan of care was off loading heels, proper nutrition, protein supplements to promote wound healing, nothing the importance of good hygiene, and a pressure reduction mattress per facility protocol. Review of the WNP note dated 05/07/25 revealed the right heel of Resident #42 was changed to a Stage III pressure ulcer. The right heel measured 3.9 cm by 3.4 cm by 0.4 cm with 90% granulation and 10% slough and moderate serosanguinous drainage. The wound bed was filling in with granulated tissue and showed positive progression. The left heel was an unstageable pressure ulcer. The left heel measured 5.9 cm by 9.9 cm by UTD depth with 30% granulation, 60% eschar and 10% epithelial tissue and moderate serosanguinous drainage. The wound was unchanged. The medial wound bed was covered with a moist eschar. The resident refused debridement. The plan of care was off loading heels, proper nutrition, protein supplements to promote wound healing, nothing the importance of good hygiene, and a pressure reduction mattress per facility protocol. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the WNP note dated 05/14/25 revealed the right heel of Resident #42 was a Stage III pressure ulcer. The right heel measured 3.6 cm by 3.4 cm by 0.4 cm with 90% granulation and 10% slough and moderate serosanguinous drainage. The wound bed was filling in with granulated tissue and showed positive progression. The left heel was an unstageable pressure ulcer. The left heel measured 5.4 cm by 11.3 cm by UTD depth with 30% granulation, 50% eschar, 10% slough and 10% epithelial tissue and moderate serosanguinous drainage. The wound remained necrotic and required debridement. The resident agreed to the debridement. The plan of care was off loading heels, proper nutrition, protein supplements to promote wound healing, nothing the importance of good hygiene, and a pressure reduction mattress per facility protocol. Review of the May 2025 physician's orders revealed Resident #42 had orders to cleanse the right heel with normal saline (NS), apply Medi-Honey ointment, calcium alginate, abdominal (ABD) pad and wrap with Kerlix daily and as needed (dated 04/30/25), and cleanse the left heel with NS, cover the wound with Dakins moisten gauze, apply an ABD pad, and wrap with Kerlix daily and as needed (dated 04/12/25), and 60 milliliters of house liquid protein twice daily for 45 days (dated 04/16/25). He did not have any other pressure relieving intervention orders in place. Review of an email from the medical supply company dated 05/20/25 revealed the facility received a low air low mattress and pump for Resident #42 on 04/19/25. On 05/20/25 at 11:15 A.M. an interview with Resident #42 revealed he had told the facility the first day he was at the facility he needed an air mattress, but they never got him one. He stated the facility got him the air mattress after his girlfriend called the Ohio Department of Health. He stated he brought the Profo boots he had on from the previous facility he came from. He stated he believed his heels were getting better, but they still hurt. He stated the facility staff did not turn him or move his feet unless he called to ask them to move them. Observation at this time revealed he had a low air loss mattress on his bed, his Profo boots were on the stand beside his bed and his heels were directly on the bed. His dressings were dated 05/20/25. On 05/20/25 at 11:20 A.M. an interview with Certified Nursing Assistant #800 verified Resident #42 did not have the Profo boots on his feet. On 05/20/25 at 2:00 P.M. an interview with Resident #7, who is the girlfriend of Resident #42, revealed the facility got Resident #42 the air mattress two days after she told them she called the State agency. She stated they finally got him new boots after she complained they smelled awful from all the draining from his heels. On 05/20/25 at 3:11 P.M. an interview with Regional Registered Nurse #522 revealed she did not know they needed to have a physician's order for an air mattress. She stated she did not know when Resident #42 received an air mattress, but she would find out. On 05/21/25 at 11:35 A.M. an interview with Regional Nurse #522 revealed she had received an email from the medical supply company confirming the date Resident #42 received his air mattress, which was on 04/19/25. She verified it was eight days after he was admitted to the facility. She stated he had a pressure-relieving mattress on his bed, and she did not know when he had asked for the air mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated April 2018 revealed the nursing staff or practitioner would assess and document an individual's significant risk factors for developing a pressure ulcer. This deficiency represents non-compliance investigated under Complaint Number OH00165337.

