STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2023
NAME OF PROVIDER OR SUPPLIER Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZI 3627 Harvey Avenue Cincinnati, OH 45229	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few			ONFIDENTIALITY** 35770 w and interview the facility failed to lazards were not present resulting in tion medications from an unlocked as of accessing and ingesting the ected one resident (#10) of seven e facility on [DATE] with diagnoses the brain) with COVID-19), attention-deficit evealed the resident was seen per ne evaluation indicated the irment related to judgment and angerous behaviors. Furthermore, to pick her up. The resident le evaluation, the resident nce usage. 4/02/23 for Resident #10, revealed

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

Facility ID: 366150

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Astoria Place of Cincinnati 3627 Harvey Avenue Cincinnati, OH 45229 Cincinnati, OH 45229		
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.	ation on the nursing home's pl	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)	REFIX TAG	
F 0600 Review of a nurse's progress note dated 05/02/23 at approximately 10:30 A.M. for Resident #10, revealed Licensed Practical Nurse (LPN) #132 was notified by STNA # 169 that resident was slow to respond and locked nunsually tired. Resident #10's vital signs were assessed as blood pressure 10/250 (normal 96:00%) or nom are in Nurse Practitione (RP) #400 was notified and provided an order to sead Resident #10 to be the emergency room (ER) for drumal 12:20), and oxygen saturation 89.6 degrees Tahemiet (normal 96:6 degrees) and normal 96:6 degrees) and Resident #10 to be the emergency room (ER) for drumal 12:20), and oxygen saturation 89.6 percent (%) (normal 96:100 %) normal 96:100 %) and some filter and provided an order to sead Resident #10 to the emergency room (ER) for drumal 12:20), and oxygen saturation 89.6 percent (%) (normal 96:6 dogree) medical services (EMS) for a mental status charge. Review of the hospital FE notes dated 05:02/23 at 10:24 A.M., revealed Resident #10 artive at the ER fo overdose. Assessment revealed the resident was from a nursing and apparently took seven Gabapentin (Neurontin) 600 miligram (mg) tablets at 9:00 A.M. Resident #10 artive at the ER fo overdose. Assessment revealed the table and discores grant at the active first percense. Review of the Administrator's witness statement dated 05/02/23, revealed she was walking down the hall of the women's secured unit with Nassistant Director of Nursing (ADON) #120 and LPN #132 was frantic stating Resident #10 to the hospital was from a dispentin, and she was suching Resident #10 to the hospital was for a charge in mental status. Review of a statement dated 05/02/23, revealed she was walking down the hall of the women's secured unit with Nassistant Director of Nursing (ADON) #120 and LPN #132 was frantic stating Resident #10 to the hospital was for a charge in mental status. <td>for actual harm</td>	for actual harm	

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2023
NAME OF PROVIDER OR SUPPLIER Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE 3627 Harvey Avenue Cincinnati, OH 45229	
For information on the nursing home's	plan to correct this deficiency, please cont	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of STNA #169's witness sta , STNA #169 went into Resident #1 person. STNA #169 immediately go #169 and LPN #132 searched the r Resident #10 appeared to be sleep Interview on 05/03/23 at 1:45 P.M. #169 came to her and stated Resid room and Resident #10 gave her th was a package of Gabapentin 600 pills missing. LPN#132 stated Resis she sent Resident #10 to the hospit of the incident with Resident #10, in documented in Resident #10's med A telephone interview on 05/03/23 at on a locked unit due to her lack of s had gotten a hold of some medicatin reported that no medicines should b ingest them. An observation on 05/04/23 at appr revealed the door was being proppi being down the hall with her back th LPN #171 saw the surveyor standin LPN #171 removed the medication #171 at the same time revealed she warm. LPN #171 verified the medic Review of the Medication Storage F that maintained the integrity of the p the Department of Health guideliner room that was accessible only to at Review of the facility policy titled At Policy, dated 11/2016 revealed the misappropriation. The facility would exploitation, mistreatment of a resid unknown source, in accordance wit employees, or facility services prov physical harm, pain, mental anguisl environment that may make neglec with needs and behaviors which mi of neglect in the nurse's notes, resu- representative and any treatment p	atement dated 05/03/23, revealed on 09 0's room to provide care and found pill ot LPN #132 and Resident #10 handed room with residents' consent and