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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>365476 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>07/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Astoria Place of Silverton |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6922 Ohio Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, and review of facility policy, the facility failed to ensure care and services to prevent falls were implemented timely and appropriately. This affected one resident (#13) of 23 residents reviewed for falls. The facility census was 71. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, and hypertension. Review of the facility Fall Risk Assessment, dated 04/15/25, revealed the resident was assessed to be at moderate risk for falls. Review of the facility incident log revealed Resident #13 experienced a fall in the facility on 05/10/25. Review of the plan of care for Resident #13 revealed a plan of care and interventions to reduce the risk of falls had not been implemented for the resident until 05/14/25, four days after the resident experienced a fall at the facility. Interview with Minimum Data Set (MDS) Nurse #390 on 07/08/25 at 3:08 P.M. confirmed a plan of care to include interventions to prevent falls should be implemented for all residents assessed to be at risk for falls. Interview with MDS Nurse #390 on 07/09/25 at 9:30 A.M. confirmed a plan of care and interventions to prevent falls had not been implemented for Resident #13 until 05/14/25, four days after the resident fell while residing in the facility. Review of the facility policy titled Fall Policy, reviewed on 01/01/25, revealed all residents will receive adequate supervision, assistance, and assistive devices to prevent falls. Each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in preventing falls. This deficiency represents non-compliance investigated under Complaint Numbers 1308974, 1308976, and 1308977.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 70 out of 71 residents in the facility. One resident (#67) was unable to consume food from the kitchen per diet order. The census was 71. Observation on 07/07/25 at 10:15 A.M. of the kitchen revealed the floor of the walk-in refrigerator had a pooling of water with a brownish tint. Interview on 07/07/25 at 10:15 A.M. with Dietary Manager (DM) #710 verified the pooling of water on the floor in the walk-in refrigerator. DM #710 stated she was newer to the position and had no information regarding the issue in the walk-in refrigerator. This deficiency represents non-compliance investigated under Complaint Number 1308977.</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observation, interview and review of the medication administration policy the facility failed to provide medications while adhering to proper infection control procedures during administration. This affected one resident (Resident #53) out of three observed during medication administration. The facility census was 71. Findings include: Record review of Resident #53 revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: Alzheimer's disease, seizures, depression, dysphagia, supraventricular tachycardia, atrial fibrillation, and benign prostatic hyperplasia. Review of the Minimum Data Set(MDS) assessment completed on 06/05/25 revealed this resident had minimal cognitive impairments. Review of Physician Orders revealed this resident was receiving the following medications observed during administration: Vitamin B12 100 milligrams (mg) 1 tablet, Zinc 50 mg 1 tablet, Sertraline 50 mg 1 tablet, Multivitamin 1 tablet, Folic Acid 800 mg 1 tablet, Flecainide Acetate 100 mg 1 tablet, Diazepam 120 mg 1 tablet, and Carbazepine 200 mg 1 tablet during the morning administration. Observation of medication administration for Resident #53 on 07/08/25 at 7:50 A.M. revealed all medications were prepared by Medication Tech #770. All medications were collected from their individual packaging by the preparer with the use of bare hands into the medication cup for administration. Hand washing was not completed prior to or following administration. Interview with Medication Tech #770 on 07/08/25 at 7:50 A.M. verified she had handled all eight medications with her bare hands, and also verified she did not wash her hands prior to or following administration to Resident #53. She stated she should not have touched the medications to put them in the medication cup. Review of the Medication Administration Policy revised on 01/01/25 revealed hand hygiene is to be performed prior to handling any medication. The policy also states if a medication becomes contaminated or compromised, the medication is discarded.</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, staff interviews, and policy review, the facility failed to maintain a clean, safe, and homelike environment. This affected one resident (#72) and had the potential to affect all residents residing in the facility. The census was 71. Findings include: 1. Observation on 07/07/25 at 8:24 A.M. revealed an area of the handrail on the 200 hall was missing. There was a wooden box between the two sections of handrail that was half-way secured to the wall. At the time of the observation, Maintenance Director (MD) #990 verified the missing section of handrail. MD #990 stated there was a water fountain that was removed from the wall, and the wooden box contained some plumbing parts. MD #990 expressed the plan was to remove the plumbing parts and replace the handrail. 2. Observation on 07/07/25 at 9:55 A.M. revealed a broken handrail on the 400 hall. The front portion of the handrail was cracked and separated from the rest of the handrail and had a sharp edge, which was verified by State Tested Nursing Assistant (STNA) #440 at 9:57 A.M. on 07/07/25. 3. Observation on 07/07/25 at 9:58 A.M. of the ceiling tiles in the hallway where the shower room is located revealed several ceiling tiles had multiple brown stains and black spots, which were confirmed by Human Resources Director #680 at the time of the observation. 4. Observation on 07/07/25 at 10:02 A.M. on the secured unit revealed several ceiling tiles near the door to the unit were cracked with various brown and black spots, which were verified by Registered Nurse (RN) #105 when observed. 5. Observation on 07/07/25 at 10:11 A.M. on the 300 hall revealed blankets on the floor that were folded up and pressed against the bottom of a ventilation unit. There was also a puddle of water near the blankets, and brownish water coming up from under the flooring. These observations were verified on 07/07/25 at 10:12 A.M. by Activities Staff #530. 6. Observation on 07/07/25 at 2:39 P.M. of the shower room revealed a blue shower chair that was broken and leaned back. STNA #220 verified the shower chair was broken and still being used. 7. Observation on 07/09/25 at 8:17 A.M. of the shower room revealed black discoloration between the tiles on the shower wall. The outer edge of the shower frame was cracked and missing pieces. There was also a hole in the ceiling of the shower room near the toilet. These observations were verified at the time of the observations with Housekeeping Staff #175. 8. Review of the medical for Resident #72 revealed an admission date of 07/07/23. Diagnoses included congestive heart failure, lobar pneumonia, acute kidney failure, type two diabetes mellitus without complications, chronic obstructive pulmonary disease, anxiety disorder, major depressive disorder, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was cognitively intact and was assessed to require partial/moderate assistance with toileting and bathing, supervision with personal hygiene and transfer, and was independent with eating, oral hygiene, dressing, and bed mobility. Observation on 07/09/25 at 9:11 A.M. in Resident #72's room revealed the edge of the column of wall between the closet and dresser was missing pieces. A piece of material had been screwed into the wall to cover some of the missing wall but there were still areas of the wall that were rough and missing. Interview on 07/09/25 at 9:15 A.M. with RN #145 verified the wall was missing drywall. Observation on 07/09/25 at 9:16 A.M. in Resident #72's room revealed the edge of the wall near the door frame was breaking off, and the flooring outside of the room was missing a section. These observations were verified on 07/09/25 at 9:17 A.M. by Housekeeping Staff #780. Review of the facility policy titled Safe, Clean, Comfortable Homelike Environment, reviewed 01/01/25, revealed it was the policy of the facility to provide a safe, clean, comfortable homelike environment for residents. This deficiency represents non-compliance investigated under Complaint Numbers 1308974, 1308976, and 1308977.</p> |   |  |