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	06/25/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure a clean and safe environment for residents. This affected two (Residents #12 and #68) of 18 residents sampled. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure resident rooms were stocked with paper towels. This affected two (Residents #11 and #68) of 18 residents sampled. The facility census was 75 residents.Findings include: 1.Review of the medical record for Resident #12 revealed an admission date of 05/13/26 with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 05/19/26 revealed the resident was cognitively intact and required assistance with activities of daily living (ADLs.) Observation on 06/22/26 at 12:21 P.M of Resident #12's room revealed there was a wooden handrail propped up against the wall which was not attached to the wall for functional use. There was a screw protruding from the handrail and there were portions of four broken screws protruding from the wall where the handrail had previously been attached. Resident #12's commode was not securely fixed to the floor and could be shifted to the left and right with minimal force applied to the toilet. There was grab bar on the windowsill of the bathroom which had previously been attached the wall. The dry wall where the grab bar had been previously damaged. Observation revealed the handwashing sink in the resident's room had no paper towels available for staff to use to dry their hands. Interview on 06/22/26 at 12:21 P.M. with Resident #12 confirmed the wooden handrail in his room was not properly attached to the wall, the bathroom grab bar was not attached to the wall, and the toilet was not firmly attached to the floor. Interview on 06/22/26 at 1:32 P.M. with Certified Nursing Assistant (CNA) #526 confirmed the handrail in Resident #12's room was not attached to the wall and there was a screw protruding from the handrail, and there were portions of four additional broken screws protruding from the wall where the handrail had previously been attached. CNA #526 also verified the grab bar in the resident's bathroom was not attached to the wall for use and that the toilet was able to be shifted to the left and right with minimal force applied to the toilet. Interview on 06/23/26 at 2:48 P.M. Director of Maintenance (DOM) #562 confirmed the handrail in Resident #12's room was not attached to the wall and there was a screw protruding from the handrail, and there were additional broken screws protruding from the wall where the handrail had previously been attached. DOM #562 stated the grab bar in the resident's bathroom was not attached to the wall (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for use and that the toilet was able to be shifted to the left and right with minimal force applied to the toilet. DOM #562 verified no previous knowledge of the detached handrail, detached grab bar, and loose toilet in Resident #12's room. 2.Review of the medical record for Resident #68 revealed an admission date of 02/10/26 with a readmission date of 03/25/26 with diagnoses including cerebral infarction, epilepsy, and type two diabetes mellitus. Review of the MDS assessment for Resident #68 dated 05/19/26 revealed the resident was cognitively impaired and was dependent on assistance for all ADLs. Observation on 06/22/26 at 12:20 P.M. of Resident #68's room revealed there was an electrical outlet located to the left of the resident's bed which was not fastened to the wall. The outlet was protruding from the wall with exposed electrical wires and both electrical receptors to the outlet had electric devices plugged into them. Interview on 06/22/26 at 12:20 P.M. with Resident #68's representative confirmed concern about the condition of the electrical outlet to the left of the resident's bed and stated this concern had been reported to the facility although she didn't have an exact date and time. Interview on 06/22/26 at 2:20 P.M. with CNA #526 confirmed the outlet to the left of Resident #69's bed was not attached to the wall and electrical wires were exposed. Interview on 06/23/26 at 2:52 P.M. with DOM #562 verified the unsecured outlet in Resident #68's living space was brought to his attention the morning of 06/23/26. Observation on 06/24/26 at 8:23 A.M. revealed there were no paper towels available in Resident #68's room at the handwashing sink. Interview on 06/24/26 at 8:23 A.M. with Licensed Practical Nurse (LPN) #572 confirmed there were no paper towels stocked in paper towel dispenser in Resident #68's room. Review of the facility policy titled Quality of Life-Homelike Environment dated May 2017 revealed residents should be provided with a safe, clean, comfortable and homelike environment. 3. Review of the medical record for Resident #11 revealed an admission date of 05/22/26 with diagnoses including fracture of shaft of right tibia, rib fracture, and respiratory failure. Observation on 06/25/26 at 9:30 A.M. revealed there were no paper towels available at the handwashing sink in the resident's bathroom. Interview on 06/25/26 at 9:30 A.M. with LPN #367 confirmed there were no paper towels stocked in paper towel dispenser in Resident #11's room. Review of facility policy titled Handwashing/Hand Hygiene dated 04/29/24 revealed hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) should be readily accessible. This deficiency represents noncompliance investigated under Complaint Number 3048157 and Complaint Number 3038387 and Complaint Number 3032925.

