

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365897	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER New Lebanon Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Mills Place New Lebanon, OH 45345	

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** 46613</p> <p>Based on medical record review and staff, resident and resident representative interviews, the facility failed to provide adequate supervision to ensure a resident, that had an order for supervised Leave of Absence (LOA), did not leave the facility unsupervised. This affected one (#06) out of three reviewed for elopement. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #06 revealed an admitted [DATE] with medical diagnoses of epilepsy, right sided hemiplegia due to cerebral infarction, chronic obstructive pulmonary disease, depression, and anxiety.</p> <p>Review of the medical record for Resident #06 revealed an annual Minimum Data Set (MDS) assessment, dated 04/19/24, which indicated Resident #06 had moderate cognitive impairment and required set-up assistance with eating, wheelchair mobility, and bed mobility, partial staff assistance with transfers and supervision with toilet hygiene, and bathing. The MDS did not indicate Resident #06 had any wandering behaviors.</p> <p>Review of the medical record for Resident #06 revealed a quarterly nursing assessment, dated 05/17/24, which included an elopement risk evaluation that indicated Resident #06 was alert and oriented, was able to leave the building, no history of wandering, exit seeking, or attempted elopements noted.</p> <p>Review of the medical record for Resident #06 revealed a physician order dated 05/04/23 that stated the resident may go on Leave of Absence (LOA) independently. The order was discontinued on 07/08/24. Further review of the medical record revealed a physician order dated 06/03/24 which stated the resident may go LOA with medications and supervised and was written by the former Director of Nursing (DON) #218. The order was discontinued on 07/08/24. Further review of the medical record for Resident #06 revealed a physician order, dated 07/08/24, which stated resident may go LOA with supervision of mother and/or her father.</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 the medical record for Resident #06 revealed a nurses' notes dated 07/08/24 at 1:51 P.M. which stated resident signed out LOA and stated she was going to the store. The note stated Resident #06 had a LOA order in place. Review of the nurses' note dated 07/08/24 at 2:56 P.M. stated the nurse received a phone call from a male in the community screaming at the nurse on the phone stating someone come get this lady that almost got hit in front of the McDonald's. The note stated the social service designee and a nurse drove to assist the resident. Further review of the nurses' notes revealed a note dated 07/08/24 at 3:02 P.M. which stated the nurse assisted the resident back to the facility safely. The note stated Resident #06 signed back into the facility at that time and denied any complaints. The note stated the nurse called and spoke with Resident #06's mother who requested Resident #06 be changed from independent LOA to supervised LOA with mother or father only.</p> <p>Review of the facility resident sign in/sign out sheet revealed on 07/08/24 Resident #06 signed out of the facility at 1:51 P.M. and signed back in at the facility on 07/08/24 at 3:02 P.M.</p> <p>Interview on 07/11/24 at 8:00 A.M. with Resident #06 confirmed she left the facility alone in her wheelchair to go to the store to get an e-cigarette. Resident #06 stated she had the right of way to cross the street at the cross walk and somebody in a car didn't want to wait until she crossed the street and became upset. Resident #06 confirmed she signed herself out of the facility and stated she had never signed herself out on a LOA before.</p> <p>Interview on 07/11/24 at 8:00 A.M. with Administrator stated Resident #06 signed herself out of the facility for LOA to go to the smoke shop to get an e-cigarette. Administrator stated that the facility was notified by a man that Resident #06 was almost hit while crossing the road and that someone needed to get her. Administrator stated Social Service and a nurse went in a car to get Resident #06. Administrator stated the nurse was able to push Resident #06 back to the facility in her wheelchair since she was located at the McDonald's around the corner from the facility. Administrator stated Resident #06 denied any injuries and was mad at the person in the car because she had the right of way to cross the street.</p> <p>Interview on 07/11/24 at 10:18 A.M. with Social Service #210 stated she assisted the nurse to bring Resident #06 back to the facility on [DATE]. Social Service #210 stated Resident #06 was located to be sitting in her wheelchair on the sidewalk near the McDonald's around the corner from the facility and had no apparent injuries. Social Service #210 stated the nurse brought Resident #06 back to the facility in her wheelchair.</p> <p>Interview on 07/11/24 at 11:43 A.M. with former DON #218 confirmed she wrote the order dated 06/03/24 for Resident #06 that stated the resident may go LOA with medications and supervised. Former DON #218 stated after she had a discussion with Resident #06's mother and the physician it was determined that Resident #06 should not go LOA independently. Former DON #218 stated she did not realize Resident #06 had an order in place for LOA independently or else she would have discontinued that order.</p> <p>Interview on 07/11/24 at 11:52 A.M. with Resident #06's mother stated she had spoken with the staff at the facility prior to 07/08/24 and informed the facility that Resident #06 was not to go on LOA unsupervised.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155529. This deficiency represents ongoing non-compliance from the survey dated 07/02/24.</p>		