

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 04/12/2023
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 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)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on record review, interviews, and policy review, the facility failed to ensure residents had access to funds on the weekends. This affected one (Resident #55) and had the potential to affect 51 residents with resident funds accounts handled by the facility. The census was 64.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #55 revealed an admitted [DATE]. Diagnoses included schizophrenia, chronic obstructive pulmonary disease, major depressive disorder, type two diabetes mellitus, acute kidney failure, and heart failure.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require supervision with transfers, dressing, eating, toileting, and bathing.</p> <p>Review of the quarterly statement for Resident #55 revealed funds were not available on the weekends for resident access.</p> <p>Interview on 04/06/23 at 12:41 P.M. with Resident #55 revealed he was unable to get money on the weekends because there was no receptionist working in the building.</p> <p>Interview on 04/06/23 at 12:17 P.M. with Receptionist #350 revealed she provided money to the residents. Receptionist #350 explained she worked Monday through Friday, and funds were available to residents on those days. Receptionist #350 stated resident did not have access to their funds on the weekends.</p> <p>Interview on 04/06/23 at 3:10 P.M. with Business Office Manager (BOM) #465 revealed resident funds were available when the receptionist was at the facility Monday through Friday. BOM #465 stated as of right now, residents did not have access to their funds on the weekends. BOM #465 verified residents should have access to funds like regular banking hours including the weekend.</p> <p>Review of a facility provided list of residents with resident fund accounts revealed there were 51 residents who had resident fund accounts through the facility, indicating 51 residents did not have access to their funds on the weekends.</p> <p>(continued on next page)</p>

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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Resident Trust Policy, dated 04/01/22 revealed each of the residents had the right to manage his or her financial affairs. Residents shall have access to petty cash on an ongoing basis and be able to arrange for access to larger funds.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00141639.</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>42731</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure residents had access to outside communication via the telephone. This had the potential to affect all 21 residents residing on the facility's women's locked unit (400-hall). The facility census was 64.</p> <p>Findings include:</p> <p>Interview on 04/03/23 at 12:38 P.M., the Administrator denied knowledge of any current problems with the facility phones. The Administrator stated the receptionist works Monday through Friday from 8:00 A.M. to 4:30 P.M. The Administrator stated the nurses did not carry cordless phones, so if they are not in the nurses' station (passing medications, doing treatments, for example), they will not answer the phone. The Administrator stated, outside of the receptionist's normal hours, families are instructed to call the facility's main number and go through the prompts to reach the desired unit or department. The Administrator stated, when she calls, she is able to get through. The Administrator further stated families are told they can select the option for Administration and leave her a voicemail. The Administrator denied knowledge of any family members complaining of not being able to get through on the phones.</p> <p>Interview on 04/03/23 at 1:36 P.M., Licensed Practical Nurse (LPN) #310 stated about a month ago, Resident #70 tore up the nurses' station on the 400 hall and the phone was briefly not working then. LPN #310 stated on the 400-hall, the receptionist calls the nurse's cell phone to give messages. LPN #310 reported at night, when the receptionist is gone, the phones ring to the nurses station. LPN #310 stated she did not think all callers knew how to use the system.</p> <p>Interview on 04/03/23 at 2:30 P.M., LPN #355 stated the phone in the nurses' station on the 400-hall was not working correctly. LPN #355 stated Resident #70 recently threw the phone against the wall and it hadn't worked right since. LPN #355 stated she can make outgoing calls, however the receptionist takes messages and calls her cell phone to give her the messages.