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	07/18/2025

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.

(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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, review of maintenance orders, resident interview, staff interview, and review of the facility policy, the facility failed to ensure a safe and homelike environment for the residents. This affected Residents #20 and #21, the following 18 residents residing on the 100- unit (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18), and the following 14 residents residing on the 400-unit (#58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71) and had the potential to affect all of the residents residing in the facility . The facility census was 71 residents. Findings include: 1. Observations on 07/07/25 between 9:20 A.M. revealed the handrail next to elevator on the 100-nursing unit was not safely secured to the wall rendering it non-functional. The handrail was missing an end cap and was secured to the wall on one end by one screw and the other end was dangling. There was an end cap and a corner cap missing from the handrail near the 100-nursing unit utility closet. Observation on 07/08/25 at 8:30 A.M. revealed the handrail next to elevator on the 100-nursing unit was not safely secured to the wall rendering it non-functional. The handrail was missing an end cap and was secured to the wall on one end by one screw and the other end was dangling. There was an end cap and a corner cap missing from the handrail near the 100-nursing unit utility closet. Observation on 07/09/25 at 1:10 P.M. accompanied by Maintenance Director (MD) #200 revealed the handrail next to elevator on the 100-nursing unit was not safely secured to the wall rendering it non-functional. The handrail was missing an end cap and was secured to the wall on one end by one screw and the other end was dangling. There was an end cap and a corner cap missing from the handrail near the 100-nursing unit utility closet. Interview on 07/09/25 at 1:16 P.M. with MD#200 confirmed the handrail next to elevator on the 100-nursing unit was not safely secured to the wall rendering it non-functional. The handrail was missing an end cap and was secured to the wall on one end by one screw and the other end was dangling. There was an end cap and a corner cap missing from the handrail near the 100-nursing unit utility closet. 2. Observation on 07/07/25 at 11:00 A.M. of Resident #20 and #21's bathroom revealed the light fixture was partially attached at the ceiling and was dropping down on one side about four inches. At the ceiling level, above the fixture, there was dried material covering the light fixture opening of what appeared to be dried grass, indicative of a animal's nest. Interview on 07/09/25 at 12:15 P.M. with the Administrator confirmed the dried material in the ceiling above the light fixture in Resident #20 and #21's room bathroom. Interview on 07/09/25 at 12:22 P.M. with Activity Director (AD) #115 confirmed she had seen what looked like a nest in Resident #20 and #21's bathroom. Interview on 07/09/25 at 12:23 P.M. with Activity Assistants (AAs) #116 and #117 confirmed the presence of grasses in the light fixture of Resident #20 and #21's bathroom. Interview on 07/10/25 at 9:20 A.M. with MD #200 confirmed the material removed from bathroom of Resident #20 and #21's bathroom appeared to be that of an animal nest of some kind. 3.Review of the medical record for Resident #24 revealed an admission date of 04/08/25 with diagnoses including paranoid schizophrenia, hypertension and history of myocardial infarction. Review of the Minimum Data Set (MDS) assessment for Resident #24 dated 04/21/25 revealed the resident had intact cognition, was occasionally incontinent of bowel and always continent of bladder, and required supervision with bathing and was independent with oral and personal hygiene, toileting, dressing, bed mobility and transfers. Interview on 07/07/25 at 10:30 A.M. with Resident #24 confirmed at night she frequently heard what she presumed to be animals making noise in her ceiling and it kept her awake and made her fearful the animals would come into her room through the ceiling. Resident #24 confirmed she heard banging, clawing, and running sounds starting at about 10:00 P.M., lasting for about one hour. Resident #24 confirmed she has heard these noises nearly every night since her admission on [DATE], and she has told the nursing staff, but no maintenance staff had assessed her concerns. Interview on 07/09/25 at 12:22 P.M. with AD #115 confirmed she had observed or heard noises indicative of animal noises during the past two years in the ceiling of her office and in the hallway of the 400 unit. In the fall of 2024, she heard and observed a squirrel in the ceiling when a ceiling tile had been temporarily removed. On 05/20/25 she reported to the former Administrator and MD #200 that she had observation an animal tail, claws and an eye looking down from the ceiling light fixture in her office. MD #200 stated he would contact the facility's pest control vendor. AD #115 stated the pest control never came to her office to assess the sighting. AD #115 stated she signed a statement and reported the animal sighting again on 06/16/25 to MD #20. MD #20 took down one tile and looked up in the ceiling, but did not observe an animal. AD #115 confirmed on 06/26/25 she heard apparent

