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	03/17/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident interview, staff interview, and policy review, the facility failed to treat residents with dignity and respect by providing disposable cutlery and dishware during meal services. This affected 67 residents as the facility identified three residents (#42, #56 and #73) who were nothing by mouth (NPO) and did not receive food from the kitchen. The facility census was 70. Findings include: During an observation of the kitchen on 03/04/26 at 10:39 A.M. with Dietary Manager (DM) #64, revealed the dishwasher was not operational. DM #53 stated there have been problems with the dishwasher since February and the facility has been using disposable dishware for all meals. DM #64 stated it gets fixed and will work for a few days and then break again. DM #64 stated the dishwasher was dispensing chemicals at the incorrect time throughout the wash cycle and dishes were not coming out clean. DM #64 stated the facility has had technicians out frequently to make repairs on the machine. Observation at the same time as the interview with DM #53 revealed a technician was working on the dishwasher. Observation of the lunch service on 03/05/26 at 12:28 P.M., revealed the residents were being served lunch in Styrofoam containers with plastic cutlery. During an interview on 03/11/26 at 11:11 A.M., Resident #54 stated she did not like receiving her meals in the Styrofoam containers as it made it difficult to cut. Resident #54 stated that she would end up cutting through the Styrofoam while trying to eat.Observation of lunch service on 03/11/26 at 12:00 P.M., revealed the residents were being served lunch in Styrofoam containers with plastic utensils. Review of the facility policy titled Quality of Life - Dignity dated August 2009, revealed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain, and protect resident Privacy, including bodily privacy during assistance with personal care and during treatment procedures. This deficiency represents non-compliance investigated under Complaint Number 2699059.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review and policy review, the facility failed to ensure care conferences were conducted. This affected two Residents (#107 and #117) of the three residents reviewed for care conferences. The facility census was 70.Findings include:1) Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] and discharged on 02/09/26 as Against medical Advice (AMA). Diagnoses included chronic viral hepatitis-c, polyneuropathy, dementia, manic episode without psychotic symptoms, bipolar disorder, depression and venous insufficiency. The resident had no Guardian at the time of discharge. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #107 had moderately impaired cognition, independent with eating, partial assistance with toileting, substantial assistance with bathing, and set up for personal hygiene. On 02/09/26, the resident was reassessed to have a Brief Interview Mental Status (BIMS) of 13 indicating the resident was cognitively intact. Review of the medical record for Resident #107 on 03/10/26 at 10:03 with Social Services (SS) #85, revealed no care conferences were conducted. During an interview with SS #85 at the same time, verified there were no care conferences conducted for Resident #107. 2) Review of the medical record revealed Resident #117 was admitted to the facility on [DATE] and discharge on [DATE]. Diagnoses included mood disorder, bipolar disorder, cauda equina syndrome, catatonic schizophrenia, and major depressive disorder. Review of the most recent MDS assessment dated [DATE], revealed Resident #117 had severely impaired cognition and required assistance with activities of daily living (ADL).Review of the medical record for Resident #117 on 03/10/26 at 1:00 P.M. with Social Services (SS) #85, revealed no care conferences were conducted. During an interview with SS #85 at the same time, verified there were no care conferences conducted for Resident #117. Review of the policy titled, Comprehensive Care Plans, revealed each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in the planning process. If the participation of the resident and his or her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.This deficiency represents non-compliance investigated under Complaint Number 2691577.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of care plans, observations, staff interviews, and policy review, the facility failed to have call lights within reach. This affected four Residents (#33, #53, #55, and #58) reviewed for call lights. The facility census was 70.Findings include: 1) Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] and discharged on 02/09/26 as AMA. Diagnoses included chronic viral hepatitis c, polyneuropathy, dementia, manic episode without psychotic symptoms, bipolar disorder, depression and venous insufficiency. The resident had no Guardian at the time of discharge. