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	12/01/2022

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** 42492 Based on medical record review, review of facility self-reported incident (SRI), review of facility investigations, observations, staff and resident interviews, and review of a facility policy, the facility failed to ensure residents were free from abuse. This resulted in Actual Harm for when Resident #118 was physically abused by Resident #72 and subsequently required hospital evaluation/treatment for a right wrist fracture, and when Resident #117 was physically abused by Resident #95 and subsequently required hospital evaluation/treatment for a broken jaw. Additionally, the facility failed to ensure Resident #19 was free from staff-to resident abuse and failed to ensure Resident #41 and #53 were free from resident-to-resident abuse which placed the residents at risk for more than minimal harm that did not result in actual harm to the residents. This affected five (#19, #41, #53, #118, and #117) of 11 residents reviewed for abuse. The facility census was 121. Findings include: 1. Review of the medical record revealed Resident #118 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia with behavioral disturbance, unspecified Alzheimer's disease, unspecified anxiety disorder, hypertension, peripheral vascular disease, and mild receptive-expressive language disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #118 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #118 was a one-person assist and required extensive assistance with bed mobility, transfers, and toileting, and supervision with dressing, eating, locomotion, and personal hygiene. Review of care plan dated 07/11/22 revealed Resident #118 had potential to exhibit physical and verbal behaviors to staff and other residents related to dementia with behavioral disturbance. Interventions included medications as ordered, anticipate needs, minimize potential for disruptive behaviors with tasks/diverting attention, and provide activities program. Additionally, Resident #118 had pain related to right upper arm related to fracture. Interventions included administer pain medications as ordered, assess pain level, assess for non-verbal signs of pain, offer medications prior to painful treatments offer relaxation techniques, assist to change positions as needed, and monitor for effects of pain medications. (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
	365005	A. Building B. Wing	12/01/2022

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	Review of hospital records dated 10/29/22 revealed emergency medical services (EMS) reported to the hospital that Resident #118 was in an altercation with another resident at the facility and was pushed down. Resident #118 presented to the emergency room (ER) with arm splinted by EMS. When the ER removed the splint, Resident #118's arm had a noticeable deformity to the right elbow. Resident #118 was holding his right elbow and grimacing with pain. On 10/29/22 the hospital completed diagnostic testing including x-rays to right humerus, right shoulder, right wrist, and bilateral elbows, and computerized tomography (CT) scans without contrast to head and cervical spine. Results of x-rays showed probable fracture to right radial head and proximal ulna. CT results showed no abnormalities. Review of progress notes revealed on 10/29/22 Resident #118 had an unwitnessed fall that may have involved a incident with another resident on the men's unit. Resident #118 was found getting up off the floor and complained of pain to his right arm. Resident #118's right arm did have some swelling at elbow, and the resident was walking with unsteady gait. Paramedics were called and the resident went to the hospital for evaluation and treatment. Review of SRI dated 10/31/22 revealed upon investigation, the facility substantiated allegations of resident-to-resident physical abuse on 10/29/22, when Resident #118 was pushed to the ground in the dining room by Resident #72 and sustained fracture to his right arm. On 10/29/22 it was noted that Resident #118 was observed getting himself up off of the floor in the dining room area. He presented with complaint of pain to his right elbow. Per the investigation, there had been an altercation between Residents #118 and #72, as Resident #72 had admitted to pushing Resident #118 down to the ground. Resident #118 was sent to the emergency room for his pain and swelling in the right elbow. Resident #72 was placed on one-on-one (1:1) supervision. Resident #118 was found to have a fracture to his right arm and returned back to facility with his right arm placed in a brace and sling in place. Staff were interviewed and no staff witnessed the altercation. No residents witnessed the altercation either. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia with behavior disturbance, paranoid schizophrenia, generalized anxiety disorder, and schizoaffective disorder bipolar-type. Review of the most recent MDS assessment dated [DATE] revealed Resident #72 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #72 was a one-person assist and required extensive assistance with bed mobility, transfers, and toileting, and supervision with dressing, eating, locomotion, and personal hygiene. Review of care plan dated 10/31/22 revealed Resident #72 had a history of being physically aggressive and physically throwing chairs related to schizoaffective disorder-bipolar type and unspecified bipolar disorder. On 10/30/22 Resident #72 exhibited physical behaviors/aggression towards another resident causing injury. Interventions included medication as ordered, assist to develop appropriate methods of coping/interaction, intervene as necessary to protect the rights/safety of others, monitor behaviors to determine underlying cause, and provide activities to accommodate the resident. (continued on next page)

