STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to ensure comprehensive and effective infection control policies and practices were developed and implemented to prevent the spread of COVID 19 within the facility. This had the potential to affect all 144 residents residing in the facility. Findings include: 1. During observations on [DATE], 12 residents (Resident #117, #119, #123, #132, #135, #136, #138, #139, #142, #148, #149 and #154) that had tested negative for COVID-19 were residing on the Lighthouse unit with 25 current residents (Resident #118, #120, #121, #122, #124, #125, #126, #127, #130, #131, #133, #134, #137, #140, #141, #143, #151, #152, #128, #129, #145, #146, #147, #150 and #153) that were positive for COVID-19. The facility did not have dedicated staff assigned only to care for those residents in isolation on the Lighthouse unit with confirmed cases of COVID-19. 2. Review of Resident #117's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #118's progress note dated [DATE] revealed test results were positive for COVID-19. Review of the physician's orders dated [DATE] revealed droplet precautions were ordered. During observations on [DATE], Residents #117 and #118 remained roommates despite the fact Resident #118 tested positive for [MEDICAL CONDITION]. 3. Review of Resident #119's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #120's progress note dated [DATE] revealed test results were positive for COVID-19. Review of the physician orders dated [DATE] revealed droplet precautions were ordered. During observation on [DATE], Residents #119 and #120 remained roommates despite Resident #118 testing positive for [MEDICAL CONDITION]. 4. Review of Resident #123's progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #124's progress notes dated [DATE] revealed test results were positive for COVID-19. Review of physician orders dated [DATE] revealed droplet precautions were ordered. On [DATE], Resident #123 tested positive for COVID-19. During observations on [DATE], Residents #123 and #124 remained roommates, despite Resident #124 testing positive for [MEDICAL CONDITION]. 5. Review of Resident #148's progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #147's progress note dated [DATE] revealed resident tested positive for COVID-19. Review of physician orders dated [DATE] revealed droplet precautions were ordered. Resident #147 was moved to the dedicated COVID-19 unit (Harmony unit) at this time. On [DATE], the resident was moved back to the Lighthouse unit. During observation on [DATE], Residents #147 and #148 remained roommates, despite Resident #147 testing positive for [MEDICAL CONDITION]. 6. Review of Resident #132's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #133's progress note dated [DATE] revealed test results were positive for COVID-19. Review of physician orders dated [DATE] revealed droplet precautions were ordered. Review of Resident #134's progress note dated [DATE] revealed test results were positive for COVID-19. Review of physician orders dated [DATE] revealed droplet precautions were ordered. During observation on [DATE], Residents #132, #133 and #134 remained roommates, despite Residents #133 and #134 testing positive for [MEDICAL CONDITION]. 7. Review of Resident #137's progress note dated [DATE] revealed test results were positive for COVID-19. Review of physician orders dated [DATE] revealed droplet precautions were ordered. Review of Resident #138's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #139's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. During observation on [DATE], Residents #137, #138 and #139 remained roommates, despite Resident #137 testing positive for [MEDICAL CONDITION]. 8. Review of Resident #142's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #143's progress note dated [DATE] revealed test results were positive for COVID-19. Review of the physician's orders dated [DATE] revealed droplet precautions were ordered. During observation on [DATE], Residents #142 and #143 remained roommates, despite Resident #143 testing positive for [MEDICAL CONDITION]. 9. Review of Resident #154's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #153's progress note dated [DATE] revealed test results were positive for COVID-19. Resident #153 was moved to the dedicated COVID-19 unit (Harmony unit) at this time. On [DATE], the resident was moved back to the Lighthouse unit. During observation on [DATE], Residents #152 and #153 remained roommates, despite Resident #153 testing positive for [MEDICAL CONDITION]. 10. Review of Resident #149's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #150's nurses progress notes dated [DATE] revealed test results were positive for COVID-19. Physician orders dated [DATE] revealed droplet precautions were ordered. Resident #150 was moved to the dedicated COVID-19 unit (Harmony unit) at this time. On [DATE], the resident was moved back to the Lighthouse unit. During observation on [DATE], Residents #149 and #150 remained roommates, despite Resident #150 testing positive for [MEDICAL CONDITION]. On [DATE], Resident #149's progress notes documented the resident was sent to the emergency room for evaluation due to the resident complaining of being weak, not eating and being more confused and disoriented. Resident #149 expired at the hospital on [DATE]. 11. Review of Resident #135's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #136's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. During observation on [DATE], Residents #135 and #136 were roommates. Additional testing revealed Resident #136 was positive for COVID-19 on [DATE]. The physician order dated [DATE] revealed she was to be in isolation. 12. Review of the facility's list of residents that were positive for COVID-19, undated, revealed additional Residents #121, #122, #125, #126, #127, #130, #131, #137, #140, #141, #145, #146, #151, #152, #300 and #301 were positive for COVID-19 and remained on the Lighthouse unit, commingled with the residents who had tested negative for COVID-19. All residents reviewed had a plan of care for risk for contracting the COVID-19 virus due to the resident's age and chronic medical conditions. Protocols for COVID-19 screening and precautions were to be followed. 13. Observation of the Lighthouse COVID-19 unit on [DATE] from 9:20 A.M. to 10:25 A.M. revealed no PPE supplies were available at either of the two entrances to the unit. There was also no PPE supplies observed outside of any resident rooms on the unit. There were no biohazard bins for doffing PPE at the entrances or inside or outside of any resident rooms. During observation of the Lighthouse unit [DATE] at 9:20 A.M., Housekeeper #01 was wearing a cloth face mask and no gown, booties, gloves or face shield. Housekeeper #01 left the unit and went into building three, 1-West unit. STNA #02 was wearing a surgical mask with no gown, booties, gloves or face shield. Interview with LPN #13 on [DATE] at 9:20 A.M. verified Housekeeper #01 and STNA #02 were not wearing an N95 face mask, gown, booties, gloves or face shield. During interview on [DATE] at 9:21 A.M., Housekeeper #01 stated the facility did not provide any PPE such as an N95 face mask, gown, booties, gloves or face shield. During interview on [DATE] at 9:21 A.M., STNA #02 stated the facility did not provide any PPE such as an N95 face mask, gown, booties, gloves or face shield. STNA #02 stated that the unit had both COVID-19 positive and COVID-19 negative residents with no separation of infected residents. 14. During observation of the Lighthouse unit on [DATE] at 9:23 A.M., STNA #03 was wearing an N95 face mask but no gown, booties, gloves or face shield. During interview at the time of the observation, STNA #03 stated he was provided an N95 face mask but no gown, booties, gloves or

