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	09/03/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interview, review of facility Self-Reported Incidents (SRIs), review of facility investigation records, and review of the facility policy, the facility failed to ensure residents were free from abuse. This affected one (Resident #25) of three residents reviewed for abuse. The facility census was 128 residents. Findings include: Review of the medical record for Resident #25 revealed the resident an admitted [DATE] with diagnoses including dementia with other behavioral disturbances, Alzheimer's disease, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #25 dated 08/09/24 revealed the resident had severely impaired cognition and had physical, verbal, and other behaviors which put the resident and others at significant risk for injury. Review of the care plan for Resident #25 revised on 08/08/24 revealed the resident was verbally combative with staff, hit staff, and head-butted staff. Interventions included the following: administer medications as ordered, provide one-on-one care as needed, explain all procedures to the resident before starting, allow the resident time to adjust to changes. Review of the progress note for Resident #25 dated 08/06/24 and timed 3:21 P.M. revealed during personal care the resident became combative and head-butted a staff member. The staff member struck the resident multiple times on the head with an open hand. The staff member was immediately separated and sent home. The nurse completed a head-to-toe assessment and a pain assessment for Resident #25 with no negative findings. The nurse notified the unit manager, the physician, and the resident's responsible party of the incident. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility SRI for Resident #25 dated 08/06/24 and initiated at 8:40 P.M. revealed the facility investigated an allegation of abuse towards the resident per State tested Nursing Assistant (STNA) #622 which the facility substantiated as physician abuse. During care Resident #25 head-butted STNA #622 and other staff witnessed the aide strike Resident #25 in the head with an open hand multiple times. STNA #622 was suspended immediately, and the police were notified of the incident. Review of the facility witness statement per Registered Nurse (RN) #435 dated 08/06/24 revealed while staff were providing care to Resident #25, the resident became combative and head-butted STNA #622. STNA #622 then struck Resident #25 multiple times in the head with an open palm. RN #425 immediately separated STNA #622 from the resident and sent the aide home. RN #425 completed a head-to-toe assessment and a pain assessment of Resident #25 with no negative findings. Review of the facility witness statement per STNA #325 dated 08/06/24 revealed while Resident #25 was receiving peri-care he became very aggressive towards staff. Resident #25 head-butted STNA #622, and then STNA #622 struck the resident with an open hand multiple times. Interview on 08/26/24 at 1:15 P.M. with Licensed Practical Nurse (LPN)/Risk Manager #329 confirmed following the incident of abuse on 08/06/24 the facility filed an SRI with the state agency, the police were notified, and an investigation was immediately initiated. LPN/Risk Manager #329 stated RN #435 immediately separated STNA #622 from Resident #25, escorted STNA #622 to the time clock and off facility premises. LPN/Risk Manager #329 confirmed the facility management obtained witness statements from all staff present during the incident and nursing staff conducted body audits for all residents in house to ensure no additional abuse had occurred, and an all staff Inservice on abuse was conducted. LPN/Risk Manager #329 stated as a result of the investigation the allegation of abuse was substantiated and STNA #622 was terminated from employment with the facility. LPN/Risk Manager #329 confirmed an investigation by the police was ongoing. Interview on 08/27/24 at 2:03 P.M. with RN #426 confirmed the nurse was sitting at the nurses' station across the hall from Resident #25's room when STNA #622 exited the room. STNA #622 said Resident #25 had just head-butted her, so she had hit him and made gestures with her hand to indicate hitting. RN #426 stated RN #435 then STNA #622 to the time clock to clock out, and then escorted STNA #622 off facility premises. Interview on 08/27/24 at 2:37 P.M. with STNA #378 confirmed she observed STNA #622 hit Resident #25 in the head with an open hand multiple times following the resident head-butting the aide. STNA #378 confirmed RN #435 immediately escorted STNA #622 out of the room and off facility premises. Review of the facility policy titled Abuse Prevention Program revised December 2016 revealed facility residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration would protect the residents from abuse by anyone including facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. The deficient practice was corrected on 08/13/24 when the facility implemented the following corrective actions: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/06/24, immediately following the witnessed incident of abuse, RN #435 separated STNA #622 from Resident #25 and escorted STNA #622 off facility premises. RN #435 notified the Administrator, physician, and responsible party for Resident #25 of the incident. -On 08/06/24 RN #435 assessed Resident #25 for pain and injuries resulting from abuse with none observed. -On 08/06/24 LPN/Risk Manager #329 filed an SRI with the state agency, filed a police report, and initiated an investigation into the incidence of abuse towards Resident #25. -On 08/06/24 LPN/Risk Manager #329 and/or designee conducted body audits on all residents in house to ensure no evidence of abuse was present. No abnormal findings were discovered. -On 08/06/24 LPN/Risk Manager #329 and/or designee educated all staff on the facility abuse policy. -Interviews with RN #426, RN #431, and STNA #378 on 08/27/24 and 08/28/24 confirmed they had received education on the facility abuse policy on 08/06/24. -Beginning on 08/07/24 audits for abuse were conducted by the Director of Nursing/designee of random residents for concerns of abuse. Audits were conducted daily Monday through Friday and were ongoing at the time of the investigation. No negative findings were identified during the audits. -On 08/13/24 STNA #622 was terminated from employment with the facility following the completion of the facility investigation. This deficiency represents noncompliance investigated under Complaint Number OH00156825.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on medical record review, staff interview, observation, and review of the facility policy, the facility failed to adequately assess residents' skin and failed to ensure adequate care and services were provided to residents to prevent the development and worsening of pressure ulcers. This resulted in Actual Harm for Resident #135 when the facility staff failed to adequately assess the resident's skin and failed to implement timely interventions for a pressure ulcer until the ulcer reached an advanced stage. Actual Harm also occurred for Resident #01 when the facility staff failed to assess the resident's skin and the resident developed an unstageable pressure to the right heel caused by a removable splint device. This affected two (Residents #135 and #01) of the three residents reviewed for pressure ulcers. The facility census was 128. Findings include: 1. Review of the medical record for Resident #135 revealed an admitted [DATE] with diagnoses including muscle weakness, need for assistance with personal care, and type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #135 dated 06/27/24 revealed the resident had intact cognition, had no pressure ulcers present, but was at risk for the development of pressure ulcers. Review of the care plan for Resident #135 most recently revised on 06/21/24 revealed the resident was at increased risk for pressure ulcer development. Interventions included the following: administer treatments as ordered and monitor for effectiveness, offer and assist with toileting on rounds and as needed, pressure reducing mattress to bed. Review of the weekly skin assessments for Resident #135 revealed there were no weekly skin assessments completed for the resident from 06/14/24 until 07/05/24. Review of the hospital emergency department visit note for Resident #135 dated 06/23/24 revealed the resident had superficial stage one sacral decubitus ulcers which did not appear infected with no surrounding erythema or discharge. Review of the nurse progress note for Resident #135 dated 06/23/24 timed 7:27 P.M. revealed Resident #135 returned to the facility from the hospital emergency department with no new orders. There was no skin assessment completed upon Resident #135's return from the hospital on 06/23/24. Review of the shower sheet for Resident #135 dated 06/26/24 revealed the resident had an area of redness to his sacral area. Review of the nurse progress note for Resident #135 dated 07/02/24 a State tested Nursing Assistant (STNA) called the nurse to the resident's room. The nurse arrived and noted an area to the resident's right buttocks which had eschar (dry, black, firm tissue which formed on full thickness wounds.) The resident voiced complaints of pain to his buttocks and the nurse administered as needed pain medication. The nurse notified the physician and the wound physician and received and implemented a treatment order for the wound to the resident's right buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's orders for Resident #135 revealed wound treatment order for the pressure ulcer to the resident's buttocks was not initiated until 07/02/24. Review of the wound physician visit note for Resident #135 dated 07/05/24 revealed the resident had an unstageable pressure ulcer to the right buttocks which measured 8.8 centimeters (cm) in length by 4.7 cm in width with the depth unable to be determined because 50 percent (%) of the wound bed was covered with 50 percent slough (a yellow or white material that accumulates in a wound bed and is made up of dead cells, pus, and other debris.) The wound had a moderate amount of drainage. Interview on 08/27/24 at 11:10 A.M. with Unit Manager (UM)/Licensed Practical Nurse (LPN) #330 confirmed the facility had not completed skin assessments for Resident #135 from 06/14/24 through 07/05/24. UM/LPN #330 further confirmed Resident #135 was assessed to have stage one pressure ulcers present to the sacral area during a hospital visit on 06/23/24, and the facility staff did not assess the resident's skin upon the resident's return from the hospital on 06/23/24. UM/LPN #330 confirmed the facility staff did not identify and implement a treatment for Resident #135 until 07/02/24 when the resident presented with an unstageable pressure ulcer with eschar to the right buttocks, and by that time the resident's pressure ulcer had already reached an advanced stage. Review of the facility policy titled Pressure Ulcer Risk Assessment revised March 2005 revealed if pressure ulcers were not treated when they were discovered, they could quickly get larger, become very painful for the resident, and often become infected. Once a pressure ulcer developed, it could be extremely difficult to heal. Staff should