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	11/05/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed medical record review, review of a facility investigation, employee file review, manufacturer guideline review, policy review and interview, the facility failed to ensure Resident #100 was transferred safely with a mechanical (Hoyer) sling lift resulting in a fall with major injury.Actual harm occurred on 09/11/25 when Resident #100, who was dependent on two staff members and the use of a mechanical sling lift with transfers, sustained a fall and a right hip fracture when being transferred from his bed to wheelchair with only the assistance of one staff member, Certified Nursing Assistant (CNA) #50 and the Hoyer lift. During the transfer, the lift tipped, Resident #100 fell to the floor, was emergently transferred to hospital and admitted with a closed right hip fracture. The resident was discharged from the hospital and admitted to another facility. This affected one resident (#100) of five residents reviewed for accidents/falls. The facility census was 65.Findings Include: Review of the closed medical record for Resident # 100, revealed an admission date of 08/23/22 and a discharge date of 09/11/25 with diagnoses including multiple fractures of ribs, unspecified side, subsequent encounter for fracture with routine healing, syncope and collapse, and anxiety disorder.Review of Resident #100's care plan, revised 07/09/24, revealed Resident #100 had an activity of daily living (ADL) deficit. An intervention (dated 12/09/24) included in the care plan indicated the resident required a mechanical lift for transfers.Review of the fall risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 10 out of 15. The resident was assessed to be dependent on staff with the use of a mechanical (Hoyer) lift for all transfers, and dependent on staff for bed mobility.Review of a nursing progress note dated 09/11/25 at 9:27 A.M., authored by Registered Nurse (RN) #5, revealed the nurse was called to the resident's room. Upon arrival the resident was lying on the floor with the Hoyer pad under him. Pain was noted when the resident tried to move his leg. Review of a facility investigation report, dated 09/11/25, revealed Resident #100 was being transferred via mechanical lift on 09/11/25 by CNA #50. During the transfer, the Hoyer lift tipped over resulting in Resident #100 falling to the floor. Nursing staff were immediately called to the resident's room to assess him for injuries; Emergency Medical Services (EMS) were called, and Resident #100 was transferred to the hospital.Review of CNA #50's witness statement dated 09/11/25 revealed she was transferring Resident #100 alone and the Hoyer lift tipped over. In review of the findings, the facility confirmed CNA #50 was self-transferring Resident #100 with the use of a Hoyer lift. (This was not the facility procedure to transfer residents with the Hoyer/mechanical lift using one staff). Interview on 10/30/25 at 9:39 A.M. with CNA #30 revealed she was working with CNA #50 on 09/11/25, but not on the same unit. CNA #50 did not ask CNA #30 for assistance with Hoyer lift transfers. However, after the incident occurred, CNA #50 asked CNA #30 for assistance getting Resident #100 up off the floor. CNA #30, CNA #50 and CNA #20 went to Resident #100's room and immediately called for the nurse, RN #5. Interview on 10/30/25 at 9:49 A.M. with CNA #20 revealed she was working with CNA #50 on 09/11/25 but not on the same unit. CNA #50 did not ask CNA #20 for assistance with Hoyer lift transfers. However, CNA #30 and CNA #50 did ask CNA #20 for assistance with Resident #100 after the incident occurred. Upon entering the room, they immediately called for the nurse, RN #5. Interview on 10/30/25 at 4:19 P.M. with RN #5 revealed CNA #50 was working the same unit as RN #5 on 09/11/25 and the CNA did not ask for assistance with transferring Resident #100 with the Hoyer lift. The CNAs working did notify her Resident #100 was on the floor and RN #5 immediately assessed him and called for the Director of Nursing (DON). Resident #100 was transferred to the ER.Interview with the DON on 10/30/25 at 11:06 A.M. confirmed Resident #100 fell while he was being transferred by staff using a Hoyer lift. She stated, based on the facility investigation, CNA #50 was using the Hoyer lift to transfer Resident #100 by herself, which was not the guidance provided in the manufacturer's guidelines and not according to facility policy, the lift tipped and Resident #100 fell to the floor resulting in a right hip fracture. The DON verified the resident did not return after hospital discharge but was admitted to another facility. The DON shared, following the incident, the facility completed the investigation, and initiated a plan of correction for this situation, which included education for nurses and CNAs, audit of residents who required mechanical lifts to ensure the lifts were being used appropriately, and mechanical lift transfer audits three times a week for four weeks with concerns