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	04/16/2025

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, staff interview, and facility policy review, the facility failed to notify the physician of a resident's significant weight loss. This affected one (#116) of eight residents reviewed for nutrition. The facility census was 119. Findings Included: Review of Resident #116's medical record revealed and admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, frontotemporal neurocognitive disorder, generalized anxiety disorder, major depressive disorder, and vascular dementia severity with other behavioral disturbance. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #116 was severely cognitively impaired. Resident #116 required supervision or touching assistance for meals and dressing the upper body. Resident #116 required partial to moderate assistance for personal hygiene, dressing the lower body, placing shoes on and off the feet, and oral care. Resident #116 required substantial to maximal assistance for bathing and toileting. Resident #116 was self-ambulatory and needed no durable medical equipment. Review of the plan of care dated 02/05/25 revealed Resident #116 required assistance with activities of daily living (ADLs) related to vascular dementia and chronic obstructive pulmonary disease. Interventions included assistance as needed with showers, encourage the resident to participate to the fullest extent possible, give the resident one step commands for completion of ADLs tasks, personal hygiene assistance with weight bearing assistance, staff to assist with completion of ADLs on a daily basis, and therapy to evaluate. Review of a physician order dated 07/31/24 revealed Resident #116 had an order for a no added salt diet with regular texture and thin liquids. Review of the medical record revealed Resident #116 weighed 126.6 pounds on 07/31/24. Review of Resident #116's medical record revealed on 08/07/24 the resident weighed 126.6 pounds, on 08/14/24 weighed the resident weighed 125.4 pounds, on 08/21/24 the resident weighed 125.4 pounds, and on 09/10/24 the resident weighed 124.2 pounds. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nutrition note dated 10/30/24 by Registered Dietician (RD) #705 revealed Resident #116 was on a no added salt diet, thin liquids, and oral intakes varied but were mostly between 75 percent (%) and 100%. The resident's weight for October 2024 was pending and it was reported Resident #116 had a good appetite. RD #705 documented the facility would continue to monitor Resident #116 for necessity of additional nutritional interventions. Review of the medical record revealed Resident #116's weight on 12/10/24 was 135.6 pounds. Review of a nutrition note dated 01/30/25 by RD #705 revealed Resident #116 remained on a no added salt diet with variable intakes, but mostly consumed between 50% and 100% of meals. Resident #116's January 2025 weight was pending and it was documented Resident #116 would be monitored for necessity of additional nutritional interventions. Review of the medical record for Resident #116 revealed on 02/19/25 the resident weighed 88.6 pounds and on 02/27/25 weighed 88.0 pounds. Review of a nutrition note dated 02/28/25 by RD #705 revealed it was recommended Resident #116 be reweighed indicating the documentation was likely inaccurate. Resident #116 was noted with significant weigh loss over 180 days. Review of the medical record for Resident #116 revealed on 04/10/25 the resident weighed 87.8 pounds. Review of the medical record between 07/31/24 and 04/14/25 revealed no documented evidence of Resident #116's physician being notified of the resident's significant weight loss. Observation on 04/07/25 from 11:30 A.M. through 4:30 P.M. revealed Resident #116 continuously walked around the facility. Resident #116 walked around the hallway, in rooms, and very rarely sat down. She walked by herself and used no durable medical equipment for assistance. Interview on 04/14/25 at 1:38 P.M. with the Director of Nursing (DON) verified she was not aware Resident #116 had lost so much weight in the last three months. Interview on 04/14/25 at 1:40 P.M. with RD #705 verified there were several months Resident #116 where the resident was not weighed including October and November 2024, and January and March 2025. RD #705 stated she asked for Resident #116 to be reweighed on 02/28/25 and the March 2025 weight was not reported. The next reported weight loss was on 04/10/25 when the resident was 87.8 pounds. RD #705 stated Resident #116 lost a lot of weight. RD #705 stated her January 2025 nutritional assessment was not complete because she never received the weight for Resident #116. RD #705 stated there was a hand full of residents that had inaccurate documentation and had weights that were not accurate because nurse aides at the facility put them incorrectly. RD #705 stated Resident #116's weights were not put in the medical record, and she could not put an intervention in place as it would not be correct. RD #705 verified there were no nutritional interventions for Resident #116 to address her significant weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/14/25 at 2:10 P.M. with Physician #710 stated Resident #116 had seen some weight loss in the past months likely due to her diagnosis of dementia. Physician #710 stated she was not aware of all the weight loss for Resident #116. Physician #710 confirmed no one at the facility notified her of Resident #116's weight loss or the resident's weights not being obtained on a consistent basis.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51069 Based on observation, resident and staff interviews, medical record review, review of service reports, and policy review, the facility failed to ensure residents were provided a homelike environment. This affected six (#29, #79, #88, #101, #109, and #118) of 17 residents reviewed for environmental concerns. The facility census was 119. Findings Include: 1. Review of the medical record for Resident #29 revealed an admitted [DATE] and diagnoses that included chronic obstructive pulmonary disease, chronic congestive heart disease, and acute kidney failure. Review of Resident #29's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Observation of Resident #29's room on 04/08/25 at 9:47 A.M. revealed an air conditioning unit sitting in an opening in the outer wall. The air conditioning unit did not fit properly in the opening. The sky and other buildings were visible through the gap at the top and sides of the wall opening. A thin plastic window covering was secured around the edges of the air conditioning unit with blue painter's tape and was noted to have holes in it. Interview with Registered Nurse (RN) #324 on 4/09/25 at 1:56 P.M. confirmed the air conditioner unit in Resident #29's room appeared to not be properly installed and light was visible around the top and sides of the unit. Interview with Resident #29 on 04/09/25 at 2:01 P.M. revealed the air conditioning unit was replaced and had never fit properly in the opening it sat in. Resident #29 reported the thin plastic around it did not keep the cold air out. On 04/09/25 at 2:10 P.M., interview with Maintenance Director (MD) #291 revealed Resident #29 had a new air conditioning unit placed about a year ago. The replacement unit was smaller than the opening in the wall for the previous unit but it was placed in the opening anyway. The new air conditioning unit was noted to have space around the top and sides that let light and air through. Clear window plastic was placed over the openings and secured with blue painter's tape in an effort to reduce the air flow from the gaps. MD #291 stated he would fix the gap around the unit with a bracket. Observation of the air conditioning unit in Resident #29's room on 04/10/05 at 8:15 A.M. revealed the thin plastic and painter's tape were not removed, but a plastic frame was placed in front of the plastic and affixed to the top of the opening with a single screw. Light continued to be visible and air was felt through the gap around the air conditioning unit. 2. Review of medical records for Resident #79 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, bipolar disorder, epilepsy, and schizoid personality disorder. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MDS assessment dated [DATE] revealed Resident #79 had mild cognitive impairment. Interview on 04/07/25 at 2:00 P.M. with Resident #79 stated some of the electrical outlets in his room did not work and he was unable to watch television in his room because it was mounted on the wall where the electrical outlets did not work. The resident stated the facility was aware of the issue but had not corrected it. Observation on 04/07/25 at 2:00 P.M. revealed Resident #79's room had outlets that did not provide electricity, including the outlets on the wall where his television was mounted. 3. Review of medical records for Resident #88 revealed an admitted d of 10/17/22 with diagnoses including chronic obstructive pulmonary disease (COPD), psychotic disorder with delusions, and traumatic brain injury. Review of the MDS assessment dated [DATE] revealed Resident #88 had mild cognitive impairment. Observation on 04/07/25 at 3:15 P.M. revealed Resident #88's room did not have electricity in some outlets in his room. 4. Review of medical records for Resident #101 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia and schizoaffective disorder. Review of the MDS assessment dated [DATE] revealed Resident #101 had mild cognitive impairment. Interview on 04/07/25 at 1:20 P.M. with Resident #101 verified some of the electrical outlets did not work in her room. Observation on 04/07/25 at 1:20 P.M. revealed Resident #101's room did not have electricity in all outlets. 5. Review of medical records for Resident #109 revealed the resident admitted on [DATE] with diagnoses including osteomyelitis, acute embolism and thrombosis of deep veins, polyneuropathy, bipolar II, and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #109 was cognitively intact. Interview on 04/07/25 at 1:40 P.M. with Resident #109 stated the electrical outlet in parts of his room did not work. Observation on 04/07/25 at 1:40 P.M. revealed Resident #109's room did not have electricity in all outlets. Interview on 04/07/25 at 4:30 P.M. with the Director of Nursing (DON) verified that not all electrical outlets were working in Resident #109, Resident #101, Resident #88, and Resident #79's rooms. 6. Review of medical records for Resident #118 revealed an admitted [DATE] with diagnoses of extradural and subdural abscess, osteomyelitis, and Arnold Chiari Syndrome. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment dated [DATE] revealed Resident #118 had mild cognitive impairment. Observation on 04/07/25 at 2:56 P.M. revealed Resident #118's room did not have electricity in all outlets. Interview on 04/08/25 at 11:00 A.M. with the DON verified the electrical outlets were not working in parts of Resident's #118's room. Review of a service report dated 02/17/25 revealed an electrical contractor identified a short in a wall that affected two rooms with no power. Review of the facility policy titled, Homelike Environment-Quality of Life, dated 11/28/17, revealed residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to extent possible including but not limited to receiving treatment and supports for daily living safely. This deficiency represents non-compliance investigated under Complaint Number OH00163411, Complaint Number OH00162927, Complaint Number OH00162789, and Complaint Number OH00162565. 44080

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40471 Based on medical record review, resident and resident family interview, staff interview, review of incident reports, and policy review, the facility failed to ensure care conferences were conducted timely as required and failed to ensure care plans were updated timely when new interventions were implemented. This affected six (#59, #79, #98, #116, #118, and #120) of 32 residents reviewed for care plans. The census was 119. Findings include: 1. Review of the medical records for Resident #79 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, bipolar disorder, epilepsy, and schizoid personality disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 had mild cognitive impairment. Review of care conference documentation revealed conferences were held for Resident #79 on 03/12/24, 06/07/24, and 10/21/24. There was no documented care conference for the first quarter of 2025. 2. Review of Resident #98's medical record revealed an admitted [DATE] with diagnoses including chronic disease, seizures, and schizophrenia. Review of the MDS assessment dated [DATE] revealed Resident #98 was cognitively intact. Review of care conferences revealed conferences were held for Resident #98 on 03/25/24, 05/14/24, 09/17/24, and 04/01/25. There was no evidence of a care conference in the fourth quarter of 2024 or the first quarter of 2025. 3. Review of Resident #118's medical records revealed an admitted [DATE] with diagnoses of extradural and subdural abscess, osteomyelitis, and Arnold Chiari Syndrome. Review of the MDS assessment dated [DATE] revealed Resident #118 had mild cognitive impairment. Review of notes for Resident #118's care conference dated 03/13/25 revealed it did not happening due to the resident being unavailable and would be rescheduled but no follow up care conference was performed. Interview on 04/14/25 at 11:31 A.M. with MDS Registered Nurse (RN) #257 verified the documented care conferences for Resident #79 were the only care conferences that took place, and there was no evidence of additional care conferences. MDS RN #257 further verified care conference were not completed timely for Resident #98 and Resident #118 for the first quarter of 2025. 42492 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record revealed Resident #120 was admitted to the facility on [DATE]. Diagnoses included Huntington's disease, unspecified dementia with behavioral disturbances, anxiety disorder, and unspecified depression. Review of the most recent MDS assessment dated [DATE] revealed Resident #120 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the care plan dated 11/04/24 revealed Resident #120 was at increased risk for falls related to deconditioning, weakness, impaired balance, poor safety awareness, medication use related to Huntington's disease, and dementia. Interventions included keeping the call light within reach, encouraging the resident to ask for assistance, therapy evaluations as ordered, observing for side effects to medications, providing activities of daily living (ADL) assistance as needed, and monitoring, documenting, reporting changes in mental status or pain. Review of the care plan dated 02/27/25 revealed Resident #120 had an actual unwitnessed falls with no injuries on 12/07/24 and 12/22/24, and an unwitnessed fall with a scalp laceration on 02/20/25. Interventions included