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	05/11/2023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770 Based on observations, record review, facility policy and procedure review and interview the facility failed to monitor and provide adequate supervision to assure that environmental hazards were not present resulting in a situation of neglect when Resident #10 accessed and ingested prescription medications from an unlocked medication room. In addition, the facility failed to ensure the circumstances of accessing and ingesting the medications were documented in Resident #10's medical record. This affected one resident (#10) of seven residents reviewed for accidents. The facility census was 63. Findings include: Record review for Resident #10, revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, cerebral infarction (disruption of blood flow to the brain) with hemiplegia/hemiparesis, epilepsy, anxiety, schizophrenia, Coronavirus (COVID-19), attention-deficit hyperactivity disorder, depression, and bipolar. Review of a psychiatry progress note dated 03/22/23 for Resident #10, revealed the resident was seen per facility request for psychiatric evaluation and medication management. The evaluation indicated the resident's cognitive status was forgetful but functional, she had mild impairment related to judgment and insight and had ongoing episodes of drug seeking behaviors that led to dangerous behaviors. Furthermore, the resident attempted to jump out of a window and would call strangers to pick her up. The resident attempted to break into the nurse's station to steal medications. During the evaluation, the resident presented with symptoms of anxiety, exit seeking behavioral, and substance usage. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 04/02/23 for Resident #10, revealed the resident had no cognitive deficits, required supervision to limited assistance with activities of daily living (ADLs), and required supervision for mobility with device. (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

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	05/11/2023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurse's progress note dated 05/02/23 at approximately 10:30 A.M. for Resident #10, revealed Licensed Practical Nurse (LPN) #132 was notified by STNA # 169 that resident was slow to respond and looked unusually tired. Resident #10's vital signs were assessed as blood pressure 102/58 (normal below 140/90), pulse 88 (normal 60-100), temperature 100.1 degrees Fahrenheit (normal 98.6 degrees Fahrenheit), respirations 17 (normal 12-20), and oxygen saturation 98 percent (%) (normal 96-100 %) on room air. Nurse Practitioner (NP) #400 was notified and provided an order to send Resident #10 to the emergency room (ER) for drug screen/ and laboratory (lab) work due to resident's previous history of psychotropic drug abuse. 911 was called and Resident #10 was transported to hospital per emergency medical services (EMS) for a mental status change. Review of the hospital ER notes dated 05/02/23 at 10:24 A.M., revealed Resident #10 arrived at the ER for overdose. Assessment revealed the resident was from a nursing and apparently took seven Gabapentin (Neurontin) 600 milligram (mg) tablets at 9:00 A.M. Resident #10 stated she did this to get high. Resident #10 was assessed to be awake, alert, and had some slurred speech and in no acute distress. Resident was diagnosed with accidental/intentional overdose and discharged back to the facility at 7:25 P.M. with no new orders. Review of the Administrator's witness statement dated 05/02/23, revealed she was walking down the hall of the women's secured unit with Assistant Director of Nursing (ADON) #120 and LPN #132 was frantic stating Resident #10 told her she took seven Gabapentin, and she was sending Resident #10 to the hospital via 911 for a change in mental status. Review of ADON #120's witness statement dated 05/02/23, revealed she was rounding with the Administrator and LPN #132 alerted them that she needed to send Resident #10 to the hospital due to an altered mental status. Resident #10 stated she took some Gabapentin. Review of a statement dated 05/03/23 provided by Resident #10 and recorded by Administrator and ADON #120, revealed Resident #10 was interviewed upon return from the hospital regarding an incident where resident reported she took/ingested medications. When Administrator and ADON #120 questioned Resident #10 about why she went to the hospital and details about the incident with Gabapentin, Resident #10 relayed on Monday night (05/01/23) some agency expletive was working and left the nurse's station unlocked when she went on break. Resident #10 reported she went in the nurse's station after the nurse left and took a pack of Gabapentin sitting on the desk. Resident #10 noted she took seven of the Gabapentin yesterday (05/02/23) but did not remember what time. Review of LPN #132's witness statement dated 05/03/23, revealed on 05/02/23 State tested Nursing Assistant (STNA) #169 came up to get her and stated there was a package of medicine on Resident #10's person. LPN #132 immediately went to the resident's room and Resident #10 gave LPN #169 the medicine. Resident #10 looked impaired, so LPN #132 called 911 and the Nurse Practitioner (NP). Resident #10 was sent to a local hospital for mental status change. Resident #10's room was searched with the residents' permission and no other medications were found. Resident #10's speech was slurred, and she would not answer if she took the pills or not. LPN #132 notified the Administrator and ADON #120 as they were passing by in the hallway. (continued on next page)