</p> <p>Interview on 04/04/23 at 9:31 A.M., LPN #300 stated the phones on the 400-hall had not worked in awhile. LPN #300 stated Resident #70 tore up the phone and the unit had gone without a properly functioning phone for at least three months. LPN #300 stated she had to use her cell phone to make calls.</p> <p>Interview on 04/04/23 at 9:56 A.M., Receptionist #350 stated the phones on the 400-hall were not accepting incoming calls. Receptionist #350 reported, when transferring a call, it immediately rings back to the reception area. Receptionist #350 stated the nurses were able to make outgoing calls. Receptionist #350 stated when she needs to get a hold of the 400-hall nurse, she calls the nurse's cell phone and leaves them a message. Receptionist #350 estimated this had probably been going on for a month or two. Receptionist #350 stated she informed the Maintenance Director, Administrator, and Director of Nursing (DON). Receptionist #350 stated maintenance was able to make repairs so the nurses could make outgoing calls.</p> <p>Interview on 04/03/23 at 4:53 P.M., the DON stated the phone at the nurses' station on the 400-hall was now working. The DON stated Resident #70 ripped the phone out of the wall but it was replaced and she made sure of it.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/03/23 at 9:54 P.M. revealed the main number to the facility was called. There was a greeting announcing the facility name. The caller was then prompted to press one for marketing, two for administration, or three for nursing. Caller pressed three for nursing. Caller then pressed 4 for the 400 hall nurses' station. There was immediately a rapid busy signal and no further options. The same process was repeated at 9:55 P.M. with the same results.</p> <p>Interview on 04/04/23 at 8:46 A.M., the Administrator was informed of the observations of the phone system on 04/03/23 and denied knowledge of the phone system not working on the 400-hall.</p> <p>Review of facility policy titled, Resident Rights-Exercise of Rights, dated 01/11/21 revealed residents had the right to communication with and access to persons and services inside and outside the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00140832.</p>		

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<p>F 0677</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731</p> <p>Based on medical record review, review of hospital medical records, staff interview, and facility policy and procedure review, the facility failed to ensure a dependent resident (Resident #57) received adequate nail care. This resulted in Immediate Jeopardy on 03/08/23 when Resident #57 was found to have his fingernails grown into his palm, forming an abscess. Resident #57 was subsequently sent to the hospital and found to be severely septic (severe infection) and diagnosed with tenosynovitis (inflammation of a tendon) of the right middle finger and gas gangrene (highly lethal infection)/necrotizing fasciitis (a rare bacterial infection that spreads quickly in the body and can cause death) of the right middle finger. Resident #57 required emergency amputation of his right third finger and partial amputation of his right fifth finger. Additionally, the facility failed to provide adequate nail care for dependent residents (#50 and #56) which did not rise to the level of Immediate Jeopardy. This affected three (#57, #50, and #56) of five residents reviewed for dependent residents receiving appropriate Activity of Daily Living (ADL) care. The facility reported all residents residing in the facility required some sort of assistance with nail care. The facility's census was 64.</p> <p>On 04/06/23 at 4:28 P.M., the Administrator, Director of Nursing (DON) #301, Registered Nurse (RN) #560, Licensed Practical Nurse (LPN) #360, and LPN #550 were notified Immediate Jeopardy began on 03/08/23 when Resident #57 was discovered to have his fingernails growing into his palm, forming an abscess, due to the lack of nail care. Resident #57 was subsequently sent to the hospital and found to be severely septic and diagnosed with tenosynovitis of the right middle finger and gas gangrene/necrotizing fasciitis of the right middle finger. Resident #57 required emergency amputation of his right third finger and partial amputation of his right fifth finger.</p> <p>The Immediate Jeopardy was removed on 04/10/23 when the facility implemented the following corrective actions:</p> <p>On 03/09/23, Resident #57 was assessed by the facility Nurse Practitioner (NP) and was immediately sent to the Emergency Department (ED) for care. Resident #57 returned to the facility on [DATE].</p> <p>On 03/10/23, the Administrator filed a Self-Reported Incident (SRI) regarding the incident involving Resident #57.