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	12/01/2022

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	Review of witness statement dated 10/31/22 at 9:20 A.M. revealed Registered Nurse (RN) #126 stated The aides and I were talking in the hallway when we heard a commotion coming from the dining room. When I got to the dining room, (Resident #118) was getting up off the floor and (Resident #72) was standing there and shouting 'He's always bothering me'. When asked neither resident was able to verbalize what happened. The nurse stated she did not report the incident as a potential abuse allegation because she did not see anything happen. RN #126 charted that it might have been an incident between two residents because the two residents were present when the unwitnessed incident occurred. Observation on 11/14/22 at 12:38 P.M. revealed Resident #118 was seated in dining room eating lunch. Resident #118's right arm had a cast wrapped with ace bandage from wrist to mid upper arm. During an interview on 11/16/22 at 10:55 A.M. Corporate Registered Nurse (RN) #211 stated the nurse on duty reported to management that Resident #118 had fallen 10/29/22 and RN #126 did not indicate that the incident might have involved another resident. Corporate RN #211 stated she was reviewing the fall on 10/31/22 and interviewed Resident #118 who stated another resident (#72) had pushed him down. During an interview with the other resident, Resident #72 admitted to pushing Resident #118 because he was tired of dealing with him. During an interview on 11/16/22 at 11:09 A.M. the Director of Nursing (DON) stated she was notified on the weekend of 10/29/22 that Resident #118 was injured after a fall in the dining room and was sent out for treatment. When the DON came in on Monday, 10/31/22 she reviewed the progress notes and discovered there was a possible altercation between two residents. Upon interviewing the residents, Resident #72 indicated that he hit Resident #118 because Resident #118 thought the chairs in the dining room were his and accused Resident #72 of sitting in his chair. The DON stated staff collected statements and also notified the police. The local police seem to feel like the facility was a nuisance, so they did not come out. The DON stated Resident #72 was placed on 1:1 supervision until he could be evaluated by psych. Resident #118 was moved to a new room. Corporate RN #211 interviewed all staff and, there were no witnesses. The DON stated staff interviewed and assessed all residents, and there was no other harm noted. The DON stated the QAPI committee reviewed the incident because it was not reported appropriately, and Corporate RN #211 was completing daily audits of nursing notes since 10/31/22. The DON stated Resident #72 was normally a very calm, sweet person, and he had never shown any violent behaviors before the incident or after. During an interview on 11/17/22 at 2:25 P.M. the DON stated the interdisciplinary team concluded after investigation that based on the history of Resident #118's fixation on ownership of chairs, the cause of the unwitnessed incident on 10/31/22 between Residents #118 and #72 was related to Resident #118 making statements to Resident #72 about sitting in his chair. Resident #72 became upset and pushed Resident #118 down. The intervention for Resident #118 was to place his name on his chair. This intervention was proven ineffective because the resident moved the chair from the common area to his room and was temporarily using a wheelchair for mobility while his arm healed. Once the staff discovered the incident was related to a resident-to-resident altercation, Resident #72 was placed on 1:1 until he was evaluated by psych services. (continued on next page)

