| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365293 | A. Building<br>B. Wing | 05/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MT Airy Gardens Rehabilitation and Nursing Center | 2250 Banning Road<br>Cincinnati, OH 45239 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023<br><br>Based on medical record review, review of the facility policy, and staff interview, the facility failed to timely notify the resident's representative of a resident's elopement from the facility. This affected one (Resident #26) of three residents reviewed for notification of change. The facility census was 88.<br><br>Findings include:<br><br>Review of the medical record for Resident #26 revealed an initial admitted [DATE]. Resident #26 had diagnoses including dementia, altered mental status, cognitive communication deficits, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/01/24, revealed Resident #26 had moderate cognitive impairment.<br><br>Review of the nursing notes revealed no recollection or documentation providing information on the events of 04/20/24.<br><br>Review of the social service progress notes from 05/02/24 revealed a late entry note was created for 04/22/24 which documented Social Services Director #200 called to speak with the niece of Resident #26 to discuss future placement of the resident on the secure unit. This was two days after Resident #26's elopement.<br><br>On 05/13/24 at 2:30 P.M., telephone interview with Housekeeper #970 revealed he had identified Resident #26 as he was ambulating on the main road in front of the facility with his wheeled walker. Housekeeper #970 stated the resident was about 0.1 miles from the facility walking in the middle of the road with vehicles swerving around him. Housekeeper #970 stated he had yelled at the resident to get out of the road and drove to the facility to alert nursing staff that the resident had left the facility grounds.<br><br>On 05/14/24 at 9:45 A.M., an interview with LPN #79 revealed she was working on the first floor and was not assigned to provide care to Resident #26 on 04/20/24. LPN #79 stated Housekeeper #970 had entered the building on 04/20/24 and reported Resident #26 was ambulating in the middle of the road into oncoming traffic. LPN #79 stated she went up to the second floor where the resident resided and the staff were not aware Resident #26 had even left the floor. LPN #79 stated an unknown staff member brought Resident #26 back to the facility and escorted him to the second floor.<br><br>(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: 365293 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MT Airy Gardens Rehabilitation and Nursing Center | 2250 Banning Road<br>Cincinnati, OH 45239 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the Director of Nursing on 05/15/24 at 8:45 A.M. verified the facility should have notified the Resident #26's representative regarding Resident #26's elopement on 04/20/24, and verified this was not done until two days later on 04/22/24.<br><br>Review of the facility's undated policy titled Change in Condition Policy revealed the facility shall notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician when there has been an accident or incident involving the resident. The Nurse Supervisor/Charge Nurse will notify the resident's family or representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00153627. |

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| NAME OF PROVIDER OR SUPPLIER MT Airy Gardens Rehabilitation and Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2250 Banning Road Cincinnati, OH 45239 | |

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| F 0657<br><br>Level of Harm - Potential for minimal harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023<br><br>Based on record review, review of the facility policy, and staff interviews, the facility failed to ensure there was an interdisciplinary team for the resident's care conference meetings. This affected four residents (Residents #5, #7, #26, and #67) of four residents reviewed for care planning and care conferences. The facility census was 88.<br><br>Findings include:<br><br>1. Record review of Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses included seizures, convulsions, muscle weakness, peripheral vascular disease, depression, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had severe cognitive impairments.<br><br>Review of the care conference notes dated 03/27/24 revealed only two staff participants during the completion of this care conference. Social Services Director (SSD) #200 and MDS Nurse #340 attended the care conference.<br><br>Interview with SSD #200 on 05/16/24 at 12:15 P.M. verified care conferences should be held with all members of the interdisciplinary team, and this was not completed for Resident #5 on 03/27/24.<br><br>2. Record review of Resident #7 revealed the resident was admitted to the facility on [DATE]. Diagnoses included hypertension, dementia, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had severe cognitive impairments.<br><br>Review of the care conference notes dated 05/02/24 revealed only two staff participants during the completion of this care conference. There was no documentation indicating if the resident representative was invited to attend the care care. Social Services Director (SSD) #200 and a Licensed Practical Nurse (unidentifiable name) attended the care conference.<br><br>Interview with SSD #200 on 05/16/24 at 12:15 P.M. verified care conferences should be held with all members of the interdisciplinary team, and this was not completed for Resident #7 on 05/02/24.<br><br>3. Record review of Resident #26 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebrovascular disease, altered mental status, anemia, and Karposi sarcoma. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had moderate cognitive impairments.<br><br>Review of the care conference notes dated 01/29/24 revealed Social Services Director (SSD) #200 was the only staff participant during the completion of Resident #26's care conference.<br><br>Interview with SSD #200 on 05/16/24 at 12:15 P.M. verified care conferences should be held with all members of the interdisciplinary team, and this was not completed for Resident #26 on 01/29/24. SSD #200 verified she was the only staff member in attendance.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 4. Record review of Resident #67 revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, atrial fibrillation, dementia, cerebrovascular accident, dysphagia, and anemia. Review of the Minimum Data Set(MDS) assessment completed on 05/02/24 revealed Resident #67 had minimal cognitive impairments.<br><br>Review of the care conference notes dated 01/20/24 revealed Social Services Director (SSD) #200 was the only staff participant during the completion of Resident #67's care conference<br><br>Interview with SSD #200 on 05/16/24 at 12:15 P.M. verified care conferences should be held with all members of the interdisciplinary team, and this was not completed for Resident #67 on 01/20/24. SSD #200 verified she was the only staff member in attendance.<br><br>Review of the facility policy titled Care Planning-Interdisciplinary Team, with a revision date of December 2008, revealed the care plan is to be based on each resident's comprehensive assessment and is developed by the entire Interdisciplinary team.<br><br>This deficiency represents noncompliance under Complaint Number OH00153627. |