</p> <p>On 03/10/23, former DON #710, RN #700, and RN #705 assessed the fingernails and hands of all residents on Resident #57's unit (100 unit) to ensure proper length and hygiene. On 03/10/23, two residents (#47 and #52) were identified with fingernails that needed trimmed, however both residents refused to have their fingernails cut and neither resident had any skin issues noted.</p> <p>On 03/28/23 and 04/07/23, current DON #301 and LPN #555 completed skin assessments on all residents on all units. On 03/28/23, LPN #555 identified three additional residents with pressure ulcers (#50, #41, and #57). Treatments were put into place immediately on 03/28/23. On 04/07/23, no additional skin concerns were identified.</p> <p>On 03/28/23 and 04/10/23, all residents on all units were assessed for proper nail care by DON #301 and LPN #555. There were no areas of further concern noted.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 03/31/23, a new wound care provider began providing services in the facility. The previous provider was removed due to incorrect documentation regarding Resident #57's skin assessments. The program consists of wound rounds with the physician and LPN #555 every Friday. The purpose of the program is to identify new wounds and treat new/existing wounds. Residents identified by LPN #555 as needing the wound care program will be referred. This program will be ongoing.</p> <p>On 04/03/23, LPN #550 reviewed all resident care plans to ensure bathing, nail care, and skin needs were updated and correct. Any care plans requiring corrections were corrected by 04/03/23.</p> <p>On 04/07/23, all resident shower schedules were reviewed by DON #301 and updated as needed to ensure resident preferences were being met and all residents were scheduled for showers/nail care twice a week.</p> <p>On 04/07/23, the Administrator reviewed the facility's bathing policy, and no changes were needed. DON #301 and the Administrator re-educated all nursing staff on the bathing policy by 04/10/23.</p> <p>On 04/09/23, DON #301 and LPN #555 updated all residents' Treatment Administration Records (TAR) to include showers and nail care to ensure proper care is being provided. Shower/nail care days were added to the TAR on the days they are scheduled, and the nurse must sign off once they are completed.</p> <p>On 04/10/23, DON #301 created binders, containing the bathing policy, nail care policy, and skin assessment procedures. The binders are for agency staff who pick up shifts at the facility. The agency staff must sign off on these policies on the included sign-off sheet in the front of the binder before starting to work on the floor.</p> <p>Beginning 04/10/23, DON #301 and/or designee will conduct audits on nail care, shower sheets, and skin assessments on five residents, twice weekly for four weeks, three residents, once a week for four weeks, and then one resident once a week for four weeks. The results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) meeting and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.</p> <p>Although the Immediate Jeopardy was removed on 04/10/23, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #57 revealed an admitted [DATE]. Resident #57 transferred to the hospital on 03/09/23 and returned to the facility on [DATE]. Diagnoses included type II diabetes mellitus, anemia, bipolar disorder, acquired absence of left leg below knee, peripheral vascular disease, acquired absence of right leg above knee, paranoid schizophrenia, cognitive communication deficit, and hypertensive heart disease.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had moderately impaired cognition. Resident #57 was assessed as not exhibiting any behaviors during the assessment period, including rejection of care. Resident #57 was dependent on staff for bed mobility, transfers, dressing, and maintaining personal hygiene, and required limited assistance for eating. Resident #57 had impaired range of motion on all extremities.</p> <p>Review of Resident #57's current care plans revealed refusals of skin care were not incorporated into the care plan until 03/10/23.</p> <p>Review of Occupational Therapy (OT) progress notes dated from 11/18/22 to 12/15/22 revealed Resident #57 worked with OT on tolerance of Bilateral Upper Extremity (BUE) splints for the resident's hands, including application and wear. Resident #57 was noted to be cooperative with treatment and was tolerating the splints for approximately two hours at a time upon discharge from therapy. The resident required maximum assistance to don (put on) and doff (take off) the right-hand splint. At the time of discharge, OT recommended to continue bilateral hand splints as tolerated.