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	10/11/2022

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 - Actual harm 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** 30802 Based on medical record review, staff interview, resident interview, hospital record review, review of a Self-Reported Incident (SRI), review of a police report, and review of facility policy, the facility failed to ensure a resident was free from verbal, and physical abuse. This resulted in actual harm when agency State tested Nursing Assistant (STNA) #150 ranted for 20 to 30 minutes, made threatening remarks towards Resident #49, and grabbed Resident #49 twisting her right hand, which resulted in Resident #49 becoming fearful of what agency STNA #150 may do next. Additionally, the resident required a hospital evaluation and was subsequently found to have a closed non-displaced fracture of the middle phalanx of the right index finger (the pointer finger) and right scaphoid fracture (a break in one of the small bones of the wrist). This affected one (Resident #49) of three residents reviewed for abuse. The facility census was 126. Findings include: Review of the medical record for Resident #49 revealed an admitted [DATE]. Resident #49's diagnoses included, but were not limited to, anxiety disorder, localization-related symptomatic epilepsy, and epileptic syndromes with complex partial seizures intractable without status epilepticus, and major depressive disorder. Review of Resident #49's quarterly Minimum Data Set (MDS) assessment, completed on 08/17/22, revealed Resident #49 was cognitively intact, did not walk, and required extensive assistance of two staff for bed mobility, and transfers. Review of Resident #49's care plan, dated 04/24/22, revealed Resident #49 had an Activities of Daily Living (ADL) self-care performance deficit related to her disease process. Resident #49 required staff assistance to complete ADL tasks daily. Review of Resident #49's skin assessment, dated 08/26/22, revealed Resident #49 did not have bruising to the right index finger indicated on the assessment. (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 - Actual harm Residents Affected - Few	Review of the SRI, dated 09/03/22, revealed on 09/03/22 at 2:00 A.M., Resident #49 expressed concerns which could rise to the level of physical abuse. Resident #49 stated a staff member (agency STNA #150) had injured her during the transfer process. The SRI indicated statements were obtained from staff, and an unidentified staff (agency STNA #150) was suspended. The SRI indicated a body assessment was being completed, the physician and family were called, and the police were contacted. The SRI indicated interviews were conducted again with staff and re-enactment was completed for leadership. The report indicated education was started, and although evidence was inconclusive, staff (agency STNA #150) was do not returned (DNR'd). Resident #49's care plan was reviewed and updated. The SRI did not include information regarding Resident #49 having been sent to the hospital on 09/03/22 and found to have sustained a closed non-displaced fracture of the middle phalanx of her right index finger. The SRI also did not include the name of the alleged perpetrator. Review of the statement obtained from agency STNA #150 on 09/03/22, revealed agency STNA #150 stated Resident #49 put on her call light and agency STNA #150 came in Resident #49's room. Agency STNA #150 indicated she entered Resident #49's room and introduced herself and said she was going to assist Resident #49 to bed. Agency STNA #150 stated she left Resident #49's room to get the Hoyer lift and came back Resident #49's room. Agency STNA #150 indicated Resident #49 was fully dressed and was sitting upright in the wheelchair facing her. Agency STNA #150 then proceeded to lock the Hoyer lift and open it, then Resident #49 began placing the Hoyer straps on the Hoyer arms, and then agency STNA #150 began to lock the wheelchair brakes. Agency STNA #150 stated Resident #49 stated don't lock my wheels, and she told Resident #49 she had to lock the wheels. Agency STNA #150 indicated she took out her phone and searched proper Hoyer technique, showed Resident #49, and Resident #49 said ok. Agency STNA #150 indicated she then went to try to lock the wheelchair again, and Resident #49 grabbed her left wrist as she was standing on Resident #49's left side. Agency STNA #150 indicated she dropped to her knees and asked Resident #49 to please let her go. Agency STNA #150 indicated Resident #49 grabbed her tighter, stared at her, and was shaking her head. She revealed she twisted her body and went under Resident #49's arm without touching Resident #49's arm or hand. Agency STNA #150 indicated Resident #49 had her left hand and the Hoyer remote was in agency STNA #150's right hand. As agency STNA #150 stood up, she was pushing the button on the Hoyer remote which was lifting the Hoyer. Agency STNA #150 indicated Resident #49 was calm. Agency STNA #150 then indicated she lifted Resident #49 with the Hoyer from the wheelchair and pushed the Hoyer over to Resident #49's bed. Agency STNA #150 looked in the hallway for assistance, and left Resident #49 on the bed in a safe position while going to look for another staff member to assist her. Agency STNA #150 indicated she found another aide (STNA #153) to assist her. Agency STNA #150 indicated she called the front desk and asked the receptionist where her nurse was and for the receptionist to listen to the way Resident #49 was treating her. She indicated as she was talking to the receptionist, Resident #49 was grabbing at her. She indicated she asked Resident #49 to please not grab her arm, as Resident #49 continued to scream for