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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365476 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/29/2024 |
| NAME OF PROVIDER OR SUPPLIER Astoria Place of Silverton | | STREET ADDRESS, CITY, STATE, ZIP CODE 6922 Ohio Avenue Cincinnati, OH 45236 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on record review, staff interviews, and review of the facility policy, the facility failed to ensure a written discharge notice with provision of the discharge was provided to resident upon discharge to the community. This affected one resident (#56) out of three residents reviewed. The facility census was 53.</p> <p>Findings include:</p> <p>Record review for Resident #56 revealed the resident was admitted on [DATE] and discharged on [DATE]. His diagnoses included, spondylosis, chronic obstructive pulmonary disease, coronary artery dissection, major depressive disorder, insomnia, hypertension, and alcohol abuse.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #56, revealed the resident was cognitively intact. Resident #56 was dependent on facility staff for medication administration and independent with all other activities of daily living.</p> <p>Review of the nursing progress notes for Resident #56 dated 05/14/24 at 4:12 P.M. revealed the resident was discharged to a local hotel's address with all of his personal belongings, a courtesy bag, a list of medications and the resident reported an understanding of discharge instructions. The progress notes revealed no documented evidence of a written discharge notice with provision of the discharge being provided to resident upon discharge to the community or a discharge appeal being offered to the resident.</p> <p>Interview with the Social Service Designee (SSD) #128 on 05/29/24 at 10:26 A.M., revealed Resident #56 discharged to a local hotel on 05/14/24 and the facility agreed to pay for seven days at the hotel. SSD #128 stated she was on vacation when Resident #56 discharged on [DATE], however, prior to her leave, she referred Resident #56 to a program that could help with finding an apartment but there was nothing set up. SSD #128 verified there was no documented evidence of a discharge summary for Resident #56 and no documented evidence of a written discharge notice with provision of the discharge being provided to resident upon discharge to the community or a discharge appeal being offered to the resident.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with the Administrator and Director of Nursing (DON) on 05/29/24 at 10:45 A.M. revealed Resident #56's discharge was initiated due to the resident wanting to sign himself out all the time and stay with a friend. The Administrator stated they also learned of Resident #56 being listed as a sexual offender on 05/14/24. The Administrator indicated the facility discharged the resident on 05/14/24 and paid for a hotel room for seven days. The DON reported the resident was given a list of his medications upon discharge. The DON reported Resident #56's physician was aware of the discharge and stated the resident was ready for discharge. The DON verified the facility had no documented evidence of a discharge summary in the medical record and no documented evidence of a written discharge notice with provision of the discharge being provided to resident upon discharge to the community or a discharge appeal being offered to the resident.</p> <p>Interview with the Medical Director (MD) #500 on 05/29/24 at 4:44 P.M. revealed he was advised Resident #56 was ready to be discharged on [DATE] and was not aware of the resident being discharged due to being a sexual offender.</p> <p>Review of the facility policy titled, Transfer or Discharge Documentation, dated December 2016 confirmed when a resident is transferred or discharged it will be documented in the medical record and the resident will be provided with a copy of the discharge summary. The resident has the right to appeal the discharge and if a resident appeals a discharge notice, the resident will not be transferred or discharged while the appeal is pending.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154263.</p> | | |

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| <p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on record review, staff interviews, and review of the facility policy, the facility failed to ensure a safe and orderly discharge. This affected one resident (#56) out of three residents reviewed. The facility census was 53.</p> <p>Findings include:</p> <p>Record review for Resident #56 revealed the resident was admitted on [DATE] and discharged on [DATE]. His diagnoses included, spondylosis, chronic obstructive pulmonary disease, coronary artery dissection, major depressive disorder, insomnia, hypertension, and alcohol abuse.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #56, revealed the resident was cognitively intact. Resident #56 was dependent on facility staff for medication administration and independent with all other activities of daily living.