

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 06/08/2026
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.			
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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 observation, interview and review of facility policy, the facility failed to ensure foods were properly stored in the [NAME] Unit kitchenette. This had the potential to affect all 32 residents (#1, #3, #8, #10, #17, #18, #20, #21, #24, #27, #29, #33, #34, #37, #40, #41, #43, #44, #45, #46, #48, #50, #51, #56, #57, #61, #62, #64, #65, #69, #70 and #77) who resided on the [NAME] Unit. The facility census was 67. Findings include: Observation on 06/04/26 at 11:45 A.M. of the [NAME] Unit kitchenette refrigerator revealed two opened and undated individual apple sauce cups and two CoolCheck (insulated food pan) containers with undated resident food items in them (one container was dirty). Further observation of the kitchenette revealed on the first shelf of the left upper cabinet was an opened and undated half loaf of bread and an opened and undated container of chow main noodles. On the second shelf of the same cabinet containing food items, was a CoolCheck container and four empty red containers with a biohazard label on each of the containers. Concurrent interview with Nursing Scheduler (NS) #878 confirmed the two opened and undated individual apple sauce cups, the two CoolCheck containers with resident food items in them with one container being dirty, the opened and undated half loaf of bread, the opened and undated container of chow main noodles and the CoolCheck container and four red containers with biohazard labels on them stored in the same cabinet at food items. NS #878 stated the refrigerator was for the storage of resident food items, including snacks from the kitchen and food brought in by residents or their families. NS #878 confirmed that the biohazard containers should not have been stored in the cabinet with food items. NS #878 stated housekeeping was responsible for keeping the kitchenette and refrigerator clean, the aides were responsible for dating food items, and the nurses were responsible to clean the CoolCheck containers as they were used to keep nutritional supplements cold during medication pass and were not to be used for resident food items. Observation on 06/04/25 at 12:10 P.M. of the [NAME] Unit kitchenette, and concurrent interview with Housekeeping Supervisor (HS) #860 confirmed the biohazard containers were not to be stored in the kitchenette, the nurses were to clean the CoolCheck containers and aides were responsible to date food items. Further interview with HS #860 confirmed the refrigerator needed cleaned and the CoolCheck container was dirty. HS #860 stated she had been off for the past two days and was responsible for cleaning the [NAME] Unit kitchenette. HS #860 confirmed housekeeping cleaned the kitchenettes on both the East and [NAME] Units and on Fridays the outdated and unlabeled items were cleaned out. HS #860 stated cabinets were to be cleaned daily. Review of facility policy titled, Food Receiving and Storage policy, revised October 2017, revealed food services, or other designated staff, would maintain clean food storage areas at all times. Food items and snacks kept on the nursing units must be maintained as indicated: all food items must be placed in the refrigerator located at the nurses' station and labeled with a date and discarded after three days; all foods belonging to residents must be labeled with the resident's name and date; other (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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Centers for Medicare & Medicaid Services

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Form Approved OMB
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opened containers must be dated and sealed or covered during storage; medications and blood or blood products may not be stored in the same refrigerator with food; and pesticides and other toxic substances and drugs would not be stored in the kitchen area or in store rooms for food.		

