

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility failed to prevent misappropriation of residents' personal property. This affected two (Residents #12 and #13) of three residents reviewed for residents' rights. The facility census was 75 residents. Findings include: Review of the medical record for Resident #12 revealed an admission date of 07/11/25 with diagnoses including anxiety disorder, infective endocarditis, human immunodeficiency virus (HIV), hepatitis C, and depression. Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 07/18/25 revealed the resident was cognitively intact and was independent with activities of daily living (ADLs). Review of the medical record for Resident #13 revealed an admission date of 3/04/25 with diagnoses including spondylosis, depression, and diabetes mellitus. Review of the MDS assessment for Resident #13 dated 06/06/25 revealed the resident had mild cognitive deficits and required extensive staff assistance with ADLs. Interview on 08/11/25 at 2:49 P.M. with the Administrator confirmed a few weeks ago he saw Residents #12 and #13 smoking in front of the facility, which was not a designated smoking area. The Administrator confirmed he told the residents they were not allowed to smoke there, and he took the residents' cigarettes and threw them in the garbage. Interview on 08/12/25 at 8:30 A.M. with Resident #12 confirmed a few weeks ago he was smoking in front of the facility in a non-designated area because it was raining and he was trying to stay dry. Resident #12 confirmed the Administrator told him he was not supposed to smoke in front of the facility and the Administrator then took the resident's cigarettes (five cigarettes in total) and threw them in the garbage. Interview on 08/12/25 at 3:05 A.M. with Resident #13 confirmed a few weeks ago he was smoking in front of the facility, and the Administrator told him he was not allowed to smoke there. Resident #13 confirmed the Administrator took his cigarette from him and threw it away. Interview on 08/12/25 at 3:30 P.M. with the Administrator confirmed a few weeks ago he took one cigarette from Resident #12 and one cigarette from Resident #13 and threw the residents' cigarettes away because they were smoking in a nondesignated area. The Administrator confirmed he had not replaced Resident #12 and #13's cigarettes. Review of the facility policy titled Abuse and Neglect Protocol dated 06/13/21 revealed misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without resident's consent. This deficiency represents noncompliance investigated under Complaint Number 2568951.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 366150	If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on medical record review, review of personnel records, review of staff statements, resident interview, staff interview, review of facility Self-Reported Incidents, and review of the facility policy, the facility failed to report allegations of verbal abuse to the state agency. This affected one (Resident #10) of three residents reviewed for abuse. The facility census was 75 residents. Findings include: Review of the medical record for Resident #10 revealed an admission date of 12/20/24 with diagnoses including Alzheimer's disease, schizophrenia, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 05/06/25 revealed the resident had no cognitive deficits and required supervision with activities of daily living (ADLs). Review of the personnel file for Business Office Manager (BOM) #58 revealed it contained a disciplinary action form dated 07/24/25 which indicated on 07/22/25 BOM #58 had used vulgar language with another employee. BOM #58 was coached and promised not to do it again. Review of an undated written statement per the Administrator revealed on 07/22/25 BOM #58 was accused of yelling at Receptionist #54. The Administrator sent Receptionist #54 home with pay because she was upset after the interaction with BOM #58. The Administrator told BOM #58 he could not talk disrespectfully to other employees, and further outbursts could result in termination. BOM #58 assured the Administrator there would not be any more issues. Approximately two or three hours following the verbal altercation between BOM #58 and Receptionist #54, Certified Nursing Assistant (CNA) #52 went to the Administrator's office and reported BOM #58 had just yelled at her. The Administrator suspended BOM #58 and had him leave the facility. A few hours late on 07/22/25 the Administrator was in his office when he heard BOM #58 raise his voice towards CNA #52 but could not make out what BOM #58 had said. The Administrator decided to terminate BOM #58's employment but was unable to reach the employee by phone or email so he completed termination paperwork and gave it to human resources. Interview on 08/12/25 at 11:35 A.M. with Resident #10 confirmed she remembered being upset about a month ago when a man on the staff yelled at her in the hallway using profanity and told her she could not get her money. Interview on 08/12/25 at 1:09 P.M. with CNA #52 confirmed on 07/22/25 she took Resident #10 downstairs to the 100-unit hallway in between the nurses' station and the Administrator's office so the resident could withdraw some cash from the resident trust account to buy soda pop and chips. CNA #52 stated BOM #58 said he only had \$20.00 available for withdrawal, and would he divide that amount between the residents waiting for their money, so that each resident would each get \$5.00. CNA #52 stated when it was Resident #10's time to get her money BOM #58 yelled at them saying, I ain't got anymore (expletive) money. Resident #10 became visibly upset and started crying. CNA #52 took Resident #10 back to the unit and she and Licensed Practical Nurse (LPN) #53 tried to calm Resident #10 who was upset about not getting her money and also at being yelled at by BOM #58. CNA #52 stated she reported Resident #10's concern to the Administrator but felt he was dismissive regarding the incident. Interview on 08/12/25 at 1:36 P.M. with LPN #53 reported when CNA #52 and Resident #10 returned to the unit on 07/22/25 after going downstairs so the resident could withdraw her money, both the aide and the resident were in tears. LPN #53 confirmed BOM #58 had yelled at them and used profanity. LPN #53 stated she then went downstairs to report concerns of verbal abuse per BOM #58 towards Resident #10 to the Administrator, he told her to stop gossiping and spreading rumors. Interview on 08/12/25 at 1:42 P.M. with