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	10/23/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on review of the medical record, staff interview, and review of the facility policy, the facility failed to implement timely care and treatment for trauma wounds. This affected one (Resident #64) of three residents reviewed for skin impairment. The facility census was 129 residents. Findings include: Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including multiple myeloma, chronic respiratory failure, malignant neoplasm of brain, and hypertension. Review of the hospital continuity of care (COC) form for Resident #64 dated 09/09/24 revealed the resident had an order to cover the left lower leg wound with Mepilex border and change every three days and as needed for drainage. Resident #64 was to follow-up with the wound care clinic on 09/13/24. Review of the progress note for Resident #64 dated 09/09/24 at 3:55 P.M. revealed the resident was readmitted from the hospital with an open area to the left leg. Review of the wound clinic progress note for Resident #64 dated 09/13/24 revealed the resident had a trauma wound to the left lateral lower leg which was acquired 08/12/24. Wound dressing to the trauma wound was to be completed daily. Review of the Minimum Data Set (MDS) assessment for Resident #64 dated 09/17/24 revealed the resident had moderate cognitive impairment and was dependent on staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #64 revealed an order dated 09/18/24 to cleanse left lateral leg with normal saline, apply Medihoney gel, Mepilex border and secure with Tubi grip once daily. Review of the Treatment Administration Record (TAR) for Resident #64 dated September 2024 revealed the resident did not receive treatments for the left lateral leg wound from 09/09/24 through 09/17/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/21/24 at 2:52 P.M. with the Director of Nursing (DON) confirmed Resident #64 was readmitted from the hospital on 09/09/24 with a trauma wound to the left lower leg. The DON confirmed the hospital COC form included treatment orders for the resident's left lower leg. Further interview with the DON confirmed the treatments orders for Resident #64's trauma wound were not implemented until 09/18/24. Interview on 10/21/24 at 3:50 P.M. with Licensed Practical Nurse (LPN) #24 confirmed Resident #64 was readmitted from the hospital on 09/09/24 with a trauma wound to the left leg, but the facility had not implemented treatment orders for the wound until 09/18/24. Review of the facility policy titled Wound Care dated December 2011 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Staff were to verify a physician's order for the procedure. The following information should be recorded in the resident's medical record: the date the wound care was given, the initials of the individual performing the wound care, any change in resident's condition, any problems made by the resident during procedure, if resident refused the treatment and why, and the signature and title of the person recording the data. This deficiency represents noncompliance investigated under Complaint Number OH00158909 and Complaint Number OH00158323.

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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 - Minimal harm or potential for 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** 44412 Based on review of the medical record, staff interview, and review of the facility policy, the facility failed to implement timely care and treatment for pressure ulcers. This affected one (Resident #64) of three residents reviewed for skin impairment. The facility census was 129 residents. Findings include: Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including multiple myeloma, chronic respiratory failure, malignant neoplasm of brain, and hypertension. Review of the admission skin assessment dated for Resident #64 dated 09/09/24 revealed the resident was readmitted from the hospital with an unstageable pressure ulcer to the left lower leg. Review of the wound clinic progress note for Resident #64 dated 09/13/24 revealed the resident had an unstageable pressure ulcer to the left lower leg and orders were given to complete dressing changes daily. Review of the physician's order for Resident #64 revealed an order dated 09/17/24 revealed to cleanse the pressure ulcer to the left lower leg with normal saline, apply Medihoney and Mepilex border and secure with Tubi grip every day. Review of the Minimum Data Set (MDS) assessment for Resident #64 dated 09/17/24 revealed the resident had moderate cognitive impairment and was dependent on staff assistance with activities of daily living (ADLs.) Review of the Treatment Administration Record (TAR) for Resident #64 dated September 2024 revealed the resident did not receive a treatment to the left lower leg pressure ulcer from 09/09/24 through 09/16/24. Interview on 10/21/24 at 2:52 P.M. with the Director of Nursing (DON) confirmed the treatment order for the unstageable pressure ulcer to Resident #64's left lower leg was not implemented timely. Interview on 10/21/24 at 3:50 P.M. with Licensed Practical Nurse (LPN) #24 confirmed treatment order for the unstageable pressure ulcer to Resident #64's left lower leg was not implemented timely. Review of the facility policy titled Wound Care dated December 2011 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Staff were to verify a physician's order for the procedure. The following information should be recorded in the resident's medical record: the date the wound care was given, the initials of the individual performing the wound care, any change in resident's condition, any problems made by the resident during procedure, if resident refused the treatment and why, and the signature and title of the person recording the data. This deficiency represents noncompliance investigated under Complaint Number OH00158909 and OH00158323. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency is a recite to complaint survey completed 09/03/24.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure the medication error rate was below five percent. The medication error was eight percent (%) with two errors out of 25 medication opportunities observed. This affected one (Resident #61) of three residents reviewed for medication administration. The facility census was 129 residents. Findings include: Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including acute hepatitis C, hypertension, and chronic respiratory failure. Review of the Minimum Data Set (MDS) assessment for Resident #61 dated 08/19/24 revealed the resident had intact cognition and required partial assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #61 revealed orders dated 06/07/24 for vitamin D3 oral tablet 25 micrograms (mcg) once per day and Entresto 24-26 mg two times per day. Observation on 10/16/24 at 9:50 A.M. revealed Licensed Practical Nurse (LPN) #21 did not administer Entresto 24-26 mg to Resident #61 because it was unavailable. LPN #21 administered Vitamin D3 50 mcg to Resident #61 instead of vitamin D3 25 mcg per the physician orders. Interview on 10/16/24 at 9:53 A.M. with LPN #21 confirmed she did not administer Entresto 24-26 mg to Resident #61 because it was unavailable. LPN #21 also confirmed Resident #61's order for vitamin D3 was for a 25 mcg tablet, but she administered a 50 mcg tablet. Review of the facility policy titled Administering Oral Medications dated October 2010 revealed the purpose of the procedure was to provide guidelines for the safe administration of oral medications. Staff should complete the following steps when administering medications: verify the physician's order for the medication, check the label on the medication and confirm the medication name and dose on the Medication Administration Record (MAR), check the medication dose, re-check to confirm the proper dose, document medication administration according to guidelines. This deficiency represents noncompliance investigated under Complaint Number OH00158323.