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	12/01/2022

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	During an interview on 11/23/22 at 8:04 A.M. RN #66 stated the unwitnessed incident between Resident #72 and #118 was initially reported to management as a fall on 10/29/22. RN #66 was notified on the night of 10/29/22 that Resident #118 had fallen and was sent out for possible injury, and RN #66 did not find out until 10/31/22 that there had been an incident with another resident. RN #66 tried to interview staff to determine what had happened, and the nurse involved, RN #126, was suspended for not reporting suspicions of abuse. All residents were assessed for abuse on 10/31/22 and Resident #72 was placed on 1:1 pending psychiatric evaluation. Resident #72 was sent out for evaluation because he was visibly upset and pacing, and Resident #72 was removed from 1:1 supervision when he came back. The staff were going to put Resident #118's name on a chair in the dining room once his injuries healed and he no longer needed to use the wheelchair, to prevent further incidents from happening. Staff suspected Resident #118's fixation on ownership of dining room chairs had started the incident. 2. Review of the medical record review revealed Resident #117 was admitted to the facility on [DATE]. Diagnoses included dementia with behaviors, chronic obstructive pulmonary disease, Alzheimer's disease, hypertension, anxiety, and major depressive disorder. Review of the MDS assessment dated [DATE] revealed an assessment for cognitive status was not able to be completed as resident was unable to answer questions. Resident #117 had behaviors directed towards others and behavioral symptoms not directed towards others, occurring one to three days during the seven-day assessment period. Resident #117 required limited assist for bed mobility, transfers, and supervision for toileting and eating. Resident #117 was assessed with no loss of liquids or solids from mouth when eating, did not hold food in mouth or checks, and no complaints of difficulty when chewing or swallowing. Resident #117 weight was documented at 135 pounds. Resident #117 had weight loss of more than five percent in last month or loss of ten percent or more in last six months. Review of the plan of care for Resident #117 dated 07/14/22 revealed the resident exhibits behavioral symptoms that are not easily altered and potentially harmful to resident or others related to cognitive impairment and dementia with behaviors, poor impulse control and urinating on the floor and other residents furniture. Interventions include administer medications as ordered, monitor for adverse side effects, monitor mood, affects and behaviors, and psychology services as needed. Review of the plan of care for Resident #117 dated 11/03/22 revealed a risk for pain and alteration in comfort related to recent dislocation of jaw with altercation. Resident #117 had fluctuating cognitive deficits due to Alzheimer's disease, increasing difficulty to process current situations and safety awareness. Interventions include administer pain medications as ordered, monitor for breakthrough pain, and monitor for effects of analgesic administered. Review of the plan of care for Resident #117 dated 11/03/22 revealed a self-care deficit in eating related to chewing problems, resident has been diagnosed with a fracture jaw and in at risk for unintended weight loss. Interventions include diet per physicians' orders, adaptive diet as ordered, report immediately an difficulty chewing or swallowing, refer to speech therapy and occupational therapy, and reassess eating ability quarterly. Review of the plan of care for Resident #117 dated 11/08/22 revealed a risk for infection/complications due to laceration to forehead. Interventions include administer medications as ordered, evaluate pain, monitor for signs and symptoms of infection, and monitor vital signs. (continued on next page)