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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** 33023

Based on observations, review of medical record reviews, interviews with resident and facility staff, and review of facility policy, the facility failed to ensure staff provided adequate supervision to prevent a resident, who had been previously assessed as being at high risk of elopement, from leaving the facility unsupervised. This resulted in Immediate Jeopardy when one resident (#26) was placed at potential risk for serious life-threatening harm and/or injury when he eloped from the facility without staff knowledge. Resident #26 was missing for an unknown amount of time and was found by an off-duty employee approximately 0.1 miles from the facility ambulating with a wheeled walker in the middle of a busy, heavily trafficked street, and cars were having to swerve around the resident to avoid hitting him. This affected one (#26) of three residents reviewed for risk of elopement. The facility identified 16 current residents (#03, #04, #05, #06, #07, #08, #11, #12, #13, #14, #16, #19, #21, #22, #23 and #26) at risk for elopement. Additionally, the facility failed to provide adequate supervision and ensure residents smoked only in the designated smoking areas which placed residents at risk for the potential for more than minimal harm that was not Immediate Jeopardy. This affected four (#32, #33, #40, and #68) of four residents reviewed for smoking. The facility identified 44 residents who smoke. The facility census was 88.

On 05/14/24 at 12:07 P.M., Director of Operations (DOO) #01, DOO #02, the Administrator, and the Director of Nursing (DON) were notified that Immediate Jeopardy began on 04/20/24 at an undocumented time when Resident #26 exited the facility without staff knowledge. Resident #26 was previously assessed as being at high risk for elopement on 08/30/23 and 09/14/23. The facility did not have a care plan in place for the resident being at a high risk for elopement nor interventions in place to prevent elopement. On 04/20/24 at an undocumented time, Resident # 26 was found by Housekeeper #970 who was driving near the facility and was not working at the time and identified the individual as a resident of the facility. Resident #26 was located about one-tenth of a mile from the facility and was walking in the street with his walker and cars were having to swerve around the resident to avoid hitting him. The facility staff were unaware Resident #26 was missing until Housekeeper #970 notified them that the resident was outside in the middle of the street. Resident #26 was returned to the facility by an unknown staff member with no physical injuries observed. The facility did not document in the medical record Resident #26's elopement on 04/20/24 and did not complete an investigation into Resident #26's elopement because the facility did not consider this incident an elopement. On 04/22/24, Resident #26 was moved into the secured unit of the facility.

The Immediate Jeopardy was removed on 05/15/24 when the facility implemented the following corrective actions:

On 04/20/24 at approximately 8:00 P.M., Resident #26 was redirected by an employee to return to the facility after leaving the facility to go to the local gas station. Facility staff assisted Resident #26 to return to the facility with no indication of negative effects.

On 04/22/24, Certified Nurse Practitioner (CNP) #91 assessed Resident #26 with no negative findings.

