STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366150	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Cincinnati	3627 Harvey Avenue Cincinnati, OH 45229

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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 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, interview, and policy review, the facility failed to ensure the physician was notified of diagnostic results in a timely manner. This affected one (Resident #60) of six residents reviewed for falls. The facility census was 69. Findings include: Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, schizoaffective disorder bipolar type, major depressive disorder, unspecified anxiety disorder, unspecified protein-calorie malnutrition, unspecified psychosis, and repeated falls. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition, had verbal behaviors, did not reject care, and did not wander. Resident #60, required supervision/setup assistance for ADLs. Review of the care plan dated 04/17/25 revealed Resident #60 had an unwitnessed fall with shoulder fracture injury related to unsteady gait due to her spilling water on the floor. Resident #60 had bruising. Interventions included providing a capped water pitcher, assessing neuro-checks for unwitnessed falls, notifying provider and family of falls, and assessing injuries. Review of left shoulder X-ray results dated 04/15/25 at 11:40 AM revealed Resident #60 had a fracture dislocation with abnormal position of the humeral head relative to the glenoid, indeterminate anterior versus posterior. Fracture fragments from an unknown donor site were seen adjacent to the glenoid. Review of progress note dated 04/15/25 at 11:46 AM revealed Licensed Practical Nurse (LPN) #88 documented X-ray results were reviewed with no new orders. During a telephone interview on 04/24/25 at 11:31 A.M. LPN #88 stated she was working on 04/15/25 when Resident #60's lab results came back. LPN #88 stated she did not notify the physician. LPN #88 stated she gave the results to the DON to call the doctor as per protocol at the time. The Director of Nursing (DON) stated the medical director had reviewed the results and there were no new orders. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/24/25 at 12:04 P.M. Medical Director #35 stated he did not receive a call from the DON on 04/15/25 and was not aware of Resident #60's X-ray results until he visited the facility on 04/17/25. Medical Director #35 stated if he had known about the fracture dislocation, he would have sent Resident #60 to the hospital for evaluation and treatment on 04/15/25. Medical Director #35 stated the nurse practitioner who worked for him was waiting on credentials and was unable to give orders. He stated he was the only practitioner the facility was able to call. Review of policy titled Assessing Falls and Their Causes dated March 2018 revealed the facility notified the practitioner immediately by phone when a fall resulted in significant injury. This deficiency represents noncompliance investigated under Complaint Number OH00164671.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews the facility failed to ensure residents were able to control room temperature and failed to maintain sanitary shower rooms. This affected one (Resident #73) of six residents sampled for appropriate room temperature controls. This had the potential to affect all residents on the first floor and in the Women's Secured Unit who used the shower rooms. The facility census was 69. Findings include: 1. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE]. Diagnoses included unspecified diastolic congestive heart failure, unspecified bipolar disorder, unspecified anxiety disorder, unspecified noncompliance with medical treatment and regimen, and cellulitis of right lower limb. During an observation on 04/30/25 at 9:06 A.M., the air conditioning unit under the window was actively blowing cold air into the room. The control panel could be opened and had metal switch to turn fan on or off. The dial for the temperature control was missing a knob. During an interview on 04/30/25 at 9:07 A.M., Resident #73 stated the air conditioner ran throughout the night on 04/28/25 and he did not know how to turn it off. He was cold and had to ask staff for a blanket. Resident #73 stated he did not know how to open the unit's control panel, and no one had explained how to adjust the temperature or turn the unit on and off. During an interview on 05/02/25 at 8:40 AM Maintenance Director #164 confirmed the knob was missing for the air conditioner control. 2. During an observation on 04/24/25 at 10:44 A.M. revealed the shower room on the women's locked unit had significant water damage to one wall causing the sheet rock to pull away from the wall, and the bottom fourth of the shower curtain was mildewed. The shower room on the 100 unit had a toilet filled with brown-colored water that would not flush. The shower room on the 300 Unit had two small formed pieces of brown stool on the floor near the drain. During an interview on 04/24/25 at 10:47 AM, Certified Nursing Assistant (CNA) #144 confirmed the toilet in the 100-Unit shower room was not working and had not been working for at least one week. CNA #144 stated he had not reported the broken toilet to maintenance. During an interview on 04/24/25 at 10:49 AM Maintenance Director #164 verified toilet in the 100-Unit shower room was not flushing. He stated he was not notified the toilet was not working. Maintenance Director #164 verified the sheet rock in the Women's Unit shower room was pulling away from the wall due to water damage and the shower curtain had mildew along the bottom quarter of the curtain. He stated he had tiles to repair the wall but had not gotten to it. During an interview on 04/24/25 at 10:54 AM, Maintenance Director #164 and the Administrator verified the shower room on the 300 Unit had feces on the floor and was unsanitary. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy titled, Environmental Services: Supplies and Equipment, dated February 2009, revealed equipment was ready for use at all times of the day or night to serve the residents' needs. This deficiency represents noncompliance investigated under Complaint Numbers OH00165501, OH00165429, OH00165255, OH00164321, OH00163006, OH00165781 and OH00165734.

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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 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 record review, staff interviews, and policy review, the facility failed to report allegations of abuse to the State Agency in a timely manner. This affected two (Residents #64 and #51) of six residents sampled for abuse. The facility census was 69. Findings include: 1. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, unspecified schizoaffective disorder, unspecified myelodysplastic syndrome, type II diabetes, unspecified heart failure, unspecified dementia, unspecified psychosis, unspecified bipolar disorder, and unspecified anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had verbal behaviors, did not reject care, and did not wander. Resident # 64 required supervision with all activities of daily living. Review of the care plan dated 06/17/24 revealed Resident #64 wandered into other resident's rooms and took their belongings. Resident #64 screamed and yelled at staff at times. Interventions included redirecting and offering activities. Review of progress note dated 03/13/25 at 3:24 P.M. revealed Certified Nursing Assistant (CNA) #113 reported she was walking up the ramp towards the dining room when she heard Resident #64 scream. CNA #113 saw Resident #51 hit Resident #64 in the face. The aide yelled for Resident #51 to stop. Resident #51 rolled away in her wheelchair. Upon assessment Resident #64 had three superficial scratches on the right side of her face. Upon interview Resident #51 stated she hit her because Resident #64 was in Resident #54's room. Resident #64 is known to wander. Resident #54 stated Resident #64 was in her room washing her hands. Appropriate notifications were made, and Resident #51 was placed on one to one supervision for 24 hours. 2. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage, unspecified schizophrenia, unspecified epilepsy, unspecified anxiety disorder, recurrent major depressive disorder, schizoaffective disorder bipolar type, chronic viral Hepatitis C, anoxic brain damage, and attention-deficit hyperactivity disorder. Review of the most recent MDS assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident #51 required one-person physical assistance for assistance with activities of daily living. Review of care plan dated 08/19/24 revealed Resident #51 had a recent increase in verbal and physical aggression with peers due to multiple diagnoses. She also has Anoxic Brain Damage related to Psychoactive Substance Abuse, for which she currently receives Zubsolv (Buprenorphine). Interventions included administering medications as ordered, assessing resident's understanding of the situation, allowing time for the resident to express feelings, consulting with psych as needed, and de-escalating by removing the resident from the situation and providing close supervision. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of incident report dated 03/13/25 revealed Certified Nursing Assistant (CNA) #113 reported to the Licensed Practical Nurse (LPN) #88 that Resident #51 scratched Resident #64 on her arms and face while trying to pull her out of Resident #54's room. When questioned Resident #51 confirmed she scratched Resident #64 because she was upset Resident #64 was in Resident #54's room. Resident #51 was placed on one to one supervision for 24 hours. During an interview on 04/25/25 at 9:00 AM the Administrator stated the facility investigated the incident between Resident #51 and #64 and determined it was not abuse. The Administrator verified the incident was not reported to the State Agency and the facility did not file an self-reported incident because it seemed like Resident #51's intent was to get Resident #64 out of the room and not to harm her. Review of policy titled Abuse dated 12/10/23 revealed the facility reported abuse allegations to the state survey agency no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. This deficiency represents noncompliance investigated under Complaint Numbers OH00165674, OH00164671, OH00164321 and OH00165734.