her to get out of her room. Agency STNA #150 indicated the other aide (STNA #153) asked Resident #49 what was wrong and asked Resident #49 to calm down. The statement indicated Resident #49 was upset and the aides left the room. Agency STNA #150 stated Resident #49 was yelling, screaming, and swinging. Agency STNA #150 indicated she left the room and called the unit manager. Agency STNA #150 indicated Resident #49 was in bed on the Hoyer pad with all her clothes on because she would not let staff provide care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a statement obtained from Receptionist #02 on 09/03/22 revealed agency STNA #150 called and asked for the unit manager's phone number. During the conversation, Receptionist #02 heard Resident #49 state get out of my room, and agency STNA #150 never responded. Receptionist #02 indicated agency STNA #150 kept talking to him (Receptionist #02) and then he overheard agency STNA #150 state get off of me. Agency STNA #150 then said Resident #49 keeps grabbing me, as Receptionist #02 continued to listen. Receptionist #02 gave agency STNA #150 the unit manager's phone number. Receptionist #02 said agency STNA #150 came over and showed him her swollen arm. Review of Resident #49's incident note dated 09/03/22 at 4:05 A.M., indicated the writer (Licensed Practical Nurse [LPN] #64) was notified by an aide that Resident #49 was refusing proper care and that Resident #49 had claimed abuse. The writer entered the resident's room and asked was she ok. The resident stated no, she broke my finger and scratched on my arms. The aide (agency STNA #150) stated she twisted away as Resident #49 was holding her arm tightly. Resident #49 stated upon entry that the aide (agency STNA #150) had broken her finger by grabbing on her while trying to put her to bed. The resident also stated that she still allowed the aide to put her in bed after they figured out that she was right about the mechanics when using the Hoyer lift. Staff immediately removed the staff member (agency STNA #150) from the facility and assessed Resident #49 for safety. The writer notified the Unit Manager (LPN #64), Assistant Director of Nursing (ADON), physician, and family. It also noted a STAT (immediate) x-ray of Resident #49's finger was ordered, a skin assessment was done, and vitals were obtained. Review of Resident #49's skin assessment, dated 09/03/22, revealed Resident #49 had bruising to her right index finger. Review of Resident #49's progress note, written on 09/03/22 at 10:46 A.M., revealed the Resident experienced trauma to her right index finger prior to day shift. An x-ray was obtained of the area. The technician stated he could not tell if the finger was broken. Resident (#49) was sent to the hospital for evaluation and possible treatment. Review of Resident #49's progress note, dated 09/03/22 at 12:00 P.M., revealed Resident #49's x-ray result was a displaced right index finger fracture. The physician was notified, and an order was received for a referral to an orthopedic physician. Review of Resident #49's x-ray results, obtained on 09/03/22, revealed Resident #49 had a fracture involving the middle phalanx with displacement and there was associated soft tissue swelling. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital report, dated 09/03/22, revealed Resident #49 presented to the emergency department on 09/03/22 at 11:05 A.M. for right finger pain and bilateral arm pain. It noted the patient was a resident of a nursing home and reported an aide (agency STNA #150) grabbed her arms that night and twisted her right index finger. It indicated the skilled nursing facility had filed a police report and the aide (agency STNA #150) no longer worked at the facility. The physical examination noted there was a mild amount of edema of the right index finger diffusely with some ecchymosis (a discoloration of the skin resulting from bleeding underneath) noted proximally. Resident #49 had a moderate amount of thrombotic thrombocytopenic purpura (TTP) (a rare disorder that causes blood clots to form in small blood vessels throughout the body) and decreased range of motion due to pain. Resident #49 also had ecchymosis to her scaphoid area (wrist) with moderate TTP. X-rays of the right hand and wrist were completed and showed a non-displaced right second middle phalangeal fracture. The report revealed there was a possibility of occult fracture of her thumb, and a thumb spica splint was ordered. The final impression was that she had a closed non-displaced fracture of the middle phalanx of the right index finger and right wrist pain. Review of the Police Department Incident Report, filed on 09/03/22 at 4:29 A.M., revealed the victim was Resident #49. The report indicated the offense involved patient abuse/neglect (simple assault). The report indicated Resident #49 sustained a minor injury but did not specify the location. Review of Resident #49's orthopedic consult report, dated 09/12/22, revealed she reported injuring her right index finger after having been assaulted by an aide at her assisted living facility. She stated the aide grabbed and twisted both of her arms. At the time of the injury, there was clear dislocation or malposition of the finger. The impression from radiographic evaluation was that Resident #49 had sustained recent displaced index finger middle phalanx shaft fracture(s) and presented requesting further treatment. Resident #49 also sustained radiographically inapparent but clinically suspected scaphoid fracture and presented requesting further treatment. The various treatment options were discussed with Resident #49 regarding her right scaphoid fracture and right index finger middle phalanx fracture. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #49 on 10/04/22 at 2:52 P.M., revealed it was late when agency STNA #150 came in her room. She revealed agency STNA #150 began to pull in the Hoyer lift. Resident #49 had already taken off her shirt, and agency STNA #150 put her gown on her. Resident #49 stated agency STNA #150 started locking the wheelchair and Resident #49 stated no, I don't do that. Agency STNA #150 stated yes I do, and Resident #49 told her No, that's not how I do it. Resident #49 indicated agency STNA #150 went into a rage and stated if Resident #49 understood how everything went then it would make things a lot easier. Resident #49 indicated agency STNA #150 got on her phone and was looking something up regarding wheelchairs and transfers. Resident #49 indicated Resident #49 said no and put her hands on the wheelchair lock. Agency STNA #150 left the room for a few minutes due to being aggravated then came back to Resident #49's room. She revealed agency STNA #150 twisted her fingers on her right hand. Resident #49 stated she felt agency STNA #150 put her nails into Resident #49's right hand. Resident #49 indicated agency STNA #150 then went to the other side and twisted her left arm. Agency STNA #150 eventually went ahead and transferred Resident #49 by herself with the Hoyer lift. Resident #49 indicated she did not grab agency STNA #150's arm. Resident #49 stated she reached for agency STNA #150 while in the Hoyer lift; however, agency STNA #150 backed away and stated you are not as fast as I am. Resident #49 stated she told agency STNA #150 she needed to put her (Resident #49) up in the bed, but agency STNA #150 left her there. Resident #49 stated she was not afraid when it first happened, but after she realized what agency STNA #150 had done to her finger, she (Resident #49) was not sure what would happen next. Resident #49 indicated she was lying on the bed after having been transferred by agency STNA #150 when agency STNA #150 ranted for 20 to 30 minutes about how black people were more important. Resident #49 indicated when agency STNA #150 took the lift, agency STNA #150 stated you better understand that black's rule and then said, you better understand that. Resident #49 indicated agency STNA #150 came back in her room with STNA #153. Resident #49 stated she told the other aide (STNA #153) what happened, and the other aide (STNA #153) said she was being too specific about her hand, then she noticed her finger was bent another way. Resident #49 indicated the injury was on her right hand. Resident #49 stated both aides left the room without taking care of her. Resident #49 revealed she went to an orthopedic specialist, and they wrapped her finger and thumb. Resident #49 stated her finger and thumb were broken. Resident #49 stated her right thumb hurt just as much as her right finger. Resident #49 indicated she did not feel afraid at the time of the interview but was afraid when the incident occurred. Interview via phone with LPN #64 on 10/04/22 at approximately 6:20 P.M., revealed agency STNA #150 told LPN #64 she was caring for Resident #49 and Resident #49 grabbed agency STNA #150's arm. Agency STNA #150 told LPN #64 she had to twist out of Resident #49's hold, then she got STNA #153 and went back to Resident #49's room. LPN #64 also indicated she spoke with STNA #153, and she said Resident #49 wanted agency STNA #150 out of her room because agency STNA #150 hurt her fingers. LPN #64 indicated agency STNA #150 stepped out of Resident #49's room and STNA #153 asked Resident #49 if there was anything else she could do. LPN #64 revealed she talked to Resident #49 and noticed Resident #49's fingers seemed out of place. Resident #49 told LPN #64 that agency STNA #150 grabbed her fingers. LPN #64 stated she made agency STNA #150 leave immediately and called the police. LPN #64 stated agency STNA #150 did not show LPN #64 any marks on agency STNA #150's arm. LPN #64 stated agency STNA #150 left the building immediately. LPN #64 indicated agency STNA #150 put Resident #49 in bed with a Hoyer lift and transferred Resident #49 by herself. LPN #64 indicated Resident #49 did not want to go to bed that night, but agency STNA #150 forced her to. LPN #64 stated Resident #49 told her she grabbed agency STNA #150. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 10/04/22 at 12:46 P.M. The DON stated she re-enacted the occurrence with agency STNA #150 and agency STNA #150 showed her how she spun herself under Resident #49 in order to release Resident #49's grip due to being taught in abuse training to never touch a resident. The DON stated agency STNA #150's arm was very swollen, and agency STNA #150 indicated she was trying to go get help to assist her with Resident #49. The DON indicated agency STNA #150 tried to call the receptionist first. An interview was conducted on 10/04/22 at 2:40 P.M. with the DON regarding the re-enactment with agency STNA #150. The DON stated agency STNA #150 indicated she never touched Resident #49's right hand, and that she demonstrated being grabbed by Resident #49's left hand. Interview via phone with Personal Crimes Detective #156 on 10/06/22 at 10:58 A.M., revealed he did not observe any swelling on agency STNA #150's arm. He revealed Resident #49 appeared to have swelling to her right and left wrists. Review of the facility policy titled Freedom from Abuse and Neglect Policy, dated 10/30/19, revealed the purpose was to prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Further review revealed the facility would conduct an internal investigation and report the results to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. This is an example of continued non-compliance from the survey dated 07/26/22. This deficiency substantiates Complaint Number OH00136227.