STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365747	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER: Astoria Place of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE: 555 Anthony Wayne Trail, Waterville, OH 43566	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on record review, review of the facility policy, review of the Self-Reported Incidents (SRI) database, facility investigation, review of hospital records, resident interviews, and staff interviews, the facility failed to prevent resident-to-resident physical abuse. This resulted in actual harm when Resident #01, a resident with known history of resident-to-resident abuse incidents, struck Resident #02 in the face causing a hematoma (a pool of clotted blood that forms in the tissue) to her face and a closed fracture of the right orbital floor (one or more bones around the eyeball break, often from a blow to the face). Additionally, the facility failed to ensure Resident #03 was free from resident-to-resident physical abuse when Resident #01, who was supposed to be on one-to-one monitoring, struck Resident #03 in the back several times, while Resident #03 was asleep. This affected three (#01, #02 and #03) of six residents reviewed for abuse. The current census is 79. Findings include: 1. Review of the SRI dated 08/14/24 revealed the incident was reported on 08/09/24 at 6:35 P.M., when Resident #01 was seen grabbing Resident #02's hair and punching her in the face. Per the SRI, the facility separated the residents, sent Resident #02 to the hospital, then upon return placed both residents in 15-minute checks until Resident #02 was transferred to another unit. Per the SRI report, the police were notified but no report was made, and no charges were filed. The SRI was unsubstantiated for abuse due to Resident #01's diagnosis of dementia. Review of the facility's investigation into the alleged resident-to-resident abuse dated 08/09/24 to 08/16/24 revealed per the investigation, two nurses and one aide were interviewed after the incident, and there was no information regarding what led up to the incident noted in the interviews. Per the aide's written statements dated 08/09/24, Resident #01 and Resident #02 were sitting in their wheelchairs in the hallway and the aide witnessed Resident #01 grabbing Resident #02 by the hair and punching her in the face. Per the nurses' interviews the aide reported the incident immediately and Resident #02 was able to report to one nurse she was punched by Resident #01 in the face. No other resident interviews were included in the investigation reports. An assessment of Resident #02 revealed the resident had facial swelling and bruising to the right side of her face. Per the investigation Resident #02 was sent to the hospital and was diagnosed with facial swelling and an orbital fracture to her right eye. a. Review of Resident #01's medical record revealed an admitted [DATE]. Diagnoses for Resident #01 included: bipolar disorder, vascular dementia, delirium, and metabolic encephalopathy. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and portrayed physical behaviors towards others during the review period. Review of Resident #01's care plans dated May 2024 and revised on 08/16/24 revealed a focus for behaviors such as physical aggression towards others. Interventions include psychological evaluation, medications per order, talk to resident when being aggressive, and intervene by talking calmly and taking resident to a quiet area when behaviors are observed. Review of the SRI dated 02/22/24 revealed at 8:40 P.M., staff witnessed Resident #01 striking another resident in the face. Per the SRI there was no marks on either resident, and no injuries were noted in the documentation. Per the SRI, staff witnessed Resident #01 near the other resident's room, and he struck her in the mouth with his hand. Per the SRI, the other resident was interviewed and stated she had not done anything to upset Resident #01. Per the SRI, Resident #01 was sent to the hospital for testing, was positive for a urinary tract infection, and was referred to the Senior Wellness Group. The other resident was moved to another unit. Review of Resident #01's behavior assessment dated , 02/23/24 at 12:05 A.M., revealed the resident was having wandering and hitting behaviors. Interventions included redirection and one-to-one interventions. Per the assessment the interventions were effective. Review of Resident #01's physician orders revealed on 06/18/24, the resident was ordered to be seen by psychiatric services. There was no documentation of Resident #01 being seen by a psychiatrist noted in the record until 08/14/24 when the psychologist saw the resident. The order was discontinued on 08/15/24. Review of Resident #01's behavior assessment dated [DATE] at 6:44 P.M., revealed the resident was having cursing, threatening others, and grabbing behaviors. Interventions included redirection and were effective. No behavior assessment was noted in Resident #01's medical records for 08/09/24 for behaviors towards Resident #02. Review of Resident #01's behavior assessment dated [DATE] at 3:15 P.M., revealed Resident #01 was having pacing, wandering, and disrobing in public behaviors. Interventions include one-to-one interventions, redirection, and toileting. Per the assessment the interventions were effective. b. Review of Resident #02's medical record revealed an admitted [DATE]. Diagnoses for Resident #02 included: dementia, dysphagia, anemia, antisocial personality disorder, and