</p> <p>Review of physician orders revealed an order dated 12/15/22 and discontinued 01/16/23 to discontinue OT as maximum potential had been reached. Continue Wrist Hand Orthotics as tolerated to improve hand Range of Motion (ROM) and function and prevent further contractures. No documentation was required with the order.</p> <p>Review of the Skin Observation Tool dated 03/01/23 revealed Resident #57's skin was intact.</p> <p>Review of the ADL charting from 03/01/23 to 03/08/23 revealed no refusals of care were documented for Resident #57 in the State Testing Nurse Aide (STNA) charting.</p> <p>Review of behavior charting from 03/05/23 to 04/03/23 revealed no behaviors noted. Resident #57 did not refuse care.</p> <p>Review of progress notes dated 01/01/23 through 03/09/23 revealed Resident #57 frequently refused ordered medications; however, there was no documentation related to Resident #57's right hand, nor his fingernails. Additional review revealed no refusal for nail care documented.</p> <p>Review of the progress note dated 03/08/23 at 6:56 P.M. revealed Resident #57 was noted with a skin infection to the right third finger. The Nurse Practitioner was notified and ordered antibiotics and indicated Resident #57 would be evaluated the following day.</p> <p>Observation on 04/03/23 at 2:05 P.M. revealed Resident #57 was in the facility following a recent hospital stay. Resident #57 was resting in bed with his right hand wrapped. Resident #57 was unable to provide any meaningful information and mostly mumbled when asked questions.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/03/23 at 3:35 P.M. with LPN #310 she stated she found the abscessed area on Resident #57's hand. LPN #310 stated she had not worked on Resident #57's unit in a while and, on 03/08/23, she noticed a foul odor in his room. LPN #310 stated, before dinner on 03/08/23, she went to check Resident #57's blood sugar. LPN #310 reported Resident #57 typically utilized a freestyle libre (device used to detect blood sugar levels without having to do a fingerstick), however the device was not working, so she went to conduct a finger stick when she noticed the resident's right hand was wrapped in the bed sheets and the resident was guarding it. LPN #310 stated Resident #57 used to wear a palm protector and was unsure of the last time she saw the resident with it. LPN #310 stated she unwrapped the resident's hand and found the nailbed was infected. LPN #310 stated Resident #57 fought with her and two other aids to get the hand open and, once they got the hand open, they found his fingernail had dug into his palm and formed an abscess. LPN #310 stated she thought the podiatrist cut his fingernails and described the nail as thick, overgrown, and calloused and described it as looking like a toenail. LPN #310 stated the nurses in the facility could not have done anything with his fingernails and further stated, for someone like Resident #57, who was a brittle diabetic, she wouldn't have touched his fingernails anyway.</p> <p>Interview on 04/04/23 at 3:09 P.M., RN #430 stated he did not recall ever seeing anything in Resident #57's hand to protect his palm prior to the abscessed area being identified.</p> <p>Interview on 04/05/23 at 10:45 A.M., LPN #440 stated sometimes Resident #57 would allow staff to apply a splint or put something in his hand to protect against pressure, however on occasion, he would refuse. LPN #440 stated, if the resident refused, it should be charted in the progress notes.</p> <p>Interview on 04/06/23 at 9:32 A.M., Podiatrist #505 stated, by law, he cannot provide care to any body parts above the ankle and denied ever cutting Resident #57's fingernails.</p> <p>Interview on 04/06/23 at 12:34 P.M., LPN #435 stated the last time he provided care to Resident #57 was prior to going out for the amputation and his hand was not wrapped. LPN #435 stated he did not know the area was there and did not recall seeing any type of barrier in place to the right palm prior to then.</p> <p>Interview on 04/06/23 at 12:52 P.M., LPN #520 stated the last time she provided care to Resident #57 was prior to him going out for the amputation, and his hand was not wrapped, nor was she aware of any conditions to the resident's hand. LPN #520 stated Resident #57 could get aggressive, so she didn't get too close to him. LPN #520 stated, sometimes she would notice a rag in Resident #57's hand and stated sometimes he would allow her to put something in it. LPN #520 stated she would document the resident's refusals in the medical record. LPN #520 stated she was unsure of the last time she tried to cut the resident's fingernails, however estimated it to be approximately two weeks prior to the area in the palm being identified and she recalled the resident was aggressive that day and she did not get far in cutting his fingernails.