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 04/22/24, the DON completed the Secured Unit Screening and Resident #26 was moved to the secured unit.<br><br>On 05/13/24, DOO #01 educated the DON and Administrator on the definition of elopement.<br><br>On 05/13/24, the Administrator and DON completed elopement in-services to all staff in-person, by telephone, and by text notification. Education included whom to notify and how to identify if an elopement had occurred. Agency staff will be provided with a copy of the education, and it will be in the assignment binder that the agency staff report to for each shift.<br><br>On 05/13/24, the Administrator began investigating Resident #26's elopement on 04/20/24. It was discovered that Resident #26 met qualifications for placement on the secured unit on 09/14/23 when Resident #26 was assessed to be at a high risk of elopement, but the resident was not moved to the unit until 04/22/24. Root cause analysis indicates the system failure was an Elopement Risk Assessment was completed with no follow up action.<br><br>On 05/13/24, the DON and designee completed audits of all 88 residents for Elopement Risk with no negative findings. No additional residents were impacted by the Elopement Risk Assessments. All 16 high-risk residents were appropriately located on the secured unit. All high-risk residents had care plans reviewed to ensure elopement risk was included. Care plans were revised to reflect changes for Residents #04, #13, #14, #21, and #26.<br><br>On 05/13/24, the Administrator provided verbal education to the DON, and two unit managers [Registered Nurse (RN) #345 and Licensed Practical Nurse (LPN) #165] on identifying high elopement risk residents and the appropriate placement of exit-seeking individuals onto the secured unit as applicable.<br><br>On 05/13/24, Minimum Data Set (MDS) Nurse #340 initiated a care plan for Resident #26. The care plan included that Resident #26 was an elopement risk/wanderer with an intervention of placement on a secured unit. Other interventions included identifying the pattern of wandering: divert as needed and intervene as appropriate.<br><br>On 05/14/24, the facility held an ad hoc Quality Assurance Performance Improvement (QAPI) meeting with Medical Director #90, the Administrator, DOO #01, DOO #02, and the DON. The long-term care Ombudsman was also notified of the Immediate Jeopardy situation involving Resident #26.<br><br>On 05/15/24, the DON or designee completed education to the nursing staff regarding Elopement Risk assessments and their completion/accuracy to ensure all nursing staff are knowledgeable.<br><br>Beginning 05/15/24, the Administrator or designee will complete weekly audits for four weeks for elopement risk assessments for all admissions, readmissions, and any resident with a change in condition.<br><br>Although the Immediate Jeopardy was removed on 05/15/24, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Findings include:<br><br>1) Review of the medical record for Resident #26 revealed an initial admitted [DATE]. Resident #26 had diagnoses including dementia, altered mental status, cognitive communication deficits, and high blood pressure.<br><br>Review of the elopement risk assessment, dated 07/12/23, revealed Resident #26 had an incomplete elopement risk assessment upon admission to the facility. Review of the elopement risk assessment completed on 08/30/23 and 09/14/23 reflected a score of 11, indicating the resident was at a high risk for elopement. Both assessments reflected Resident #26 had poor decision-making skills and poor safety awareness.<br><br>Review of the quarterly MDS assessment, dated 04/01/24, revealed Resident #26 had moderate cognitive impairment, and required supervision from staff with ambulation and personal care.<br><br>Review of the care plan, dated 07/12/23 through 05/13/24, revealed there was no care plan in place for Resident #26 for elopement or interventions to prevent elopement.<br><br>Review of the nursing notes revealed no recollection or documentation providing information on the events of 04/20/24.<br><br>Review of the census record revealed Resident #26 was transferred to the secured memory care unit on 04/22/24.<br><br>Review of CNP #91's assessment dated [DATE] revealed no negative findings as a result of Resident #26's elopement.<br><br>Review of the Secured Unit Screening dated 04/22/24 revealed Resident #26 was assessed to be appropriate for the secured locked unit.<br><br>Review of the social service progress notes from 05/02/24 revealed a late entry note was created for 04/22/24 which documented Social Services Director #200 called to speak with the niece of Resident #26 to discuss future placement of the resident on the secure unit. The niece agreed and will come to the facility to visit. Resident #26 was made aware of future placement in the secured unit; agrees and presents with excitement regarding possible change.<br><br>A request to review the facility's investigation on 05/13/24 revealed the facility did not complete an investigation following Resident #26's elopement on 04/20/24.<br><br>On 05/13/24 at 12:45 P.M., an observation and interview with Resident #26 revealed the resident was walking up and down the hallway on the secured unit. Resident #26 was self-ambulating with the use of a wheeled walker. Resident #26 stated that he knew he messed up when he went outside a few weeks ago to go to the store, which he thought was around 04/20/24. Resident #26 stated he was now completely locked up because of it.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/13/24 at 1:20 P.M., an interview with the Administrator and the DON verified Resident #26 often left the facility prior to 04/20/24 without incident. The Administrator and DON verified the resident was at risk for elopement per the elopement risk assessments completed on 08/30/23 and 09/14/23 and would often exit the front doors to sit outside. The Administrator and DON verified Resident #26 had walked away from the facility on 04/20/24, without staff knowledge, and stated he was trying to go to the store. The DON stated has never eloped from the facility and was placed on the locked unit after an agreement with the guardian. The DON stated Resident #26 was trying to go to the store which he had never done before. The DON verified the facility did not complete an investigation into Resident #26's elopement and explained the facility did not consider it an elopement. The DON verified Resident #26 had impaired cognition, was off the facility property, and found in the middle of the road.<br><br>On 05/13/24 at 2:15 P.M., an interview with Social Services Director #140 revealed Resident #26 was identified by another staff member walking into oncoming traffic near a four-way intersection on 04/20/24. She verified Resident #26 was placed on the secured unit on 04/22/24 following the incident two days earlier. She verified the niece of the resident was notified of the move on 04/22/24.<br><br>On 05/13/24 at 2:30 P.M., telephone interview with Housekeeper #970 revealed he had identified Resident #26 as he was ambulating on the main road in front of the facility with his wheeled walker. Housekeeper #970 stated the resident was about 0.1 miles from the facility walking in the middle of the road with vehicles swerving around him. Housekeeper #970 stated he had yelled at the resident to get out of the road and drove to the facility to alert nursing staff that the resident had left the facility grounds.<br><br>On 05/14/24 at 9:45 A.M., an interview with LPN #79 revealed she was working on the first floor and was not assigned to provide care to Resident #26 on 04/20/24. LPN #79 stated Housekeeper #970 had entered the building on 04/20/24 and reported Resident #26 was ambulating in the middle of the road into oncoming traffic. LPN #79 stated she went up to the second floor where the resident resided and the staff were not aware Resident #26 had even left the floor. LPN #79 verified this was not a very safe situation for this resident. LPN #79 stated an unknown staff member brought Resident #26 back to the facility and escorted him to the second floor. She then stated the resident was placed on the secured unit on 04/22/24 following these events.<br><br>On 05/14/24 at 10:00 A.M., an interview with the DON verified she was not sure who the nurse on duty was for Resident #26 on 04/20/24. She verified there has been no elopement care plan since the resident was identified as an elopement risk on 08/30/23 and 09/14/23. The DON also verified the facility did not have any type of policy to define or prevent elopement.<br><br>42728<br><br>2) Record review for Resident #40 revealed the resident was admitted to the facility on [DATE] and had diagnoses including epilepsy, hemiplegia affecting the right dominant side, dementia, and tobacco use. Review of the quarterly MDS assessment, dated 04/26/24, revealed the resident was assessed to have moderately impaired cognition.<br><br>Review of the care plan, most recently revised on 02/15/24, revealed Resident #40 had the potential for injury related to smoking and was non-compliant with supervised smoking. Interventions included providing smoking aprons for use during supervised smoking.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the facility's Smoking-Safety Screen, dated 01/18/24, revealed Resident #40 was assessed to be safe to smoke with supervision.<br><br>Observation on 05/15/24 at 10:35 A.M. revealed Resident #40 was sitting in a chair less than 10 feet away from the facility entrance smoking a cigarette. Hanging above the resident's head was a sign which read No Smoking. The resident was observed to finish his cigarette and throw the cigarette butt onto the ground in front of him as there was not a cigarette butt receptacle available to throw it into. The resident was not wearing a smoking apron and no staff had been outside monitoring the resident.<br><br>Interview with the DON at the time of the observation on 05/15/24 at 10:35 A.M. verified Resident #40 was sitting outside smoking a cigarette without staff supervision and was not wearing a smoking apron. The DON additionally verified the area was not a designated smoking area.<br><br>3) Record review for Resident #32 revealed the resident was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, chronic obstructive pulmonary disorder, and tobacco use. Review of the admission MDS assessment, dated 04/18/24, revealed Resident #32 was assessed to have intact cognition.<br><br>Review of the care plan, dated 04/15/24, revealed Resident #32 had a potential for injury related to smoking and could smoke with supervision. Interventions included assessing and monitoring the resident's ability to smoke safely.<br><br>Review of the assessments for Resident #32 revealed a safe smoking assessment had not been completed.<br><br>Observation on 05/14/24 at 4:00 P.M. revealed Resident #32, Resident #33, and Resident #68 were sitting less than 10 feet away from the facility entrance smoking a cigarette. Hanging above the residents' heads was a sign which read No Smoking. The residents were observed to finish their cigarettes and throw the cigarette butts onto the ground in front of them as there was not a cigarette butt receptacle available to throw them into. No staff were outside monitoring the residents while they were smoking.<br><br>Observation on 05/15/24 at 8:15 A.M. revealed Resident #32 was sitting in a wheelchair less than 10 feet away from the facility entrance smoking a cigarette. Hanging above the resident's head was a sign which read No Smoking. The resident was observed to finish his cigarette and throw the cigarette butt onto the ground in front of him as there was not a cigarette butt receptacle available to throw it into. No staff were outside monitoring the resident while he was smoking.<br><br>Interview with the DON on 05/15/24 at 10:35 A.M. verified Resident #32 and several other residents frequently sat outside within 10 feet of the facility smoking cigarettes without staff supervision. The DON additionally verified the area was not a designated smoking area.<br><br>4) Record review for Resident #68 revealed the resident was admitted to the facility on [DATE] and had diagnoses including angina, chronic obstructive pulmonary disease, and nicotine dependence. Review of the quarterly MDS assessment, dated 02/28/24, revealed the resident was assessed to have mildly impaired cognition.<br><br>(continued on next page) |