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #107 had moderately impaired cognition, independent with eating, partial assistance with toileting, substantial assistance with bathing, and set up for personal hygiene. On 02/09/26, the resident was reassessed to have a Brief Interview Mental Status (BIMS) of 13, indicated the resident was cognitively intact. Review of a facility documented titled Unauthorized Discharge Release of Responsibility dated 02/09/26 revealed Resident #107 signed out of the facility AMA. The facility documented discussion of the risks of the resident leaving AMA and attempted to get the resident to say. During an interview on 03/16/26 at 1:48 P.M., Regional Clinical Director #205 verified the Medical Director/Provider was not notified when Resident #107 signed out of the facility AMA facility on 02/09/26. During an interview with the Medical Director #320 on 03/11/26 at 11:23 A.M., verified he was never notified of Resident #107's AMA discharge on [DATE]. 2) Review of the medical record revealed Resident #105 was admitted to the facility on [DATE] and discharged on 11/01/25 as AMA. Diagnoses included cerebrovascular disease, chronic obstructive pulmonary disease, major depressive disorder, and essential hypertension.Review of the most recent MDS assessment dated [DATE], revealed Resident #105 did not have a Brief Interview Mental Status (BIMS); however, the resident was independent with eating, dependent on staff for toileting, dependent for bathing, and partial assistance with personal hygiene. Review of the progress note for Resident #105 dated 11/01/25, revealed the resident was signed out AMA by the resident's Guardian.Review of the medical records for Resident #105 on 03/16/26 at 1:45 P.M., revealed no documented evidence that the Medical Director/Provider was notified when Residents #105 left the facility AMA.During an interview on 03/16/26 at 1:48 P.M., Regional Clinical Director #205 verified the Medical Director/Provider was not notified when Resident #105 was signed out of the facility AMA by the Guardian on 11/01/25. Review of the policy titled, Discharging a Resident Without a Physician's Approval, revealed should a resident, or the representative (sponsor), request a discharge earlier than outlined in the care plan and without the approval of the physician or provider (Against Medical Advice), the resident's attending physician or provider is to be promptly notified. This deficiency represents non-compliance investigated under Complaint Number 2699059.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to notify the Medical Director/ Provider of residents leaving the facility Against Medical Advice (AMA). This affected two Residents (#105 and #107) of the three reviewed. The facility census was 70.Findings include: 1) Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] and discharged on 02/09/26 as AMA. Diagnoses included chronic viral hepatitis c, polyneuropathy, dementia, manic episode without psychotic symptoms, bipolar disorder, depression and venous insufficiency. The resident had no Guardian at the time of discharge. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #107 had moderately impaired cognition, independent with eating, partial assistance with toileting, substantial assistance with bathing, and set up for personal hygiene. On 02/09/26, the resident was reassessed to have a Brief Interview Mental Status (BIMS) of 13, indicated the resident was cognitively intact. Review of a facility documented titled Unauthorized Discharge Release of Responsibility dated 02/09/26 revealed Resident #107 signed out of the facility AMA. The facility documented discussion of the risks of the resident leaving AMA and attempted to get the resident to say. During an interview on 03/16/26 at 1:48 P.M., Regional Clinical Director #205 verified the Medical Director/Provider was not notified when Resident #107 signed out of the facility AMA facility on 02/09/26. During an interview with the Medical Director #320 on 03/11/26 at 11:23 A.M., verified he was never notified of Resident #107's AMA discharge on [DATE]. 2) Review of the medical record revealed Resident #105 was admitted to the facility on [DATE] and discharged on 11/01/25 as AMA. Diagnoses included cerebrovascular disease, chronic obstructive pulmonary disease, major depressive disorder, and essential hypertension.Review of the most recent MDS assessment dated [DATE], revealed Resident #105 did not have a Brief Interview Mental Status (BIMS); however, the resident was independent with eating, dependent on staff for toileting, dependent for bathing, and partial assistance with personal hygiene. Review of the progress note for Resident #105 dated 11/01/25, revealed the resident was signed out AMA by the resident's Guardian.Review of the medical records for Resident #105 on 03/16/26 at 1:45 P.M., revealed no documented evidence that the Medical Director/Provider was notified when Residents #105 left the facility AMA.During an interview on 03/16/26 at 1:48 P.M., Regional Clinical Director #205 verified the Medical Director/Provider was not notified when Resident #105 was signed out of the facility AMA by the Guardian on 11/01/25. Review of the policy titled, Discharging a Resident Without a Physician's Approval, revealed should a resident, or the representative (sponsor), request a discharge earlier than outlined in the care plan and without the approval of the physician or provider (Against Medical Advice), the resident's attending physician or provider is to be promptly notified. This deficiency represents non-compliance investigated under Complaint Number 2793259.