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	02/19/2026

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on review of the survey results notebook in the main receptionist area, review of the Certification and Licensure System (CALS), review of facility policy, and staff interview, the facility failed to ensure the most recent survey of the facility conducted by Federal or State surveyors and any plan of corrections was maintained in a readily accessible. This affected all 84 residents in the facility. Review of the survey results notebook in the main receptionist area revealed the last facility survey results were dated 08/16/23. Review of the CALS survey history for the facility revealed the facility had surveys on 08/31/23, 09/21/23, 10/24/23, 11/08/23, 12/26/23, 01/23/24, 02/22/24, 03/13/24, 04/09/24, 04/18/24, 06/12/24, 08/12/24, 09/19/24, 10/02/24, 10/22/24, 12/24/24, 05/19/25, 07/10/25, 07/18/25, 08/12/25, 10/22/25, 12/09/25, and 01/22/26. None of these survey results were in the Survey Results notebook located in the main receptionist area. During an interview on 02/18/26 at 1:28 P.M. the Administrator verified the facility survey results notebook had not been updated since 08/16/23. Review of the policy titled, Resident Rights, not dated, revealed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to examine survey results.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review and policy review, the facility failed to ensure meals delivered to the residents matched the residents ' meal tickets and the daily menu. This affected all residents in the facility as the facility identified all 84 residents received food from the kitchen. The facility census was 84.1) Review of medical record of Resident #37 revealed an admission date of 12/10/25. Diagnoses included chronic obstructive pulmonary disease (COPD), unspecified, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, left bundle-branch block, unspecified, unspecified mood disorder, acute kidney failure, unspecified, other toxic encephalopathy, and cocaine abuse. Review of admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #37's cognitive status was not assessed. The resident was independent for eating, oral hygiene, and ambulation, supervision assistance for toileting, bathing, dressing, personal hygiene, and transfers. Observation on 02/18/26 at 9:10 A.M. revealed Resident #37 had a breakfast tray delivered to her room which contained milk, grape juice, hot oatmeal, breakfast ham, and scrambled eggs. The breakfast ticket on Resident #37's tray indicated the tray should include cold or hot cereal, juice of choice, waffles, breakfast ham, milk, and coffee or hot tea. During an interview on 02/18/26 at 9:10 A.M. with Resident #37, she reported that tray tickets and menus often do not match the meal that is served. Resident #37 stated that the tray ticket and menu did not match the meal she was provided on 02/18/26. During an interview on 02/18/26 at 9:24 A.M., Certified Nursing Assistant (CNA) #526 confirmed Resident #37's meal tray included milk, grape juice, hot oatmeal, breakfast ham, and scrambled eggs. CNA#526 confirmed the tray ticket indicated the tray should include cold or hot cereal, juice of choice, waffles, breakfast ham, milk, and coffee or hot tea, which did not match the meal served. During an interview on 02/18/26 10:18 A.M., Dietary Manager (DM) #605 confirmed the document titled Maple Grove, Regular diet Week at a glance, included the following menu items for breakfast on 02/18/26 cold cereal or hot cereal, juice of choice, waffles, breakfast ham slice, milk of choice, coffee or hot tea. DM #605 stated the cook on staff for breakfast on 02/18/26 forgot to make and serve the waffles listed on the document Maple Grove, Regular diet Week at a glance on 02/18/26. Review of a document titled Maple Grove, Regular diet Week at a glance, which included breakfast meal items listed for date 02/18/26 listed the following items to be served for breakfast on 02/18/26 cold cereal or hot cereal, juice of choice, waffles, breakfast ham slice, milk of choice, coffee or hot tea. 2) Review of the lunch menu for 02/18/26 revealed the residents would be served lemon zest broccoli, chocolate cake with icing, chicken patty on bun, and rice. Observation of the lunch service on 02/18/26 at 11:57 A.M. with Dietary Manager (DM) #605 revealed the residents' trays included lettuce and tomatoes on their chicken patties. Continued observation of the lunch service on 02/18/26 at 12:28 P.M., revealed the kitchen ran out of (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lettuce for the chicken sandwiches. Interview with DM #605 at the same time verified the facility did not have enough lettuce and tomatoes and 17 residents did not receive the two items on their chicken sandwich. Continued observation of the lunch service on 02/18/26 at 1:03 P.M. revealed all residents received chocolate pudding instead of chocolate cake. Interview with DM #605 at the same time verified the facility had chocolate cake; however, a cook followed the incorrect menu and served chocolate pudding instead. Review of the facility policy titled, Menus dated October 2017, revealed menus are developed and prepared in advance to meet needs of the residents. This deficiency represents non-compliance investigated under Complaint Number 2742960.