

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/20/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3537 12th Street, NW Canton, OH 44708	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> THE FOLLOWING SURVEY FINDINGS PERTAINS TO AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of weather information at <a href="http://www.timeanddate.com">www.timeanddate.com</a>, review of the police report, review of the facility's Self-Reported Incident (SRI) investigation, resident representative interview, staff interview, and facility policy review, the facility failed to provide adequate interventions and supervision to prevent the elopement of a severely cognitively impaired resident. This resulted in Immediate Jeopardy when Resident #12, who was severely cognitively impaired and high risk for wandering and elopement, exited the facility in the early morning hours on [DATE] and was found by a concerned citizen/Good Samaritan walking in the middle of the road approximately 0.55 miles away from the facility. The resident was dressed in a t-shirt, pajama pants and had no shoes on. Local weather temperatures were approximately 46 degrees Fahrenheit during this time. The police were called on [DATE] at 4:16 A.M. by this Good Samaritan and the resident was transported to the hospital for evaluation. Prior to the incident, Resident #12 required the use of a wander guard device and there was no verifiable evidence the wander guard was in place on the night of the elopement. This affected one resident (Resident #12) out of three residents reviewed for elopement. The facility census was 60. On [DATE] at 10:05 A.M., the Administrator, Director of Clinical Services #101, Regional Compliance Specialist, and Regional Director of Operations #118 were notified Immediate Jeopardy began on [DATE] when Resident #12 exited the facility during the overnight hours without staff knowledge and was located 0.55 miles away from the facility in the middle of the road by a Good Samaritan, who notified local law enforcement on [DATE] at 4:16 A.M. Facility staff were unaware of Resident #12's absence until local law enforcement notified them the resident was located outside the facility on [DATE] at 4:35 A.M. The Immediate Jeopardy was removed and the deficiency was corrected on [DATE] when the facility implemented the following corrective actions: On [DATE] at 4:35 A.M., local law enforcement called facility and spoke with Licensed Practical Nurse (LPN) #107. Law enforcement officers stated they located Resident #12 walking and were taking him to the hospital for an assessment. On [DATE] from 4:35 A.M. to 4:40 A.M., LPN #107 and Registered Nurse (RN) #108 completed a head count of all residents. All other residents were present and accounted for with no variances noted. On [DATE] at 4:40 A.M., LPN #107 attempted to notify Resident #12's Responsible Party of Resident #12 leaving the facility and being taken to the hospital by law enforcement and had to leave a message. On [DATE] from 4:45 A.M. to 5:17 A.M., LPN #107 notified RN Manager #109 of Resident #12 leaving the facility and being taken to the hospital by law enforcement. RN Manager #109 notified the Administrator. On [DATE] at 5:00 A.M., RN Manager #109 attempted to contact Resident #12's Responsible Party with no answer and had to leave a message. On [DATE] from 7:00 A.M. to 7:10 A.M., RN Manager #109 called and spoke with the hospital nurse for an update on Resident #12. The hospital nurse stated Resident #12 appeared to be in good health, was free of any injuries or adverse outcomes, was absent of any distress, and they were monitoring him. On [DATE] at 8:15 A.M., RN #111 spoke with Resident #12's Responsible Party (RP) and notified the RP of Resident #12 leaving the facility and being taken to hospital by law enforcement. On [DATE] at 9:30 A.M., Resident #12 returned to the facility accompanied by paramedics. RN #111 obtained vital signs and assessed Resident #12. Resident #12's Responsible Party was notified of the resident's return to the facility and present at bedside at the time of assessment. Resident #12 was non-verbal, had non-sensical speech, and was unable to provide any pertinent information due to cognitive impairment. On [DATE] at 9:30 A.M., Resident #12's wander guard was placed back on by RN #111 and Resident #12 was placed on one-on-one (1:1) supervision. On [DATE] from 9:00 A.M. to 1:57 P.M., RN Manager #109, Administrator, and Assistant Director of Nursing (ADON) #103, Therapy Director #112, and Housekeeping Supervisor #113 educated facility staff on the Wandering/unsafe resident policy, Behavioral Assessment, Intervention, and Monitoring policy, ensuring interventions were in place for residents with exit seeking behaviors which may include but was not limited to 15 min checks, 1:1, and wander guards, ensuring interventions were put back in place when residents returned from the hospital, and not giving residents or families the door code. On [DATE] from 9:30 A.M. to 10:17 A.M., RN #101 audited resident orders and care plans for wander guards. Any variances were corrected immediately upon audit. On [DATE] from 10:00 A.M. to 11:30 A.M., Receptionist #114 and Maintenance Director #115 audited all residents with wander guards for functioning, placement, and to ensure all were within expiration date. All</p>		