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 _____	03/04/2020

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, review of facility policy and staff interviews, the facility failed to notify the physicians and responsible parties after two resident's falls. This affected two (#81 and #80) of three residents reviewed for notification. The resident census was 150. Findings include: 1. Review of Resident #81's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Review of Resident #81's quarterly Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a severe cognitive impairment, was dependent on two staff with transfers and required the extensive assistance of two staff with bed and mobility. Review of Progress Notes dated 01/22/20 at 4:00 A.M., documented during nightly rounds the nurse observed Resident #81 sitting on the floor with the right side of his head rested against the bed rail and his right arm was caught between the bed and bed rail. The nurse called for assistance from other nurse aides and lowered the resident to the floor for neurological checks, vital signs, skin and pain assessment. The resident's blood pressure was 150/92, pulse 80, respiratory rate 20 breaths per minute, temperature of 98.4 degrees Fahrenheit (F.) and the resident rated his pain as an eight on a scale of zero to 10 and 10 being the worst pain. After completing a full assessment the nurses and aides used the Hoyer mechanical lift to get the resident into bed. The nurse administered PRN (as needed) Tylenol, 30 minute safety checks, notified the Unit Manager and would continue to monitor the resident. Review of the fall investigation document #3037 documented Resident #81 had an unwitnessed fall in his room on 01/22/02 at 3:30 A.M. This investigation was blank for an incident description, level of pain, mental status, predisposing environmental factors, predisposing environmental factors, predisposing physiological factors, predisposing physiological factors, predisposing situation factors and documented no witnesses were found and there were no notifications of agencies/people found. Further review of the medical record revealed no documentation of the family/resident representative or physician being notified of the fall. Interview with the Director of Nursing (DON) at 2:00 P.M., verified there was no documented evidence of Resident #81's Power of Attorney or physician being notified of the fall. 2. Review of Resident #80's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]., [MEDICAL CONDITION] disorder, restlessness, agitation [MEDICAL CONDITION] disorder, [MEDICAL CONDITION] type, dementia without behavioral disturbance, [MEDICAL CONDITION], diabetes mellitus with complications and extrapyramidal and movement disorder. Review of Resident #80's quarterly MDS assessment dated [DATE] documented the resident's cognition was intact and required supervision with set up help only with bed mobility, transfer, ambulation in room and corridor. Resident #80 demonstrated behaviors of delusions and wandered on a daily basis. Review of the fall investigation document #3045 documented Resident #80 had a witnessed fall on 01/30/20 at 9:30 P.M. The incident was described as the resident was being redirected to his room, walking backward in the hallway and tripped over his untied shoe lace. Resident #80 sustained an abrasion on his right elbow and denied hitting his head. This fall investigation document reported no injuries were reported post fall. Further, this investigation was blank for the resident's mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors and predisposing situation factors. Further review of the medical record revealed no documentation of the family/resident representative or physician being notified of the fall. Interview with the DON at 2:00 P.M., verified there was no documented evidence of Resident #80's family/resident representative or physician being notified of the fall. Review of facility policy titled Fall Response Policy dated 11/05 revealed the purpose of this policy was to identify standards of practice for post-fall interventions. This policy documented the resident's physician and family would be notified after a fall. This deficiency was discovered during the complaint investigation and is an example of continued noncompliance from the annual survey of 10/28/19.
F 0689 **Level of harm** - Minimal harm or potential for 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** Based on medical record review, policy review and staff interviews, the facility failed to thoroughly investigate falls for two residents. This affected two (#81 and #80) of three residents reviewed for falls. The resident census was 150. Findings include: 1. Review of Resident #81's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Review of Resident #81's quarterly Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a severe cognitive impairment, was dependent on two staff with transfers and required the extensive assistance of two staff with bed and mobility. Review of Progress Notes dated 01/22/20 at 4:00 A.M., documented during nightly rounds the nurse observed Resident #81 sitting on the floor with the right side of his head rested against the bed rail and his right arm was caught between the bed and bed rail. The nurse called for assistance from other nurse aides and lowered the resident to the floor for neurological checks, vital signs, skin and pain assessment. The resident's blood pressure was 150/92, pulse 80, respiratory rate 20 breaths per minute, temperature of 98.4 degrees Fahrenheit (F.) and the resident rated his pain as an eight on a scale of zero to 10 and 10 being the worst pain. After completing a full assessment the nurses and aides used the Hoyer mechanical lift to get the resident into bed. The nurse administered PRN (as needed) Tylenol, 30 minute safety checks, notified the Unit Manager and would continue to monitor the resident. Review of the fall investigation document #3037 documented Resident #81 had an unwitnessed fall in his room on 01/22/02 at 3:30 A.M. This investigation was blank for an incident description, level of pain, mental status, predisposing environmental factors, predisposing environmental factors, predisposing physiological factors, predisposing physiological factors, predisposing situation factors and documented no witnesses were found and there were no notifications of agencies/people found. Further review of the medical record revealed no documentation of the family/resident representative or physician being notified of the fall. Interview with the Director of Nursing (DON) at 2:00 P.M., verified there was no documented evidence of Resident #81's Power of Attorney or physician being notified of the fall. 2. Review of Resident #80's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]., [MEDICAL CONDITION] disorder, restlessness, agitation [MEDICAL CONDITION] disorder, [MEDICAL CONDITION] type, dementia without behavioral disturbance, [MEDICAL CONDITION], diabetes mellitus with complications and extrapyramidal and movement disorder. Review of Resident #80's quarterly MDS assessment dated [DATE] documented the resident's cognition was intact and required supervision with set up help only with bed mobility, transfer, ambulation in room and corridor. Resident #80 demonstrated behaviors of delusions and wandered on a daily basis. Review of the fall investigation document #3045 documented Resident #80 had a witnessed fall on 01/30/20 at 9:30 P.M. The incident was described as the resident was being redirected to his room, walking backward in the hallway and tripped over his untied shoe lace. Resident #80 sustained an abrasion on his right elbow and denied hitting his head. This fall investigation

