Printed: 11/24/2024 Form Approved OMB No. 0938-0391

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 SUPPLII Astoria Place of Cincinnati	Astoria Place of Cincinnati 3627		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 con	tact 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)		on)	
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN	evealed the resident was admitted to thal infarction (disruption of blood flow to anxiety, schizophrenia, Coronavirus (Cand bipolar. The dated 03/22/23 for Resident #10, restation and medication management. The petful but functional, she had mild impart of drug seeking behaviors that led to do of a window and would call strangers to station to steal medications. During the ty, exit seeking behavioral, and substanta Set (MDS) 3.0 assessment, dated 0-lits, required supervision to limited assistants.	ONFIDENTIALITY** 35770 w and interview the facility failed to azards were not present resulting in tion medications from an unlocked as of accessing and ingesting the exted one resident (#10) of seven e facility on [DATE] with diagnoses the brain) with COVID-19), attention-deficit evealed the resident was seen per the evaluation indicated the imment related to judgment and langerous behaviors. Furthermore, on pick her up. The resident e evaluation, the resident nice 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

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 366150

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	ald Services		No. 0938-0391
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 SUPPLIE Astoria Place of Cincinnati	ER	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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	EFICIENCIES d by full regulatory or LSC identifying information)	
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurse's progress note Licensed Practical Nurse (LPN) #11 looked unusually tired. Resident #11 140/90), pulse 88 (normal 60-100), Fahrenheit), respirations 17 (normaroom air. Nurse Practitioner (NP) # emergency room (ER) for drug screpsychotropic drug abuse. 911 was medical services (EMS) for a mental Review of the hospital ER notes da overdose. Assessment revealed the (Neurontin) 600 milligram (mg) tabl #10 was assessed to be awake, ale diagnosed with accidental/intention orders. Review of the Administrator's witnes the women's secured unit with Assi Resident #10 told her she took sev for a change in mental status. Review of ADON #120's witness st Administrator and LPN #132 alerter altered mental status. Resident #10 was in resident reported she took/ingested #10 about why she went to the hos on Monday night (05/01/23) some as she went on break. Resident #10 re of Gabapentin sitting on the desk. If (05/02/23) but did not remember with Review of LPN #132 immediately were Resident #10 looked impaired, so Les sent to a local hospital for mental sepermission and no other medication and provided in the remember with the permission and no other medication and provided in the medication and no other medication and provided in the medication and no other medication and provided in the medication and provided in the medication and no other medication and provided in the provided in the provided in	dated 05/02/23 at approximately 10:30 32 was notified by STNA # 169 that res 0's vital signs were assessed as blood temperature 100.1 degrees Fahrenhei al 12-20), and oxygen saturation 98 per 400 was notified and provided an order end and laboratory (lab) work due to recalled and Resident #10 was transport al status change. Atted 05/02/23 at 10:24 A.M., revealed Figure 19:00 A.M. Resident #10 stated sert, and had some slurred speech and it all overdose and discharged back to the erest at 9:00 A.M. Resident #10 stated sert, and had some slurred speech and it all overdose and discharged back to the erest at 0:00 at a content of Nursing (ADON) #120 at a content of Nursing (ADON) #120 at a content of the took some Gabapentin. Attended 19:02/23, revealed she did them that she needed to send Reside 0 stated she took some Gabapentin. Attended 19:02/23, revealed she did them that she needed to send Reside 0 stated she took some Gabapentin. Attended 19:02/23, revealed she did medications. When Administrator and pital and details about the incident with agency expletive was working and left is eported she went in the nurse's station Resident #10 noted she took seven of the state of the service	A.M. for Resident #10, revealed sident was slow to respond and pressure 102/58 (normal below t (normal 98.6 degrees reent (%) (normal 96-100 %) on r to send Resident #10 to the esident's previous history of ed to hospital per emergency Resident #10 arrived at the ER for arently took seven Gabapentin he did this to get high. Resident in no acute distress. Resident was e facility at 7:25 P.M. with no new I she was walking down the hall of 0 and LPN #132 was frantic stating Resident #10 to the hospital via 911 was rounding with the ent #10 to the hospital due to an orded by Administrator and ADON al regarding an incident where I ADON #120 questioned Resident and Gabapentin, Resident #10 relayed the nurse's station unlocked when after the nurse left and took a pack the Gabapentin yesterday 02/23 State tested Nursing ge of medicine on Resident #10's #10 gave LPN #169 the medicine. actitioner (NP). Resident #10 was a searched with the residents' was slurred, and she would not