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) face shield. 15. During observation on [DATE] at 9:40 A.M., LPN #05 was working on the Lighthouse unit while wearing an N95 mask but no gown, gloves, booties or face shield. LPN #05 walked around the unit and spoke to Residents #135 and #136 while standing at the doorway to their room. She then went back to the nursing station to work on the computer, pulling her mask down below her nose to do so. Resident #147 was standing at the ledge of the nursing station talking on the telephone while LPN #05 was sitting on her computer with her mask pulled forward below her nose. Resident #147 asked LPN #05 to speak to the person on the telephone and LPN #05 put her mask back over her nose and proceeded to use the same telephone as Resident #147 without disinfecting it. LPN #05 gave the phone back to Resident #147 without sanitizing it. LPN #05 used a sanitizer wipe to disinfect the phone after Resident #147 was finished using it. LPN #05 continued to pull her mask down below her nose while at the nursing station. During an interview at the time of the observation, LPN #05 stated she had her mask below her nose because it did not fit correctly and fogged up her glasses. She verified she was not wearing a gown, gloves, booties or face shield and verified Resident #147 was positive for COVID-19 and had used the telephone at the nursing station. When questioned about the location of PPE, LPN #05 stated PPE was kept in the locked medication room. LPN #05 verified that there was no PPE outside the unit to don or biohazard bin outside the unit to doff PPE after use. LPN #05 also verified there was no PPE outside of the resident rooms. LPN #05 stated she dons and doffs PPE on the unit, and when she removes soiled PPE it is placed in the regular trash can. LPN #05 stated that the facility has both COVID-19 and non-COVID-19 residents on the unit and that the facility continues to keep positive and negative residents together as roommates. LPN #05 reported Resident #117, Resident #119, Resident #123, Resident #132, Resident #138, Resident #139, Resident #142, Resident #148, Resident #149 and Resident #154 were all negative for COVID-19 but had roommates that were positive for COVID-19. 16. During observation on [DATE] at 9:40 A.M., Laundry Staff #06 was on the Lighthouse unit at the nursing station wearing an N95 face mask, but no gown, booties gloves or face shield. Laundry Staff #06 asked LPN #05 for a gown. LPN #05 unlocked the medication room and gave Laundry Staff #06 a gown. 17. Observation of the Lighthouse unit on [DATE] at 9:45 A.M. revealed STNA #03 going in and out of the rooms of Residents #121, #122, #130, #131, #136, #137, #138, #142, #143, #144, #145, #146, #147, #148, #149, #150 and #151 wearing only an N95 mask to retrieve breakfast trays. STNA #03 was not wearing a gown, gloves, face shield or booties and did not wash or sanitize hands or don/doff any PPE between rooms. STNA #03 and LPN #05 were observed putting trash from breakfast trays that were collected by STNA #03 in a trash bag. LPN #05 was holding the bag with gloves and was wearing an N95 mask but no other PPE. STNA #03 was putting items from meal trays into the trash bag wearing an N95 mask, but no other PPE including gloves. Residents #136, #138, #142, #148 and #149 were COVID-19 negative; however, all other residents STNA #03 encountered during the observation were COVID-19 positive. During an interview at the time of the observation, STNA #03 stated she was not told which residents had been COVID-19 positive or negative but thought they all had it now. STNA #03 verified there were no bins to doff or don PPE, there was no PPE outside the unit and no PPE outside of the resident's rooms. 18. During observation on [DATE] at 10:00 A.M., Housekeeper #01 returned to the Lighthouse unit and asked LPN #05 for a gown. LPN #05 again unlocked the medication storage room and provided Housekeeper #01 with a blue plastic gown. Housekeeper #01 proceeded to clean rooms wearing an N95 face mask under his cloth mask and a gown. He was not wearing any other PPE. During an interview at the time of the observation, Housekeeper #01 stated he did not know which patients had COVID-19 on the unit, but the facility used a bleach solution to clean. 19. During observations on [DATE] at 10:22 A.M., STNA #03 walked with Resident #133 to the shower room wearing an N95 face mask but no gown, gloves, booties or face shield. Resident #133 was COVID-19 positive. At the time of the observation, LPN #05 verified STNA #03 was only wearing an N95 face mask. 20. During a telephone interview on [DATE] at 6:15 P.M., STNA #40 stated she had symptoms of fever and chills on [DATE], then tested positive for COVID-19 on [DATE]. STNA #40 stated she worked on the Lighthouse unit prior to testing positive for COVID-19. She stated several residents tested positive for COVID-19 prior to her testing positive. She stated the facility provided the staff with a surgical mask to wear but did not provide them with an N95 face mask, face shield or gown. 21. During interview on [DATE] at 7:20 A.M., Local Health Department (LHD) Staff #100 stated she had been working with the facility and had been in contact with the DON. LHD Staff #100 reported that she has requested a line list from the facility, but they have not provided it. LHD Staff #100 stated the facility originally had one unit that was for COVID-19 residents but then someone infected several residents on another unit. As a result, they opened a second COVID-19 unit. LHD Staff #100 stated the DON told her that they were moving all the positive cases to one area of the building and then the negative cases would remain on that unit in another area in a private room for 14 days. LHD Staff #100 reported she discussed the use of appropriate PPE including wearing N95 masks, gowns, gloves, face shield and booties with the facility for residents with COVID-19 and provided Centers for Disease Control (CDC) resources for the use of PPE. LHD Staff #100 stated facilities should never have positive and negative cases in the same room together. 22. During telephone interview on [DATE] at 9:03 A.M., LPN Unit Manager #102 revealed she was the unit manager of the Lighthouse unit but worked everywhere in the facility. LPN Unit Manager #102 stated she has been working on the floor recently and had not been on the Lighthouse unit. She stated she had moved her office off the Lighthouse unit. The facility provides PPE, but staff do not always wear it. LPN Unit Manager #102 stated she thinks some of the staff want to get COVID-19 because they do not wear the PPE that is provided. 23. During telephone interview on [DATE] at 2:48 P.M., Medical Director (MD) #01 revealed he was aware of cases of COVID-19 in the facility. MD #01 stated that the facility should be using precautions including the use of gowns, N95 face masks and gloves on the COVID-19 units. MD #01 stated he was at the facility on [DATE] and had a meeting with the facility regarding COVID-19 at that time. MD #01 stated the facility only had one COVID-19 unit at the time of his visit. MD #01 stated he was not aware of residents with positive and negative cases of COVID-19 being cohorted in the same rooms on the Lighthouse unit prior to [DATE]. 