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	05/11/2023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of STNA #169's witness statement dated 05/03/23, revealed on 05/02/23 at approximately 10:00 A.M. , STNA #169 went into Resident #10's room to provide care and found pills (Gabapentin) on the resident's person. STNA #169 immediately got LPN #132 and Resident #10 handed the medication to the nurse. STNA #169 and LPN #132 searched the room with residents' consent and did not find any other medications. Resident #10 appeared to be sleepy and looked impaired. Interview on 05/03/23 at 1:45 P.M. with LPN #132, revealed on 05/02/23 at approximately 10:00 A.M., STNA #169 came to her and stated Resident #10 had medications on her person. LPN #132 went to the resident's room and Resident #10 gave her the medicine and told the nurse she took seven of them. LPN #132 stated it was a package of Gabapentin 600 mg 30 count belonging to another resident (#15) and there were seven pills missing. LPN#132 stated Resident #10 appeared to be very sleepy, slurring her words, and just off so she sent Resident #10 to the hospital via 911. During the interview, LPN #132 was asked why the specifics of the incident with Resident #10, including the resident accessing and ingestion of the medications were not documented in Resident #10's medical record. The LPN replied administration told her not to chart about it. A telephone interview on 05/03/23 at 3:35 P.M. with Medical Director #410, reported Resident #10 resided on a locked unit due to her lack of safety awareness and drug seeking/use. Medical Director #410 stated she had gotten a hold of some medications yesterday (05/02/23) and she took some. Medical Director #410 reported that no medicines should be left unlocked or available because Resident #10 would take them and ingest them. An observation on 05/04/23 at approximately 1:30 P.M. of the secured women unit's medication room door revealed the door was being propped open with a locked medication cart while LPN #171 was observed being down the hall with her back turned to the medication room looking at her personal mobile phone. When LPN #171 saw the surveyor standing at the medication room, the nurse rushed back to the medication room. LPN #171 removed the medication cart, and the door automatically shut and locked. An interview with LPN #171 at the same time revealed she had the medication room door propped open due to the room being warm. LPN #171 verified the medication was unsecured. Review of the Medication Storage Policy, dated 04/01/22 revealed medications would be stored in a manner that maintained the integrity of the product, ensured the safety of the residents, and was in accordance with the Department of Health guidelines. All medications would be stored in a locked cabinet, cart of medication room that was accessible only to authorized personnel. Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Resident Property Policy, dated 11/2016 revealed the facility would not tolerate abuse, neglect exploitation of its residents or misappropriation. The facility would investigate and document all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property including injuries of unknown source, in accordance with this policy. The policy indicated neglect was the failure of the facility, the employees, or facility services providers to provide good and service to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility shall do an analysis of the physical environment that may make neglect more likely to occur and facility would care plan and monitor residents with needs and behaviors which might lead to conflict or neglect. The facility would document the allegations of neglect in the nurse's notes, results of the assessment, notification of the physician and to the resident's representative and any treatment provided. All incidents and allegations of neglect must be reported immediately to the Administrator or designee and reported to the Ohio Department of Health.