did no by and looked impaired. with LPN #132, revealed on 05/02/23 a lent #10 had medications on her person he medicine and told the nurse she tool mg 30 count belonging to another resid dent #10 appeared to be very sleepy, s tal via 911. During the interview, LPN # including the resident accessing and ing lical record. The LPN replied administra at 3:35 P.M. with Medical Director #410 safety awareness and drug seeking/use ions yesterday (05/02/23) and she took be left unlocked or available because F roximately 1:30 P.M. of the secured wo ed open with a locked medication cart y urned to the medication room looking a ng at the medication room door propper ation was unsecured. Policy, dated 04/01/22 revealed medication s. All medications would be stored in a	5/02/23 at approximately 10:00 A.M s (Gabapentin) on the resident's the medication to the nurse. STN/ ot find any other medications. At approximately 10:00 A.M., STNA h. LPN #132 went to the resident's c seven of them. LPN #132 stated dent (#15) and there were seven durring her words, and just off so f132 was asked why the specifics gestion of the medications were no ation told her not to chart about it. 0, reported Resident #10 resided e. Medical Director #410 stated she some. Medical Director #410 Resident #10 would take them and men unit's medication room door while LPN #171 was observed ther personal mobile phone. Whe ushed back to the medication room nd locked. An interview with LPN ed open due to the room being ations would be stored in a manner lents, and was in accordance with locked cabinet, cart of medication propriation Resident Property ict exploitation of its residents or violations involving abuse, neglect, operty including injuries of ect was the failure of the facility, th resident necessary to avoid all do an analysis of the physical care plan and monitor residents's f neglect must be reported

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		IENCIES full regulatory or LSC identifying informati	ion)
F 0689	Ensure that a nursing home area is accidents.	free from accident hazards and provid	les adequate supervision to prever
Level of Harm - Immediate jeopardy to resident health or safety		AVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 35770
Residents Affected - Few	Based on observation, record review, review of the Cincinnati Fire Department (CFD) first responders rereview of an Emergency Medical Services (EMS) report, review of the facility policy regarding elopement interviews, the facility failed to provide adequate supervision to prevent Resident #10, who resided on are had physician orders (dated [DATE]) for placement on the facility's secured behavioral unit due to poor judgment and insight and safety concerns from eloping. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm/death on [DATE] at approximately 9:50 P.M. when Resident #* exited the secured behavioral unit through an alarmed basement door without staff's knowledge. After exited the secured behavioral unit through an alarmed basement door without staff's knowledge. After exited the secured behavioral unit through an alarmed basement door without staff's knowledge. After exited the secured behavioral unit through an alarmed basement door without staff's knowledge. After exited the a motorist discovered the resident. Upon CFD first responders and EMS arrival to the scene they recognized Resident #10 and knew she resided on the facility's secured behavioral unit. EMS took for resident back to the facility on [DATE] at approximately 10:25 P.M.; however, staff were not aware Resider #10 had eloped or how she exited the facility without staff knowledge. Consequently, Resident #10 was transported to the local emergency department (ED) where she was treated for possible injuries from be found in the street and for a psychiatric evaluation. This affected one resident (#10) of the seven resident reviewed for being at risk for elopement. The facility identified 10 residents (#1, #2, #3, #4, #5, #8, #10, # #12, and #13) currently residing in the facility at risk for elopement. The facility census was 63. On [DATE] at 2:57 P.M., the Administrator and Assistant Director of Nursing (ADON) were notified Immediate Jeopardy began on [DATE] at approximately 9:50 P.M. when Reside		
