

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER New Lexington Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 South Main Street 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on record review, interview and policy review the facility failed to begin the discharge planning process upon admission. This affected one (Resident #39) of one residents reviewed for choices. The facility census was 62.</p> <p>Findings included:</p> <p>Record review revealed Resident #39 admitted to the facility on [DATE] with diagnoses including chronic and acute respiratory failure, muscle weakness, and difficulty in walking. Review of an assessment titled Interdisciplinary Care Conference Summary dated 10/04/24 revealed Resident #39 would receive long term care and would apply for Medicaid. Review of the sign in sheet for the care conference revealed only the social worker and nursing staff signed in. The resident and family did not sign in.</p> <p>Review of an admission minimum data set (MDS) completed on 10/08/24 revealed Resident #39 remained cognitively intact, had no behaviors, and had a discharge goal to remain in the facility.</p> <p>Review of a care plan dated 10/22/24 revealed Resident #39 would remain in the facility for long term care for the best interest of the residents and a discharge to the community would not be pursued.</p> <p>Interview on 10/28/24 at 1:27 P.M. with Resident #39 revealed he wanted to go home on Wednesday (10/30/24) and the surveyor informed the Administrator and Social Worker.</p> <p>Interview on 10/30/24 at 8:19 A.M. with Resident #39 revealed he had not spoken to the Social Worker regarding discharge planning. Resident #39 stated his wife would be visiting the facility at 10:30 A.M. and would take care of everything.</p> <p>Review of a discharge planning note dated 10/30/24 at 8:25 A.M. by the Social Worker revealed he spoke with Resident #39 and his wife, who decided the resident would discharge home on 10/31/24 with home health services.</p> <p>There was no further documentation regarding discharge planning or care conference in the medical record.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER New Lexington Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 South Main Street 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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/30/24 at 8:35 A.M. with the Social Worker revealed he was working on an unplanned discharge after being informed on Tuesday (10/29/24) Resident #39 wanted to go home. The Social Worker stated no one had ever indicated Resident #39's goal was to go home and he was supposed to remain in the facility for long term care.</p> <p>Interview on 10/30/24 at 11:51 A.M. with Resident #39's wife revealed the resident was admitted to the facility to participate in physical and occupational therapy, then return home. Resident #39's wife stated she and the resident had not ever stated long term care was their choice and there was no admission care plan meeting upon re-admission to the facility on [DATE] or after. Resident #39's wife stated the resident made his own decisions.</p> <p>Interview on 10/30/24 at 1:02 P.M. with the Social Worker verified there were no signatures from Resident #39 or his wife on the admission care plan sign-in sheet because it was completed over the phone. The Social Worker stated he was told by Resident #39's wife the resident would be long term care.</p> <p>Review of a policy titled Discharge Planning Policy dated 05/2022 revealed the Social Services Department/designee is to initiate discharge planning upon admission and review quarterly and as needed for changes. Impending discharges should be discussed with the resident and family, communication should be completed, a discharge summary should be completed and transportation arranged as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER New Lexington Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 South Main Street 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987</p> <p>Based on observation, interview, record review, and policy review, the facility failed to maintain a comprehensive plan of care and properly implement pressure relieving interventions. This affected one resident (#165) of two residents reviewed for pressure ulcers. The facility census was 62.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #165 revealed an admitted [DATE]. Diagnoses included but were not limited to encounter for orthopedic aftercare following surgical amputation, acquired absence of right and left leg above the knees, type 2 diabetes, depression and peripheral vascular disease.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The resident was assessed to require partial/moderate assistance with bed mobility, dependence with toilet hygiene and transfers. No wound assessment was completed due to assessment still in progress from being a new admission.</p> <p>Review of the skin grid pressure assessment dated [DATE] revealed Resident #165 had a coccyx suspected deep tissue injury measuring nine centimeters (cm) by (x) 8 cm x undetermined with eschar present and a yellow, necrotic wound bed discovered on admission.</p> <p>Review of the active plan of care dated 10/21/24 revealed Resident #165 was admitted to the facility with pressure wound to the coccyx with no intervention for a low air loss mattress.</p> <p>Review of the physician order dated 10/21/24 revealed a low air loss mattress to check every shift for proper placement and function.</p> <p>Review of the Braden Scale for Predicting Pressure Sore Risk dated 10/27/24 revealed Resident #165 was at risk for pressure ulcer development with a score of 15.</p> <p>Review of the weight dated and timed 10/28/24 at 5:44 A.M. for Resident #165 was 155 pounds.