STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365747	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Waterville	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the Certification, Licensure, and Survey (CALS) system (system for maintaining healthcare provider information), staff interview, and review of facility policy, the facility failed to notify the Ohio Department of Health (ODH) of a resident elopement. This affected one (#09) of three residents reviewed for elopement. The facility census was 60.Findings include: Review of the medical record revealed Resident #09 was admitted on [DATE] and transferred to the hospital on [DATE]. Diagnoses included localization-related symptomatic epilepsy and epileptic syndromes with simple partial seizures, chronic obstructive pulmonary disease, chronic kidney disease, bipolar disorder, schizoaffective disorder, morbid obesity, and major depressive disorder.Review of the Minimum Data Set (MDS) assessment, dated 12/26/25, revealed the resident was moderately cognitively impaired. Resident #09 did not have mood concerns or behaviors. Review of a nursing progress note, dated 01/02/26, revealed the writer was notified the resident was outside, nine-one-one (911) was called. The writer stayed with the resident until emergency services arrived and had control of the situation. All parties were notified.Review of the CALS system from 01/01/26 to 01/07/26, revealed no evidence the facility notified the ODH of Resident #09's elopement from the facility. Interview on 01/07/26 at 8:40 A.M. with the Administrator verified Resident #09 exited the building through his window on 01/02/26 and was located outside of the facility. The Administrator confirmed the facility did not notify the ODH. The Administrator stated hospice informed her they were required to report the incident to ODH but she was not aware that she was required to. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated 01/02/25, revealed all incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and all injuries of unknown source must be report immediately to the Administrator or designee. If abuse was alleged or serious bodily injury was identified, the Administrator/designee would notify ODH immediately but not later than two hours after the allegation was made or the serious bodily injury identified.

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 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, hospice interview, review of the local weather conditions, emergency medical services (EMS) interview, review of the EMS run report, and review of hospital records, the facility failed to adequately assess, monitor, document, and address a decline in a resident's mental health. This resulted in Actual harm to Resident #09 when on the evening of 01/01/26, the resident did not sleep, appeared to be experiencing hallucinations, and was aggressive toward staff. Facility staff failed to notify the physician or implement any interventions throughout the night. Subsequently, on 01/02/26 at approximately 7:50 A.M., Resident #09 was found outside of the facility, after exiting from his room window and without appropriate clothing for the cold temperatures, in the snow. Consequently, Resident #09 was transferred to the hospital due hypothermia (body temperature falls below 95 degrees Fahrenheit [F]) and placed on an Emergency Application (an involuntary emergency evaluation for someone believed to be a danger to themselves or others due to acute mental illness). This affected one (#09) of three residents reviewed for behavioral health services. The facility census was 60. Findings include:Review of the medical record revealed Resident #09 was admitted on [DATE] and transferred to the hospital on [DATE]. Diagnoses included localization-related symptomatic epilepsy and epileptic syndromes with simple partial seizures, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), bipolar disorder (a serious mental illness characterized by periods of intense highs [mania] and lows [depression]), schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia [psychosis like hallucinations, delusions] with symptoms of a mood disorder [depression, bipolar mania]), and major depressive disorder. Further review revealed Resident #09 received hospice services.Review of the Minimum Data Set (MDS) assessment, dated 12/26/25, revealed Resident #09 was moderately cognitively impaired. Further review of the assessment revealed Resident #09 did not have mood concerns or behaviors.Review of the physician orders revealed on 10/28/25, Resident #09 was ordered Abilify (antipsychotic medication) 10 milligrams (mg) one time daily. On 11/11/25, Resident #09's Abilify was decreased to five mg in the morning.Review of the behavior tasks documentation from 12/07/25 through 01/02/26 revealed Resident #09 had no documented behaviors.Review of a psychology follow-up visit note, dated 12/10/25, revealed Resident #09 endorsed depression related to his health. Resident #09 was calm, attentive, and in no acute distress. Judgement, insight, and impulse control were intact. Resident #09's speech was coherent with normal rate and