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	07/26/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40471 Based on medical record review, review of a Self-Reported Incident (SRI), staff and resident interviews, staff written statements, review of the local police report, review of the facility investigation, and policy review, the facility failed to ensure Resident #01 was free from physical abuse by facility staff. This resulted in Immediate Jeopardy and the potential for serious physical and psychosocial harm for Resident #01, when on 07/09/22 from approximately 7:15 P.M. until 7:50 P.M., Licensed Practical Nurse (LPN) #200 was observed by three State tested Nursing Assistants (STNA) #300, #301, and #302, telling Resident #01 to sit down in the chair. LPN #200 attempted to force Resident #01 into a chair by twisting Resident #01's wrist, pushed, grabbed Resident #01 by the neck and choked the resident. LPN #200 then threw water on Resident #01, yelled no, sit down and you want to wrestle, and slammed Resident #01 multiple times, including to the ground, and then drug him across the floor. This affected one resident (#01) of four reviewed for abuse. The facility census was 135. On 07/18/22 at 9:50 A.M., the Licensed Nursing Home Administrator (LNHA) was notified Immediate Jeopardy began on 07/09/22 at approximately 7:30 P.M. when LPN #200 was observed physically abusing Resident #01 by three STNAs (#300, #301, and #302). LPN #200 was removed from the facility by the police, arrested, and charged with assault. The Immediate Jeopardy was removed on 07/19/22 when the facility implemented the following corrective actions: On 07/09/22 at approximately 7:40 P.M., STNA #301 reported the incident to the facility Scheduler #400 who was on the grounds in the reception area that LPN #200 was physically abusing Resident #01. On 07/09/22 at approximately 7:50 P.M., STNA # 302 was able to move Resident #01 to safety when STNA #300 and STNA #301 were able to redirect LPN #200. Scheduler #400 arrived on the locked unit at approximately 7:50 P.M., and immediately suspended LPN #200. LPN #200 was placed in a secure location where he was unable to interact with residents while waiting for the police, who were called at that time. The remaining residents were checked to ensure that the other residents were not abused by LPN #200. On 07/09/22 at 8:00 P.M., LPN #215 completed a count of the medication cart with LPN #200 and took over the care of the locked unit. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/09/22 at 8:10 P.M., Unit Manager (UM) #601 arrived and immediately started an investigation. On 07/09/22 at approximately 8:30 P.M., UM #601 notified Medical Director #800 of the situation, of the impending Quality Assurance and Performance Improvement (QAPI) meeting and received an order to send Resident #01 to the emergency room . On 07/09/22, Assistant Director of Nursing (ADON) #600 and UM #601 started observational rounds throughout the facility to ensure residents were free from abuse during care by staff. All residents with a Brief Interview of Mental Status (BIMS) of eight and above were interviewed with no concerns noted. All residents with a BIMS score below eight had head-to-toe skin assessments completed by ADON #600 and UM #601 and no signs of abuse were observed. On 07/09/22 at 8:45 P.M., the local police arrived to investigate. LPN #200 was arrested for assaulting Resident #01. On 07/09/22 at 9:00 P.M., the Administrator arrived at the facility. On 07/09/22 at 9:19 P.M., Resident #01 arrived at the hospital for evaluation. On 07/09/22 at 9:21 P.M., the allegation of abuse was reported to the Ohio Department of Health (ODH) by the Administrator. On 07/09/22 at 9:45 P.M., ADON #600, arrived at the facility. UM #601 initiated a QAPI meeting at that time, approximately 9:45 P.M. The meeting included Executive [NAME] President and Chief Operations Officer (EVP/COO) #900, Senior [NAME] President of Clinical Services (SVPCS) #901, Registered Nurse (RN) #100, Senior [NAME] President of Operations (SVPO) #902, [NAME] President of Operations Eastern Region (VPOER) #903, the Administrator, and the DON. On 07/09/22 at 10:30 P.M., Social Services (SS) #602 arrived at the facility and began psychosocial assessments of the residents. SS #602 performed all interviews of residents who were able to answer questions. On 07/09/22, the Administrator, the DON, Housekeeping Manager #700, Dietary Manger #701, SS #602, and Maintenance Director #702 re-educated all facility staff and all agency staff on the facility's abuse policy and specifically to intervene immediately and to notify the Administrator and the DON as soon as the resident was moved to safety. Staff were in-serviced in person or via the telephone. Anyone not educated would be removed from the schedule and would not work a shift until education was completed. VPOER #903 re-educated the Administrator and the DON on the abuse policy. The Administrator and the DON educated Housekeeping Manager #700, Dietary