24. During tour of the facility on [DATE] at 8:15 A.M. to 8:42 A.M., Activities Aide #12 and Activities Aide #21 were passing trays and assisting residents with setting up items on their trays while wearing cloth masks on the 2-West unit. Activities Aide #12 was wearing her cloth mask below her nose. Observation of the Leisure Women's unit revealed Maintenance Staff #10 walking around the building while wearing a cloth mask. Observation of the Leisure Men's unit revealed Housekeeper #25 in the dining room of the unit wearing a cloth mask. Interview with Administrative Assistant #20 on [DATE] from 8:15 A.M. to 8:42 A.M. verified Activities Aide #12, Activities Aide #21, Maintenance #10 and Housekeeper #25 were wearing cloth masks. 25. Interview with the Director of Nursing (DON) on [DATE] at 8:47 A.M. revealed the Harmony and Lighthouse units were the quarantined units at the facility, with residents that had tested positive for COVID-19 residing on both units. The DON stated all staff are required to wear either homemade or surgical masks on the non-COVID units. 26. Observation of Building 1, the lower floor offices, on [DATE] at 7:27 A.M. revealed State tested Nurse Aide (STNA) #459 was not wearing a mask and walking around talking to a staff member that was clocking out at the time clock. Interview on [DATE] at 7:27 A.M. with STNA #459 verified she was not wearing a mask while walking around in Building 1 lower floor offices. 27. Observation of the Leisure Women's unit on [DATE] at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #578 wearing a cloth mask while in the nursing station on the unit. 28. During observation on [DATE] at 7:55 A.M., no disposal bins or PPE was seen outside of the resident rooms or at either of the two doors to enter the unit. Interview with LPN #570 on [DATE] at 7:55 A.M. verified there was no red bins to doff PPE on the unit. LPN #570 also verified there was no PPE outside of resident rooms or located at either of two doors to enter the unit. 29. Observation of the Lighthouse dining room on [DATE] at 8:05 A.M. revealed Resident #129 sitting at a table in the dining room continually coughing. Resident #153 was also observed sitting at a table in the dining room while coughing intermittently. Residents #118, #119, #120, #124, #125, #130, #133 #137, #138, #145 and #154 were also present in the dining room for communal dining with no social distancing in place. All residents were sitting within six feet of each other. STNA #571 and LPN #570 were serving trays to residents in the dining room without sanitizing their hands between each resident. Interview with LPN #570 on [DATE] at 8:05 A.M. verified Residents #129 and #153 were coughing in the dining room with the other residents present and verified all residents were present for communal dining in the dining room on the unit. Interview with STNA #40 and STNA #572 on [DATE] at 8:05 A.M. verified neither sanitized their hands while passing breakfast trays. They stated they did not have access to hand sanitizer. 30. During observation of the COVID-19 Harmony unit on [DATE] at 8:30 A.M., STNA #456 went from room to room, serving breakfast trays, opening the Styrofoam boxes of food, taking lids off of cups and adjusting resident beds. STNA #456 did not sanitize hands between rooms. Housekeeper #458 was wearing a cloth mask and blue gown while mopping the hallway floor on the COVID-19 Harmony unit with doors to resident rooms open. Interview with STNA #456 on [DATE] at 8:30 A.M. verified she did not sanitize in between going in and out of rooms while delivering room trays. Interview with Housekeeper #458 on [DATE] at 8:30 A.M. verified he was wearing a cloth mask on the Harmony COVID-19 unit. 31. Interview with the DON on [DATE] at 8:50 A.M. revealed no one in the Lighthouse unit is on quarantine due to being asymptomatic and having completed their 10-day quarantine. The DON stated Resident #119, Resident #120, Resident #129 and Resident #153 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) coughs because they were smokers but verified they had tested positive for [MEDICAL CONDITION] and had not had any negative tests. 32. On [DATE] at 12:30 P.M. during tour of the facility, six residents on the One West unit were sitting in the dining room, not social distancing. Only one resident was wearing a mask; five others were not. Interview with Licensed Practical Nurse (LPN) #250 revealed she asked for a mask earlier from the supervisor on duty that morning and no one has brought them. 33. On [DATE] beginning at 11:09 A.M. and ending at 12:05 P.M., a tour of the facility was conducted with Admissions Director (AD) #744. On the secured men's Leisure Unit, Residents #53 and #08 were observed sitting next to each other, elbow to elbow, in the unit dining/activity room. Neither resident was wearing a mask. Nursing staff were in the general vicinity and were not redirecting the residents to practice social distancing. AD #744 affirmed the two male residents were sitting next to each other, not socially distant from one another and alerted nursing staff present. On the 2 West unit, Activity Staff (AS) #12 was observed sitting in the unit dining/activity room with her mask under her chin. There were six residents present in the unit activity/dining room. When asked if she was supposed to be wearing her mask over the mouth and nose, she replied that she was sitting away from the residents and the mask was not necessary as the unit did not have any COVID-19 positive residents. An interview was conducted with LPN #105 present on the 2 West unit regarding the mask wearing policy, and what was communicated by AS #12. LPN #105 reported that AS #12 should be wearing her mask at all times per facility policy. On the Lighthouse unit, Residents #145, #154, #152, and #118 were sitting around a table in the unit dining/activity room together, elbow to elbow. None of the four residents were wearing a mask. The residents were in full view of nursing staff present at the nursing station including LPN #759 and STNA's #40 and #2. AD #744 affirmed the four specified residents were sitting in close proximity to one another and not wearing masks. She alerted the nursing staff at the nursing station who then attempted to get the residents to spread out. During interview with LPN #759 on the Lighthouse unit, she stated staff were required to wear a surgical or N95 mask at all times. When queried regarding if information and training was given on how to care for the mask, or how many times it could be worn consecutively, LPN #759 reported that one mask could be worn for the entire week on days scheduled; typically staff work three days and the mask could be worn consecutive days in a row. She stated she could take the mask home, and she takes her mask home and hangs it up on a clothesline. During an interview with STNA #02 on the Lighthouse unit, she stated she was told she could take the mask home and hang it up between wears, but did not recall anyone telling her how many times (shifts) she could or could not wear the mask consecutively. 