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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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the care plan, most recently revised on 10/30/23, revealed Resident #68 was a smoker. Interventions included to notify the charge nurse immediately if it was suspected the resident had violated the smoking policy.<br><br>Review of the facility's Smoking-Safety Screen, dated 01/24/24, revealed Resident #68 could smoke with staff supervision.<br><br>Observation on 05/14/24 at 4:00 P.M. revealed Resident #32, Resident #33, and Resident #68 were sitting less than 10 feet away from the facility entrance smoking a cigarette. Hanging above the residents' heads was a sign which read No Smoking. The residents were observed to finish their cigarettes and throw the cigarette butts onto the ground in front of them as there was not a cigarette butt receptacle available to throw them into. No staff were outside monitoring the residents while they were smoking.<br><br>Interview with the DON on 05/15/24 at 10:35 A.M. verified Resident #68 and several other residents frequently sat outside within 10 feet of the facility smoking cigarettes without staff supervision. The DON additionally verified the area was not a designated smoking area.<br><br>5) Record review for Resident #33 revealed the resident was admitted to the facility on [DATE] and had diagnoses including weakness, glaucoma, and peripheral vascular disease. Review of the admission MDS assessment, dated 03/15/24, revealed the resident was assessed to have intact cognition.<br><br>Review of the care plan, dated 03/11/24, revealed Resident #33 had a history of smoking in the community and was an independent smoker. Interventions included to complete the smoking evaluation and encourage compliance.<br><br>Review of the assessments for Resident #33 revealed a safe smoking assessment had not been completed.<br><br>Observation on 05/14/24 at 4:00 P.M. revealed Resident #32, Resident #33, and Resident #68 were sitting less than 10 feet away from the facility entrance smoking a cigarette. Hanging above the residents' heads was a sign which read No Smoking. The residents were observed to finish their cigarettes and throw the cigarette butts onto the ground in front of them as there was not a cigarette butt receptacle available to throw them into. No staff were outside monitoring the residents while they were smoking.<br><br>Interview with the DON on 05/15/24 at 10:35 A.M. verified Resident #33 and several other residents frequently sat outside within 10 feet of the facility smoking cigarettes without staff supervision. The DON additionally verified the area was not a designated smoking area.<br><br>Review of the facility policy titled Smoking, revised 01/02/24, revealed residents will be evaluated upon admission and routinely to determine if he or she is able to smoke safely with or without supervision (per smoking assessment). Residents who require supervision shall always have the supervision of a staff member, family member, visitor, or volunteer worker while smoking. Designated smoking times will be provided for residents that require supervision. Smoking is only permitted in designated smoking areas. Appropriate containers and receptacles must be available in smoking areas. Residents who do not require supervision with smoking do not have to adhere to designated smoking times but must smoke in designated areas only.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365293 | A. Building<br>B. Wing | 05/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MT Airy Gardens Rehabilitation and Nursing Center | 2250 Banning Road<br>Cincinnati, OH 45239 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | This deficiency represents non-compliance investigated under Complaint Number OH00153627. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365293 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MT Airy Gardens Rehabilitation and Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2250 Banning Road Cincinnati, OH 45239 | |