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	05/11/2023

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** 35770 Based on observation, record review, review of the Cincinnati Fire Department (CFD) first responders report, review of an Emergency Medical Services (EMS) report, review of the facility policy regarding elopement and interviews, the facility failed to provide adequate supervision to prevent Resident #10, who resided on and had physician orders (dated [DATE]) for placement on the facility's secured behavioral unit due to poor judgment and insight and safety concerns from eloping. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm/death on [DATE] at approximately 9:50 P.M. when Resident #10 exited the secured behavioral unit through an alarmed basement door without staff's knowledge. After exiting the facility, Resident #10 wheeled herself up an exterior wheelchair ramp, across the facility's parking lot and into a dimly lit, busy, curvy two-way street where Resident #10 had fallen out of her wheelchair and on to the street when a motorist discovered the resident. Upon CFD first responders and EMS arrival to the scene, they recognized Resident #10 and knew she resided on the facility's secured behavioral unit. EMS took the resident back to the facility on [DATE] at approximately 10:25 P.M.; however, staff were not aware Resident #10 had eloped or how she exited the facility without staff knowledge. Consequently, Resident #10 was transported to the local emergency department (ED) where she was treated for possible injuries from being found in the street and for a psychiatric evaluation. This affected one resident (#10) of the seven residents reviewed for being at risk for elopement. The facility identified 10 residents (#1, #2, #3, #4, #5, #8, #10, #11, #12, and #13) currently residing in the facility at risk for elopement. The facility census was 63. On [DATE] at 2:57 P.M., the Administrator and Assistant Director of Nursing (ADON) were notified Immediate Jeopardy began on [DATE] at approximately 9:50 P.M. when Resident #10 exited the secured behavioral unit through an alarmed basement door without staff's knowledge. The resident was subsequently found on the ground in the road in a dimly lit, busy, curvy two-way street area by a motorist. The resident was returned to the facility by EMS at approximately 10:25 P.M. and staff were not aware Resident #10 had eloped or how. Consequently, Resident #10 was transported to the local emergency department (ED) where she was treated for possible injuries. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], Maintenance Director #151 changed all doors, elevator, and stairwell codes and no numbers 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 copies of the door code to the department heads each time the codes were changed. On [DATE] at 2:00 P.M., Assistant Director or Nursing (ADON) #120 reviewed the care plan, the elopement risk assessments, and the physician orders for Resident #10. No changes were made. On [DATE] at 4:00 P.M., the elopement policy was reviewed by Medical Director #400, the Administrator, ADON #120, and Maintenance Director #151. No changes were made. (continued on next page)

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	05/11/2023

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	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. On [DATE] and [DATE] Human Resources Director #148 and/or the Administrator educated all staff regarding elopement. Topics included 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. Staff educated included: ADON #120, 17 licensed nurses, 15 State tested Nursing Assistants (STNAs), Business Office Manager (BOM) #128, Admissions Director #119, Activities Director #180 and two activities aids, Social Service Designee (SSD) #108, Dietary Manager #109 and eight dietary staff, Minimum Data Set (MDS) /Care Plan Coordinator #124, Medical Records Clerk #113, Receptionist #163, Housekeeping Manager #159 and eight housekeepers, Maintenance Director #151 and two maintenance workers. The facility also planned additional mandatory staff education on [DATE] at 7:00 A.M., 2:00 P.M. and 4:00 P.M. for topics including the facility elopement policy, active shooter, facility key code usage, and resident safety. Those staff who were not able to attend would be in serviced prior to their next shift being worked. To monitor ongoing compliance, beginning on [DATE], head counts on all residents would be completed by ADON #120 or designee every 15 minutes for 48 hours, then beginning on [DATE] head counts for all residents would be conducted three times a week for four weeks. The findings will be reviewed by Quality Assurance Performance Improvement (QAPI) weekly. On [DATE] at 4:18 A.M. and 10:27 A.M., elopement drills were completed by Maintenance Director #151 and the staff participated with no issues discovered. The missing resident identified in the drill was found within minutes after the drill began. On [DATE] at 1:38 P.M., the Administrator spoke with the staffing agency supervisor and did education with her via telephone regarding the facility elopement policy and to ensure when employees entered the door codes, it was discreet/confidential, residents were not around, and not to give codes to residents and/or family members. The Staffing Agency Supervisor informed the Administrator this education would be reviewed and acknowledged by all agency staff before they could pick up a shift at the facility. On [DATE] between 8:30 A.M. and 9:00 A.M., interviews with SSD #108, STNAs (#142 and #129) Housekeeping #127, Receptionist #163, Licensed Practical Nurse (LPN) #171, verified they were educated on resident elopements and wandering as well as responding to resident alarms.? All staff members interviewed were knowledgeable of the content of each education provided by the facility. On [DATE], a staffing agency orientation binder was created by the Administrator and left at each nurse's station with helpful facility information, including the above in-services and any future in-services. This information was also communicated to the Staffing Agency Supervisor on [DATE] and she would communicate this with her agency staff immediately. On [DATE], ADON #120 reviewed the care plans, the elopement risk assessments, and the physician's order for all facility residents. The facility also identified the Immediate Jeopardy action plan would be a Quality Assessment and Performance Improvement (QAPI) plan and would be followed-up with facility QAPI team members. (continued on next page)