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	12/01/2022

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	Review of the nurses' progress notes dated 11/02/22 at 5:12 P.M. revealed Resident #117 was observed exiting Resident #95's room by a State tested Nursing Assistant (STNA). Resident #117 was noted to be bleeding from forehead and distraught. First aide was provided by RN #57, vitals were obtained and range of motion was unchanged. Review of the nurse's progress note dated 11/02/22 at 10:33 P.M. for Resident #117 revealed resident was noted to be in a physical altercation with another resident and was assessed, physician was notified of resident laceration to the forehead by another resident . Incident was report to the state, police, resident's physician and emergency contact. Orders were obtained to send the resident to the hospital for evaluation and treatment. Resident #117 was unable to communicate what happened in the incident with the other resident. Review of the After Care Visit Summary from the hospital dated 11/02/22 for Resident #117 revealed instruction orders for liquid diet only and follow up with oral maxillofacial trauma surgery tomorrow morning related to jaw fracture. Review of the hospital progress notes dated 11/02/22 for Resident #117 revealed resident was punched in the head by another resident without loss of consciousness. Review of the radiology reports for a CT scan of the head revealed an acute displaced fracture of the right mandibular condyle. Further review of the progress note revealed a consult with a facial trauma physician was completed with recommendations to wait a week for repair of jaw and continue with a liquid diet. No other injuries were noted. Review of the SRI dated 11/02/22 at 6:52 P.M. revealed after investigation, the facility substantiated allegations of resident-to-resident abuse. The incident happened on 11/02/22 at 5:12 P.M. when Resident #95 reported Resident #117 entered Resident #95's room and would not leave. Resident #95 was trying to push Resident #117 out of the room. Resident #117 started to get Resident #95 off of him and an altercation occurred resulting in Resident #95 hitting Resident #117 in the head. A statement from Resident #95 admitting to the altercation with Resident #117 resulting in a fracture that required hospitalization and follow up care. An audit of like residents on the unit revealed no reports of feeling unsafe or had a physical altercation with any residents in the last week. Resident #95 was placed on 1:1 monitoring until he can be evaluated by psychology services. The police, the physician and the power of attorneys were notified of the incident. Review of the nurse's progress note dated 11/03/22 at 12:05 P.M. revealed Resident #117 returned to the facility with orders for liquid diet for six weeks until 12/15/22 related to dislocated jaw. Review of the nurses' progress note dated 11/03/22 at 12:11 P.M. revealed Resident #117 has a follow up appointment for treatment of a dislocated jaw on 12/15/22. (continued on next page)

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	12/01/2022

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	Review of the nurse's progress note dated 11/03/22 at 2:34 P.M. revealed a thorough investigation and review of Resident #117 medical records including interviews with staff and residents revealed Resident #117 was in another residents' room watching television when he began going through the other residents' belongings and the other resident hit him. The STNA noted Resident #117 coming out of the room holding his face. The STNA assisted Resident #117 to the nurse for assessment. Resident #117 was noted as having a laceration to his forehead and pain to his jaw. Resident #117 was unable to state what happened to him when questioned. Resident #117 was sent to the hospital for evaluation and treatment. Resident #117's emergency contact was notified along with psych services. Resident #117 was moved off the men's secured unit a different secured unit. Resident #117 care plans have been updated. The dietician was notified of the new diet orders and the fractured jaw. Social services will follow up with resident. Resident #117 does not display any psychosocial issues at this time. Review of the After Care Visit Summary dated 11/07/22 for Resident #117 revealed a follow up appointment was completed with a follow up appointment in six weeks for treatment of facial injury due to closed fracture of condylar process of the mandible. Review of the active physician orders for Resident #117 revealed a pureed diet with thin liquids dated 11/11/22, speech therapy three times a week for thirty days dated 11/07/22, and oxycodone concentrate 100 milligrams/milliliter (mg/ml) give five mg by mouth every four hours as needed for pain for thirty days dated 11/03/22. Review of the medical record revealed Resident #95 was admitted to the facility on [DATE]. Diagnoses included schizophrenia, diabetes, dementia, cognitive decline, hypertension, and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #95 had intact cognition. Resident #95 was not coded with any behaviors. Resident #95 required extensive assist with bed mobility, transfers, and toileting. Resident #95 was independent with eating. Review of the plan of care for Resident #95 revealed the resident exhibits verbal and physically aggressive behaviors toward staff and residents related to schizophrenia, cognitive decline, bipolar disorder, and dementia with behaviors. Can become physically aggressive towards other residents and staff members when he feels his territory/space has been intruded upon/residents wandered into his room without his permission. Interventions include administer medications as ordered, monitor/document for side effects and effectiveness, anticipate the resident's needs, consult behavioral services as needed, intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, remove from situation and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause. Review of the plan of care revealed Resident #95 exhibits behavioral symptoms that are not easily altered and potentially harmful himself and others. Interventions include resident noted to break/disassemble the furniture in his room, stop sign to doorway to help prevent other residents from entering. Give medications per physician order, monitor for adverse reactions of medications, monitor mood, affect, and behaviors with all hands on care and contacts, approach in a calm manner, allow resident to calm down before attempting to continue with care, attempt to identify and resolve basis for voiced/demonstrated anger and verbally abusive behaviors. (continued on next page)