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of facility policy, the facility failed to ensure physician orders were following when administering medications to residents. This affected three Residents (#53, #54, and #55) of the four residents reviewed for medication administration. The facility census was 70. Findings include: 1) Review of the medical record for Resident #53 revealed an admission date of 02/03/25 with diagnoses including hemiplegia and hemiparesis affecting the left non-dominate side, gastro esophageal reflux disease (GERD), and chronic pain. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #53 was cognitively intact. Review of the physician orders for Resident #53 dated 07/01/25, revealed the resident was ordered to receive a Pain Relief Maximum Strength external topical pain patch (Lidocaine) to be applied at 9:00 P.M. (bedtime), diclofenac Sodium external gel (pain relief) one percent four times daily (8:00 A.M., 11:00 A.M., 4:00 P.M. and 9:00 P.M., cyclobenzaprine (muscle relaxer) 10 milligrams (mg) tablet every eight hours at 6:00 A.M., 2:00 P.M. and 10:00 P.M., and atorvastatin calcium (high cholesterol) 80 mg daily at 9:00 P.M Review of the physician order for Resident #53 dated 07/02/25, revealed the resident was ordered to receive omeprazole (GERD) 20 mg daily at 5:00 A.M. Review of the physician order for Resident #53 dated 07/24/25, revealed the resident was ordered to receive Melatonin (sleep aid) three mg daily at 9:00 P.M. Review of the physician order for Resident #53 dated 07/28/25, revealed the resident was ordered to receive Senna S (Laxative) 8.6-50 mg twice daily at 9:00 A.M. and 9:00 P.M. for constipation. Review of the physician orders for Resident #53 dated 11/17/25, revealed the resident was ordered to receive methocarbamol (muscle relaxer) 750 mg tablet every eight hours at 6:00 A.M., 2:00 P.M. and 10:00 P.M. and Tylenol (pain) Extra Strength 500 mg two tablets every eight hours. Review of the February 2026 MAR for Resident #53, revealed the cyclobenzaprine 10 mg, methocarbamol 750 mg and Tylenol 1,000 mg were not administered at the 6:00 A.M. dose on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and 02/28/26. The cyclobenzaprine, methocarbamol and Tylenol were not administered at the 10:00 P.M. dose 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26.Review of the February 2026 MAR for Resident #53, revealed the omeprazole was not administered on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and 02/25/26. Review of the February 2026 MAR for Resident #53, revealed the Lidocaine patch, diclofenac sodium external gel one percent, Senna S 8.6-50 mg, atorvastatin calcium, and Melatonin was not administered at the 9:00 P.M. dose on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26.During an interview on 03/12/26 at 2:50 P.M., Regional Clinical Director #205 verified Resident #53's medications were not administered on the dates/times listed above. 2) Review of the medical record for Resident #54 revealed an admission date of 03/21/24 with diagnoses including hypertensive heart disease with heart failure, intervertebral disc degeneration, and chronic pain syndrome.Review of the physician orders for Resident #54 dated 07/01/25, revealed the resident was ordered atorvastatin calcium (high cholesterol) daily at 9:00 P.M., tamsulosin (benign prostatic hyperplasia) 0.4 mg daily at 9:00 P.M. for angina pectoris, trazodone (sleep aid/antidepressant) 150 mg daily at 9:00 P.M., Advair Diskus (asthma/COPD) inhalation aerosol powder 250-50 micrograms (mcg) one puff orally every 12 hours (9:00 A.M. and 9:00 P.M.)., Lyrica (controlled medication for neuropathy) 100 mg twice daily at 9:00 A.M. and 9:00 P.M. sodium chloride one gram (gm) twice daily at 9:00 A.M. and 9:00 P.M. for supplement, valsartan (hypertension) 80 mg twice daily twice daily at 9:00 A.M. and 9:00 P.M., buspirone (anxiety) 15 mg three times daily at 6:00 A.M., 2:00 P.M. and 10:00 P.M., and cyclobenzaprine (muscle relaxer) 10 mg three times daily at 6:00 A.M., 2:00 P.M. and 10:00 P.M. Review of the physician order for Resident #54 dated 07/02/25, revealed the resident was ordered metoprolol succinate (hypertension/heart rate control) extended release (ER) daily at 9:00 A.M. and Pataday Ophthalmic Solution 0.2 percent one drop in both eyes daily at 5:00 A.M. Review of the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order for Resident #54 dated 08/19/25, revealed the resident was ordered Biotene dry mouth throw liquid (mouthwashes) 30 mg/milliliter (mL) twice daily at 9:00 and 9:00 P.M.Review of the physician order for Resident #54 dated 10/25/25, revealed the resident was ordered levothyroxine (thyroid replacement) 112 mcg daily at 6:00 A.M. Review of the physician order for Resident #54 dated 11/17/25, revealed the resident was ordered to receive Senna S (laxative) oral table 8.6-50 mg twice daily at 9:00 A.M. and 9:00 P.M. Review of the MDS assessment dated [DATE], revealed Resident #54 was cognitively intact. Review of the physician order for Resident #54 dated 12/18/25, revealed the resident was ordered to receive Naproxen 500 mg twice daily at 9:00 A.M and 9:00 P.M. related to painReview of the physician order for Resident #54 dated 01/19/26, revealed the resident was ordered to receive omeprazole 20 mg twice daily 9:00 A.M. and 9:00 P.M for heartburn. Review of the physician order for Resident #54 dated 01/30/26, revealed the resident was ordered to receive Mucinex ER twice daily at 9:00 A.M. and 9:00 P.M. related to influenza.Review of the February 2026 MAR for Resident #54, revealed atorvastatin, Trazodone, tamsulosin, Advair Diskus, Biotene, Lyrica, Mucinex ER, Naproxen, omeprazole, Senna S, sodium Chloride, and valsartan were not administered at the 9:00 P.M. dose on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26.Review of the February 2026 MAR for Resident #54, revealed Buspar and cyclobenzaprine were not administered at the 10:00 P.M. dose on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and 02/25/26 at the 6:00 A.M. dose, and 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26 and 02/28/26.Review of the February 2026 MAR for Resident #54, revealed levothyroxine was not administered on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and 02/25/26 at the 6:00 A.M. dose. Review of the February 2026 MAR for Resident #54, revealed the Pataday Ophthalmic solution 0.2 percent was not administered on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and 02/25/26 at the 5:00A.M. dose. During an interview on 03/12/26 at 2:50 P.M., Regional Clinical Director #205 verified Resident #54 missed medications on the date/times listed above. 3) Review of the medical record for Resident #55 revealed an admission date of 06/14/13 with diagnoses including hemiplegia and hemiparesis affecting the left non-dominate side, epileptic seizures, and vascular dementia. Review of the MDS assessment dated [DATE], revealed Resident #55 is severely cognitively impaired. Review of the physician orders for Resident #55 dated 07/01/25, revealed the resident was ordered melatonin (sleep aid) five mg daily at 9:00 P.M., baclofen 10 mg twice daily 9:00 A.M. and 9:00 P.M. for muscle spasms, and Depakote sprinkles 250 mg twice daily at 9:00 A.M and 9:00 P.M. for dementia, artificial tears 0.4 percent twice daily at 9:00 A.M and 9:00 P.M. for dry eyes, house supplement plus twice daily at 9:00 A.M and 9:00 P.M. for protein calorie malnutrition, hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg with pain level assessment every three times daily at 6:00 A.M., 2:00 P.M., and 10:00 P.M. Review of the physician orders for Resident #55 dated 07/02/25, revealed the resident was ordered levothyroxine (thyroid replacement) 100 mcg daily at 6:00 A.M.Review of the physician orders for Resident #55 dated 11/01/25, revealed the resident was ordered famotidine (GERD) 10 mg daily at 9:00 P.M., Review of the February 2026 MAR for Resident #55, revealed the famotidine, melatonin, artificial tear, baclofen, Depakote Sprinkles, and house supplement were not administered at the 9:00 P.M. doses on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26.Review of the February 2026 MAR for Resident #55, revealed levothyroxine 100 mcg was not administered on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and 02/25/26.Review of the February 2026 MAR for Resident #55, revealed the 6:00 A.M. doses of hydrocodone 5-235 mg were not administered on 02/08/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, and the 10:00 P.M. doses were not administered on 02/25/26, 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26.During an interview on 03/12/26 at 2:50 P.M., Regional Clinical Director #205 verified Resident #54 missed the medications on the date/times listed above. Review of the policy titled, Administering Medications, dated 02/14/24, revealed the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right time, and right method (route) of administration before giving the medication.This deficiency represents non-compliance investigated under Complaint Numbers 2699059, 2710143, and 2587217.