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, an Ombudsman interview, police interviews, medical record review, and policy review, the facility failed to provide a safe discharge for Resident #19. This resulted in Immediate Jeopardy on 04/10/25 when Resident #19 was placed at risk for potential serious life-threatening harm, injuries, negative health outcomes and/or death when the facility discharged Resident #19 without providing a safe discharge location or provisions for a wound treatment. This affected one (Resident #19) of three residents reviewed for discharge. The facility census was 69. On 04/23/25 at 1:07 P.M., the Administrator, Director of Nursing (DON), and Regional Director of Operations (RDO) #200 were notified that Immediate Jeopardy began on 04/10/25 at 3:00 P.M. when Resident #19 was refused access to the facility and the facility issued an emergency discharge based on allegations from two other residents on 04/09/25 that Resident #19 was in possession of a firearm. On 04/09/24, the resident left the facility at approximately 9:00 A.M. and the facility packed Resident #19's belongings in trash bags while Resident #19 was on leave of absence, and did not locate a firearm. Upon Resident #19's return to the building on 04/10/25 at 3:00 P.M., the resident was not allowed in, and the police were called. Police arrived, were on-site at the facility, and searched Resident #19 for a weapon and did not find one. Police escorted Resident #19 off the property and staff placed Resident #19's personal items by the garbage dumpster. The nurse who discharged the resident gave him his face sheet, his medication list and all his routine medications, except the narcotics. Resident #19 was not provided with a safe discharge destination. The Immediate Jeopardy was removed on 04/23/25 when the facility implemented the following corrective actions: • On 04/16/25 and 04/23/25, the DON/Designee reviewed all facility-initiated discharges in the last 90 days for safe discharge criteria. The Administrator/Designee will conduct weekly audits for four weeks, monthly for one quarter, and periodically thereafter to ensure all facility-initiated discharges are completed in a safe, orderly manner. All findings will be reviewed through the Quality Assurance and Performance Improvement (QAPI) committee, and any negative findings will be corrected immediately. • On 04/16/25, the Administrator reviewed the facility's discharge policy for compliance with safe, orderly discharge criteria, with no revisions made. • On 04/23/25, RDO #200 in-serviced the Administrator about completing a safe and orderly discharge. The education included obtaining orders for discharge, obtaining orders for appropriate services and equipment when transferring to a location in the community, preparing a discharge summary and/or assessment, preparing medications to be discharged with the resident as permitted by law, assisting with transportation as applicable, and communicating with resident and/or representative regarding the discharge plan and appropriate documents. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• On 04/23/25, the Administrator in-serviced members of the interdisciplinary team, including the DON, Assistant Director of Nursing (ADON) #127, Minimum Data Set (MDS) Nurse #124, Social Worker #135, and Business Office Manager (BOM) #166, and all nurses about completing a safe and orderly discharge. The education included obtaining orders for discharge, obtaining orders for appropriate services and equipment when transferring to a location in the community, preparing a discharge summary and/or assessment, preparing medications to be discharged with the resident as permitted by law, assisting with transportation as applicable, and communicating with resident and/or representative regarding the discharge plan and appropriate documents. Any nurse that was not educated was not allowed back to the floor until they were in-serviced. Although the Immediate Jeopardy was removed on 04/23/25, the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] and was discharged on 04/10/25. Diagnoses included unspecified paraplegia, stage III pressure ulcer to the left heel, chronic pain syndrome, unspecified protein calorie malnutrition, morbid obesity, unspecified bipolar disorder, and neuromuscular dysfunction of the bladder. Review of the care plan dated 01/28/25 revealed Resident #19 wanted to discharge to home or community. Interventions included encouraging the resident to discuss feelings/concerns about discharge, evaluating the resident's ability to safely discharge to the community, and providing community referrals to determine/address gaps in the resident's strengths and abilities that could affect a safe discharge. Review of the most recent Minimum Data Set (MDS) assessment, dated 02/04/25, revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of progress notes revealed on 04/09/25 at approximately 7:30 A.M. a male resident on 300 unit asked Licensed Practical Nurse (LPN) #109 to keep Resident #19 out of his room. Resident #19 shouted for the male resident to shut up, and Resident #19 returned to his room. At approximately 9:00 A.M., Resident #19 could not be located in the building and staff stated Resident #19 had left without signing out. The facility notified the Ombudsman who recommended Resident #19 be given an emergency discharge. The facility notified the physician. Review of a progress note dated 04/09/25 at 11:18 A.M. revealed the DON and Administrator were notified that Resident #19 allegedly had a firearm and threatened two male residents earlier that morning. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress noted dated 04/09/25 at 1:29 P.M. revealed Resident #19 was placed in Emergency Discharge status. Social Worker (SW) #135 attempted to locate emergency placement for Resident #19 with four long-term care facilities, but each denied admission. SW #135 attempted to schedule a follow-up appointment for Resident #19 at University of Cincinnati Health but was unsuccessful. SW #135 reached out to community housing programs for emergency housing but was unsuccessful. Resident #19 was unavailable for participation in the discharge process. Review of a progress note dated 04/09/25 at 6:35 P.M. revealed the facility checked Resident #19's room for safety hazards and found none. The administration directed staff to notify authorities if Resident #19 returned to the facility. Review of the Discharge summary dated [DATE] revealed Resident #19 had a planned, emergency discharge recommended by the Ombudsman related to threats with a firearm. Social Services attempted to locate emergency placement with several long-term care facilities, but the resident was not accepted for admission. The resident was away from the building and was unable to be reached to discuss his plans for discharge location. Resident #19 received a copy of his discharge instructions. Review of the document titled Emergency Notice of Discharge, dated 04/10/25, documented Resident #19 was discharged from the facility because the safety of other residents was endangered. Specific allegations in support of the reason included residents had alleged Resident #19 had threatened them with a gun. The resident had been offered services to assist with placement, and discharge was made to Mountain Crest Health Care. The discharge notice listed the resident's right to appeal the discharge and the right to remain in the facility until the appeal was heard by a Hearing Official. Contact information was listed for the Ohio Office of Legal Services and State Long-Term Care Ombudsman. The document was signed by the Administrator with LPN #88 signing as a witness. Review of the Social Service Recapitulation note, dated 04/10/25 at 5:21 P.M., documented that the social worker was unable to discuss discharge plans with Resident #19 due to him having to exit the building because of an emergency discharge. The physician was notified and gave orders that directed Resident #19 could not have narcotic medications. Staff gave Resident #19 his face sheet, orders, and medications. Review of a progress note dated 04/10/25 at 5:53 P.M. revealed Resident #19 arrived on facility property and police were called. Resident #19 spoke with the Administrator regarding an emergency discharge and Resident #19 refused to accept the discharge notice. Review of progress note dated 04/10/25 at 6:49 P.M. revealed Resident #19 was discharged with all his possessions and a nurse provided discharge instructions. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the entrance conference on 04/16/25 at 9:25 A.M., the Administrator stated on 04/09/25 Residents #42 and #43 reported Resident #19 had threatened each of them on separate occasions with a gun. Each resident stated he had seen Resident #19 with a gun. Resident #19 left the facility without signing himself out. The facility placed the building in lockdown status and vetted anyone who entered the facility. The facility called the police right away. Upon police suggestion, the facility searched Resident #19's room and did not find a weapon. Police instructed the facility not to let Resident #19 back into the building until the police questioned him. Resident #19 returned to the building the next day. The facility told Resident #19 he could not come into the building, but he entered anyway and went towards his room. The police arrived. The facility gave Resident #19 his medications, medical records, and an emergency discharge notice. After making the initial police report the facility contacted the Ombudsman who told them due to the threat, they had to issue an emergency discharge to keep the other residents safe. Resident #19 refused to take the discharge paperwork. Resident #19 took all of his things with him. The police ensured all of his things were out of the building. The Administrator stated Resident #19's sister came and picked him up in the parking lot and took all his items. During a telephone interview on 04/16/25 at 10:18 A.M., Ombudsman #71 stated the facility called her on 04/09/25 for guidance. They stated that Resident #19 had allegedly threatened someone with a gun. They never found a gun. Ombudsman #71 stated she advised the facility they could discharge Resident #19, but it had to be a safe discharge, which they had to provide for both him and his representative in writing. Ombudsman #71 stated Resident #19 returned to the facility on [DATE], and staff alerted her they were putting Resident #19 on the street. Resident #19 slept in a car for two days and was hospitalized at Christ Hospital. During concurrent interviews on 04/16/25 at 10:55 A.M., Residents #42 and #43 each stated they had seen Resident #19 with a nine-millimeter pistol, and he had threatened each of them. During a telephone interview on 04/16/25 at 12:33 P.M., Certified Nursing Assistant (CNA) #172 stated she was working on 04/10/25 from 7:00 A.M. to 7:00 P.M. Resident #19's possessions were in plastic trash liners and lined up by the back door. Resident #19 arrived at the facility around 3:00 P.M. accompanied by another young male. CNA #172 stated she took a 15-minute break and as she went outside, Resident #19 zoomed past her into the building. CNA #172 stated the police pulled up while she was on break, and a task force entered the building through the back. When she went back into the building, the police and Administrator were talking to Resident #19. An officer asked her if she had ever seen Resident #19 with a gun, and she said no. CNA #172 stated per police request, she carried bags of Resident #19's personal items out of the facility and placed them near the garbage dumpster. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/17/25 at 8:30 A.M., SW #135 stated Resident #19 met her at the time clock when she came into work on 04/09/25. He asked her to search him. Resident #19 explained other residents had made accusations that he had threatened them with a gun. Resident #19 went to his room. ADON #127 was there. Resident #19 asked her to search him. Resident #19 said he had an appointment, and he left the building. SW #135 stated she went to the morning meeting, but the meeting was canceled when the police arrived. The management team held an emergency meeting with all staff to discuss the active shooter policy. Staff were instructed to inform the Administrator if Resident #19 returned to the building, to not let him inside until the police arrived. The building was placed on lockdown. Staff could come and go but residents had to stay inside. While he was gone, the social worker attempted to get Resident #19 placement at four long term care facilities. Each rejected him. She tried to set up an appointment with a primary care provider at UC Health and was told to call back the next day. Resident #19 returned to the facility on [DATE] between 2:00 to 3:00 P.M. SW #135 stated she went outside. Resident #19 called the police since the Administrator was not at the building. Human Resources (HR) Staff #176 came out too. They waited together for the police, but no one came. The police called Resident #19 back, and SW #135 talked to them. The officer was confused as to why a police presence was needed and stated the police were not coming. The police advised calling on Friday and talking to Officer #32 in District 4 because he was handling the case. SW #135 stated she looked and saw the Administrator in the building. Resident #19 asked him to come out, but the Administrator refused. SW #135 stated she went back into the building. Later, Resident #19 followed staff into the building. He went towards his room to get his clothes. The Administrator told him he could not be in the building and told him to leave. Police entered the building wearing body [NAME] with guns drawn and were shouting Where is the gun? repeatedly. Resident #19 said they could search him and denied having a weapon. Resident #19 was very upset because he did not have anywhere to go. There was no family there to get him. Management assumed Resident #19 had a sister who worked in housekeeping at the facility, but she was not his sister and of no blood relation. She had no vehicle and had stairs in front of her house that Resident #19 would not have been able to access while in his wheelchair. Police asked staff to move Resident #19's possessions off the property so police would not later be called back to arrest him for trespassing. Resident #19 left and rolled up the hill in his wheelchair. SW #135 stated she stopped her car after exiting out of the parking lot so Resident #19 could cross the street in his wheelchair. SW #135 stated no one knew where Resident #19 went after he left the facility. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/17/25 at 9:09 A.M., HR Staff #176 stated when Resident #19 was accused of having a gun, ADON #127 was right there. Resident #19 asked ADON #127 to search him and his things. She did not search him, told him not to worry about it, and said he could leave. On 04/10/25, Resident #19 called HR Staff #176 and said he was coming to the facility to talk to the Administrator about the situation. HR Staff #176 stated she informed the Administrator. Around 3:00 P.M., HR Staff #176 saw Resident #19 approaching the front door. She went out to speak to him. Resident #19 said he had already called the police. HR Staff #176 waited outside with him for about 30 minutes. The police never came. Resident #19 tried to call the police again and put the call on speaker phone. The officer was confused why a police presence was necessary for Resident #19 to enter the building. HR Staff #176 explained the events to the officer who said he would check and call back. When the officer called back, the officer spoke with the social worker. He was still confused and gave her the name of someone to call the next day. The Administrator returned to the facility and entered through the ambulance entrance. HR Staff #176 stated she explained to the Administrator that the police were confused about why they needed to come to the building. Somehow Resident #19 followed someone into the building and started going towards his room. The Administrator told him he had to leave. Resident #19 said they could not just put him out on the streets, stated he did not have a gun, and stated he called the police, and they weren ' t coming. HR Staff #176 stated around 5:00 P.M., she was driving out of the parking lot when multiple police vehicles approached the facility. She pulled back into the parking lot and entered the building. A male officer was shouting for the DON. He stated the DON called police and reported Resident #19 had a gun. Police started questioning staff if they had seen a gun. All staff denied seeing a gun. HR Staff #176 stated she had gone to her car. An officer approached her and asked her to carry Resident #19's items to the curb so he would not have to be trespassed off the property. Resident #19 was heard saying, How can you put me out? I have no gun. No one saw a gun. The police did not see a gun. Now you got the DON calling in saying I got a gun? HR Staff #176 stated when she finally left the facility, she saw Resident #19 wheeling himself up the street. Staff were still setting his stuff on the curb. He did not take any of his items with him and she did not know what happened to his items. During an interview on 04/17/25 at 10:54 A.M., Housekeeper #97 stated she was not related to Resident #19, and he was not discharged into her care. During a telephone interview on 04/17/25 at 2:21 P.M., Police Supervisor #25 stated he advised the facility that police could not search Resident #19's property without a search warrant and advised the facility to follow their policy. The officer stated the police would respond if the facility called again with additional concerns once Resident #19 returned. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/22/25 Resident #19 denied having a weapon or threatening other residents with a weapon at the facility. Resident #19 stated he asked multiple staff to search himself and his property prior to leaving on 04/09/25. Resident #19 stated that ADON #127 assured him he did not need to be searched before he left. Resident #19 stated he called the facility on 04/10/25 prior to going to the facility and spoke with two staff members who advised him to call the detectives before returning to the facility. Resident #19 stated when he spoke to police, they said they would meet him at the facility. Resident #19 stated he waited outside the facility for approximately two hours before entering the building. Police never came. When he called back, the officers seemed confused as to why they were needed. Resident #19 stated he had put the call on speaker phone so staff waiting outside with him could hear them say they were not coming before he entered the building. After he entered the building, the Administrator yelled at him, told him he could not be there, and said he was calling the police. The police came charging in asking him where his gun was. Resident #19 denied having a weapon. The Administrator stated Resident #19 needed to leave the premises and handed Resident #19 a face sheet. Resident #19 stated they had to send him somewhere. The Administrator stated it was an emergency discharge, and they did not have to do anything but get him out of the building. The administrator had police and staff set his things out by the dumpster. Resident #19 stated he did not carry anything with him in his wheelchair. The police said he had to leave his things and get off the lot so they would not have to arrest him for trespassing. Resident #19 stated he propelled down the street in his wheelchair. Two staff members stopped their cars so he could cross the street. It started raining and Resident #19 stated he began checking cars because he was cold. When he found an unlocked vehicle, Resident #19 pulled himself and his wheelchair inside. Resident #19 stated he stayed in the car for two days until it stopped raining. Resident #19 stated he propelled himself to his cousin's house, within five miles of the facility, and called for an ambulance. Resident #19 stated he was admitted to the hospital on [DATE] for a stomach infection and was to be discharged to another nursing facility on 04/22/25 because he was homeless. During an interview on 04/22/25 at 10:31 A.M., the Administrator verified the discharge notice signed on 04/10/25 had an inaccurate discharge destination. The Administrator stated he was trying to change it, but Resident #19 would not let him. The Administrator stated he did not see Resident #19 leave the building and was told by staff he discharged with his sister. During an interview on 04/22/25 at 12:54 P.M., Scheduler #98 stated she was sitting at the reception desk from 04/09/25 at 9:00 P.M. until 04/10/25 at 7:00 A.M. She had a white envelope with discharge papers inside. She was instructed that if Resident #19 came to the building, she was to notify the Administrator and police. Staff were not allowed to let Resident #19 in the building. During an interview on 04/22/25 at 1:08 P.M., Maintenance Staff #164 stated he covered the front desk on 04/09/25 from 4:00 P.M. until 9:00 P.M. He was instructed that if Resident #19 returned to the building, he was to have Resident #19 sign his discharge papers and to call the police if he refused to sign. During a telephone interview on 04/22/25 at 2:26 P.M., LPN #122 stated she and ADON #127 searched Resident #19's room on 04/09/25 and did not find a weapon. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/22/25 at 2:35 P.M., LPN #88 stated she was working upstairs on 04/10/25 when Resident #19 returned to the facility. LPN #88 stated the Administrator asked her to assist with Resident #19's discharge. LPN #88 stated she prepared Resident #19's medications, reviewed the orders, and read the discharge notice to him. The paper said he was discharged to another nursing facility. Resident #19 refused to sign the paper. The Administrator had LPN #88 sign the discharge notice, and she returned to her assignment upstairs. LPN #88 stated she did not see Resident #19 leave the building. During an interview on 04/22/25 at 3:35 P.M., Receptionist #163 stated on 04/10/25 around 4:30 P.M., Resident #19 wheeled himself into the building. She told him he was not allowed to be in the building. Resident #19 continued to propel towards his room while the receptionist notified the Administrator. Shortly after, the police entered the building from both entrances. They searched the building and did not find a weapon. The Administrator asked the police to get Resident #19 off the property. Resident #19 asked the police where he was supposed to go, and they said they could not help him. An unidentified nurse gave Resident #19 a plastic bag with medications and papers. The receptionist watched Resident #19 propel himself down the sidewalk away from the building, and the police left. The receptionist stated Resident #19 appeared to be wearing a long-sleeved t-shirt and pants. He was not wearing a coat. During a telephone interview on 04/24/25 at 10:30 A.M., Medical Director (MD) #35 stated the facility notified him on 04/09/25 that Resident #19 had left the building, and they did not know where he had gone. The DON called the police on 04/10/25 because Resident #10 brandished a weapon at the facility. He was being given an emergency discharge. MD #35 approved for the facility to discharge Resident #19 with routine medications. MD #35 stated Resident #19 had active unspecified wounds to his heel, great toe, and ankle. MD #35 verified staff did not ask about treatments and he did not give orders for wound care. During a telephone interview on 04/28/25 at 3:09 P.M., Police Officer #40 stated he was among several officers who responded on 04/10/25 when the DON alerted police that a resident was in the building with a firearm. Other officers were already on scene when Officer #40 and his partner arrived. The Administrator was speaking with Resident #19 and another officer. The Administrator had signed discharge papers and stated that Resident #19 needed to leave because he was no longer a patient. Officer #40 stated he told Resident #19 to stay off the property. Staff carried Resident #19's personal items out of the building in bags. Officer #40 stated Resident #19 was in the parking lot speaking to staff when the officers left. Review of the facility policy titled Preparing a Resident for Transfer or Discharge, dated 12/2016, revealed residents were prepared in advance for discharge. Nursing services included obtaining orders for discharge, preparing a discharge summary and post-discharge plan, preparing medications for discharge, providing discharge summary and plan to the resident/family, packing resident belongings, assisting with transportation, and escorting the resident to transportation. This deficiency represents non-compliance investigated under Complaint Numbers OH00165501, OH00164746, and OH00164671.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure residents received appropriate screening for pre-admission screening and resident review (PASRR) prior to admission. This affected one (Resident #43) of six residents reviewed for PASRR. The facility census was 69. Findings include: Review of the medical record revealed Resident #43 was admitted to the facility on [DATE]. Diagnoses included paraplegia, uncomplicated opioid dependence, chronic post-traumatic stress disorder, schizoaffective disorder bipolar type, dependent personality disorder, and generalized anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of the medical record revealed Resident #43 had no PASRR screening documented in his medical record. During an interview on 05/13/25 at 9:34 AM Social Worker (SW) #135 stated a resident coming from the hospital should have been screened for PASRR prior to admission. SW #135 verified Resident #43 had no evidence of PASRR screening in his medical record. Review of policy titled Admission/readmission Policy, dated 10/21/21 revealed residents were screened for major mental disability before admission to ensure the needs of the resident could be managed in a skilled nursing facility. Level II PASRR screens were sent to Behavioral Consulting Services (BCS) prior to admission. This deficiency represents noncompliance identified under Complaint Number OH00165501.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents were reassessed for pre-admission screening and resident review (PASRR) after new mental health diagnoses and new psychotropic medications were ordered. This affected one (Resident #36) of six residents reviewed for PASRR. The facility census was 69. Findings include: Review of the medical record revealed Resident #36 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, type II diabetes, unspecified anxiety disorder, unspecified persistent mood disorder, and chronic systolic heart failure. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was not assessed for cognition status, had self-directed behaviors, did not reject care, and did not wander. Review of the medical record revealed Resident #36 had physician orders for psychotropic medications including (0)Divalproex sodium 250 mg delayed release tablet, 500 milligrams (mg) by mouth three times daily for persistent mood disorder, Ativan 0.5 mg by mouth three times daily for anxiety, and Lexapro 5 mg by mouth once daily for mood disorder. Review of the medical record revealed no evidence a significant change PASRR was completed after Resident #36 was diagnosed on [DATE] with unspecified anxiety disorder, or on 02/25/25 when Resident #36 was diagnosed with persistent mood (affective) disorder. There was no evidence Resident #36 was assessed after he was prescribed psychotropic medications on 02/24/25, 03/04/25, or 03/18/25. During an interview on 05/13/25 at 11:48 A.M. Social Worker #135 verified she had not reassessed Resident #36 for PASRR after changes in his diagnoses and medications because she was unaware these changes had occurred. Review of policy titled Astoria Place of Cincinnati Procedure for Completion of PASRR, not dated, revealed the social worker coordinated assessments with the PASRR screening program and notified Behavioral Consulting Services if Level II services were required. This deficiency represents noncompliance identified under Complaint Number OH00165501.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review, the facility failed to ensure residents received quarterly conferences attended by members of the clinical team. This affected three (Residents #36, #51, and #60) of five residents reviewed for care conferences. The facility census was 69. Findings include: 1. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, type II diabetes, unspecified anxiety disorder, unspecified persistent mood disorder, and chronic systolic heart failure. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was not assessed for cognition status, had self-directed behaviors, did not reject care, and did not wander. Review of the medical record revealed Resident #36 had a care conference on 12/23/24 with the social worker. There were no additional members of the interdisciplinary (IDT) team represented at this meeting. Review of the medical record revealed Resident #36 had no additional care conference documented. During an interview on 05/13/25 at 11:48 A.M., Social Worker (SW) #135 verified Resident #36 had not had quarterly care conferences. SW #135 stated they were in the process of getting a guardian for Resident #36 and he was not cognitively appropriate to participate in a care conference. 2. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage, unspecified schizophrenia, unspecified epilepsy, unspecified anxiety disorder, recurrent major depressive disorder, schizoaffective disorder bipolar type, chronic viral Hepatitis C, anoxic brain damage, and attention-deficit hyperactivity disorder. Review of the most recent MDS assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of progress notes revealed Resident #51's last documented care conference was held on 09/06/23. During an interview on 05/13/25 at 11:48 A.M. SW #135 verified Resident #51 had not had quarterly care conferences. SW #135 stated she spoke with Resident #51's guardian frequently but had not documented any care conversations as a care conference and did not have the IDT team represented in those conversations. SW #135 stated she emailed the team when care conferences were scheduled, but she rarely got a response and only recently learned she could include the nursing staff working on the floor in the meetings to represent the nursing department. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, schizoaffective disorder bipolar type, major depressive disorder, unspecified anxiety disorder, unspecified protein-calorie malnutrition, unspecified psychosis, and repeated falls. Review of the most recent MDS assessment dated [DATE] revealed the resident had moderately impaired cognition, had verbal behaviors, did not reject care, and did not wander. Resident #60 required supervision/setup assistance for activities of daily living. Review of the medical record revealed Resident #51's last documented care conference occurred on 11/17/24 via telephone between SW #135 and Resident #75's legal representative. Neither Resident #75 nor additional members of the IDT team were present at the care conference. During an interview on 05/13/25 at 11:48 A.M., SW #135 verified Resident #60 had not had quarterly care conferences. SW #135 stated Resident #60 was able to make her needs known, but excluded her from care conferences with her legal representative because her involvement resulted in the resident becoming tearful and talking about her family. SW #135 also stated conferences were missed because when she attempted to reach Resident #60's legal representative for conferences, he did not return her calls. Review of policy titled Resident Participation- Assessment/Care Plans dated 12/2016, revealed residents and resident representative were encouraged to participate in the care planning process and were given advance notice of care conferences. This deficiency represents noncompliance investigated under Complaint Number OH00165501.