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	05/11/2023

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	On [DATE], Resident #10 had an expert evaluation by Physician #181 and the resident was deemed to be incompetent. Resident #10's father would pursue guardianship. On [DATE], Resident #10 was placed on 1:1 observation until a wanderguard device (elopement monitoring device) could be placed on the resident. The wanderguard was ordered on [DATE] and was scheduled to be delivered and implemented on [DATE]. To monitor on-going compliance, beginning on [DATE], the interim Director of Nursing (DON) will complete audits on exit seeking residents three times a week for four weeks. Findings to be reviewed in QAPI weekly for four weeks. On [DATE], ADON #120 updated the elopement risk evaluations for residents (#01, #02, #03, #04, #05, #08, #11, #12, and #13). 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 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings Include: Review of the medical record for Resident #10 revealed an admitted [DATE]. The resident had a diagnosis including schizophrenia, cerebral infarction (disrupted blood flow to the brain) with hemiplegia/hemiparesis, epilepsy, and anxiety. Review of Resident #10's plan of care, dated [DATE] revealed the resident was at risk for elopement related to impaired safety awareness with interventions to distract the resident from wandering, staff to identify patterns of wandering and to monitor exit seeking behavior. Review of a psychiatry progress note dated [DATE] revealed Resident #10 was seen per the facility request for a psychiatric evaluation and medication management. The evaluation indicated resident's cognitive status was forgetful but functional, she had mild impairment related to judgment and insight and she had ongoing 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. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #10, revealed the resident had no cognitive deficits and required supervision to limited assistance with activities of daily living (ADLs). (continued on next page)

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	05/11/2023

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	Review of a progress note, dated [DATE] revealed Resident #10 left the secured unit at approximately 11:45 A.M. When staff searched the building, the resident was found on the lower level (basement) in the employee break room. STNA #116 brought Resident #10 back to the secured unit. When the on-duty nurse questioned Resident #10 on how she got down to the basement, the resident replied that she knew the codes to the door and the elevator. Resident #10 was placed on every 15-minute checks throughout the night. Review of an elopement risk evaluation, dated [DATE] completed by ADON #120, revealed Resident #10 was assessed as being an elopement risk. Further review of Resident #10's elopement/wandering assessment indicated the resident had impaired decision-making skills. Review of the progress note dated [DATE] at 10:48 P.M. completed by LPN #117, revealed the nurse was coming out of another resident's room when STNA #116 alerted her that the fire department was outside with Resident #10. Resident #10 had been outside the building trying to cross the street when she was seen by a pedestrian who called 911 out of concern. The note revealed Resident #10 was last seen in the dining area by STNA #107 who was assigned to the secured unit. Resident #10 stated she was going to bed since she had already received her night-time medications, and LPN #117 did not see Resident #10 again until she was returned by the fire department. Review of the Cincinnati Fire Department (CFD) report, dated [DATE], revealed the first responder (Engine #32) was dispatched to the area of [NAME] Avenue at 10:17 P.M. for a person who was found in the street. The CFD first responders arrived on the scene at 10:21 P.M. and found a person (later identified as Resident #10) in a wheelchair, seated on the sidewalk with bystanders stating they found the person in the middle of the street.? Resident #10 had no medical complaints, she was a resident at Astoria Place Nursing Home, under the care of a behavioral psychiatrist locked down unit on the second floor. Resident #10 was wheeled back to the nursing home when the resident began acting to be unresponsive. However, the resident was responsive to painful stimuli of a sternal rub. The nursing home staff stated they did not know how Resident #10 got out of the facility. Resident #10 was transported to the ER for an evaluation due to patients' known history of street drug usage and prior medical history of a stroke from drug usage. Review of the EMS report dated [DATE], revealed EMS was dispatched to the area of [NAME] Avenue at 10:27 P.M. EMS arrived on scene at 10:31 P.M. and found Resident #10 acting erratic, outside her rehabilitation facility and refused to go back in Resident #10 stated she wanted to go see her boyfriend. Resident #10 faked sleeping when questioned by the police.?Resident #10 stated she got out of the facility and wanted someone to drive her to her boyfriend's home. Resident #10 was noted to be in the middle of the street as she had deficits from a previous stroke and a broken hip. Resident #10 vital signs were normal, she had no complaints, and was transported to a local emergency room for evaluation. The resident returned to the facility after being evaluated in the emergency room . Review of a witness statement from STNA #107, dated [DATE], revealed STNA #107 was in the women's secured unit's dining room with other residents including Resident #10 going through and giving out clothes that a staff member had brought in for the residents. STNA #107 was talking to Resident #10 between 9:30 P. M. and 10:00 P.M. STNA #107 reported she did not hear any alarms go off on the units. (continued on next page)