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and policy review the facility failed to ensure food served was palatable and at an appetizing temperature. This had the potential to affect all 84 residents as the facility identified all residents received food from the kitchen. The facility census was 84. Findings include:Review of the lunch menu for 02/18/26 revealed the residents would be served lemon zest broccoli, chocolate cake with icing, chicken patty on bun, and rice. Observations of puree diets being prepared on 02/18/26 at 11:21 A.M., revealed Dietary Manager (DM) #65 initially added chicken patties, lettuce, tomatoes, mayonnaise, and slices of bread to a blender. After blending, hot water was added to thin the consistency to the desired texture. During an interview on 02/18/26 at 11:28 A.M., DM #605 verified that the mixture was too thick, and he added hot water to create a pudding like consistency. DM #605 verified that the facility had recipe cards for all meals; however, he knows the consistency that he is looking for and does not use the recipe. Observation on 02/18/26 at 11:32 A.M., revealed DM #605 added oil to a pan that was heated on the stove. DM #605 added flour to the oil to create a roux and then mixed in hot water to thin the consistency. Interview with DM #605 verified that he was making gravy for the puree and mechanical soft diets. DM #605 verified that the only ingredients used for the gravy were oil, flour, and water. Observation on 02/18/26 at 11:47 A.M., revealed DM #605 add six scoops of rice and two glasses of hot water to a blender. The consistency of the mixture was thick and sticky. Observation of the test tray on 02/18/26 at 1:03 P.M. with DM #605, revealed the chicken sandwich was 106 degrees Fahrenheit (F), broccoli was 139 degrees F, rice was 120 degrees F and the chocolate pudding was 58 degrees F. The surveyor tasted the items and the broccoli tasted bland and the chicken sandwich was cold. Interview with DM #605 at the same verified the chicken sandwich was cold and that lemon seasoning was supposed to be added to the broccoli. Review of the spreadsheet for lunch on 02/18/26 revealed the cream of rice should have been substituted for rice for the residents with a puree diet. During an interview on 02/19/26 at 1:04 P.M., Registered Dietician (RD) #600 stated the kitchen staff should be following recipe cards and spreadsheets. RD #600 also verified that gravy made with only oil, water, and flour would not taste very good and he would expect something like a chicken or beef base to be used for flavoring. Review of the recipe card Chicken Patty on Bun revealed the meat, mayonnaise and bread should be pureed together. The gravy should be added a little at a time to achieve smooth consistency. Review of the recipe card Gravy revealed that gravy should be made with flour, fat (meat drippings), black pepper, chicken or beef base, and water. Review of the facility policy titled, Food and Nutrition Services dated October 2017 revealed each resident is provided a nourishing, palatable well-balanced diet that meets his or her daily nutritional and special dietary needs. This deficiency represents non-compliance investigated under Complaint Number 2742960.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, record review, staff interviews and policy review, the facility failed to ensure foods were made to the correct consistency for residents with a puree and mechanical soft diet order. This affected seventeen Residents (#08, #34, #75, #05, #06, #17, #25, #27, #32, #46, #53, #54, #56, #73, #79, #81, and #95) who the facility identified as receiving a puree or mechanical soft diet order. The facility census was 84. Review of the medical records revealed three Residents (#08, #34, and #75) had physician orders for a puree diet. Further review revealed fourteen Residents (#05, #06, #17, #25, #27, #32, #46, #53, #54, #56, #73, #79, #81, and #95) had physician orders for a mechanical soft diet. Review of the lunch menu for 02/18/26 revealed the residents would be served lemon zest broccoli, chocolate cake with icing, chicken patty on bun, and rice. Review of the lunch spreadsheet for 02/18/26 revealed the residents with a mechanical soft diet should receive chopped bite size broccoli and the residents with a puree diet should receive cream of rice. Observation of the lunch service on 02/18/26 at 11:57 A.M., revealed the residents ordered a mechanical soft diet were served the same broccoli as the regular diets and the residents ordered a puree diet, were served rice pureed with water. During an interview on 02/19/26 at 1:04 P.M., Registered Dietician (RD) #600 stated he would expect the kitchen staff to follow the items listed on the spread sheets. During an interview on 02/19/26 at 2:43 P.M., Dietary Manager (DM) #605 verified the spreadsheet for 02/18/25 indicated the residents with a mechanical soft diet should have received cut broccoli and the residents ordered a puree diet should have been served cream of rice. DM #605 verified the residents were not served cut broccoli and cream of rice. Review of the facility policy titled, Food and Nutrition Services dated October 2017 revealed each resident is provided a nourishing, palatable well-balanced diet that meets his or her daily nutritional and special dietary needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the facility policy, the facility failed to store and prepare food in a sanitary manner to prevent foodborne illness. This had the potential to affect all residents residing in the facility. The facility census was 84 residents.Findings include: 1.Observation of the kitchen on 02/17/26 at 9:27 A.M. revealed the soda gun nozzle was dirty and had a build-up of a red substance. Interview on 02/17/26 at 9:27 A.M. with Dietary Manager (DM) #605 confirmed the soda gun nozzle was dirty. Review of the facility policy titled Sanitization dated October 2008 revealed all kitchen equipment should be kept clean. 2.Observation on 02/17/26 at 9:29 A.M. revealed that the white cutting block attached to the front of the steam table was dirty with black residue on the top surface. Interview on 02/17/26 at 9:29 A.M. with DM #605 confirmed the white cutting block attached to the front of the steam table was dirty. Review of the facility policy titled Sanitization dated October 2008 revealed all counters and utensils should be kept clean. 3. Observation of the walk-in cooler on 02/17/26 at 9:33 A.M. revealed it contained the following undated items: vanilla pudding, white American cheese, Swiss cheese, provolone cheese, bologna. A container of unpasteurized raw eggs were stored on the top shelf above potatoes. Interview on 02/17/26 at 9:33 A.M. with DM #605 verified that the foods items should have been dated when they were prepared or opened and raw eggs should be stored on the bottom shelf. Review of the facility policy titled Food Receiving and Storage dated October 2017 revealed food will be dated. 