	 into a dimly lit, busy, curvy two-way street when a motorist discovered t they recognized Resident #10 and resident back to the facility on [DAT #10 had eloped or how she exited t transported to the local emergency found in the street and for a psychia reviewed for being at risk for eloper #12, and #13) currently residing in 10 On [DATE] at 2:57 P.M., the Admin Immediate Jeopardy began on [DA behavioral unit through an alarmed found on the ground in the road in a was returned to the facility by EMS 	street where Resident #10 had fallen he resident. Upon CFD first responder knew she resided on the facility's secu [E] at approximately 10:25 P.M.; howe he facility without staff knowledge. Cor department (ED) where she was treat atric evaluation. This affected one resident the facility at risk for elopement. The facility istrator and Assistant Director of Nursi TE] at approximately 9:50 P.M. when F basement door without staff's knowled a dimly lit, busy, curvy two-way street a	across the facility's parking lot and out of her wheelchair and on to the s and EMS arrival to the scene, red behavioral unit. EMS took the ver, staff were not aware Resident nsequently, Resident #10 was ed for possible injuries from being dent (#10) of the seven residents s (#1, #2, #3, #4, #5, #8, #10, #11, acility census was 63. ng (ADON) were notified Resident #10 exited the secured dge. The resident was subsequent area by a motorist. The resident were not aware Resident #10 had
	 into a dimly lit, busy, curvy two-way street when a motorist discovered t they recognized Resident #10 and resident back to the facility on [DAT #10 had eloped or how she exited t transported to the local emergency found in the street and for a psychia reviewed for being at risk for eloper #12, and #13) currently residing in 10 On [DATE] at 2:57 P.M., the Admin Immediate Jeopardy began on [DA behavioral unit through an alarmed found on the ground in the road in a was returned to the facility by EMS eloped or how. Consequently, Resi she was treated for possible injurier. 	street where Resident #10 had fallen he resident. Upon CFD first responder knew she resided on the facility's secu [E] at approximately 10:25 P.M.; howe he facility without staff knowledge. Con department (ED) where she was treate atric evaluation. This affected one reside nent. The facility identified 10 residents the facility at risk for elopement. The fa- istrator and Assistant Director of Nursi TE] at approximately 9:50 P.M. when F basement door without staff's knowled a dimly lit, busy, curvy two-way street a at approximately 10:25 P.M. and staff dent #10 was transported to the local of	across the facility's parking lot and out of her wheelchair and on to the s and EMS arrival to the scene, red behavioral unit. EMS took the ver, staff were not aware Resident insequently, Resident #10 was ed for possible injuries from being dent (#10) of the seven residents s (#1, #2, #3, #4, #5, #8, #10, #11, acility census was 63. ng (ADON) were notified Resident #10 exited the secured dge. The resident was subsequent area by a motorist. The resident were not aware Resident #10 had emergency department (ED) where
	 into a dimly lit, busy, curvy two-way street when a motorist discovered t they recognized Resident #10 and resident back to the facility on [DAT #10 had eloped or how she exited t transported to the local emergency found in the street and for a psychia reviewed for being at risk for eloper #12, and #13) currently residing in the Gon [DATE] at 2:57 P.M., the Admin Immediate Jeopardy began on [DA behavioral unit through an alarmed found on the ground in the road in a was returned to the facility by EMS eloped or how. Consequently, Resi she was treated for possible injuries. The Immediate Jeopardy was removed for the same. In addition, the facility here the same. In addition, the facility here the same at the mutual door codes were at the maintenance Director #151 each time. 	street where Resident #10 had fallen he resident. Upon CFD first responder knew she resided on the facility's secu 'E] at approximately 10:25 P.M.; howe he facility without staff knowledge. Con department (ED) where she was treate atric evaluation. This affected one resident. The facility identified 10 resident: the facility at risk for elopement. The fa- istrator and Assistant Director of Nursi TE] at approximately 9:50 P.M. when F basement door without staff's knowled a dimly lit, busy, curvy two-way street a at approximately 10:25 P.M. and staff dent #10 was transported to the local of s.	across the facility's parking lot and out of her wheelchair and on to the s and EMS arrival to the scene, red behavioral unit. EMS took the ver, staff were not aware Resident nsequently, Resident #10 was ed for possible injuries from being dent (#10) of the seven residents s (#1, #2, #3, #4, #5, #8, #10, #11, acility census was 63. ng (ADON) were notified Resident #10 exited the secured dge. The resident was subsequentl area by a motorist. The resident were not aware Resident #10 had emergency department (ED) where mented the following corrective stairwell codes and no numbers nged, per the elopement policy. to the nursing staff by ce Director #151 would give copies
