STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Chateau at Mountain Crest Nursing & Rehab Ctr	2586 Lafeuille Avenue Cincinnati, OH 45211

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, staff interview, review of the facility's investigation, review of witness statements, review of the hospital records, and policy review, the facility failed to ensure residents were free from resident-to-resident abuse. This resulted in Actual Harm on 05/31/24 when Resident #52, a resident with a known history of aggressive behaviors towards other residents, intentionally ran over Resident #14 with his wheelchair. Subsequently, Resident #14 was sent to the local hospital where she was diagnosed with a closed fracture of the right tibial plateau initial encounter. The facility also failed to ensure Resident #60 was free from resident- to-resident abuse when Resident #52 intentionally ran into the resident with his wheelchair causing the two residents to become involved in a physical altercation. This affected two (#14 and #60) out of three residents reviewed for abuse. The facility census was 126. Findings include: 1) Review of Resident #14's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included vascular dementia, difficulty in walking, muscle weakness, chronic obstructive pulmonary disease (COPD), osteoarthritis, psychotic disturbance, mood disturbance and anxiety, congestive heart failure, adult failure to thrive, anxiety disorder, alcohol dependence, retention of urine, acute kidney failure, schizoaffective disorder, and major depressive disorder. Review of Resident #14's activities of daily living (ADL) care plan dated 12/15/23 and revised 06/17/24, revealed Resident #14 required assistance with ADLs and Resident #14 does ambulate with her walker but is often non-complaint with using her walker and is a fall risk. Interventions included Resident #14 had a rollator walker and a wheelchair, but she did not use them daily, staff to assist with completion of ADLs on a daily basis and Resident #14 required weight bearing assistance with ambulation. Review of Resident #14's annual Minimum Data Set (MDS) assessment dated [DATE], revealed the resident to be cognitively intact. Review of Resident #14's late entry progress note dated 05/30/24 at 10:30 A.M., revealed Resident #14 returned from the hospital with a right tibia fracture and a urinary tract infection (UTI). New medications were updated on the medication administration record (MAR) and sent to Nurse Practitioner (NP) #550. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #14's progress note dated 05/30/24 at 11:43 A.M., revealed Resident #14 was in the hallway trying to get her food order for lunch. Another resident (facility identified #52) ran over Resident #14 with his wheelchair and her leg was dislocated in the wheelchair and the resident hitting her head. NP #550 was at the facility and was aware and new orders were placed to initiate neurological checks, to get x-rays, and for Resident #14 to be sent out for evaluation. Review of Resident #14's hospital After Visit Summary (AVS) dated 05/30/24 revealed Resident #14 was seen due to her being an assault victim with diagnoses listed as assault, fall initial encounter, closed fracture of the right tibial plateau and urinary tract infection (UTI) without hematuria. Resident #14 was treated with antibiotics and pain medications, placed in a knee immobilizer and released back to the facility. Review of Resident #14's progress note dated 06/03/24 revealed another resident rolled into the resident with their wheelchair, resident expressed pain, the physician was called, and the resident was sent to the hospital on 05/30/24 where she was diagnosed with right tibia fracture and a UTI. Resident #14 had orders for Tramadol (narcotic pain relief), Norco (narcotic pain relief) and ibuprofen. The other resident (Resident #52) was moved to a different unit. Review of Resident #14's progress note dated 06/14/24 revealed Resident #14 had a follow up appointment scheduled with orthopedics on 06/18/24 at 2:00 P.M. 2) Review of Resident #60's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included COPD, acute and chronic respiratory failure with hypoxia, anemia, insomnia, sepsis, schizoaffective disorder and hypertension. Review of Resident #60's most recent MDS assessment dated [DATE], revealed the resident to be cognitively intact. Review of Resident #60's progress note dated 04/05/24 at 7:31 P.M. revealed the State tested Nurse Aide (STNA) (unknown and the facility was unable to verify) was observed separating the residents (the facility identified Resident #52 as being the other resident) and the STNA and Licensed Practical Nurse/Unit Manager (LPN/ UM) #167 deescalated the situation. Head to toe skin assessments were completed and no injury was notified. The physician and Resident #60's guardian were notified. Review of Resident #60's Interdisciplinary Team (IDT) note dated 04/12/24 at 4:24 P.M., revealed Resident #60 was involved in a physical aggressive incident on 04/05/24. Another resident (facility identified as Resident #52) aggressively rolled into Resident #60 with their wheelchair. Resident #60 then kicked the resident in the stomach. The two began to throw blows with closed fists. The residents were immediately separated and assessed for injuries. No injuries were noted at the time of initial assessment. Resident #60 was continually monitored with no complaints, signs, or symptoms of pain. The aggressor was placed on one-on-one, and no further incidents of aggression were noted. Review of the medical record for Resident #52 revealed the resident was admitted to the facility on [DATE]. Diagnoses included schizophrenia, non-pressure chronic ulcer of other part of right foot, malnutrition, diabetes mellitus, schizoaffective disorder, cannabis dependence, depression, anxiety disorder and COPD. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #52's physician order dated 02/19/24 revealed Resident #52 resided on a secured unit. Review of Resident #52's quarterly MDS assessment dated [DATE] revealed the resident to be cognitively intact. Review of Resident #52's progress note dated 04/05/24 at 7:02 P.M., revealed STNA (unknown and the facility was unable to verify) was observed separating the residents and the STNA and LPN/UM #167 deescalated the situation. Head to toe skin assessments were completed with no injuries. The physician and Resident #52's guardian were notified. Review of Resident #52's behavior care plan dated 04/09/24 and revised 06/10/24, revealed Resident #52 exhibited verbal and aggressive behaviors at times. Interventions included medications as ordered, caregivers to provide an opportunity for positive interaction, consult behavioral services as needed, explain all procedures to the resident before starting and allow the resident time to adjust to changes, intervene as necessary to protect the right and safety of others, divert attention, remove from the situation, and monitor behavior episodes and attempt to determine underlying causes. Review of Resident #52's Psychiatric Consent to Treat, dated 04/26/23 revealed Resident #52 refused the consent. Interview of the IDT meeting note dated 04/12/24 at 4:35 P.M. revealed Resident #52 was a [AGE] year-old male with a history of schizoaffective disorder, depression, and schizophrenia. Resident #52 initiated the incident of physical aggression on 04/05/24. Resident #52 aggressively rolled his wheelchair into the back of another resident (facility identified as Resident #60). The other resident then kicked Resident #52 in the stomach. Both residents started throwing blows and were immediately separated and assessed for injuries. Skin assessment, neurological assessment, and pain assessments were initiated. No injuries or pain were noted. Resident #52 was placed on one-on-one. No further incidents of aggression were noted since the incident. Review of Resident #52's progress note dated 05/09/24 at 2:13 P.M. revealed Resident #52 had increased agitation, aggressively rolled his wheelchair on other residents, was cursing residents out, called other residents names and attempted to jump on them. Resident #52 did not eat for three days and refused his medications. The nurse redirected Resident #52, but it was unsuccessful. The physician was notified, and Resident #52 had a new order in place to send Resident #52 to the hospital for a psychiatric evaluation. All management staff were notified. Review of Resident #52's progress note dated 05/09/24 at 6:00 P.M., revealed transportation arrived to pick Resident #52 up and the resident refused to go to the hospital for a psychiatric evaluation. Review of Resident #52's progress note dated 05/30/24, revealed Resident #52 intentionally ran another resident (facility identified as Resident #14) over with his wheelchair. Resident #52 had no new injuries noted and refused to allow staff to take vital signs. NP #550 was made aware, and a new order was given to send Resident #52 out to the hospital for evaluation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #52's progress note dated 06/12/24 at 2:04 P.M., revealed Resident #52 returned to the facility from the hospital. A head-to-toe assessment was completed with no skin issues. The resident was in a pleasant mood with no complaints of pain or discomfort. Review of Resident #52's one-on-one observation forms dated 04/05/24 to 05/30/24, revealed Resident #52 was on a one-on-one monitoring from 04/05/24 at 10:15 A.M. to 04/12/24 at 12:45 A.M., on 05/09/24 from 1:00 A.M. to 05/10/24 at 12:45 P.M. and again on 05/30/24 from 10:00 A.M. to 10:30 A.M. Review of the facility's Self-Reported Incident (SRI) dated 04/05/24 at 3:37 P.M. for an alleged physical abuse, revealed Resident #52 and Resident #60 were involved in a physical altercation and both residents were separated for continued safety measures. Resident #52 was observed to be yelling aimlessly in the hallway in an aggressive manner. Resident #60 was exiting his room and Resident #52 was observed to roll into Resident #60. Resident #60 then turned and struck Resident #52 and Resident #52 grabbed Resident #60 by his collar as the two struck each other. Both residents were separated, and Resident #52 was placed on one-on-one monitoring. The SRI was unsubstantiated. Review of the facility's SRI dated 05/31/24 at 10:01 A.M. for alleged physical abuse, revealed Resident #52 was observed being aggressive towards Resident #14. Both residents were separated and continued safety measures. Resident #14 was knocked down on the ground and was taken to the emergency room for further evaluation. All responsible parties were made aware of the incident. Resident #52 was observed, to be unprovoked, and to use his wheelchair to intentionally knock over Resident #14. Resident #14 complained of pain in her right leg following the incident and was transferred to the emergency room for further evaluation. Resident #14 was transferred to the hospital and was diagnosed with a right tibia fracture and urinary tract infection. Resident #52 was transferred to the men's unit and was transferred to the hospital for psychiatric evaluation. The SRI was