4. Observation of the walk-in freezer on 02/17/26 at 9:40 A.M. revealed the temperature was 25 degrees Fahrenheit (F) food was soft to the touch. Interview on 02/17/26 at 9:40 A.M. with DM #605 confirmed the freezer was put into defrost mode the day prior and verified that the food should have been frozen solid. Review of the facility policy titled Food Receiving and Storage dated October 2017 revealed frozen food should be frozen to a solid state. 5.Observation of the dry storage room on 02/17/26 at 9:42 A.M. revealed it contained the following opened and undated items: a bag of spaghetti noodles, three bags of egg noodles. Interview on 02/17/26 at 9:42 A.M with DM #605 verified opened bags of pasta were undated. Review of the facility policy titled Food Receiving and Storage dated October 2017 revealed food will (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be dated. 6. Observation in the food prep area on 02/17/26 at 9:50 A.M. revealed there were five dirty knives stored in the clean knife storage case. Interview on 02/17/26 at 9:50 A.M with DM #605 verified the five knives stored in the clean knife case were dirty. Review of the facility policy titled Sanitization dated October 2008 revealed all counters and utensils should be kept clean. 7.Observation of the walk-in freezer on 02/18/26 at 10:20 A.M. revealed there was an icicle coming from the condenser and there was an open box of peas stored underneath it. Interview on 02/18/26 at 10:20 A.M. with DM #605 verified the peas were open and should not be stored under the leaking condenser. 8.Observation on 02/18/26 at 12:20 P.M. revealed the ice machine in the kitchen was leaking. Interview on 02/18/26 at 12:20 P.M with DM #605 confirmed the ice machine did not stop making ice once it was full. The ice machine would then be overfilled with water and would leak down the side. 9.Observation of the lunch service on 02/18/26 at 12:35 P.M. revealed the broccoli on the steam table was being held at 123 degrees F. Interview on 02/18/26 at 12:35 P.M. with DM #605 confirmed half of the steam table was not working, and all hot food should be held above 135 degrees F. Review of the facility policy titled Food Preparation and Service dated October 2017 revealed hot food should be stored above 135 degrees F. This deficiency represents noncompliance investigated under Complaint Number 2727645.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility documents, staff interview, and review of the facility policy, the facility failed to complete the facility assessment. This affected all residents in the facility. The facility census was 84 residents. Findings include: Review of facility Quality Assurance and Performance Improvement (QAPI) documents revealed the facility did not have a completed facility assessment document on file. Interview on 02/10/26 at 5:48 P.M. with the Director of Nursing (DON) verified the facility had not completed a facility assessment. Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Plan dated 2001 revealed the facility should develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, staff interview, and review of the facility policy, the facility failed to develop, implement, and maintain an effective Quality Assurance Performance Improvement (QAPI) program that identified and addressed systemic noncompliance. This affected all residents in the facility. The facility census was 84 residents. Findings include: Review of the facility documents revealed the facility could not provide any documentation of any facility QAPI activities for the entirety of 2025. Interview on 02/10/26 at 5:48 P.M. with the Director of Nursing (DON) verified the facility did not have any QAPI activities for the entirety of 2025, including a QAPI Plan, facility assessment, or proof that QAPI meetings were held monthly and/ or quarterly for the entirety of 2025. Review of the policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated 2001 revealed the facility should develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and review of the facility policy, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to perform any QAPI activities for the entirety of 2025. This affected all residents in the facility. The facility census was 84 residents. Findings include: Review of the facility documents revealed there was no documentation of a QAPI Plan, a facility assessment, performance improvement projects, or QAPI meeting minutes for the entirety of 2025. Interview on 02/10/26 at 5:48 P.M. with the Director of Nursing (DON) verified the facility did not have documentation the facility QAPI Plan, a facility assessment, performance improvement projects, or QAPI meetings minutes for the entirety of 2025. Review of the policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated 2001,revealed the facility should develop, implement, and maintain an ongoing facility-wide QAPI Plan to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, staff interview, and review of the facility policy, the facility failed to ensure Quality Assurance and Performance Improvement (QAPI) meetings were conducted on a quarterly basis. This affected all residents in the facility. The facility census was 84 residents. Findings include: Review of the facility documents revealed the facility had no documentation of QAPI meetings conducted monthly and/or quarterly for the entirety of 2025. Interview on 02/10/26 at 5:48 P.M. with the Director of Nursing (DON) verified the facility did not conduct monthly and/or quarterly QAPI meetings for the entirety of 2025. Review of the policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated 2001 revealed the QAPI committee should meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, staff interview, review of the facility policy, and review of online resources from the Centers for Disease Control and Prevention (CDC), the facility failed to ensure a comprehensive water management plan was implemented to minimize the risk of waterborne pathogens including Legionella. This had the potential to affect all residents living in the