	 into a dimly lit, busy, curvy two-way street when a motorist discovered t they recognized Resident #10 and resident back to the facility on [DAT #10 had eloped or how she exited t transported to the local emergency found in the street and for a psychia reviewed for being at risk for eloper #12, and #13) currently residing in 10 On [DATE] at 2:57 P.M., the Admin Immediate Jeopardy began on [DA behavioral unit through an alarmed found on the ground in the road in a was returned to the facility by EMS eloped or how. Consequently, Resi she was treated for possible injuries: The Immediate Jeopardy was removed for the same. In addition, the facility here the same. In addition, the facility for the door code to the department on [DATE] at 2:00 P.M., Assistant 	street where Resident #10 had fallen he resident. Upon CFD first responder knew she resided on the facility's secu 'E] at approximately 10:25 P.M.; howe he facility without staff knowledge. Con department (ED) where she was treated atric evaluation. This affected one resid nent. The facility identified 10 resident: the facility at risk for elopement. The fa- istrator and Assistant Director of Nursi TE] at approximately 9:50 P.M. when F basement door without staff's knowled a dimly lit, busy, curvy two-way street a at approximately 10:25 P.M. and staff dent #10 was transported to the local e s. wed on [DATE] when the facility impler #151 changed all doors, elevator, and lity indicated door codes would be cha each secured nurse's station and given ne they would be changed. Maintenan	across the facility's parking lot and out of her wheelchair and on to the s and EMS arrival to the scene, red behavioral unit. EMS took the ver, staff were not aware Resident insequently, Resident #10 was ed for possible injuries from being dent (#10) of the seven residents s (#1, #2, #3, #4, #5, #8, #10, #11, acility census was 63. ng (ADON) were notified Resident #10 exited the secured dge. The resident was subsequentlate area by a motorist. The resident were not aware Resident #10 had emergency department (ED) where stairwell codes and no numbers nged, per the elopement policy. to the nursing staff by ce Director #151 would give copies ged. ewed the care plan, the elopement
	 into a dimly lit, busy, curvy two-way street when a motorist discovered t they recognized Resident #10 and resident back to the facility on [DAT #10 had eloped or how she exited t transported to the local emergency found in the street and for a psychia reviewed for being at risk for eloper #12, and #13) currently residing in 10 On [DATE] at 2:57 P.M., the Admin Immediate Jeopardy began on [DA behavioral unit through an alarmed found on the ground in the road in a was returned to the facility by EMS eloped or how. Consequently, Resi she was treated for possible injuries: The Immediate Jeopardy was removed for the same. In addition, the facility in the door codes were at the door code to the department on [DATE] at 2:00 P.M., Assistant risk assessments, and the physicia On [DATE] at 4:00 P.M., the elope 	street where Resident #10 had fallen he resident. Upon CFD first responder knew she resided on the facility's secu [E] at approximately 10:25 P.M.; howe he facility without staff knowledge. Cor department (ED) where she was treate atric evaluation. This affected one reside nent. The facility identified 10 residents the facility at risk for elopement. The fa- istrator and Assistant Director of Nursi TE] at approximately 9:50 P.M. when F basement door without staff's knowled a dimly lit, busy, curvy two-way street a at approximately 10:25 P.M. and staff dent #10 was transported to the local of s. wed on [DATE] when the facility impler #151 changed all doors, elevator, and lity indicated door codes would be cha ach secured nurse's station and given ne they would be changed. Maintenan heads each time the codes were chan Director or Nursing (ADON) #120 revio	across the facility's parking lot and out of her wheelchair and on to the s and EMS arrival to the scene, red behavioral unit. EMS took the ver, staff were not aware Resident insequently, Resident #10 was ed for possible injuries from being dent (#10) of the seven residents s (#1, #2, #3, #4, #5, #8, #10, #11, acility census was 63. Ing (ADON) were notified Resident #10 exited the secured dge. The resident was subsequentla area by a motorist. The resident were not aware Resident #10 had emergency department (ED) where stairwell codes and no numbers nged, per the elopement policy. In to the nursing staff by ce Director #151 would give copies iged. ewed the care plan, the elopement is were made.

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Astonia Place of Cincinnati		Cincinnati, OH 45229	
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIEN (Each deficiency must be preceded by full			on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	On [DATE] at 5:04 P.M., Regional Registered Nurse (RN) #410 educated the Administrator on the elopement policy, door codes, (including ensuring when employees entered the door codes, it was discreet/confidential and the residents were not around), and not to give codes to residents and/or family members.		