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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.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure residents or their representatives were notified in writing of the facility's transfer and bed hold policy for Residents #13, #75, and #76. Additionally, the facility failed to notify the Office of the State Long-Term Care Ombudsman of Residents #75 and #76's transfers to the hospital. This affected three Residents (#13, #75, and #76) of three residents reviewed for hospitalizations. The facility census was 67. Findings include: 1. Review of the medical record for Resident #75 revealed an admission date of 01/24/25 and discharge date of 01/17/26. Diagnoses included chronic respiratory failure with hypoxia, morbid obesity, type II diabetes mellitus, depressive type schizoaffective disorder, personality disorder, and paranoid personality disorder. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #75 was cognitively intact. Review of a progress note dated 01/17/26 revealed Resident #75 called emergency medical services (EMS) due to thoughts of suicide. Resident #75 was on one-on-one supervision for safety. Review of progress note dated 01/18/26 revealed Resident #75 was transferred for inpatient psych stay for suicidal ideations. Further review of the medical record revealed there was no evidence Resident #75 was provided a copy of the transfer notice or a bed hold notice. There was no evidence the Office of the State Long-Term Care Ombudsman was notified of Resident #75's transfer to the hospital. Interview on 06/08/26 at 2:34 P.M. with the Administrator confirmed they were unable to provide evidence of transfer notice, bed hold, or notice to the Office of the State Long-Term Care Ombudsman for Resident #75's hospitalization. 2. Review of the medical record for Resident #76 revealed an admission date of 05/28/21 and discharge date of 04/21/26. Resident #76 was readmitted to the facility on [DATE]. Diagnoses included anxiety disorder, hypertension, type II diabetes mellitus, cognitive communication disorder, cirrhosis of the liver, and morbid obesity. Review of the Brief Interview for Mental Status (BIMS) score completed on 05/29/26 revealed Resident #76 had a severe cognitive impairment. Review of a progress note dated 04/21/26 revealed Resident #76 was transferred for inpatient psych stay for medication review and adjustment. Further review of the medical record revealed there was no evidence Resident #76 was provided a copy of the transfer notice or a bed hold notice. There was no evidence the Office of the State (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Long-Term Care Ombudsman was notified of Resident #76's transfer to the hospital. Interview on 06/08/26 at 2:34 P.M. with the Administrator confirmed they were unable to provide evidence of transfer notice, bed hold, or notice to the Office of the State Long-Term Care Ombudsman for Resident #76's hospitalization. 3. Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including cerebrovascular accident (CVA) with left-sided hemiparesis, diabetes mellitus, chronic respiratory failure with hypoxia, schizoaffective disorder, hypertension, anemia, post-traumatic stress disorder (PTSD), polyneuropathy, peripheral vascular disease (PVD), atrial fibrillation, insomnia, and aphasia. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 required moderate assistance with transfers, setup to maximum assistance with activities of daily living, was frequently incontinent of bladder, and occasionally incontinent of bowel. Review of a nursing progress note dated 04/10/26 at 12:10 P.M. revealed an order was received to send Resident #13 to the hospital for a stroke workup. The note documented the resident was sent to a local hospital and a voicemail was left for the resident representative. Review of a nursing progress note dated 04/11/26 at 6:45 P.M. revealed Resident #13 returned to the facility from the hospital in stable condition. Record review failed to reveal evidence Resident #13 or the resident representative was provided written bed-hold information at the time of the hospital transfer. Further review failed to reveal evidence a transfer/discharge notice was provided to the resident or resident representative. Interview with the Administrator on 06/08/26 at 2:34 P.M. confirmed there was no evidence Resident #13 or the resident representative had been provided transfer notice or bed-hold information related to the resident's hospital transfer.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, and facility policy review, the facility failed to ensure resident were provided the opportunity to participate in care plan meetings. This affected two residents (#3 and #43) of three residents reviewed for care plan meetings. The facility census was 67. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 04/18/26 and diagnoses included type II diabetes mellitus, end stage renal disease, acute and chronic respiratory failure with hypoxia, and chronic systolic congestive heart failure. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #3 was cognitively intact. Review of the Care Conference Sheet and Care Plan Review dated 05/15/26 revealed a plan of care meeting was held including the interdisciplinary team and Resident #3's family was noted to teleconference to the meeting. There was no evidence of Resident #3 being invited to or participating in the care conference. Interview on 06/02/26 at 8:43 A.M. with Resident #3 revealed he had not attended or participated in a care plan meeting. Resident #3 stated he thought someone from his family participated but stated he would like to participate as well. Interview on 06/04/26 at 7:58 A.M. with the Administrator confirmed there were no additional care plan meetings with evidence of Resident #3's participation. 2. Review of the medical record for Resident #43 revealed an admission date of 04/22/26 and diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting non-dominant left side, and symptoms and signs involving cognitive functions following cerebral infarction. Review of the MDS admission assessment dated [DATE] revealed Resident #43 was cognitively intact. Review of the Plan of Stay Conference sheet dated 05/21/26 revealed a phone conference was held with Resident #43's daughter, Rehab Director #842, and Social Service Director (SSD) #843 to discuss an insurance cut and the plan for long term care. There was no evidence Resident #43 participated in the meeting. Interview on 06/01/26 at 9:34 A.M. with Resident #43 revealed she had not participated in a care plan meeting since admission. Interview on 06/04/26 at 8:25 A.M. with the Administrator confirmed there were no additional care plan meetings with evidence of Resident #43's participation. Review of the facility policy Care Planning - Interdisciplinary Team dated September 2013 revealed a comprehensive care plan would be developed within seven days of completion of the resident assessment. The resident and/or representatives were encouraged to participate in the development and revision of the care plan. Every effort would be made to schedule care plan meetings at the best time of day for the resident and family.		