</p> <p>Review of the nursing progress notes for Resident #56 dated 05/14/24 at 4:12 P.M. revealed the resident was discharged to a local hotel's address with all of his personal belongings, a courtesy bag, a list of medications and the resident reported an understanding of discharge instructions. The progress notes revealed no documented evidence of any follow-up services being set for the resident.</p> <p>Interview with the Social Service Designee (SSD) #128 on 05/29/24 at 10:26 A.M. revealed Resident #56 discharged to a local hotel on 05/14/24 and the facility agreed to pay for seven days at the hotel. SSD #128 stated she was on vacation when Resident #56 discharged on [DATE], however, prior to her leave, she referred Resident #56 to a program that could help with finding an apartment but there was nothing set up. SSD #128 verified there was no documented evidence of a discharge summary for Resident #56 and no documented evidence of any follow up services being initiated for Resident #56 at the time of discharge.</p> <p>Interview with the Administrator and Director of Nursing (DON) on 05/29/24 at 10:45 A.M. revealed Resident #56's discharge was initiated due to the resident wanting to sign himself out all the time and stay with a friend. The Administrator stated they also learned of Resident #56 being listed as a sexual offender on 05/14/24. The Administrator indicated the facility discharged the resident on 05/14/24 and paid for a hotel room for seven days. The DON reported the resident was given a list of his medications upon discharge. The DON reported Resident #56's physician was aware of the discharge and stated the resident was ready for discharge. The DON verified the facility had no documented evidence of a discharge summary in the medical record and no evidence of a discharge summary being provided to the resident.</p> <p>Interview with the Medical Director (MD) #500 on 05/29/24 at 4:44 P.M. revealed he was advised Resident #56 was ready to be discharged on [DATE] and was not aware of the resident being discharged due to being a sexual offender.</p> <p>(continued on next page)</p> | | |

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| <p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A subsequent interview with the Administrator on 05/29/24 at 5:22 P.M. revealed the facility learned of Resident #56's sexual offender status from his Case Manager. The Administrator provided an email thread, and it was dated 05/14/24. The email thread discussed Resident #56 could not be part of the placement program because he was a registered sex offender in [NAME] County, Ohio and the case manager provided the verification. The Administrator stated the facility utilized the national sexual offender listing and not the local one. The Administrator stated once they learned of Resident #56's sexual offender status, they discharged him to a local hotel and paid for his room for seven days. She indicated the facility did notify other residents and their representatives.</p> <p>Review of facility policy titled Admission Criteria revealed all new admission are to be screened through the Dru [NAME] National Sex Offender Public Website.</p> <p>Review of the facility policy titled, Transfer or Discharge Documentation, dated December 2016 confirmed when a resident is transferred or discharged it will be documented in the medical record and appropriate information will be communicated to the receiving provider. When a resident is discharged from the facility, the following information should be documented in the medical chart, the basis for discharge, the date and time of discharge, the new location address, the mode of transportation, a summary of the resident's mental, physical, and mental condition, and dispositions of medications.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154263.</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on record review, observation, staff interviews, and review of facility policy, the facility failed to provide a clean, safe, and sanitary environment. This directly affected three residents (#14, #25, and #42) but had the potential to affect all 18 residents (#01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, #12, #13, #14, #15, #16, #25 and #42) who resided on the memory care unit. The facility census was 53.</p> <p>Findings include:</p> <p>1) Record review for Resident #14 revealed he was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, chronic respiratory failure with hypercapnia, diabetes mellitus (DM)2, Alzheimer's disease, depression, insomnia, and anxiety disorder. Review of Resident #14's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #14 had impaired cognition.</p> <p>Observation of Resident #14's room on 05/29/24 at 11:20 A.M. revealed the following:</p> <ol style="list-style-type: none"> The cove base around the outside of the bathroom wall was hanging off the wall. There was white drywall mud splatter all along the wall. The resident was sitting on the side of his bed and there was a large brownish/red stain on the resident's bed sheet. There was an unknown brown liquid substance in the floor around the resident's bed and black smudges/stains throughout the floor. A metal electric box with four receptacles that had been removed from the wall and sitting on the floor near the unknown brown liquid all over the floor. The metal base board heater in the resident's bathroom was rusted and rust was hanging from the heater. <p>Interview with Resident #14 on 05/29/24 at 11:25 A.M. revealed the large unknown brown liquid substance had been in the floor for two days and he had requested for the staff to clean his room.