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of staff witness statements, review of hospital records, staff interview, resident interview, and review of the facility policy, the facility failed to ensure residents were free from resident-to-resident abuse. This resulted in Actual Harm on 07/01/25 to Resident #38 when Resident #43, a resident with a known history of aggressive behaviors towards other residents, struck Resident #38 in the face causing a nasal fracture. This affected one (Resident #38) of three residents reviewed for abuse. The facility census was 71 residents.Findings include: 1. 1.Review of the medical record for Resident #38 revealed an admission date of 05/13/25 with diagnoses including dementia without behavioral disturbance, hepatitis C, and atrioventricular heart block. Review of the Minimum Data Set (MDS) assessment for Resident #38, dated 05/22/25, revealed the resident had intact cognition and ambulated with a cane. Review of the census profile for Resident #38 revealed the resident was moved into a room with Resident #43 on 06/25/25 because Resident #38 was not getting along with his roommate. Review of the progress note for Resident #38, dated 07/01/25 at 6:06 P.M., revealed Resident #38 had been punched in the face by Resident #43. Upon entering the room, Resident #38 was sitting on his bed with blood and blood clots gushing out of his right nostril. The nose appeared to be injured. Emergency medical services (EMS) were called, and Resident #38 was sent to the hospital for evaluation. Review of the witness statement from Certified Nursing Assistant (CNA) #530 revealed the aide was coming back from a break and was passing Resident #38 and Resident #43's room when the aide noticed blood on the sheets. CNA #530 entered the room and Resident #38 told the aide that Resident #43 had hit him. CNA #530 then notified the nurse. Review of the Self-Reported Incident (SRI) regarding Resident #38 dated 07/01/25 revealed on 07/01/25 at 6:00 P.M., Resident #43 struck Resident #38 in the nose resulting in a bloody nose and a nasal fracture for Resident #38. The facility substantiated abuse had occurred by Resident #43 towards Resident #38. Review of the hospital note for Resident #38, dated 07/01/25 at 6:35 P.M., revealed the resident presented at the hospital due to blunt force trauma to the head and was diagnosed with a closed fracture of nasal bone, which was confirmed by a computerized tomography (CT) scans of the maxillofacial area and the head. Review of the hospital discharge instructions for Resident #38, dated 07/01/25 at 7:42 P.M., revealed the resident had a nasal bone fracture and should follow up with an ear, nose, and throat (ENT) physician for further examination and recommendation. Review of the progress note for Resident #38, dated 07/02/25 at 3:03 A.M., revealed the resident returned from the hospital with a fractured nasal bone. A report from the hospital nurse revealed the resident received tranexamic acid (a medication to help control bleeding) due to the resident's bloody nose. Resident #38 was to follow up with an ENT physician as soon as possible. Resident #38 was moved to a new room and was monitored frequently by staff. Review of the progress note for Resident #38, dated 07/03/25 at 2:43 P.M., revealed the resident returned to the facility after his ENT physician follow up visit with new orders for Amoxicillin 500 milligrams (mg), give one tablet by mouth two times a day for ten days for nasal swelling. The ENT physician's note indicated surgical repair of the nasal fracture was not indicated and staff should monitor the swelling to the resident's nose. 2. Review of the medical record for Resident #43 revealed an admission date of 04/23/25 with diagnoses including schizoaffective disorder (bipolar type), anxiety disorder, unspecified dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), and hypertension. Review of the MDS assessment for Resident #43 dated 05/06/25 revealed the resident had severe cognitive impairment and was