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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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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. Based on observation, medical record review and staff interview, the facility failed to ensure admission assessments were completed timely upon admission. This affected one resident (Resident #66) of 26 residents reviewed for assessments. The facility also failed to ensure positioning aide devices were in place as ordered by the physician. This affected one resident (Resident #67) of five residents reviewed for accidents. The facility census was 67. Findings include: 1. Review of Resident #66's closed medical record revealed an admission date of 02/25/26 with diagnoses that included status post spinal surgery, intervertebral disc disease, spinal stenosis and diabetes mellitus. Review of the admission Minimum Data Set (MDS) 3.0 assessment with a reference date of 02/25/26 indicated an admission date of 02/25/26. Further review of the medical record revealed the admission nursing assessment was not completed until 02/26/26 at 5:50 P.M., one day after admission to the facility. Review of the resident's progress notes revealed no evidence of any notation made by medical staff of the resident arriving to the facility to identify the time the resident arrived at the facility. On 06/04/26 at 9:05 A.M., interview with the Director of Nursing (DON) verified the admission assessment was completed on 02/26/26, and not 02/25/26 which was the day the resident was admitted. The DON also verified no progress note was entered to indicate when Resident #66 arrived at the facility. 2. 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 physician's orders revealed on 03/16/26, the resident's physician ordered the use of a lateral support for trunk positioning in the wheelchair. Observation of Resident #67 on 06/02/26 at 9:10 A.M. revealed the resident was seated in a high-back wheelchair in the East unit dining room. The resident was asleep and leaning over the left arm rest of the wheelchair, poorly positioned. Continued observation at 9:18 A.M. revealed Resident #67 woke up and repositioned himself independent to a correct position in the wheelchair. At 9:19 A.M., the resident had again leaned over the wheelchair's left arm rest. Observation of Resident #67 on 06/02/26 at 3:21 P.M. revealed the resident asleep in his bed. The high-back wheelchair was observed in his room. There was no evidence of any left lateral support to the wheelchair observed at this time. On 06/02/26 at 3:55 P.M. observation and interview with the DON verified the left lateral support was not in place to Resident #67's high-back wheelchair as ordered.		