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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) document reported no injuries were reported post fall. Further, this investigation was blank for the resident's mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors and predisposing situation factors. Further review of the medical record revealed no documentation of the family/resident representative or physician being notified of the fall. Interview with the DON at 2:00 P.M., verified there was no documented evidence of Resident #80's family/resident representative or physician being notified of the fall. 1. Review of Resident #81's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Review of Resident #81's quarterly Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a severe cognitive impairment, was dependent on two staff with transfers and required the extensive assistance of two staff with bed and mobility. Review of Progress Notes dated 01/22/20 at 4:00 A.M., documented during nightly rounds the nurse observed Resident #81 sitting on the floor with the right side of his head rested against the bed rail and his right arm was caught between the bed and bed rail. The nurse called for assistance from other nurse aides and lowered the resident to the floor for neurological checks, vital signs, skin and pain assessment. The resident's blood pressure was 150/92, pulse 80, respiratory rate 20 breaths per minute, temperature of 98.4 degrees Fahrenheit (F.) and the resident rated his pain as an eight on a scale of zero to 10 and 10 being the worst pain. After completing a full assessment the nurses and aides used the Hoyer mechanical lift to get the resident into bed. The nurse administered PRN (as needed) Tylenol, 30 minute safety checks, notified the Unit Manager and would continue to monitor the resident. Review of the fall investigation document #3037 documented Resident #81 had an unwitnessed fall in his room on 01/22/02 at 3:30 A.M. This investigation was blank for an incident description, level of pain, mental status, predisposing environmental factors, predisposing environmental factors, predisposing physiological factors, predisposing physiological factors, predisposing situation factors and documented no witnesses were found and there were no notifications of agencies/people found. Further review of the medical record revealed no documentation of the fall investigations being completed Interview with the Director of Nursing (DON) at 2:00 P.M., verified the fall investigation document #3037, had blank boxes for the specified categories noted above and was unable to provide an explanation as to why the fall was not thoroughly investigated. 2. Review of Resident #80's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]., [MEDICAL CONDITION] disorder, restlessness, agitation [MEDICAL CONDITION] disorder, [MEDICAL CONDITION] type, dementia without behavioral disturbance, [MEDICAL CONDITION], diabetes mellitus with complications and extrapyramidal and movement disorder. Review of Resident #80's quarterly MDS assessment dated [DATE] documented the resident's cognition was intact and required supervision with set up help only with bed mobility, transfer, ambulation in room and corridor. Resident #80 demonstrated behaviors of delusions and wandered on a daily basis. Review of the fall investigation document #3045 documented Resident #80 had a witnessed fall on 01/30/20 at 9:30 P.M. The incident was described as the resident was being redirected to his room, walking backward in the hallway and tripped over his untied shoe lace. Resident #80 sustained an abrasion on his right elbow and denied hitting his head. This fall investigation document reported no injuries were reported post fall. Further, this investigation was blank for the resident's mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors and predisposing situation factors. Further review of the medical record revealed no documentation of the family/resident representative or physician being notified of the fall. Interview with the DON at 2:00 P.M., verified the fall investigation document #3045, had blank boxes for the specified categories noted above and was unable to provide an explanation as to why the fall was not thoroughly investigated. Review of facility policy titled Fall Response Policy dated 11/05 revealed the purpose of this policy was to identify standards of practice for post-fall interventions. This policy documented the resident's physician and family would be notified after a fall. This deficiency was discovered during the complaint investigation and is an example of continued noncompliance from the annual survey of 10/28/19.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility policy review, observation and staff interviews, the facility failed to implement physician ordered contact precautions for a resident with [MEDICAL CONDITION] Resistant Staph Aureus (MRSA). This affected one (#84) of one resident identified by the facility with a transmission based infection. The resident census was 150. Findings include: Review of Resident #84's medical record revealed and admission date of [DATE], with [DIAGNOSES REDACTED]. pneumonia. Review of Resident #84's physician's orders [REDACTED]. Observation was made on 03/03/20 at 12:35 P.M., of a intravenous pump ringing in Resident #84's room. An empty intravenous (IV) medication bag was hanging on the pump and the message indicated air was in the line. The resident was sleeping. There was not a sign hanging on the door to see the nurse before entering the room or to indicate any precautions should be taken prior to entering the room. Licensed Practical Nurse (LPN) #54 and LPN #300 entered the room and took down the intravenous bag. Neither nurse donned any personal protective equipment, prior to disconnecting the IV medication. Interview with LPN #54 and #300 on 03/03/20 at 12:37 P.M., verified neither of the nurse had had not donned appropriate personal protective equipment when entering the room to remove the IV bag and there was no sign to indicate the resident required any isolation. Interview with the Director of Nursing (DON) on 03/03/20 at 1:00 P.M., verified there should be a sign on the door to see the nurse before entering the room. The DON verified LPN #54 and LPN #300 should have donned appropriate personal protective equipment before entering the resident's room. Review of the undated facility policy titled, Isolation - Categories of Transmission-Based Precautions documented Transmission-Based Precautions would be used whenever measures more stringent than Standard Precautions were needed to prevent or control the spread of infection. In addition to Standard Precautions, the facility would implement Contact Precautions for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. In addition to wearing gloves as outlined under Standard Precautions, wear gloves when entering the room. Wear a disposable gown upon entering the Contact Precautions room. This deficiency was discovered during the complaint investigation and is an example of continued noncompliance from the annual survey of 10/28/19.