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	12/01/2022

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	Review of the progress notes for Resident #95 at 11/02/22 at 5:18 P.M. revealed resident admitted to punching another resident in face due to the other resident wandering into his room without consent and laying in his bed. Skin assessment completed, no complaints of pain. Police were notified. Review of the progress note dated 11/02/22 at 10:39 P.M. revealed Resident #95's physician and guardian were notified of the resident-to-resident incident. Resident #95 placed 1:1 to ensure no further incident. Psych services and social services to follow up with resident. Resident #95 is calm and watching television with his 1:1. Review of the progress notes dated 11/03/22 at 1:51 P.M. for Resident #95 revealed through a thorough investigation and a review of the resident's medical record including staff and resident interviews, it was noted that Resident #95 and another resident was watching television together and the other resident began searching through Resident #95 belongings, the resident asked him to stop, and he would not and Resident #95 stated I hit that [explicit term], he shouldn't have been watching television and not going through my [explicit term] belongings. Resident #95 was placed 1:1 and physician, guardian and psych services were notified of incident. Resident #95 was assessed by the nurse without any findings. As an intervention Resident #95 has a stop sign placed in front of door, and management staff presence has been increased on the men's unit. Resident #95 care plan was updated. Resident has not displayed any aggression since incident and continues 1:1. Review of the progress notes for Resident #95 dated 11/03/22 at 5:32 P.M. revealed the resident has been sent out to hospital for a psych evaluation, unit manager aware, physician aware, call placed to guardian no answer received voicemail left, will continue to monitor. Review of the psychology notes dated 11/09/22 for Resident #95 revealed the resident is alert and oriented to person, place, and time. Resident #95 stated he continues to hear voices. Further review of management notes revealed an investigation was completed and it was noted that Resident #95 hit Resident #117. Resident #95 was placed on 1:1 monitoring continuing. Observation on 11/14/22 at 1:02 P.M. revealed Resident #117 sitting at table in dining room eating pureed food without assist, no signs and symptoms of pain observed. Interview 11/22/22 at 8:54 A.M. with Behavioral Specialist #226 from psych services verified he has meet with Resident #95 regarding the altercation between the resident and Resident #117. Resident #95 has a history of physical abuse and has been physically abused himself. Resident #95 continues to receive services three times a week. Observation on 11/23/22 at 11:19 A.M. revealed Resident #95 continues to have 1:1 monitoring in place. Interview on 11/23/22 at 12:51 P.M. with Office Staff #225 verified Resident #117 does not have any scheduled surgery in the near future for repair of fractured jaw. (continued on next page)