bipolar disorder. Review of the comprehensive MDS assessment dated [DATE], revealed the resident had impaired cognition and had no documented behaviors at the time of the review period. Review of Resident #02's care plans dated 04/24/24 revealed the resident did not have any behaviors of aggression towards others. Per the care plan there were no behaviors relating to abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #02's assessments revealed the resident denied pain during the assessments dated from 06/01/24 to 08/09/24. Review of the vital sign monitoring revealed on 08/09/24 at 8:13 A.M., the resident denied any pain. On 08/10/24 at 8:43 A.M., Resident #02 reported a pain level of 4 out of 10 (10 rated as the highest pain). On 08/11/24 at 8:26 A.M., Resident #02 reported a pain level of 5 out of 10. Review of the progress note dated 08/09/24 at 6:40 P.M., revealed Resident #02 was being sent to the hospital for evaluation of facial swelling due to an altercation with another resident. Review of Resident #02's hospital documentation dated 08/09/24 at 9:19 P.M., revealed the resident was treated for a hematoma to her face and a fractured orbital space. The hospital diagnosed Resident #02 with a closed fracture of the right orbital floor. Discharge orders included to start taking cephalexin 250 milligrams orally three times a day for 10 days, and to apply ice packs to affected area. Resident #02 was discharged from the hospital back to the facility on [DATE]. Review of the progress note dated 08/10/24 at 2:20 A.M., Resident #02 returned from the hospital to the facility. Observations on 09/04/24 at 10:02 A.M., revealed Resident #02 was observed on another unit than Resident #01. During an attempt to interview Resident #02 on 09/05/24 at 10:05 A.M., Resident #02 did not answer any questions. During the interview attempt, the resident did not appear to be in distress. Interview on 09/04/24 at 10:10 A.M. with State tested Nurse Aide (STNA) #300 revealed she was the aide that had cared for Resident #02 after she returned from the hospital on 08/10/24. Per STNA #300 the resident had bruising under her eye and some swelling. STNA #300 stated she did get the resident ice to place on her face after she reported pain. Interview on 09/04/24 at 11:20 A.M. and on 09/17/24 at 11:02 A.M., with Social Worker (SW) #333 revealed after the incident Resident #02 was moved to another unit when she returned from the hospital on 08/09/24. Per SW #0333, the resident denied any concerns, stating she could not recall what happened or why it happened, and stated she felt safe in the facility. SW #333 stated she did interview Resident #02 on 08/12/24 and the resident stated she had no pain from the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/04/24 at 2:15 P.M., with the Director of Nursing (DON) revealed the DON was notified on 08/09/24 around 7:00 P.M., after the incident with Resident #01 and Resident #02 occurred. The DON stated due to Resident #01's dementia abuse could not be substantiated. The DON stated he felt Resident #01 had a 'focus' on Resident #02 which caused the resident to strike her. The DON stated Resident #01 had a 'fixation' on Resident #02 and once she was moved off the unit, there was no other behaviors from Resident #01 to any other resident until the incident on 08/13/24. The DON did not explain what he meant by fixation and there was no other history per records or interviews of Resident #01 and Resident #02 having any issues prior. The DON stated he felt by moving Resident #02 off the unit he had fixed the problem; the DON did not reveal the previous issues Resident #01 had with another resident. The DON verified there was no interviews or assessment included in the investigation regarding the behaviors or factors which could have provoked the incident. The DON stated despite previous allegations of resident-to-resident abuse regarding Resident #01, the DON felt placing Resident #01 back into 15-minute checks was sufficient to ensure the safety of the other remaining residents on the unit. Interview on 09/17/24 at 11:45 A.M. with the DON verified Resident #01 was seen by the psychologist in the facility which was a Certified Nurse Practitioner (CNP), and a social worker who was employed by the psych services. Interview on 09/17/24 at 9:33 A.M., with Licensed Practical Nurse (LPN) #100 revealed she assessed Resident #02 on 08/10/24, after she transferred from another unit. LPN #100 stated the resident did complain of slight pain in her face and was provided ice for discomfort per hospital paperwork. 2. Review of the SRI dated 08/14/24 revealed Resident #03 reported to the nurse on 08/13/24 at 11:38 P.M., Resident #01 had struck him multiple times in the back. Per the SRI the facility reported the incident on 08/14/24 at 10:15 P.M. Per the SRI the facility unsubstantiated the abuse due to Resident #01's dementia. Review of the facility's investigation dated 08/14/24 revealed on 08/13/24 at 11:38 P.M., Resident #03 came to the nurse's station and reported to the nurse that Resident #01 had hit him 5 times in the back. Per the investigation Resident #03 was assessed for injuries and his back was noted to be bruised and swelling. The facility staff reported they separated the residents and notified all parties of the incident. The staff and residents were interviewed. Per the interviews Resident #01 had returned from the hospital and showed no behaviors prior to the incident. All other residents were assessed for injuries, and none were found. Resident #03 refused to be sent to the hospital for evaluation and Resident #01 was placed on one-to-one monitoring until he was transferred to a behavioral facility on 08/14/24. a. Review of Resident #01's medical record revealed a re-admitted [DATE]. Diagnoses for Resident #01 included: bipolar disorder, vascular dementia, delirium, and metabolic encephalopathy. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and portrayed physical behaviors towards others during the review period. Review of Resident #01's care plans dated May 2024 and revised on 08/16/24 revealed a focus for behaviors such as physical aggression towards others. Interventions include psychological evaluation, medications per order, talk to resident when being aggressive, and intervene by talking calmly and taking resident to a quiet area when behaviors are observed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #01's behavior assessment dated [DATE] at 3:15 P.M., revealed Resident #01 was having pacing, wandering, and disrobing in public behaviors. Interventions include one-to-one interventions, redirection, and toileting. Per the assessment the interventions were effective. Review of Resident #01's progress notes revealed on 08/12/24 at 10:35 A.M., the interdisciplinary team added the intervention of 15-minute checks for the resident. The medical record contained no evidence of 15-minute checks being completed. Review of Resident #01's behavior assessment dated [DATE] at 11:38 P.M., revealed Resident #01 was having behaviors of crawling around on the floor. Interventions of redirection were ineffective. No behavioral assessments dated 08/13/24 were noted in Resident #01's medical records after the incident with Resident #03. Review of Resident #01's progress note dated 08/13/24 at 5:34 P.M., Resident #01 was sent to the hospital due to critical laboratory values. Per the note dated 08/13/24 at 11:04 P.M., Resident #01 had returned from the hospital and was being monitored. No behavioral assessments dated 08/13/24 were noted in Resident #01's medical records after the incident with Resident #03. Review of the psych service note dated 08/14/24 at 9:33 A.M., signed by the social worker for psych services revealed the plan listed on the note was to have Resident #01 be seen by psych services 6 visits in 3 months to reach the goal of increasing interpersonal interactions and activities. Therapeutic interventions attempted were listed as supportive therapy. No mention of the aggressive behaviors was noted in the progress note. Review of Resident #01's behavior assessment dated [DATE] revealed the resident exhibited behaviors of being combative with care, hitting and grabbing. Interventions attempted were redirection, one-to-one intervention, and change in scenery. Per the assessments the interventions were ineffective. No documentation was noted in the records in regard to what the staff did if the interventions were ineffective. Review of Resident #01's physician orders revealed on 09/03/24, Resident #01 was to be on one-to-one supervision at all times. No orders predating the 09/03/24 order for one-to-one supervision was noted in the medical record for Resident #01. Observations made on 09/04/24 at 9:44 A.M. and 09/17/24 at 11:00 A.M., of Resident #01 revealed the resident to be resting in his room, and the resident did not respond to questions. A staff member was observed throughout the survey to be sitting in Resident #01's room watching the resident as a one-to-one intervention. b. Review of Resident #03's medical record revealed an admitted [DATE]. Diagnoses for Resident #03 included: chronic obstructive pulmonary disease, heart failure, cognitive communication deficit, and vascular dementia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and had no behaviors during the review period. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #03's care plans dated 09/22/23 revealed no focus for behaviors of aggression towards others or himself. Review of Resident #03 medical record revealed no documentation of Resident #03's injuries after the incident on 08/13/24 at 11:52 P.M. No monitoring of the bruising or skin assessment was included in the records. Per Resident #03's vital signs no reports of pain were recorded in the records. Observation and interview on 09/04/24 at 11:03 A.M. with Resident #03 revealed the resident denied any further incidents with Resident #01, after he returned to the facility. Resident #03 could not provide details of the incident on 08/13/24. Interview on 09/04/24 at 3:30 P.M., with Clinical Nurse Manager (CNM) #500 and Regional Registered Nurse (RRN) #555 and the DON revealed after the incidents occurred on 08/09/24 and 08/13/24, all staff were interviewed after the incident regarding the details of each incident. The DON verified there were no assessments or documentation of Resident #01's behaviors prior to the incident. CNM #500 stated Resident #01 was assessed by the facility's psychologist on 08/08/24 and 08/13/24 and was stable with no behaviors. RRN #555 stated the resident was not on one-to-one monitoring despite a history of aggressive behaviors towards other residents due to the psychiatric evaluation of being stable on 08/08/24 and 08/13/24. The DON and CNM #500 verified 15-minute checks were not documented in the records and stated on 08/13/24, Resident #01 returned to the facility around 11:00 P.M., and was not documented as being observed until 11:45 P.M., after Resident #03 had reported he was being hit by Resident #01. Interview on 09/17/24 a 11:45 A.M. with the DON verified Resident #01 was seen by the psychologist in the facility which was a Certified Nurse Practitioner, (CNP), and a social worker who was employed by the psych services. Review of the policy titled, Abuse, Mistreatment, Exploitation, and Misappropriation of Resident Property, dated October 2022, revealed abuse is defined as instances of abuse, irrespective of mental or physical condition causing harm, pain, and/or mental anguish. The policy stated in order to prevent abuse the facility will complete ongoing assessments of behaviors. To protect other residents increased supervision of the alleged perpetrator and/or immediate transfer out of the facility. Per the policy the facility will complete ongoing assessments and care planning for appropriate interventions for monitoring the residents with behaviors. If a resident is accused or suspected of resident-to-resident abuse the facility will ensure all other residents are protected as determined by the circumstances which can include increased monitoring of accused residents and/or the immediate transfer or discharge of the resident. This deficiency represents non-compliance with control numbers OH00156980 and OH00156909.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35035 Based on review of the Self-Reported Incident (SRI) database, review of policy, and staff interview, the facility failed to timely report allegations of resident-to-resident abuse. This affected three (#01, #02, and #03) of three residents reviewed for abuse reporting of allegations of abuse. The current census is 76. Findings include: Review of the Self-Reported Incident dated 08/14/24 at 5:33 P.M., revealed the incident was reported on 08/09/24 at 6:35 P.M., when Resident #01 was seen grabbing Resident #02's hair and punching her in the face. Per the SRI, the facility separated the residents, sent Resident #02 to the hospital, then upon return placed both residents in 15-minute checks until Resident #02 was transferred to another unit. Per the SRI report, the police were notified but no report was made, and no charges were filed. The SRI was unsubstantiated for abuse due to Resident #01's diagnosis of dementia. Review of the facility's investigation into the resident-to-resident abuse dated 08/09/24 to 08/16/24 revealed no evidence the incident was reported to the SRI database on 08/09/24. Per the investigation, two nurses and one aide were interviewed after the incident, no information regarding what led up to the incident was noted in the interviews. Per the aide's written statements dated 08/09/24, Resident #01 and Resident #02 were sitting in their wheelchairs in the hallway and the aide witnessed Resident #01 grabbing Resident #02 by the hair and punching her in the face. Per the nurses' interviews the aide reported the incident immediately and Resident #02 was able to report to one nurse she was punched by Resident #01 in the face. No resident interviews were included in the investigation reports. An assessment of Resident #02 revealed the resident had facial swelling and bruising to the right side of her face. Per the investigation Resident #02 was sent to the hospital and was diagnosed with facial swelling and an orbital fracture to her right eye. Further review of the facility's investigation into the incident revealed no other staff were interviewed regarding the observed behaviors of Resident #01 prior to the incident on 08/09/24. No residents written statements were included in the investigation. Interview on 09/04/24 at 2:00 P.M., with the Director of Nursing (DON) verified the allegations of resident-to-resident abuse was reported to him as the designee of abuse reporting, on 08/09/24 around 7:00 P.M. Per the DON, the facility began the investigation and he filed the SRI on 08/09/24. The DON verified Resident #02 had suffered a facial orbital fracture and a black eye from the incident. The DON verified there was no evidence he had filed the SRI in the database on 08/09/24. The DON stated he did not check to see if the SRI was filed and did not follow up with the SRI investigation until 08/14/24. The DON stated he did notify the local law enforcement and an officer came to the facility but did not file a report regarding the abuse due to Resident #01's cognitive deficit. 2. Review of the SRI dated 08/14/24 at 10:15 P.M., revealed Resident #03 reported to the nurse on 08/13/24 at 11:38 P.M., Resident #01 had struck him multiple times in the back. Per the SRI the facility unsubstantiated the abuse due to Resident #01's dementia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/04/24 at 2:00 P.M., with the DON verified the 08/13/24 incident was not filed into the SRI database until 08/14/24 at 10:15 P.M. The DON verified Resident #03 had suffered a bruise to his back from the incident. The DON also stated in the interview the local law enforcement were not notified of the allegations of abuse for the 08/13/24 incident between Resident #01 and Resident #03. Review of the policy titled, Abuse, Mistreatment, Exploitation, and Misappropriation of Resident Property, dated October 2022 revealed all allegation of abuse are to be reported to the Ohio Department of Health (ODH) database for SRIs involving bodily injury immediately or within 2 hours of the incident being reported. Per the policy if a crime is suspected the facility will notify the local law enforcement. This deficiency represents non-compliance with control numbers OH00156980 and OH0015690.