

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Xenia Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 126 Wilson Drive Xenia, OH 45385	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on record review, interview, and review of policy, the facility failed to assess residents identified prior to admission as a fall risk and failed to thoroughly investigate a fall. This affected two (Residents #38 and #43) of three residents reviewed for falls. The facility census was 42.</p> <p>Findings include:</p> <p>1. Record review for Resident #38 revealed he was admitted to the facility on [DATE]. His diagnoses included hypertensive crisis, essential primary hypertension, hemiplegia, gout, spinal stenosis, and syncope.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively impaired. Resident #38 was dependent on staff for medication administration, bathing, and toileting. He required assistance from staff with eating, oral hygiene, and personal hygiene.</p> <p>Review of Resident #38's hospital referral prior to entering the facility stated Resident #38 was a high fall risk.</p> <p>Review of Resident #38's assessment titled, Fall Risk Assessment, dated 06/12/24 revealed the facility failed to complete the fall risk assessment.</p> <p>Interview on 07/18/24 at 4:45 P.M. with Regional Nurse (RN) #500 confirmed Resident #38 should have been marked a fall risk related to his hospital paperwork and the fall assessment was not completed.</p> <p>2. Record review for Resident #43 revealed he was admitted to the facility on [DATE]. He discharged to the hospital on 06/28/24 related to a fall with head injury. His diagnoses included, hemiplegia, hemiparesis, schizoaffective disorder, acute respiratory failure with hypoxia, dysphagia, essential primary hypertension, sepsis, pneumonia, major depressive disorder, anxiety disorder, gastro-esophageal reflux disease (GERD), hyperlipidemia, heart failure, and insomnia.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #43's most recent MDS assessment dated [DATE] revealed he was severely cognitively impaired. Further review of the MDS assessment revealed he was dependent on staff for medication administration, bathing, transfers, lower body dressing, walking, and taking/off shoes. Resident #43 required maximum assistance from staff with eating, oral hygiene, upper body dressing, sit to lying, and sit to standing, Resident #43 needed partial assistance from staff to roll back and forth.</p> <p>Record review for Resident#43's preadmission hospital stay revealed he was admitted to the hospital on 06/09/24 with dizziness and frequent falls for the previous five days. Resident #43's hospital record revealed a diagnosis of acute infarct in the left frontal lobe.</p> <p>Review of Resident #43's nurse progress notes revealed on a late entry dated 06/27/24 for 06/26/24 revealed Resident #43 was found on the floor next to the bed at 8:30 P.M. on 06/26/24. The resident was agitated and tried to get himself off the floor. The nurse assessed Resident#43's skin and took his vitals. Resident #43 was assisted by the nurse and two nurse aides back into bed. Further review of the nursing progress notes revealed Resident #43 had a fall on 06/28/24 at 11:56 P.M. in the dining room and the fall was witnessed by staff and residents. The progress notes stated Resident #43 slid out of his wheelchair. The nurse notified a family member of the fall with laceration to Resident #43's side of his head. Resident was sent to the hospital for evaluation and was admitted to the hospital.</p> <p>Review of the facility report titled, Neurological Assessment Flow Sheet, with a start date of 06/26/24 at 8:30 P.M. for Resident #43 revealed the last neurological assessment was completed on 06/17/24 at 2:20 P.M. Further review of the Neurological Assessment form confirmed the instructions included neurological check every 16 minutes for the first hour, every hour for the next four hours, and every four hours for the next 19 hours.</p> <p>Review of Resident #43's assessment titled, Fall Risk Assessment, dated 06/24/24, revealed the assessment was started upon entry to the facility, however, it was not completed and signed. Further review of the initial Fall Risk Assessment revealed the facility staff marked Resident #43 had no falls in the past three months and was alert and oriented to person, place, and time.</p> <p>Review of the facility report titled, Incident and Accident Log, for the past ninety days, revealed Resident #43 had a fall incorrectly dated for 06/27/24 (should have read 06/26/24) and nothing listed related to Resident #43's fall on 06/28/24.</p> <p>Review of Resident #43's fall investigation dated 06/27/24, revealed Resident #43 was found on the floor next to his bed on 06/26/24 at 8:30 P.M. Resident #43 was agitated and tried to get himself off the floor.</p> <p>Review of Resident #43's fall investigation dated 06/28/24, revealed the facility failed to complete a fall investigation and did not gather any investigative information related to the fall. However, the facility did provide a report taken at the initial time of the fall. The report was titled, Fall Triage, dated 06/28/24, confirmed Resident #43 fell in the dining room on 06/28/24. Further review of the Fall Triage reported for Resident #43 revealed there were no witnesses to the fall in the dining room before lunch. Resident #43 was lifted from the floor by three members with a gait belt and sent to the emergency room .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 07/18/24 at 3:27 P.M. with the RN #500 confirmed Resident #43's admission hospital paperwork confirmed Resident #43 was a fall risk. RN #500 confirmed the facility failed to accurately fill out and complete Resident #43's fall risk assessment.</p> <p>A subsequent interview on 07/22/24 at 10:48 A.M. with RN #500 confirmed the facility failed to provide a thorough investigation related to Resident #43's fall on 06/28/24. RN #500 confirmed the Triage Report, and the Nursing Fall report gave conflicting information related to witnesses to the fall. RN #50 confirmed the facility failed to provide statements or a complete investigation related to Resident #43's fall.</p> <p>Review of the facility policy titled, Fall Prevention Program, dated 09/22/22, confirmed the facility will utilize a standardized risk assessment to determine the resident's fall risk. Further review of the policy revealed the Fall Risk Assessment will be completed upon admission to determine the level of fall risk.</p> <p>Review of the facility policy titled, Maintenance of Medical Records, dated 2023, confirmed the facility will maintain medical records for each resident in accordance with acceptable standard of practice. The policy stated, a complete and accurate medical record will be maintained.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155726.</p>		