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	12/01/2022

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	Interview on 11/23/22 at 1:17 P.M. with RN #57 revealed the nurse assigned to Resident #117 on 11/02/22 (day of altercation) and stated Resident #117 was observed by staff exiting Resident #95's room holding his face. RN #57 stated Resident #117 does not have the ability to communicate what happened, just indicated that he was in pain. RN #57 obtained vital signs and contacted the physician for additional orders. RN #57 notified the DON and the Resident #117's emergency contact before transferring the resident to the hospital for evaluation. RN #57 stated Resident #95 admitted to punching Resident #117 in the face and was immediately placed into 1:1 monitoring. RN #57 stated Resident #117 returned to the facility the next day and was moved to another building. RN #57 stated Resident #95 remains on one-to-one monitoring. Interview on 11/23/22 at 1:45 P.M. with the DON verified the incident involving Resident #117 and Resident #95 was investigation and determined to be resident to resident abuse. 3. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, unspecified schizoaffective disorders, type II diabetes, generalized anxiety disorder, unspecified major depressive disorder, unspecified personality disorder, and unspecified intellectual disabilities. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #19 was a one-person assist and required supervision with all activities of daily living (ADL's). Review of SRI revealed after investigation, the facility substantiated allegations of staff-to-resident emotional /verbal abuse. The incident happened on 11/16/22 at 5:55 P.M. Resident #19 reported on 11/17/22 that night nurse, Registered Nurse (RN) #88, kicked his prosthetic leg across the room following a fall. Upon interview, RN #88 admitted to kicking Resident #19's prosthetic leg because it was in his way. Resident #19's roommate (Resident #92) witnessed RN #88 kicking prosthetic leg. During an interview on 11/23/22 at 8:23 A.M. RN #66 stated the incident involving RN #88 and Resident #19 was first reported to staff on 11/17/22. RN #88 was doing two-hour rounds and found Resident #19 sitting on the floor in the bathroom against the wall. Upon interview Resident #92, Resident 19's roommate, stated RN #88 told Resident #19 to quit being a crybaby and kicked his prosthetic leg across the room. Resident #19 was not wearing his prosthetic leg at the time the incident occurred. When the nurse was questioned, RN #88 stated he kicked the leg because it was in his way. RN #66 stated RN #88 was immediately fired and the facility called the police. 4. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included paranoid schizophrenia, unspecified psychosis, and history of traumatic brain injury. Review of the most recent MDS assessment dated [DATE] revealed Resident #41 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #41 required supervision and no physical assistance with ADL's. Review of the care plan dated 10/05/22 revealed Resident #41 had a mood problem related to history of traumatic brain injury, psychosis, and paranoid schizophrenia. Interventions included medication as ordered, reinforce strengths and positive coping skills, behavioral health consults as needed, encourage to verbalize feelings, institute 15-minute checks for 24 if changes in behavior demonstrate risk, and monitor/report behaviors. (continued on next page)

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	12/01/2022

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	Review of SRI revealed after investigation, the facility substantiated resident-to resident physical abuse. The unwitnessed incident occurred on 11/08/22. Resident #96 stated the altercation started because Resident #41 (roommate) was going through his things. The facility was unable to determine who started it. Both residents sustained minor scratches and bruises and after times Resident #41 had a black eye. On 11/08/22, Resident #41 was moved to a private room on the same unit, and Resident #96 was moved to another unit on 11/09/22. Review of Resident #41's progress notes revealed both Residents #41 and #96 were in their shared room when a physical altercation took place. Resident #41 stated that Resident #96 socked him in the back of the head. Staff separated and assessed each resident. Resident #41 had a reddened area noted to the middle of his forehead, a scratch noted to the right side of his nose, and swelling noted to his right eye. Resident #41 stated that he was having some pain but didn't need medication. Review of the medical record revealed Resident #96 was admitted to the facility on [DATE]. Diagnoses included hypothyroidism, emphysema, glaucoma, and hypertension. Review of the most recent MDS assessment dated [DATE] revealed Resident #96 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #96 was a one-person assist and required extensive assist with bed mobility and transfers, and supervision with locomotion, eating, dressing, toileting, and personal hygiene. Review of care plan dated 07/20/22 revealed Resident #96 required the safety of residing on a secured unit due to impaired safety decisions and poor safety awareness. Interventions included provide activities of interest, provide redirection as needed, an resident to be supervised on a secures unit. Review of progress note dated 11/08/22 revealed Resident #96 got into a physical altercation with another resident while in his room. Resident #96 stated that resident was going through his drawer. The residents were separated and assessed. Resident #96 had a scratch noted to the left side of his neck and denied pain. Observation on 11/14/22 revealed Resident #41 had a visible purple bruise noted to his right eye. During an interview on 11/23/22 at 8:15 A.M. RN #66 stated he was on the unit when the incident happened and did not see the incident. Resident #41 came out his room, and sat down [NAME] the area, visibly upset. RN #66 walked up and asked what was wrong. Resident #41 pointed to Resident #96 and said Resident #96 had hit him. RN #66 asked and Resident #96 stated he hit Resident #41 because he was In my [explicit term]. Resident #41 stated he hit Resident #96 back. Upon assessment it was noted Resident #41 had a slight scratch on his nose and complained of pain to his nose. Resident #41 was worried because he had a history of previous fracture. The facility ordered an x-ray, completed 11/08/22,and it was negative for nasal fracture. By this time there was a noticeable bruise forming to Resident #41's right eye. The residents were placed in separated rooms, Resident #41 was moved to a private room and on 11/09/22, Resident #96 was moved to another building/unit. This was during the first week the facility had started their increased management presence on the unit in response to the incidents on the men's unit. (continued on next page)