</p> <p>An interview with Licensed Practical Nurse (LPN) #126 on 05/29/24 at 11:39 A.M. verified the condition of Resident #14's room.</p> <p>2) Record review for Resident #25 revealed she was admitted to the facility on [DATE]. Diagnoses included osteoarthritis, schizoaffective disorder, anemia, post-traumatic stress disorder (PTSD), bipolar disorder, and conversion disorder. Review of the most recent MDS assessment revealed Resident #25 was cognitively intact.</p> <p>(continued on next page)</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation of Resident #25's room on 05/29/24 at 3:20 P.M. with Maintenance Supervisor (MS) #169 revealed a large crack in the resident's wall that ran the entire length of her wall and a large crack under the window with the peeling, exposed drywall. MS #169 verified the condition of Resident #25's room.</p> <p>3) Record review for Resident #42 revealed she was admitted to the facility on [DATE]. Diagnoses included, hemiplegia, hemiparalysis, diabetes mellitus, morbid obesity, bradycardia, and anemia. Review of the most recent MDS assessment dated [DATE], revealed Resident #42 had impaired cognition.</p> <p>Observation of Resident #42's room on 05/29/24 at 11:40 P.M. revealed the walls had areas of damaged drywall and black marks. Interview with Resident #42 at the same time indicated had been damaged for a while.</p> <p>Interview with MS #169 on 05/29/24 at 3:20 P.M. verified the condition of Resident #42's walls.</p> <p>4) Observation of the Memory Care Unit shower room on 05/29/24 at 3:18 P.M. with MS #169 revealed the shower room contained a large, white, chunky substance on top of the shower room tile floor, a black fuzzy substance throughout the tile grout, the overhead light was not working, there were missing ceiling tiles, the toilet was missing the tank and the main floor and the floor in the shower had uneven edges. MS #169 stated confirmed the condition of the resident's shower room. MS #169 stated the white substance on the floor was floor leveler.</p> <p>Review of facility policy titled Quality of Life -Homelike Environment revealed the residents are provided with the safe, clean. Comfortable and homelike environment.</p> |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>43062</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, staff interviews, record review and review of facility policy, the facility failed to maintain an effective pest control program. This had the potential to affect all 53 residents who resided at the facility. The facility census was 53.</p> <p>Findings include:</p> <p>Interview on 05/29/24 at 4:00 P.M. with Resident #35 revealed the facility has had an on-going issue with various bugs. Resident #35 stated she observed several bugs in her room recently.</p> <p>Interview with Resident #42 on 05/29/24 at 11:40 P.M. revealed she has observed various bugs in her room recently.</p> <p>An interview with an unknown Visitor #51 on 05/29/24 at 11:22 A.M. revealed she was very upset with the conditions of the facility. Visitor #51 took out her phone and showed Surveyor several pictures of large bugs she had observed in the facility.</p> <p>Interview with Resident #47 on 05/29/24 at 11:28 A.M. revealed she had large bugs in her room. Observed at the same time revealed a dead, large, black hard-shelled bug approximately one inch inside her door frame and a live one underneath the resident's sink. Resident #47 stated she just kills them as she sees them.</p> <p>Interview with Activity Director (AD) #78 on 05/29/24 11:30 A.M. verified the bugs inside Resident #47's room. When AD #78 opened Resident #47's bathroom door, there were three large bugs crawling around the base of the toilet.</p> <p>Interview with Housekeeper (HK) #64 on 05/29/24 at 4:12 P.M. revealed she had observed bugs in the resident's rooms while cleaning. Observation at the same time with HK #64, revealed a large, brown, hard-shelled bug crawling in the hallway near Resident #20's room.</p> <p>Interview with State tested Nurse Aide (STNA) #88 on 05/29/24 at 4:18 P.M. revealed the facility has had an ongoing issue with several types of pests throughout the facility. STNA #88 stated the residents have voiced concerns related to the pest control.</p> <p>Interview with the Administrator on 05/29/24 at 5:22 P.M. revealed the facility has had an ongoing issue with large water bugs for several months and reported the pest control procedures currently in place were not effective.</p> <p>Review of the facility policy titled, Pest Control, dated May 2008, confirmed the facility will maintain an effective pest control program to ensure the facility is kept free of pests and rodents.</p> | | |