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			NO. 0936-0391
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 SUPPLIE Astoria Place of Cincinnati	ER	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 con	tact 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)		on)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of STNA #169's witness starts, STNA #169 went into Resident #1 person. STNA #169 immediately gu #169 and LPN #132 searched their Resident #10 appeared to be sleep. Interview on 05/03/23 at 1:45 P.M. #169 came to her and stated Resider oom and Resident #10 gave her the was a package of Gabapentin 600 pills missing. LPN#132 stated Resishe sent Resident #10 to the hospitof the incident with Resident #10, in documented in Resident #10's mediated with a search with a sea	atement dated 05/03/23, revealed on 08/10's room to provide care and found pill of LPN #132 and Resident #10 handed froom with residents' consent and did no by and looked impaired. with LPN #132, revealed on 05/02/23 at lent #10 had medications on her person the medicine and told the nurse she tool mg 30 count belonging to another resident #10 appeared to be very sleepy, stal via 911. During the interview, LPN #10 including the resident accessing and the medication room looking a figure to the medication room looking a mg at the medication room, the nurse rucart, and the door automatically shut are had the medication room door propperation was unsecured. Policy, dated 04/01/22 revealed medication chart of the resident accessing and the resident accessing and the resident accessing and the resident accessing acceptance and the safety of the resident accessing acceptance and the safety of the resident acceptance acceptance acceptance and the safety of the resident acceptance acceptance acceptance and the safety of the resident acceptance acceptance acceptance acceptance acceptance and the safety of the resident acceptance a	5/02/23 at approximately 10:00 A.M. s (Gabapentin) on the resident's the medication to the nurse. STNA of find any other medications. at approximately 10:00 A.M., STNA in. LPN #132 went to the resident's a seven of them. LPN #132 stated it dent (#15) and there were seven sturring her words, and just off so the second of the medications were not action told her not to chart about it. 30, reported Resident #10 resided in the medical Director #410 stated she is some. Medical Director #410
	of neglect in the nurse's notes, resurepresentative and any treatment p	ults of the assessment, notification of the provided. All incidents and allegations o	ne physician and to the resident's f neglect must be reported

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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 SUPPLII	FR	STREET ADDRESS, CITY, STATE, ZI	P CODE
Astoria Place of Cincinnati		3627 Harvey Avenue Cincinnati, OH 45229	
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	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0689	Ensure that a nursing home area is accidents.	s free from accident hazards and provid	les adequate supervision to prevent
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS H	NAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 35770
Residents Affected - Few	review of an Emergency Medical S interviews, the facility failed to prov had physician orders (dated [DATE judgment and insight and safety copotential for serious life-threatening exited the secured behavioral unit the facility, Resident #10 wheeled I into a dimly lit, busy, curvy two-way street when a motorist discovered they recognized Resident #10 and resident back to the facility on [DATE] and eloped or how she exited transported to the local emergency found in the street and for a psychi reviewed for being at risk for elope #12, and #13) currently residing in On [DATE] at 2:57 P.M., the Admir Immediate Jeopardy began on [DA behavioral unit through an alarmed found on the ground in the road in was returned to the facility by EMS	ew, review of the Cincinnati Fire Departs ervices (EMS) report, review of the facilities adequate supervision to prevent Reservices (EMS) report, review of the facilide adequate supervision to prevent Reservices from eloping. This resulted in Inguitary and a provided the provided and alarmed basement door with the resident. Upon CFD first responders knew she resided on the facility's secure at approximately 10:25 P.M.; however the facility without staff knowledge. Condepartment (ED) where she was treated attric evaluation. This affected one resident. The facility identified 10 residents the facility at risk for elopement. The facility