</p> <p>Interview on 04/06/23 at 12:41 P.M., LPN #460 stated she was unsure of the last time she saw a washcloth or splint in Resident #57's right hand. LPN #460 stated she did not perform Passive Range of Motion (PROM) services at any point for Resident #57's right hand. LPN #460 stated she had probably tried to cut the resident's fingernails in the past, and was probably not successful, and stated she probably would not have documented that.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/06/23 at 12:46 P.M., Nurse Practitioner (NP) #515 stated the area and condition of Resident #57's palm definitely did not form overnight. NP #515 stated, upon visiting Resident #57 during the morning of 03/09/23, there was nothing in his right hand and, during prior visits, she did not recall seeing anything in his right hand. NP #515 denied being aware of any problems with staff cutting the resident's fingernails. She stated staff informed her of refusing medications and sometimes, personal care, however they did not say anything specific relating to his fingernails.</p> <p>Review of the Emergency Department (ED) Physician note dated 03/09/23 at 3:13 P.M. revealed Resident #57 presented to the ED via EMS (emergency medical services) from a local nursing home with reports of a tender, swollen right middle finger, which Resident #57 refused to allow staff to cut his fingernail on. Resident #57's other fingernails were noted to be cut. Resident #57 stated he did not want his fingernail touched, which was noted to be curled around the end of his fingertip and pierced the skin over the volar aspect of the distal phalanx (fingertip). There were reports the NP at the nursing home had hoped Resident #57 could be sedated in the ED to cut the fingernail. Resident #57's [NAME] Blood Cell Count (WBC) was 19.38 (high) in the ED. Resident #57 was determined to be severely septic and was diagnosed with tenosynovitis of the right middle finger and gas gangrene/necrotizing fasciitis of the right middle finger.</p> <p>Review of the Orthopedic Surgery Consultation dated 03/09/23 at 6:29 P.M. revealed Resident #57 had little use of his right hand and maintained it in a clenched fashion. As a result, his fingernails had grown back into his fingertips and his right middle finger had become severely infected. Orthopedics was consulted for management of an acute and severe infection. Resident #57 was noted to be seen for a limb threatening condition and a life-threatening condition.</p> <p>Review of the Orthopedic Op-Note dated 03/09/23 at 8:41 P.M. revealed a post-op diagnosis of osteomyelitis of entire third finger, full necrosis (dead tissue) and death of distal fifth digit as a result of the fingernail growing into the finger, flexor tenosynovitis (infection) of the third flexor sheath, mild flexor tenosynovitis of the fifth flexor sheath, and palmar abscess (a hand abscess is an accumulation of pus affecting the hand, usually caused by a bacterial infection). The procedure included amputation of the right third finger through the MCP joint (metacarpophalangeal joint), amputation of the right fifth finger through the PIP joint (the middle joint of each of your fingers). Incision and Drainage (I and D) of flexor sheath right finger, I and D of flexor sheath of right fifth finger, I and D of palmar abscess, and I and D of volar distal forearm.</p> <p>Review of the facility policy titled, Bathing Policy, dated 03/01/21 revealed care of fingers is part of the bath. Be sure nails are clean and notify the nurse if the nails are challenging.</p> <p>2. Review of the medical record of Resident #50 revealed an admitted [DATE]. Diagnoses included hypertensive heart and chronic kidney disease with heart failure, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, gastro-esophageal reflux disease, history of covid-19, type II diabetes mellitus, adult failure to thrive, and chronic pain syndrome.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #50 had moderately impaired cognition. Resident #50 was dependent on one staff for personal hygiene and bathing. Resident #50 required limited assistance with eating. Resident #50 was assessed as having impairment on one side of his upper extremities.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care dated 07/28/20 revealed Resident #50 had an ADL self-care performance deficit. Interventions included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.</p> <p>Review of task documentation dated 03/13/23 through 04/10/23 revealed Resident #50 did not refuse personal hygiene/grooming,</p> <p>Observation on 04/10/23 at 9:56 A.M. revealed Resident #50 lying in his bed. Resident #50's fingernails were observed to extend approximately 1/4 inch beyond the fingertip and an unidentified brown substance was observed beneath all fingernails.