unsubstantiated by the facility as evidence indicated abuse did not occur. Review of STNA #138's witness statement dated 05/31/24, revealed STNA #138 was at the nurse's station charting when she noticed Resident #52 roll away from the nurse's station in the direction of Resident #14 and then rolled over her. When STNA #138 stood up, she noticed that Resident #14 was under Resident #52's wheelchair and Resident #14 began to complain of right knee and leg pain. The nurse on duty then began to administer aid to her after separating the two residents. Interview on 06/17/24 at 12:37 P.M. with LPN/UM #167 and the Director of Nursing (DON) revealed, LPN/UM #167 observed Resident #52 going down the hallway and Resident #60 was coming out into the hallway on 04/05/24. LPN/UM #167 stated he went to his office and staff called him out to the hallway and he witnessed Resident #52 holding onto Resident #60's collar and Resident #52 was swinging at him. LPN/UM #167 stated Resident #60 had his leg out kicking Resident #52. LPN/UM #167 stated Resident #52 was the aggressor in the incident because he intentionally rolled over Resident #60 with his manual wheelchair. LPN/UM #167 also stated Resident #52 had an additional incident on 05/31/24. LPN/UM #167 reported Resident #52 was in the hallway talking to the staff and Resident #52 ran over Resident #14 with his manual wheelchair. Resident #14 was sent to the hospital, and she was diagnosed with a closed fracture of the right tibial plateau. LPN/UM #167 stated Resident #14 was able to walk independently without a mobility device prior to the incident and she was walking without assistive device at the time of the incident. LPN/UM #167 reported Resident #14 was not able to walk since Resident #52 ran her over with his manual wheelchair on 05/31/24 and Resident #14 had a knee immobilizer that was put in place at the hospital on her right leg. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with STNA #138 on 06/17/24 at 12:49 P.M. revealed STNA #138 was behind the nurse's station charting and Resident #52 was mumbling but it was not towards anyone. STNA #138 stated Resident #14 was at the medication cart and Resident #14 went to walk past Resident #52 and he aggressively rolled her over with his manual wheelchair. STNA #138 stated that she ran out to assist Resident #14 and the nurse and physician came to assess Resident #14 before staff moved her to a wheelchair. STNA #138 stated Resident #14 was taken to her room and placed into bed until she was sent to the hospital. A telephone interview with NP #550 on 06/17/24 at 12:59 P.M., revealed she was at the nurse's station getting a report on the residents when she heard Resident #14 saying stop! stop! and she observed Resident #14 walk in front of Resident #52. NP #550 stated Resident #52 rolled Resident #14 over with his manual wheelchair and it did not appear accidental. NP #550 reported Resident #52 did not appear remorseful and NP #550 stated Resident #14 was ambulating with no assistive device at the time of the incident. NP #550 stated Resident #14 was sent out to the emergency room , and she sustained a fracture to her right leg as a result of the incident. NP #550 reported Resident #52 was sent out for a psychiatric evaluation on 05/31/24. NP #550 stated Resident #14 currently required a wheelchair and could not walk due to the fracture. Observation of Resident #14 on 06/17/24 at 1:13 P.M. revealed the resident was sitting in her room in a wheelchair wearing an immobilizer on her right knee. Interview with Resident #14 at the same time, revealed Resident #14 could not recall the date of the incident but stated a man was sitting in his manual wheelchair near the nurse's station and he decided to run her over with his manual wheelchair. Resident #14 stated the man was going back and forth over her with his manual wheelchair and she had pain in her right leg after the incident. Resident #14 reported the man was cursing prior the incident, but he was not cursing at her. Resident #14 stated she was able to walk prior to the incident and Resident #14 stated she was walking without an assistive device on the date of the incident, but she was not able to walk after the incident. Resident #14 stated she had a knee brace that she received at the hospital after she broke her leg. Observation of Resident #52 on 06/17/24 at 4:17 P.M. revealed Resident #52 was rolling himself in the hallway in his manual wheelchair by picking up his feet and using his arms to maneuver the wheelchair. Interview with Resident #52 at the same time, revealed Resident #52 accidentally hit Resident #14 with his manual wheelchair on 05/31/24. Resident #52 stated he did not intentionally hit Resident #14 and he denied any prior incidents or altercations at the facility. Observation of Resident #60 on 06/18/24 at 10:26 A.M. revealed Resident #60 was sitting in the common area on the unit. Resident #60 was observed to get up and ambulate independently. Interview with Resident #60 at the same, revealed the resident did not want to discuss the incident between him and Resident #52. Interview on 06/18/24 at 10:30 A.M. with the DON, verified the progress note on 05/09/24 stated Resident #52 attempted to run over residents with his wheelchair. The DON stated Resident #52 denied psychiatric care on 04/05/24 and he was ordered to go out to the hospital on 05/09/24 but he refused. The DON stated Resident #14 was placed on one-on-one monitoring from 04/05/24 to 04/12/24 and again on 05/09/24 to 05/10/24. (continued on next page)

