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	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Chateau at Mountain Crest Nursing & Rehab Ctr	2586 Lafeuille Avenue Cincinnati, OH 45211

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, resident interview, review of the facility's policy, review of the facility's Self-Reported Incidents (SRIs), the facility failed to ensure a verbal and physical resident-to-resident altercations were reported to the State Survey Agency, Ohio Department of Health (ODH). This affected one (Resident #36) of seven SRIs reviewed. The facility census was 132. Findings include: Review of the medical record for Resident #36 revealed an admitted [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact and required extensive assistance of two staff with activities of daily living (ADLs). Review of the nursing progress note dated 05/20/22 revealed Resident #36 was admitted to the facility and had a history of alcohol abuse, suicidal ideations, and depressive disorder. There no notes regarding any behavioral concerns. The nursing progress note dated 06/13/22 revealed Resident #36 was transferred off the men's behavioral unit to regular long term care unit. Review of the medical record for Resident #17 revealed an admitted [DATE] with a diagnosis of vascular dementia with behavioral disturbance. Review of the MDS assessment dated [DATE] revealed Resident #17 was cognitively impaired and required supervision and set up with ADLs. Review of the care plan dated 04/07/22 revealed Resident #17 had the potential to be physically aggressive related to anger and poor impulse control. Goal of care was the resident would have fewer episodes of physically aggressive behavior per week and would not harm self or others. Review of the nursing progress note dated 05/20/22 revealed Resident #17 was physically aggressive when he saw his roommate and slammed the door on staff and yelled out I don't want anybody in my room. The nurse redirected the resident about having roommate, but he does not listen. The other resident (Resident #36) expressed to punch resident back when Resident #17 tried to hit him. The nurse was unable to inform clinical management of the incident. Review of the facility's Self-Reported Incidents (SRI) from 05/20/22 to 06/22/22 revealed there was no SRI involving Resident #17 and #36 regarding the resident-to-resident altercation on 05/20/22. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/23/22 at 3:00 P.M. with the Director of Nursing (DON) and Unit Manager Licensed Practical Nurse (LPN) #560 confirmed the facility did not report the resident-to-resident altercation involving Resident #17 and #36 to the State Survey Agency. Interview on 06/23/22 at 3:46 P.M. with Resident #36 confirmed when he first arrived to the facility, the facility had placed him on the men's behavior unit and when he was there other residents had threatened to harm him. He was unable to recall names or details but confirmed he did not feel safe in the behavioral unit. Review of the facility's policy titled Freedom from Abuse, dated 06/25/17, revealed all allegations of resident verbal and physical abuse including resident to resident altercations should be reported to ODH. This was an incidental finding during the course of the complaint investigation.

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, resident and staff interview, review of the hospital records, review of the facility's Self-Reported Incident (SRI), review of the written statements from staff, and review of the facility's policy, the facility failed to ensure staff provided appropriate care for residents with behavioral management concerns. This resulted in Actual Harm to Resident #74 when a staff member grabbed Resident #74's wrist to block a punch from the resident and when the staff let go, Resident #74 fell to the ground and sustained a wrist fracture. This affected one (#74) of three residents reviewed for behavior management. The facility census was 132. Findings include: Review of the medical record for Resident #74 revealed an admitted [DATE] with a diagnosis of schizophrenia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 was cognitively impaired and required supervision and set up help with activities of daily living (ADLs.) Review of the care plan, last updated on 06/14/22, revealed Resident #74 had the potential to be physically and verbally aggressive toward other residents and staff related to schizophrenia, mood disorder, anxiety, depression, and poor impulse control. Resident #74 had a history of verbal and physical aggressive behavior towards others. Interventions included when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response was aggressive, staff to walk calmly away, and approach later. Review of the nursing progress note for Resident #74 dated 06/10/22 at 11:53 A.M. revealed the nurse was notified by a state tested nursing aide (STNA) that Resident #74 had fallen backwards landing on her bottom. The STNA reported Resident #74 was trying to punch a staff member and the staff member threw his hands up to protect himself from getting hit using a blocking motion which caused Resident #74 to fall back. Resident #74 fell on her right hand and her right hand was swollen. Resident #74 alleged the staff member pushed her and caused the fall, but another staff witnessed the incident and said that was not true. Resident #74's attending physician was notified and gave order for an x-ray to Resident #74's right hand. The nurse progress note dated 06/11/22 at 12:17 A.M. revealed Resident #74 was sent to the hospital related to the results of the x-ray to the right hand. The nurse progress note dated 06/11/22 revealed Resident #74 returned to the facility on [DATE] at 3:45 A.M. with a splint to her right wrist. Review of the hospital note dated 06/11/22 at 12:02 A.M. revealed Resident #74 presented to the emergency room via emergency transport with complaint of right wrist pain. Resident #74 reported she was pushed which caused her to fall. Resident #74 reported she was trying to break the fall with her hands out and sustained injury to right wrist. The x-ray showed Resident #74 had sustained a fracture to her right wrist. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Self-Reported Incident (SRI) control number 222625 dated 06/10/22 revealed Resident #74 alleged STNA #550, grabbed her wrists and then threw Resident #74 to the ground. The facility's investigation did not substantiate abuse had occurred. The facility's investigation revealed Resident #74 was verbally aggressive and went to be psychically aggressive with STNA #550, and STNA #550 grabbed the resident's wrist and Resident #74 went to snatch away and threw herself on the ground causing pain to her wrist. Review of STNA #550's written statement dated 06/10/22 revealed STNA #550 pushed the meal cart onto the unit where Resident #74 resided and was joking with his coworker STNA #570 when Resident #74 began calling him names and then attempted to hit him. STNA #550 stopped Resident #74's hand from hitting his face and when STNA #550 let go of her hand, Resident #74 fell to the ground. Review of STNA #570's written statement dated 06/10/22 revealed STNA #570 was in the hallway and observed Resident #74 call STNA #550 names and then Resident #74 tried to hit STNA #550. STNA #550 attempted to block the hit and grabbed Resident #74's hands. Resident #74 yanked herself away from him and she fell on the ground. Review of the facility's fall investigation for Resident #74 dated 06/11/22 revealed factors contributing to resident's fall on 06/10/22 included interference with a staff member and resident behaviors due to resident's cognitive diagnoses. Observation on 06/23/22 at 3:50 P.M. of Resident #74 revealed her right arm was wrapped and she was wearing a sling to her right arm. Interview on 06/23/22 at 3:50 P.M. with Resident #74 confirmed she had sustained a fracture to her right wrist on 06/10/22 when allegedly STNA #550 threw her on the ground causing her to break her arm. Interview on 06/23/22 at 12:39 P.M. with the Director of Nursing (DON) confirmed the facility had investigated the incident on 06/10/22 in which Resident #74 had a fall and sustained a right wrist fracture. The DON further confirmed the facility's investigation did not substantiate abuse. DON confirmed STNA #550 received verbal re-education following the incident which involved the facility's abuse policy and how to respond to agitated and physically aggressive residents. Interview on 06/27/22 at 10:39 A.M. with STNA #550 stated he was pushing a meal cart onto the secured behavior unit where Resident #74 resided. He was not assigned to the unit. STNA #550 confirmed he was joking with STNA #570 when Resident #74 started calling him names. STNA #550 confirmed he told Resident #74 she was being disrespectful, and she began swinging her hands at up and he grabbed her hands to try to block her. STNA #550 confirmed when he let go of Resident #74's hands, Resident #74 fell backward. Resident #74 stated STNA #550 pushed her down. STNA #550 confirmed he received re-education following the incident from the facility's management. Facility management told him in the future he should step away or walk away if a resident was aggressive and not to take it personally if a resident calls you a name. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled Behavior Assessment and Management, dated 06/25/17, revealed resident problem behaviors had both internal and external causes and staff should explore potential solutions including asking if staff can change reaction or approach to the behavior and to ensure responding in a calm and supportive way. Residents could exhibit aggressive behaviors which could be verbal (shouting, name calling), or physical (hitting, kicking) and might occur suddenly with no apparent reason or could result from a frustrating situation. The facility should develop an individualized care plan for residents with behavioral problems and should remember the following steps in responding to residents: remain flexible, patient and calm, respond to the emotion, not the behavior, don't argue or try to convince, try to identify the unmet need, acknowledge requests, and respond to them, look for reasons behind each behavior, and don't take the behavior personally. This deficiency substantiates Complaint Number OH00133255.