independently mobile. Review of Resident #38's medical record revealed preadmission progress notes from the nursing home where Resident #43 had previously resided. The progress note dated 03/01/25 at 9:02 A.M., revealed the resident was involved in a physical altercation with another resident after Resident #43 had wandered into the other resident's room. Review of a preadmission progress note dated 03/18/25 at 6:20 P.M., revealed Resident #43 told the nurse he had gotten into a fight with his roommate. Resident #43's roommate had mistakenly laid down in the wrong bed and Resident #43 struck the roommate in the face with a closed fist. The other resident sustained a bruise and an abrasion to his forehead. Review of a preadmission progress note, dated 03/25/25 at 10:27 A.M., revealed Resident #43 was propelling himself in his wheelchair through the common area when he stopped behind another resident who was eating breakfast and punched the other resident twice in the back. Review of a preadmission progress note, dated 03/27/25 at 11:37 A.M., revealed social services spoke with Resident #43's guardian regarding finding alternate placement of the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to implement Enhanced Barrier Precautions (EBP) while providing incontinence and wound care and failed to change gloves and perform appropriate hand hygiene during incontinence care. This affected one (Resident #10) of three residents reviewed for infection control. The facility census was 71 residents. Findings include: Review of the medical record for Resident #10 revealed an admission date of 04/22/25 with diagnoses including dementia, hypertension and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 05/05/25 revealed the resident had intact cognition, was frequently incontinent of bowel and occasionally incontinent of bladder, was independent for eating and bed mobility, required set up assistance with oral hygiene, required supervision with toileting, and required moderate assistance with personal hygiene, dressing, bathing, and transfers. Review of the physician's orders for Resident #10 revealed an order dated 06/16/25 for the resident to be placed in Enhanced Barrier Precautions (EBP). Review of the physician's orders for Resident #10 revealed an order dated 07/02/25 to cleanse the right heel with normal saline, apply Hydrogel, and cover with dry dressing daily. Observation on 07/10/25 at 10:40 A.M. revealed there was a sign on the door of Resident #10's room indicating the resident was on EBP. The sign indicated that everyone must clean their hands, including before entering and when leaving the room, and providers and staff must also wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, central line care, urinary catheter care, feeding tube care, tracheostomy care, wound care, and care of any skin opening requiring a dressing. Personal Protective Equipment (PPE) was available in a cart in the corridor adjacent to Resident #10's room door. Observation of incontinence care for Resident #10 on 07/10/25 at 10:40 A.M. per Certified Nursing Assistant (CNA) #506 with assistance from Registered Nurse (RN) #314 revealed the staff did not don gowns prior to providing care. CNA #506 cleansed feces from Resident #10's buttocks with gloved hands. CNA #509 did not remove her gloves, perform hand hygiene, and don new gloves after cleansing the resident's buttocks. CNA #506 then touched the resident's clean brief, the resident's pajama bottoms, the resident's sheets, and the outside of the resident's wash basin. Observation of wound care for Resident #10 on 07/10/25 at 10:58 A.M. per Registered Nurse #314 with CNA #506 assisting revealed the staff did not don gowns prior to providing care. Interview on 07/10/25 at 11:13 P.M. with RN #314 and CNA #506 confirmed they should have donned gowns during incontinence care and wound care for Resident #10 and CNA #506 should have doffed gloves, performed hand hygiene, and donned clean gloves after cleansing feces from Resident #10's buttocks. Interview on 07/10/25 at 12:38 P.M. with the Director of Nursing (DON) confirmed Resident #10 had orders for EBP, and RN #314 and CNA #506 should have donned gowns prior to providing incontinence care and wound care. The DON confirmed CNA #506 should have doffed gloves, performed hand hygiene, and donned clean gloves after cleansing feces from Resident #10's buttocks. Review of the facility policy titled Infection Control dated 02/04/21 revealed it was the facility's policy to ensure appropriate infection control prevention and control measures were taken to prevent the spread of communicable diseases, and to change gloves after handling infected material (fecal material, urine, wound drainage, vomit, sputum).