facility. The facility census was 84 residents. Findings include:Review of the facility documents revealed the facility did not have a water management plan to prevent the growth of Legionella. Interview on 02/18/26 at 3:18 P.M. with Director of Clinical Operations (DCO)#900 verified the facility did not have a water management plan in place to prevent the growth of Legionella. Review of facility policy titled Legionella Water Management Program undated revealed the facility as part of the infection prevention and control program would have a water management program in place. Review of online resources from the CDC at https://www.cdc.gov/control-legionella/php/wmp/wmp-steps.html titled Steps to Develop a Water Management Program revealed development of a water management program was a multi-step process that required continuous review. An approved plan consisted of the following teps to building an effective Legionella water management program: establish a water management program team, describe the building water systems, identify areas where Legionella could grow and spread, decide where to apply and how to monitor control measures, establish interventions when control limits aren't met, make sure the program runs as designed and is effective, document and communicate all the activities.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, and review of the facility policy, the facility failed to maintain the building in a safe and sanitary manner for residents, staff, and the public. This had the potential to affect all residents in the facility. The facility census was 84 residents. Findings include: 1. Observation on 02/19/26 at 10:47 A.M. of the facility's laundry area revealed there was a pool of water on the floor directly inside the entrance to the dirty linens area of the laundry area which was approximately three feet wide by six feet long and approximately one-eighth inch deep. Further observation revealed water was being released from a pipe located under a sink next to the pool of water. The wall adjacent to the pool of water on the floor was missing drywall from the bottom two inches of the wall which was in contact with the pooled water. The metal studs inside the wall appeared to be rusted. Interview on 02/19/26 at 10:47 A.M. with Laundry Aides (LAs) #710 and #712 confirmed there was pool of water on the floor just inside the entrance to the dirty linens side of the laundry area. LA's #710 and #712 further confirmed dirty linens were brought into the laundry area through the entrance impacted by the pool of water. Interview on 02/19/26 at 10:56 A.M. with Maintenance Director (MD) #200 confirmed the existence of a pool of water on the floor directly inside the entrance to the dirty linens area of the laundry area. Further interview with MD #200 verified the pool of water was approximately three feet wide by six feet long and approximately one-eighth of an inch deep. MD #200 further confirmed water was actively being released from a pipe located under a sink, which was located to the right of the pool of water. MD #200 reported the water being released from the pipe under the sink was the source of the water pooled on the floor. MD #200 also confirmed that approximately two inches of drywall was missing from the bottom of the wall adjacent to the pool of water and the studs in the wall appeared to be degraded by rust. MD #200 he reported awareness of the pipe leaking under the sink in the dirty linens area of the laundry room since his first day of employment as Maintenance Director with the facility. Interview on 02/19/26 at 11:35 A.M. with Human Resources (HR) #125 confirmed MD #200's hire date was 12/08/25. 2. Observation on 02/17/26 at 12:16 PM during lunch service in the 400-hall dining area revealed the heating unit was uncovered with a wire sticking out from left of the unit. The cover to the heating unit was sitting on the floor. Interview on 02/17/26 at 12:17 P.M. with the Scheduler and Certified Nursing Assistant (CNA) #185 confirmed the heating unit in the 400-hall dining area was uncovered with a wire sticking out from the left side of the unit, and the cover to the unit was on the floor. The Scheduler further confirmed this was a safety hazard for the residents and she would report it to the maintenance department. Observation on 02/19/26 at 10:00 A.M. of the 400-hall dining area revealed the heating unit was covered, but there was still a wire sticking out of the left side of the unit. Interview on 02/19/26 at 10:00 A.M. with the Director of Nursing (DON) confirmed the heating unit in the dining area was covered but there was a wire coming out of the left side of the unit and it was a safety hazard for all the residents in the 400 hall since they were all mobile and ate their meals in the dining area. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observation on 02/19/26 at 11:08 A.M. with Registered Nurse (RN) #305 of Resident #7's room revealed there was a square floor fan in the room which was approximately 24 inches by 24 inches with a white grate that was covered with black dust particles some of which were approximately two inches long. The fan was pointed towards Resident #7 who was in bed. Interview on 02/19/26 at 11:08 A.M. with RN #305 verified Resident #7's fan grate was covered with black dust/lint and the fan was on and pointed directly at the resident. Review of the facility policy titled Quality of Life – Homelike Environment revealed the facility staff and management would maintain a clean, sanitary and orderly environment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record reviews, interviews, and policy review, the facility failed to conduct quarterly care conferences. This affected five Residents (#03, #06, #07, #61 and #49) of five residents reviewed for care conferences. The facility census was 84. 1) Review of the medical record revealed Resident #03 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, hypertension, atrial fibrillation, bipolar disorder and anxiety disorder. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #03 had intact cognition. Review of care conferences for Resident #03, as provided by the facility, revealed the only documented care conference for Resident #03 was in the third quarter of 2025. There were no documented care conferences at admission and fourth quarter of 2025. During an interview on 02/19/26 at 11:50 A.M. the Director of Nursing (DON) verified Resident #03 was not provided with an admission care conference or a care conference in the fourth quarter of 2025. 2) Review of the medical record revealed Resident #06 was admitted to the facility on [DATE] with diagnoses of cerebral vascular accident with left (non-dominant) side hemiplegia and hemiparesis, dysphagia, congestive heart failure and depression. Review of the MDS admission assessment dated [DATE] revealed Resident #06 had moderate cognitive impairment. Review of care conferences for Resident #06, as provided by the facility, revealed there was no documented admission care conference. During an interview on 02/17/26 at 11:11 A.M. Resident #06's representative stated there had been no communication about Resident #06's plan of care. Resident #06's representative stated the facility had not conducted an admission care conference for the resident. During an interview on 02/19/26 at 11:50 A.M., the DON verified Resident #06 was not provided with an admission care conference. 3) Review of the medical record revealed Resident #07 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia, tracheostomy, mechanical ventilation, dysphagia, enteral feeding tube, diabetes mellitus type II, atrial fibrillation and depression. Review of the MDS Quarterly assessment dated [DATE] revealed Resident #07 had intact cognition. Review of care conferences for Resident #07, as provided by the facility, revealed there were no documented care conferences provided to Resident #07 in the first, second, third and fourth quarters of 2025. During an interview on 02/19/26 at 11:50 A.M., the DON verified Resident #07 was not provided care conferences in the first, second, third and fourth quarters of 2025. 4) Review of the medical record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses of schizophrenia, chronic obstructive pulmonary disease, Alzheimer's disease, peripheral vascular disease, bipolar disorder and anxiety disorder. Review of the MDS Quarterly assessment dated [DATE] revealed Resident #61 had moderate cognitive impairment. Review of care conferences for Resident #61, as provided by the facility, revealed a conference was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with Resident #61 and Resident #61's Representative in the third quarter of 2025. There were no documented care conferences for the first, second and fourth quarters of 2025. During an interview on 02/19/26 at 11:50 A.M., the DON verified Resident #61 was not provided with a care conference in the first, second, third and fourth quarters of 2025. 5) Review of medical record of Resident #49 revealed an admission date of 12/20/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type II diabetes mellitus without complications, anxiety disorder, polyneuropathy, muscle weakness, major depressive disorder, and alcohol use with alcohol induced persisting dementia. Review of most recent annual MDS assessment dated [DATE] revealed Resident #49 had severe problems with thinking and memory. The resident was maximal assistance for eating and oral hygiene, dependent for toileting, bathing, dressing, personal hygiene, transfers, and mobility with a manual wheelchair. Review of care conferences for Resident #49 revealed a care conference was conducted on 06/19/25 with the resident's legal guardian. There was no documented evidence of any additional care conferences being completed. Interview on 02/18/2026 at 2:46 P.M. with Social Services Worker (SSW) #150 confirmed documentation of a care conference on 06/19/25 which included Resident #49's legal guardian. SSW #150 confirmed there was no additional documentation of care conferences for Resident #49. Review of the Care Planning Conferences policy revealed the resident and his or her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. The facility staff supports and encourages resident/representative participation in the care planning process by holding care planning meetings at times of day when the resident, representative and family members can attend and are functioning at their best. A seven day advance notice of the care planning conference is provided to the resident and his or her representative. Such notice is made by mail and/or telephone.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and policy review, the facility failed to dispose of expired vaccines. This had the potential to affect the forty-six Residents (#01,#02, #03, #06, #07, #09, #10, #11, #15, #16, #20, #22, #25, #28, #29, #30, #33, #34, #35, #37, #38, #39, #40, #41,#47, #49, #50, #52, #54, #57, #58, #59, #61, #62, #64, #69, #71, #73, #74, #77, #78, #80, #85, #94, #95, and #96) housed in the 100 and 300 halls who the facility identified as receiving vaccines. The census was 84.During a medication storage observation on [DATE] at 4:01 P.M., three 0.5 milliliter (mL) single dose Influenza Vaccine Afluria were found to be expired (expiration date [DATE]). Four boxes each containing ten Pneumococcal Vaccine Polyvalent Pneumovax – 23, single dose 0.5 mL syringes were found to be expired (expiration date [DATE]). During an interview on [DATE] at 4:30 P.M., The Director of Nursing ([NAME]) confirmed all the products in the medication storage room on the first floor are intended for the Residents in the 100 and 300 halls, and staff were required to remove and properly dispose of all expired vaccines. The DON verified expired vaccines were in the medication storage room. Review of facility policy titled, Storage of Medications), revised [DATE], revealed discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the facility policy, the facility failed to provide privacy curtains in resident rooms. This affected five (Residents #30, #96, #10, #80 and #18) of five residents reviewed for privacy. The facility census was 84 residents. Findings include: 1.Observation on 02/17/26 at 11:21 A.M. revealed the room of Residents #96 and #30 only had one privacy curtain which was not adequate to provide visual privacy to either resident. Interview on 02/17/26 at 11:21 A.M. with Certified Nursing Assistant #505 verified the one privacy curtain that was in place was not adequate to provide either Resident #96 or Resident #30 privacy during care. 2.Observations on 02/18/26 at 10:34 A.M. and on 02/19/26 at 8:08 A.M. revealed the room of Residents #96 and #30 continued to have only one privacy curtain in place. Observation on 02/18/26 at 12:15 P.M. with Registered Nurse (RN) #309 revealed there were no privacy curtains in Resident #18's room. Interview on 02/18/26 at 12:16 P.M. with RN #309 confirmed there were no privacy curtains in Resident #18's room and she was unsure how long the curtains had been missing. 