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	05/11/2023

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	Review of a progress note dated [DATE] at approximately 10:00 A.M. and authored by LPN #132 revealed this nurse was notified by the on-call manager that Resident #10 had an elopement attempt and questioned if Resident #10 was on 1:1 observation. LPN #132 informed the on-call manager, Resident #10 was on every 15-minute checks and the unit was staffed with two STNAs and one nurse. One aide was giving a shower, the nurse was performing medication administration, and the other aide was on the floor providing resident care. The on-call manager informed LPN #132 that Resident #10 was to be always in sight of staff. When LPN #132 went to inform the unit staff about Resident #10's 1:1 observation, the unit staff went to get Resident #10 for continued close observation. After a unit sweep, Resident #10 was found hiding in another resident's closet with the door closed. Resident #10 was immediately assigned to have a 1:1 aide and the on-call manager was called and made aware of events. The activities aid was pulled to the unit to be 1:1 with Resident #10 for the remainder of the shift. Interview on [DATE] at 7:03 A.M. with SSD #108, revealed the door pass codes were not hidden when staff entered the numbers and often times the staff would just say the codes aloud and in front of the residents. Interview [DATE] at 12:22 P.M. with LPN #117, revealed Resident #10 was in the dining room on [DATE] at unknown time going through clothes that were brought in for residents when the resident stated she was going to bed and the next thing she knew, the fire department was at the door bringing Resident #10 back into facility. LPN #117 stated she was not aware Resident #10 was out of the facility. LPN #117 stated she was not sure of the time frame when Resident #10 was in the dining room, but stated it was after 9:00 P.M. because she had given the resident her nighttime medications. Interview on [DATE] at approximately 1:00 P.M. with Maintenance Director #151, revealed every time there was an elopement, he was required to immediately change all the key codes on the doors, stairwells, and the elevators. Maintenance Director #151 stated he was in the facility after Resident #10's elopement on [DATE] for most of the night changing the codes to all the doors, stairwells, and elevator. Maintenance Director #151 stated when he changed the codes, he had to send out an all-staff alert as to what the codes were, so they were able to get in and around the building. Maintenance Director #151 stated he was not aware Resident #10 had gotten off the secured unit on [DATE]. On [DATE] at 2:30 P.M. observation of the facility's video footage from [DATE] with Maintenance Director #151, revealed Resident #10 was seen propelling into the parking lot from an exterior ramp on the north side of the parking lot. Resident #10 wheeled through the parking lot and onto the sidewalk where the resident went south and visual was lost when she went around the facility's van parked in the lot. The ambulance entrance video footage at 9:50 P.M. revealed EMS were at the door with Resident #10. Interview on [DATE] at 4:07 PM with Resident #10's power-of-attorney (father) revealed the resident was supposed to be on a locked unit because she had brain damage to the frontal lobe from a stroke she suffered, and she made bad judgments and bad decisions. He stated the resident had been in multiple other nursing homes because of her behaviors and none of them wanted to keep her. He was unaware the resident had eloped on [DATE] but stated he does not always get his calls when he has no service. Interview on [DATE] at 7:40 AM with Interim Nurse Practitioner (NP #400), revealed she was unable to comment on Resident #10's competency since she had only seen the resident a couple of times. (continued on next page)

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	05/11/2023

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	Observation of the active camera times on [DATE] at 8:15 A.M. with Maintenance Director #151 revealed the camera times were showing 7:49 AM and the real time was 8:15 AM. Maintenance Director #151 confirmed that the camera times were off by 35 minutes. Interview on [DATE] at 9:48 A.M. with Resident #10, revealed someone gave her the pass codes, but she was not going to say who it was. Resident #10 stated on [DATE], she was trying to get a ride to Colerain and when she was crossing the street, a bra that she had on her lap got caught in the front wheel of her wheelchair which led her to getting stuck in the middle of the road. Resident #10 stated she fell out of the wheelchair and almost got hit by two cars when a third car noticed her, stopped, and the guy got out and called 911. Resident #10 could not focus on the interview and kept looking at the ground and yelling expletives. Interview on [DATE] at 3:35 P.M. with Medical Director (MD) #410 reported Resident #10 makes very bad choices which were dangerous for her safety due to her brain injuries. MD #410 indicated Resident #10 should be on a secured unit. On [DATE] at approximately 3:30 P.M., an interview with the Administrator revealed she did not do a thorough assessment of Resident #10's cognitive status, so she was going to have an expert evaluation completed on Resident #10. Review of the Statement of Expert Evaluation dated [DATE] by Physician #181, revealed Resident #10 was incompetent due to poor judgement and insight and guardianship should be granted. Review of the Elopement Prevention and Missing Resident Policy dated [DATE] revealed the policy indicated to create an environment that was as safe as possible for residents at risk for elopement. The policy also included to develop a plan of action that would ensure a prompt, effective, and coordinated response when a resident was reported missing. This deficiency represents non-compliance investigated under Complaint Number OH000142443. This deficiency represents ongoing non-compliance from the surveys dated [DATE] and [DATE].