routinely assess and document the condition of the residents' skin per the facility wound and skin care program for any signs and symptoms of irritation or breakdown. Staff should immediately report any signs of a developing pressure ulcer to the supervisor. Staff should assess resident's skin for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 2. Review of the medical record for Resident #01 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, unspecified psychosis, and displaced bimalleolar fracture of the right lower leg. Review of the MDS assessment for Resident #01 dated 07/27/24 revealed the resident had mildly impaired cognition, had no pressure ulcers present, but was at risk for the development of pressure ulcers. Review of the care plan for Resident #01 dated 03/26/24 revealed the resident was at increased risk for pressure ulcer development. Interventions included the following: administer treatments as ordered and monitor for effectiveness, assist with turning and repositioning on rounds and as needed to relieve pressure areas, low air loss mattress to bed. Review of the hospital progress notes for Resident #01 dated 06/20/24 through 07/20/24 revealed the resident had a surgical procedure to the right ankle which required an ortho-glass splint with an ace wrap. Review of facility progress notes, physician's orders, and assessments for Resident #01 dated 07/20/24 to 08/16/24 revealed there was no documentation of a splint to the resident's right leg, ankle, or foot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the wound physician visit note for Resident #01 dated 08/16/24 revealed the resident had an unstageable pressure ulcer which measured 3.1 centimeters in length by 2.6 cm in width covered with eschar to the right heel related to a medical device, a cast boot which was first identified on 08/15/24. Observation on 08/27/24 at 3:50 P.M. revealed Resident #01 had a dime-sized pressure ulcer to the right heel which was covered in eschar. Telephone interview on 08/28/24 at 11:40 A.M. with Wound Physician (WP) #601 confirmed facility staff reported Resident #01 had a cast or splint present to his right foot when he returned from the hospital following surgery on 07/20/24. WP #601 confirmed staff reported when the cast or splint was removed on 08/15/24 staff discovered a new pressure ulcer was present to the resident's right heel. Interview on 08/28/24 at 11:48 A.M. with UM/LPN #330 confirmed there was no documentation of a cast, splint, or other device being present on Resident #1's right foot following the resident's return from the hospital on 07/20/24. Interview on 08/28/24 at 2:20 P.M with Registered Nurse (RN) #431 confirmed Resident #01 returned from the hospital on 07/20/24 with a hard, splint type device in place to the right lower leg and heel which was held in place by an ace bandage. RN #431 confirmed the splint device was removable, but the staff had not removed the device until 08/15/24 when RN #431 removed the splint in order to remove the sutures Resident #01 had in place to the right ankle. RN #431 confirmed staff discovered Resident #01 had developed an unstageable pressure ulcer to the right heel underneath the splint. Review of the facility policy titled Pressure Ulcer Risk Assessment revised March 2005 pressure ulcers were usually formed when a resident remained in the same place position for an extended period of time causing increased pressure or a decrease in circulation to an area, which destroys tissue. Pressure could also come from splints, casts, bandages, or wrinkles in the bed linen. This deficiency represents noncompliance investigated under Complaint Number OH00157073 and Complaint Number OH00156967 and Complaint Number OH00156451.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to provide adequate catheter care for residents with an indwelling urinary catheter. This affected one (Resident #57) of three residents reviewed for urinary catheter use. The facility census was 128 residents. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including extradural and subdural abscess, hepatitis C, paraplegia, congenital malformation of the brain, psychoactive substance abuse, hypertension, depression, sepsis, chronic pain, chronic migraine without aura. Review of physician's orders for Resident #57 revealed an order dated 08/15/24 for staff to straight catheterize the resident as needed every eight hours. If the resident has not voided, reinsert indwelling catheter. There were no physician orders for foley catheter care. Review of the nurse progress note for Resident #57 dated 08/17/24 timed at 7:22 P.M. revealed the nurse changed the resident's indwelling urinary catheter and once the catheter was inserted there was a return of yellow urine in the catheter bag. Review of the Minimum Data Set (MDS) assessment for Resident #57 dated 08/20/24 revealed the resident had minimal cognitive impairment and was dependent on staff for all care. Interview on 08/26/24 at 10:00 A.M with Resident #57 confirmed she had been a resident of the facility since 08/13/24 and had an indwelling catheter since 08/17/24. Resident #57 confirmed she had not received catheter care from staff for seven days, and they only had only been emptying the catheter bag when it was full of urine. Interview on 08/26/24 at 10:15 A.M with Licensed Practical Nurse (LPN) #531 confirmed the facility staff placed an indwelling urinary catheter to Resident #57 on 08/17/24 due to the resident's inability to void. LPN #531 confirmed she had not obtained an order for catheter care to be completed and Resident #57's medical record included no documentation of daily catheter care. Review of the facility policy titled Urinary Catheter Care dated April 2010 revealed the facility staff should empty the urinary collection bag at least every eight hours and staff should provide routine daily hygiene, cleansing of the catheter insertion site using warm soap and water and clean washcloths. This deficiency represents noncompliance investigated under Complaint Number OH00157082 and Complaint Number OH00157073 and Complaint Number OH00156967.