at risk for elopement. The facility at approximately 9:50 P.M. when Fel basement door without staff's knowledge ad dimly lit, busy, curvy two-way street a at approximately 10:25 P.M. and staff ident #10 was transported to the local else.	ility policy regarding elopement and esident #10, who resided on and ed behavioral unit due to poor immediate Jeopardy and the ely 9:50 P.M. when Resident #10 hout staff's knowledge. After exiting across the facility's parking lot and out of her wheelchair and on to the sand 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 is (#1, #2, #3, #4, #5, #8, #10, #11, icility census was 63. Ing (ADON) were notified Resident #10 exited the secured lige. The resident was subsequently area by a motorist. The resident #10 had
	actions:	oved on [DATE] when the facility impler	Ç
	On [DATE], Maintenance Director #151 changed all doors, elevator, and stairwell codes and no number were the same. In addition, the facility indicated door codes would be changed, per the elopement policy. Then updated door codes were at each secured nurse's station and given to the nursing staff by Maintenance Director #151 each time they would be changed. Maintenance Director #151 would give of the door code to the department heads each time the codes were changed.		nged, per the elopement policy. to the nursing staff by ce Director #151 would give copies
		Director or Nursing (ADON) #120 revieus orders for Resident #10. No changes	
		ement policy was reviewed by Medical I ector #151. No changes were made.	Director #400, the Administrator,
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2023
NAME OF PROVIDER OR SUPPLI	FD.	STREET ADDRESS, CITY, STATE, ZI	P CODE
Astoria Place of Cincinnati			PCODE
Astona Flace of Officialitati	3627 Harvey Avenue Cincinnati, OH 45229		
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	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		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.		ed the door codes, it was
Residents Affected - Few	regarding elopement. Topics including discreet/confidential and the reside members. Staff educated included: (STNAs), Business Office Manager activities aids, Social Service Designata Set (MDS) /Care Plan Coordi Housekeeping Manager #159 and workers. The facility also planned a and 4:00 P.M. for topics including the resident safety. Those staff who we worked.	esources Director #148 and/or the Adm ded ensuring when employees entered ents were not around, and not to give contents were not appeared in the second second for the second se	the door codes, it was odes to residents and/or family state tested Nursing Assistants 19, Activities Director #180 and two 19 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 ced prior to their next shift being
	ADON #120 or designee every 15 residents would be conducted three Assurance Performance Improvem	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 lings will be reviewed by Quality
		7 A.M., elopement drills were completed sues discovered. The missing resident	
	her via telephone regarding the fac codes, it was discreet/confidential, family members. The Staffing Ager	nistrator spoke with the staffing agency sility elopement policy and to ensure wh residents were not around, and not to ncy Supervisor informed the Administra agency staff before they could pick up	nen 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) # ering 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 informati	ntation binder was created by the Admi ion, including the above in-services and d to the Staffing Agency Supervisor on staff immediately.	I any future in-services. This
	order for all facility residents. The f	the care plans, the elopement risk ass acility also identified the Immediate Jec nce Improvement (QAPI) plan and wou	ppardy action plan would be a
	(continued on next page)		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED
	366150	B. Wing	05/11/2023
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Astoria Place of Cincinnati		3627 Harvey Avenue Cincinnati, OH 45229	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate	On [DATE], Resident #10 had an expert evaluation by Physician #181 and the resident was deemed to incompetent. Resident #10's father would pursue guardianship.		nd the resident was deemed to be
jeopardy to resident health or safety		ced on 1:1 observation until a wanderg ident. The wanderguard was ordered o TE].	
Residents Affected - Few		peginning on [DATE], the interim Direct ree times a week for four weeks. Findin	
	On [DATE], ADON #120 updated #11, #12, and #13).	the elopement risk evaluations for resid	lents (#01, #02, #03, #04, #05, #08,
	On [DATE] review of the medical records for Resident # #4, #5, #6, #7, #8, #9, and #10, identified by the facility as elopement risks revealed no additional concerns related to actual elopements from the facility. The elopement risk assessments were current and accurate, and care plans were initiated and updated with appropriate interventions to prevent elopement.		