volume, thought processes were organized with normal associations, no delusions, paranoia, hallucinations, or other perceptual disturbances. Resident #09 denied suicidal ideation and had good sleep and concentration.Additional review of the physician orders revealed on 12/11/25, Resident #09's Abilify was decreased from five mg to 2.5 mg in the morning.Review of a nursing progress note dated 12/18/25 revealed Resident #09 admitted to hospice with a diagnosis of metabolic encephalopathy with prognosis of six months or less if disease continued natural progression.Review of a nursing progress note dated 12/22/25 revealed Resident #09 was noted to have symptoms of low energy, inability to sleep, quiet, and flat affect. No other behaviors were observed.Review of a behavior note dated 12/22/25 revealed Resident #09 was experiencing anhedonia (persistent inability or reduced capacity to experience pleasure or joy in activities). The behavior was described as sadness.Review of a Patient Health Questionnaire (PHQ)-9 interview progress note, dated 12/23/25, revealed questions for little interested/pleasure in doing things and feeling down, depressed, or hopeless symptoms present were documented as no. Further review revealed the question related to whether the staff (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	mood interview should be conducted was answered no.Review of a psychology follow-up visit progress note dated 12/24/25 revealed Resident #09 presented with depressed affect with low energy and poor concentration observed. Resident #09 reported lack of motivation, interest in activities, and felt sad. Resident #09 was in no acute distress and had poor concentration. Judgment, insight and impulse control were intact. Thought processes were organized and the resident had no delusions, paranoia, hallucinations or other perceptual disturbances. Mood was depressed. Resident reported good sleep.Review of a nursing progress note, dated 12/30/25, revealed the hospice nurse was advised of increased aggression. The nurse stated she would bring it up in the meeting on him (Resident #09) tomorrow. The PNP was also in to see the resident and informed the writer she would be adjusting the resident's medications.Additional review of Resident #09's progress notes and behavior charting revealed no evidence of documentation related to Resident #09's aggression or other behaviors. There was also no documentation that the PNP was in to see Resident #09 on 12/30/25 or that any medication changes occurred.Review of a behavior charting progress note, dated 01/02/26 at 5:59 A.M., revealed when the staff approached (Resident #09) to assess, the resident became verbally aggressive, yelling profanities and instructing staff to leave the room and not shut the door. The resident got out of bed and displayed aggressive gestures toward staff, including shaking hands in a threatening manner. The resident was unapproachable and appeared highly agitated. The resident remained awake throughout the night and did not sleep. Resident #09 was observed talking very loudly and using aggressive, profane language to himself. The physician and on-call provider were notified of the resident's behaviors and lack of sleep. The resident remained in the room and no physical altercations occurred. Review of a nursing progress note, dated 01/02/26, revealed the writer was notified the resident was outside, nine-one-one (911) was called. The writer stayed with the resident until emergency services arrived and had control of the situation. All parties were notified.Review of the EMS run report revealed a call was received on 01/02/26 at 8:09 A.M. and EMS arrived on scene at 8:18 A.M. The resident was noted to be kneeling in the snow with a cold wet blanket. The facility staff were standing approximately 20 feet from the resident. Drag marks in the snow gave the impression the resident ostensibly rolled down the hill. It was reported by facility staff the resident's last known well check was during 7:00 A.M. rounds. The resident presented with an altered mental status, psychosis, aggressive/combative behaviors, injuries from a fall, and hypothermia. The skin was pale with extremities purple and abrasions to the left forehead and bilateral lower extremities with oozing bleeding. The resident was aggressive and attempted to bite and hit responders. Soft restraints were applied with assistance from law enforcement. Unable to obtain reliable pulse oxygen and oxygen was applied at six liters per minute (lpm). Due to combative behavior, five mg of Versed (benzodiazepine used as a sedative) was administered. Resident #09 had multiple brief (less than four seconds) focal seizures.Review of the hospital records, dated 01/02/26, revealed Resident #09 presented to the hospital with a suicide attempt, reportedly jumping from a window at his facility, and remained in the snow/low 20-degree F weather. Upon arrival to the emergency department (ED), Resident #09 was cold to the touch with scattered abrasions. His core body temperature was 95.6 degrees F via rectal thermometer. He had nonblanchable (does not fade or turn white when pressed, indicating