monitoring, documenting, and reporting changes in pain or mental status for 72 hours, initiating neurological checks, and consulting with physical therapy for strength and mobility. Review of the progress notes revealed Resident #120 had an unwitnessed fall on 12/07/24 at 12:34 A.M. during which he sustained a laceration to the right upper eye. The nurse implemented non-skid socks immediately for fall prevention. Review of an incident report dated 12/07/24 revealed interventions recommended for Resident #120's fall prevention included monitoring for delayed injuries and pain, notifying therapy to assist with fall interventions, providing treatments as per orders, and consulting the pharmacy to evaluate medications. Review of incident report dated 02/20/25 revealed resident fell due to noncompliance with safety precautions and ambulating without assistance. Interventions included therapy consult and frequent (increased) monitoring to assist with transfers related to noncompliance with requesting assistance. During an interview on 04/10/25 at 3:13 P.M. the Director of Nursing (DON) verified the nursing intervention documented in the progress note for the fall on 12/07/24 for non-skid socks was not placed on the care plan. The DON stated typically when risk management reviewed falls and completed the root cause analysis (RCA), the interdisciplinary team (IDT) decide what intervention to put in place. The non-skid footwear was an immediate intervention the nurse initiated at the time of the fall, but was not the intervention the IDT team put in place. The intervention the IDT team put in placed was for a pharmacy/medication review. The DON stated after the fall on 02/20/25, the IDT team sent Resident #120 to the emergency room and placed increased monitoring to assist with transfers. The final intervention that was added related to the care plan was for a scoop mattress. The DON stated that was not included on the RCA because the facility had to order the mattress first. She stated it was added to the care plan on 02/24/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/14/25 at 8:27 A.M. the DON stated the intervention for Resident #120's fall on 12/07/24 was to have a pharmacy review for medications. The DON verified the intervention was not on the resident's care plan. The DON stated the intervention for Resident #120's fall on 02/20/25 was a scoop mattress. The DON verified that intervention was not created in the care plan until 04/10/25 although it was back-dated in the documentation to look like it was initiated on 02/24/25. 44080 5. Review of the medical records for Resident #116 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, frontotemporal neurocognitive disorder, generalized anxiety disorder, major depressive disorder, and vascular dementia severity with other behavioral disturbance. Review of a quarterly MDS assessment dated [DATE] revealed Resident #116 had severely impaired cognition. Review of the medical records for Resident #116 revealed care conference were held on 08/01/24 with a daughter present and on 11/13/24 with no family member present. Interview on 04/08/25 at 8:27 A.M. with Resident #116's daughter stated she never had a care conference at the facility. Resident #116's daughter stated she had one call a month ago and was told Resident #116 fell . Resident #116's daughter stated she would like to attend care conferences since the facility did not answer the telephone when she called. Interview on 04/14/25 at 11:25 A.M. with MDS RN #257 stated she did not perform care conferences at the facility. MDS RN #257 verified Resident #116 only had two care conferences at the facility and should have had more. 51069 6. Review of the medical record for Resident #59 revealed an admitted [DATE] and diagnoses included stage III chronic kidney disease, type II diabetes mellitus, depression, and anxiety disorder. Review of Resident #59's MDS assessment dated [DATE] revealed the resident had mild cognitive impairment. Review of care conference documentation revealed the facility scheduled care conferences for Resident #59 on 07/11/24, 10/14/24, and 03/27/25. Resident #59 was noted to be out of the facility on 10/14/24 and 03/27/25 and quarterly care conferences would be rescheduled. Further review revealed no care conferences were rescheduled for Resident #59. Interview 04/10/25 at 12:43 P.M. with Resident #59 revealed the resident did not recall having a care conference for a very long time. Interview 04/10/25 at 1:04 P.M. with Social Worker (SW) #173 confirmed Resident #59 had not had a care conference since 07/11/24 and care conferences scheduled for 10/14/24 and 03/27/25 were not completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with MDS Nurse #257 on 04/14/25 at 11:26 A.M. confirmed care conferences were to be held quarterly and should be rescheduled at the earliest convenience of the resident if the resident is out of the facility at the time of the scheduled care conference. Review of policy titled, Care Planning, dated December 2008, revealed the interdisciplinary team was responsible for the development of individualized comprehensive care plans and the resident, resident's family, and/or resident's representative were encouraged to participate in developing and revising the residents care plan during care plan meetings that were scheduled at times of day convenient to the resident and family.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on medical record review, resident and staff interview, and review of resident lists, the facility failed to ensure residents received follow-up care for audiology services. This affected one (#10) of six residents reviewed for ancillary services. The facility census was 119. Findings include: Review of the medical record revealed Resident # 10 was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder bipolar type, unspecified anxiety disorder, unspecified impulse disorder, pseudobulbar affect, and type II diabetes. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 10 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #10 had adequate hearing with no hearing aids. Review of the care plan dated 01/30/24 revealed Resident # 10 had potential for inability to understand others related to decline in cognitive status. Interventions included to refer for an audiology evaluation as needed. Review of an audiologist visit document dated 05/30/24 revealed Resident # 10 had a history of impacted cerumen (ear wax) and currently had impacted cerumen bilaterally which completely occluded the ear canals. The audiologist instilled ear wax removal drops to both ears, but Resident #10 declined cerumen removal attempts. Recommendations included cerumen evaluation in four to six months. Further review of Resident #10's medical record revealed no further documentation provided regarding follow up appointments to address impacted cerumen since the appointment on 05/30/24. The facility provided a list of residents who had been seen for audiology services on 02/06/25, and Resident #10 was not seen. During an interview on 04/07/25 at 2:05 P.M., Resident # 10 stated his right ear kept clogging up and he had never seen an audiologist at the facility. During an interview on 04/10/25 at 3:32 P.M., Social Worker (SW) #173 verified Resident #10 had not been seen by audiologist since last appointment on record on 05/30/24. During an interview on 04/14/25 at 9:59 A.M., Care Referral Specialist #333 stated Resident #10 was not scheduled for or refused any audiology appointments since 05/30/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, medical record review, staff interview, interview with local health clinic staff, review of hospital documentation, and policy review, the facility failed to recognize potential hazards related to residents attending community appointments unsupervised an failed to ensure a resident was properly assessed for use of a sit-to-stand lift for transfers. This affected one (#75) of one residents sampled for community appointments and one (#5) of 10 residents reviewed for accidents and hazards. The facility census was 119. Findings include: 1. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] and was discharged on [DATE]. Diagnoses included unspecified dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD), unspecified severe protein calorie malnutrition, unspecified anxiety disorder, unspecified psychosis, mixed adjustment disorder, psychotic disorder with delusion, and alcohol dependence. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had self-directed behaviors, did not reject care, and did not wander. Review of the care plan dated 06/06/23 revealed Resident #75 wanted to discharge to an apartment. Family had concerns about independent living and advised assisted living. The family indicated the resident had failed at independent living in the past and ended up homeless. Interventions included identifying barriers to discharge goals, educating the resident to assist with a successful discharge, identifying home service needs, identifying home equipment needs, and identifying the resident's desired location for discharge. Review of the care plan dated 10/28/24 revealed Resident #75 was at risk for elopement related to impaired safety awareness, hovering near exit doors, and expressing desires to return to the community. Resident #75 resided on a secured unit related to impaired cognitive function. Interventions included distracting the resident from wandering, identifying patterns of wandering, and monitoring for tailgating behaviors. Review of a secured unit evaluation dated 01/08/25 revealed Resident #75 did not wander, was able to ambulate independently, had combative behaviors that could be managed on a general unit, could perform activities of daily living (ADLs) independently or with one-person assistance, and residing on a secured unit was the least restrictive approach to ensuring his safety. (continued on next page)

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	365005	A. Building B. Wing	04/16/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes revealed on 03/24/25 a 6:35 P.M., Resident # 75 went to an appointment at a health clinic via transport provided by the clinic. Upon noting Resident #75 had not returned to the facility, Registered Nurse (RN) #169 attempted to call both the clinic and the resident and received no answer from either. RN #169 notified the unit manager and Resident #75's daughter. On 03/24/25 at 8:58 P.M., Resident #75 contacted RN #169 and reported he was not coming back to the facility. The unit manager notified Resident #75's daughter and the provider on-call. On 03/26/25, Social Worker (SW) #173 attempted to call the local police department twice with no answer. On 03/26/25 at 4:02 P.M., SW #173 contacted adult protective services (APS) and informed the facility the family should contact the police and file a police report. When SW#173 contacted the family, Resident #75's daughter stated Resident #75 called her from another location in the same county as the facility. She reported the information to the police, but when police arrived at the location, Resident #75 was not located. On 03/27/25 at 6:31 P.M., RN #169 contacted the local police department, an officer came to the facility, and the facility filed a police report. During an interview on 04/03/25 at 9:30 A.M., RN #169 stated Resident #75 approached him on 03/24/25 between 12:30 P.M. and 1:00 P.M. holding papers in his hands and stated he had an appointment at a health clinic. The car was waiting outside to take him. RN #169 stated the appointment was a follow up to a lung examination. RN #169 stated Resident #75 had been to multiple appointments at that clinic in the past and would go unsupervised. In the past, the clinic sent either an Uber car or a marked van to pick him up and always returned Resident #75 to the facility after the appointments. RN #169 stated he became concerned when Resident #75 had not returned between 4:00 P.M. to 5:00 P.M. RN #169 stated when he attempted to contact the clinic, the clinic was closed, and after-hours staff were not able to provide any information. RN #169 stated he attempted to telephone and text message Resident #75 but got no response. Resident #75 telephoned RN #169 between 7:00 P.M. and 8:00 P.M. and stated he would not be returning to the facility. Resident #75 indicated he was unharmed. When RN #169 notified Resident #75's family, the daughter reported Resident #75 had already informed her he had left the facility and was not returning. She indicated Resident #75 was safe but did not know where he was staying or how he would get his medications. RN #169 stated the social worker had contacted APS and asked RN #169 to contact the police after her attempts were unsuccessful. RN #169 stated he contacted police and they came to the facility to file the report. During an interview on 04/03/25 at 3:05 P.M., the Director of Nursing (DON) stated the clinic sent an unmarked car to pick Resident #75 up for his appointment at the health clinic. RN #169 tried to call the clinic when Resident #75 did not return. The DON verified no one from the facility attempted to follow up further with the clinic after Resident #75 called and reported he was discharging himself against medical advice (AMA). The DON stated all appointments were kept in an appointment log. The DON verified Resident #75 did not have an appointment listed on the appointment log for 03/24/25 and told the nurse at the last minute about the appointment. The DON stated the incident was not reported as an elopement but was considered a case of a resident leaving AMA. The DON stated SW #173 informed her the procedure in the past for any resident who left AMA included reporting to APS and the police for safety when the resident went to an unknown location and had no access to medications, but that was not in any policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/03/25 at 3:17 P.M. a Service Advocate at the health clinic stated Resident #75's last scheduled appointment was 03/10/25 at the clinic, and Resident #75 did not show up to the appointment. The service advocate stated Resident #75 did not have an appointment at the clinic on 03/24/25 and the clinic did not send a vehicle to the facility to pick Resident #75 up from the facility. The service advocate stated if the clinic had picked up a resident from a facility for an appointment, they would have returned the resident to his facility after the appointment as part of their service. During an interview on 04/03/25 at 4:12 P.M., RN #169 verified he was unaware Resident #75 had an appointment until Resident #75 told him he had an appointment on 03/24/25. RN #169 verified Resident #75 approached him with a bunch of papers in his hands and stated the car was outside to pick him up for his appointment at the clinic. RN #169 confirmed he did not look at the papers Resident #75 held in his hand to verify that the resident had an appointment before he allowed Resident #75 to leave the unit. RN #169 stated he watched Resident #75 get into the backseat of of an unmarked car which he assumed was an Uber provided by the health clinic. RN #169 verified he did not attempt to re-contact staff at the health clinic after Resident #75 reported he was not returning to the facility on [DATE]. Review of policy titled, Elopements, dated December 2007 revealed the facility investigated and reported all cases of missing residents. 