Receptionist #54 confirmed on 07/22/25 in the morning BOM #58 had yelled and cursed at her which made her so upset that the Administrator had sent her home for the rest of the day with pay. Interview on 08/12/25 at 2:20 P.M. with LPN #55 confirmed she was working on the 100 unit on 07/22/25 and from the nurses' station she heard BOM #58 yell at CNA #52 and Resident #10, I ain't got anymore (expletive) money. LPN #55 reported Resident #10 and CNA #52 were visibly upset regarding the way BOM #58 had spoken to them. Interview on 08/12/25 at 2:28 P.M. with the Administrator confirmed CNA #52 reported on 07/22/25 that BOM #58 had yelled loudly within earshot of Resident #10, I ain't got anymore (expletive) money, but he did not feel that it rose to the level of verbal abuse, so he did not report it to the state agency. Review of the facility SRIs dated 07/22/25 to 08/12/25 revealed there were no reports filed regarding verbal abuse/mistreatment per BOM #58 towards Resident #10. Review of the facility policy titled Abuse and Neglect Protocol dated 06/13/21 revealed verbal abuse was defined as any use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. If an incident of suspected abuse occurred, the facility should report it immediately to designated state agency. The facility should then</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Place of Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on medical record review, review of personnel records, review of staff statements, resident interview, staff interview, review of facility Self-Reported Incidents, and review of the facility policy, the facility failed to thoroughly investigate allegations of abuse/mistreatment of residents. This affected one (Resident #10) of three residents reviewed for abuse. The facility census was 75 residents. Findings include: Review of the medical record for Resident #10 revealed an admission date of 12/20/24 with diagnoses including Alzheimer's disease, schizophrenia, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 05/06/25 revealed the resident had no cognitive deficits and required supervision with activities of daily living (ADLs). Review of the personnel file for Business Office Manager (BOM) #58 revealed it contained a disciplinary action form dated 07/24/25 which indicated on 07/22/25 BOM #58 had used vulgar language with another employee. BOM #58 was coached and promised not to do it again. Review of an undated written statement per the Administrator revealed on 07/22/25 BOM #58 was accused of yelling at Receptionist #54. The Administrator sent Receptionist #54 home with pay because she was upset after the interaction with BOM #58. The Administrator told BOM #58 he could not talk disrespectfully to other employees, and further outbursts could result in termination. BOM #58 assured the Administrator there would not be any more issues. Approximately two or three hours following the verbal altercation between BOM #58 and Receptionist #54, Certified Nursing Assistant (CNA) #52 went to the Administrator's office and reported BOM #58 had just yelled at her. The Administrator suspended BOM #58 and had him leave the facility. A few hours later on 07/22/25 the Administrator was in his office when he heard BOM #58 raise his voice towards CNA #52 but could not make out what BOM #58 had said. The Administrator decided to terminate BOM #58's employment but was unable to reach the employee by phone or email so he completed termination paperwork and gave it to human resources. Interview on 08/12/25 at 11:35 A.M. with Resident #10 confirmed she remembered being upset about a month ago when a man on the staff yelled at her in the hallway using profanity and told her she could not get her money. Interview on 08/12/25 at 1:09 P.M. with CNA #52 confirmed on 07/22/25 she took Resident #10 downstairs to the 100-unit hallway in between the nurses' station and the Administrator's office so the resident could withdraw some cash from the resident trust account to buy soda pop and chips. CNA #52 stated BOM #58 said he only had \$20.00 available for withdrawal, and would he divide that amount between the residents waiting for their money, so that each resident would each get \$5.00. CNA #52 stated when it was Resident #10's time to get her money BOM #58 yelled at them saying, I ain't got anymore (expletive) money. Resident #10 became visibly upset and started crying. CNA #52 took Resident #10 back to the unit and she and Licensed Practical Nurse (LPN) #53 tried to calm Resident #10 who was upset about not getting her money and also at being yelled at by BOM #58. CNA #52 stated she reported Resident #10's concern to the Administrator but felt he was dismissive regarding the incident. Interview on 08/12/25 at 1:36 P.M. with LPN #53 reported when CNA #52 and Resident #10 returned to the unit on 07/22/25 after going downstairs so the resident could withdraw her money, both the aide and the resident were in tears. LPN #53 confirmed BOM #58 had yelled at them and used profanity. LPN #53 stated she then went downstairs to report concerns of verbal abuse per BOM #58 towards Resident #10 to the Administrator, he told her to stop gossiping and spreading rumors. Interview on 08/12/25 at 1:42 P.M. with Receptionist #54 confirmed on 07/22/25 in the morning BOM #58 had yelled and cursed at her which made her so upset that the Administrator had sent her home for the rest of the day with pay. Interview on 08/12/25 at 2:20 P.M. with LPN #55 confirmed she was working on the 100 unit on 07/22/25 and from the nurses' station she heard BOM #58 yell at CNA #52 and Resident #10, I ain't got anymore (expletive) money. LPN #55 reported Resident #10 and CNA #52 were visibly upset regarding the way BOM #58 had spoken to them. Interview on 08/12/25 at 2:28 P.M. with the Administrator confirmed CNA #52 reported on 07/22/25 that BOM #58 had yelled loudly within earshot of Resident #10, I ain't got anymore (expletive) money, but he did not feel that it rose to the level of verbal abuse, so he did not conduct an abuse investigation. Review of the facility SRIs dated 07/22/25 to 08/12/25 revealed there were no reports filed regarding verbal abuse/mistreatment per BOM #58 towards Resident #10. Review of the facility policy titled Abuse and Neglect Protocol dated 06/13/21 revealed verbal abuse was defined as any use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. If an incident of suspected abuse occurred, the facility should report it immediately to designated state agency. The facility</p>		