Residents Affected - Few	regarding elopement. Topics includ discreet/confidential and the reside members. Staff educated included: (STNAs), Business Office Manager activities aids, Social Service Desig Data Set (MDS) /Care Plan Coordin Housekeeping Manager #159 and workers. The facility also planned a and 4:00 P.M. for topics including the	esources Director #148 and/or the Adm led ensuring when employees entered nts were not around, and not to give co ADON #120, 17 licensed nurses, 15 S r (BOM) #128, Admissions Director #11 gnee (SSD) #108, Dietary Manager #10 nator #124, Medical Records Clerk #11 eight housekeepers, Maintenance Dire additional mandatory staff education on he facility elopement policy, active shoo ere not able to attend would be in service	the door codes, it was odes to residents and/or family state tested Nursing Assistants 9, Activities Director #180 and two 9 and eight dietary staff, Minimum 3, Receptionist #163, ctor #151 and two maintenance [DATE] at 7:00 A.M., 2:00 P.M. oter, facility key code usage, and
	ADON #120 or designee every 15 r	eginning on [DATE], head counts on al minutes for 48 hours, then beginning or e times a week for four weeks. The find ent (QAPI) weekly.	n [DATE] head counts for all
	On [DATE] at 4:18 A.M. and 10:27 A.M., elopement drills were completed by Maintenance Director #151 and the staff participated with no issues discovered. The missing resident identified in the drill was found within minutes after the drill began.		
	her via telephone regarding the fac codes, it was discreet/confidential, family members. The Staffing Agen	nistrator spoke with the staffing agency ility elopement policy and to ensure wh residents were not around, and not to g icy Supervisor informed the Administra agency staff before they could pick up	en employees entered the door give codes to residents and/or tor this education would be
	Housekeeping #127, Receptionist # on resident elopements and wande	d 9:00 A.M., interviews with SSD #108, #163, Licensed Practical Nurse (LPN) # pring as well as responding to resident a f the content of each education provide	#171, verified they were educated alarms.? All staff members
	station with helpful facility information	ency orientation binder was created by the Administrator and left at each nurse's information, including the above in-services and any future in-services. This municated to the Staffing Agency Supervisor on [DATE] and she would r agency staff immediately.	
	order for all facility residents. The fa	the care plans, the elopement risk ass acility also identified the Immediate Jec nce Improvement (QAPI) plan and wou	pardy action plan would be a
	(continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	 incompetent. Resident #10's father On [DATE], Resident #10 was placed device) could be placed on the residelivered and implemented on [DATE] To monitor on-going compliance, be audits on exit seeking residents thread for four weeks. On [DATE], ADON #120 updated te #11, #12, and #13). On [DATE] review of the medical refacility as elopement risks revealed elopement risk assessments were of appropriate interventions to prevent Although the Immediate Jeopardy wactual harm with potential for more process of implementing their corree Findings Include: Review of the medical record for Refine including schizophrenia, cerebral in epilepsy, and anxiety. Review of Resident #10's plan of cato impaired safety awareness with i patterns of wandering and to monite Review of a psychiatry progress no for a psychiatric evaluation and mewas forgetful but functional, she have episodes of drug seeking behaviors resident attempted to jump out of a the resident presented with sympto 	ced on 1:1 observation until a wanderg dent. The wanderguard was ordered o TE]. beginning on [DATE], the interim Direct ee times a week for four weeks. Findin the elopement risk evaluations for resid ecords for Resident # #4, #5, #6, #7, # no additional concerns related to actu current and accurate, and care plans w t elopement. was removed on [DATE], the deficiency than minimal harm that is not Immedia active action plan and monitoring to ensi- esident #10 revealed an admitted [DAT farction (disrupted blood flow to the br are, dated [DATE] revealed the resident fro	uard device (elopement monitoring in [DATE] and was scheduled to be tor of Nursing (DON) will complete igs to be reviewed in QAPI weekly dents (#01, #02, #03, #04, #05, #08 8, #9, and #10, identified by the al elopements from the facility. The vere initiated and updated with a y remains at a Severity Level 2 (no ate Jeopardy) as the facility is in the sure on-going compliance. TEJ. The resident had a diagnosis ain) with hemiplegia/hemiparesis, nt was at risk for elopement related om wandering, staff to identify 0 was seen per the facility request indicated resident's cognitive statu- and insight and she had ongoing hermore, the note revealed the ck her up. During the evaluation, ance usage. [DATE] for Resident #10, revealed

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A.M. When staff searched the build employee break room. STNA #116 questioned Resident #10 on how si codes to the door and the elevator. night. Review of an elopement risk evaluation	DATE] revealed Resident #10 left the s ling, the resident was found on the low brought Resident #10 back to the sec he got down to the basement, the resic Resident #10 was placed on every 15 ation, dated [DATE] completed by ADC ent risk. Further review of Resident #10	er level (basement) in the ured unit. When the on-duty nurse lent replied that she knew the -minute checks throughout the NN #120, revealed Resident #10
