

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 10/09/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, staff interview, review of hospital documentation, review of Omnicell (automatic medication dispensing cabinet) documentation, and policy review, the facility failed to administer medication as ordered. This affected one (#97) out of three residents reviewed for medication administration. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #97 revealed an admitted [DATE] with medication diagnoses of staphylococcal arthritis of left ankle and foot, schizophrenia, anxiety, bipolar disorder, and mild cognitive impairment.</p> <p>Review of the medical record for Resident #97 revealed an admission Minimum Data Set (MDS) assessment, dated 09/20/24, which indicated Resident #97 had severe cognitive impairment and was independent with toilet hygiene, bed mobility, and transfers and required supervision with bathing. The MDS indicated Resident #97 received antipsychotic and antianxiety medications.</p> <p>Review of the medical record for Resident #97 revealed a nurse's progress note dated 09/25/24 at 3:32 A.M. written by Registered Nurse (RN) #111 which stated Resident #97 had shown signs of agitation, anxiety, and confusion. The note also stated Resident #97 had been crying out loud and screaming at staff and residents. The note continued to state Resident #97 was given a schedule dose of Ativan 1 milligram (mg) and an order for Haldol 5 mg intramuscular (IM) was given by the physician. The note stated the nurse was not able to obtain the dose of Haldol from the Omnicell because she did not have the appropriate access. The note stated Resident #97 was sent out to the hospital and family and physician were notified. Further review revealed a nurse's note, dated 09/25/24 at 4:10 A.M. which stated Resident #97 had returned from the hospital and was given a dose of Haldol at the hospital. The note stated Resident #97 was resting with no signs of discomfort.</p> <p>Review of the medical record for Resident #97 revealed no documentation to support the nurse entered the order for the Haldol 5 mg IM on 09/24/24 under physician orders.</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 0755</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 #97 revealed a hospital emergency room (ER) note, dated 09/24/24, which stated Resident #97 was seen in the ER with agitation. The note stated Resident #97 was given Ativan at the facility but was unable to get the one-time dose of haloperidol (Haldol) because the night nurse did not have access to the medication. The ER note stated Resident #97 arrived at the ER on [DATE] at 9:25 P.M., received a dose of haloperidol in the ER, and was discharged back to the facility on [DATE] at 3:39 A.M.</p> <p>Review of Omnicell medication list revealed two vials of haloperidol 5 mg per milliliter (ml) were available in the facility's Omnicell dispenser. Review of the Omnicell user list report revealed RN #111 had access to the Omnicell effective 09/20/24.</p> <p>Interview on 10/08/24 at 2:20 P.M. with Director of Nursing (DON) stated she was not notified Resident #97 was sent to the ER on [DATE] until 09/25/24. DON stated she did not know why RN #111 was unable to access the Haldol 5 mg from the Omnicell on 09/24/24. DON confirmed Resident #97 was sent to the ER and received Haldol while at the ER. The DON confirmed RN #111 was not the only nurse in the facility on 09/24/24 so the haloperidol could have been obtained from the Omnicell dispenser if RN #111 was having difficulties accessing the device/medications.</p> <p>Review of the facility policy titled, Medication Administration, stated all medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158398.</p>

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<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** 46613</p> <p>Based on medical record review, observation, staff interview, and policy review, the facility failed to follow infection control procedures during medication administration. This affected one (#09) out of the two residents observed for medication administration. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #09 revealed an admitted [DATE] with medical diagnoses of right above the knee amputation, diabetes mellitus, asthma, schizoaffective disorder, and chronic respiratory failure.</p> <p>Review of the medical record for Resident #09 revealed a quarterly Minimum Data Set (MDS) assessment, dated 06/30/24, which indicated Resident #09 was cognitively intact and required partial/moderate staff assistance with toilet hygiene, bathing, bed mobility, and transfers.</p> <p>Review of the medical record for Resident #09 revealed physician orders dated 03/20/24 for Ascorbic acid 500 milligram (mg) one tablet by mouth two times per day, multivitamin one tablet by mouth two times per day, senna 8.6-50 mg one tablet by mouth two times per day, loratadine 10 mg one tablet by mouth daily, benzotropine 1 mg two tablets by mouth daily, metformin 500 mg one tablet by mouth two times per day, and Depakote sodium 500 mg one tablet three times per day, an order dated 05/06/24 for metoprolol 50 mg one tablet by mouth two times per day, an order dated 06/20/24 for gabapentin 100 mg two tablets by mouth every eight hours, orders dated 07/17/24 for Eliquis 5 mg one tablet by mouth two times per day and lisinopril 2.5 mg one tablet by mouth daily, an order dated 08/05/24 for haloperidol 5 mg one tablet by mouth two times per day, and an order dated 10/08/24 for magnesium oxide 500 mg one tablet by mouth two times per day.