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F 0695 Level of Harm - 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** Based on closed record review, review of hospital records, facility policy and procedure review and interview, the facility failed to timely identify a change in Resident #60's respiratory condition to ensure the resident was provided timely and adequate care. This affected one resident (#60) of three residents reviewed for death. Actual harm occurred beginning on [DATE] when the facility failed to adequately and timely treat respiratory complications exhibited by Resident #60, who was a Full Code (advance directives), non-verbal and had a tracheostomy, which included labored breathing, the resident testing positive for Coronavirus (COVID-19) and being treated with an antibiotic for pneumonia. Licensed Practical Nurse (LPN) #500, who had not provided care to Resident #60 prior to [DATE], failed to notify Physician #511 regarding Resident #60's labored breathing as well as the resident having no secretions when suctioned. Resident #60 was found on [DATE] at 5:10 A.M. by LPN #500 with no vital signs, cardiopulmonary resuscitation (CPR) was initiated, and Resident #60 was transferred to the hospital. Findings included: Review of the closed medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses including respiratory failure, pneumonia, encephalopathy, protein-calorie malnutrition, thyrotoxicosis, asthma, epilepsy, pacemaker status, transient ischemic attacks, tracheostomy, anxiety disorder, depression, acute kidney failure, adult failure to thrive, and diabetes. Resident #60 passed away at the hospital on [DATE]. Review of a handwritten baseline plan of care dated [DATE] revealed Resident #60 had behaviors related to touching and manipulating her tracheostomy. Interventions included one on one and conversations to calm and reassure. Review of a handwritten baseline plan of care dated [DATE] revealed Resident #60 had behaviors related to touching and manipulating her tracheostomy. Interventions included using towels or fidget balls for diversional activity, educating the need to not handle her tracheostomy, and medication review related to anxiety. Review of the progress note dated [DATE] at 12:30 P.M. revealed Resident #60 was suctioned via inline suction, oxygen continued at four liters (L) and her oxygen saturation (SpO2) was 95 percent (%)(normal range being 95% to 100%, though some people with chronic respiratory issues may have a normal range around 90%). Resident #60's daughter was at the facility earlier and Resident #60 was suctioned, pulled up in bed, in an upright position, oxygen was at four liters, and a nebulizer treatment was given. SpO2 was maintained at 90% to 94%. Resident #60 was alert, and her skin was warm and dry to touch. Resident #60's daughter requested if anything changed to give her a call. At 12:30 A.M. Resident #60's daughter was notified Resident #60 was suctioned and her SpO2 was 95%. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress note dated [DATE] at 1:48 A.M. revealed at 12:30 A.M., Resident #60 was suctioned and her oxygen continued to be at four liters with a SpO2 level of 95%. At 1:15 A.M. the nurse was called to the resident's room by the nursing assistant, stating the resident did not look right. Once at the bedside the resident's eyes were rolled back in her head, she was able to move her arms and her SpO2 was 70% on four liters of oxygen, she was warm to touch and continued to be non-responsive. The resident's SpO2 was dropping to 60% on oxygen via her tracheostomy. Attempts to suction her obtained no secretions. Resident #60 continued to have shallow breath and her SpO2 was continuing to drop. The nurse called for assistance from the registered nurse on the other floor, a non-rebreather venti-mask was obtained and connected to the oxygen. The resident's SpO2 was not improving. Resident #60's respirations stopped, and (chest) compressions were started. Resident #60 was not breathing. The Artificial Manual Breathing Unit (Ambu)-bag was connected to her oxygen (tracheostomy) and rescue breaths were continued until Emergency Medical Services (EMS) arrived. Rescue measures continued and a heart rate of 95 beats per minute (bpm)(normal ranges from 60 to 100 bpm) showed on the monitor. The resident was taken to the hospital and the daughter was called. Review of a progress note dated [DATE] at 3:24 A.M. revealed Resident #60 was at the hospital and placed on a Bipap (machine that supports breathing) and a further update could be obtained at a later time. A progress noted dated [DATE] at 3:32 A.M. revealed the hospital stated Resident #60 was on a ventilator and admitted for further observation. Review of the hospital notes from [DATE] revealed Resident #60 was admitted to the hospital for acute on chronic respiratory failure with hypoxia. It noted the resident was found to be unresponsive by nursing home staff and CPR was initiated. Upon