	coming out of another resident's ro Resident #10. Resident #10 had be pedestrian who called 911 out of co by STNA #107 who was assigned to	[DATE] at 10:48 P.M. completed by LF om when STNA #116 alerted her that t een outside the building trying to cross oncern. The note revealed Resident #1 to the secured unit. Resident #10 state e medications, and LPN #117 did not so t.	he fire department was outside wit the street when she was seen by a 0 was last seen in the dining area d she was going to bed since she
	#32) was dispatched to the area of The CFD first responders arrived o #10) in a wheelchair, seated on the the street.? Resident #10 had no m under the care of a behavioral psyc back to the nursing home when the responsive to painful stimuli of a ste #10 got out of the facility. Resident	rtment (CFD) report, dated [DATE], rev [NAME] Avenue at 10:17 P.M. for a pe n the scene at 10:21 P.M. and found a sidewalk with bystanders stating they iedical complaints, she was a resident chiatrist locked down unit on the second resident began acting to be unrespon- ernal rub. The nursing home staff state #10 was transported to the ER for an e or medical history of a stroke from drug	erson who was found in the street. person (later identified as Resider found the person in the middle of at Astoria Place Nursing Home, d floor. Resident #10 was wheeled sive. However, the resident was d they did not know how Resident evaluation due to patients' known
	10:27 P.M. EMS arrived on scene a rehabilitation facility and refused to Resident #10 faked sleeping when and wanted someone to drive her t street as she had deficits from a pro-	ATE], revealed EMS was dispatched to at 10:31 P.M. and found Resident #10 go back in Resident #10 stated she wa questioned by the police.?Resident #10 o her boyfriend's home. Resident #10 evious stroke and a broken hip. Reside orted to a local emergency room for ev the emergency room.	acting erratic, outside her anted to go see her boyfriend. 0 stated she got out of the facility was noted to be in the middle of th ent #10 vital signs were normal, sh
	secured unit's dining room with other that a staff member had brought in	n STNA #107, dated [DATE], revealed er residents including Resident #10 go for the residents. STNA #107 was talki orted she did not hear any alarms go o	ing through and giving out clothes ing to Resident #10 between 9:30
	(continued on next page)		

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366150 B. Wing 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Astoria Place of Cincinnati 3627 Harvey Avenue Cincinnati, OH 45229 Cincinnati, OH 45229 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
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 F 0689 Review of a progress note dated [DATE] at approximately 10:00 A.M. and authored by LPN #132 revealed this nurse was notified by the on-call manager that Resident #10 had an elopement attempt and questioned safety Resident health or safety Residents Affected - Few Resident #10 for continued close observation. After a unit sweep, Resident #10 was including in anothe resident's close with the door closed. Resident #10 was immediately sasginged to have a 1:1 aide and the oncall manager was called and made aware of events. The activities ad was publied to the unit to b 1:1 with Resident #10 for continued close observation. After a unit sweep, Resident #10 was in the dining room on [DATE] at units own in the staff would just say the codes aloud and in front of the residents. Interview (DATE] at 12:22 P.M. with LPN #117, revealed Resident #10 was in the dining room on [DATE] at units was one of the fire frame when Resident #10 was in the dining room on [DATE] at units was required to immediately change all the kay codes on the doors. Starwells, and i every time there was an elopement, he was required to immediately change all the kay codes on the doors. Maintenance Director #151, revealed every time there was an elopement, he was required to immediately change all the kay codes on the doors. Maintenance Director #151, revealed Resident #10 was in the facility. LPN #117 stated she was not preventing the codes was not aware Resident #10 was in the facility. LPN #117 stated she was not aware frequent fr	Level of Harm - Immediate jeopardy to resident health or safety	 mmediate if Resident #10 was on 1:1 observ 15-minute checks and the unit was the nurse was performing medicat care. The on-call manager informe LPN #132 went to inform the unit service is closet with the door close on-call manager was called and m Resident #10 for continued close of resident's closet with the door close on-call manager was called and m Resident #10 for the remainder of Interview on [DATE] at 7:03 A.M. we entered the numbers and often tim Interview [DATE] at 12:22 P.M. with unknown time going through clother going to bed and the next thing she into facility. LPN #117 stated she was not sure of the time frame wh because she had given the resider. Interview on [DATE] at approximation was an elopement, he was require elevators. Maintenance Director # for most of the night changing the stated when he changed the code were able to get in and around the #10 had gotten off the secured unit On [DATE] at 2:30 P.M. observation #10 had gotten off the secured unit on going to be on a locked unit busuffered, and she made bad judgm