

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2024
NAME OF PROVIDER OR SUPPLIER  The Chateau at Mountain Crest Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37447</b></p> <p>Based on medical record review, staff interview, review of the facility policy, and review of online guidelines per the American Heart Association (AHA), the facility failed to administer cardiopulmonary resuscitation (CPR) per the facility policy and per professional standards of care. This affected one (Resident #132) of three residents reviewed for change in condition. The facility census was 128 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #132 revealed an admitted [DATE] with diagnoses including multiple sclerosis, dementia, attention-deficit hyperactivity disorder, gastro-esophageal reflux disease, metabolic encephalopathy, morbid obesity and schizophrenia. Resident #132 expired in the facility on [DATE].</p> <p>Review of the care plan for Resident #132 dated [DATE] revealed the resident's code status was full code.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #132 dated [DATE] revealed the resident was moderately impaired for decision making and required staff assistance with activities of daily living (ADLs.)</p> <p>Review of the monthly physician's orders for Resident #132 dated [DATE] revealed the resident's code status was full code.</p> <p>Review of a progress note for Resident #132 per Registered Nurse (RN) #188 dated [DATE] timed at 9:25 P. M. revealed the aide reported to the nurse that the resident was not breathing. When the nurse entered the room, Resident #132 was unresponsive, not responding to verbal stimulation or a sternal rub, and had no pulse, or heart or breath sounds. A code was called per the resident's advance directives with CPR initiated immediately and 911 called.</p> <p>(continued on next page)</p>

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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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 2:12 P.M. with RN #188 confirmed Certified Nursing Assistant (CNA) #236 notified the nurse on [DATE] at approximately 9:20 P.M. when doing rounds that Resident #132 was nonresponsive. RN #188 confirmed he immediately went to the resident's room, assessed her, called a code, immediately started chest compressions, and directed CNA #236 to take over chest compressions while the nurse called 911. RN #188 reported they continued with CPR from approximately 9:25 P.M. until 9:32 P.M. with Registered Nursing Supervisor (RNS) #163 arriving later to assist with CPR. RN #188 confirmed emergency services personnel continued CPR for approximately 30 minutes before stopping as Resident #132 was deceased .</p> <p>Interview on [DATE] at 5:10 P.M. with CNA #236 confirmed when doing rounds around 9:20 P.M. on [DATE] he checked on Resident #132 and noticed she wasn't responding and had no pulse so he went to get RN #188. CNA #236 confirmed RN #188 started chest compressions and the CNA took over chest compressions while the nurse left the room to call 911. CNA #236 confirmed neither he nor RN #188 provided any rescue breaths and further confirmed he did not know how to use the artificial manual breathing unit (Ambu) bag (device used in medical settings to provide rescue breaths.) CNA #236 confirmed after he and RN #188 alternated doing chest compressions for several minutes RNS #163 arrived and set up the ambu bag to deliver rescue breaths.</p> <p>Interview on [DATE] at 6:51 A.M. with CNA #185 confirmed CNA #236 found Resident #132 non-responsive and then ran down the hall to get RN #188. CNA #185 confirmed she, CNA #236, and RN #188 alternated doing chest compressions and no one delivered rescue breaths to the resident until RNS #163 arrived and set up the Ambu bag.</p> <p>Interview on [DATE] at 11:28 A.M. with the RNS #163 confirmed CNA #185 contacted her by phone on [DATE] at 9:27 P.M. to report Resident #132 was not breathing and they needed assistance. RNS #163 confirmed she ran to Resident #132's room and found the resident on the floor receiving chest compressions from RN #188. RNS #163 confirmed no staff were providing rescue breaths to Resident #132, so she got the Ambu bag from the crash cart that was in the room, assembled and connected it and then asked CNA #185 to administer the breaths while she took over the compressions.</p> <p>Interview on [DATE] at 6:52 A.M. with RN #188 confirmed he did not administer any rescue breaths to Resident #132 when he initiated the code and that no one administered rescue breaths to the resident until RNS #163 arrived to the room on [DATE] at approximately 9:27 P.M. during the code in progress.</p> <p>Review of the facility policy titled Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) revised [DATE] revealed the facility's procedure for administering CPR should incorporate the steps covered in the AHA guidelines to include administering rescue breaths.</p> <p>Review of online guidance per the AHA retrieved on [DATE] at <a href="https://cpr.heart.org/en/resources/what-is-cpr">https://cpr.heart.org/en/resources/what-is-cpr</a> revealed for healthcare providers and those trained conventional CPR consisted of using chest compressions and providing rescue breaths at a ratio of 30 compressions to two breaths.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00159255.</p>		