34. A tour of the COVID-19 dedicated Harmony building was conducted on [DATE] at 11:50 A.M. LPN #675 was the only staff person present in the building. He identified seven residents with COVID-19 that were currently receiving care on the unit. Upon entering the building, PPE was applied outside in the airlock. When asked where the PPE for staff coming onto the unit was, he reported it was kept in the nursing office. LPN #675 was asked about the small chest of drawers in the airlock leading into the unit, and if any PPE was kept in the drawers for staff to don when entering. He opened the drawers and affirmed there was no PPE present, that it had to be given to staff coming on duty directly from the nursing office. They could put in on in the airlock. LPN #675 opened a closet door in the nursing office that had a couple cases each of gowns and gloves. The boxes were open with some of the gowns lying on the floor. LPN #675 confirmed the condition of the PPE closet as described. LPN #675 reported there were no face shields or goggles in the closet. He found one face shield on the floor next to the medication cart and reported that he could not find any goggles. He stated that he brought his own isolation gown and face shield to work. Further observation of the unit revealed there were no diagrams or instructional aides/posters at the entrance to the unit, on the doors of the resident's rooms, or in the hallways of what specific PPE needed to be worn when entering the resident rooms for each of the residents who were COVID-19 positive rooms. LPN #675 affirmed there were no diagrams or instructional aides/posters regarding what was to be donned before entering a room on the unit and did not recall ever seeing anything like that on the unit. 35. An interview was conducted off-site with the Director of Nursing (DON) on [DATE] at 3:56 P.M. regarding any staff training/education on wear and care of the N95 masks. She reported that all staff were given information on how to care for the N95 masks, including how often the same mask could be worn. She reported the masks were not to be worn two days, i.e. two shifts, in a row and were to have a 72-hour waiting period between use of the same mask. The DON stated that the masks were to be disinfected with a disinfectant spray, and then placed in a labeled/dated bag to ensure a 72-hour rotation, and each mask could be worn five times. She communicated that staff should not be taking the used N95 masks home. The DON stated that N95 masks were provided to staff when the COVID-19 unit opened and were available as needed in the screening area. Review of the facility's policy titled COVID 19 Unit Policy and Procedure, undated, revealed all COVID-19 positive residents will reside in the Harmony unit or building two of the campus. The policy indicated everyone is to wear appropriate PPE. N95 masks are to be worn in COVID-19 or Harmony unit until management notifies you otherwise. Gown, shoe covers, and bouffant caps are to be worn for the day unless excessively soiled or torn. Gloves are to be changed between each room or patient encounter. Review of the facility policy titled Infection Control Measures during Pandemic Illness, dated [DATE], revealed isolation of infected residents in private rooms or cohort units and the use of appropriate barrier precautions or PPE during resident care are measures for early prevention of an outbreak. The policy also stated if an outbreak of the pandemic illness occurs within the facility, strict adherence to standard and transmission-based precautions and other infection control measures will be implemented according to the most current CDC recommendations for pandemic influenza. Review of an online resource from the CDC, (HTTPS://www.cdc.gov/Coronavirus/2019-ncov/hcp/long-term-care-strategies.html) dated [DATE], revealed the following guidance regarding face masks: ensure all healthcare care personnel (HCP) wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect HCP is unknown. Cloth face coverings should not be worn instead of a respirator or facemask if more than source control is required. Review of an online resource from the CDC, (HTTPS://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wear-cloth-face-coverings.html), dated [DATE] revealed the following guidance regarding proper wearing of face coverings: put it over your nose and mouth and secure it under your chin. Review of the CDC's article Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID 19 Pandemic, (HTTPS://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) dated [DATE], revealed staff who enter the room of a patient with suspected or confirmed COVID-19 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. Review of an online resource from the CDC (HTTPS://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) titled Responding to COVID-19 in nursing homes, dated [DATE], revealed if a resident is confirmed to have COVID-19 regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates or residents with COVID-19 should be considered exposed and potentially infected and if all possible should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for COVID-19, 14 days after exposure. Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. Further review of the guidance revealed cohorting of residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents. Health care personnel (HCP) should use all recommended PPE to care for all residents on affected units including both symptomatic and asymptomatic residents. Further review of the guidance revealed dedicated HCP should be assigned to work only the COVID-19 care unit. Review of CMS and CDC's COVID-19 Long Term Care Facility Guidance (HTTPS://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf), dated [DATE], revealed full PPE should be worn per CDC guidelines for care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. The guidance also reported long term care facilities should separate residents who have COVID-19 from residents who are COVID-19 negative. Further review of the guidance revealed facilities should use separate staffing teams for COVID-19 positive residents to the best of their ability to avoid transmission within long term care facilities. This deficiency substantiates Complaint Numbers OH 211 and OH 369.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential Declaration of a State of National Emergency dated [DATE], the Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) COVID-19 Long Term Care Facility Guidance dated [DATE], Nursing Home Guidance from the Centers for Disease Control (CDC), observations, record reviews, review of the facility's infection control policies, and interviews with staff and the local health department, the facility failed to implement effective and recommended infection control practices to prevent the spread of COVID-19 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) the Lighthouse unit. On [DATE], 40 residents of the Lighthouse dementia unit were tested for COVID-19. Seven residents (#128, #129, #145, #146, #147, #150 and #153) tested positive for COVID-19. These residents were then moved to the Harmony unit, a dedicated unit which is currently being utilized to house residents who test positive for COVID-19. On [DATE], the facility received notification that 20 additional residents on the Lighthouse unit (#118, #120, #121, #122, #124, #125, #126, #127, #130, #131, #133, #134, #137, #140, #141, #143, #151, #152, #300 and #301) had tested positive for COVID-19. At this time, the seven residents