3.Observation on 02/17/26 at 12:39 P.M. revealed no privacy curtains were present in Resident #10's room and the resident had a roommate. Interview on 02/17/26 at 12:39 P.M. with Resident #10 confirmed privacy curtains were not present in the resident's room. Interview on 02/17/26 at 3:20 P.M. with Human Resources (HR) #125 confirmed privacy curtains were not present in Resident #10's room. 4.Observation on 02/17/26 at 12:41 P.M. revealed privacy curtains were not present in Resident #80's room. Interview on 02/17/26 at 12:42 P.M. with Resident #80 confirmed privacy curtains were not present in the resident's room and the resident had a roommate. Resident #80 confirmed there had been no privacy curtains in the room since his admission on [DATE]. Interview on 02/17/26 at 3:20 P.M. with Human Resources (HR) #125 confirmed privacy curtains were not present in Resident #80's room. HR #125 was unable to confirm how long privacy curtains had not been present in Resident #80's room. Review of the facility policy titled Resident Rights undated revealed residents had a right to privacy.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews and policy review, the facility failed to provide residents with regular utensils during meals. This directly affected three Residents (#37, #03 and #61) but had the potential to all affect all 84 residents as the facility identified all residents received Meals from the kitchen. The facility census was 84. Findings include: 1) Review of medical record of Resident #37 revealed an admission date of 12/10/25. Diagnoses included chronic obstructive pulmonary disease (COPD), unspecified, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, left bundle-branch block, unspecified, unspecified mood disorder, acute kidney failure, unspecified, other toxic encephalopathy, and cocaine abuse. Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a cognitive status was not assessed. The resident was independent for eating, oral hygiene, and ambulation, supervision assistance for toileting, bathing, dressing, personal hygiene, and transfers. Observation on 02/18/26 at 9:10 A.M. revealed Resident #37 was utilizing plastic utensils to feed herself breakfast in her room. During an interview on 02/18/26 at 9:10 A.M. Resident #37 stated she was displeased with being provided plastic utensils for meals and would prefer regular utensils. Resident #37 further reported that often residents are provided with plastic utensils instead of metal utensils with their meals. During an interview on 02/18/26 at 9:24 A.M., Certified Nursing Assistant (CNA) #526 verified Resident #37 was provided with plastic utensils to eat breakfast. CNA #526 stated the residents were periodically provided with plastic utensils for meals when the kitchen ran out of regular utensils. CNA #256 stated the regular utensils were not often returned to the kitchen in a timely manner causing the kitchen to run out of regular utensils. 2) Review of the medical record revealed Resident #03 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, hypertension, atrial fibrillation, bipolar disorder and anxiety disorder. Review of the MDS Quarterly assessment dated [DATE] revealed Resident #03 had intact cognition and required set up assistance for eating. Observation of Resident #03's room on 02/19/26 at 12:10 P.M. revealed the breakfast tray was delivered with plastic utensils instead of traditional metal utensils. Resident #03 stated he disliked plastic utensils and preferred regular utensils. 3) Review of the medical record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses of schizophrenia, chronic obstructive pulmonary disease, Alzheimer's disease, peripheral vascular disease, bipolar disorder and anxiety disorder. Review of the MDS Quarterly assessment dated [DATE] revealed Resident #61 had moderate cognitive impairment. The resident was independent for eating. Observation of Resident #61's room on 02/19/26 at 12:21 P.M. revealed the breakfast tray was delivered with plastic utensils instead of traditional metal utensils. Resident #03 stated he disliked (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plastic utensils and preferred regular utensils. Resident #61 stated he disliked plastic utensils and preferred regular utensils. Review of a facility document titled Quality of Life – Homelike Environment which indicated version 1.2 stated, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. This deficiency represents non-compliance investigated under Complaint Number 2747574.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, staff interview and policy review, the facility failed to ensure a safe, functional and homelike environment for the residents. This affected three Residents (#10, #49 and #80) of four resident rooms reviewed for a safe, functional and homelike environment. The facility census was 84. 