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, review of Controlled Substance Records, review of hospice notes, staff interview, and review of facility policy, the facility failed to ensure residents were free of any significant medication errors. This affected four Residents (#117, #53, #54, and #55) of the the four residents reviewed for medication administration. The facility census was 70. Findings include:1) Review of the medical record revealed Resident #117 was admitted to the facility on [DATE] and discharged on 12/25/25. Diagnoses included mood disorder, bipolar disorder, cauda equina syndrome, catatonic schizophrenia, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #117 had severely impaired cognition, supervision with eating, substantial assistance with toileting, substantial assistance with bathing, and partial assistance with personal hygiene. Review of the physician order for Resident #117 dated 12/01/25, revealed the resident was ordered to receive Morphine sulfate (a rapid-acting, potent opioid analgesic used to treat severe acute or chronic pain) 100 milligrams (mg) per five milliliters (mL) and give 0.5 ml (10 mg) orally every two hours as needed (PRN). The order was discontinued on 12/03/25 and there were no additional orders for Morphine. Review of a physician order for Resident #117 dated 12/01/25, revealed the resident was ordered to receive lorazepam (short-term treatment of anxiety disorders, anxiety-related insomnia, and acute seizure disorders) oral concentrate two mg per ml and give 0.5 ml (one mg) every two hours PRN. The order was discontinued on 12/15/25 and there were no additional orders for lorazepam. Review of a nurse's progress note for Resident #117 dated 12/22/25 at 10:36 A.M., revealed the resident was difficult to arouse reference to his medications and the hospice nurse was in to see the resident. Review of the Hospice Note for Resident #117 dated 12/25/25 at 8:40 P.M. and authored by Registered Nurse (RN) #500, revealed the resident was seen as a PRN visit due to the resident being lethargic and minimally responsive. The resident was unresponsive although his eyes were open. The resident had a long history of psychiatric care, so unsure if resident was really lethargic or wanted to be left alone. RN #500 spoke with night shift Licensed Practical Nurse (LPN) #307 about the day shift nurse not medicating the resident. Medication adjustments were obtained from the Hospice Nurse Practitioner and approved by the facility provider. The medication adjustments included lorazepam 0.5 mg every two hours PRN and morphine 10 mg every two hours. LPN #307 administered both medications to Resident #117 during RN #500's visit. Review of the electronic triage messages (the facility's electronic messaging system between the facility staff and the providers) dated 12/25/25 and authored by LPN #307 with messages to NP #501, revealed an initial message was sent to NP #501 at 9:56 P.M., indicating Resident #117's lorazepam order was not active and asked if the orders could be put back in because the resident was breathing at 44 breathes per minute and needed to have the lorazepam increased to at least one mg because LPN #315 and RN #500 recommended the change. NP #501 messaged back and asked if the medications were on hand, at which time LPN #307 indicated the medications were on hand, but the resident hadn't been getting it so it might be safe to keep the dosage at 0.5 mg. LPN #315 indicated the resident had the medication administered on 12/09/25 and again on today's date. LPN #315 noted (continued on next page)

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	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Silverton	6922 Ohio Avenue Cincinnati, OH 45236

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was mottled (blotchy purple or reddish appearance indicating slowing circulation) and the staff were not getting any vital signs. NP #501 messaged back to clarify the dose and then closed the thread due to no responses from LPN #315. Review of the electronic triage messages dated 12/26/25 at 12:59 A.M. and authored by LPN #307 with messages to NP #501, revealed Resident #117 passed away at 11:53 P.M. (12/25/25). Review of the progress note for Resident #117 dated 12/26/25 at 6:05 A.M. and authored by LPN #307, revealed the resident was actively passing when the LPN started the shift. The Hospice nurse was called and came in to assess the resident. The resident was breathing at 44 breaths per minute, and the resident was given lorazepam and morphine. Review of the December 2025 medication administration record (MAR) for Resident #117, revealed no documentation the resident received any doses of morphine or lorazepam in December 2025. Review of the Individual Patient Controlled Substance Administration Record (Narcotic Log) for Resident #117 on 03/16/26 at 1:17 P.M. with the Regional Clinical Director #205,, revealed the resident was ordered to receive lorazepam oral concentrate two mg per mL give 0.5 ml by mouth every two hours PRN. The doses were documented as being administered on 12/18/25 at two different times and both entries were illegible. Two doses were documented as being administered on 12/25/25 and both entries were illegible. Interview with Regional Clinical Director #205 at the same time, verified lorazepam doses were given to Resident #117 on 12/18/25 and 12/25/25 without any active physician orders in place. Regional Clinical Director #205 also verified the entries on the Controlled Substance Record were illegible. Review of the Individual Patient Controlled Substance Administration Record (Narcotic Log) for Resident #117 on 03/16/26 at 1:17 P.M. with the Regional Clinical Director #205, revealed the resident was ordered to receive Morphine oral solution 0.5 mL by mouth every two hours as needed. The doses were documented as being administered on 12/09/25 and 12/18/25 and all entries were illegible. The doses were also documented as being administered on 12/25/25 at 9:00 P.M. and 11:00 P.M. Interview with Regional Clinical Director #205 at the same time, verified Morphine doses were given to Resident #117 on 12/09/25, 12/18/25 and 12/25/25 without any active physician orders in place. Regional Clinical Director #205 also verified the entries on 12/09/25 and 12/18/25 were illegible. 2) Review of the medical record for Resident #53 revealed an admission date of 02/03/25 with diagnoses including hemiplegia and hemiparesis affecting the left non-dominate side. Review of the physician order for Resident #53 dated 09/24/25, revealed the resident was ordered to receive Latanoprost Ophthalmic (treatment for eye pressures related to glaucoma) Solution 0.005 percent one drop in both eyes at 9:00 P.M. for high eye pressure. Review of the physician order for Resident #53 dated 10/24/25, revealed the resident was ordered Rhopressa Ophthalmic (treatment for eye pressures related to glaucoma) solution 0.02 percent one drop in right eye at 9:00 P.M. for high eye pressure and Brimonidine Tartrate Ophthalmic (treatment for eye pressures related to glaucoma) solution 0.025 percent one dop in right eye twice daily (9:00 A.M. and 9:00 P.M.) for high eye pressure. Review of the physician order for Resident #53 dated 10/25/25, revealed the resident was ordered Methazolamide (treatment for eye pressures related to glaucoma) 50 mg twice daily (9:00 A.M. and 9:00 P.M.) for high eye pressure. (continued on next page)

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	03/17/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order for Resident #53 dated 11/03/25, revealed the resident was ordered Dorzolamide -Timolol Ophthalmic solution (treatment for eye pressures related to glaucoma) 2-0.5 percent one dop in both eyes twice daily (9:00 A.M. and 9:00 P.M.) for high eye pressure. Review of the MDS assessment dated [DATE], revealed Resident #53 was cognitively intact. Review of the February 2026 MAR for Resident #53, revealed the Latanoprost Ophthalmic Solution 0.005 percent and Rhopressa Ophthalmic solution 0.02 percent were not administered at the 9:00 P.M. doses on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26,02/14/26, 02/24/26, and 02/28/26. Review of the February 2026 MAR for Resident #53, revealed the Brimonidine Tartrate Ophthalmic Solution 0.025 percent, Dorzolamide -Timolol Mal ophthalmic solution and Methazolamide 50 mg was not administered at the 9:00 P.M. dose on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26 During an interview on 03/12/26 at 2:50 P.M., Regional Clinical Director #205 verified Resident #53's medications were not administered on the dates/times listed above. 3) Review of the medical record for Resident #54 revealed an admission date of 03/21/24 with diagnoses including hypertensive heart disease with heart failure, intervertebral disc degeneration, and chronic pain syndrome. Review of the MDS assessment dated [DATE], revealed Resident #54 was cognitively intact. Review of the physician order for Resident #54 dated 07/01/25, revealed the resident was ordered to receive Eliquis (anticoagulant) five mg tablet at 9:00 P.M. Review of the February 2026 MAR for Resident #54 revealed the Eliquis five mg was not administered on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26. During an interview on 03/12/26 at 2:50 P.M., Regional Clinical Director #205 verified Resident #54 missed the medications on the date/times listed above. 4) Review of the medical record for Resident #55 revealed an admission date of 06/14/13 with diagnoses including hemiplegia and hemiparesis affecting the left non-dominate side, epileptic seizures, and vascular dementia. Review of the physician orders for Resident #55 dated 02/20/17, revealed the resident was ordered topiramate 50 mg daily at 9:00 P.M. for epilepsy. Review of the MDS assessment dated [DATE] revealed Resident #55 is severely cognitively impaired. Review of the February 2026 MAR for Resident #55, revealed the 9:00 P.M. doses of topiramate 50 mg were not administered on 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/14/26, 02/24/26, and 02/28/26. During an interview on 03/12/26 at 2:50 P.M., Regional Clinical Director #205 verified Resident #54 missed the medications on the date/times listed above. Review of the policy titled, Administering Medications, dated 02/14/24, revealed the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. This deficiency represents non-compliance investigated under Complaint Numbers 2699059, 2710143, and 2587217.