Manager #701, SS #602, and Maintenance Director #702 prior to educating the staff. On 07/10/22 at approximately 3:00 A.M., Resident #01 returned to the facility from the hospital with no new orders and no injuries noted from hospital evaluation. Resident #01's psychosocial needs were evaluated by facility nursing. Resident #01 was placed on one-on-one for exit seeking behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/11/22, Resident #01 was moved from the locked unit to the memory care unit. Resident #01's psychosocial care plan was updated to reflect the focus psychosocial well-being problem related to cognitive impairment, Alzheimer's, and dementia with behavioral disturbances. Interventions included encouraging participation in activities, allow the resident to answer questions and to verbalize feelings, perceptions, and fears, and when conflict arises, remove the resident to a calm, safe environment. Daily rounds will be completed by the DON, the Administrator and/or their designee to observe residents were free from abuse during care beginning on 07/09/22, on all shifts for four weeks, and the audit findings will be reviewed in the QAPI meeting for additional recommendations. Although the Immediate Jeopardy was removed on 07/19/22, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure continued compliance. Findings included: Review of the medical record for Resident #01 revealed an admitted [DATE]. Diagnoses included dementia with behaviors, Alzheimer ' s dementia, and encephalopathy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 had severe cognitive impairment. Review of the care plan revealed Resident #01 was an elopement risk/wanderer as evidenced by history of attempts to leave the facility unattended. Interventions included distract Resident #01 from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book; identify pattern of wandering; and provide toilet use, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of a progress note dated 07/09/22 at 9:19 P.M. revealed Resident #01 was sent to the local hospital emergency room (ER) due to an alleged assault. On 07/10/22 at approximately 3:00 A.M., Resident #01 returned to the facility with no new orders. Resident #01 was placed on one-to-one when he was awake due to his exit seeking. Review of the local hospital records dated 07/09/22 at 9:19 P.M. revealed Resident #01 reported his neck hurt after he was assaulted. Review of the SRI dated 07/09/22 and timed 9:21 P.M. revealed Resident #01 was attempting to stand and walk when LPN #200 told him to sit down in the chair. LPN #200 grabbed the resident and physically forced him to sit. Resident #01 was assessed, and a small abrasion was noted on his thumb. The local law enforcement, the Administrator, the DON, and UM #601 were contacted. Resident #01 was sent out for an evaluation. LPN #200 was escorted off the premises in the police car. The SRI revealed Resident #01 was immediately moved to another unit upon his return. Review of the facility's investigation revealed the following written statements: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	STNA #300 ' s written witness statement dated 07/09/22 revealed LPN #200 was really aggressive at the beginning of the shift, around 7:30 P.M. with Resident #01. LPN #200 grabbed Resident #01 by his shirt and was slamming him. STNA #300 observed fresh blood from a scratch coming from Resident #01 ' s hand. STNA #301 ' s written witness statement dated 07/09/22 revealed LPN #200 was physically abusive with Resident #01. He pushed, choked, slammed, and threw water on Resident #01. LPN #200 was very upset because Resident #01 would not sit in a chair. STNA #302 ' s witness statement dated 07/09/22 revealed Resident #01 attempted to stand and walk, and LPN #200 yelled No, sit down and started forcing him to sit in the chair. LPN #200 stated you want to wrestle and slammed Resident #01 multiple times. STNA #302 stated LPN #200 grabbed Resident #01 by his neck. Resident #01 ' s witness statement dated 07/09/22 revealed LPN #200 grabbed him by the neck and that his neck hurt. Interview on 07/13/22 at 9:02 A.M., the Administrator said three STNAs (#300, #301, and #302) reported LPN #200 grabbed Resident #01 by the neck. The facility called the police, who arrested LPN #200. The Administrator stated LPN #200 was scheduled to attend additional abuse training beyond the Crisis Prevention and Intervention (CPI) training on 07/08/22 but did not show up for the training. Interview on 07/13/22 at 9:45 A.M., Resident #01 said someone had him by the neck and it hurt, he had been in a bar fight in another city, and he didn ' t want to go back there. Interview on 07/13/22 at 10:24 A.M. with Scheduler #400 revealed she was present the night of 07/09/22 in her office when STNA #301 called. STNA #301 wanted to report an incident on the locked unit and reported LPN #200 tried to force Resident #01 into a chair and twisted his wrist. By the time Scheduler #400 arrived on the locked unit at approximately 7:50 