originally moved to the Harmony unit were moved back to the Lighthouse unit. This resulted in Immediate Jeopardy on [DATE], as the Lighthouse unit had 12 residents (#117, #119, #123, #132, #135, #136, #138, #139, #142, #148, #149 and #154) that tested negative for COVID-19. These 12 residents were not removed from the unit or quarantined from the 27 residents who tested positive for COVID-19. Additionally, staff were observed with no direct access to Personal Protective Equipment (PPE) on the Lighthouse unit as the PPE was stored in the locked medication room at the nursing station, they were not wearing the required PPE to prevent the spread of COVID-19 per the facility policy and Centers for Disease Control (CDC) recommendations and staff were observed entering and exiting the rooms of all residents wearing only an N95 mask, regardless of their COVID-19 status. There were no bins on the Lighthouse unit in which to dispose of used PPE. The facility also failed to ensure social distancing during communal dining and activities and failed to ensure staff practiced proper hand hygiene when passing meal trays. On [DATE] at 12:53 P.M., an attempt was made to notify the Administrator of the Immediate Jeopardy that started on [DATE], however the Administrator refused the notification. During observations on [DATE], 12 residents (Resident #117, #119, #123, #132, #135, #136, #138, #139, #142, #148, #149 and #154) that had tested negative for COVID-19 were residing on the Lighthouse unit with 25 current residents (Resident #118, #120, #121, #122, #124, #125, #126, #127, #130, #131, #133, #134, #137, #140, #141, #143, #151, #152, #128, #129, #145, #146, #147, #150 and #153) that were positive for COVID-19. The facility did not have dedicated staff assigned only to care for those residents in isolation on the Lighthouse unit with confirmed cases of COVID-19. Staff failed to ensure the proper use of PPE and failed to ensure appropriate PPE was utilized when caring for a resident with COVID-19 in isolation (droplet) precautions and throughout the facility placing 40 residents in the Lighthouse unit at risk for contracting COVID-19 and experiencing the potential for serious harm associated with COVID-19 including hospitalization and/or death. The facility census was 144. The Immediate Jeopardy was removed on [DATE] at 3:53 P.M. when the facility implemented the following corrective actions: On [DATE] through [DATE], all residents in the facility received a baseline test for COVID-19. Seven residents in the Lighthouse dementia unit tested positive and were immediately moved to Harmony, the COVID-19 positive unit. On [DATE], all residents in the Lighthouse unit were tested and results on [DATE] through [DATE] showed more residents to be positive. All residents had either already tested positive or presumptive positive and droplet precautions continued in Lighthouse for all residents. Harmony unit has been split by a plastic barrier for a COVID-19 positive/active side and a quarantine side for hospital admissions or presumptive positives due to exposure. All staff on the Harmony unit will remain in full PPE, including use of N95 masks. All other units will use surgical/medical masks at all times. The facility's policy related to COVID-19 droplet precautions, quarantine and discontinuation of precautions, titled COVID + Residents: Screening and Management was implemented on [DATE]. As of [DATE], all of the Lighthouse residents have been removed from droplet precautions per CDC protocol and are now no longer on droplet precautions. They remain in the Lighthouse Unit. PPE is available on every unit in the facility. It is maintained at the nursing station and replenished twice weekly and as needed. For PPE on isolation/quarantine units, staff are to call the unit and PPE is brought to the staff member so they can don before they enter. Staff are to doff and dispose of PPE as they leave the unit and dispose of it in red bins, which are located on each unit. Masks can be obtained at the check-in area at all times. Staff are to wear masks when they enter all care areas. If an outbreak occurs on any other unit, residents will be moved to the Harmony COVID-19 unit. If there are not enough beds on the COVID-19 unit or the resident is not able to be moved due to the need for a secured environment (the Lighthouse Unit) residents will only be cohorted in rooms with other residents that have a positive COVID-19 [DIAGNOSES REDACTED]. All staff in the facility will be in-serviced by the Director of Nursing (DON) or Infection Control nurse on the facility's policy on PPE, including correct use of PPE, donning and doffing PPE, and when PPE must be changed between resident care by [DATE]. The DON and Infection Preventionist were in-serviced by the Corporate Clinical Liaison on [DATE] on the need to ensure that all residents in the facility will be placed in droplet precautions and cohorted in accordance with the facility policy. The DON or Infection Preventionist will conduct daily observations of staff on all units to ensure that staff are using PPE appropriately, donning and doffing appropriately and disposing appropriately. The observations will be done for the next 4 weeks, twice weekly for two weeks, once weekly for one week, then to the Quality Assurance and Performance Improvement committee as needed. The DON and Infection Preventionist will monitor all newly diagnosed residents to ensure that they are placed in the Harmony unit or cohorted appropriately. During interview on [DATE] at 1:35 P.M., State tested Nursing Assistant (STNA) #201 stated he had access to plenty of PPE and did receive educational material on how to don and doff PPE. He reported that if PPE supplies were running low, he would tell the unit nurse and she would get it for him, and he also was able to get additional masks where he checked in each day at the front office. During interview on [DATE] at 1:39 P.M., Licensed Practical Nurse (LPN) #5 stated she has enough PPE to care for the residents. She stated that staff can were a surgical mask or N95 mask when caring for residents that are not in isolation/quarantine, an N95 for residents in isolation/quarantine, but no cloth masks are to be worn by staff. During interview on [DATE] at 1:44 P.M., STNA #3 stated he had received training on donning and doffing PPE and has sufficient PPE, disinfecting wipes, and alcohol-based hand rub when he needs it. STNA #3 was wearing an N95 mask and reported that staff are to wear the N95 masks on the Lighthouse and Harmony units but could wear surgical masks on the other units. During interview on [DATE] at 1:55 P.M., LPN #250, working the 2 West unit, reported she has access to plenty of PPE. LPN #250 affirmed she has training recently on the proper way to don and doff PPE, that handouts with pictures on the proper sequence were provided. During interview on [DATE] at 2:06 P.M., STNA #399, working the 2 West unit, stated he has received information and training on donning and doffing PPE and the head nurse on the unit watches him. He stated he had enough PPE available to take care of the residents, that there are supplies on the unit, and he can contact central supply staff if he needed more. During interview on [DATE] at 2:15 P.M., STNA #323, working the men's side of the Leisure building, stated she did get recent training materials/handouts with pictorials on donning and doffing PPE correctly. She reported she had enough PPE and could get new/additional masks in the business office area. During observation of the Central supply room on the first floor of the Leisure Building, on [DATE] at 2:25 P.M. revealed eight 24 count cases of pocket size hand sanitizers, multiple cases of caps, disposable isolation gowns, surgical masks, a large case of face shields, and gloves. In addition, there was an ample supply of alcohol bases hand rub refills for the dispensers. During interview on [DATE] at 2:30 P.M., LPN #759 working the Harmony unit reported that there was a sufficient supply of PPE to provide care to the residents [DIAGNOSES REDACTED].