nursing homes because of her bel resident had eloped on [DATE] but Interview on [DATE] at 7:40 AM w comment on Resident #10's comp 	all manager that Resident #10 had an e ation. LPN #132 informed the on-call ma is staffed with two STNAs and one nurse ion administration, and the other aide we de LPN #132 that Resident #10 was to b staff about Resident #10's 1:1 observation observation. After a unit sweep, Resider red. Resident #10 was immediately assi- ade aware of events. The activities aid we the shift. with SSD #108, revealed the door pass of the shift. with SSD #108, revealed the door pass of the shift. with SSD #108, revealed Resident #10 wa es the staff would just say the codes and the LPN #117, revealed Resident #10 wa es that were brought in for residents who e knew, the fire department was at the of was not aware Resident #10 was out of en Resident #10 was in the dining room in ther nighttime medications. Tely 1:00 P.M. with Maintenance Directo d to immediately change all the key cood 151 stated he was in the facility after Re codes to all the doors, stairwells, and el s, he had to send out an all-staff alert as building. Maintenance Director #151 st t on [DATE]. on of the facility's video footage from [D/ seen propelling into the parking lot from teeled through the parking lot and onto en she went around the facility's van pa <i>M</i> . revealed EMS were at the door with F at Resident #10's power-of-attorney (fai ecause she had brain damage to the from nents and bad decisions. He stated the for aviors and none of them wanted to kee t stated he does not always get his calls with Interim Nurse Practitioner (NP #400)	Alopement attempt and questioned anager, Resident #10 was on every e. One aide was giving a shower, as on the floor providing resident be always in sight of staff. When on, the unit staff went to get at #10 was found hiding in another gned to have a 1:1 aide and the was pulled to the unit to be 1:1 with codes were not hidden when staff oud and in front of the residents. us in the dining room on [DATE] at en the resident stated she was door bringing Resident #10 back the facility. LPN #117 stated she , but stated it was after 9:00 P.M. r #151, revealed every time there des on the doors, stairwells, and the esident #10's elopement on [DATE] evator. Maintenance Director #151 is to what the codes were, so they ated he was not aware Resident ATE] with Maintenance Director an exterior ramp on the north side the sidewalk where the resident rked in the lot. The ambulance Resident #10. ther) revealed the resident was intal lobe from a stroke she resident had been in multiple other p her. He was unaware the s when he has no service. , revealed she was unable to

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	 camera times were showing 7:49 A that the camera times were off by 3 Interview on [DATE] at 9:48 A.M. w was not going to say who it was. R when she was crossing the street, wheelchair which led her to getting wheelchair and almost got hit by tw called 911. Resident #10 could not expletives. Interview on [DATE] at 3:35 P.M. w choices which were dangerous for should be on a secured unit. On [DATE] at approximately 3:30 F thorough assessment of Resident #10. Review of the Statement of Expert incompetent due to poor judgement Review of the Elopement Prevention to create an environment that was included to develop a plan of action resident was reported missing. This deficiency represents non-comment that was reported missing. 	mes on [DATE] at 8:15 A.M. with Main M and the real time was 8:15 AM. Main S minutes. With Resident #10, revealed someone g esident #10 stated on [DATE], she was a bra that she had on her lap got caugh stuck in the middle of the road. Reside to cars when a third car noticed her, sto focus on the interview and kept looking with Medical Director (MD) #410 reporte her safety due to her brain injuries. MD P.M., an interview with the Administrato #10's cognitive status, so she was going Evaluation dated [DATE] by Physician t and insight and guardianship should the on and Missing Resident Policy dated [I as safe as possible for residents at risk in that would ensure a prompt, effective, mpliance investigated under Complaint compliance from the surveys dated [D/	At the pass codes, but she is trying to get a ride to Colerain and the tim the front wheel of her ent #10 stated she fell out of the opped, and the guy got out and g at the ground and yelling and Resident #10 makes very bad 0 #410 indicated Resident #10 r revealed she did not do a g to have an expert evaluation #181, revealed Resident #10 was be granted. DATE] revealed the policy indicated if or elopement. The policy also and coordinated response when a Number OH000142443. This	

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F 0727	Have a registered nurse on duty 8 a full time basis.	hours a day; and select a registered n	urse to be the director of nurses on
Level of Harm - Minimal harm or potential for actual harm	35770		
Residents Affected - Many		terviews, the facility failed to designate n a full-time basis. This had the potenti	
	Findings include:		
	for the name of the Director of Nurs	on 05/02/23 at 7:30 A.M., Social Servic sing (DON). SSD #108 replied the facili ed out of the building about a week ag	ity did not currently have a DON;
	another facility) revealed the forme	tely 12:00 P.M. with Administrator #20 r DON had been terminated on 04/27/2 cility was in the process of hiring a nev	23 because they were not jiving.
