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	12/09/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, review of Self-Reported Incidents (SRI), review of staff time punches, and policy review, the facility failed to follow abuse policy relating to alleged abuse by staff. This affected one (Resident #15) of three reviewed for abuse. The facility census was 78.Findings include:Review of the medical record for Resident #15 revealed an admission date of 10/09/23. Diagnoses included diffuse traumatic brain injury, vascular dementia, mood disorder, and major depressive disorder.Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident#15 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11. This resident was independent with activities of daily living (ADL). Interview with Resident #15 on 12/08/25 at 10:06 A.M. revealed he was verbally abused on 12/05/25 by two staff members (Certified Nursing Assistant [CNA] #13 and CNA #15), who were working on the current shift. When the surveyor asked if he had reported the abuse, and Resident #15 reported no.Interview with the Administrator on 12/08/25 at 10:35 A.M., and reported the alleged abuse reported by Resident #15. The Administrator reported not being aware of the abuse allegations and would start an investigation and create a self-reported incident.Interview with the Administrator on 12/08/25 at 2:15 P.M. verified CNA #13 and CNA #15 were still on duty and caring for residents. The Administrator verified that any staff involved in allegations of abuse should be removed from the facility immediately pending an investigation.Review of the time sheet dated 12/08/25 for CNA #15, revealed time punch in was 7:31 A.M. and time punch out was 2:33 P.M.Review of the time sheet dated 12/08/25 for CNA #13, revealed time punch in was 7:13 A.M. and time punch out was 2:33 P.M.Review of the facility policy titled, Policy and Guidelines for Implementation for Abuse, dated 12/10/23 revealed immediately upon receiving report an alleged abuse, the Administrator, and or designee will coordinate delivery of appropriate medical and/or psychological care and attention. The alleged perpetrator will immediately be removed and resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation.

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 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 review of the medical record, review of Self-Reported Incidents (SRI), review of emergency room (ER) records, staff interviews, and review of facility policy, the facility failed to report an allegation of abuse to the state agency. This affected one (Resident #79) of three residents reviewed for abuse. The facility census was 78.Findings include:Review of the medical record for Resident #79 revealed an admission date of 06/12/25 with a discharge date of 10/06/25. Diagnoses included dementia, type II diabetes mellitus (DM II), and bipolar disorder.Review of the ER records dated 08/28/25 at 7:01 P.M., revealed Resident #79 was admitted to the ER related to a reported sexual assault. The ER notes indicated Emergency Medical Services (EMS) were called to the facility for a hyperglycemic related incident. When EMS arrived, they found the resident shaking and sweating and stated his roommate fondled him the bathroom. The resident denied any active pain to his genitals, chest, abdomen, or limbs. The hospital Social Worker spoke with the Director of the facility, who indicated the resident was more distraught than normal during the morning. The Director stated the had received similar allegations regarding the roommate who allegedly groped the resident and a police report had been filed. The resident was diagnosed/treated for urinary tract infection and returned to the facility with antibiotics. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #79 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. This resident required supervision for activities of daily living (ADL). Review of the reported SRIs on 12/09/25 at 12:15 P.M., revealed the facility did not create an SRI for Resident #79's alleged sexual abuse reported to the hospital staff on 08/28/25. Interview on 12/09/25 at 12:25 P.M., the Administrator stated he sent an email to Ohio Department of Health (ODH) reporting the issue but never heard back from anyone and never followed-up. The Administrator verified there was no SRI created. Review of the facility policy titled, Policy and Guidelines for Implementation of Abuse, dated 12/10/23 revealed abuse and neglect exit in many forms and to varying degrees. Abuse can include verbal, mental, sexual, physical abuse, corporal punishment, or involuntary seclusion. The facility will ensure that alleged violators involving abuse, neglect, exploitation, or mistreatment, including injuries or unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation was made to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of Self-Reported Incidents (SRI), review of emergency room (ER) records, staff interviews, and review of facility policy, the facility failed to complete a thorough investigation for an alleged sexual abuse allegation. This affected one (Resident #79) of three residents reviewed for abuse. The facility census was 78Findings include: Review of the medical record for Resident #79 revealed an admission date of 06/12/25 with a discharge date of 10/06/25. Diagnoses included dementia, type II diabetes mellitus (DM II), and bipolar disorder.Review of the ER records dated 08/28/25 at 7:01 P.M., revealed Resident #79 was admitted to the ER related to a reported sexual assault. The ER notes indicated Emergency Medical Services (EMS) were called to the facility for a hyperglycemic related incident. When EMS arrived, they found the resident shaking and sweating and stated his roommate fondled him the bathroom. The resident denied any active pain to his genitals, chest, abdomen, or limbs. The hospital Social Worker spoke with the Director of the facility, who indicated the resident was more distraught than normal during the morning. The Director stated the had received similar allegations regarding the roommate who allegedly groped the resident and a police report had been filed. The resident was diagnosed/treated for urinary tract infection and returned to the facility with antibiotics. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #79 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. This resident required supervision for activities of daily living (ADL). Review of the reported SRIs on 12/09/25 at 12:15 P.M., revealed the facility did not create an SRI for Resident #79's alleged sexual abuse reported to the hospital staff on 08/28/25. Interview on 12/09/25 at 1:35 P.M., the Administrator stated he could not find an investigation when Resident #79 alleged a sexual abuse incident. The Administrator verified the facility did not complete an investigation when Resident #79 alleged his roommate fondled/groped him on 08/28/25.Review of the facility policy titled, Policy and Guidelines for Implementation of Abuse, dated 12/10/23 revealed abuse and neglect exit in many forms and to varying degrees. Abuse can include verbal, mental, sexual, physical abuse, corporal punishment, or involuntary seclusion. The investigation was the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis would be completed. The information gathered was given to administration. All staff must cooperate during the investigation to ensure the residents were fully protected.This violation represents non-compliance investigated under Complaint Number 2639011.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observations, staff interviews, and policy review, the facility failed to ensure infection control measures were followed during incontinence care. This affected one (Resident #46) of three reviewed for incontinence care. The facility census was 78.Findings include:Review of the medical record for Resident #46 revealed an admission date of 04/29/24. Diagnoses included type II diabetes mellitus (DM II), anxiety disorder, bipolar disorder, and functional urinary incontinence.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #46 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require setup with eating, substantial assistance with toileting, bathing, and dressing, and partial assistance with transfers. Review of Section H (bowel and bladder), revealed Resident #46 was frequently incontinent of bowel and bladder.Observation on 12/08/25 at 1:38 P.M., revealed incontinence care was completed to Resident #46 by Certified Nursing Assistant (CNA) #11 and CNA #12. After providing peri care to Resident #46, CNA #11 did not change her gloves and complete any hand hygiene after cleaning up a soiled depends and then applying a new depends on the residentInterview on 12/08/25 at 1:50 P.M. with CNA #11, verified she did not change her gloves and complete hand hygiene after they were soiled with urine before placing a new depends on Resident #46.Review of the facility policy titled, Infection Control - Hand Hygiene, dated 02/04/21 revealed the facility's policy was to perform hand hygiene by national standards from Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO). Soap and water were required for hand hygiene when hands were visibly soiled or contaminated with blood or other body fluids.