#759 reported that all the required PPE is now in the drawers of the isolation cabinet in the airlock/anteroom at the entrance to the unit including gloves, shoe covers, hair covers, gowns, and face shield. He reported there were also additional supplies of each item on the unit. LPN #759 shared that he had all PPE needed to provide care on the unit and was in the process of re-organizing the closet containing the PPE. Although the Immediate Jeopardy was removed, the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1. Review of Resident #117's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #118's progress note dated [DATE] revealed test results were positive for COVID-19. Review of the physician's orders [REDACTED]. During observations on [DATE], Residents #117 and #118 remained roommates despite the fact Resident #118 tested positive for [MEDICAL CONDITION]. 2. Review of Resident #119's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #120's progress note dated [DATE] revealed test results were positive for COVID-19. Review of the physician orders [REDACTED]. During observation on [DATE], Residents #119 and #120 remained roommates despite Resident #118 testing positive for [MEDICAL CONDITION]. 3. Review of Resident #123's progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #124's progress notes dated [DATE] revealed test results were positive for COVID-19. Review of physician orders [REDACTED]. On [DATE], Resident #123 tested positive for COVID-19. During observations on [DATE], Residents #123 and #124 remained roommates, despite Resident #124 testing positive for [MEDICAL CONDITION]. 4. Review of Resident #148's progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #147's progress note dated [DATE] revealed resident tested positive for COVID-19. Review of physician orders [REDACTED]. Resident #147 was moved to the dedicated COVID-19 unit (Harmony unit) at this time. On [DATE], the resident was moved back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) to the Lighthouse unit. During observation on [DATE], Residents #147 and #148 remained roommates, despite Resident #147 testing positive for [MEDICAL CONDITION]. 5. Review of Resident #132's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #133's progress note dated [DATE] revealed test results were positive for COVID-19. Review of physician orders [REDACTED]. Review of Resident #134's progress note dated [DATE] revealed test results were positive for COVID-19. Review of physician orders [REDACTED]. During observation on [DATE], Residents #132, #133 and #134 remained roommates, despite Residents #133 and #134 testing positive for [MEDICAL CONDITION]. 6. Review of Resident #137's progress note dated [DATE] revealed test results were positive for COVID-19. Review of physician orders [REDACTED]. Review of Resident #138's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #139's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. During observation on [DATE], Residents #137, #138 and #139 remained roommates, despite Resident #137 testing positive for [MEDICAL CONDITION]. 7. Review of Resident #142's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #143's progress note dated [DATE] revealed test results were positive for COVID-19. Review of the physician's orders [REDACTED]. During observation on [DATE], Residents #142 and #143 remained roommates, despite Resident #143 testing positive for [MEDICAL CONDITION]. 8. Review of Resident #154's progress note dated [DATE] revealed test results were negative for COVID-19. Review of Resident #153's progress note dated [DATE] revealed test results were positive for COVID-19. Resident #153 was moved to the dedicated COVID-19 unit (Harmony unit) at this time. On [DATE], the resident was moved back to the Lighthouse unit. During observation on [DATE], Residents #152 and #153 remained roommates, despite Resident #153 testing positive for [MEDICAL CONDITION]. 9. Review of Resident #149's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #150's nurses progress notes dated [DATE] revealed test results were positive for COVID-19. Physician orders [REDACTED]. Resident #150 was moved to the dedicated COVID-19 unit (Harmony unit) at this time. On [DATE], the resident was moved back to the Lighthouse unit. During observation on [DATE], Residents #149 and #150 remained roommates, despite Resident #150 testing positive for [MEDICAL CONDITION]. On [DATE], Resident #149's progress notes documented the resident was sent to the emergency room for evaluation due to the resident complaining of being weak, not eating and being more confused and disoriented. Resident #149 expired at the hospital on [DATE]. 10. Review of Resident #135's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. Review of Resident #136's nurses progress notes dated [DATE] revealed test results were negative for COVID-19. During observation on [DATE], Residents #135 and #136 were roommates. Additional testing revealed Resident #136 was positive for COVID-19 on [DATE]. The physician order [REDACTED]. Review of the facility's list of residents that were positive for COVID-19, undated, revealed additional Residents #121, #122, #125, #126, #127, #130, #131, #137, #140, #141, #145, #146, #151, #152, #300 and #301 were positive for COVID-19 and remained on the Lighthouse unit, commingled with the residents who had tested negative for COVID-19. All residents reviewed had a plan of care for risk for contracting the COVID-19 virus due to the resident's age and chronic medical conditions. Protocols for COVID-19 screening and precautions were to be followed. Observation of the Lighthouse COVID-19 unit on [DATE] from 9:20 A.M. to 10:25 A.M. revealed no PPE supplies were available at either of the two entrances to the unit. There was also no PPE supplies observed outside of any resident rooms on the unit. There were no biohazard bins for doffing PPE at the entrances or inside or outside of any resident rooms. During observation of the Lighthouse unit [DATE] at 9:20 A.M., Housekeeper #01 was wearing a cloth face mask and no gown, booties, gloves or face shield. Housekeeper #01 left the unit and went into building three, 1-West unit. STNA #02 was wearing a surgical mask with no gown, booties, gloves or face shield. Interview with LPN #13 on [DATE] at 9:20 A.M. verified Housekeeper #01 and STNA #02 were not wearing an N95 face mask, gown, booties, gloves or face shield. During interview on [DATE] at 9:21 A.M., Housekeeper #01 stated the facility did not provide any PPE such as an N95 face mask, gown, booties, gloves or face shield. During interview on [DATE] at 9:21 A.M., STNA #02 stated the facility did not provide any PPE such as an N95 face mask, gown, booties, gloves or face shield. STNA #02 stated that the unit had both COVID-19 positive