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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>42728<br><br>Based on observations, staff interviews, resident interviews, record review, and review of the facility policy, the facility failed to ensure the elevators were maintained in good working order and failed to ensure cigarette butts were disposed of in appropriate containers. This had the potential to affect all residents residing in the facility except the 27 residents who resided on the secured unit of the facility. The facility census was 89.<br><br>Findings include:<br><br>1. Observation on 05/13/24 at 10:00 A.M. revealed there were numerous cigarette butts lying on the ground in front of the facility entrance doors.<br><br>Observation on 05/14/24 at 8:00 A.M. revealed there continued to be numerous cigarette butts lying on the ground in front of the facility entrance doors, in the mulch across from the facility entrance doors, and in the rocks located beside the facility entrance doors.<br><br>Observation on 05/14/24 at 4:00 P.M. revealed there were three residents sitting outside within ten feet of the facility entrance doors smoking cigarettes. When finished with the cigarettes, the residents disposed of the cigarette butts on the ground as there was not a receptacle to place them in. Numerous cigarette butts continued to be observed on the ground in front of the facility entrance doors, in the mulch across from the facility entrance doors, and in the rocks located by the facility entrance doors.<br><br>Observation on 05/15/24 at 8:15 A.M. revealed one resident sitting outside within ten feet of the facility entrance doors smoking a cigarette. When finished with the cigarette, the resident disposed of the cigarette butt on the ground as there was not a receptacle to place it in. Numerous cigarette butts continued to be observed on the ground in front of the facility entrance doors, in the mulch across from the facility entrance doors, and in the rocks located by the facility entrance doors.<br><br>Observation and interview with the Director of Nursing (DON) on 05/15/24 at 10:35 A.M. confirmed there were numerous cigarette butts located on the ground in front of the facility entrance doors, in the mulch across from the facility entrance doors, and in the rocks located by the facility entrance doors. The DON additionally confirmed the area was not a designated smoking area and contained a sign which read No Smoking but residents continued to sit outside smoking cigarettes and threw the cigarette butts on the ground.<br><br>Review of the facility policy titled Smoking, revised 01/02/24, revealed smoking was only permitted in designated smoking areas and appropriate containers and receptacles must be available in smoking areas.<br><br>2. Observation on 05/13/24 at 11:10 A.M. revealed there were two elevators located next to each other inside the facility. The elevator on the right had a sign indicating the elevator was out of order. The elevator on the left was observed to be in service.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365293 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: MT Airy Gardens Rehabilitation and Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2250 Banning Road, Cincinnati, OH 45239 | |