2. Review of the medical record for Resident #50 revealed an admitted d 03/29/24. Diagnoses included cognitive communication deficit, chronic diastolic heart failure, chronic obstructive pulmonary disease, atrial fibrillation, major depressive disorder, anxiety, and dementia. Review of an admission document dated 03/29/24 for Resident #50 revealed he was assessed as a two-person transfer in mechanical lift. Review of the hospital discharge summary dated 03/11/25 revealed Resident #50 was admitted to local hospital with onset of stroke-like symptoms that included leaning to the left side and was more confused and aphasic than his baseline. Resident #50 was negative for hemorrhage or evolving ischemia. Review of a quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. Resident #50 was assessed to require supervision or touching assistance for meals. Resident #50 required partial to moderate assistance for oral care. Resident #50 was dependent for dressing the upper and lower body, placing shoes on and off, personal hygiene, toileting, and bathing. Resident #50 used a wheelchair to ambulate with staff at the facility. Review of the plan of care dated 03/27/25 revealed Resident #50 was at risk for falls, having history of falls. Interventions included frequent monitoring for attempting to transfer self from the bed, air loss mattress overlay with bolsters, frequent monitoring for attempting to transfer self from bed, leave the door open if the resident allowed to visualize him, occupational therapy to evaluate related to increased weakness, provide activities that promote exercise, and physical consult for strength and mobility. Resident #50 was at risk for assistance with activities of daily living related to muscle weakness, dementia, aphasia, and congestive heart failure. Interventions included staff to assist with completion of activity of daily living on a daily basis, therapy to evaluate and treat, and the resident was transferring assist with weight-bearing assistance. Resident #50 used a wheelchair with staff ambulating him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/09/25 from 11:18 A.M. through 11:31 A.M. revealed Certified Nurse Aid (CNA) #165 and CNA #192 assisted Resident #50 with care, dressing, and providing a transfer out of the bed. CNA #165 and CNA #192 placed a sit-to-stand lift chest lift pad under Resident #50's arms and locked in the legs to both leg straps on each shin rest at the lower lift bar. Resident #50 was educated to stand and hold the handle grips on the sit-to-stand when being lift. Resident #50 held the sit-to-stand lift grip to the right hand tightly, and the left hand he lightly grabbed the bar under the bar handle. CNA #165 verified at 11:27 A.M. Resident #50 let go of his left hand and dangled his entire arm to the left side. Resident #50 transferred to the wheelchair by sit-to-stand with two nurse aides and in wheelchair. Resident #50 was leaning in wheelchair to the left side. Interview on 04/09/25 at 12:44 P.M. with Therapy Director (TD) #153 stated Resident #50 was not assessed for sit-to-stand lift to be used. TD #153 stated Resident #50 was private pay for the therapy. TD #153 stated the resident's power of attorney did not want to pay for his therapy. Resident #50 was a contact guard assist with about 25 percent (%) with hands with therapy. Resident #50 should have been transferred with a gait belt with two person assist at this time. TD #153 stated he was in the process of getting a new wheelchair with a splint to left arm due to weakness from a recent stroke a month ago. TD #153 stated if Resident #50 was not holding the handle grips on the sit-to-stand lift, then it was a concern since he would have left side weakness in his leg. TD #153 stated Resident #50 would need evaluation for using a lift with transfers. Interview on 04/09/25 at 1:01 P.M. with the DON stated she expected staff would assess Resident #50 when admitted to the facility. The DON stated he was assessed on admission with a nurse for a mechanical lift. Review of the facility document titled, Lift Transfer Reposition Evaluation, dated 03/29/25, revealed Resident #50 had an evaluation that he was a two-person transfer and was unable to provide 50% assistance during transfer or transfers without assistance using a slide board. Resident #50 can sit-to the side of the bed or have limited assistance to sit up, and the type of lift indicated was a sit-to-stand lift. Review of the facility document titled, Safe Lifting and Movement of Residents, dated October 2009, revealed in order to protect the safety and well-being of staff and residents, and to promote quality of care, the facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care of plan. Such an assessment shall include residents' preferences for assistance, mobility, residents size, weight-bearing ability, cognitive status, whether residents were usually cooperative with staff, and goals for rehabilitation. This deficiency represents non-compliance investigated under Master Complaint Number OH00164250, Complaint Number OH00162927, and Complaint Number OH00163411. 44080

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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** 44080 Based on observation, medical record review, staff interview, and facility policy review, the facility failed to provide timely assistance for a resident who was dependent for incontinence care. This affected one (#5) of one residents reviewed for incontinence. The facility census was 119. Findings Included: Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included spastic diplegic cerebral palsy, impulse disorder, epilepsy, psychotic disorder, bipolar disorder, dementia, intermittent explosive disorder, bipolar two disorder, anxiety disorder, and intellectual disabilities. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had moderately impaired cognition. Resident #5 required substantial assistance for meals, oral care, dressing the upper body, and personal hygiene. Resident #5 was dependent for putting on and taking off shoes, dressing the lower body, toileting, and bathing. Review of a plan of care dated 01/17/25 revealed Resident #5 was at risk for activities of daily living (ADLs) self-care performance deficit related to disease process. Resident #5 was at risk for decline in physical function related to osteoarthritis. Interventions included assistance as needed with showers twice weekly, encouraging the resident to participate to the fullest extent, and total dependence with showers and personal care. Review of the care plan dated 01/17/25 revealed Resident #5 had potential for impairment to the skin integrity related to incontinence and decreased mobility. Resident #5 was at risk for decline in his continence status related to his current medical condition, impaired cognition, and overall medical condition. Resident #5 required assistance from staff for toileting and was incontinent of bowel and bladder. Interventions included urinary incontinence brief use, clean peri-area with each incontinence episode, and check the resident for incontinence during rounds. Observation on 04/07/25 from 1:39 P.M. through 4:31 P.M. revealed Resident #5 was sitting in the main lobby watching television. During this timeframe, Certified Nurse Aide (CNA) #228 was moved to another hall and left the floor. Interview on 04/07/25 at 3:05 P.M. with Licensed Practical Nurse (LPN) #254 stated CNA #228 was pulled to another floor to work. Interview on 04/07/25 at 4:31 P.M. with LPN #254 verified Resident #5 was moderately saturated with urine in incontinent brief and was wet. LPN #254 also verified Resident #5 had an old scar area to the right upper buttocks. Interview on 04/09/25 at 11:54 A.M. with CNA #228 stated he left the floor on memory care unit at 3:00 P.M. and was pulled to another floor. CNA #228 stated Resident #5 was last changed for incontinence before lunch at 12:20 P.M. as the lunch was later that day. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility document titled, Perineal Care, revealed the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Review the resident's care plan to assess for any special needs of the resident. Also report other information in accordance with facility policy and professional standards of practice. This deficiency represents non-compliance investigated under Complaint Number OH00162789.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, staff interview, and facility policy review, the facility failed to monitor weights on a consistent basis and failed to address and implement interventions for a resident with significant weight loss in a timely manner. This affected one (#116) of eight residents reviewed for nutrition. The facility census was 119. Findings Included: Review of Resident #116's medical record revealed and admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, frontotemporal neurocognitive disorder, generalized anxiety disorder, major depressive disorder, and vascular dementia severity with other behavioral disturbance. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #116 was severely cognitively impaired. Resident #116 required supervision or touching assistance for meals and dressing the upper body. Resident #116 required partial to moderate assistance for personal hygiene, dressing the lower body, placing shoes on and off the feet, and oral care. Resident #116 required substantial to maximal assistance for bathing and toileting. Resident #116 was self-ambulatory and needed no durable medical equipment. Review of the plan of care dated 02/05/25 revealed Resident #116 required assistance with activities of daily living (ADLs) related to vascular dementia and chronic obstructive pulmonary disease. Interventions included assistance as needed with showers, encourage the resident to participate to the fullest extent possible, give the resident one step commands for completion of ADLs tasks, personal hygiene assistance with weight bearing assistance, staff to assist with completion of ADLs on a daily basis, and therapy to evaluate. Review of a physician order dated 07/31/24 revealed Resident #116 had an order for a no added salt diet with regular texture and thin liquids. Review of the medical record revealed Resident #116 weighed 126.6 pounds on 07/31/24. Review of Resident #116's medical record revealed on 08/07/24 the resident weighed 126.6 pounds, on 08/14/24 weighed the resident weighed 125.4 pounds, on 08/21/24 the resident weighed 125.4 pounds, and on 09/10/24 the resident weighed 124.2 pounds. Review of a nutrition note dated 10/30/24 by Registered Dietician (RD) #705 revealed Resident #116 was on a no added salt diet, thin liquids, and oral intakes varied but were mostly between 75 percent (%) and 100%. The resident's weight for October 2024 was pending and it was reported Resident #116 had a good appetite. RD #705 documented the facility would continue to monitor Resident #116 for necessity of additional nutritional interventions. Review of the medical record revealed Resident #116's weight on 12/10/24 was 135.6 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nutrition note dated 01/30/25 by RD #705 revealed Resident #116 remained on a no added salt diet with variable intakes, but mostly consumed between 50% and 100% of meals. Resident #116's January 2025 weight was pending and it was documented Resident #116 would be monitored for necessity of additional nutritional interventions. Review of the medical record for Resident #116 revealed on 02/19/25 the resident weighed 88.6 pounds and on 02/27/25 weighed 88.0 pounds. Review of a nutrition note dated 02/28/25 by RD #705 revealed it was recommended Resident #116 be reweighed indicating the documentation was likely inaccurate. Resident #116 was noted with significant weigh loss over 180 days. Review of the medical record for Resident #116 revealed on 04/10/25 the resident weighed 87.8 pounds. Review of the medical record between 07/31/24 and 04/14/25 revealed no nutritional interventions were implemented, including nutritional drinks or supplements, to address Resident #116's significant weight loss. Observation on 04/07/25 from 11:30 A.M. through 4:30 P.M. revealed Resident #116 continuously walked around the facility. Resident #116 walked around the hallway, in rooms, and very rarely sat down. She walked by herself and used no durable medical equipment for assistance. Interview on 04/14/25 at 1:38 P.M. with the Director of Nursing (DON) verified she was not aware Resident #116 had lost so much weight in the last three months. Interview on 04/14/25 at 1:40 P.M. with RD #705 verified there were several months Resident #116 where the resident was not weighed including October and November 2024, and January and March 2025. RD #705 stated she asked for Resident #116 to be reweighed on 02/28/25 and the March 2025 weight was not reported. The next reported weight loss was on 04/10/25 when the resident was 87.8 pounds. RD #705 stated Resident #116 lost a lot of weight. RD #705 stated her January 2025 nutritional assessment was not complete because she never received the weight for Resident #116. RD #705 stated there was a hand full of residents that had inaccurate documentation and had weights that were not accurate because nurse aides at the facility put them incorrectly. RD #705 stated Resident #116's weights were not put in the medical record, and she could not put an intervention in place as it would not be correct. RD #705 verified there were no nutritional interventions for Resident #116 to address her significant weight loss. Interview on 04/14/25 at 2:10 P.M. with Physician #710 stated Resident #116 had seen some weight loss in the past months likely due to her diagnosis of dementia. Physician #710 stated she was not aware of all the weight loss for Resident #116. Physician #710 stated no one at the facility notified her of Resident #116's weight loss or the resident's weights not being obtained on a consistent basis. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Weight Assessment and Intervention, dated December 2008, revealed the multidisciplinary team will strive to prevent, monitor, and intervene for weight loss for the residents. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51069 Based on observation and staff interview, the facility failed to ensure medications were secure and inaccessible to unauthorized staff and residents. This had the potential to affect five (#31, #54, #79, #84, and #109) of five residents observed in the hallway during medication administration. The facility census was 119. Findings Include: Observation on 04/09/25 at 9:00 A.M., during medication administration, Registered Nurse (RN) #260 was observed to discard two 300 milligram (mg) gabapentin capsules and one five (5) mg memantine tablet into the open trash receptacle on the end of the medication cart. RN #260 left the medication cart locked and unattended on four occasions to administer medications during observation. The medication cart was placed in a common area between the front entrance to the facility and the rehabilitation room. Five (#31, #54, #79, #84 and #109) residents were observed to be in the hallway when the medication cart was left unattended with three unsecured pills in the trash receptacle. Interview with RN #260 on 04/09/25 at 9:11 A.M. confirmed the three medications should not have been discarded in an unsecure trash receptacle and stated any resident who walked by had access to those medications. Interview with the Director of Nursing (DON) 04/09/2025 at 12:30 P.M. revealed no medications should be left unattended where residents had access to them.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review and staff interview, the facility failed to obtain laboratory values as ordered by the physician. This affected three (#5, #116, and #118) of 32 resident medical records reviewed. The facility census was 119. Findings Included: 1. Review of medical records for Resident #5 revealed an admitted [DATE]. Diagnoses included spastic diplegic cerebral palsy, impulse disorder, epilepsy, psychotic disorder, bipolar disorder, dementia, intermittent explosive disorder, bipolar two disorder, anxiety disorder, and intellectual disabilities. Review of a physician order dated 02/19/24 revealed Resident #5 had an order for laboratory tests for a complete blood count (CBC), renal panel, and Dilantin level every February, May, August, and November. Review of a physician order dated 02/19/24 revealed Resident #5 had an order for laboratory tests for fasting lipid panel, liver function test, hemoglobin A1C, and prostate specific antigen (PSA) yearly that was due April. Review of a physician order dated 02/19/24 revealed Resident #5 had an order for laboratory tests for a Phenytoin level every three months. Review of a facility document titled, Laboratory Result, dated 05/21/24, revealed Resident #5 had laboratory values obtained for a renal panel, lipid function panel, PSA, hemoglobin A1C, CBC, platelet level, and Phenytoin level. Review of a facility document titled, Laboratory Result, dated 10/03/24, revealed Resident #5 had laboratory values obtained for a renal panel, lipid function panel, hemoglobin A1C, CBC, platelet level, valproic acid level, and Phenytoin level. Review of a facility document titled, Laboratory Result, dated 04/01/25, revealed Resident #5 had laboratory values obtained for a renal panel, lipid function panel, CBC, and platelet level. Interview on 04/10/25 at 2:40 P.M. with the Director of Nursing (DON) stated she could not find anymore laboratory results for Resident #5 and stated all ordered laboratory values were not completed as ordered. 2. Review of medical records for Resident #116 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, frontotemporal neurocognitive disorder, generalized anxiety disorder, major depressive disorder, and vascular dementia severity with other behavioral disturbance. Review of physician order dated 08/02/24 revealed Resident #116 had an order to obtain a lipid panel and hepatic function every six months. (continued on next page)

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	365005	A. Building B. Wing	04/16/2025

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

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document titled, Laboratory Result, dated 08/02/24, revealed Resident #116 had laboratory tests completed for a CBC with differential, platelet count, renal function, hepatic panel, lipid panel, thyroid stimulating hormone (TSH), and prealbumin. Review of a physician order dated 09/01/24 revealed Resident #116 had an order for CBC with differential and renal panel every three months. Interview on 04/10/25 at 2:00 P.M. with DON verified the laboratory results in Resident #116's medical record were the only values available and stated the tests were integrated with the laboratory company and show up in electronic chart. Interview on 04/10/25 at 2:40 P.M. with the DON stated there were no additional laboratory values available for Resident #16 and confirmed the laboratory tests were not completed as ordered. 40471 3. Review of the medical record for Resident #118 revealed an admitted [DATE] with diagnoses of extradural and subdural abscess, osteomyelitis, and Arnold Chiari Syndrome. Review of a physician order dated 03/22/25 revealed an order for a toxicology drug screen. Review of laboratory results revealed no toxicology drug screen was completed for Resident #118. Interview on 04/14/25 at 1:47 P.M. with the DON verified no toxicology drug screen was performed for Resident #118.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, resident and staff interview, and medical record review, the facility failed to serve food in a form to to meet resident needs. This affected one (#28) of eight residents reviewed for nutrition. The facility census was 119. Findings Included: Review of the medical record revealed Resident #28 was admitted on [DATE]. Diagnoses included dysphagia oropharyngeal phase, cognitive communication deficit, occlusion and stenosis of the right carotid artery, chronic diastolic heart failure, type two diabetes, atrial fibrillation, anxiety disorder, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact. Review of the physician order dated 11/04/24 revealed Resident #28 was ordered a regular diet with mechanical soft texture and thin liquids. Review of the care plan dated 04/14/25 revealed Resident #28 required monitoring of intakes, weight, skin, laboratory values, medication, diet tolerance, and to serve the diet as ordered. A registered dietitian was to evaluate and make diet change recommendations as needed. Observation on 04/07/25 at 5:20 P.M. revealed Resident #28 was served brussel sprouts that were sliced with the leaves whole, approximately three pieces of chopped meat in approximately one and one-half inch to two inch squares, and bow tie pasta in a sauce. Interview on 04/07/25 at 5:21 P.M., with Licensed Practical Nurse (LPN) #254 stated Resident #28 had squares of chicken or pork meat served with his meal and verified the resident was not to have that food. Observation on 04/07/25 at 5:25 P.M. revealed LPN #254 took Resident #28's plate so he would not eat the food. Interview with Resident #28 at the time of the observation revealed the resident was full and did not want another plate of food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44080 Based on observation and staff interview, the facility failed to store foods in a manner to prevent spoilage and failed to ensure kitchen staff appropriately wore hair restraints while in the kitchen. This had the potential to affect all 119 residents at the facility. The facility census was 119. Findings Included: 1. Observation on 04/08/25 from 9:50 A.M. through 10:00 A.M. revealed an opened and undated quarter pound package of ham lunch meat, two halved tomatoes wrapped in plastic that were undated, an opened and undated package of yellow cheeses with a quarter pound left, and three ham sandwiches, three bologna sandwiches, and six peanut butter sandwiches individually packaged in plastic bags that were not labeled or dated in refrigerator. Interview on 04/07/25 at 9:58 A.M. with Food Service Director (FSD) #196 verified all the food items were not labeled or dated, and should have been, in the refrigerator. Review of the facility policy titled, Food Receiving and Storage, dated December 2008, revealed the facility foods shall be received and stored in a manner that complies with practices. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). 2. Observation on 04/08/25 at 11:00 A.M. of Dietary Assistant (DA) #263 revealed she was wearing a hat with braided hair in a pony tail down to the middle of her back. The braided pony tail was not contained within the hat. Interview on 04/08/25 at 11:00 A.M. with DA #263 verified her hair down her back was not contained in her hat or by another means. Observation on 04/08/25 at 11:35 A.M. revealed [NAME] #287 entered the kitchen and had no hair net on when entering on the other side of the kitchen located at the dishwasher station. [NAME] #287 was also observed with a short cut beard and had no beard protector on his face. Interview on 04/08/25 at 12:48 P.M. with [NAME] #287 verified he did not have a hair net or beard protector on his face while in the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) when providing direct care to residents on enhanced barrier precautions. This affected one (#67) of three residents sampled for enhanced barrier precautions. The facility census was 119. Findings Include: Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included chronic viral hepatitis C, type II diabetes, morbid obesity, cannabis and other stimulant dependence, unspecified psychoactive substance abuse, unspecified anxiety and mood disorders, paraplegia, and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of a care plan dated 05/08/24 revealed Resident #67 had an indwelling urinary catheter related to a neurogenic bladder. Interventions included enhanced barrier precautions, following up with urology as needed, and monitoring, documenting, and reporting signs of increased pain and/or infection. Observation on 04/09/25 at 6:44 A.M. revealed Certified Nurse Aide (CNA) #237 did not wear an isolation gown when emptying Resident #67's urinary catheter bag. During an interview on 04/09/25 at 6:48 A.M., CNA #237 verified he did not wear an isolation gown when he emptied Resident #67's urinary catheter bag. CNA #237 stated enhanced barrier precautions were placed for the first week or so after a resident came from the hospital or if a resident was sick. CNA #237 stated he did not know why Resident #67 had a pocketed display on the wall which held isolation gowns and stated Resident #67 was not in any infection control precautions. CNA #237 verified there was a sign for enhanced barrier precautions outside of Resident #67's room in the hand rail but denied having ever been educated on enhanced barrier precautions. Review of policy titled, Enhanced Barrier Precautions, dated 04/01/24, revealed staff were required to wear an isolation gown and gloves during high contact resident care activities including device care for an indwelling urinary catheter.

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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** 44080 Based on observation, resident and staff interview, medical record review, and review of a facility policy, the facility failed to ensure resident call systems were functioning in an appropriate manner. This affected two (#42 and #77) of three residents reviewed for call lights. The facility census was 119. Findings Included: Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included palliative care, schizoaffective disorder, dementia, borderline personality disorder, brief psychotic disorder, type two diabetes, and adult sexual abuse. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was assessed with mil;d cognitive impairment. Resident #42 required supervision or touching assistance for eating meals. Resident #42 required partial to moderate assistance for dressing the upper body. Resident #42 required substantial maximal assistance for dressing the lower body, putting shoes on and off, personal hygiene, bathing, and toileting. Resident #42 used a wheelchair with assistance from staff to ambulate at the facility. Review of a plan of care dated 03/06/25 revealed Resident #42 was at risk for falls related to deconditioning, dementia, osteoarthritis, chronic obstructive pulmonary disease, incontinence, and medication use. Interventions included be sure Resident #42's call light was within reach and encourage the resident to use it for assistance as needed, check and change on rounds, ensure the resident was wearing appropriate footwear or nonskid shoes, observe for side effects of medication, and physical therapy to evaluate and treat. Review of the medical records for Resident #77 revealed and admitted [DATE]. Diagnoses included cognitive communication deficit, dysphagia oropharyngeal phase, major depressive disorder, and anxiety disorder. Review of a quarterly MDS assessment dated [DATE] revealed Resident #77 had severely impaired cognition. Resident #77 required setup or clean up assistance for eating meals, oral care, toileting hygiene, dressing the upper body and lower body, putting on and off shoes, and personal hygiene. Resident #77 required partial to moderate assistance for bathing and used a walker self-ambulate. Review of a plan of care dated 02/26/25 revealed Resident #77 was at increased risk for falls related to a history of falls, muscle weakness, cognition, medication use, and chronic medical conditions. Interventions included be sure the resident's call light was within reach and encourage the resident to use, encourage the resident for activities, ensure the resident was wearing appropriate shoes, the resident needed a safe environment with even floors, free from spills, and clutter, and provide additional activity of daily living assistance post-fall as needed. Observation on 04/09/25 at 10:55 A.M. revealed Resident #77 was sitting on her bed and a call light was placed on the top of the bed. Interview with Resident #77 at the time of the observation stated she needed staff and was unable to get their attention because the call light was not working. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/09/25 at 10:56 A.M. revealed Resident #42 was sitting on her bed and asking for help up. Interview with Resident #42 at the time of the observation stated she needed help with personal care. Observation and interview on 04/09/25 at 10:58 A.M. with Certified Nurse Aide (CNA) #165 confirmed both Resident #77 and Resident #42's call lights were not working. Interview on 04/09/25 at 11:07 A.M. with Unit Manager (UM) #175 verified Resident #77 and Resident #42 did not have working call lights or a silver bell to ring in their room. Review of an undated facility policy titled, Answering the Call Light, revealed staff should be sure the call light was plugged in at all times and when the resident was in bed or confined to a chair, be sure the call light was within easy reach of the resident. Staff should report all defective call lights to the nurse supervisor promptly, and some residents may not be able to use their call light, so be sure to check these residents frequently. This deficiency represents non-compliance investigated under Complaint Number OH00163411, Complaint Number OH00162927, Complaint Number OH00162789, and Complaint Number OH00162565.