and COVID-19 negative residents with no separation of infected residents. During observation of the Lighthouse unit on [DATE] at 9:23 A.M., STNA #03 was wearing an N95 face mask but no gown, booties, gloves or face shield. During interview at the time of the observation, STNA #03 stated he was provided an N95 face mask but no gown, booties, gloves or face shield. During observation on [DATE] at 9:40 A.M., LPN #05 was working on the Lighthouse unit while wearing an N95 mask but no gown, gloves, booties or face shield. LPN #05 walked around the unit and spoke to Residents #135 and #136 while standing at the doorway to their room. She then went back to the nursing station to work on the computer, pulling her mask down below her nose to do so. Resident #147 was standing at the ledge of the nursing station talking on the telephone while LPN #05 was sitting on her computer with her mask pulled forward below her nose. Resident #147 asked LPN #05 to speak to the person on the telephone and LPN #05 put her mask back over her nose and proceeded to use the same telephone as Resident #147 without disinfecting it. LPN #05 gave the phone back to Resident #147 without sanitizing it. LPN #05 used a sanitizer wipe to disinfect the phone after Resident #147 was finished using it. LPN #05 continued to pull her mask down below her nose while at the nursing station. During an interview at the time of the observation, LPN #05 stated she had her mask below her nose because it did not fit correctly and fogged up her glasses. She verified she was not wearing a gown, gloves, booties or face shield and verified Resident #147 was positive for COVID-19 and had used the telephone at the nursing station. When questioned about the location of PPE, LPN #05 stated PPE was kept in the locked medication room. LPN #05 verified that there was no PPE outside the unit to don or biohazard bin outside the unit to doff PPE after use. LPN #05 also verified there was no PPE outside of the resident rooms. LPN #05 stated she dons and doffs PPE on the unit, and when she removes soiled PPE it is placed in the regular trash can. LPN #05 stated that the facility has both COVID-19 and non-COVID-19 residents on the unit and that the facility continues to keep positive and negative residents together as roommates. LPN #05 reported Resident #117, Resident #119, Resident #123, Resident #132, Resident #138, Resident #139, Resident #142, Resident #148, Resident #149 and Resident #154 were all negative for COVID-19 but had roommates that were positive for COVID-19. During observation on [DATE] at 9:40 A.M., Laundry Staff #06 was on the Lighthouse unit at the nursing station wearing an N95 face mask, but no gown, booties gloves or face shield. Laundry Staff #06 asked LPN #05 for a gown. LPN #05 unlocked the medication room and gave Laundry Staff #06 a gown. Observation of the Lighthouse unit on [DATE] at 9:45 A.M. revealed STNA #03 going in and out of the rooms of Residents #121, #122, #130, #131, #136, #137, #138, #142, #143, #144, #145, #146, #147, #148, #149, #150 and #151 wearing only an N95 mask to retrieve breakfast trays. STNA #03 was not wearing a gown, gloves, face shield or booties and did not wash or sanitize hands or don/doff any PPE between rooms. STNA #03 and LPN #05 were observed putting trash from breakfast trays that were collected by STNA #03 in a trash bag. LPN #05 was holding the bag with gloves and was wearing an N95 mask but no other PPE. STNA #03 was putting items from meal trays into the trash bag wearing an N95 mask, but no other PPE including gloves. Residents #136, #138, #142, #148 and #149 were COVID-19 negative; however, all other residents STNA #03 encountered during the observation were COVID-19 positive. During an interview at the time of the observation, STNA #03 stated she was not told which residents had been COVID-19 positive or negative but thought they all had it now. STNA #03 verified there were no bins to doff or don PPE, there was no PPE outside the unit and no PPE outside of the resident's rooms. During observation on [DATE] at 10:00 A.M., Housekeeper #01 returned to the Lighthouse unit and asked LPN #05 for a gown. LPN #05 again unlocked the medication storage room and provided Housekeeper #01 with a blue plastic gown. Housekeeper #01 proceeded to clean rooms wearing an N95 face mask under his cloth mask and a gown. He was not wearing any other PPE. During an interview at the time of the observation, Housekeeper #01 stated he did not know which patients had COVID-19 on the unit, but the facility used a bleach solution to clean. During observations on [DATE] at 10:22 A.M., STNA #03 walked with Resident #133 to the shower room wearing an N95 face mask but no gown, gloves, booties or face shield. Resident #133 was COVID-19 positive. At the time of the observation, LPN #05 verified STNA #03 was only wearing an N95 face mask. During a telephone interview on [DATE] at 6:15 P.M., STNA #40 stated she had symptoms of fever and chills on [DATE], then tested positive for COVID-19 on [DATE]. STNA #40 stated she worked on the Lighthouse unit prior to testing positive for COVID-19. She stated several residents tested positive for COVID-19 prior to her testing positive. She stated the facility provided the staff with a surgical mask to wear but did not provide them with an N95 face mask, face shield or gown. During interview on [DATE] at 7:20 A.M., Local Health Department (LHD) Staff #100 stated she had been working with the facility and had been in contact with the DON. LHD Staff #100 reported that she has requested a line list from the facility, but they have not provided it. LHD Staff #100 stated the facility originally had one unit that was for COVID-19 residents but then someone infected several residents on another unit. As a result, they opened a second COVID-19 unit. LHD Staff #100 stated the DON told her that they were moving all the positive cases to one area of the building and then the negative cases would remain on that unit in another area in a private room for 14 days. LHD Staff #100 reported she discussed the use of appropriate PPE including wearing N95 masks,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) gowns, gloves, face shield and booties with the facility for residents with COVID-19 and provided Centers for Disease Control (CDC) resources for the use of PPE. LHD Staff #100 stated facilities should never have positive and negative cases in the same room together. During telephone interview on [DATE] at 9:03 A.M., LPN Unit Manager #102 revealed she was the unit manager of the Lighthouse unit but worked everywhere in the facility. LPN Unit Manager #102 stated she has been working on the floor recently and had not been on the Lighthouse unit. She stated she had moved her office off the Lighthouse unit. The facility provides PPE, but staff do not always wear it. LPN Unit Manager #102 stated she thinks some of the staff want to get COVID-19 because they do not wear the PPE that is provided. During telephone interview on [DATE] at 2:48 P.M., Medical Director (MD) #01 revealed he was aware of cases of COVID-19 in the facility. MD #01 stated that the facility should be using precautions including the use of gowns, N95 face masks and gloves on the COVID-19 units. MD #01 stated he was at the facility on [DATE] and had a meeting with the facility regarding COVID-19 at that time. MD #01 stated the facility only had one COVID-19 unit at the time