STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366150	A. Building B. Wing	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Cincinnati	3627 Harvey Avenue 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 39703 Based on medical record review, observation, resident interview, staff interview, review of the facility's timeline, review of staff statements, review of the facility's incident log, review of information from MapQuest, review of a weather report, review of facility investigative files, and review of a facility policy, the facility failed to complete thorough investigations following resident elopements to potentially prevent additional elopements. Additionally, the facility failed to update residents' elopement assessments and care plans following elopements. Lastly, the facility failed to identify like-residents at risk for elopement to ensure appropriate interventions were in place to potentially prevent future elopements. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries and/or death on [DATE] at approximately 10:45 P.M. when Resident #59 exited the facility's secured, all-female unit on the second floor via an alarmed door which led to a stairwell and exited the building through an exterior door. Resident #59 was found by staff the following morning sitting on a bench approximately 4.7 miles away from the facility. The Immediate Jeopardy continued when Resident #41 exited the secured, all-male unit on the second floor of the facility, without staff knowledge, on [DATE] at approximately 12:01 A.M. and was returned to the facility by police on [DATE] at approximately 1:45 A.M. Resident #41 left the faciity on [DATE] and walked approximately 1.8 miles from the facility and was found by police wandering near a local hospital. The facility failed to follow their elopement policy and did not review and update Resident #41's elopement risk assessment and care plan to prevent recurrence. This affected two (Residents #41 and #59) of three residents reviewed for elopements. The facility census was 69. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:30 P.M., the Administrator was notified Immediate Jeopardy began on [DATE] at 10:45 P.M. when Resident #59 eloped from the facility and was not found until the following morning. Resident #59 was found by the Director of Nursing (DON) sitting on a bench at a busy intersection 4.7 miles away from the facility. Resident #59 complained she was cold but refused to have her body temperature taken and refused evaluation at the hospital. Temperature in the area in which the facility was situated for [DATE] in the late-night hours was approximately 28 degrees Fahrenheit (F) with a wind chill of 25 degrees F. Upon Resident #59's return to the facility, the facility did not conduct a re-assessment of her elopement risk nor did they update her elopement risk care plan to prevent recurrence. Additionally, the facility did not identify like-residents to ensure appropriate interventions were in place to potentially prevent future elopements. The Immediate Jeopardy continued when Resident #41 left the facility without staff knowledge and was found wandering outside a hospital 1.8 miles away from the facility. Temperature in the area in which the facility was situated for [DATE] in the late-night hours was approximately 39 degrees F with a wind chill of 34 degrees F. The facility did not conduct a physical assessment of Resident #59 when he was returned to the facility by the police. Upon Resident #41's return to the facility, the facility did not conduct a reassessment of his elopement risk, nor did they update his elopement risk care plan to prevent recurrence. Additionally, the facility did not identify like-residents to ensure appropriate interventions were in place to potentially prevent future elopements. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], the DON identified nine residents in the facility at risk for elopement and completed updated elopement risk assessments. On [DATE], Minimum Data Set Nurse (MDSN) #295 updated all care plans for residents at risk for elopement. On [DATE], Maintenance Director (MD) #515 did a physical audit of all alarmed and coded doors and ensured they were functioning properly. MD #515 also changed the elevator code. On [DATE] at 6:15 P.M., all department heads were assigned continuous 4-hour supervisory shifts over the weekend, including the night shift. The supervising staff observed to ensure staff responded to alarms appropriately and were conducting 15-minute checks on all units throughout the weekend until [DATE]. On [DATE] at 6:30 P.M., the DON and Administrator began conducting in-person in-servicing of dayshift and nightshift staff addressing the elopement policy, specifically how to respond to elopement situations. Staff education concluded on [DATE]. On [DATE] at 7:00 P.M., clinical staff completed rounding and 15-minute checks on all residents with all residents present in the facility. The clinical staff will continue every 15-minute checks on all residents until [DATE]. On [DATE], elopement drills were completed by the Administrator on all three shifts. Elopement drills are to continue once per month for four months. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviews on [DATE] at 11:53 A.M. with Floor Tech (FT) #520, at 11:55 A.M. with State tested Nurse Aide (STNA) #400 and at 11:57 A.M. with Human Resources Director (HRD) #525 confirmed they received education and were knowledgeable regarding the importance of responding immediately to door alarms and the importance of following the facility elopement policy. Medical record review on [DATE] for Residents #59, #41, #44, #58, and #62 identified as elopement risk revealed their care plans and elopement risk assessments were updated. On [DATE], the DON and/or Administrator will complete audits to determine staff knowledge of the facility's elopement procedures to continue twice per week for four weeks. On [DATE], the facility's Quality Assurance and Performance Improvement (QAPI) committee will meet to review the elopements and the facility's abatement plan to determine the need for further monitoring. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including schizoaffective disorder bipolar type, psychosis, paranoid schizophrenia, major depressive disorder, anxiety disorder, and diabetes mellitus (DM). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively impaired and required supervision and physical assistance of one staff with activities of daily living (ADLs). Review of the most recent elopement risk assessment dated [DATE] revealed Resident #59 was at risk for elopement. Further review of the medical record revealed no additional elopement assessments were completed. Review of the elopement care plan for Resident #59, last updated [DATE], revealed the resident had a behavior problem which included repeated attempts to elope from the facility, laughs repeatedly without cause or reason, makes up fictitious stories about her children, asks repeatedly about her upcoming discharge, and will say she needs to leave immediately to go home and get her kids. Interventions included the following: 15 minute checks for 24 hours ([DATE]), administer medications as ordered and monitor for effectiveness, anticipate and meet the resident's needs, caregivers to provide positive interaction, stop and talk with the resident when passing by, medication review ([DATE]), monitor behavior episodes and attempt to determine the underlying cause, and provide a program of activities that is of interest and accommodates resident's status. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nurse progress note dated [DATE] at 9:30 A.M. revealed Resident #59 returned to the facility escorted by staff. Medications were administered as ordered and the resident was observed to have random verbal outbursts. Resident #59 denied pain but complained of being cold and was offered blankets. Vital signs were within normal limits, but the resident refused to have her temperature taken. The resident was to be transferred to the hospital for an evaluation. Further review of the progress note revealed no details about how the resident eloped from the facility. Review of the nurse progress note dated [DATE] revealed Resident #59 was evaluated by Nurse Practitioner (NP) #600 due to her elopement from the facility during the night of [DATE] and not returning until the morning on [DATE]. The resident denied pain and was receiving one-on-one (1:1) supervision at the time of the visit. Review of a timeline provided by the facility revealed on [DATE] at 10:30 P.M., Resident #59 was observed in the hallway of the secured all-female behavioral unit on the second floor of the facility, and Licensed Practical Nurse (LPN) #465 directed the resident to go to her room to get some rest. At 10:45 P.M., the coded and alarmed door adjacent to Resident #59's room was noted to alarm. Resident #59's room was immediately searched without success. Staff searched all rooms on the unit and a resident headcount was completed noting Resident #59 was not present. At 10:50 P.M., all units were alerted that Resident #59 was not on the unit and the DON was notified via telephone that Resident #59 could not be located. Police were contacted by LPN #245. Direct care staff conducted a search of the facility and a resident headcount of all residents. At 11:00 P.M., LPN #465 was instructed to participate in an outside facility grounds search including the rear of the building and parking lot without success. At 11:05 P.M., Resident #59's physician and responsible party were contacted and notified of the resident's elopement. Management staff arrived at the facility along with emergency services personnel. At 11:10 P.M., management staff were instructed to drive their vehicles within the closely connected neighborhoods to look for Resident #59. On [DATE] at 8:30 A.M., management personnel arrived at the facility and the search recommenced. At 10:00 A.M., the resident was located. Resident #59 declined to go the hospital for an evaluation. Review of the in-service provided to staff dated [DATE] revealed, 'should an exit alarm sound, staff shall immediately respond and determine the cause of the alarm. If no reason can be found, the Supervisor shall be notified, and an account of all residents identified to be at risk for elopement shall be performed.' Review of agency STNA #545's statement dated [DATE] revealed the aide was in the hallway when an alarm went off, and she checked the door by the nurses' station and the television room. STNA #545 then asked where it was coming from and was told it was the back door by the elevator. STNA #545 went to turn off the alarm and while doing so, noticed Resident #59 was not on the unit. Review of STNA #225's statement dated [DATE] revealed she was notified Resident #59 was missing. She and LPN #240 went looking in all the rooms for Resident #59 and did not find her. Review of agency STNA #545's added statement dated [DATE] revealed on the night of Resident #59's elopement, she, and another (undisclosed) aide went to the door at the back of the hallway (where the resident had left from). The aide turned off the alarm and they checked the stairways and hallway rooms, and another aide went outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations on [DATE] during initial tour of the facility with MD #515 revealed the facility's secured doors were in working order and alarmed appropriately, including the door Resident #59 exited through. Observation on [DATE] at 1:19 P.M. of Resident #59 revealed the resident was ambulating in the hallway on the women's secured unit on the second floor of the facility. Interview on [DATE] at 1:19 P.M. with Resident #59 revealed the resident was confused but stated, I want to get out of here. Interview on [DATE] at 1:30 P.M. with the Administrator and the DON confirmed Resident #59 eloped from the facility on [DATE] at approximately 10:45 P.M. Interview confirmed the resident's record did not include a description of the elopement. STNA #545 heard a door alarm on the women's secured behavioral unit located on the second floor. Interview confirmed the staff statements did not say how long it took STNA #545 to respond to the alarm, nor did the statements or facility timeline indicate the area outside the facility was searched until [DATE] at 11:00 P.M., approximately fifteen minutes after the alarm had sounded. Interview further confirmed STNA #545 checked the stairwell, and no one saw Resident #59 leave the facility. Staff did a headcount and determined Resident #59 was missing. The Police, DON, and Administrator were notified of the missing resident, and other management staff came in to assist with the search. Staff searched nearby neighborhoods in their vehicles but did not find the resident. Staff notified the resident's family the resident was missing. On [DATE] at 8:30 A.M. staff resumed the search. The DON found Resident #59 at approximately 9:30 A.M. downtown sitting on a bench at a busy intersection approximately 4.5 miles away from the facility. Interview confirmed the facility had not updated Resident #59's elopement risk assessment or care plan following the elopement. Additionally, the facility did not review other residents in the facility who were at risk for elopement. Interview on [DATE] at 10:33 A.M. with the Administrator and DON confirmed they had no other statements regarding Resident #59's elopement besides the ones provided. The Administrator confirmed STNA #545 was employed with an agency at the time of Resident #59's elopement. They learned she is no longer employed with the agency, but they were able to reach her again on [DATE] to question her. A phone interview with STNA #545 was attempted on [DATE] at 11:34 A.M. STNA #545 answered the phone and confirmed her identity but when the surveyor explained the reason for the call, STNA #545 hung up the phone. A second attempt was made to interview STNA #545 on [DATE] at 11:35 A.M. but was unsuccessful. A phone interview with STNA #225 was attempted on [DATE] at 11:46 A.M. and 5:16 P.M. but was unsuccessful. Phone interview on [DATE] at 3:47 P.M. with STNA #545 revealed she worked the night Resident #59 eloped. STNA #545 reported she was in another resident's room when she heard an alarm. STNA #545 stated she responded to the alarm, and herself and an unidentified aide looked up and down the floor and had not seen anyone leave. STNA #545 went down the stairs and did not see anyone. STNA #545 verified she did not go outside. When asked how staff figured out which resident was missing, STNA #545 reported a headcount was completed, and once it was discovered Resident #59 was missing, then staff went outside to look. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Phone interview on [DATE] at 4:09 P.M. with LPN #245 revealed he helped search for Resident #59, but he was not working on her floor. LPN #245 reported he did not see the resident leave, but he did call the police to report the missing resident. Review of an online map per the website MapQuest, revealed the intersection where Resident #59 was located on [DATE] was 4.7 miles from the facility. Review of the online weather resource at https://world-weather.info/forecast/usa/cincinnati/08-january/ revealed the air temperature was 28 degrees F, and the wind chill was 25 degrees F for the night of [DATE] for the city in which the facility was situated. 2) Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including schizoaffective disorder bipolar type, dementia with behavioral disturbance, DM, and hypertension (HTN). Review of the MDS assessment dated [DATE] revealed Resident #41 was cognitively impaired and required supervision with ADLs. Review of the most recent elopement risk assessment completed for Resident #41, prior to this survey, was dated [DATE] and revealed the resident was at risk for elopement. Review of the elopement care plan for Resident #41, last updated [DATE], revealed the resident was at risk for elopement. Interventions included: apply Wanderguard (bracelet device used to alert staff if a resident exits an alarmed door to prevent elopement); monitor function and placement, monitor exit seeking behavior, provide structured activities, toileting, walking inside and outside, and