blood had leaked under the skin) skin overlying the heels and knees. Dorsalis Pedis (DP) pulses (checks for blood flow to the foot, weak or absent pulses indicate reduced circulation to the lower limbs) were difficult to obtain and only the left was found via Doppler (ultrasound). The resident was in four-point restraints upon arrival with reports of him being extremely violent in route. When asked his name the resident responds, you tell me, and reported that he was pregnant. Wet clothing was removed and active rewarming was initiated (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	with blanket, warm intravenous (IV) fluids, and Bair Hugger (forced air warming blanket that circulates warm air to maintain stable body temperature) was initiated. The resident exhibited paranoia. Psychiatry was consulted for a suspected suicide attempt and Resident #09 was placed on an Emergency Application and Abilify was increased to 10 mg one time daily. Resident #09 was admitted to a medical unit with diagnoses including hypothermia due to exposure, stage one frostbite to the bilateral heels, and delusions, with a plan to transfer to inpatient psychiatry once the resident's medical condition was stabilized. Interview on 01/07/26 at 8:30 A.M. with Licensed Practical Nurse (LPN) #131 revealed he arrived to work on 01/02/26 at approximately 7:45 A.M. and about 20 minutes later, was notified a resident was outside in the snow. Observation on 01/07/26 at 9:06 A.M. of Resident #09's room revealed the room was located on the unsecured unit on the first floor, near the nurses' station. Further observation revealed the side of the facility that the room was on faced the backyard area. The facility sat on a hill, with some of the first-floor rooms being elevated from ground level. Continued observation revealed Resident #09's room window measured 77 inches (approximately 6.5 feet) from the bottom of the window to the ground below. The window screen was folded in half and on the floor. Concurrent interview with Maintenance Director (MD) #146 verified the measurement of 77 inches from the bottom of Resident #09's window to the ground below.Interview on 01/07/26 at 9:47 A.M. with the Director of Nursing (DON) revealed she received a call at approximately 6:00 A.M. on 01/02/26 from the hall nurse (LPN #137) reporting that Resident #09 was having behaviors throughout the shift (nursing shift was from 6:00 P.M. to 6:00 A.M.) of talking to himself and talking to people who were not there. The DON stated she instructed the nurse to call hospice. The DON reported she arrived at the facility at approximately 7:00 A.M. to work in the hall Resident #09 resided on. The DON stated she was told Resident #09 was sleeping and she did not check on him. At approximately 8:00 A.M., Transportation Driver (TD) #120 informed her there was a resident outside. The DON stated she found Resident #09 outside in the snow. The DON reported the resident would not allow any care or treatment, stating that he was dead and to leave him alone. The DON reported Resident #09 was trying to roll into the bushes and the road and was very combative. The DON stated Resident #09 was wearing shorts, a t-shirt, socks and slippers. The DON was unable to assess him but observed scratches on his forehead and right leg and his skin was red. After EMS arrived, the DON stated it took six EMS personnel to get Resident #09 on the stretcher (due to his combativeness).Interview on 01/07/26 at 10:10 A.M. with TD #120 revealed on 01/02/26, he arrived at that facility at approximately 7:50 A.M. and saw something in the snow a little distance from the building. TD #120 stated he discovered Resident #09 outside, approximately 100 feet from the resident's window, and it appeared he had crawled to the area where he was found. TD #120 stated he checked on the resident, and Resident #09 was agitated and stated he wanted to die. TD #120 noted the resident had abrasions to his forehead, saw dried blood, and the resident's skin was bright red. TD #120 stated the resident was wearing a t-shirt, pajama bottoms, and slippers. TD #120 stated he went into the facility to get nursing staff and 911 was called. TD #120 stated staff took blankets outside to Resident #09, which he refused, but they were able to get one on his shoulders. TD #120 stated Resident #09 was on his knees and trying to get into the brush area near the road to get away from EMS staff.Observation on 01/07/26 at 10:18 A.M. of the outdoor area where TD #120 found Resident #09 revealed the resident was located approximately 100 feet from the resident's room window.Interview on 01/07/26 at 10:31 A.M. with Certified Nursing Assistant (CNA) #170 revealed she worked from 7:00 P.M. on 01/01/26 until 7:00 A.M. on 01/02/26 on the hall Resident #09 resided on. CNA #170 stated on that night, Resident #09 was not right, adding that it was actually scary. CNA #170 stated that during the night, Resident #09 was laying in his bed, (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	talking quietly to himself, and when she walked by his room he would shout out (profanity) you! CNA #170 reported it was very out of character for