P.M., STNA #300 and #302 had separated Resident #01 to a safe location. Scheduler #400 said Resident #01 reported LPN #200 put his hand on Resident #01 ' s throat. During the same interview, the DON stated at that time the DON suspended LPN #200 by phone. Interview on 07/13/22 at 5:26 P.M., STNA #300 stated he arrived on the locked unit at 7:30 P.M. and saw LPN #200 trying to isolate Resident #01 and put him in a chair. STNA #300 said he could not recall everything that happened in which order but verified LPN #200 grabbed Resident #01 by the shirt and slammed him around and threw Resident #01 to the ground and then dragged him on the ground. STNA #300 said STNA #301 left the unit to report the situation after the abuse had started, but he was unsure of the time. STNA #300 said he tried to intervene with little success. STNA #300 said he received no instructions from the facility related to who to contact in case of an emergency and had not received any additional training or information on how to handle a situation like this if it should happen again. Interview on 07/19/22 at 11:00 A.M., LPN #200 said when he arrived, LPN #215 told him Resident #01 was trying to elope. LPN #200 denied allegations of abusing Resident #01 or any other resident. LPN #200 stated that he took Resident #01 by the hand to lead him back to a chair. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/19/22 at 11:26 A.M., STNA #302 said she arrived on the unit at approximately 7:10 P.M., and the situation began after that and escalated for 30 to 35 minutes. She said Resident #01 was in the common area and stood up, when LPN #200 told STNA #302 to stop him. STNA #302 tried to redirect Resident #01. LPN #200 grabbed Resident #01 and forced him back into the chair. Resident #01 tried to walk again, and LPN #200 started to choke Resident #01 and threw chairs around. She and STNA #301 tried to disengage LPN #200 from Resident #01, with little success. STNA #302 said LPN #200 used unnecessary force. STNA #302 verified LPN #200 slammed Resident #01 on the floor, like a wrestling move. LPN #200 picked up Resident #01 and slammed him to the floor. STNA #302 said she was not aware of who to report the incident to. STNA #302 said LPN #215 was on the unit for approximately 15 to 20 minutes and witnessed some of the behavior and had not intervened, just instructed Resident #01 to sit back down. STNA #302 said STNA #301 left the unit to get help and then Scheduler #400 arrived and intervened as well. STNA #302 denied being provided any abuse education the night of the incident or since the incident. STNA #302 subsequently worked with Resident #01 on his new unit and had no issues. STNA #302 verified that she had not received additional abuse training prior to returning to the facility to work additional shifts. Follow-up interview on 07/19/22 at 11:35 A.M., STNA #300 verified he worked on 07/18/22 night shift but had not received any additional training related to the facility ' s abuse policy or expectations. Interview 07/19/22 at 12:00 P.M., LPN #215 said she left the unit around 7:57 P.M., on 07/09/22. LPN #215 said she witnessed no abuse. LPN #215 said if there was an altercation, it couldn ' t have been too bad because she was unaware of the issue. She said she saw Resident #01 sitting in a chair, but LPN #200 was blocking Resident #01 with his body to prevent him from getting up out of the chair. LPN #215 said she was not present when Scheduler #400 arrived and at no time had anyone requested assistance from her related to the situation with Resident #01. She said nothing occurred while she was there that would have led her to believe LPN #200 would have been arrested. She also said she had not received additional abuse training after the incident but did complete her CPI training on 07/18/22, as planned. Review of the local police report dated 07/09/22 revealed the time of dispatch was 8:37 P.M., the time of arrival was 8:45 P.M., and LPN #200 was arrested at 9:30 P.M. for simple assault. Review of a policy titled Freedom from Abuse and Neglect Policy, dated 10/30/19 revealed a comprehensive policy that explained abuse was the willful infliction of injury, unreasonable confinement, intimidation of, punishment with resulting physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological wellbeing. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish included verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy indicated that all new and current employees received training to identify aspects of abuse prohibition, including identification of potential victims of abuse or neglect, interventions, and reporting, as well as staff indicators, i.e., stress that may lead to the potential for abuse, who mandatory reporters were, and that suspected abuse should be reported to the Administrator and other officials in accordance with State law. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This deficiency substantiates Master Complaint Number OH00134173 and Complaint Number OH00134078.