

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 01/30/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39967</p> <p>Based on observation, resident and staff interviews and review of facility policy, the facility failed to maintain comfortable air temperatures and failed to provide a homelike environment. This affected 10 (#01, #02, #03, #04, #05, #06, #07, #08, #09, and #10) out of 123 residents that resided at the facility. The facility census was 123.</p> <p>Findings include:</p> <p>Observation of Maintenance Assistant (MA) #631 revealed he was obtaining air temperatures in resident rooms on 01/27/25 at 9:53 A.M. Further observation revealed Resident #02's room was 57.6 degrees Fahrenheit (F), Resident #06's room was 61.7 degrees F, Resident #07's room was 61.8 degrees F and the common shower room on the women's secured unit was 66.5 degrees F.</p> <p>Interview with MA #631 on 01/27/25 at 9:53 A.M. verified the air temperature in Resident #02's room was 57.6 degrees F, the air temperature in Resident #06's room was 61.7 degrees F, the air temperature in Resident #07's room was 61.8 degrees F, and the air temperature in the shower room on the women's secured unit was 66.5 degrees F. MA #631 confirmed the packaged terminal air conditioner (PTAC) units in Resident #02, Resident #06, and Resident #07's rooms were not working or putting out heat, and the shower room on the women's secured unit had a fan but did not have a heater. MA #631 reported Resident #01, Resident #02, Resident #03, Resident #04, Resident #05, Resident #06, Resident #08, Resident #09, and Resident #10 had their beds moved from their rooms to the dining room on the women's secured unit because there were concerns about air temperatures in the facility.</p> <p>Interview with Resident #02 on 01/27/25 at 10:00 A.M. revealed it was cold in her room and on the women's secured unit. Resident #02 reported she had to sleep in the dining room on the unit due to the air temperature.</p> <p>Interview with Resident #08 on 01/27/25 at 10:10 A.M. revealed she had to sleep in the dining room for approximately one week with all the other residents because the motor burned up in the heater in her room. Resident #08 stated she disliked sleeping in the dining room and it was cold in her room and on the women's secured unit.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Certified Nurse Aide (CNA) #240 on 01/27/25 at 10:11 A.M. verified Resident #01, Resident #02, Resident #03, Resident #04, Resident #05, Resident #06, Resident #08, Resident #09, and Resident #10 had their beds moved from their rooms to the dining room on the women's secured unit last week because the temperature in their rooms was too cold.</p> <p>Interview with the Administrator and Maintenance Director (MD) #252 on 01/28/25 at 2:02 P.M. revealed the facility identified the PTAC units in Resident #02, Resident #06, Resident #07's rooms were not working on 01/21/25. MD #252 stated the facility's heating and cooling company assessed the units on 01/21/25 and it was determined that the units needed new motors. The Administrator stated all the residents on the women's secured unit had their beds moved to the dining room on the unit due to concerns with the heat in the facility on 01/21/25 when the facility had a break in the sprinkler pipe in a different area of the facility. MD #252 reported the residents were moved to the dining room because the dining room had a different heating system that was not impacted by the break in the sprinkler pipe. MD #252 stated the sprinkler pipe was repaired on 01/21/25 and heat was restored to all the rooms in the women's secured unit on 01/21/25 except for Resident #02, Resident #06, and Resident #07's rooms which had PTAC units that were not functioning properly. The Administrator and MD #252 verified Resident #01, Resident #03, Resident #04, Resident #05, Resident #08, Resident #09, and Resident #10's beds were not returned to their rooms on 01/21/25 after heat was restored and that their beds remained in the dining room on the women's secured unit.</p> <p>Further interview with MD #252 on 01/28/25 at 2:45 P.M. revealed he did not have any documentation of the PTAC units in Resident #02, Resident #06, and Resident #07's rooms were inspected in the past year.</p> <p>Review of the facility's homelike environment policy, dated August 2009, revealed the facility shall provide person centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. 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 comfortable temperatures.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161091.</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>39967</p> <p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>Based on observation, resident interview, and staff interview, the facility failed to ensure residents had full visual privacy as required. This affected nine (#01, #02, #03, #04, #05, #06, #08, #09, and #10) out of 123 residents that resided at the facility. The facility census was 123.</p> <p>Findings include:</p> <p>Observation of the dining room on the women's secured unit on 01/27/25 at 9:53 A.M. revealed Resident #01, Resident #02, Resident #03, Resident #04, Resident #05, Resident #06, Resident #08, Resident #09, and Resident #10 had their beds in the dining room on the women's secured unit. There were not any privacy curtains or barriers between the residents' beds and the beds could be visualized by the entire room.</p> <p>Interview with Resident #02 on 01/27/25 at 10:00 A.M. revealed it was cold in her room and on the women's secured unit. Resident #02 reported she had to sleep in the dining room on the unit due to the air temperatures.</p> <p>Interview with Resident #08 on 01/27/25 at 10:10 A.M. revealed she had to sleep in the dining room for approximately one week with all the other residents because the motor burned up in the heater in her room. Resident #08 stated she disliked sleeping in the dining room and it was cold in her room and on the women's secured unit.</p> <p>Interview with Certified Nurse Aide (CNA) #240 on 01/27/25 at 10:11 A.M. verified Resident #01, Resident #02, Resident #03, Resident #04, Resident #05, Resident #06, Resident #08, Resident #09, and Resident #10 had their beds moved from their rooms to the dining room on the women's secured unit last week because the temperature in their rooms was too cold.</p> <p>Interview with the Administrator and Maintenance Director (MD) #252 on 01/28/25 at 2:02 P.M. revealed the facility identified the PTAC units in Resident #02, Resident #06, Resident #07's rooms were not working on 01/21/25. MD #252 stated the facility's heating and cooling company assessed the units on 01/21/25 and it was determined the units needed new motors. The Administrator stated all the residents on the women's secured unit had their beds moved to the dining room on the unit due to concerns with the heat in the facility on 01/21/25 when the facility had a break in the sprinkler pipe in a different area of the facility. MD #252 reported the residents were moved to the dining room because the dining room had a different heating system that was not impacted by the break in the sprinkler pipe. MD #252 stated the sprinkler pipe was repaired on 01/21/25 and heat was restored to all the rooms in the women's secured unit on 01/21/25 except for Resident #02, Resident #06, and Resident #07's rooms which had PTAC units that were not functioning properly. The Administrator and MD #252 verified Resident #01, Resident #03, Resident #04, Resident #05, Resident #08, Resident #09, and Resident #10's beds were not returned to their rooms on 01/21/25 after heat was restored and that their beds remained in the dining room on the women's secured unit.</p> <p>(continued on next page)</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing (DON) on 01/28/25 at 2:50 P.M. verified Resident #01, Resident #02, Resident #03, Resident #04, Resident #05, Resident #06, Resident #08, Resident #09, and Resident #10's beds remained in the dining room on the women's secured unit and there were not any privacy curtains or dividers to provide residents privacy when they were in their beds.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161091.</p>		