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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** 33023 Based on medical record review, review of hospital discharge record, observation, resident interviews and staff interview the facility failed to provide needed and timely therapy services to residents. This affected one (Resident #57) of three residents reviewed for therapy services. The facility census was 128 residents. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including extradural and subdural abscess, hepatitis C, paraplegia, congenital malformation of the brain, psychoactive substance abuse, hypertension, depression, sepsis, chronic pain, chronic migraine without aura. Review of hospital discharge records for Resident #57 dated 08/13/24 revealed per hospital therapy notes, the resident was required to wear a thoracic-lumbar-sacral orthosis (TLSO) due to a recent thoracic spine surgery conducted while the resident was in the hospital. Review of the Minimum Data Set (MDS) assessment for Resident #57 dated 08/20/24 revealed the resident had minimal cognitive impairment and was dependent on staff for all care. Review of therapy notes revealed Resident #57 received an initial therapy assessment on 08/23/24. Interview with Resident #57 on 08/25/24 at 10:30 A.M. confirmed she had a back brace from the hospital which was lost in transit from the hospital when she admitted to the facility. The resident stated she had not received any therapy services since she admitted to the facility on [DATE]. Interview on 08/26/24 at 1:10 P.M. with Physical Therapist (PT) #451 confirmed Resident #57 was not evaluated for therapy services till 08/23/24, but confirmed the resident did need therapy services. PT #451 confirmed he had seen the recommendation for the back brace for Resident #57 in the hospital therapy notes and had been attempting to clarify whether the use of the brace was mandatory or optional. PT #451 confirmed he did not want to waste the therapy days until a clarification on the back brace could be obtained. Review of the therapy timeline provided by the facility for Resident #57 revealed on 08/15/24 PT #451 called the hospital for clarification on the back brace. PT #451 made a second phone call to the hospital on 08/20/24 with no response. PT #451 made a third telephone call on 08/23/24 to the hospital social worker with no response. Facility therapy services evaluated Resident #57 on 08/23/24 to obtain a baseline and to instruct staff on the shower bed while waiting on the hospital for clarification. On 08/26/24 PT #451 called and got through to the hospital therapy department, but they told him the Occupational Therapist (OT) who had ordered the TLSO brace could not take phone calls until after 4:30 P.M. each day. On 08/28/24 PT #451 called the facility physician who recommended a follow-up with the orthopedic surgeon at the hospital due to no responses from the hospital or hospital therapy services. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) and Physical Therapist #451 on 08/28/24 at 2:00 P.M. confirmed Resident #57 was admitted to the facility on [DATE] and needed therapy services due to a recent back surgery. The DON and PT #451 confirmed the facility had attempted to get clarification of the back brace from the ordering hospital but was not successful. Further interview confirmed Resident #57 had been in the facility for 16 days and had had only a therapy evaluation and had not received therapy services. This deficiency represents noncompliance investigated under Complaint Number OH00157082 and Complaint Number OH00157073 and Complaint Number OH00156967.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review, observation, resident interview, and staff interview, the facility failed to provide an operational call light system which would allow for residents to alert staff of their individual needs. This affected one (Resident #57) of five residents reviewed for functioning call lights. The facility census was 128 residents. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including extradural and subdural abscess, hepatitis C, paraplegia, congenital malformation of the brain, psychoactive substance abuse, hypertension, depression, sepsis, chronic pain, chronic migraine without aura. Review of the Minimum Data Set (MDS) assessment for Resident #57 dated 08/20/24 revealed the resident had minimal cognitive impairment and was dependent on staff for all care. Observation on 08/27/24 at 11:45 A.M. revealed Resident #57's call light was not operational. There was no bell or alternative device for Resident #57 to use in order to summon staff assistance. Interview on 08/27/24 at 11:45 A.M. with Resident #57 confirmed the resident's call light had been non-operational since the evening of 08/26/24. Interview on 08/27/24 at 2:00 P.M. with the Administrator confirmed Resident #57's call light was non-operational and she was unaware of how long it had been that way. The Administrator further confirmed Resident #57 did not have the use of a bell or other device to summon staff assistance. This deficiency represents noncompliance investigated under Complaint Number OH00157082 and Complaint Number OH00157073 and Complaint Number OH00156451.