	Although the Immediate Jeopardy was removed on [DATE], the deficiency remains at a Severity Level 2 (actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in process of implementing their corrective action plan and monitoring to ensure on-going compliance.		te Jeopardy) as the facility is in the
	Findings Include:		
		nedical record for Resident #10 revealed an admitted [DATE]. The resident had a diagnosis phrenia, cerebral infarction (disrupted blood flow to the brain) with hemiplegia/hemiparesis, exiety. Ident #10's plan of care, dated [DATE] revealed the resident was at risk for elopement related the awareness with interventions to distract the resident from wandering, staff to identify dering and to monitor exit seeking behavior.	
	to impaired safety awareness with		
	Review of a psychiatry progress note dated [DATE] revealed Resident #10 was seen per the facility recommon for a psychiatric evaluation and medication management. The evaluation indicated resident's cognitive was forgetful but functional, she had mild impairment related to judgment and insight and she had ongo episodes of drug seeking behaviors that led to dangerous behaviors. Furthermore, the note revealed the resident attempted to jump out of a window and would call strangers to pick her up. During the evaluation the resident presented with symptoms of anxiety, exit seeking, and substance usage.		
		Oata Set (MDS) 3.0 assessment dated [its and required supervision to limited a	
	(continued on next page)		

ROVIDER/SUPPLIER/CLIA	(VO) 1 (III TIPLE CONSTRUCTION	
TIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2023
	STREET ADDRESS, CITY, STATE, ZI 3627 Harvey Avenue Cincinnati, OH 45229	P CODE
rect this deficiency, please con	tact the nursing home or the state survey	agency.
IARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
w of a progress note, dated [In When staff searched the build yee break room. STNA #116 oned Resident #10 on how so to the door and the elevator. What of an elopement risk evaluates sessed as being an elopement indicated the resident who of the progress note dated gout of another resident's roent #10. Resident #10 had be trian who called 911 out of con NA #107 who was assigned the trian who called 911 out of con NA #107 who was assigned the trian who called 911 out of con NA #107 who was assigned the trian who called 911 out of con NA #107 who was assigned to trian who called 10 the area of FD first responders arrived on a wheelchair, seated on the rest.? Resident #10 had no maked the care of a behavioral psycolothe nursing home when the native to painful stimuli of a stort out of the facility. Resident who facility and refused to ent #10 faked sleeping when anted someone to drive her that she had deficits from a procomplaints, and was transpositity after being evaluated in the word a witness statement from the did unit's dining room with oth staff member had brought in	DATE] revealed Resident #10 left the sating, the resident was found on the lower brought Resident #10 back to the secure to the got down to the basement, the resident Resident #10 was placed on every 15 ation, dated [DATE] completed by ADO ent risk. Further review of Resident #10 had impaired decision-making skills. [DATE] at 10:48 P.M. completed by LF om when STNA #116 alerted her that the end outside the building trying to cross oncern. The note revealed Resident #10 to the secured unit. Resident #10 stated endications, and LPN #117 did not seen the endications, and LPN #117 did not seen the endications and LPN #117 did not seen the endications are stating they nedical complaints, she was a resident chiatrist locked down unit on the second eresident began acting to be unresponsemal rub. The nursing home staff state #10 was transported to the ER for an endication of the endication of a stroke from drug the endication of the endicati	ecured unit at approximately 11:45 or level (basement) in the unit. When the on-duty nurse lent replied that she knew the -minute checks throughout the with 120, revealed Resident #10 or elopement/wandering IN #120, revealed Resident #10 or elopement/wandering IN #117, revealed the nurse was the fire department was outside with the street when she was seen by a or was last seen in the dining area of she was going to bed since she was going to bed since she was going to bed since she was going to head since she was found in the street. The person (later identified as Resident found the person in the middle of at Astoria Place Nursing Home, of floor. Resident #10 was wheeled sive. However, the resident was do they did not know how Resident evaluation due to patients' known go usage. The area of [NAME] Avenue at acting erratic, outside her anted to go see her boyfriend. O stated she got out of the facility was noted to be in the middle of the wast and the properties of the saluation. The resident returned to struck and struck and giving out clothes ing through and giving out clothes ing through and giving out clothes ing to Resident #10 between 9:30 P.