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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 Note: The nursing home is disputing this citation.	Review of the facility's abuse investigation and reporting policy dated December 2016, revealed all reports of resident abuse shall be promptly reported to local, state and federal agencies as defined by current regulations and thoroughly investigated by facility management. This deficiency represents non-compliance investigated under Complaint Number OH00154689.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed to ensure a resident received therapy services as evaluated by the therapy department and ordered by the physician. This affected one resident (#900) out of three residents reviewed for therapy services. The facility census was 126. Findings include: Review of Resident #900's medical record revealed the resident admitted to the facility on [DATE]. Diagnoses including muscle weakness, malignant neoplasm of right kidney, mixed hyperlipidemia, hypertension, syncope and collapse, type two diabetes mellitus without complications and hypothyroidism. Resident #800 discharged from the facility on 05/26/24. Review of Resident #900's physician order dated 04/16/24, revealed an Occupational Therapy (OT) evaluation was completed, and an order was put in place to treat the resident up to five times in thirty days. Review of Resident #900's physician order dated 04/16/24, revealed Resident #900 was to ordered to receive Physical Therapy (PT) five times over four weeks to work on impairments noted in the initial evaluation. Review of Resident #900's OT evaluation, dated 04/16/24, revealed the resident was to receive therapy services five times in a 30-day period from 04/16/24 to 05/15/24. The treatment approaches may include therapeutic exercises, group therapeutic procedure, an occupational therapy evaluation, therapeutic activities and self-care management training. Review of Resident #900's PT evaluation dated 04/16/24 revealed the resident was to receive therapy services five times in a 30-day period from 04/16/24 to 05/15/24. The Treatment approaches may include therapeutic exercises, neuromuscular reeducation, gait training therapy, group therapeutic procedure, and therapeutic activities. Review of Resident #900's OT progress note dated 04/16/24, revealed Resident #900 was sitting on the edge of the bed upon arrival and was agreeable to the therapy session. Resident #900 stated he lived with his family member prior to hospitalization and hoped to return home following therapy services. Resident #900 was eager to participate in therapy and stated he hoped to be walking with a rollator walker independently. Resident #900 was educated on the role of occupational therapy and the plan of care. Review of Resident #900's PT progress note dated 04/16/24, revealed Resident #900 had a therapy evaluation completed. Resident #900 was educated on the objective measures, plan of care and how therapy would dress subjective goals. Review of Resident #900's admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #900 was cognitively intact and Resident #900 received OT and PT during the review period. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #900's activities of daily living (ADL) care plan dated 04/26/24, revealed Resident #900 required assistance with ADLs. Interventions included therapy to evaluate and treat as indicated. Review of Resident #900's occupational therapy progress note dated 05/17/24, revealed Resident #900 was frustrated and questioned why he did not receive more therapy and the Occupational Therapist educated Resident #900 that the therapy department was waiting on insurance approval that did not come through and Resident #900 was educated on the need for approval from the insurance company prior to any additional therapy visits. Review of Resident #900's PT progress note dated 05/17/24, revealed Resident #900 was educated on objective measures, discharge rationale and it was suggested resident continue therapy at the next facility. Review of Resident #900's OT discharge summary dated 05/17/24, revealed Resident #900 was discharged due to Resident #100 exhausting benefits or Resident #900 declining treatment. Review of Resident #900's PT discharge summary dated 05/17/24, revealed Resident #900 was discharged per the physician, care manager and the family. Resident #900 had minimal progress towards goals secondary to no treatment sessions. Resident #900 was transferring to a different facility. Resident #900's payer source was listed as private pay. Telephone interview with the Administrator on 06/21/24 at 12:05 P.M., verified Resident #900 only received PT and OT services on 04/16/24 when Resident #900's initial PT and OT evaluations were completed and on 05/17/24 when Resident #900 was discharged from PT and OT services. The Administrator confirmed Resident #900 was ordered and was evaluated to have five PT and five OT sessions in 30 days on 04/16/24. The Administrator verified Resident #900 did not receive any additional documented therapy sessions between the initial PT and OT evaluations on 04/16/24 and PT and OT discharge visit on 05/17/24. The Administrator was not able to provide any information related to the facility billing for therapy services. Resident #900's therapy billing information was requested from the Administrator on 06/18/24 at 3:00 P.M., on 06/20/24 at 8:18 A.M., on 06/20/24 at 4:50 P.M., on again on 06/21/24 at 9:36 A.M. but the requested information was never provided to the state surveying agency. This deficiency represents non-compliance investigated under Complaint Number OH00154204.