1) Review of the medical record of Resident #10 revealed an admission date of 12/28/25. Diagnoses included acute kidney failure with tubular necrosis, rhabdomyolysis, encephalopathy, abnormal levels of other serum enzymes, and cocaine abuse. Review of the admission Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #10 was cognitively intact. Observation of Resident #10's room on 02/17/26 at 12:39 P.M. revealed the door to the resident's bathroom did not close completely, thus not providing privacy for the resident while using the bathroom adjacent to his sleeping quarters. This was a semi-private room shared with Resident #80. Interview with Resident #10 at the same time expressed concerns that the door to the bathroom would not close completely and thus did not provide enough privacy for him or his roommate. During an interview on 02/17/26 at 3:20 P.M. with Human Resources (HR) #125 confirmed the bathroom door adjacent to Resident #10's sleeping quarters would not close completely. 2) Review of the medical record of Resident #80 revealed an admission date of 12/22/25. Diagnoses included radiculopathy, lumbar region, human immunodeficiency virus, post-traumatic stress disorder, major depressive disorder, chronic viral hepatitis C, and other psychoactive substance dependence. Review of the admission MDS assessment dated 12/28 /25 revealed Resident #80 was cognitively intact. Observation of Resident #80's room on 02/17/26 at 12:39 P.M. revealed the door to the resident's bathroom did not close completely, thus not providing privacy for the resident while using the bathroom. Interview with Resident #80 at the same time, expressed concerns that the door to the bathroom did not close completely, and thus did not provide privacy for he or his roommate when using the bathroom. During an interview on 02/17/26 at 3:20 P.M. Human Resources (HR) #125 verified the bathroom for Resident #80 and Resident #`10's door adjacent to Resident #80's sleeping quarters did not close completely thus providing privacy. Review of a facility document titled Resident Rights which contained no date or version number revealed the Federal and State laws guarantee certain basic rights to all residents of this facility which included the rights to privacy. 3) Review of medical record of Resident #49 revealed an admission date of 12/20/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type II diabetes mellitus without complications, anxiety disorder, polyneuropathy, muscle weakness, major depressive disorder, and alcohol use, unspecified with alcohol induced persisting dementia. Review of most recent annual MDS assessment dated [DATE] revealed Resident #49 had severe problems with thinking and memory. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation oof Resident #49's room on 02/17/26 at 10:31 A.M. revealed an unmonitored space heater which was plugged in, running and was located on the floor in the resident's room with the resident's door standing open. During an interview on 02/17/26 at 11:03 A.M. Certified Nursing Assistant (CNA) #508 verified Resident #49's room had a space heater running. During an interview on 02/19/26 at 10:37 A.M. the Director of Nursing (DON) #300 stated the heat was not working properly in Resident #49's room and a space heater was being used in the resident's room. Review of a facility document titled Electrical Safety for Residents with a revised date of January 2011 stated, Portable space heaters are not permitted in the facility. Review of the policy titled, Quality of Life-Homelike Environment, dated 2001, revealed residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include a clean, sanitary and orderly environment. This deficiency represents non-compliance investigated under Complaint Number 2747574.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Minimum Data Set (MDS) assessments, review of medical record, and staff interview, the facility failed to ensure a significant change assessment was completed for one (Resident #02) of one resident reviewed for significant change assessments. The facility census was 84.Findings include: Review of the medical record revealed Resident #02 was admitted to the facility on [DATE] with diagnoses of cerebral vascular accident with aphasia, diabetes mellitus type II, post-traumatic stress disorder, hypertension and epilepsy. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #02 had severe cognitive impairment and was frequently incontinent of bowel and occasionally incontinent of bladder. The resident required supervision for eating, toileting, bed mobility and transfers, and moderate assistance for bathing and dressing, and was independent for oral and personal hygiene. Review of Hospice progress note dated 01/14/26 at 5:27 P.M. revealed Resident #02 was admitted to Hospice services for a diagnosis of cerebral vascular accident. Review of physician orders for Resident #02 revealed an order dated 01/14/26 authored by Medical Director (MD) #900 for Resident #02 to be admitted to Hospice services. Review of the MDS assessments for Resident #02 revealed a Significant Change assessment was not completed when Resident #02 transitioned to Hospice services. During an interview on 02/18/26 at 3:25 P.M. the Director of Nursing (DON) verified Resident #02 did not have a Significant Change assessment completed when the resident transitioned to Hospice services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interviews, and facility policy review, the facility failed to provide a discreet cover for a resident's catheter bag and ensure appropriate placement of catheter bag. This affected one (Resident #94) of two residents reviewed for catheter care. The facility census was 84. Review of the medical record of Resident #94 revealed an admission date of 02/16/26. Diagnoses included acute hematogenous osteomyelitis, left ankle and foot, complete lesion at T1 level of thoracic spinal cord, neuromuscular dysfunction of bladder, borderline personality disorder, antisocial personality disorder, paraplegia, schizoaffective disorder, and acquired absence of right leg above knee. The admission Minimum Data Set (MDS) assessment for Resident #94 was still in progress. A Brief Interview for Mental Status (BIMS) revealed Resident #94 was cognitively intact. Observation on 02/18/26 at 10:44 A.M. revealed Resident #94 was present in the main lobby with his catheter bag sitting on his lap and not covered. During an interview on 02/18/26 at 10:44 A.M., Resident #94 acknowledged his catheter bag was lying on his lap uncovered. Resident #94 reported he would like to have cover for his catheter bag. During an interview on 02/18/26 at 10:52 A.M. Director of Clinical Operations (DCO) #915 , confirmed Resident #94's catheter bag was lying on the resident's lap and was not covered while the resident was present in the main lobby. Review of the policy titled, Resident Rights, not dated, revealed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence. Review of policy titled Catheter Care, Urinary revealed the urinary drainage bag must be held or positioned lower than the bladder at all times.