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	05/11/2023

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35770 Based on observations and staff interviews, the facility failed to designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) on a full-time basis. This had the potential to affect all 63 residents residing in the facility. 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. Observations of the facility on 05/02/23, 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 for the week of 05/01/23 through 05/07/23. The Administrator noted the new DON was hired and started on 05/08/23.

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	05/11/2023

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35770 Based on observations, staff interviews and review of facility policy, the facility failed to ensure a medication cart on the first floor 100-unit with numerous prescription medications inside, was properly secured at all times. This had the potential to affect seven residents (#26, #25, #24, #23, #22, #21 and #20) who the facility identified as being independently mobile. The facility census was 63. Findings Include: An observation on 05/02/23 at 7:55 A.M. revealed a medication cart on the 100 unit on first floor was left unattended, unlocked with residents walking around in the hallway and no nurse in sight. An interview on 05/02/23 at 7:57 A.M. with Licensed Practical Nurse (LPN) #141, verified the medication cart was unlocked, unattended and with independently mobile residents in the area at risk of accessing the medication cart. LPN #141 stated she forgot to lock the medication cart when she left the floor to get some applesauce and pudding from the kitchen which was on a separate level. Review of the Medication Storage Policy, dated 04/01/22 revealed medications would be stored in a manner that maintained the integrity of the product, ensured the safety of the residents, and was in accordance with the Department of Health guidelines. All medications would be stored in a locked cabinet, cart of medication room that is accessible only to authorized personnel.

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	05/11/2023

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35770 Based on record review, staff interviews, physician interview, review of the facility policy regarding elopement, and review of the facility's prior surveys documentation regarding Quality Assurance and Performance Improvement (QAPI) plans, the facility failed to develop, implement, and ensure a comprehensive and effective plan of action was in place to correct identified quality deficiencies. This had the potential affect all 63 residents who resided in the facility. Findings include: Review of the facility survey history revealed during the complaint survey completed on 03/07/23 a concern with resident elopement was identified and cited at F689 as an Immediate Jeopardy. Review of the facility corrective action plan for the 03/07/23 survey revealed the facility would hold QAPI committee meetings to review the deficiencies, create plans and review audits to ensure 100 percent compliance was achieved. During the survey completed on 05/11/23 ongoing concerns related to resident safety/supervision and elopement (involving Resident #10) were identified. An Immediate Jeopardy at F689 was issued during this survey. Interview on 05/02/23 at approximately 1:00 P.M. with Maintenance Director #151, revealed every time there was an elopement, he was required to immediately change all the key codes on the doors, stairwells, and the elevators. Maintenance Director #151 stated he was in the facility after Resident #10's elopement on 04/19/23 for most of the night changing the codes to all the doors, stairwells, and elevator. Maintenance Director #151 stated when he changed the codes, he had to send out an all-staff alert as to what the codes were, so they were able to get in and around the building. However, Maintenance Director #151 stated he was not aware Resident #10 had also gotten off the secured unit on 04/12/23. Interview on 05/03/23 at 9:48 A.M. with Resident #10, revealed someone gave her the pass codes, but she was not going to say who it was. Resident #10 stated on 04/19/23, she was trying to get a ride to Colerain and when she was crossing the street, a bra that she had on her lap got caught in the front wheel of her wheelchair which led her to getting stuck in the middle of the road. Resident #10 stated she fell out of the wheelchair and almost got hit by two cars when a third car noticed her, stopped, and the guy got out and called 911. Resident #10 could not focus on the interview and kept looking at the ground and yelling expletives. Interview on 05/03/23 at 3:35 P.M. with Medical Director (MD) #410 reported Resident #10 makes very bad choices which were dangerous for her safety due to her brain injuries. MD #410 indicated Resident #10 should be on a secured unit. (continued on next page)

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	05/11/2023

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 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 reported missing.