re-orientation strategies including signs, pictures and memory boxes. Review of the facility incident log dated [DATE] to [DATE] revealed Resident #41 had an elopement on [DATE]. Review of nurse's progress notes dated [DATE] at 6:48 P.M. revealed the nurse questioned Resident #41 about his elopement from the facility, and the resident indicated he had learned the elevator code and exited the facility via the coded and alarmed elevator on the all-male secured behavioral unit on the second floor of the facility. Further review of progress notes revealed no additional documentation regarding the resident's elopement or the resident's condition following the elopement. Review of a timeline provided by the facility dated [DATE] revealed at 12:00 A.M., Resident #41 was noted to be sitting in his doorway in his wheelchair by the aide. At 1:45 A.M., the resident was returned to the facility by the police. The resident was placed on 1:1 supervision for 72 hours. Review of agency STNA #550's statement dated [DATE] revealed the aide observed Resident #41 lying in bed on [DATE] at approximately 12:00 A.M. Review of LPN #240's statement dated [DATE] revealed the nurse last observed Resident #41 up in his wheelchair on [DATE] at approximately 12:00 A.M. Further review of the statement revealed the police brought the resident back to the facility at 1:45 A.M. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations on [DATE] during initial tour of the facility with Maintenance Director #515 revealed the facility's secured doors were in working order and alarmed appropriately. Observation on [DATE] at 1:05 P.M. of Resident #41 revealed the resident was seated in his wheelchair on the first floor (off the secured unit) and was getting ready to go outside with staff for a supervised smoke break. Interview on [DATE] at 1:05 P.M. with Resident #41 revealed he wanted to go home. Interview on [DATE] at 1:30 P.M. with the Administrator and the DON confirmed Resident #41 eloped from the facility without staff knowledge on [DATE] and was brought back to the facility by local police. Interview confirmed STNA #550, and LPN #240 were the staff on the all-male secured behavioral unit on the second floor of the facility. Police said resident was found at a nearby hospital about 1.5 miles away from the facility. Interview confirmed there was no documentation in the resident's medical record regarding the elopement. Additionally, there was no assessment of the resident following his return by the police regarding possible injuries. Resident #41's elopement risk assessment and elopement risk care plan were not updated following the elopement, and the facility did not review other residents at risk for elopement. The Administrator confirmed Resident #41's care plan listed placement of a Wanderguard bracelet as an intervention, but the facility did not have a Wanderguard system. Interview on [DATE] at 10:03 A.M. with the Administrator and the DON confirmed they interviewed LPN #240 again on [DATE] and he confirmed when Resident #41 was brought back to the facility by police, the resident was on foot and had not taken his wheelchair. A phone interview with LPN #240 was attempted on [DATE] at 11:36 A.M. and 5:17 P.M. but was unsuccessful. Phone interview on [DATE] at 4:09 P.M. with LPN #245 revealed he was Resident #41's nurse the night of the elopement. LPN #245 reported Resident #41 was sitting in a regular chair outside of his room the last time he saw the resident (not a wheelchair as described in the facility's timeline). LPN #245 reported Resident #41 did not use a wheelchair. LPN #245 further verified he had no idea Resident #41 was gone. LPN #245 suspects the resident learned the code for the elevator and eloped through the smoking area because the smoke door did not shut all the way. LPN #245 reported 'everyone' was aware the smoke patio door did not shut all the time and it could just be pushed open sometimes. Review of an online map per the website MapQuest, revealed the hospital where Resident #41 was found by police on [DATE] was 1.8 miles from the facility. Review of the online weather resource at https://world-weather.info/forecast/usa/cincinnati/10-february/ revealed the air temperature was 39 degrees F and the wind chill was 34 degrees F for the night of [DATE] for the city in which the facility was situated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Elopement Prevention and Missing Resident, dated [DATE] revealed the facility will ensure the environment is as safe as possible for residents at risk for elopement and develop a plan of action that will ensure a prompt, effective, and coordinated response when a resident is reported missing. Upon admission, re-admission, or the development of elopement behaviors, all residents will be assessed for elopement risk. A comprehensive elopement prevention plan of care will be developed for each resident identified as at risk for elopement. Should an exit alarm sound, staff shall immediately respond and determine the cause of the alarm. Should an elopement occur, the facility's QAPI Committee should review the facility's systems, policies, procedures, and responses to elopements to evaluate all systems. Should a resident attempt to elope, a review of the resident's care plan shall be conducted for possible adjustments in care practices or safety precautions. This deficiency represents non-compliance investigated under Complaint Number OH00140432.