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	12/01/2022

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	5. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included type II diabetes, unspecified anxiety disorder, hypertension, unspecified epilepsy, and schizoaffective disorder bipolar type. Review of the most recent MDS assessment dated [DATE] revealed Resident # 53 had severely impaired cognition, had no behaviors, and did not reject care. Resident # 53 was a one-person assist and required extensive assistance with bed mobility, was independent with eating, and required supervision for transfers, dressing, toileting, and personal hygiene. Review of care plan dated 05/26/22 revealed Resident #53 had a behavior problem related to schizoaffective disorder and anxiety. Interventions included medication as ordered, anticipate needs, intervene as necessary to protect the safety of others, and monitor behaviors. Additionally, Resident # 53 was at risk for impaired psychosocial well-being related to witnessed aggressive events and other resident conflicts. Interventions included medication as ordered, monitor for adverse reactions, 1:1 counseling as needed, private room, and refer to psych services as needed. Review of progress notes revealed on 11/14/22 around 1:00 P.M. Resident #53 was verbally aggressive and spit on staff as she went into his room to collect his lunch tray. Around 3:40 P.M. the aide reported to the nurse Resident #90 had entered Resident #53's room and hit him. Resident #53 confirmed that Resident #90 had struck him but was unable to provide details regarding the altercation. Review of the medical record revealed Resident #90 was admitted to the facility on [DATE]. Diagnoses included moderate hypoxic ischemic encephalopathy, pseudobulbar effect, diffuse traumatic brain injury, unspecified bipolar disorder, unspecified schizophrenia, and unspecified anxiety disorder. Review of the the most recent Minimum Data Set assessment dated [DATE] revealed Resident #90 had moderately impaired cognition, had no behaviors, did not wander, and [TRUNCATED]

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	12/01/2022

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37093 Based on record review and staff interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing upon the resident's transfer to the hospital. This affected three (#62, #102, and #117) of three residents reviewed for hospitalization s. The facility census was 121. Findings include 1. Review of the medical record for Resident #102 revealed an admitted [DATE]. Diagnoses included displaced intertrochanteric fracture or right femur, for closed fracture with routine healing, dementia, mood affective disorder, conversion disorder with seizures or convulsions, cognitive communication, and dysphagia oropharyngeal. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/05/22, revealed the resident had impaired cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation. Review of MDS assessment dated [DATE] was discharged from the facility with a return anticipated. Review of nurse progress notes for Resident #102 revealed resident was sent to hospital on 10/13/22 per physician order to right leg and knee x-ray results. Discharge from hospital dated 10/19/22 revealed Resident #102 was admitted on [DATE] due to closed right hip fracture. Further review revealed there was no evidence the Ombudsman was notified of Resident #102's hospitalization . 35770 2. A record review revealed Resident #62 was admitted on [DATE]. Diagnoses include anxiety, hypertensive heart and kidney disease, epilepsy, diabetes, congestive heart failure, atrial fibrillation, and depression. Review of the quarterly MDS dated [DATE] revealed Resident #62 has no cognitive deficits, requires extensive assistance with toileting, transfers, bed mobility, with total dependence with personal hygiene, dressing and is incontinent of bowel and bladder. Review of health status note dated 09/29/22 revealed Resident #62 with complaints of shortness of breath and a headache, upon assessment it was noted Resident #62 was having difficulty breathing with exertion in between communication. Vitals signs as follows: blood pressure 156/62, pulse 26, oxygen saturation 94% on room air, respirations 28 and temperature 98.2 with wheezing noted in bilateral lung upon auscultation. Resident #62 was sent to hospital via stretcher and the Director of Nursing (DON) was informed. Review of health status note dated 10/02/22 revealed the called the hospital for an update on Resident #62's condition and Resident #62 was admitted with pneumonia. Further record review revealed there was no documented evidence of the Ombudsman being notified of Resident #62's hospitalization . 39702 (continued on next page)