</p> <p>Observation on 10/08/24 at 9:02 A.M. revealed Registered Nurse (RN) #103 prepare Resident #09's medications for administration. RN #103 was observed placing Resident #103's ascorbic acid, multivitamin, senna, loratadine, Benzotropine, Depakote sodium, gabapentin, Eliquis, lisinopril, haloperidol and magnesium oxide tablets directly from medication card into medication cup. The observation revealed RN #103 placed Resident #09's metformin and metoprolol tablets directly into her bare hands prior to placing the medications into the medication cup. RN #103 was observed administering medications to Resident #09 and watched Resident #09 consume the medications.</p> <p>Interview on 10/08/24 at 9:15 A.M. with RN #103 confirmed she placed Resident #09's metformin and metoprolol tablets into her bare hands prior to placing the medications into the medication cup and administering to Resident #09.</p> <p>Review of the facility policy titled, Medication Administration, stated the facility staff shall follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the medication medications as applicable.</p> <p>This deficiency is based on incidental findings discovered during the course of this complaint investigation. This deficiency represents ongoing noncompliance from the survey dated 09/18/24.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record reviews, staff interviews, observations, and pest control invoices, the facility failed to ensure resident rooms were free from flies and gnats. This affected two (#11 and #13) out of the three reviewed for environment. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #11 revealed an admitted [DATE] with medical diagnoses of cervical disc disorder with myelopathy, mood disorder, metabolic encephalopathy, diabetes mellitus, congestive heart failure, and hypertension.</p> <p>Review of the medical record for Resident #11 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/01/24, which indicated Resident #11 was cognitively intact and was dependent for toilet hygiene, bathing, bed mobility, and transfers. The MDS indicated Resident 311 was always incontinent of bladder, frequently incontinent of bowel, and refused care at times.</p> <p>2. Review of the medical record for Resident #13 revealed an admitted [DATE] with medical diagnoses of emphysema, cerebral infarction, diabetes mellitus, vascular dementia, and chronic obstructive pulmonary disease.</p> <p>Review of the medical record for Resident #13 revealed an annual MDS assessment, dated 09/08/24, which indicated Resident #13 had moderate cognitive impairment and required partial/moderate assistance for bed mobility and substantial/maximum assistance with toilet hygiene, bathing, and transfers. The MDS indicated Resident #13 was frequently incontinent of bladder and bowel.</p> <p>Observation with interview on 10/08/24 at 10:35 A.M. with Resident #11 revealed the resident was lying in bed holding onto a fly swatter. The observation revealed gnats and a few flies flying around Resident #11 and her room. Interview with Resident #11 stated she had the fly swapper because of the flies and gnats in her room all the time.</p> <p>Observation on 10/08/24 at 1:33 P.M. of Resident #13's room revealed several flies and gnats in his room. The room also had a strong urine smell and the floor near Resident #13's bed appeared to have a dried sticky substance under the bedside table.</p> <p>Interview on 10/08/24 at 1:33 P.M. with State tested Nursing Assistant (STNA) #101 confirmed Resident #11 and Resident #13 had flies and gnats in their rooms. STNA #101 confirmed the floor to Resident #13's room had an area of sticky substance on the floor under the bedside table that appeared to be spilled juice that had dried and not been cleaned up. STNA #101 stated both Resident #11 and Resident #13 are incontinent and at times refuse cares. STNA #101 stated both residents had flies and gnats in their rooms for a while.</p> <p>Observation on 10/08/24 at 3:14 P.M. of Resident #11's room revealed gnats flying near the resident. Observation of Resident #13's room revealed flies near the resident and on the blinds. The room for Resident #13 had a strong urine odor.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/09/24 at 7:23 A.M. with Licensed Practical Nurse (LPN) #107 confirmed Resident #11 and Resident #13 have had issues with flies and gnats in their rooms for a while.</p> <p>Review of a pest control company invoice, dated 09/25/24, stated the company provided pest treatment for food area, public areas, and perimeter. The invoice did not contain documentation that individual resident rooms were treated. Review of the pest control company invoice, dated 10/08/24, indicated Resident #11's room was provided with a treatment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158674. This deficiency represents ongoing noncompliance from the survey dated 09/18/24.</p>		