AVENCE OF AFILE COST APEN	of the Cincinnati Fire Departure of the area of as dispatched to the area of as dispatched to the area of a wheelchair, seated on the cet.? Resident #10 had no must be to painful stimuli of a state of the nursing home when the sive to painful stimuli of a state of street drug usage and provide of the EMS report dated [DP.M. EMS arrived on scene attation facility and refused to the the total form and the state of the	of the Cincinnati Fire Department (CFD) report, dated [DATE], revalue at dispatched to the area of [NAME] Avenue at 10:17 P.M. for a per ED first responders arrived on the scene at 10:21 P.M. and found a a wheelchair, seated on the sidewalk with bystanders stating they set.? Resident #10 had no medical complaints, she was a resident the care of a behavioral psychiatrist locked down unit on the second the nursing home when the resident began acting to be unresponsive to painful stimuli of a sternal rub. The nursing home staff state to out of the facility. Resident #10 was transported to the ER for an experiment of street drug usage and prior medical history of a stroke from drug of the EMS report dated [DATE], revealed EMS was dispatched to P.M. EMS arrived on scene at 10:31 P.M. and found Resident #10 attation facility and refused to go back in Resident #10 stated she want #10 faked sleeping when questioned by the police.?Resident #10 was she had deficits from a previous stroke and a broken hip. Resident complaints, and was transported to a local emergency room for evility after being evaluated in the emergency room. Of a witness statement from STNA #107, dated [DATE], revealed dunit's dining room with other residents. STNA #107 was talking the staff member had brought in for the residents. STNA #107 was talking 10:00 P.M. STNA #107 reported she did not hear any alarms go o

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	this nurse was notified by the on-cal if Resident #10 was on 1:1 observa 15-minute checks and the unit was the nurse was performing medicatic care. The on-call manager informed LPN #132 went to inform the unit s Resident #10 for continued close or resident's closet with the door close on-call manager was called and material manager was and often time. 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 whe because she had given the resident mass an elopement, he was required elevators. Maintenance Director #1 for most of the night changing the codes were able to get in and around the #10 had gotten off the secured unit On [DATE] at 2:30 P.M. observatio #151, revealed Resident #10 was sof the parking lot. Resident #10 was sof the parking lot. Resident #10 who went south and visual was lost whe entrance video footage at 9:50 P.M. Interview on [DATE] at 4:07 PM with supposed to be on a locked unit be suffered, and she made bad judgm nursing homes because of her behresident had eloped on [DATE] but Interview on [DATE] at 7:40 AM with the parking locked in the parking homes because of her behresident had eloped on [DATE] but Interview on [DATE] at 7:40 AM with the parking locked unit be suffered, and she made bad judgm nursing homes because of her behresident had eloped on [DATE] but Interview on [DATE] at 7:40 AM with the parking locked unit be suffered.	with SSD #108, revealed the door passes the staff would just say the codes all the LPN #117, revealed Resident #10 was that were brought in for residents where knew, the fire department was at the was not aware Resident #10 was out of an Resident #10 was in the dining room at the nighttime medications. The series of the s	elopement attempt and questioned anager, Resident #10 was on every e. One aide was giving a shower, ras on the floor providing resident be always in sight of staff. When on, the unit staff went to get nt #10 was found hiding in another igned 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. It is in the dining room on [DATE] at en the resident stated she was door bringing Resident #10 back the facility. LPN #117 stated she in, but stated it was after 9:00 P.M. In #151, revealed every time there does not he doors, stairwells, and the esident #10's elopement on [DATE] levator. Maintenance Director #151 is to what the codes were, so they eated he was not aware Resident was another the sidewalk where the resident was ontal lobe from a stroke she resident #10. Ither) revealed the resident was ontal lobe from a stroke she resident had been in multiple other exp her. He was unaware the sident was not service.

SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by Observation of the active camera ticamera times were showing 7:49 A that the camera times were off by 3	full regulatory or LSC identifying information mes on [DATE] at 8:15 A.M. with Maint M and the real time was 8:15 AM. Mair	enance Director #151 revealed the
SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by Observation of the active camera ticamera times were showing 7:49 A that the camera times were off by 3	3627 Harvey Avenue Cincinnati, OH 45229 Eact the nursing home or the state survey a IENCIES full regulatory or LSC identifying information mes on [DATE] at 8:15 A.M. with Maint M and the real time was 8:15 AM. Mair	enance Director #151 revealed the
SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by Observation of the active camera ticamera times were showing 7:49 A that the camera times were off by 3	3627 Harvey Avenue Cincinnati, OH 45229 Eact the nursing home or the state survey a IENCIES full regulatory or LSC identifying information mes on [DATE] at 8:15 A.M. with Maint M and the real time was 8:15 AM. Mair	enance Director #151 revealed the
SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by Observation of the active camera ticamera times were showing 7:49 A that the camera times were off by 3	Cincinnati, OH 45229 Eact the nursing home or the state survey as IENCIES full regulatory or LSC identifying information mes on [DATE] at 8:15 A.M. with Maint M and the real time was 8:15 AM. Maint	enance Director #151 revealed the
SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by Observation of the active camera ticamera times were showing 7:49 A that the camera times were off by 3	IENCIES full regulatory or LSC identifying information mes on [DATE] at 8:15 A.M. with Maint M and the real time was 8:15 AM. Mair	enance Director #151 revealed the
Cach deficiency must be preceded by Cobservation of the active camera ticamera times were showing 7:49 A that the camera times were off by 3	full regulatory or LSC identifying information mes on [DATE] at 8:15 A.M. with Maint M and the real time was 8:15 AM. Mair	enance Director #151 revealed the
camera times were showing 7:49 A that the camera times were off by 3	M and the real time was 8:15 AM. Mair	
was not going to say who it was. Re when she was crossing the street, a 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 I should be on a secured unit. On [DATE] at approximately 3:30 P thorough assessment of Resident # completed on Resident #10. Review of the Statement of Expert incompetent due to poor judgement Review of the Elopement Preventio to create an environment that was a included to develop a plan of action resident was reported missing. This deficiency represents non-com	ith Resident #10, revealed someone gasident #10 stated on [DATE], she was a bra that she had on her lap got caugh 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 reportener safety due to her brain injuries. MD .M., an interview with the Administrator 10's cognitive status, so she was going that and insight and guardianship should be as safe as possible for residents at risk that would ensure a prompt, effective, appliance investigated under Complaint I	ave her the pass codes, but she trying to get a ride to Colerain and it in the front wheel of her nt #10 stated she fell out of the apped, and the guy got out and get the ground and yelling. d Resident #10 makes very bad #410 indicated Resident #10 revealed she did not do a get to have an expert evaluation. #181, revealed Resident #10 was be granted. DATE] revealed the policy indicated for elopement. The policy also and coordinated response when a
www.ce Ircs Otto Fir Ftring T	when she was crossing the street, a wheelchair which led her to getting wheelchair and almost got hit by two salled 911. Resident #10 could not expletives. Interview on [DATE] at 3:35 P.M. whoices which were dangerous for labould be on a secured unit. In [DATE] at approximately 3:30 P. horough assessment of Resident #10. Review of the Statement of Expert Incompetent due to poor judgement and the statement of the competent due to poor judgement of the create an environment that was a collected to develop a plan of action esident was reported missing.	when she was crossing the street, a bra that she had on her lap got caugh wheelchair which led her to getting stuck in the middle of the road. Reside wheelchair and almost got hit by two cars when a third car noticed her, stock alled 911. Resident #10 could not focus on the interview and kept looking expletives. Interview on [DATE] at 3:35 P.M. with Medical Director (MD) #410 reported thoices which were dangerous for her safety due to her brain injuries. MD should be on a secured unit. In [DATE] at approximately 3:30 P.M., an interview with the Administrator horough assessment of Resident #10's cognitive status, so she was going completed on Resident #10. Review of the Statement of Expert Evaluation dated [DATE] by Physician and competent due to poor judgement and insight and guardianship should be create an environment that was as safe as possible for residents at risk included to develop a plan of action that would ensure a prompt, effective,

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 PROMPER OR CURRU		CTREET ADDRESS SITV STATE 7	ID CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	IP CODE
Astoria Place of Cincinnati	3627 Harvey Avenue Cincinnati, OH 45229		
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	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0727	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses of a full time basis.		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:		
	During the initial tour of the facility on 05/02/23 at 7:30 A.M., Social Service Designee (SSD) #108 was asked for the name of the Director of Nursing (DON). SSD #108 replied the facility did not currently have a DON; the previous DON had been escorted out of the building about a week ago. Interview on 05/02/23 at approximately 12:00 P.M. with Administrator #200 (Administrator on site from another facility) revealed the former DON had been terminated on 04/27/23 because they were not jiving. Administrator #200 indicated the facility was in the process of hiring a new DON.		ity did not currently have a DON;
			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.