</p> <p>Observation on 10/28/24 at 10:56 A.M. revealed Resident #165 on a low air loss mattress with a weight set to 165 pounds.</p> <p>Review of the weight dated and timed 10/29/24 at 6:28 A.M. for Resident #165 was 153.2 pounds.</p> <p>Interview on 10/29/24 at 9:58 A.M. with Licensed Practical Nurse (LPN) #565 revealed she was unsure of how the low air loss mattress functioned and it came pre-set. The LPN verified the resident's air mattress was not identified in the resident's plan of care and the order did not specify settings based on the resident's weight.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER New Lexington Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 South Main Street 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 10/29/24 at 11:15 A.M. with the Director of Nursing verified the resident's air mattress was set for 165 pounds and the resident's current weight was 153.2 pounds, making the weight setting for the air mattress incorrect.</p> <p>Review of the facility policy titled Pressure Ulcer Prevention and Risk Identification no date, revealed the facility will establish measures to prevent the development of pressure ulcers within the facility or to prevent further decline of already existing pressure ulcers and a care plan will be developed and updated routinely with identified skin risk and/or actual wound development.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER New Lexington Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 South Main Street 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)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538</p> <p>Based on medical record review and staff interview, the facility failed to set parameters for as needed diuretic medication based on weight gain. This affected one of six residents (Resident#50) sampled for unnecessary medications. The facility census was 62.</p> <p>Findings include:</p> <p>Review of Resident #50's medical record revealed an admitted [DATE] with diagnoses including acute systolic congestive heart failure, myocardial infarction, nonrheumatic aortic (valve) stenosis, and anxiety.</p> <p>Review of the quarterly Minimum Data Set(MDS) dated [DATE] revealed the resident had severe cognitive impairment. Further review of the MDS revealed an active diagnosis for heart failure.</p> <p>Review of Resident #50's physician's orders revealed an order for furosemide oral tablet (a diuretic medication), give 20 milligrams (mg) by mouth every 24 hours as needed for weight gain and an order to weigh the resident daily.</p> <p>Review of Resident #50's care plan revealed no care plans were present for the use of diuretic medication, daily weights or the diagnosis of acute systolic congestive heart failure.</p> <p>In an interview on 10/30/24 at 1:04 P.M. with Licensed Practical Nurse (LPN) #565 verified the furosemide order did not contain instructions related to how much weight Resident #50 should gain before the medication was to be administered.</p> <p>In an interview on 10/30/24 at 3:10 P.M. the Director of Nursing (DON) verified the furosemide order did not contain instructions related to how much weight Resident #50 should gain before the medication was given and that no care plans were present for the use of diuretic medication, daily weights or the diagnosis of acute systolic congestive heart failure.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER New Lexington Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 South Main Street 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571</p> <p>Based on medical record review, observation, staff interview and policy review, the facility failed to maintain infection control procedures during a dressing change. This affected one (Resident #18) of two residents reviewed for pressure ulcers. The census was 62.</p> <p>Findings include:</p> <p>Review of Resident #18's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, paraplegia, peripheral vascular disease (PVD) and anxiety.</p> <p>Review of the quarterly minimum data set assessment dated [DATE] revealed his cognition was intact (BIMS of 15). Functional limitations in range of motion to the lower extremities (Impairment on both sides), and used a wheelchair for mobility. The resident had an indwelling suprapubic (a tube that drains urine through a small incision in the abdomen) urinary catheter and was always incontinent of bowel.</p> <p>Review of the physicians orders revealed an order to cleanse the coccyx area with wound cleanser, pat dry, apply medihoney (a medical grade honey product that supports wound healing and removes necrotic tissue) to the wound bed, apply calcium alginate (a type of wound dressing derived from seaweed that absorbs exudate and forms a moist gel) and cover with a silicone dressing every day shift.</p> <p>Observation of the dressing change on 10/29/24 at 4:50 P.M. Licensed Practical Nurse #537 washed her hands and put on gloves, she removed the old dressing from the coccyx wound, then removed her gloves and washed her hands. LPN #537 then donned new gloves, cleansed the wound with normal saline and gauze, and patted the wound dry. LPN #537 removed her gloves and without washing her hands, donned new gloves, applied medihoney to the wound and covered with Calcium Alginate and a dressing. LPN #537 then removed her gloves, donned new gloves again without washing her hands and assisted with replacing the resident's incontinence brief and repositioned the resident in bed. LPN #537 then remove her gloves and washed her hands.</p> <p>On 10/29/24 at 5:04 P.M. interview with LPN #537 verified she did not wash her hands between glove changes.</p> <p>Review of the policy and procedure Wound Care dated 04/18 and revised 10/21 revealed after removing disposable gloves wash and dry your hands thoroughly.</p>