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	04/25/2023

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, resident interview, staff interview, review of hospital reports, and review of facility policy, the facility failed to ensure staff safely assisted residents with transfers. This resulted in actual harm when a staff person was pushing Resident #73 via wheelchair without the footrests in place. Resident #73 fell face forward and sustained a laceration to his head requiring emergency hospital transfer and sutures. This affected one (Resident #73) of three reviewed for accidents. The facility's census was 133. Findings include: Review of the medical record for Resident #73 revealed an admitted [DATE] with diagnoses including quadriplegia, anxiety disorder, bipolar disorder, and schizoaffective disorder. Review of the Minimum Data Set (MDS) for Resident #73 dated 04/01/23, revealed the resident was cognitively intact and was totally dependent upon the assistance of two staff with transfers and was non-ambulatory. Review of the fall risk assessment for Resident #73 dated 02/04/23 revealed the resident was at risk for falls. Review of the care plan for Resident #73 updated 04/11/23, revealed the resident was at risk for falls related to dependence on staff for transfers/mobility. Interventions included be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, education for safety of foot pedals to be on and resident sitting in an upright position in wheelchair, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, follow facility fall protocol, and physical therapy to evaluate and treat as needed. Review of the nurse progress note for Resident #73 dated 03/24/23 per Licensed Practical Nurse (LPN) #250, revealed the nurse was at the nurse's desk and heard a loud thump noise and when she stood up, she saw the resident lying face down on the floor in front of his wheelchair. Resident #73 had a gash above his right eye, which was bleeding. The nurse applied pressure to the laceration and called 911. Emergency personnel arrived and wrapped Resident #73's head with an ace wrap and took the resident to the hospital. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of hospital notes for Resident #73 dated 03/24/23 revealed the resident presented to the hospital with complaint of head injury and laceration over the right eyebrow from a fall at the facility. The resident was quadriplegic from a past history of trauma and he accidentally fell to the ground from his wheelchair and struck his head, causing bleeding from a laceration above the right eyebrow. Resident #73 received a tetanus shot and the laceration above the right eyebrow was noted to be six centimeters (cm) in length and required closure with ten sutures. Observation on 04/24/23 at 9:23 A.M. of Resident #73 revealed the resident was sitting in his custom high-back manual wheelchair with footrests in place and the resident's feet were positioned on the footrest. Resident #73 had a healing laceration noted above his right eyebrow which was approximately six cm in length. Interview on 04/24/23 at 9:23 A.M. with Resident #73 confirmed on 03/24/23, he was up in his wheelchair in the common area outside the therapy gym. His legs were not on the footrests, and they had been pushed to the side because he was getting ready to have therapy soon. Resident #73 confirmed Business Office Manager (BOM) #425 approached him in the hall because he had requested to have someone from administration discuss his finances. Resident #73 confirmed he did not want to discuss financial matters in the common area and BOM #425 suggested they talk in the resident's room. Resident #73 confirmed BOM #425 did not place the footrests back in position and did not place his feet on the footrests, and his feet were still dangling when BOM #425 began to push his wheelchair. Resident #73 confirmed he has quadriplegia and is unable to move his extremities. Resident #73 confirmed because his feet were not on the footrests, when BOM #425 pushed his wheelchair forward it caused him to fall face forward out of the chair and onto the floor. Resident #73 confirmed he did not lose consciousness and he felt a large amount of blood coming from a gash on his head. Resident #73 confirmed the nursing staff provided first aid and called 911. He went to the hospital and had to have a tetanus shot and stitches to close the gash to his right eyebrow. Interview on 04/24/23 at 1:40 P.M. with the Administrator, [NAME] President of Clinical Services (VPCS) #975, and Licensed Practical Nurse (LPN) #640 confirmed the facility conducted an investigation of Resident #73's fall on 03/24/23. Interview confirmed Resident #73 had quadriplegia and was unable to move his extremities himself. The resident used a high back custom wheelchair with footrests for mobility. Resident #73 was unable to propel his wheelchair himself. Interview confirmed BOM #425 pushed the resident's wheelchair forward without the footrests in place and the resident's feet were left dangling, causing Resident #73 to fall forward and sustain a laceration about his right eye, in which required hospitalization and sutures. Interview confirmed the facility's investigation determined the root cause of Resident #73's fall on 03/24/23, was due to an untrained staff member transporting him from one place to another without ensuring a safe transfer. Interview confirmed the facility's follow up intervention was to have LPN #635 provide education to BOM #425 on 04/25/23 to allow clinical staff to transfer residents. Interview on 04/24/23 at 2:30 P.M. with LPN #250 confirmed she was at the nurse's station on 03/24/23 when she heard a loud thump and stood up and saw Resident #73 on the floor face down in front of his wheelchair. Resident #73's footrests were not in place but had been pushed to the side. Resident #73 had a laceration to his head with a copious amount of blood. LPN #250 confirmed she applied pressure to the resident's head and called 911. LPN #250 confirmed Resident #73 said he fell face forward when a staff person pushed his wheelchair forward without his feet on the footrests and they got caught on the floor, which caused him to fall face forward out of his chair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Falls Clinical Protocol, dated March 2018 revealed the facility would assess the resident's risk for falls, and the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. This deficiency is based on incidental findings discovered during the course of the complaint investigation.