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	06/08/2026

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. Based on resident representative interview, medical record review and staff interview, the facility failed to ensure timely notification was provided to a resident representative following an accident. This affected one (Resident #67) of five residents reviewed for accidents. The facility census was 67. Findings include: Review of the medical record for Resident #67 revealed an admission date of 03/21/23 with diagnoses that included cerebrovascular accident, osteoarthritis to the left hip and benign prostate hypertrophy. Further review of Resident #67's medical record, including progress notes, revealed no documentation of any fall, accident, or incident on 03/10/26. A progress note on 03/16/26 indicated the resident's responsible party was updated on a [unspecified] prior incident and new interventions for fall prevention. Telephone interview with Resident #67's responsible party on 06/01/26 at 1:35 P.M. revealed on 03/10/26, the resident had a fall incident in the facility and the responsible party was not notified until several days after the incident occurred. On 06/02/25 at 3:50 P.M., interview with the Director of Nursing (DON) indicated Resident #67 had an incident on 03/10/26 where he slid out of his wheelchair. Further interview with the DON on 06/03/26 at 10:35 A.M. verified the fall incident on 03/10/26 for Resident #67 was not documented in the medical record and the resident's responsible party was not notified until 03/16/26. This deficiency represents non-compliance investigated under Complaint Number 2960506.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and facility policy review, the facility failed to ensure a dependent resident received adequate assistance with nail care. This affected one Resident (#62) of three residents reviewed for activities of daily living. The facility census was 67.Findings include: Review of the medical record for Resident #62 revealed an admission date of 05/20/25 and diagnoses including acute respiratory failure with hypoxia, moderate protein calorie malnutrition, anxiety disorder, contracture of bilateral knees, muscle wasting and atrophy, and stage three chronic kidney disease.Review of Medicare Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #62 was cognitively intact. Resident #62 was dependent on staff assistance for bathing, dressing, personal hygiene, transfers, and mobility.Observation on 06/01/26 at 10:01 A.M. revealed Resident #62's fingernails appeared long and had visible debris under the nails.Interview on 06/01/26 at 10:01 A.M. with Resident #62 revealed he agreed his fingernails appeared long and dirty. Resident #62 stated no one had offered to cut them, so he had been biting them or trying rip them off.Observation and interview on 06/01/26 at 10:09 A.M. with Assistant Director of Nursing (ADON) #851 confirmed Resident #62's nails were long and dirty. ADON #851 stated nail care was completed by Certified Nursing Assistants (CNAs) on an as needed basis. ADON #851 asked Resident #62 if he would like his nails cut and he stated that he would like them cut.Review of the facility policy Fingernails/Toenails, Care of dated February 2018 revealed nail care included daily cleaning and regular trimming.This deficiency represents non-compliance investigated under Complaint Number 2794766.

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide the necessary treatment to promote healing of a pressure ulcer for one resident (#57) of three residents reviewed for pressure ulcers. The facility identified eight residents with current pressure ulcers at the time of the annual survey. The facility census was 67. Findings include: Record review revealed Resident #57 admitted to the facility on [DATE] with diagnoses including cerebrovascular accident (CVA), metabolic encephalopathy, polyneuropathy and dementia.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 had moderate cognitive impairment, required maximum assistance with activities of daily living and mobility, was frequently incontinent of bladder, occasionally incontinent of bowel, and reported occasional pain.Review of the care plan revised 05/20/26 revealed Resident #57 had actual skin integrity alterations including a left inner buttock pressure wound, right gluteal fold pressure wound, and sacral moisture associated skin damage (MASD). The care plan further directed staff to encourage and assist with turning and repositioning with routine rounds and as needed. Additional interventions included the use of a pressure-relieving mattress and follow-up by the facility's wound care team.Review of consultant wound care notes dated 05/13/26 revealed Resident #57 had a right gluteal stage two pressure ulcer (a partial-thickness wound involving the epidermis and/or dermis and typically presents as a shallow, open wound) which was noted to have declined. The note identified poor compliance with offloading (strategic redistribution of pressure and friction away from a vulnerable or ulcerated area to promote healing) as a contributing factor. Further documentation revealed education was provided to staff and the resident regarding the importance of offloading to promote wound healing and recommended pressure reduction interventions and repositioning per facility protocol. Subsequent wound care follow up notes dated 05/20/26 and 05/27/26 continued to include recommendations for pressure reduction and repositioning interventions.Observation of Resident #57 on 06/03/26 at 8:53 A.M. revealed Resident #57 was lying on her right side in bed. A follow-up observation at 9:43 A.M. during wound care revealed the resident remained positioned on her right side. Following completion of wound care, STNA #872 offered to place a pillow under the resident's hip. Resident #57 stated she was comfortable. No education was provided to the resident regarding the benefits of turning and repositioning to promote wound healing. Subsequent observations at 10:30 A.M., 11:00 A.M., 12:30 P.M., and 1:42 P.M. revealed Resident #57 remained positioned on her right side in bed. During the observation period, staff