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	365476	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, staff interview, record review and policy review, the facility failed to store and destroy controlled substances appropriately. This affected four Residents (#117, #132, #119, and #118) but had the potential to affect 56 residents who the facility identified as being independently mobile. The facility census was 70.Findings include: During an interview with the Director of Nursing (DON) and Regional Clinical Director #205 on 03/12/26 at 10:48 A.M. inside the DON's office, revealed an observation of numerous narcotic medication bottles lying on the desk. The bottles include: 1) One package of lorazepam (anti-anxiety) oral concentrate 30 milliliter (mL) bottle (two milligram (mg)/ per mL) for Resident #117 with a fill date of 12/01/25 and 29 mL left in the bottle.2) One package of morphine sulfate (a rapid-acting, potent opioid analgesic used to treat severe acute or chronic pain) oral solution 30 mL bottle (100 mg per five mL) for Resident #117 with fill date of 12/02/25 and 12 mL left in bottle.3) Three bottles of morphine sulfate oral liquid 30 mL (100 mg per five mL) for Resident #132 (discharged on 11/26/25). The fill dates were 11/25/25, 11/28/25, and 11/30/25 and each had varying amounts of Morphine remaining in the bottles. 4) Three containers of lorazepam concentrate 30 mL (two mg/ml) for Resident 132. The fill dates were 10/11/25, 10/28/25, and 12/02/25 and each had varying amounts of lorazepam remaining in the bottles. 5) One bottle liquid morphine liquid 30 mL (100 mg per five mL) for Resident #119 (discharged on 01/17/26) with fill date of 01/10/26 and medication remained in the bottle. 6) Two bottles of morphine sulfate oral liquid 30 mL (100 mg per five mL) for Resident #118 (discharged on 01/09/26) both with fill dates of 01/03/26 and medication remained in the bottles. The DON verified the aforementioned controlled medications were unsecured and lying on her desk. The DON stated controlled medications should be secured in a permanently affixed compartment. The DON stated she was behind with destroying the controlled substances. The DON stated the controlled medications on her desk were for residents who had been released. Review of the policy titled, Controlled Substances, dated 05/30/25, revealed controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged would be securely locked in an area with restricted access until destroyed.Review of the policy titled, Discarding and Destroying Medications, dated 04/2019, revealed all unused controlled substances shall be retained in a securely locked area with restricted access until disposed of. Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident.

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	365476	A. Building B. Wing	03/17/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, resident interview, staff interviews, review of the menu, review of the substitution log, and policy review, the facility failed to ensure they had an adequate supply of food to follow the menu. This affected 67 residents as the facility identified three Residents (#42, #56 and #73) who were nothing by mouth (NPO) and did not receive food from the kitchen. The facility census was 70. Findings include:Observation of the dry stock area of the kitchen on 03/04/26 at 11:30 A.M. with Dietary Manager (DM) #64, revealed the facility had a low stock of food. Interview with DM #64 at the same time verified there was a low stock of food and stated the facility received a truck delivery with food once a week and if the facility ran out of food, she would go to the local store and get food. DM #64 verified that there was not an emergency stock of food available. Observation of today's lunch menu on 03/05/26 at 11:32 P.M., revealed the residents would receive beef and noodles, broccoli florets, and two baked cookies. Observation of the food line on 03/05/26 at 12:28 P.M., revealed the residents with a regular diet received only one cookie. Residents on a mechanical soft and puree diet received pudding. During an interview on 03/05/26 at 12:35 P.M., DM #64 verified that she did not have enough cookies made to follow the menu. DM #64 verified the menu indicated the residents should have received two cookies. During an interview on 03/09/26 at 10:21 A.M., Resident #51 stated she does not always get everything listed on her meal tickets. During an interview on 03/09/26 at 10:30 A.M., Resident #36 stated the facility does not follow the meal tickets and he feels like he is not getting enough food to meet his daily calorie needs. Observation of the substitution logs on 03/09/26 at 12:14 P.M. with DM #64, revealed the menu substitution log was last filled out in July of 2025. Interview with DM #64 verified she does not keep a substitution log or documentation of meals that have been served. Review of the facility policy titled Menus dated October 2017, revealed menus are created to meet the nutritional needs of residents and should be followed. Any deviations from the menu should be recorded and archived. Review of the facility policy titled Dietary Considerations for Residents dated January 2011, revealed the facility should have food available to last a minimum of seven days. This deficiency represents non-compliance investigated under Complaint Number 2646616.