arrival at the hospital the resident had a decent amount of secretions from her tracheostomy and some dried secretions, and there was concern for a possible mucus plug. The resident was placed on a ventilator. The notes included the resident was cachectic (an appearance of extreme loss of muscle and fat mass, often associated with chronic illness) and ill appearing. The notes indicate a high troponin level (indicating damage to the heart muscle) and a high white blood cell count (indicating an infection). The hospital nurse practitioner noted diagnostic impressions as acute on chronic hypoxemic respiratory failure status post chronic tracheostomy, severe sepsis, suspected aspiration pneumonia, and a non-ST-elevation myocardial infarction (NSTEMI)(a type of heart attack where a part of the heart isn't getting enough oxygen). Cardiology was consulted and blood cultures were obtained. There were no additional medical notes related to additional radiologic studies, laboratory services, specific diagnoses, discharge orders, or physician/nurse's notes available to review from the resident's hospital stay. Review of a plan of care dated [DATE] revealed Resident #60 was a full code. Interventions included CPR to be initiated in the event of cardiac arrest and to notify the physician of a change in condition. Review of a progress note dated [DATE] timed 3:04 P.M. revealed Resident #60 was re-admitted to facility. There were no additional notes or records related to updates to the resident's status, discharge plans or discharge orders. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #60's physician's orders, dated [DATE] and discontinued on [DATE], revealed the resident was placed on a ventilator at assisted control with settings for Tidal volume (amount of air delivered for each breath) at 18 for 350 milliliters and the Positive End-Expiatory Pressure (the pressure remaining in the residents airways at the end of exhalation) at positive 5.0. The orders also included an order for oxygen to maintain SpO2 greater than 92% and an order to suction via tracheostomy as needed for pulmonary hygiene from [DATE] to [DATE]. Review of the Respiratory Therapist (RT) note dated [DATE] at 11:42 P.M. revealed the nurse called the RT at home via Facetime (a video phone call). The nurse was not able to get the low Tidal volume alarm on the ventilator to stop. The RT suggested several options and nothing worked. The RT instructed the nurse to put the resident back on oxygen, and she was on her way into the facility. Upon arrival, the RT noticed the resident needed suctioned which she had watched the nurse do while they were previously Facetiming. Resident #60's secretions were very thick and copious. The RT called for help and called for the code cart. The RT began bagging 15 liters of oxygen to assist the resident. No chest compressions were necessary, only assistance with breathing. Resident #60's SpO2 remained 58% to 65% until the paramedics arrived. Review of hospital discharge paperwork for Resident #60 revealed she was admitted to the hospital on [DATE] and was discharged back to the facility on [DATE]. The hospital discharge information noted the resident was still a full code, her transfer of care prognosis was poor, and they submitted education material related to community-acquired pneumonia (including instructions to contact the healthcare provider for worsening shortness of breath) with new orders for the antibiotic, Doxycycline 100 milligrams twice daily (with no specified length of time), and no new orders for oxygen therapy. There were no medical notes related to radiologic studies, laboratory services, specific diagnoses, or physician/nurses notes available to review from the resident's hospital stay. Review of the RT progress note dated [DATE] at 12:36 A.M. revealed Resident #60 arrived at the facility at approximately 9:45 P.M. [indicating the night before, on [DATE]]. The resident's SpO2 was 92% to 93% on five liters of oxygen (via tracheostomy). The resident was not ventilator dependent upon her re-admission on [DATE]. The note included the resident was suctioned four times with a small amount of thick white secretions obtained. The RT suggested the nurse's suction the resident about every two to three hours to keep the resident's airway clear. The RT checked the resident's inner cannula for patency, placed it back in and changed the gauze under the tracheostomy. Review of the progress note dated [DATE] at 5:43 P.M. revealed the physician was in for a visit and ordered the antibiotic Doxycycline 100 milligrams twice daily for 10 days for pneumonia, clarifying the length of time the resident was to be on the antibiotic. The resident's responsible party (RP) was notified. Review of the RT progress note dated [DATE] at 10:28 P.M. revealed Resident #60 was on three liters of oxygen with a SpO2 of 98%. The RT decreased her to two liters of oxygen and her SpO2 was 97%. She was suctioned three times with a moderate amount of thick white secretions obtained without incident. She was given two scheduled breathing treatments which she tolerated well. Tracheostomy care was completed, and the inner cannula was examined for patency and put back in place. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the RT progress note dated [DATE] at 10:04 P.M. revealed Resident #60 remained on two liters of oxygen with a SpO2 of 97%. She received two scheduled breathing treatments, and she tolerated them well. She was suctioned four times with moderate amounts of very thick white secretions obtained without incident. Tracheostomy care was completed, and the inner cannula was examined for patency and put back in place. Review of the Five-Day Medicare Minimum Data Set assessment dated [DATE] revealed Resident #60 had severely impaired cognition and was dependent on staff for all activities of daily living (ADL). The MDS included Resident #60 was on continuous oxygen therapy, required intermittent suctioning, had a tracheostomy and was admitted with an invasive mechanical ventilator. Review of Resident #60's [DATE] physicians orders revealed the resident was a full code (indicating CPR was to be performed if someone's heart stopped beating or their breathing stopped), tracheostomy to be changed every three months, tracheostomy care twice daily, vital signs twice daily, change tracheostomy dressing every night shift and as needed, droplet isolation precautions due to COVID-19, monitor for signs and symptoms of aspiration pneumonia and notify the physician or nurse practitioner of any abnormal findings. Medication orders included Budesonide suspension 0.5 milligrams per two milliliters inhalation every 12 hours for shortness of breath, Doxycycline 100 milligram tablets twice daily via percutaneous endoscopic gastrostomy (PEG) tube for 10 days, and Ipratropium-albuterol solution 0.5 milligrams per three milliliter inhalation four times daily for pneumonia. Resident #60 did not have an order for mechanical ventilation in [DATE], contrary to the MDS assessment on [DATE]. Review of Resident #60's [DATE] Medication Administration Record (MAR) and TAR revealed her vital signs for day shift on [DATE] included blood pressure 141/64 millimeters of mercury(mmHg)(normal range being around 120/80), pulse 86 beats per minute (bpm)(normal range being around 60 to 100 bpm), temperature 98.1 degrees Fahrenheit (F)(normal range being from 97.8 degrees F to 99.1 degrees F), respirations were 18 breaths per minute (normal range being around 12 to 20), and a SpO2 98%. During the night shift vital sign documentation included blood pressure 108/58, pulse 86 bpm, temperature 98.8 degrees F, respirations 21 breaths per minute, and SpO2 at 98%. Review of the nursing progress note dated [DATE] at 7:34 P.M. revealed Resident #60 was currently on Doxycycline for pneumonia. She had increased yellowish secretions noted during suctioning and coughing. She had no signs of respiratory distress or discomfort. The resident's lung sounds were noted to have rhonchi (lung sounds characterized as a low-pitched continuous sound that resembles snoring or gurgling) when auscultated. The head of the resident's bed was elevated to a 60-degree angle for lung expansion. Her temperature was 97.3 degrees F. Review of the late entry progress notes dated [DATE] at 7:50 P.M., created on [DATE] at 2:06 P.M. by Regional Nurse #600, revealed the physician was in the facility earlier in the day and was aware of Resident #60's continued yellow secretions, and no new orders were noted. However, there was no physician progress note from this date. Review of the SpO2 documentation in the resident's medical record revealed on [DATE] the SpO2 for Resident #60 was 79% at 7:59 A.M. on room air. Oxygen was administered at three liters and her oxygen level came up to 90%. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the late entry progress note dated [DATE] at 7:54 A.M., created on [DATE] at 7:55 A.M. by Unit Manager #513, revealed Resident #60 was tested for COVID-19 and was positive. The note included the physician and the resident's responsible party were notified. There were no other nursing progress notes entered on [DATE] related to the resident's condition/status. Review of the plan of care dated [DATE] revealed Resident #60 was at risk for complications related to COVID-19. Interventions included notifying the physician of a worsening condition and to complete a respiratory assessment per facility protocol. Review of the plan of care dated [DATE] revealed Resident #60 was at risk for respiratory complications related to tracheostomy status and was at risk for dislodgement due to her removing her tracheostomy (nursing progress notes included incidents of resident removal on [DATE], [DATE] and [DATE]). Interventions included administering humidified oxygen as prescribed, assessing respiratory rate, depth and quality every shift, assessing tracheostomy incision for redness, warmth, tenderness and exudate, ensuring tracheostomy ties were secured, and suction as necessary. Record review revealed there was no documented evidence of a respiratory/tracheostomy care plan prior to [DATE]. Review of the nursing progress note (authored by LPN #500) dated [DATE] at 7:11 A.M. revealed Resident #60 was having labored breathing when LPN #500 arrived for her shift [the LPN worked on [DATE] at 7:00 P. M. through [DATE] at 7:00 A.M.]