were not observed assisting the resident with turning or repositioning.Interview with Resident #57 on 06/03/26 at 10:35 A.M. revealed staff asked her if she wanted to turn once in awhile. Resident #57 stated she was unaware that turning and relieving pressure from her wounds would assist with healing and stated she would turn if she knew it would help. Resident #57 further stated staff occasionally offered a pillow under her hip but had not explained the importance of turning and repositioning for wound healing.Interview with Certified Nursing Assistant (CNA) #872 on 06/08/26 at 9:46 A.M. revealed she attempted to keep Resident #57 comfortable and would sometimes allow the resident to remain in the same position when the resident complained of pain associated with her sacral wounds and stated she was comfortable. CNA #872 stated she had educated the resident on the need to turn and reposition; however, she believed the resident forgets.Review of the facility Wound Care Policy revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to use supportive devices as instructed during wound care. After wound care was completed, position the bed linens and resident for comfort. The policy indicated to report other information in accordance with facility policy and professional standards of practice. This deficiency represents non-compliance investigated under Complaint Number 2592902

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, interview, and facility policy review, the facility failed to ensure Resident #43 was free from a significant medication error. This affected one Resident (#43) of five reviewed for unnecessary medications. The facility census was 67.Findings include: Review of the medical record for Resident #43 revealed an admission date of 04/22/26 and diagnoses including cerebral infarction, essential hypertension, and chronic kidney disease.Review of a physician's order dated 04/22/26 revealed inject 1 milligram (mg) subcutaneously of Heparin Sodium (an injectable anticoagulant medication commonly used to prevent blood clots) 5000 unit per milliliter (Unit/mL) two times per day for prophylaxis. The order was discontinued on 04/24/26.Review of a physician's order dated 04/24/26 revealed inject 5000 units subcutaneously of Heparin Sodium 5000 Unit/mL two times per day related to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.Review of the Medication Administration Record (MAR) for April 2026 revealed the evening dose of Heparin on 04/23/26, 04/27/26, and 04/28/26 was marked as on hold. The morning dose of Heparin was blank on 04/24/26. The morning dose of Heparin on 04/25/26 was marked as see nurses note. Review of progress notes revealed a note dated 04/23/26 at 8:36 P.M. which revealed the facility was awaiting delivery of Resident #43's Heparin from pharmacy. An additional progress note dated 04/25/26 at 8:25 A.M. revealed the facility was awaiting delivery of Resident #43's Heparin from pharmacy. It was noted there were no doses left in the automated medication dispensing cabinet (Pyxis). Progress notes dated 04/28/26 at 4:30 A.M. and 04/28/26 at 8:01 P.M. revealed Resident #43's Heparin was on order.Interview on 06/08/26 at 12:14 P.M. with Regional Quality Assurance Nurse (RQAN) #798 confirmed Resident #43 had missed doses of Heparin medication on 04/23/26, 04/24/26, 04/25/26, 04/27/26, and 04/28/26. RQAN #798 indicated the facility kept two doses of Heparin in their e-kit.Review of the facility policy Administering Medications dated April 2019 revealed medications were administered in accordance with prescriber orders including any required time frames.This deficiency represents non-compliance investigated under Complaint Numbers 2960506, 2794766, and 2592902.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family representative interview, staff interview, and medical record review, the facility failed to maintain complete and accurate medical records. This affected three residents (#2, #57, and #67) of seven residents reviewed for accuracy of records during the annual survey. The facility census was 67. Findings include: 1. Telephone interview with Resident #67's responsible party on 06/01/26 at 1:35 P.M. revealed on 03/10/26 the resident had a fall incident in the facility. Review of the medical record for Resident #67 revealed an admission date of 03/21/23 with diagnoses that included cerebrovascular accident, osteoarthritis to the left hip and benign prostate hypertrophy. Further review of the medical record including progress notes revealed no documentation of any fall or accident incident on 03/10/26. A progress note on 03/16/26 indicated the resident's responsible party was updated on prior incident and new interventions for fall prevention. On 06/02/25 at 3:50 P.M., an interview with the Director of Nursing (DON) indicated Resident #67 had an incident on 03/10/26 where he slid out of his wheelchair. Further interview with the DON on 06/03/26 at 10:35 A.M. verified the accident incident on 03/10/26 for Resident #67 was not documented in the medical record. 2. Review of Resident #2's medical record revealed an admission date of 02/01/24 with diagnoses that included presence of a percutaneous endoscopic gastrostomy (PEG) tube (used for providing liquid nutritional support via a tube straight to the stomach through a surgically created opening through the abdominal wall), cerebrovascular accident, diabetes mellitus, chronic kidney disease and protein-calorie malnutrition. Further review of the medical record including current physician's orders indicated on 04/17/26 Resident #2's tube feeding orders noted if the resident ate less than fifty percent of a meal to provide a 240 milliliter (ml) bolus of Nepro Carb Steady (liquid nutritional support) via the resident's PEG tube. Review of the Medication Administration Record (MAR) for Resident #2 revealed documentation each day for each meal indicating the percent of meal consumed and a check mark with the nurse's initials. It was unable to be determined if the tube feeding was provided or held based upon the physician's orders. On 06/02/26 at 12:35 P.M., an interview with Licensed Practical Nurse (LPN) #897 verified the MAR for Resident #2 did not indicate whether the tube feeding was held or administered and was unclear. On 06/02/26 at 12:40 P.M., an interview with the DON verified the MAR for Resident #2 did not indicate if the bolus tube feeding was held or administered. The DON stated the MAR needed to be clarified to ensure proper documentation based upon the percentage of meal consumed. 