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	365476	A. Building B. Wing	03/17/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and review of the facility policy, the facility failed to ensure food was stored, prepared and served in a safe and sanitary manner to prevent foodborne illness. This affected 67 residents as the facility identified three Residents (#42, #56 and #73) who were nothing by mouth (NPO) and did not receive food from the kitchen. The facility census was 70. Findings include:Observation of the kitchen on 03/04/26 at 9:45 A.M. with [NAME] #67, revealed an air vent in the ceiling leaking water, with droplets falling onto the floor below. Immediately adjacent to this location was a food preparation table that was actively being used. Below the preparation table, clean dishes were stored and water droplets were splashing off the floor and onto the dishes. Interview at the time of the observation with [NAME] #67 verified that the air vent was leaking next to the preparation area and near the clean dishes. During an interview on 03/02/26 at 9:47 A.M., Maintenance Supervisor (MS) #91 stated the air vent was connected to the air conditioning unit and it was leaking condensation water. Observation of the kitchen on 03/04/26 at 9:50 A.M. with [NAME] #67, revealed dust on the ceiling and a black residue on the fan shields in the walk-in cooler. Interview at the time of the observation with [NAME] #67 verified that the walk-in cooler was unclean. Observation on 03/04/26 at 10:02 A.M., revealed Activities Assistant (AA) #04 was passing drinks to the residents. Further observation revealed a metal water dispenser that was unclean with a brown residue and had discolored tape on the lid. Interview at the time of the observation with AA #04 revealed that the water dispenser was taped because the lid would frequently come off. AA #04 verified the dispenser was unclean and that it was difficult to clean due to the tape. Observation of the kitchen on 03/04/26 at 11:07 A.M. with Dietary Manager (DM) #64, revealed a sheet of wood covering the floor under the preparation area. The wood appeared to be unclean with a black residue covering it. Interview with DM #64 at the time stated the facility had plumbing work completed a few months prior and that the wood was covering a hole in the floor. DM #64 verified that the wood was unclean with black residue covering it and could not be cleaned. Observation of the kitchen on 03/04/26 at 11:14 A.M. with DM #64, revealed two knives with the tip of the blade broken off and two knives with a painted blade had chipped paint being stored on the magnetic knife storage strip. Interview with DM #64 at the same time verified the knives were not safe to use and should not be stored in the kitchen. Observation of the kitchen on 03/05/26 at 12:11 P.M., revealed [NAME] #52 with gloved hands, grabbed a container of steamed broccoli, adjusted his glasses with his hand, and then started pureeing the broccoli. Interview with [NAME] #52 verified that he adjusted his glasses with gloved hands and that he should have washed his hands afterwards. Observation of the kitchen on 03/05/26 at 12:14 P.M., revealed [NAME] #52 was cleaning a rubber spatula in the three-compartment sink. After cleaning and rinsing the spatula, [NAME] #52 dipped the spatula in sanitizer and then brought it back to the preparation area to use. [NAME] #52 donned gloves and began preparing food. Interview with [NAME] #52 verified that he did allow the spatula to sit in the sanitizer for the required amount of time and he should have washed his hands before returning to food preparation. During an interview on 03/05/26 at 12:27 P.M., DM #64 verified that when cleaning dishes, they were required to have a contact time of one minute in the sanitizer and they should be fully air dried before use. Observation of the tray line on 03/05/26 at 12:58 P.M., revealed the food and utensils were being placed on wet trays. Interview with DM #64, verified that the trays were wet with sanitizer from when they were cleaned. DM #64 stated the trays were stacked while wet after cleaning in the three-compartment sink and they did not have a place to allow them to air dry. Review of the facility policy titled, Sanitization dated October 2008, revealed the kitchen areas shall be kept clean. All utensils and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas. Equipment and utensils will be allowed to air dry. This deficiency represents non-compliance investigated under Complaint Number 2566761.

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	365476	A. Building B. Wing	03/17/2026

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations, staff interviews, review of dishwasher logs, and facility policy review, the facility failed to ensure the dishwasher was maintained in working order. This had the potential to affect all 70 residents residing in the facility. The facility census was 70. Findings include:During an observation of the kitchen on 03/04/26 at 10:39 A.M. with Dietary Manager (DM) #64, revealed the dishwasher was not operational. DM #53 stated there had been problems with the dishwasher since February and the facility had been using disposable dishware and utensils for all meals. DM #64 stated it gets fixed, and will work for a few days, and then break again. DM #64 stated the dishwasher was dispensing chemicals at the incorrect time throughout the wash cycle and dishes were not coming out clean. DM #64 stated the facility had technicians out frequently to make repairs on the dishwasher. Observation at the same time with DM #53, revealed a technician was working on the dishwasher. During an interview on 03/05/26 at 11:19 A.M., Regional Director of Operations (RDO) #300 stated the technician was able to get the dishwasher to work the previous day; however, it was currently not working again. RDO #300 stated a new dishwasher was recently ordered; however, it would take six weeks to be delivered. Observation of the lunch service on 03/05/26 at 12:28 P.M., revealed the residents were being served lunch in Styrofoam containers with plastic cutlery. During an interview on 03/11/26 at 11:11 A.M., Resident #54 stated she did not like receiving her meals in the Styrofoam containers as it made it difficult to cut. Resident #54 stated that she would end up cutting through the Styrofoam while trying to eat. Observation of lunch service on 03/11/26 at 12:00 P.M., revealed the residents were being served lunch in Styrofoam containers with plastic utensils. Review of the Dishwasher Temperature Log, revealed that the dish machine was broken 11/21/25 through 11/31/25, 01/24/26 through 02/01/26, 02/07/26 through 03/01/26, and 03/04/26 through 03/17/26. Review of the facility policy titled Sanitization dated October 2008, revealed all equipment shall be maintained in good repair.