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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, interview and policy review, the facility failed to timely treat residents with displaced joints. This affected one (Resident #60) of five residents reviewed for falls. The facility census was 69. Findings include: Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, schizoaffective disorder bipolar type, major depressive disorder, unspecified anxiety disorder, unspecified protein-calorie malnutrition, unspecified psychosis, and repeated falls. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition, had verbal behaviors, did not reject care, and did not wander. Resident #60 required supervision/setup assistance for activities of daily living. Review of the care plan dated 04/17/25 revealed Resident #60 had an unwitnessed fall with shoulder fracture injury related to unsteady gait due to her spilling water on the floor. Resident #60 had bruising. Interventions included providing a capped water pitcher, assessing neuro-checks for unwitnessed falls, notifying provider and family of falls, and assessing injuries. Review of progress note dated 04/14/25 at 2:25 PM Resident #60 attempted to throw herself on the floor. Licensed Practical Nurse (LPN) #88 was able to break her fall. Resident #60 was crying and yelling that her arm hurt from a previous fall. Resident #60 stated she did not tell the nurse before, but the pain was getting worse. New orders were received for X-ray. Family was notified. Review of left shoulder X-ray results dated 04/15/25 at 11:40 AM revealed Resident #60 had a fracture dislocation with abnormal position of the humeral head relative to the glenoid, indeterminate anterior versus posterior. Additionally, fracture fragments were seen to the glenoid. Review of progress note dated 04/15/25 at 11:46 AM revealed X-ray results were reviewed with no new orders. Review of progress note dated 04/17/25 at 12:43 PM revealed Resident #60 was in the dining room eating lunch and was unable to feed herself independently without food and drink falling onto her clothes. Resident #60 complained of left arm pain and had swelling and discoloration. The doctor was notified and gave new orders for Resident #60 to be sent to the hospital for evaluation and treatment. Review of progress note dated 04/18/25 revealed staff spoke with hospital staff: Resident #60 was admitted to the hospital for pain related to a dislocated left shoulder. Hospital staff put her shoulder back in proper position. Review of progress note dated 04/19/25 at 8:00 PM revealed Resident #60 was readmitted to the facility from the hospital at 7:25 PM. Resident #60 had a sling in place to the left arm. Resident #60 had orders to be no weight-bearing and there was to be no range of motion to the left upper extremity. Resident #60 was being treated with antibiotics for pneumonia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 Resident #60 stated her left arm was hurting after she fell and hit it hard. Resident #60 stated she did not remember when the fall happened. She was running and tripped landing on her left arm and she heard something snap. Resident #60 stated Licensed Practical Nurse (LPN) #88 and an unidentified aide helped her up. During a telephone interview on 04/24/25 at 11:31 A.M., LPN #88 stated she was working on 04/15/25 when Resident #60's X-ray results came back. LPN #88 stated she did not notify the physician. LPN #88 stated she gave the results to the Director of Nursing (DON) to call the doctor as per protocol at the time. The DON stated the medical director had reviewed the results and there were no new orders and LPN #88 stated she documented the results were reviewed and there were no new orders. During a telephone interview on 04/24/25 at 12:04 P.M. Medical Director #35 stated he did not receive a call from the DON on 04/15/25 and was not aware of Resident #60's X-ray results until he visited the facility on 04/17/25. Medical Director #35 stated if he had known about the fracture dislocation, he would have sent Resident #60 to the hospital for evaluation and treatment on 04/15/25. Review of policy titled Assessing Fallsdated March 2018 revealed after a fall, if there was evidence of injury, notify the attending physician in a timely manner and obtain medical treatment immediately. This deficiency represents noncompliance investigated under Complaint Number OH00164671.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of hospital records, staff interviews, and policy review, the facility failed to ensure adequate supervision was in place to prevent one resident, identified as an elopement risk and who was assessed with purposeful exit seeking behaviors, from eloping from the facility unknown to staff. This resulted in Immediate Jeopardy and serious physical harm and injuries on 04/26/25 when Resident #75 was removed from one-on-one supervision and was subsequently found on the ground outside of the facility after removing a windowpane from the window in his room and dropping two stories to the pavement below, sustaining bilateral ankle fractures which required surgery. This affected one (Resident #75) of three residents reviewed for elopement risk. The facility census was 69. On 05/02/25, the Administrator was notified that Immediate Jeopardy began on 04/26/25 at 7:50 A.M. when the facility removed Resident #75 from one-on-one supervision. At 8:10 A.M., staff found Resident #75 on the ground outside of the facility. He was unable to stand or walk. On 04/25/25 around 11:00 A.M., Resident #75 stated to Licensed Practical Nurse (LPN) #106 if the facility did not let him leave to go to the bank, he would jump out the window. LPN #106 educated Resident #75 to the risks of his actions. Resident #75 stated he would rather be homeless than stay at the facility. Staff pursued having Resident #75 sent to the hospital for involuntary psychiatric treatment for suicidal ideations. Resident #75 was sent to the hospital on [DATE] around 4:00 P.M. The hospital sent Resident #75 back to the facility on [DATE] around 8:00 P.M. with documentation stating Resident #75 was assessed and did not have suicidal ideations; Resident #75 wanted to leave the facility and go to the bank. The facility continued with one-on-one supervision from 04/25/25 at 9:00 P.M. to 04/26/25 at 7:50 A.M. On 04/26/25 at 8:10 AM, kitchen staff reported to nursing staff they found Resident #75 on the sidewalk near the outside entrance after responding to a loud thud noise. Nursing staff sent Resident #75 to the hospital via emergency transport after Resident #75 was assessed and unable to bear weight or ambulate. The initial facility investigation revealed that Resident #75 had removed the lower pane from his window to exit the facility. The hospital reported on 04/26/25 that Resident #75 was admitted with bilateral ankle fractures and required surgery. Immediate Jeopardy was removed on 05/02/25 when the facility implemented the following corrective actions: • On 04/26/25, Resident #75 was found outside, the nurse immediately assessed the resident and called 911, and he was sent to the hospital for evaluation and treatment. • On 04/26/25, the facility immediately notified Resident #75 ' s responsible party and doctor. • On 04/26/25, Maintenance Director (MD) #164 or/designee completed immediate audits on all windows that were accessible to residents on the second floor to ensure they were secure. All windows that were found unsecure were immediately addressed to ensure they could not be pulled out of the frame. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• On 04/26/25, the Administrator/designee held an in-service for staff to provide education and expectations as it relates to monitoring suicidal ideation. The Administrator/designee held an in-service for maintenance staff as it relates to window maintenance. • On 05/02/25, the Administrator/designee commenced an in-service for staff to provide education on policies and procedures as it relates supervision to prevent elopement. No staff will be allowed to start their shift until they have completed said education. • On 05/02/25, Assistant Director of Nursing (ADON) #127/designee completed elopement assessments for all residents to assess risk for elopement and ensure there is proper supervision in place. Although the Immediate Jeopardy was removed on 05/02/25, the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] and remains in active status. Diagnoses included schizoaffective disorder bipolar type, suicidal ideations, other uncomplicated psychoactive substance abuse, antisocial personality disorder, uncomplicated nicotine dependence, uncomplicated alcohol dependence, mild neurocognitive disorder with behavioral disturbance, and mild cognitive condition with behavioral disturbance. Review of elopement assessment dated [DATE] revealed Resident #75 was at risk for elopement based on medical diagnoses, independent mobility, purposeful exit-seeking, and recent admission. Interventions included placement on a locked (secured) unit in the facility. Review of the care plan dated 04/23/25 revealed Resident #75 had no care plan related to placement on a secured unit for increased risk for elopement. Review of the document titled Statement of Expert Evaluation dated 04/22/25 revealed a University of Cincinnati Physician evaluated Resident #75 and determined him to be mentally impaired with a low level of fundamental knowledge and incapable of managing personal finances, personal property, incapable of caring for activities of daily living, and incapable of making decisions concerning medical treatments, living arrangements, and diet. Resident #75 had a poor prognosis, especially if he became noncompliant and began using drugs or alcohol again. The physician indicated Resident #75 was incompetent and guardianship should be granted. The evaluation had a disclaimer stating the evaluation did not declare the prospective ward to be incompetent but was evidence to be considered by the Court. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of progress notes documented on 04/24/25 at 11:08 A.M., an unidentified therapy staff noticed Resident #75 pulling on doors, exit-seeking, and requesting to leave. Therapy staff notified management (specific person unidentified) and Social Worker (SW) #135. On 04/24/25, SW #135 spoke with Resident #75 ' s responsible party to inquire about guardianship. The responsible party stated he was working on it. On 04/25/25 at 10:54 A.M., Resident #75 was agitated and pacing. He told the staff he wanted to leave immediately and threatened to jump out the window if he was not allowed to sign out immediately. LPN #106 educated Resident #75 of the risks of jumping out the window. Resident #75 stated he did not care, he just wanted to leave. LPN #106 notified the Director of Nursing (DON), Psychiatric Nurse Practitioner (PNP) #45 and SW #135. On 04/25/25 at 11:08 A.M., the DON placed Resident #75 on one-on-one supervision and called PNP #45 after LPN #106 reported Resident #75 threatened to kill himself by jumping out the second-floor window. PNP #45 authorized a pink slip for suicidal ideation. The DON notified Resident #75 ' s responsible party. On 04/25/25 at 2:51 P.M., SW #135 went to the men ' s locked unit and spoke to Resident #75. Resident #75 stated he wanted to leave Against Medical Advice (AMA). He did not like being around others and stated he felt confined/closed in. Resident #75 stated he did not want to be in a room with a person who required professionals to clean him and stated this was a trigger for him. Resident #75 stated he was a lander and chose to be homeless, living outside or in a shelter. Resident #75 verbalized knowledge of community resources. Resident #75 stated when he went to the bank, his ATM (Automated Teller Machine) card got stuck in the ATM machine. The bank was closing and staff told him to come back the next day. He did not want to sleep outside, so he took himself to the hospital. Resident #75 stated he wanted to go to the bank to get money for cigarettes and stated if they let him leave, he would return to the facility. Review of a late entry progress note created on 04/26/25 at 8:45 P.M. for 04/25/25 at 8:55 P.M. revealed Resident #75 returned from the hospital via stretcher and was placed back on one-on-one supervision while he was re-acclimated to the facility. The hospital reported Resident #75 did not have suicidal ideation. Resident #75 was calm and cooperative. He stated all he wanted to do was smoke. Resident #75 slept through the night with no signs of suicidal ideation. Review of the late entry progress note created 04/26/25 at 8:46 P.M. for 04/26/25 at 7:30 A.M. documented provider was notified of discontinuation of one-on-one supervision. Resident #75 was stable with no signs of suicidal ideation. Review of progress notes dated 04/26/25 at 9:48 A.M. revealed at 8:10 A.M. staff reported Resident #75 was outside on the ground after jumping out of a second-floor window on the 200 Unit. Prior to this incident, Resident #75 had asked LPN #42 to call 911 and tell them to get him out of there. Upon investigation, LPN #42 noted the windowpane was on the floor leaning against the wall. At 10:08 A.M., LPN #42 notified Resident #75 ' s responsible party who questioned why there were no additional safety measures placed after Resident #75 had first threatened to jump out the window and voiced concerns for safety moving forward. At 7:41 P.M., LPN #42 called the hospital and learned Resident #75 was admitted for bilateral ankle fractures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During concurrent interviews with the Administrator, ADON #127 and Scheduler #98 on 04/30/25 at 9:54 A.M. , ADON #127 stated after the original admission, the former DON decided to place Resident #75 in the secured unit due to his history of admission from the hospital on a psychiatric hold. ADON #127 was unaware of any assessment required for the secured unit placement. ADON #127 stated on the elopement risk assessment, if a patient was identified at risk, the nurse would add the intervention on the assessment to place in a secured unit. ADON #127 stated when Resident #75 returned from the hospital on [DATE], he was placed back on one-on-one supervision for 12 hours out of an abundance of caution for safety. When Resident #75 had remained calm during those 12 hours and made no further statements of wanting to leave, the one-on-one supervision was removed at change of shift on 04/26/25 after 7:00 A.M. During an interview on 04/30/25 at 11:28 A.M., Regional Director of Operations (RDO) #200 stated Resident #75 came from a psychiatric hospital and had paranoid delusions. His responsible party was going to retain guardianship. He was placed on a secured unit for safety after he was discharged from the psychiatric unit. He was focused on getting out of the facility and going to the bank. While the Ohio Department of Health was present in the building for a survey, the facility could not spare staff to go downtown. Staff had planned to take Resident #75 to the bank next week. Resident #75 had stated, If you don ' t let me go, I ' m going to jump out the window. RDO #200 stated he did not know if staff specifically asked Resident #75 if he wanted to hurt himself, but the facility had him sent out for suicidal ideation. The hospital sent him back. They said he wanted to go to the bank, and he did not have suicidal ideations. Out of caution, staff continued one-on-one supervision for 12 hours after his return. He seemed calm and pleasant, so staff removed the one-on-one supervision after night shift ended. The doctor was notified immediately after the incident. The facility decided on 04/29/25 to begin auditing all resident records to ensure admission paperwork was completed and all residents upstairs had assessments for placement on the secured unit. Resident #75 was a skinny 140-pound man, and staff were not sure how he did it. On 04/26/25, the maintenance department secured all windows with washers and screws so the windows could not be opened. During a telephone interview on 04/30/25 at 2:27 P.M., Resident #75 ' s responsible party stated he was trying to obtain guardianship for his responsible party. He stated he had three or four separate phone calls with female staff on 04/25/25 but did not remember all their names. One said Resident #75 stated he was being held against his will, and he was leaving. If they did not let him leave, he was going to jump out the window. The responsible party stated he was not there to determine Resident #75 ' s state of mind but based on prior history that statement could have easily been interpreted as both ways. Resident #75 was very labile and would swing easily from desperation to suicidal ideation. The responsible party described Resident #75 as having the mind and emotional control of an 8-year-old. He could be very cooperative and sweet one minute and become aggressive and temperamental the next with little warning. He said he recommended staff not let Resident #75 leave the facility unsupervised. The responsible party stated Resident #75 was an alcoholic, and if they had let him go, he would have been drunk by 5:00 P.M. The responsible party stated he almost told them to just let him go based on how upset Resident #75 was, but he thought it would be a shame to waste all the hard work the hospital staff had completed to make him stable. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/30/25 at 3:02 P.M. Activity Aide (AA) #108 stated on 04/25/25 around 10:45 A.M. she noticed Resident #75 pacing near the door between the men and women ' s locked units repeatedly punching his fisted hand into his palm. AA #108 stated she reported it to the activities director that he seemed agitated, and she was afraid he was going to hit somebody. Staff assigned AA #108 to one-on-one supervision with Resident #75 around 11:00 A.M. until about 4:00 P.M., and SW #135 came to the unit and there was a meeting in the activity room with Resident #75, SW #135, Activities Director #75 and MDS nurse #124. They spoke about the resident wanting to leave AMA to go to the bank, about his lifestyle as a lander, and about his knowledge of community resources. Resident #75 stated he had enough money in the bank to get a car or apartment. SW #135 said she could help him with that if he gave her the time. He was calm during the meeting and made no remarks about wanting to hurt himself or anyone else. He said he had to get to the bank downtown and get his ATM card from the machine. The facility bus was not there, or staff could have taken him to the bank that day. Staff took Resident #75 downstairs to ask the DON about signing him out to go to the bank. She told him he could not leave, and they returned to the locked unit. AA #108 stated she was with Resident #75 until he left with EMS personnel, and stated Resident #75 never made any comments to her about self-harm or jumping out the window. During an interview on 04/30/25 at 3:23 P.M., LPN #106 stated she was assigned to the men ' s locked unit on 04/25/25. It was before 11:00 A.M. when Resident #75 approached the nurse ' s station and stated he wanted to leave the facility. He said, I want to get out of this place. I don ' t want to be here. If I don ' t get out of here, I will jump out the window. LPN #106 stated she educated Resident #75 about the potential harm his actions could cause. He stated he did not care, and he would rather be homeless than stay there. LPN #106 stated she did not believe Resident #75 was suicidal at the time; he was just desperate to leave. LPN #106 reported the incident to the DON, and they placed Resident #75 on one-on-one supervision. She called PNP #45 and got a pink slip to send him out to the hospital for suicidal ideations. During an interview on 04/30/25 at 3:41 P.M., LPN #42 stated she met Resident #75 when he admitted to the facility on [DATE] but she was not his admitting nurse. LPN #42 stated Resident #75 repeatedly and obsessively spoke about going to the bank and getting his ATM card. LPN #42 stated Resident #75 needed to speak to the social worker about getting assistance to go to the bank. LPN #42 stated she had no knowledge Resident #75 was on one-on-one supervision on 04/26/25 when she reported to work. It was not communicated to her in nurse-to-nurse report that Resident #75 had been on one-on-one supervision overnight, or that the one-on-one supervision had been removed. LPN #42 stated she had been downstairs for approximately five minutes on 04/26/25 when kitchen staff reported Resident #75 was outside on the ground. He was sitting on the concrete at the top of the steps near the entrance to the kitchen, smiling, and asking for a cigarette. He had attempted to walk but could not and stated his ankles hurt. Staff called 911, and he was sent to the hospital. LPN #42 stated she called the hospital later and was informed that Resident #75 was admitted for bilateral ankle fractures and had no head injuries. LPN #42 stated her investigation revealed Resident #75 had removed the lower windowpane and placed it against the wall before eloping by climbing out the window. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/01/25 at 10:18 A.M., Medical Director (MD) #35 stated the admissions team made the decision of where to place residents on admission based on the resident ' s past medical history, mental health history, behaviors, and mental status at the time of admission. MD #35 stated he was aware of the incident with Resident #75 but had not reviewed his chart. MD #35 stated he was in the building on 04/24/25 but did not see Resident #75 because he was not on his schedule to be seen that day. Review of the facility policy titled Wandering, Unsafe Resident, not dated, revealed staff identified residents who were at risk for harm for unsafe wandering and elopement and developed a detailed monitoring plan to maintain safety as indicated. Review of the facility policy titled Safety and Supervision of Residents, dated July 2017, revealed the care team implemented resident-centered interventions to reduce individual risks related to hazards in the environments, including adequate supervision and assistive devices. Monitoring included evaluating the effectiveness of interventions and modifying or replacing interventions as needed. This deficiency represents non-compliance investigated under Complaint Numbers OH00165190, OH00163006 and OH00165734.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure residents attended mental heath appointments as scheduled. This affected one (Resident #75) of seven residents reviewed for mental health services. The facility census was 69. Findings include: Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] and was never discharged out of the system. Diagnoses included schizoaffective disorder bipolar type, suicidal ideations, other uncomplicated psychoactive substance abuse, antisocial personality disorder, uncomplicated nicotine dependence, uncomplicated alcohol dependence, mild neurocognitive disorder with behavioral disturbance, and mild cognitive condition with behavioral disturbance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident#75 was cognitively intact. Review of hospital records revealed Resident #75 had a telemedicine appointment on 08/24/25 at 10:00 A. M. with UC Psychiatry Bridge Clinic to ensure needs were being met and to assist with any additional required resources. The Licensed Social Worker (LSW) from the hospital would call Resident #75 at the facility. During an interview on 04/30/24 at 9:54 A.M., Assistant Director of Nursing (ADON) #127 stated the clinical team normally reviewed admissions in the next morning meeting; however, the team was unable to have a morning meeting on 04/24/25 because ADON #127 had an assignment on the floor. Staff had communicated the highlights, but Resident #75's admission was not reviewed. ADON #127 stated she was not aware that Resident #75 had a telemedicine appointment on 04/24/25. During an interview on 05/02/25 at 12:05 P.M. the Administrator verified Resident #75 had a mental health telemedicine consult scheduled for 04/24/25 at 10:00 AM that was listed on three separate pages in Resident #75's hospital papers that came with him upon admission. Review of policy titled Admissions/Re-Admissions, dated 10/21/21, revealed admission paperwork was sent to nursing staff and leadership prior to admission, and admission information was communicated to the appropriate department in a timely manner. This deficiency represents noncompliance investigated under Complaint Number OH00165190.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure medications were given as prescribed. This affected three (Residents #38, #45, and #73) of eight residents reviewed for medication administration. The facility census was 69. Findings include: 1. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE]. Diagnoses included unspecified humerus fracture, type II diabetes, unspecified protein calorie malnutrition, essential hypertension, and nontraumatic intracerebral hemorrhage in the brain stem. Resident #38 had physician orders dated 03/26/25 for Carvedilol 25 milligrams (mg) twice daily. 2. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included unspecified combined congestive heart failure, interstitial lung disease with progressive fibrotic phenotype, type II diabetes, psychotic disorder with delusions, and unspecified dementia with behavioral disturbances. Resident #45 had physician orders dated 10/15/24 for Tricor (Fenofibrate) 145 mg once daily at bedtime. 3. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE]. Diagnoses included unspecified diastolic congestive heart failure, unspecified bipolar disorder, unspecified anxiety disorder, unspecified noncompliance with medical treatment and regimen, and cellulitis of right lower limb. Review of the medical record revealed Resident #73 had physician orders dated 04/28/25 for routine medications including Depakote ER 12-hour tablet 250 mg daily, Fenofibrate 145 mg once daily at bedtime, Valsartan 40 mg once daily in the morning, Colace 100 mg once daily, Digoxin 125 micrograms (mcg) daily, Carvedilol 25 mg twice daily, Spironolactone 25 mg once daily in the morning, Eliquis 5 mg twice daily, and Flomax 0.4 mg once daily. Review of Medication Administration Record (MAR) dated April 2025 revealed on 04/28/25 Resident #73 was scheduled to receive the following medications at 9:00 PM: Colace 100 mg, Eliquis 5 mg, Fenofibrate 145 mg, and Carvedilol 25 mg. Resident #73 received Colace 50 mg and refused the rest of the medications. During a telephone interview on 05/01/25 at 4:28 P.M., Licensed Practical Nurse (LPN) #136 stated on 04/28/25 he borrowed medications from three residents (Resident #38, Resident #35, and one unidentified resident on 100-Hall) to give to Resident #75 because Resident #75's medication were unavailable. LPN #136 stated he took Fenofibrate 145 mg from Resident #45, Eliquis 5 mg from an unidentified resident in 100-Hall, and Coreg (Carvedilol) 25 mg from Resident #38. LPN #136 stated it was possible to pull medications from the emergency drug supply, but it was easier to get them from other residents. LPN #136 stated he offered the borrowed medications to Resident #73 but Resident #73 refused them and the medications were wasted. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Administering Medications, dated 04/2019, revealed medications ordered for one resident were not permitted to be administered to another resident. This deficiency represents noncompliance investigated under Complaint Numbers OH00165255 and OH00165734.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, record review, interview and policy review, the facility failed to notify residents of changes to the menu in a timely manner. This all residents who accepted food from the kitchen. The facility identified two (Residents ##10 and #18) residents who did not receive food form the kitchen. The facility census was 69. Findings include: Review of the menu titled Week-At-A-Glance Cincinnati Fall-Winter 24-25 Week 3 printed 04/14/25 revealed the lunch menu for Wednesday, 04/16/25 included three ounces beef pot roast, two ounces brown gravy, four ounces mashed potatoes, four ounces glazed carrots, and four ounces pineapple tidbits. Observation of meal preparation on 04/16/25 at 11:32 A.M. revealed dietary staff prepared resident lunch trays with beef patties on wheat bread, mashed potatoes with brown gravy, and glazed carrots. During an interview on 04/16/25 at 11:35 AM, Dietary Manager #92 stated he substituted hamburgers on the lunch menu because the pot roast did not finish cooking in time. He stated he did not notify residents of the substitution but it was ok because they loved hamburgers. Review of policy titled Food and Nutrition Policy: Menu Change and Notification, no date, revealed residents were notified of menu changes at the earliest convenience either by visible notes posted or verbal communication. This is an incidental deficiency discovered during the course of the complaint investigation.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure information documented in the medical record was accurate. This affected three (Residents #19, #60, and #75) of six residents reviewed for accurate documentation. The facility census was 69. Findings include: 1. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] and was discharged on 04/10/25. Diagnoses included unspecified paraplegia, stage III pressure ulcer to the left heel, chronic pain syndrome. Unspecified protein calorie malnutrition, morbid obesity, unspecified bipolar disorder, and neuromuscular dysfunction of the bladder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of the care plan dated 01/28/25 revealed Resident #19 wanted to discharge to home or community. Interventions included encouraging the resident to discuss feelings/concerns about discharge, evaluating the resident's ability to safely discharge to the community, and providing community referrals to determine/address gaps in the resident's strengths and abilities that could affect a safe discharge. Review of progress noted dated 04/09/25 at 1:29 PM revealed Resident #19 was placed in Emergency Discharge status. Social Worker (SW) #135 attempted to locate emergency placement with four long-term care facilities, but each denied admission. SW #135 attempted to schedule a follow-up appointment for Resident #19 at University of Cincinnati Health but was unsuccessful. SW #135 also reached out to community housing programs for emergency housing but was unsuccessful. Resident #19 was unavailable for participation in the discharge process. Review of Emergency Notice of discharge date d 04/10/25 revealed Resident #19 was discharged from the facility because the safety of other residents was endangered. Specific allegations in support of the reason included residents had alleged Resident #19 had threatened them with a gun. The resident had been offered services to assist with placement and discharge was made to another nursing home. The discharge notice listed the Resident's right to appeal the discharge and the right to remain in the facility until the appeal was heard by a Hearing Official. Contact information was listed for the Ohio Office of Legal Services and State LTC Ombudsman. The document was signed by the Administrator and Licensed Practical Nurse (LPN) #88 as a witness. During interviews on 04/17/25 from 8:30 AM to 9:09 AM, SW #135 and Human Resources (HR) Staff #176 each stated they stopped their vehicles in the street on 04/10/25 so Resident #19 could safely cross the street and watched him propel himself down the street in his wheelchair after being discharged . During an interview on 04/22/25 at 10:31 AM the Administrator confirmed the discharge location on Notice of Discharge was not correct, and that Resident #19 was not discharged to another facility on 04/10/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366150	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Cincinnati	3627 Harvey Avenue Cincinnati, OH 45229

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident # was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, schizoaffective disorder bipolar type, major depressive disorder, unspecified anxiety disorder, unspecified protein-calorie malnutrition, unspecified psychosis, and repeated falls. Review of the most recent MDS assessment dated [DATE] revealed the resident had moderately impaired cognition, had verbal behaviors, did not reject care, and did not wander. Resident #60, required supervision/setup assistance for activities of daily living. Review of the care plan dated 04/17/25 revealed Resident #60 had an unwitnessed fall with shoulder fracture injury related to unsteady gait due to her spilling water on the floor. Resident #60 had noted bruising. Interventions included providing a capped water pitcher, assessing neuro-checks for unwitnessed falls, notifying provider and family of falls, assessing for injuries. Review of left shoulder X-ray results dated 04/15/25 at 11:40 AM revealed Resident #60 had a fracture dislocation with abnormal position of the humeral head relative to the glenoid, indeterminate anterior versus posterior. Additionally, fracture fragments were seen to the glenoid. Review of progress note dated 04/15/25 at 7:210 PM revealed LPN #88 documented X-ray results were reviewed and there were no new orders. During a telephone interview on 04/24/25 at 11:31 A.M. LPN #88 stated she was working on 04/15/25 when Resident #60's lab results came back. LPN #88 stated she did not notify the physician. LPN #88 stated she gave the results to the Director of Nursing to call the doctor as per protocol at the time. The DON stated the medical director had reviewed the results and there were no new orders. During a telephone interview on 04/24/25 at 12:04 P.M. Medical Director #35 stated he did not receive a call from the DON on 04/15/25 and was not aware of Resident #60's x-ray results until he visited the facility on 04/17/25. Medical Director #35 stated if he had known about the fracture dislocation, he would have sent Resident #60 to the hospital for evaluation and treatment on 04/15/25. 3. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] and was never discharged out of the system. Diagnoses included schizoaffective disorder bipolar type, suicidal ideations, other uncomplicated psychoactive substance abuse, antisocial personality disorder, uncomplicated nicotine dependence, uncomplicated alcohol dependence, mild neurocognitive disorder with behavioral disturbance, and mild cognitive condition with behavioral disturbance. Review of late entry progress noted created 04/26/25 at 8:46 PM for 04/26/25 at 7:30 AM revealed LPN #153 documented the provider was notified of discontinuation of one to one supervision. Resident #75 was stable with no signs of suicidal ideation. During a telephone interview on 04/30/25 at 4:55 PM LPN #153 verified she falsely documented she had notified the provider that one to one supervision was removed. LPN #153 stated she did not notify any provider on 04/26/25 regarding one to one supervision. Review of policy titled Charting and Documentation, not dated, revealed documentation in the medical record was objective, complete, and accurate. (continued on next page)

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	366150	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This represents noncompliance investigated under Complaint Numbers OH00165501, OH00164671, and OH00164321.