3. Record review revealed Resident #57 was admitted to the facility on [DATE] with diagnoses (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including cerebrovascular accident (CVA), metabolic encephalopathy, chronic kidney disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD), dementia, hypertension, and obesity. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had a BIMS score of 9 indicating moderately impaired cognition and required extensive to maximum assistance with activities of daily living and mobility. Review of the care plan revised 05/20/26 revealed Resident #57 had actual skin integrity alterations including a left inner buttock Stage III pressure ulcer, right gluteal Stage II pressure ulcer, and sacral moisture associated skin damage (MASD). Review of the Skin Grid Pressure Assessments revealed the resident's left buttock pressure ulcer was documented as a Stage three (III) pressure ulcer (wound featuring full-thickness skin loss where subcutaneous fat is visible) on 05/13/26 and 05/20/26. Review of the Skin Grid Pressure assessment dated [DATE] revealed the same left buttock pressure ulcer was documented as a Stage two (II) pressure ulcer (partial-thickness skin loss that presents as a shallow red/pink open wound, a scrape, or an intact/ruptured blister and does not extend into subcutaneous tissue). Further review revealed the wound measurements and wound location remained consistent with the previously identified left buttock pressure ulcer. Review of consultant Wound Care documentation notes dated 05/13/26, 05/20/26, and 05/27/26 revealed the resident's left inner buttock wound continued to be identified as a Stage III pressure ulcer. Interview with Assistant Director of Nursing (ADON) #851 on 06/04/26 at 11:49 A.M. revealed the left buttock pressure ulcer had been incorrectly entered as a Stage II pressure ulcer on the 05/27/26 Skin Grid Pressure Assessment and should have been documented as a Stage III pressure ulcer. ADON #851 stated the Stage II documentation was entered in error. This deficiency represents non-compliance investigated under Complaint Number 2960506.

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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 observation, interview, record review, and facility policy review, the facility failed to maintain effective infection control standards during wound care. This affected one resident (#57) of three residents reviewed for wound care. The facility identified eight current residents with pressure ulcers at the time of the annual survey. The facility census was 67.Findings include: Record review revealed Resident #57 admitted on [DATE] with diagnoses including cerebrovascular accident (CVA), metabolic encephalopathy, polyneuropathy and dementia.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 had moderate cognitive impairment, required maximum assistance with activities of daily living and mobility, was frequently incontinent of bladder, occasionally incontinent of bowel, and reported occasional pain.Review of the care plan dated 04/24/26 revealed Resident #57 was identified as being at risk for impaired skin integrity with new wounds and increased nutritional needs related to wound healing. Interventions included to provide a therapeutic diet, obtain weekly weights and place interventions to promote skin integrity.Review of Resident #57's physician orders revealed a wound treatment order dated 05/13/26 for the right gluteal wound directing staff to cleanse the wound with wound wash, pat dry, apply collagen powder, and cover with Triad (a zinc-oxide based cream that provides a protective moisture barrier) twice daily and as needed for soilage. Resident had an additional order dated 05/13/26 for a low air loss mattress related to wound management. Continued review of the physician orders revealed an additional wound treatment order dated 05/20/26 called for the resident's sacral wound to be cleansed with wound wash, pat dry, apply Triad cream every shift and as needed. An additional order dated 05/27/26 for the left inner buttock wound directed staff to cleanse the wound with wound wash, pat dry, apply Triad cream every shift and as needed.Observation on 06/03/26 at 9:43 A.M. revealed Registered Nurse (RN) #870 with assistance from Certified Nursing Assistant (CNA) #872 providing wound care to Resident #57. RN #870 brought the wound treatment cart into the resident's room during wound care. During the treatment, RN #870 wore gloves while providing wound care and subsequently opened a drawer to obtain additional wound cleanser without removing gloves or performing hand hygiene. CNA #872 removed dirty gloves and donned clean gloves during the procedure without performing hand hygiene between glove changes. Following resident care, staff continued to touch environmental surfaces while still wearing the soiled gloves.Interview with the Director of Nursing/Infection Preventionist on 06/04/26 at 12:45 P.M. revealed wound treatment carts were not to be brought into resident rooms due to the potential for contamination and cross transmission of pathogens. The Director of Nursing/Infection Preventionist further stated staff were expected to perform hand hygiene following glove removal and prior to donning clean gloves and should not touch environmental surfaces with contaminated gloves.Review of the facility Wound Care Policy revealed staff were to wash and dry their hands thoroughly prior to wound care, after removal of dressings, and following completion of wound treatment. The policy further directed staff to take only the disposable supplies necessary for treatment into the resident room and indicated disposable supplies could not be returned to the treatment cart. This deficiency represents non-compliance investigated under Complaint Number 2592902.