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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 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 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 maintain safe and responsible smoking practices. This affected two Residents (#13 and #24) of 25 sampled residents. The facility census was 67. Findings include: 1. Review of the medical record for Resident #13 revealed an admission date of 04/15/24 and diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type II diabetes mellitus, and bipolar type schizoaffective disorder. Review of a Smoking assessment dated [DATE] revealed Resident #13 had cognitive loss and visual deficits which required Resident #13 to have supervision during smoking. The facility would store Resident #13's lighter and cigarettes. 2. Review of the medical record for Resident #24 revealed an admission date of 03/23/26 and diagnoses including chronic obstructive pulmonary disease, dementia with behavioral disturbance, and essential hypertension. Further review of the medical record revealed Resident #24 was not identified as a smoker. Interview on 06/01/26 at 1:00 P.M. with the Administrator revealed the smoking area was at the back of the facility. The Administrator showed the smoking area which was near the dumpster area with ashtrays. Observation on 06/03/26 at 9:56 A.M. revealed more than 10 cigarette butts on the ground and nearby combustible trash in the courtyard by the 400 hallway. This courtyard was not identified as a smoking area, so no ashtrays nor a metal can were readily available. Interview on 06/03/26 at 9:56 A.M. with Regional Maintenance Director #797 observed and verified the presence of cigarette butts in a non-smoking area. Observation on 06/03/26 at 10:40 A.M. revealed more than 10 cigarette butts on the ground and nearby combustible trash in the courtyard by 100 hallway. This courtyard was not identified as a smoking area, so no ashtrays nor a metal can were readily available. Interview on 06/03/26 at 10:40 A.M. with Regional Maintenance Director #797 observed and verified the presence of cigarette butts in a non-smoking area. Observation on 06/04/26 at 11:34 A.M. revealed Resident #13 and #24 sitting in the courtyard by the 400 hallway. Resident #13 and #24 were observed to have a lit cigarette. There were no staff observed supervising the two residents. It was unclear where the cigarettes or lighter had come from. Interview on 06/04/26 at 11:36 A.M. with Registered Nurse (RN) #799 confirmed Resident #13 and #24 were observed to have a lit cigarette in the 400 hallway courtyard and were unsupervised. RN #799 stated she was unsure of the smoking safety needs of Resident #13 and Resident #24. Review of the undated smoking times provided by the facility revealed staff would assist residents with smoking at 6:00 A.M., 10:00 A.M., 1:00 P.M., 3:00 P.M., 6:00 P.M., and 9:00 P.M. Review of the facility policy Smoking Policy - Residents dated August 2022 revealed smoking was only permitted in designated resident smoking areas. Ashtrays would be available in smoking areas. Any resident with smoking privileges that required monitoring shall have direct supervision of staff or family while smoking. Residents were not permitted to give smoking materials to other residents.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, observation, interview, dialysis contract review, and facility policy review, the facility failed to ensure routine monitoring was completed prior to and following dialysis treatments. Additionally, the facility failed to provide evidence of ongoing communication and collaboration with the dialysis center. This affected one Resident (#3) of one resident reviewed for dialysis treatments. The facility census was 67. Findings include: Review of the medical record for Resident #3 revealed an admission date of 04/18/26 and diagnoses include type II diabetes mellitus, end stage renal disease, and essential hypertension. Review of a progress note dated 04/19/26 revealed Resident #3 had fistula (a surgically created connection between an artery and a vein, typically in the arm used to facilitate hemodialysis treatments) to the right arm with bruit (audible whooshing or humming sound heard when listening to the fistula with a stethoscope) and thrill (palpable vibration or buzzing sensation felt when you place your fingers over the fistula) present. Resident #3 noted to receive hemodialysis. Review of the physician's orders dated 04/19/26 revealed Resident #3 had hemodialysis treatments on Mondays, Wednesdays, and Fridays. Resident #3 had additional orders also dated 04/19/26 to send dialysis communication forms with the resident on dialysis treatment days, to obtain vital signs pre- and post-dialysis on Mondays, Wednesdays, and Fridays, and to monitor the dialysis site [fistula] for bruit and thrill as applicable. Review of the Minimum Data Set (MDS) admission assessment revealed Resident #3 was cognitively intact. Resident #3 received dialysis treatments. Review of the Treatment Administration Record (TAR) for April 2026, May 2026, and June 2026 (through 06/05/26) revealed no evidence the facility had