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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 medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents received wound care in a timely fashion. This affected one (Resident #11) of 18 residents sampled. The facility census was 75 residents.Findings include: Review of the medical record for Resident #11 revealed an admission date of 05/22/26 with diagnoses including respiratory failure, traumatic brain injury, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 05/29/26 revealed the resident was cognitively impaired and was dependent on staff assistance for all activities of daily living (ADLs). Review of the weekly skin assessment for Resident #11 dated 05/22/26 revealed upon admission the resident had the following areas of impaired skin integrity: a skin tear to the groin, a laceration to the front right lower leg, a laceration to the rear right lower leg, lacerations to the left toes. Review of the physician's orders for Resident #11 revealed the following orders dated 05/31/26: cleanse the skin tear to the right groin with normal saline, apply triad paste, and leave open to air every shift, cleanse the right lower leg wounds with normal saline, apply Xeroform, cover with ace bandage, and secure with Kerlix gauze once daily, cleanse the wounds to the left toes with normal saline, pat dry, apply Betadine, and leave open to air once daily Interview on 06/25/26 at 2:08 P.M. with Regional Director of Clinical Operations (RDCO) #701 confirmed Resident #11 was admitted to the facility on [DATE] with the following areas of impaired skin integrity: a skin tear to the groin, a laceration to the front right lower leg, a laceration to the rear right lower leg, lacerations to the left toes. RDCO #701 verified the facility did not initiate wound treatment orders until 05/31/26. Review of facility policy titled Wound Care dated October 2010 revealed wound treatments should be completed per physician's orders. This deficiency represents noncompliance investigated under Complaint Numbers 3048157, 3038387, 3027940, and 2989279.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents received treatment of pressure ulcers. This affected one (Resident #11) of two resident reviewed for pressure ulcers. The facility census was 75 residents.Findings include:Review of the medical record for Resident #11 revealed an admission date of 05/22/26 with diagnoses including respiratory failure, traumatic brain injury, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 05/29/26 revealed the resident was cognitively impaired and was dependent on staff assistance for all activities of daily living (ADLs). Review of the weekly skin assessment for Resident #11 dated 05/22/26 revealed upon admission the resident had a stage II pressure ulcer to his sacrum. Review of the physician's orders for Resident #11 revealed an order dated 05/31/26 to cleanse the pressure ulcer with normal saline, apply triad paste and leave open to air every shift. Review of the Treatment Administration Record (TAR) for Resident #11 dated May 2026 revealed the treatment for the resident's pressure ulcer was not initiated until 05/31/26. Interview on 06/25/26 at 2:08 P.M. with Regional Director of Clinical Operations (RDCO) #701 confirmed Resident #11 was admitted to the facility on [DATE] with a stage II sacral pressure ulcer and the facility did not initiate treatment to the wound until 05/31/26. Review of facility policy titled Wound Care dated October 2010 revealed wound treatments should be completed per physician's orders. This deficiency represents noncompliance investigated under Complaint Number 3048157, 3038387, 3032925, 3027940, and 2989279.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents received medications as ordered. This affected one (Resident #68) of 18 residents sampled. The facility census was 75 residents.Findings include:Review of the medical record for Resident #68 revealed an admission date of 02/10/26 with diagnoses including cerebral infarction, epilepsy, type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #68 dated 05/19/26 revealed the resident was cognitively impaired and was dependent on staff assistance for all activities of daily living (ADLs). Review of physician's orders for Resident #68 revealed an order dated 05/24/26 for cefuroxime 250 milligram (mg) tablet give one tablet via gastrostomy tube (g-tube) two times a day for five days for pneumonia until 05/29/26 and an order for azithromycin 500mg tablet give one tablet via g-Tube at bedtime for pneumonia util 05/26/26. Review of Medication Administration Report (MAR) for Resident #68 dated May 2026 revealed the resident did not receive a morning or evening dose of cefuroxime on the following dates: 05/24/26, 05/25/26, 05/26/26, 05/27/26, 05/28/26. Resident #68 did not receive an evening dose of cefuroxime on 05/29/26. Resident #68 did not receive a dose of azithromycin on 05/24/26 or 05/25/26. Interview on 06/24/26 at 2:37 P.M. with Director of Clinical Operations (DCO) #700 confirmed Resident #68 missed 10 of 11 scheduled doses of cefuroxime and two of three scheduled doses of azithromycin. Review of the facility policy titled Administering Medications dated April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. This deficiency represents noncompliance investigated under Complaint Numbers 3048157 and 3038387.Bottom of Form

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and policy review, the facility failed to follow enhanced barrier precautions (EBP) while providing wound care. This affected one (Resident #56) of three residents reviewed for wound care. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure staff performed appropriate hand hygiene during meal service. This affected six (Residents #71, #8, #10, #20, and #23) of 18 residents sampled. The facility census was 75. Findings include: 1.Review of medical record for Resident #56 reveled an admission date of 12/02/25 with diagnoses including gastrostomy status and traumatic brain injury. Review of the physician's orders for Resident #56 revealed an order dated 06/16/26 for the resident to be on EBP due to gastrostomy tube (g-tube) and an order for wound care. Review of the Minimum Data Set (MDS) assessment for Resident #56 dated 06/16/16 revealed the resident was moderately cognitively impaired and required substantial/maximal assistance activities of daily living (ADLs.) Observation on 06/24/26 at 3:00 P.M. of wound care for Resident #56 per Licensed Practical Nurse (LPN) #511 revealed the nurse provided wound care to the resident's left scalp and was not wearing a gown. Observation revealed there was a sign posted on Resident #56's door indicating the resident was on EBP and staff should wear personal protective equipment (PPE) while providing care to residents. Interview on 06/24/26 at 3:11 P.M. with LPN #511 confirmed he did not wear a gown while providing wound care to Resident #56 and also confirmed the resident had an active order for EBP and an EBP sign was posted on the resident's door. Review of the facility policy titled Enhanced Barrier Precautions dated August 2022 revealed enhanced barrier precautions employed targeted gown and glove use during high contact resident care activity including wound care. 2.Observation on 06/22/26 at 12:35 P.M. revealed Certified Nursing Assistant (CNA) #526 delivered lunch trays to Resident #71 in the dining room, and Residents #8, #10, #20, and #23 in their rooms. CNA #526 did not wash or sanitize her hands between the delivery of these food trays to residents. Interview on 06/22/26 at 12:46 P.M. with CNA #526 confirmed she did not wash or sanitize her hands between lunch tray deliveries to Residents #71, #8, #10, #20, and #23. Review of the facility policy titled Handwashing/Hand Hygiene dated October 2013 revealed the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene was indicated after touching a resident and after touching the resident's environment.Bottom of Form