| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365578 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| New Lexington Healthcare and Rehabilitation Center | 920 South Main Street<br>New Lexington, OH 43764 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923<br><br>Based on record review, observation, staff interview, and policy review, the facility failed to ensure a resident, who was dependent on staff for personal care, received the assistance needed with routine incontinence care and repositioning as needed when up in her wheelchair. This affected one (Resident #39) of three residents reviewed.<br><br>Findings include:<br><br>Review of Resident #39's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included multiple sclerosis (MS), cognitive communication deficit, abnormal posture, scoliosis, morbid obesity, mild cognitive impairment of uncertain or unknown etiology, and chronic pain syndrome.<br><br>Review of Resident #39's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was usually able to make herself understood and was usually able to understand others. Her cognition was severely impaired, she was not known to display any behaviors nor was she known to reject care. She had a functional limitation in range of motion (ROM) of her bilateral upper and lower extremities and a wheelchair was listed as the only mobility device used. The resident was dependent on staff for bed mobility, transfers, and toileting hygiene. She was known to be always incontinent of her bowel and bladder and was not on a toileting program for either. She was identified as being at risk for pressure ulcers, but did not have any unhealed pressure ulcers.<br><br>Review of Resident #39's Braden Scale for Predicting Pressure Ulcer Risk dated 10/02/24 revealed the resident was assessed to be a high risk for pressure ulcers. Risk factors included a slightly limited sensory perception, her skin being very moist (degree to which skin was exposed to moisture), being chairfast, being completely immobile, and she had a problem with friction and shearing.<br><br>Review of Resident #39's Bowel and Bladder assessment dated [DATE] revealed the resident had a history of bowel and bladder incontinence. She was always incontinent of her bowel and bladder, was dependent on staff for toileting, and did not request toileting when needing to go. She was not able to tell when her urine flow started or stopped. The plan was for the resident to be checked and changed.<br><br>(continued on next page) |