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	02/19/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to implement nutritional recommendations made by the Registered Dietitian (RD) for a resident with weight loss. This affected one (Resident #03) of three residents reviewed for nutrition. The facility census was 84.Findings include:Review of the medical record revealed Resident #03 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, hypertension, atrial fibrillation, bipolar disorder and anxiety disorder.Review of weights for Resident #03 revealed on 08/03/25 Resident #03 had a documented weight of 221 pounds and on 02/01/26 Resident #03 had a documented weight of 189.8 pounds. This represented a 14.12 percent (%) weight loss in six months.Review of RD progress note for Resident #03 dated 10/15/25 authored by RD #600 revealed Resident #03 was ordered to receive double portions for all meals.Review of weights for Resident #03 revealed on 11/04/25 Resident #03 had a documented weight of 209.8 pounds and on 02/01/26 Resident #03 had a documented weight of 189.8 pounds. This represented a 9.53 percent (%) weight loss in three months.Review of RD progress note for Resident #03 dated 12/11/25 authored by RD #600 revealed Resident #03 triggered for a significant weight loss over the past 90 days. Meal acceptance noted was at 75% to 100% most days and there were no chewing or swallowing issues reported. RD #600 ordered to recheck the resident's weights to confirm and to liberalize the resident's diet to regular from No Added Salt (NAS) to promote palatability and intakes for the resident. RD #600 recommended to monitor weekly weights if weight loss is confirmed.Review of the physician order for Resident #03 revealed an order dated 12/12/25 for Resident #03 to receive a regular diet, regular texture, regular (thin) consistency.Review of weights for Resident #03 revealed Resident #03 had a documented weight on 12/24/25 and was not weight again until 02/01/26. During this period Resident #03's experienced continued weight loss from 194 pounds to 189.8 pounds.Review of RD progress note for Resident #03 dated 01/15/26 authored by RD #600 revealed Resident #03 was noted with significant weight loss of 11.4% over the past 180 days. The resident previously received additional portions with meals, but an order was no longer in place since the resident's hospitalization. RD #600 noted given the history of weight loss, RD #600 recommended resuming large portions with meals to support intake and nutritional adequacy. And obtaining January 2026 weight and to start weekly weights.Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #03 had intact cognition and was frequently incontinent of bowel, and always continent of bladder. The resident required set-up assistance for eating, supervision for oral and personal hygiene, toileting, bathing, dressing, bed mobility and transfers. Interview on 02/19/26 at 11:32 A.M. with Resident #03 revealed he was not trying to lose weight. The resident revealed he was not receiving double portions of food.Review of the menu tray card for Resident #03 dated 02/19/26 revealed Resident #03 was not indicated to receive large portions and/or double portions.Observation of breakfast tray for Resident #03 on 02/19/26 revealed Resident #03 was provided with three pieces of dry white toast and two bowls of frosted flakes cereal with no milk (resident does not drink milk). The breakfast menu for 02/19/26 revealed pancakes were to be served and Resident #03 said he wanted pancakes. During an interview on 02/19/26 at 1:48 P.M., Dietary Manager #605 verified Resident #03's menu tray card did not indicate Resident #03 was to receive large portions and/or double portions for all meals.During an interview via phone on 02/19/26 at 1:13 P.M., RD #600 verified since 01/15/26, Resident #03 should have received double portions and verified Resident #03 should have been weighed weekly. RD #600 verified neither recommendation had been implemented for Resident #03.Review of list of residents to receive large portions and/or double portions on 02/19/26 at 5:00 P.M., as provided by the facility, revealed Resident #03 was not on the list to receive large portions and/or double portions.During an interview on 02/19/26 at 5:48 P.M., the Director of Nursing (DON) verified Resident #03 had experienced a significant weight loss and that RD #600's recommended (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions of large/double portions and weekly weights had not been implemented. The DON also verified Resident #03 had no documented weights from 12/24/25 to 02/01/26. Review of the February 2026 active plan of care for Resident #03 revealed Resident #03 was at moderate nutrition/hydration risk related to being on medication which may impact nutritional status with a goal to experience no significant unplanned weight change. Interventions included to monitor for difficulties chewing/swallowing. monitor laboratory findings (labs), weights, intakes and skin assessments, observe for sign and symptoms of dehydration, provide and serve diet and supplements as ordered, provide dietary education as needed, and update dietary preferences as needed. Review of the policy titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, not dated, revealed the nursing staff would monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria:a. 1 month - 5 % weight loss is significant; greater than 5 % is severe.b. 3 months - 7.5 % weight loss is significant; greater than 7.5 % is severe.c. 6 months - 10 % weight loss is significant; greater than 10 % is severe.