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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 05/13/24 at 4:00 P.M. revealed the elevator on the right continued to have a sign indicating it was out of order. The button for the elevator on the left was pressed and the doors opened. After entering the elevator and pressing the button containing the number two the elevator proceeded to move up to the second floor but the doors would not open. After approximately 30 seconds, the elevator was felt to be moving back down and the doors opened to the first floor.<br><br>Interview with State tested Nursing Assistant (STNA) #189 on 05/14/24 at 12:29 P.M. confirmed the elevators located in the facility were frequently out of order or not working properly.<br><br>Interview with Resident #68 on 05/14/24 at 12:48 P.M. confirmed the elevators in the facility were frequently out of order or not working properly.<br><br>Telephone interview with Ombudsman #500 on 05/14/24 at 3:39 P.M. confirmed the facility frequently had complaints regarding the elevators not functioning properly which included complaints made by the local Fire Chief.<br><br>Interview with the DON on 05/14/24 at 4:30 P.M. confirmed one elevator was currently out of service and the second elevator did not always open on the second floor to allow people to get off prior to going back down to the first floor.<br><br>Observation and interview with the DON on 05/15/24 at 10:45 A.M. confirmed while taking the elevator from the first floor up to the second floor the elevator stopped on the second floor but the doors would not open. The elevator then proceeded back to the first floor and the doors opened.<br><br>Interview with the Administrator on 05/16/24 at 10:45 A.M. confirmed one elevator was out of order and the other elevator was not functioning properly despite multiple repairs being done.<br><br>Interview with the DON on 05/16/24 at 11:05 A.M. confirmed the facility did not have a policy pertaining to elevator maintenance.<br><br>Review of the Resident Council Meeting minutes, dated 04/25/24, revealed documented concerns of the elevators not being in good, working order.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00153836, Complaint Number OH00153830, Complaint Number OH00153679, and Complaint Number OH00153493. |