</p> <p>Interview on 04/10/23 at 9:57 A.M., LPN #555 verified Resident #50's fingernails were long and had a brown substance underneath.</p> <p>3. Review of the medical record of Resident #56 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, major depressive disorder, schizoaffective disorder.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #56 had intact cognition. The resident did not exhibit behaviors during the assessment period. The resident was dependent on staff for personal hygiene.</p> <p>Review of the plan of care dated 05/14/22 revealed Resident #56 had an ADL self-care performance deficit related to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. Interventions included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.</p> <p>Review of task documentation dated 03/13/23 through 04/10/23 revealed the resident did not refuse personal hygiene/grooming.</p> <p>Review of progress notes from 03/01/23 to 04/10/23 revealed no documentation of refusals of nail care</p> <p>Observation and interview on 04/10/23 at 10:00 A.M. revealed Resident #56's fingernails of his left (contracted) hand extended approximately 1/4 inch beyond the fingertip and an unidentified brown substance was observed beneath some of the fingernails. Resident #56 stated it had been awhile since someone cut his fingernails.</p> <p>Interview on 04/10/23 at 10:01 A.M., Activity Aid (AA) #410 verified Resident #56's fingernails were long and had an unidentified brown substance underneath.</p> <p>This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>		

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NAME OF PROVIDER OR SUPPLIER Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE 3627 Harvey Avenue Cincinnati, OH 45229	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731</p> <p>Based on medical record review, staff interview, review of punch details and review of the staffing schedules, the facility failed to provide adequate supervision to prevent accidents. This affected one (#70) of three residents reviewed for accidents. The facility census was 64.</p> <p>Findings include:</p> <p>Review of the medical record of Resident #70 revealed an admitted [DATE]. Resident #70 transferred to the hospital on 03/28/23, readmitted to the facility on [DATE], and transferred out to a mental health facility on 03/29/23. Diagnoses included paranoid schizophrenia, schizoaffective disorder, bipolar type, delusional disorders, generalized anxiety disorder, major depressive disorder, insomnia, bipolar disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had intact cognition. Resident #70 exhibited hallucinations and delusions during the assessment period. Resident #70 required supervision for bed mobility, transfers, dressing, eating, toileting, and personal hygiene.</p> <p>Review of the plan of care dated 01/07/20 revealed Resident #70 was at risk for development or actual depression related to major depressive disorder. Interventions included to monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, intentionally harmed or tried to harm self, sense of hopelessness or helplessness, impaired judgement or safety awareness and monitor/document/report PRN any signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness.</p> <p>Review of a progress note dated 03/05/23 revealed Resident #70 was tearful and did not know why. Resident #70 was redirected and returned to her room without incident. Medications were given per order and no distress was noted.</p> <p>Review of a progress note dated 03/10/23 at 8:50 A.M. revealed Resident #70 was tearful and said she wanted to go to the hospital.</p> <p>Review of a progress note dated 03/14/23 at 4:38 P.M. revealed Resident #70 was tearful, sitting outside of the nurses station door, crying, saying she was upset and did not know why. One-on-one, redirection, and offering of food/fluids was ineffective. PRN medication administered.</p> <p>Review of a progress note dated 03/21/23 at 2:52 P.M. revealed Resident #70 was tearful and anxious. One-on-one was effective.