	Telephone interview on 05/09/23 at 12:19 P.M. with Receptionist #163, revealed the facility did not have a DON. Receptionist #163 indicated the facility did have an Assistant Director of Nursing (ADON) who was a Licensed Practical Nurse (LPN). A telephone interview on 05/11/23 at 9:47 A.M. with the Administrator verified there was no DON present fo 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2023
NAME OF PROVIDER OR SUPPLIE Astoria Place of Cincinnati	ER	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 con	tact 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)		on)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	professional principles; and all drug locked, compartments for controlled 35770 Based on observations, staff intervity cart on the first floor 100-unit with ritimes. This had the potential to affect identified as being independently in 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 sapplesauce and pudding from the Review of the Medication Storage I that maintained the integrity of the	iews and review of facility policy, the far numerous prescription medications insi- ect seven residents (#26, #25, #24, #23 nobile. The facility census was 63. 6 A.M. revealed a medication cart on the is walking around in the hallway and not independently mobile residents in the she forgot to lock the medication cart want citchen which was on a separate level. Policy, dated 04/01/22 revealed medical product, ensured the safety of the resides. All medications would be stored in a	cility failed to ensure a medication de, was properly secured at all , #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 lents, and was in accordance with

	a.a 55.7.555		No. 0938-0391
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 SUPPLIE Astoria Place of Cincinnati	R	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 conf	tact 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)		ion)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessm corrective plans of action. 35770 Based on record review, staff intervelopement, and review of the facility Performance Improvement (QAPI) comprehensive and effective plan optential affect all 63 residents who Findings include: Review of the facility survey history with resident elopement was identificated and the facility corrective actic committee meetings to review the occompliance was achieved. During the survey completed on 05 elopement (involving Resident #10) survey. Interview on 05/02/23 at approximated was an elopement, he was required elevators. Maintenance Director #1 04/19/23 for most of the night changuirector #151 stated when he chand were, so they were able to get in an arwas 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 strewheelchair which led her to getting wheelchair and almost got hit by two called 911. Resident #10 could not expletives. Interview on 05/03/23 at 3:35 P.M.	ent and assurance group to review quarters, physician interview, review of the y's prior surveys documentation regard plans, the facility failed to develop, import action was in place to correct identification.	e facility policy regarding ding Quality Assurance and plement, and ensure a led quality deficiencies. This had the completed on 03/07/23 a concern a Jeopardy. ed the facility would hold QAPI udits to ensure 100 percent led as fety/supervision and redy at F689 was issued during this less on the doors, stairwells, and the lesident #10's elopement on ells, and elevator. Maintenance 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 leaught in the front wheel of her lent #10 stated she fell out of the lopped, and the guy got out and g at the ground and yelling leted Resident #10 makes very bad

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NAME OF PROVIDER OR SUPPLIER Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE 3627 Harvey Avenue	
ASIONA FIACE OF CHICHINALI		Cincinnati, OH 45229	
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	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A follow up interview with the MD #410 on 05/11/23 at 9:27 A.M. revealed he started providing physician services to the residents in the facility during the middle of March 2023. MD #410 indicated he had not attended any QAPI meetings since starting in March 2023. MD #410 stated he was aware of the April 2023 survey and the deficiencies; however, he was never informed of a QAPI meeting and/or asked to attend one. MD #410 indicated his expectations were for the facility to include him in the QAPI meetings since he was a required to attend and participate. Interview with Administrator on 05/11/23 at 10:04 A.M. indicated the facility had no documented evidence of a QAPI meeting or the plans of actions for the March 2023 survey or the April 2023 survey where the facility had deficiencies identified. The administrator stated the previous administrator set up a meeting on 03/03/23; however, there were no minutes, note or signatures of any attendees for a meeting. The Administrator verified the facility should have conducted a QAPI meeting as planned. The Administrator reported the facility had no policy that addressed QAPI meetings or plans of actions for identified deficiencies. Review of the Elopement Prevention and Missing Resident Policy dated 01/05/21 revealed the policy indicated to create an environment that was as safe as possible for residents at risk for elopement. The policy also included developing a plan of action that would ensure a prompt, effective, and coordinated		
	response when a resident was repo		pt, circuive, and coordinated