. In shift report, the off going nurse stated Resident #60 was positive for COVID-19. LPN #500 noted at 7:00 P.M. [on [DATE]] she administered night medications and checked the resident's SpO2 which was 92%. Resident #60 was suctioned and very little mucous came out. At around 11:00 P.M. [on [DATE]] while the nursing assistants were doing rounds the nurse checked on Resident #60 and she was still having labored breathing and at that time she called the RT [RT #700] to check and see what the resident's baseline (condition) was. The RT informed her that this was the resident's normal. She suctioned her and the resident's SpO2 was 98%. The nursing assistants did rounds at 1:30 A.M. [on [DATE]] with no change in the resident status. Resident #60 was suctioned at 3:30 A.M. with a small amount of mucous obtained. The note included the nurse visually laid eyes on the resident around 4:45 A.M. At approximately 5:10 A.M. the nurse headed down the hall and noticed Resident #60 did not seem to be breathing. She checked for a pulse, called for help, had the aide get a second nurse, and the crash cart. The second nurse called the EMS, a board was placed under the resident, a third nurse began CPR, and the writer/nurse gave breaths through an Ambu-bag. The second nurse took over for this nurse and she went to the nurse's station to print out her face sheet and medication list. EMS arrived and took over performing CPR. The daughter was notified immediately, and the physician was called to inform her of the situation, but she did not answer. It was noted also that at some point between 11:00 P.M. and midnight, the resident's daughter had called the facility for an update and the nurse informed her of what the RT told her about the resident being at her baseline. Review of the nursing progress note dated [DATE] at 5:31 A.M. revealed Resident #60 was transported to the hospital via EMS with CPR in progress to the hospital. Review of the nursing progress note dated [DATE] at 7:57 A.M. revealed the facility received a call from the hospital indicating Resident #60 had passed away. Review of Resident #60's nurse's notes and RT notes from [DATE] through [DATE] revealed no documented evidence that the resident had previously had labored breathing or that it was normal for the resident. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:35 A.M. an interview with Regional Registered Nurse #522 revealed Physician #511 was not actually in the building as charted on [DATE] at 7:50 P.M. However, Resident #60 was being treated for pneumonia and yellow secretions at that time. Regional Registered Nurse #522 stated she was not with the company in [DATE]; Additionally, the nurse who wrote the late entry note (Regional Nurse #600) no longer worked for the company. On [DATE] at 11:50 A.M. an interview with Physician #511 revealed Resident #60 was aphasic (unable to speak) after a stroke, she had a tracheostomy and had several re-hospitalizations due to respiratory failure and sepsis. She stated she had spoken to the family several times about updating the resident's code status from full code to do-not-resuscitate (DNR), but they would not change it. She verified she was never called on the night Resident #60 expired. She stated with this resident; she would have had her transferred to the hospital if she was having labored breathing. She stated the only thing she could think of as to why they did not call her or send her out was because there had been times when she was having trouble breathing and she had a mucous plug. She stated the nurses were usually able to suction it out and the resident would be fine afterwards. She stated that she could not speak for the nurse on duty regarding why the nurse did not call her. On [DATE] at 3:56 P.M. an interview with LPN #500 revealed she had not worked at the facility in a while, and this day [[DATE] into [DATE]] was her first time working with Resident #60. She stated she received report from the previous nurse, but she was unsure of the nurse's name. She stated the only thing the previous nurse told her was that Resident #60 had COVID-19, she was pretty much okay, and she was in isolation. She stated she received a call from the resident's daughter around 11:00 P.M. calling to check up on her mom. She stated when she went in to give Resident #60 her medication, she was having trouble breathing so she asked the nursing assistant if it was normal and the nursing assistant stated sometimes the resident had trouble breathing. She stated she called the RT [RT #700] on Facetime and