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

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

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #39's active care plans revealed she had a care plan in place for the potential for impairment to skin integrity related to decreased activity, incontinence, limited mobility, shear/friction risks, and history of a chaffed area. She was at risk for skin breakdown to her posterior thighs secondary to incontinence. The goal was for the resident to maintain intact skin with no breakdown. The interventions included keeping body parts from excessive moisture and encourage the resident to turn and reposition on routine care rounds and as needed. She also had a care plan for being incontinent of her bowel and bladder related to MS, impaired mobility, and recurrent urinary tract infections (UTI). The goal was for the resident to be clean, dry, and odor free through the review date. The interventions included providing skin care after each incontinent episode and to apply a moisture barrier.<br><br>On 12/17/24 at 9:00 A.M., an observation of Resident #39 noted her to be sitting up in her wheelchair in her room. She was in a tilt space wheelchair and was leaning to the right. A neck pillow and bolsters were noted on her bilateral armrests.<br><br>On 12/17/24 at 9:59 A.M., ongoing observations of Resident #39 noted her out of her room and in the dining room for a music activity. The resident was sitting in her tilt space wheelchair leaning over to the right side and not actively engaged in the activity.<br><br>On 12/17/24 at 10:46 A.M., Resident #39 was observed to be wheeled out of the dining room by another female resident that was also in a wheelchair and pushing Resident #39 from behind. The other resident assisted Resident #39 to leave the dining room after the activity had been completed, and left her in the front lobby area.<br><br>On 12/17/24 at 11:37 A.M., Resident #39 was still up in her tilt space wheelchair in the front lobby area sitting there with her eyes closed and leaning to the right. No staff members were noted to come and check on her or offer to change her. No staff members were noted to reposition the resident or assist her with shifting her weight while she sat in her wheelchair.<br><br>On 12/17/24 at 11:47 A.M., Resident #39 was observed to be taken to the dining room for lunch. She was assisted by an activity aide that was in the dining room preparing for the upcoming meal. She remained sitting in her tilt space wheelchair leaning to the right until she was served her meal tray at 12:17 P.M.<br><br>On 12/17/24 at 12:35 P.M., Resident #39 was removed from the dining room and assisted back to her hallway by an aide. She was left sitting in the middle of her hallway in her tilt space wheelchair and continued to lean to the right, while staff members collected meal trays from the residents that ate their lunch in their rooms. The area that she was placed in the hall was not outside of her room. She remained there as the aides on that hall began doing rounds at the opposite end of the hall from where the resident's room was. It was not until 1:05 P.M. that Certified Nursing Assistant (CNA) #100 was noted to take the resident into her room and close the door.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/17/24 at 1:12 P.M., an interview with Licensed Practical Nurse (LPN) #155 revealed Resident #39 was totally dependent on staff for care and was a mechanical lift for transfers. The resident was completely incontinent of her bowel and bladder. The nurse reported the resident had no idea when she needed to go to the bathroom and did not alert the staff when she was incontinent. The staff were to turn and reposition her, as she couldn't move herself. She indicated the resident was flaccid on the left side. The resident was to be checked and changed every two hours and turning and repositioning should be done with every two hour rounds. She stated the CNA's knew what each residents' care needs were based on the care plans and the Kardex they had access to in the computer. The nurses were responsible for ensuring the CNA's were doing their jobs. She revealed she had been in and out of the resident's room a few times that day, when passing meds or answering call lights. She further revealed she no longer considered the resident to be at risk for falls as the resident did not move enough on her own to be a fall risk.<br><br>On 12/17/24 at 1:28 P.M., an interview with CNA #100 revealed Resident #39 was totally dependent on staff for care. They helped the resident with changing her as needed. She indicated the resident was incontinent of her bowel and bladder at all times and she required the staff to assist with turning and repositioning/chair mobility, and was a mechanical lift for transfers. The CNA revealed the resident had the use of only one arm. She revealed the staff did rounds to check and change residents every two to three hours. She stated sometimes Resident #39 had been known to have irritation between her legs, but she described the resident as being compliant with her care. The resident's normal routine was to get up before 7:00 A.M. The night shift aides would have her up before they got there in the morning. The night shift aides usually left her in her room with her television on, then at breakfast time, they took her down to the dining room to eat. She went to the dining room for breakfast that morning and after breakfast she usually came back to her room and staff would check her. If she needed changed, they would put her in bed to change her. They had a music activity after breakfast that morning, so the resident did not go back to her room until after the activity was over. CNA #100 was not sure what time that was. She stated the music activity started at 10:00 AM and usually lasted between 30 minutes to an hour. The resident would have went back to her room sometime after that. She confirmed they placed the resident back in bed to change her around 1:05 P.M. She stated the resident was found to be incontinent of her bladder at that time. She acknowledged, with the observations made and her interview, it was able to be determined that the resident had not been changed between the hours of 7:00 A.M. and 1:05 P.M. She further acknowledged the resident had not been observed to be out of the chair or repositioned or have her body weight shifted from the time she was observed on 12/17/24 at 9:00 A.M. until they placed her in bed at 1:05 P.M.<br><br>On 12/17/24 at 2:55 P.M., an interview was conducted with the facility's Director of Nursing (DON) and she confirmed there had been concerns raised from the resident's family regarding the facility staff not going in the room to change her on a regular basis. They had a care conference where that was discussed. The DON was informed observations of Resident #39 made during the complaint investigation and interviews with facility staff confirmed the resident had been up in her chair since before 7:00 A.M. and was not observed to be provided any incontinence care or repositioning in her wheelchair until 1:05 P.M., when the day shift aides put her back in bed and changed her. She confirmed it was the expectation of the staff to complete rounds every two hours and assist residents with incontinence care and repositioning.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy on Activities of Daily Living (ADL), revised January 2022, revealed it was the policy of the facility that each resident would have their ADL needs determined within seven days of their admission, then would have an individualized plan of care to guide the staff in delivering the necessary ADL support and care. The facility's ADL goal was that a resident's abilities in ADL did not diminish unless circumstances of the individual's clinical condition demonstrated that decline was unavoidable. That included the resident's ability to toilet, transfer, and ambulate. ADL care plans would be implemented in the following categories that included toileting and mobility. Staff were to carry out the ADL care tasks by following the resident's ADL care plan and document the assistance provided. Residents that had the decreased ability to reposition themselves would be repositioned throughout the course of the day during routine ADL's when in bed or in their wheelchair. Incontinence care would be delivered timely as necessary while attempting to anticipate the resident's needs. Frequent rounding on the unit (recommended at least every hour) was to be done to observe residents, needs, and unit atmosphere.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159738. |