monitored Resident #3's dialysis site for bruit and thrill. There was no evidence of monitoring of Resident #3's vital signs following dialysis treatments on 04/24/26, 04/29/26, 05/04/26, 05/06/26, 05/13/26, 05/18/26, and 05/27/26. Further review of the medical record revealed no evidence of dialysis communication forms were completed or sent with Resident #3 to dialysis treatments. Observation on 06/03/26 at 9:40 A.M. revealed Resident #3 was picked up for his scheduled dialysis treatment. Resident #3 did not have a dialysis communication form with him. Interview on 06/03/26 at 11:01 A.M. with Registered Nurse (RN) #868 revealed Resident #3 went to dialysis treatments. RN #868 stated Resident #3 had a fistula. RN #868 stated she would check over Resident #3 prior to dialysis treatments for blood glucose check and vital signs. RN #868 stated the dialysis center faxed over pre and post treatment pages. RN #868 stated Resident #3 did not have any kind of communication binder or pre- or post-dialysis assessments in the electronic medical record (EMR). Interview on 06/03/26 at 8:07 A.M. with the Director of Nursing (DON) and Regional Quality Assurance Nurse (RQAN) #798 revealed the dialysis center faxed reports to the facility. The DON indicated they normally send a communication form with the resident to dialysis. RQAN #798 indicated dialysis keeps the forms and confirmed she was unable to provide evidence the facility completed communication forms with dialysis. The DON provided a dialysis communication binder for review. The DON was unable to provide evidence of monitoring of bruit and thrill and monitoring of vital signs post-dialysis on 04/24/26, 04/29/26, 05/04/26, 05/06/26, 05/13/26, 05/18/26, and 05/27/26. Interview on 06/04/26 at 8:14 A.M. with Assistant Director of Nursing (ADON) #851 revealed the facility did not send any paperwork with Resident #3 to dialysis. ADON #851 indicated the dialysis center faxed her copies of their reports. Review of the dialysis communication binder revealed there was a copy of the face sheet, a copy of code status, and a copy of current orders. There were also blank copies of a dialysis communication form. There were no forms that had been previously completed. The facility had copies of post dialysis communication forms from the dialysis (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	center.Review of facility policy, End-Stage Renal Disease, Care of a Resident with dated September 2010 revealed an agreement would state how communication would exchange between facilities. Review of the Long-Term Care Facility Outpatient Dialysis Service Coordination Agreement dated 09/11/25 revealed the long-term care facility shall provide interchange of information useful or necessary for care of end stage renal disease (ESRD) residents. Both parties shall ensure there was documented evidence of collaboration of care and communication.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive assessment and informed consent were completed prior to implementing bed rails for one resident (#57). 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 Restraint Enabler Decision Tree dated 05/09/26 identified side rails as an enabler device. Further record review failed to reveal documentation of informed consent or a comprehensive assessment for the resident's side rail use. Observations of Resident #57 conducted throughout the survey period from 06/01/26 through 06/08/26 revealed bilateral half side rails in use while the resident was in bed. The resident was observed utilizing the side rails for repositioning and bed mobility. Interview with the Director of Nursing (DON) on 06/08/26 at 1:00 P.M. confirmed the facility was unable to provide documentation of informed consent for Resident #57's side rail use. The DON further confirmed the facility was unable to provide documentation of a comprehensive assessment for the resident's side rail use.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review and staff interview, the facility failed to ensure residents were not receiving duplicate medication treatment for gastroesophageal reflux disease (GERD). This affected one (Resident #11) of five residents reviewed for medications. The facility census was 67. Findings include: Review of Resident #11's medical record revealed an admission date of 06/12/24 with diagnoses that include GERD, diabetes mellitus, and chronic kidney disease. Further review of the medical record including current physician's orders revealed on 07/16/25 Resident #11 was prescribed Famotidine (an oral medication used to treat GERD) 20 milligrams (mg) twice daily and on 08/21/25 was prescribed Pantoprazole (an oral medication used to treat GERD) 40 mg twice daily. Further review of the medical record including progress notes and physician and nurse practitioner examination notes revealed no evidence of any rationale indicating concurrent use of the two medications used to treat GERD. On 06/04/26 at 9:00 A.M., interview with the Director of Nursing (DON) verified no rationale was indicated for Resident #11 to be treated with duplicate medication therapy with Famotidine and Pantoprazole to treat the resident's GERD.		