turned the camera around to ask her if her breathing was normal and she also asked the RT if the resident was on hospice. The LPN revealed the resident did not talk, but was awake. She stated the RT told her the resident was like that [indicating her breathing was normal], and the RT never told her Resident #60 might have a mucous plug. She stated she attempted to suction her three times and did not get hardly any mucous out. She stated if she would have known about the mucus plug, she would have done something, but stated she was not told this until after the resident had passed away. She stated other staff told her that she needed to put saline in the resident's tracheostomy to loosen up secretions. She stated Resident #60 was completely dry when she suctioned her. LPN #500 stated she had never had to put saline down a tracheostomy before so she would have had to have someone show her how to do that. She stated she did not go get the other nurse for assistance with the resident until she found the resident not breathing. She stated she called a code [indicating an emergency code for staff to respond as a resident needed immediate medical attention, usually due to cardiac or respiratory arrest], and the other two nurses came over and started CPR. The squad got to the facility fast and took over CPR. She stated she called the daughter and the physician to notify them of what had happened. She stated the doctor did not seem surprised. She stated she never thought to call the doctor earlier in the night because the RT told her this was normal for the resident. (continued on next page)

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	366391	A. Building B. Wing	06/04/2025

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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(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 - Actual harm Residents Affected - Few	On [DATE] at 5:10 P.M. an interview with RT #700 revealed she had been the RT for the facility since 2000. She stated the nurses would Facetime her after hours (when she wasn't working onsite) if they needed to. She was knowledgeable about Resident #60 and stated Resident #60 would get a mucous plug quite often and they would have to suction her very vigorously to get the mucous plug out. She stated when she had a mucus plug, her oxygen saturations would drop, but she would be fine after they removed the mucous plug. She stated it was a little hard to tell with the resident if she had mucous because staff could not always tell when the resident needed suctioned. She stated with most people you could automatically tell if they needed suctioned, but not with Resident #60, so she always told the nurses to make sure they went in and suctioned her even if she did not look like she needed suctioned. She stated the night Resident #60 passed away, LPN #500 called her and asked her if Resident #60 always looked like she was distressed and RT #700 told her yes, she always looked a little bit distressed. She stated her oxygen saturation was up and down, but stated she did not believe the resident's oxygen saturations would be up in the 92% and 98% range if she had a mucous plug. She stated LPN #500 called her around 11:30 P.M. and at that time she did not believe Resident #60 needed to be transferred to the hospital. She stated she had been off that day, so she didn't treat Resident #60 that day. She stated her schedule was to work four days per week from 3:00 P.M. through 11:00 P.M. and that she was the only RT on staff for the facility so she was on-call at all other times. On [DATE] at 10:40 A.M. an interview with Vital Statistics Staff #400 revealed Resident #60's death certificate indicated she expired from respiratory failure. On [DATE] at 11:30 A.M. an interview with Regional Registered Nurse #522 revealed when Resident #60 went out to the hospital on [DATE], they had weaned her off the ventilator and she came back to the facility on oxygen only with humidification. On [DATE] at 2:25 P.M. an interview with Regional Registered Nurse #522 confirmed Resident #60 did not have an actual physician order for oxygen or humidified oxygen when she came back from the hospital on [DATE]. She further confirmed there should have been an order for oxygen with parameters for its use for Resident #60. On [DATE] at 4:10 P.M. a follow-up interview with RT #700 revealed the last day she actually worked with, and assessed Resident #60, was on [DATE]. The RT revealed she could not state what was wrong with Resident #60 on [DATE] or [DATE] as she had not personally assessed the resident on these dates. On [DATE] at 10:01 A.M. an email communication from Regional Registered Nurse #522 revealed that one on one was provided as needed for Resident #60. If the behavior of touching/manipulating her tracheostomy was observed, she would be one on one until determined it was no longer necessary by the team, however, the behavior was not an ongoing issue but was left on the care plan as a precaution. On [DATE] at 1:50 P.M. an interview with RT #700 revealed she did not remember if Resident #60 had oxygen on when she Facetimed the nurse (on [DATE]). She stated Resident #60 did not always need oxygen because it was not an issue of saturation for her and she would not necessarily need the oxygen with labored breathing, because she felt it could be more of a hindrance due to her grabbing at things all the time. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:15 A.M. an interview with Family Member #817 revealed she called the nursing home for an update every couple hours for Resident #60. She stated on [DATE] the last time she had called the nursing home to check on her mother was around 2:30 A.M. She stated it was LPN #500's first night working with her mother and the nurse told her she had called the RT to get Resident #60's baseline. She stated LPN #500 never told her that her mother was having trouble breathing or had labored breathing. She stated the only time her mother had trouble breathing was when she got junky and needed to be suctioned, then she would be fine. She stated her mother was fidgety and would grab at her tracheostomy and feeding tube, but she had brought in fidget toys for her to play with and they did help with her grabbing at stuff. On [DATE] at 11:40 A.M. an interview with LPN #500 revealed Resident #60 was not messing with her tracheostomy the night of [DATE] into [DATE]. She stated the resident had oxygen on, but she could not remember at what flow rate. Review of the facility policy titled, Change in Residents Condition or Status, dated [DATE] revealed the facility would promptly notify the resident, his or her attending physician, and the RP of changes in the resident's medical or mental condition and/or status. The nurse would notify the resident's physician or physician on -call when there had been an incident involving the resident, significant change in the resident physical or mental condition, and the need to transfer the resident to the hospital. This deficiency represents non-compliance investigated under Master Complaint Number OH00165463.

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with staff the facility failed to set up a dental appointment as ordered for Resident #39. This affected one resident (#39) of three reviewed for appointments. Findings included: Review of the medical record revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, diabetes, obstructive sleep apnea, schizoaffective disorder, personality disorder, lymphedema, paranoid personality, kidney disease, congestive heart failure, edema, hypertension, depression, and chronic obstructive pulmonary disease. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #39 had moderately impaired cognition and had no behaviors. Review of the nursing progress note dated 03/27/25 at 11:30 A.M. revealed Resident #39 notified the nurse his tooth fell out. Resident #39 did not complain of any pain associated with the area, however he was concerned because there was no blood. The physician was notified, and a new order was given for Clindamycin 300 milligrams (mg) every six hours for one week, to monitor his temperature, and to schedule a dentist appointment as soon as possible. There was no documented evidence that Resident #39's dentist appointment was scheduled/completed. Review of Resident #39's physician orders dated 03/27/25 revealed orders for Clindamycin 300 mg four times per day for one week for prophylaxis and an order to schedule a dental appointment as soon as possible. Review of Resident #39's care plan dated 03/31/25 revealed the resident was at risk for chewing problems, swallowing difficulties or dental problems related to poor dentition, missing or broken teeth, poor dental hygiene, history of oral infections, and the resident had a history of self tooth removal. Interventions included administer medications as ordered, dentist referral as needed, and follow up dentistry as scheduled and as needed with coordinating pain management. Review of the nursing progress note dated 04/27/25 at 12:46 P.M. revealed Resident #39 called nine-one-one (911) for toothache pain and feeling dizzy. His blood pressure was 130/88 millimeters of mercury (mmHg)(normal rate around 120/80 mmHg). The note stated this was the first time the resident complained to the nurse about being dizzy or having a toothache. Resident #39 left with the paramedics. Review of the nursing progress note dated 04/27/25 at 5:49 P.M. revealed Resident #39 returned to the facility and went immediately into the kitchen for something to eat. He received new orders for Clindamycin 150 mg three tablets three times daily for dental caries and a periapical abscess. Review of Resident #39's physician orders dated 04/27/25 revealed orders for Clindamycin 150 mg with instructions to give three capsules three times per day for five days for infected dental caries. Review of the nursing progress note dated 04/28/25 at 1:29 P.M. revealed a dental appointment was scheduled for Resident #39 on 06/10/25 at 10:15 A.M. and transportation was set up. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated 05/08/25 at 12:00 P.M. revealed the facility received an order from the physician to refer Resident #39 to a dentist. The physician was informed he had an appointment already on 06/10/25. The physician started him on Clindamycin 450 milligrams three times daily for one week due to a left lower molar tooth infection. Review of Resident #39's physician orders dated 05/08/25 revealed orders for Clindamycin 450 mg three times per day for one week for a tooth abscess. On 05/21/25 at 4:01 P.M. an interview with Regional Registered Nurse #522 revealed Resident #39 had a dental appointment scheduled for 06/10/25. However, she verified it was not set up until after he had gone out to the hospital on [DATE] for dental pain, though the original order to see the dentist was in March 2025. This deficiency represents non-compliance investigated under Complaint Number OH00164926 and OH00163019.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview with staff, the facility failed to maintain a clean sanitary kitchen area. This affected all residents in the facility except for the three residents (#5, #6, and #58) who did not receive food from the kitchen. The facility census was 60. Findings included: Interview and observations of the kitchen with Dietary Manager #301 on 05/20/25 at 8:20 A.M. revealed the following sanitary concerns: a. Three trash cans which were dirty with a dark substance spilled down the sides of them. b. The bottom shelf of the steel table along the back wall was dirty with an orange substance soiled all over it. [NAME] #310, who was also present at the time of the observation, stated it was like that when she came in that day. c. The flour container had a measure cup in the flour. d. There were two black three-tiered carts what were visibly dirty with a buildup of several different spilled substances on them. e. The refrigerator had two packages of American cheese wrapped in aluminum foil with no date as to when it was opened and no expiration date. The cheese was observed to be hard/discolored on the edges. Additionally, a package of deli ham slices were opened with no date as to when it was opened. All of the above issues were verified with Dietary Manger #301 during the tour of the kitchen. Review of the facility policy titled, Sanitization, dated October 2008 revealed the foods service area would be maintained in a clean and sanitary manner. This deficiency represents non-compliance investigated under Complaint Number OH00164252 and Complaint Number OH00163019.

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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** Based on review of the medical record, observation, interview with staff, and review of facility policy, the facility failed to maintain appropriate infection control measures during incontinence care for Resident #41. This affected one resident (Resident #41) of three reviewed for incontinence care. Findings included: Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of the colon, duodenal ulcer, dementia, retention of urine, depression, chronic pain syndrome, gastritis, and moderate protein-calorie malnutrition. Observation of incontinence care on 05/27/25 at 9:45 A.M. revealed Certified Nursing Assistant (CNA) #219 provided incontinence care to Resident #41. CNA #219 brought into the room, two washcloths and a bath towel to provide care to Resident #41. CNA #219 washed the perineal and rectal area of Resident #41 and got feces on the washcloth. CNA #219 continued to wash the perineal area with the same washcloth, but used a different part of the washcloth even though you could visibly see the washcloth was soiled with feces. CNA #219 laid the feces-soiled wash cloth on the clean towel. She then rinsed the perineal area of Resident #41 and dried her with the towel she had the feces-soiled/contaminated wash cloth on. She rolled Resident #41 over on her left side and started to wipe her from her perineal area to her rectum with the feces-soiled washcloth. CNA #219 realized Resident #41 had feces on her rectum and grabbed some tissues from the resident's bedside stand and cleaned up the feces. She then proceeded to utilize the feces-soiled washcloth and wipe the resident two times from her perineal area to her rectum. The surveyor then intervened and asked her to stop and obtain a clean washcloth to wash the resident with. On 05/27/25 at 10:00 A.M. an interview with CNA #219 verified she had used a feces-soiled washcloth to wash the perineal area of Resident #41 during incontinence care. Review of the facility policy titled, Perineal Care, dated April 2018 revealed the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident's skin condition. This deficiency represents non-compliance investigated under Complaint Number OH00164926 and Complaint Number OH00163019.