him, and she started to approach him to ask if he was alright, but he only became more agitated and acted like he was going to get out of bed. At approximately 5:00 A.M., CNA #170 stated the resident settled and appeared to be asleep. CNA #170 stated she reported her concerns with the resident's behavior to the nurse, who was floating between two units. CNA #170 stated in the two or three years she had cared for Resident #09; she had never seen him like that. CNA #170 reported the last time she checked on him was shortly after 7:01 A.M., at which time he was calm, lying in bed, and appeared to be asleep. CNA #170 stated the residents' window was not open.A telephone interview on 01/07/26 at 11:06 A.M. with Hospice Executive Director ([NAME]) #200 verified the facility did not contact the hospice agency regarding Resident #09's change in condition. [NAME] #200 stated hospice became aware of the change in the resident's mental status when the hospice nurse arrived at the facility for a routine visit on 01/02/26 at 8:47 A.M. and saw the resident being assisted by EMS. A telephone interview on 01/07/26 at 11:34 A.M. with LPN #137 revealed she was the nurse assigned to provide care for Resident #09 during the night shift on 01/01/26 into 01/02/26. LPN #137 verified CNA #170 reported concerns with Resident #09's behaviors during the shift. LPN #137 stated on 01/01/26 at approximately 7:30 P.M., she attempted to provide the resident his night medications, but he refused. LPN #137 stated they kept his door open to keep an eye on him. LPN #137 stated she sent a text on 01/02/26 at 6:07 A.M. to the physician (not hospice as instructed to do by the DON) to notify him of the concerns, but she did not hear anything back and clocked out at 6:36 A.M.A telephone interview on 01/07/26 at 3:47 P.M. with Hospice Care Manager (HCM) #201 revealed on 12/30/25, she spoke with facility staff, including the facility's PNP, and was informed Resident #09 did best when he was on five to 10 mg of Abilify; however, he was only ordered Abilify 2.5 mg. HCM #201 reported she reviewed the hospice Medication Administration Record (MAR) and, according to their records, Resident #09 was to receive five mg of Abilify. HCM #201 stated she planned to address this with the facility during her visit on 01/02/26.Interview on 01/08/26 at 9:15 A.M. with PNP #300 revealed a gradual dose reduction (GDR) was implemented for Resident #09 on 12/11/25, reducing Ability from five mg to 2.5 mg one time daily. PNP #300 had not seen Resident #09 since October 2025. PNP #300 revealed she had received no reports of increased psychiatric symptoms until 12/30/25, when the hospice nurse stated she planned to discuss increasing the resident's medication (Abilify) with the hospice physician. PNP #300 stated she typically assessed a resident within 30 days of a GDR, and he was on her schedule to be seen on 01/08/26 (Resident #09 was not seen on 12/30/25 as indicated in the nursing progress note). PNP #300 stated the facility staff did not always document behavioral concerns and she was only aware of potential concerns because the hospice nurse reached out to her on 12/30/25.A telephone interview on 01/08/26 at 11:08 A.M. with Fire Chief (FC) #301 revealed he was onsite at the facility for Resident #09 on the morning of 01/02/26. FC #301 stated Resident #09 was combative and potentially hypothermic due to the windchill temperatures being lower than 20 degrees F and there was snow on the ground. FC #301 stated EMS was unable to get an accurate body temperature reading for the resident but, in addition to medication administered to calm the resident, EMS administered warm IV fluids to address potential hypothermia. A telephone interview on 01/08/26 at 1:15 P.M. with Registered Nurse (RN) #158 revealed she authored the nursing progress note on 12/30/25 that indicated Resident #09 had increased aggression. RN #158 stated the resident had been arguing with a roommate, refusing medications, and throwing things in his room. Interview on 01/08/26 at 4:10 P.M. with the Administrator and [NAME] President of Clinical Operations (VPCO) #500 revealed the facility did not have a policy related to meeting residents' behavioral or psychological (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	needs.Review of the local weather information, located at https://www.wunderground.com/history/daily/us/oh/[NAME]/KTOL/date/2026-1-1, revealed the temperature on 01/02/26 at 7:52 A.M. was 21 degrees F.Review of the facility policy titled, Notification of Change in Condition, reviewed June 2025, revealed the intent of the policy was to maintain open communication and continuity of care between nursing staff, resident and/or resident representative, and the resident's physician as it relates to the change in the resident's medical condition. The nurse would inform the resident and consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status or when there was a need to alter treatment significantly (for example, discontinue an existing form of treatment or to commence a new form of treatment). This deficiency represents non-compliance investigated under Complaint Number 2707548.