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	12/01/2022

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Medical record review for Resident #117 revealed an admitted [DATE]. Diagnoses include dementia with behaviors chronic obstructive pulmonary disease, Alzheimer's disease hypertension, anxiety, major depressive disorder and hyperlipidemia. Resident #117 was sent to the hospital on 11/2/22 and returned on 11/3/22. Review of the MDS assessment dated [DATE] revealed Resident #117's cognitive status was not able to be completed as resident was unable to answer questions. Resident #117 had behaviors directed towards others and behavioral symptoms not directed towards others, occurred one to three days during the seven-day assessment period. Resident #117 required limited assist for bed mobility, transfers, and supervision for toileting and eating. Review of progress note dated 11/02/22 at 5:12 P.M. for Resident #117 revealed the resident was observed exiting another residents room by a State tested Nursing Assistant (STNA). Resident #117 observed to be bleeding from forehead and distraught. First aide was provided by the Registered Nurse (RN), vitals taken, range of motion unchanged. Review of the progress note dated 11/02/22 at 10:38 P.M. revealed Resident #117 was noted to be in a physical altercation with another resident, resident was assessed, and physician notified of resident's laceration to forehead from being hit in the forehead by another resident. Orders obtained to send resident to the hospital for evaluation and treatment. Resident #117 was unable to communicate what happened in the incident with the other resident. Further record review revealed there was no evidence the Ombudsman was notified of Resident #117's hospitalization . An interview on 11/17/22 at 9:30 A.M. with the DON reported that the Licensed Social Worker (LSW) is responsible for notifying the Ombudsman when a resident is admitted to the hospital. An interview on 11/17/22 at 9:49 A.M. with LSW #27 stated that she does not notify the Ombudsman that the Business Office Manager (BOM) is responsible for that. An interview on 11/17/22 at 10:07 A.M. with BOM #12 stated she was not notifying the Ombudsman when residents are admitted to the hospital because she did not know the Ombudsman was supposed to be notified and she does not who the Ombudsman is. The BOM #12 confirmed the Ombudsman was not notified of Resident #62, #102 and #117's hospitalization s.

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	12/01/2022

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review and staff interview, the facility failed to provide medications to residents when they are on a leave of absence with family. This affected one (#8) out of 24 residents reviewed during the annual survey. The in-house census was 121. Findings include: A chart review revealed the Resident #8 was admitted on [DATE] and a re-entry on 12/28/19 with diagnosis including schizoaffective disorder, COVID, bipolar disorder, mood disorder, head injury, nausea, episodic tension-type headache, and traumatic brain injury. Review of the Annual Minimum Data Set, dated dated dated [DATE] revealed the Resident #8 had no cognitive deficits, requires supervision with activities of daily living, and is occasionally incontinent of bowel and bladder. Review of 12/02/19 physician order dated 12/02/19 revealed to give clonazepam one milligram (mg) by mouth at bedtime related to schizoaffective disorder, bipolar type. Review of physician order dated 12/30/19 revealed Resident #8 may on go on leave of absence with family/responsible party with medications as indicated. Review of physician order dated 11/03/22 revealed to give klonopin 0.5 (mg) two times a day. An interview on 11/21/22 at 2:46 P.M. with Licensed Practical Nurse (LPN) #36 reported that the pharmacy does not send single dose packets with narcotics and the pharmacy policy is to not punch controlled medications out of the sleeve of medications, so Resident #8 did not get to take his narcotic medications on 10/28/22 when he left for the day with his family. An interview on 11/21/22 at 2:53 P.M. with Pharmacy Technician #201 reported that they do send single packets of medication for leave of absence but not controlled substances and the nurse is to punch the medication out of the sleeve and label it so the resident can take in absence from the facility. This deficiency represents non-compliance investigated under Complaint Number OH00137725.