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a psychiatry progress note dated 03/22/23 revealed Psychiatric Advanced Practice Registered Nurse (APRN) #715 revealed Resident #70 was observed sitting in her wheelchair in the common area talking with other residents. Upon being approached by APRN #715, Resident #70 stated she wanted to go somewhere private to talk. APRN #715 and Resident #70 sat alone at the end of a hallway by a window and Resident #70 started crying and stated she felt sad and needed to go to the hospital. Resident #70 stated she felt depressed most of the time and admitted to suicidal ideation's and stated she thinks about cutting her wrists with her razor, but stated she would not do it. APRN #715 documented the information was shared with staff. The decision was made not to send Resident #70 to the hospital. Medications were ordered and staff were to monitor and report changes. The resident was agreeable with the plan. Current risk factors revealed Resident #70 was currently a danger to herself and to others. The Staff RN was notified on 03/22/23 at 2:00 P.M.</p> <p>Review of a progress note dated 03/23/23 at 10:38 A.M. revealed Resident #70 was exhibiting anxiety, refusing to leave the nurses' station, repeatedly asking for unordered med's. Resident #70 was provided with one-on-one, counseling, and redirection, which was ineffective. PRN medications were administered.</p> <p>Review of a progress note dated 03/27/23 at 9:29 A.M. revealed Resident #70 was at the nurses' station yelling, crying, and screaming, saying she wanted to go to the hospital. Medications were not effective and the Resident #70's guardian/brother was in the facility providing one-on-one supervision.</p> <p>Review of a progress note dated 03/28/23 at 9:22 A.M. revealed Resident #70 was tearful and yelling at times. Resident #70 stated she wanted to go to the hospital and she could not rest and the television was watching her and the people seemed to be coming out. Resident #70 stated she could not do this anymore and did not want to be here anymore and stated she wanted to die. Resident #70 did not verbalize or indicate a plan. Resident #70's guardian, DON, and psych services were notified.</p> <p>Review of a progress note dated 03/28/23 at 2:17 P.M. revealed Resident #70 was yelling, crying, getting out of her wheelchair and laying on the floor, then getting off the floor independently and returning to her wheelchair. Resident #70 was saying she did not want to be alone. One-on-one was provided by staff.</p> <p>Review of a progress note dated 03/29/23 at 8:06 A.M. revealed Resident #70's injuries were assessed. The nurse applied four by four (4 x 4) gauze and ace bandage to control the bleeding while applying pressure. The DON was notified of the incident and arrived on the unit within five minutes, 911 was called, Resident #70 was assessed by Emergency Medical Services (EMS) and transported to the hospital.</p> <p>Review of progress notes dated 03/29/23 at 12:19 P.M. and 12:32 P.M., revealed Resident #70 returned to the facility from the hospital ER. Resident #70 had superficial cuts on her left wrist left open to air. No medication changes were made and the ER nurse stated the left wrist was cleaned with saline and antibiotic ointment was applied. Resident #70 was awaiting transfer to a local mental health facility.</p> <p>Review of a progress note dated 03/29/23 at 4:30 P.M. revealed Resident #70 transferred out of the facility via facility transportation and accompanied by nursing, to a local mental health facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/04/23 at 9:47 A.M., APRN #715 stated, when she saw Resident #70 on 03/22/23, Resident #70 stated she wanted to go to the hospital, so she started the pink slip process. APRN #715 affirmed the resident told her she was thinking about slitting her wrists but said she would never do it. APRN #715 stated she is new to the facility and was told Resident #70 was manipulative. APRN #715 stated she was unsure what nurse she told of Resident #70's statements because she did not yet know the staff.</p> <p>Interview on 04/04/23 at 10:10 A.M., Activity Aid (AA) #330 stated, on 03/28/23, she provided one-on-one supervision to Resident #70 but not for the whole day. AA #330 stated she left at approximately 5:30 P.M. and, when queried on who took over the one-on-one supervision after she left, AA #330 stated she was unsure if anyone took over.</p> <p>Interview on 04/04/23 at 11:26 A.M., LPN #340 stated the one-on-one supervision provided to Resident #70 on 03/28/23 was not continuous. LPN #340 stated the DON told her Resident #70 needed to be one-on-one at some point during the day and all of the staff were doing different things during the day, so they traded off. When queried, LPN #340 stated she was not sure who was watching Resident #70 when she ended her shift and stated she last saw Resident #70 at approximately 7:00 P.M. and she was sitting in the hallway with her and following her while she was doing her med pass. LPN #340 stated she saw an aid in the common area when she was leaving, however did not know who was watching Resident #70 when she left. LPN #340 affirmed, as the nurse on duty, she should have known who was watching the Resident #70 when she left and verified she should have known at all times during her shift, who was watching a resident receiving one-on-one supervision.