of his visit. MD #01 stated he was not aware of residents with positive and negative cases of COVID-19 being cohorted in the same rooms on the Lighthouse unit prior to [DATE]. During tour of the facility on [DATE] at 8:15 A.M. to 8:42 A.M., Activities Aide #12 and Activities Aide #21 were passing trays and assisting residents with setting up items on their trays while wearing cloth masks on the 2-West unit. Activities Aide #12 was wearing her cloth mask below her nose. Observation of the Leisure Women's unit revealed Maintenance Staff #10 walking around the building while wearing a cloth mask. Observation of the Leisure Men's unit revealed Housekeeper #25 in the dining room of the unit wearing a cloth mask. Interview with Administrative Assistant #20 on [DATE] from 8:15 A.M. to 8:42 A.M. verified Activities Aide #12, Activities Aide #21, Maintenance #10 and Housekeeper #25 were wearing cloth masks. Interview with the Director of Nursing (DON) on [DATE] at 8:47 A.M. revealed the Harmony and Lighthouse units were the quarantined units at the facility, with residents that had tested positive for COVID-19 residing on both units. The DON stated all staff are required to wear either homemade or surgical masks on the non-COVID units. Observation of Building 1, the lower floor offices, on [DATE] at 7:27 A.M. revealed State tested Nurse Aide (STNA) #459 was not wearing a mask and walking around talking to a staff member that was clocking out at the time clock. Interview on [DATE] at 7:27 A.M. with STNA #459 verified she was not wearing a mask while walking around in Building 1 lower floor offices. Observation of the Leisure Women's unit on [DATE] at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #578 wearing a cloth mask while in the nursing station on the unit. During observation on [DATE] at 7:55 A.M., no disposal bins or PPE was seen outside of the resident rooms or at either of the two doors to enter the unit. Interview with LPN #570 on [DATE] at 7:55 A.M. verified there was no red bins to doff PPE on the unit. LPN #570 also verified there was no PPE outside of resident rooms or located at either of two doors to enter the unit. Observation of the Lighthouse dining room on [DATE] at 8:05 A.M. revealed Resident #129 sitting at a table in the dining room continually coughing. Resident #153 was also observed sitting at a table in the dining room while coughing intermittently. Residents #118, #119, #120, #124, #125, #130, #133 #137, #138, #145 and #154 were also present in the dining room for communal dining with no social distancing in place. All residents were sitting within six feet of each other. STNA #571 and LPN #570 were serving trays to residents in the dining room without sanitizing their hands between each resident. Interview with LPN #570 on [DATE] at 8:05 A.M. verified Residents #129 and #153 were coughing in the dining room with the other residents present and verified all residents were present for communal dining in the dining room on the unit. Interview with STNA #40 and STNA #572 on [DATE] at 8:05 A.M. verified neither sanitized their hands while passing breakfast trays. They stated they did not have access to hand sanitizer. During observation of the COVID-19 Harmony unit on [DATE] at 8:30 A.M., STNA #456 went from room to room, serving breakfast trays, opening the Styrofoam boxes of food, taking lids off of cups and adjusting resident beds. STNA #456 did not sanitize hands between rooms. Housekeeper #458 was wearing a cloth mask and blue gown while mopping the hallway floor on the COVID-19 Harmony unit with doors to resident rooms open. Interview with STNA #456 on [DATE] at 8:30 A.M. verified she did not sanitize in between going in and out of rooms while delivering room trays. Interview with Housekeeper #458 on [DATE] at 8:30 A.M. verified he was wearing a cloth mask on the Harmony COVID-19 unit. Interview with the DON on [DATE] at 8:50 A.M. revealed no one in the Lighthouse unit is on quarantine due to being asymptomatic and having completed their 10-day quarantine. The DON stated Resident #119, Resident #120, Resident #129 and Resident #153 had coughs because they were smokers but verified they had tested positive for [MEDICAL CONDITION] and had not had any negative tests. On [DATE] at 12:30 P.M. during tour of the facility, six residents on the One West unit were sitting in the dining room, not social distancing. Only one resident was wearing a mask; five others were not. Interview with Licensed Practical Nurse (LPN) #250 revealed she asked for a mask earlier from the supervisor on duty that morning and no one has brought them. On [DATE] beginning at 11:09 A.M. and ending at 12:05 P.M., a tour of the facility was conducted with Admissions Director (AD) #744. On the secured men's Leisure Unit, Residents #53 and #08 were observed sitting next to each other, elbow to elbow, in the unit dining/activity room. Neither resident was wearing a mask. Nursing staff were in the general vicinity and were not redirecting the residents to practice social distancing. AD #744 affirmed the two male residents were sitting next to each other, not socially distant from one another and alerted nursing staff present. On the 2 West unit, Activity Staff (AS) #12 was observed sitting in the unit dining/activity room with her mask under her chin. There were six residents present in the unit activity/dining room. When asked if she was supposed to be wearing her mask over the mouth and nose, she replied that she was sitting away from the residents and the mask was not necessary as the unit did not have any COVID-19 positive residents. An interview was conducted with LPN #105 present on the 2 West unit regarding the mask wearing policy, and what was communicated by AS #12. LPN #105 reported that AS #12 should be wearing her mask at all times per facility policy. On the Lighthouse unit, Residents #145, #154, #152, and #118 were sitting around a table in the unit dining/activity room together, elbow to elbow. None of the four residents were wearing a mask. The residents were in full view of nursing staff present at the nursing station including LPN #759 and STNA's #40 and #2. AD #744 affirmed the four specified residents were sitting in close proximity to one another and not wearing masks. She alerted the nursing staff at the nursing station who then attempted to get the residents to spread out. During interview with LPN #759 on the Lighthouse unit, she stated staff were required to wear a surgical or N95 mask at all times. When queried regarding if information and training was given on how to care for the mask, or how many times it could be worn consecutively, LPN #759 reported that one mask could be worn for the entire week on days scheduled; typically staff work three days and the mask could be worn consecutive days in a row. She stated she could take the mask home, and she takes her mask home and hangs it up on a clothesline. During an interview with STNA #02 on the Lighthouse unit, she stated she was told she could take the mask home and hang it up between wears, but did not recall anyone telling her how many times (shifts) she could or could not wear the mask consecutively. A tour of the COVID-19 dedicated Harmony building was conducted on [DATE] at 11:50 A.M. LPN #675 was the only staff person present in the building. He identified seven residents with COVID-19 that were currently receiving care on the unit. Upon entering the building,