	Observations of the facility on 05/0	2/23, 05/03/23, and 05/04/23 revealed	no DON present in the facility.
		t 12:19 P.M. with Receptionist #163, re the facility did have an Assistant Direct	
	A telephone interview on 05/11/23 at 9:47 A.M. with the Administrator verified there was no DON present the week of 05/01/23 through 05/07/23. The Administrator noted the new DON was hired and started on 05/08/23.		
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used professional principles; and all drug locked, compartments for controlled 35770 Based on observations, staff intervi cart on the first floor 100-unit with m times. This had the potential to affe identified as being independently m Findings Include: An observation on 05/02/23 at 7:55 unattended, unlocked with resident An interview on 05/02/23 at 7:57 A. was unlocked, unattended and with medication cart. LPN #141 stated s applesauce and pudding from the k Review of the Medication Storage F that maintained the integrity of the	in the facility are labeled in accordance is and biologicals must be stored in loc d drugs. Hews and review of facility policy, the facture of the facility policy, the facture of the facility policy, the facture of the facility census was 63. A.M. revealed a medication cart on the swalking around in the hallway and no M. with Licensed Practical Nurse (LPN independently mobile residents in the he forgot to lock the medication cart with the fact of the medication cart with the fact of the medication cart with the fact of the fact	e with currently accepted sked compartments, separately acility failed to ensure a medication de, was properly secured at all a, #22, #21 and #20) who the facility e 100 unit on first floor was left o nurse in sight. I) #141, verified the medication cart area at risk of accessing the hen she left the floor to get some ations would be stored in a manner dents, and was in accordance with

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	 corrective plans of action. 35770 Based on record review, staff intervelopement, and review of the facility Performance Improvement (QAPI) i comprehensive and effective plan of potential affect all 63 residents who Findings include: Review of the facility survey history with resident elopement was identific committee meetings to review the of compliance was achieved. During the survey completed on 05 elopement (involving Resident #10) survey. Interview on 05/02/23 at approximative was an elopement, he was required elevators. Maintenance Director #1 04/19/23 for most of the night change Director #151 stated when he change was not aware Resident #10 had all Interview on 05/03/23 at 9:48 A.M. was not going to say who it was. Reand when she was crossing the strew wheelchair which led her to getting wheelchair and almost got hit by two called 911. Resident #10 could not expletives. 	ent and assurance group to review quartiews, physician interview, review of the y's prior surveys documentation regard plans, the facility failed to develop, implifaction was in place to correct identifier resided in the facility. revealed during the complaint survey ied and cited at F689 as an Immediate on plan for the 03/07/23 survey reveale leficiencies, create plans and review at /11/23 ongoing concerns related to rest were identified. An Immediate Jeopart tely 1:00 P.M. with Maintenance Direct to immediately change all the key cost were identified. An Immediate Jeopart tely 1:00 P.M. with Maintenance Direct to immediately change all the key cost of the codes to all the doors, stairwe ged the codes to all the doors, stairwe ged the codes to all the doors, stairwe and around the building. However, Maint so gotten off the secured unit on 04/12 with Resident #10, revealed someone esident #10 stated on 04/19/23, she was est, a bra that she had on her lap got c stuck in the middle of the road. Reside o cars when a third car noticed her, sto focus on the interview and kept looking with Medical Director (MD) #410 reported to her safety due to her brain injuries. MD	e facility policy regarding ling Quality Assurance and obernent, and ensure a ed quality deficiencies. This had the completed on 03/07/23 a concern e Jeopardy. ed the facility would hold QAPI udits to ensure 100 percent sident safety/supervision and dy at F689 was issued during this tor #151, revealed every time there des on the doors, stairwells, and the esident #10's elopement on all-staff alert as to what the codes tenance Director #151 stated he 2/23. gave her the pass codes, but she as trying to get a ride to Colerain raught in the front wheel of her ent #10 stated she fell out of the opped, and the guy got out and g at the ground and yelling ted Resident #10 makes very bad

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