</p> <p>Interview on 04/04/23 at 11:02 A.M., STNA #360 affirmed she worked 03/28/23 and stated she was told Resident #70 needed one-on-one supervision toward the end of her shift. STNA #360 stated did not recall anyone sitting with Resident #70 providing one-on-one supervision.</p> <p>Interview on 04/04/23 at 1:39 P.M., the Administrator and DON affirmed Resident #70 was supposed to be receiving one-on-one supervision at the time of the incident on 03/28/23.</p> <p>Interview on 04/03/23 at 1:36 P.M., LPN #310 denied knowledge of Resident #70's statements to APRN #715 regarding intent to hurt herself.</p> <p>Interview on 04/04/23 at 9:31 A.M., LPN #300 stated, on 03/28/23, she arrived at work at approximately 7:00 P.M., and at approximately 7:15 P.M., Resident #70 rolled up in her wheelchair with dried blood on her hand and arm and was asking for medications and said she wanted to be sent to the hospital. LPN #300 stated she immediately called the DON, who came up to the unit, and then 911.</p> <p>Interview on 04/03/23 at approximately 4:50 P.M., the DON stated, on 03/28/23, earlier in the day, she told the staff Resident #70 needed to be supervised one-on-one by a staff member, when Resident #70 started expressing concerns. The DON stated the incident occurred sometime during the evening shift change, when Resident #70's one-on-one supervision was not fully executed and the floor staff did not have eyes on Resident #70. The DON stated Resident #70 utilized a razor to cut her wrists and, upon investigation of the incident, she found a pack of razors in the Resident #70's room that was not from the facility. The DON stated Resident #70 told her she purchased the razors on her own.</p> <p>Review of the punch detail for AA #330 revealed, on 03/28/23, AA #330 clocked out at 5:46 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing schedule dated 03/22/23 revealed LPN #310 was the nurse assigned to Resident #70's unit on the day APRN #715 visited the facility and documented on Resident #70.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00141639. This deficiency represents ongoing non-compliance from the survey dated 03/07/23.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731</p> <p>Based on review of facility documents, staff interview, and review of the facility policy, the facility failed to conduct ongoing surveillance of infections. This had the potential to affect all 64 residents residing in the facility. Facility census was 64.</p> <p>Findings include:</p> <p>Review of the facility-provided document, titled Infection Control Log revealed, a list of several residents in the facility with orders for antibiotic medications for infections such as urinary tract infection (UTI), dental infection, abnormal findings of blood chemistry, toe fungus, fungal infection, and infection both active and discontinued, from 01/10/23 to 04/03/23. Surveyor requested infection log for the facility from January through April 2023 on 04/03/23 at approximately 12:00 P.M.</p> <p>Interview on 04/03/23 at 4:54 P.M., the Director of Nursing (DON) stated she was new to her role in the facility and was unable to locate the facility infection logs requested for January through April 2023. The Administrator stated the Infection Preventionist (IP) is responsible for maintaining an up-to-date infection log and the former IP (Registered Nurse [RN] #705 left the facility on [DATE] without notice and that was all they were able to produce for an infection log. The DON and Administrator confirmed the facility should conduct ongoing infection surveillance and there should be a chronological line-listing of infections, list the residents' name and type of infection, date of onset and treatment so the facility could watch for trends and concerns regarding infections.</p> <p>Review of the facility policy titled, Infection Control-Surveillance of Infections, dated 02/04/21, revealed the Infection Prevention and Control Coordinator (IPC Coordinator) or designee will document review and work to minimize infections in the facility by detecting, documenting, and reviewing trends and possible outbreaks of infections in the facility and collecting data necessary for making infection prevention and control decisions. The IPC Coordinator or designee will utilize the Infection Prevention and Control Log by completing all required data complete a monthly analysis of the infection form, analyzing the data and reviewing the log and action plan in IPC meetings.</p> <p>This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>		