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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 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure past survey results were available in a prominent area accessible to residents. This affected twelve residents (#8, #13, #16, #22, #25, #30, #31, #43, #52, #63, #64, and #68) who were in attendance at the Resident Council interview during the annual survey and had the potential to affect all residents of the facility. The facility census was 67. Findings include: Interview on 06/02/26 at 2:00 P.M. with Residents #8, #13, #16, #22, #25, #30, #31, #43, #52, #63, #64, and #68, during the Resident Council interview, revealed each had no knowledge of where the facility's past survey results were kept, nor did any of the residents know if they were available for review without having to request them. Observation on 06/04/26 at 11:34 A.M. revealed a notice measuring approximately eight inches by six inches on the reception desk stating, Past survey results available upon request. Continued observation revealed a small note measuring approximately seven inches by three inches to the left of the main entryway in a display case which stated, Past survey results are available upon request. Observation on 06/04/26 at 11:36 A.M. revealed Resident #8 entered the facility through the main entryway, utilizing a wheelchair for mobility. Further observation revealed the display case containing the notice that past survey results were available upon request was above the resident's eye level. Interview on 06/04/26 at 11:45 A.M. with Resident #8 confirmed the height of the display case at the entrance of facility was too high for residents in wheelchairs to view notices in the display case. Resident #8 stated he had not noticed the posting at the reception desk with information on how to access past survey results. Interview on 06/08/26 at 10:43 A.M. with Receptionist #859 revealed the facility's past survey results were kept in a binder behind the reception desk and residents needed to ask for the binder to review the facility's survey history. Continued interview with Receptionist #859 revealed no residents had requested to view the survey binder. Interview on 06/08/26 at 1:15 P.M. with Activity Director (AD) #852 confirmed the facility's past survey results were located in a binder behind the reception desk and residents had to ask to see the past survey results. AD #852 verified the facility's past survey results were not accessible to residents in any other area.		

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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 0574 Level of Harm - Potential for minimal harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation and interview, the facility failed to ensure a list of advocacy groups, including contact information, was easily accessible to residents in wheelchairs. This affected nine (#8, #13, #16, #22, #25, #43, #52, #64 and #68) of twelve residents who attended the Resident Council interview and utilized wheelchairs for mobility. The facility identified 47 (#1, #2, #3, #4, #7, #8, #9, #10, #11, #12, #13, #16, #18, #22, # 23, #25, #26, #29, #32, #33, #34, #36, #37, #38, #39, #40, #41, #42, #43, #44, #46, #48, #49, #50, #51, #52, #56, #57, #58, #59, #62, #64, #65, #67, #68, #76 and #77) residents who utilized wheelchairs for mobility. The facility census was 67. Findings include: Interview on 06/02/26 at 2:00 P.M. with Residents #8, #13, #16, #22, #25, #30, #31, #43, #52, #63, #64, and #68, during the Resident Council interview, revealed the residents did not know where the list of advocacy groups with contact information was located within the facility. Residents #8, # 13, #16, #22, #25, #43, #52, #64 and #68 utilized wheelchairs for mobility. Observation on 06/04/26 at 11:34 A.M. revealed a display case on the wall to the left of the main door of the facility containing a listing of advocacy groups with contact information. Continued observation revealed a notice, located approximately four to five feet high, on the receptionist's desk with the local Ombudsman's contact information. Observation on 06/04/26 at 11:36 A.M. revealed Resident #8 entered the facility through the main entrance, utilizing his wheelchair for mobility. Further observation revealed the display case containing the list of advocacy groups was above the resident's eye level. Interview on 06/04/26 at 11:45 A.M. with Resident #8 confirmed the height of the display case at the entrance of facility was too high for residents in wheelchairs to view. Resident #8 stated he had not noticed the Ombudsman information at the receptionist's desk. Interview on 06/08/26 at 10:43 A.M. with Receptionist #859 revealed they had some requests for the Ombudsman's contact information and pointed out there was an informational sheet on the desk with contact information. Interview on 06/08/26 at 1:15 P.M. with Activity Director (AD) #852 confirmed the only location for the full list of advocacy groups was located in the display case near the main entrance of the facility and there were no other accessible lists posted in the facility.		