STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365476	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Silverton	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interviews, and policy review, the facility failed to allow a resident to remain in the facility and not transfer or discharge the resident without justification and proper documentation. This affected one (#61) resident out of three residents reviewed for transfer and discharge. The facility census was 53. Findings include: Review of the closed medical record for Resident #61 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder, bipolar disorder, and alcohol use, unspecified with alcohol-induced persisting dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/01/24, revealed Resident #61 had moderately impaired cognition. Resident #61 was assessed to be independent for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer. Review of the progress notes from 07/01/24 to 08/20/24 revealed no documentation related to discussion of transfer or discharge with Resident #61's guardian. Review of the incomplete discharge summary dated 08/20/24 revealed Resident #61 was discharged to another nursing home. The summary indicated the reason for discharge was being incompatible with other residents on unit. Interview on 09/10/24 at 5:47 P.M. via telephone with Resident #61's guardian revealed he had not been involved in the discharge process. Resident #61's guardian stated the facility contacted him and informed him of concerns with Resident #61's behaviors, and he believed the facility did not want Resident #61 to remain a resident there. Resident #61's guardian reported he was unaware Resident #61 was being transferred to another facility until he was called to meet with staff and Resident #61 at the proposed new facility because Resident #61 had refused to stay. Resident #61's guardian also revealed that Resident #61 was returned to the facility and was ultimately transferred to another facility days later. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/11/24 at 11:38 A.M. with the Director of Nursing (DON) revealed Resident #61's behaviors had escalated, and the decision was made after speaking with the guardian to transfer Resident #61 for safety reasons. Interview on 09/11/24 at 12:29 P.M. with the Administrator revealed multiple conversations occurred with the guardian regarding Resident #61's desire to leave the facility. The Administrator stated the guardian was advised that alternate placement would be needed if Resident #61 wished to leave the facility. Interview on 09/11/24 at 2:33 P.M. with the Administrator verified the lack of documentation regarding Resident #61's transfer. Review of the policy titled Resident Transfer and Discharge, dated 04/01/22, revealed all transfers or discharges must be documented in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00156824.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interviews, and policy review, the facility failed to give proper notice before a transfer or discharge. This affected one (#61) resident out of three residents reviewed for transfer and discharge. The facility census was 53. Findings include: Review of the closed medical record for Resident #61 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder, bipolar disorder, and alcohol use, unspecified with alcohol-induced persisting dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/01/24, revealed Resident #61 had moderately impaired cognition. Resident #61 was assessed to be independent for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer. Review of the progress notes from 07/01/24 to 08/20/24 revealed no documentation related to discussion of transfer or discharge with Resident #61's guardian. Review of the incomplete discharge summary dated 08/20/24 revealed Resident #61 was discharged to another nursing home. The summary indicated the reason for discharge was being incompatible with other residents on unit. Interview on 09/10/24 at 5:47 P.M. via telephone with Resident #61's guardian revealed he had not been involved in the discharge process. Resident #61's guardian stated the facility contacted him and informed him of concerns with Resident #61's behaviors, and he believed the facility did not want Resident #61 to remain a resident there. Resident #61's guardian reported he was unaware Resident #61 was being transferred to another facility until he was called to meet with staff and Resident #61 at the proposed new facility because Resident #61 had refused to stay. Resident #61's guardian also revealed that Resident #61 was returned to the facility and was ultimately transferred to another facility days later. Interview on 09/11/24 at 11:38 A.M. with the Director of Nursing (DON) revealed Resident #61's behaviors had escalated, and the decision was made after speaking with the guardian to transfer Resident #61 for safety reasons. Interview on 09/11/24 at 12:29 P.M. with the Administrator revealed multiple conversations occurred with the guardian regarding Resident #61's desire to leave the facility. The Administrator stated the guardian was advised that alternate placement would be needed if Resident #61 wished to leave the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/11/24 at 2:33 P.M. with the Administrator verified the lack of documentation regarding Resident #61's transfer. The Administrator stated Resident #61 was not given a formal discharge notice because the guardian had agreed with the transfer. Review of the policy titled Resident Transfer and Discharge, dated 04/01/22, revealed before the facility transfers or discharges a resident, the facility would provide a written notice that notified the resident and the resident's representative of the transfer or discharge and the reasons for the move, and record the reasons for the transfer or discharge in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number OH00156824.