

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/30/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview and policy review, the facility failed to prepare, store, and distribute food in a safe manner. This had the potential to affect all 96 residents who received food from the facility. The facility census was 96. Findings include: 1. Observation on 09/22/25 at 8:23 A.M. revealed during the initial tour with the DM #155 revealed a swarm of flying gnats throughout the kitchen areas. Interview on 09/22/25 at 8:25 A.M. confirmed the facility has an ongoing issue with fruit flies and gnats. DM #155 stated she will check to ensure she does not have overripe bananas as she peered over a box of bananas and confirmed that is not the issue to cause the active gnats. DM #155 stated the facility has an ongoing issue with active gnats in the kitchen. 2. Observation on 09/23/25 at 3:01 P.M. during the observation of purged and mechanical meal preparation revealed active black flies in the kitchen during meal preparation. Interview on 09/23/25 at 3:02 P.M. with DM #155 confirmed the active flies in the kitchen while the staff prepared the dinner meal. Interview with DM #155 on 09/23/25 at 5:20 P.M. confirmed the findings identified on the tray line. The facility confirmed all 96 residents residing in the facility receive their meals from the kitchen. Review of the facility policy titled Food Handling dated September 2021 confirmed food will be stored, prepared, handled, and served so the risk of food borne illness will be minimized. This deficiency represents noncompliance investigated under Complaint Numbers 1260765 (OH00161730) and 1260763 (OH00161206).		

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interviews, and policy review, the facility failed to provide medical records to a resident upon his or her request. This affected one (#37) out of one residents reviewed for medical record request. The facility census was 96. Findings include: Medical record review for Resident #37 revealed she was admitted to the facility on [DATE]. Her diagnoses included candidiasis, multiple sclerosis, obstructive sleep apnea, obesity, essential primary hypertension, anemia, anxiety, post-traumatic stress disorder, asthma, major depressive disorder, and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 37 was cognitively intact. Resident #37 was dependent on staff for medication administration. Resident #37 is independent with eating, upper body dressing, and personal hygiene. She required assistance with oral hygiene and supervision with toilet use, bathing, and lower body dressing. Interview on 09/24/25 at 1:33 P.M. with Resident #37 revealed she requested a copy of her medical records on 03/09/25, however, she has never received a copy of the records. Resident #37 stated she was told by the Medical Records Manager (MRM) #218 manager that the copy machine was broken, however, once repaired she would have copies. Interview with the MRM #218 on 09/24/25 at 3:17 P.M. confirmed Resident #37 had asked for medical records on 03/09/25. MRM #218 stated she told Resident #37 the copier was broken and MRM #218 confirmed she told Resident #37 she could have copies of Resident #37's medical records once it was repaired. However, MRM #218 pointed at a pile of records on a desk and revealed Resident #37 had never ask for her records again, so the record have been in the office. MRM #218 confirmed she had not offered the records to Resident #37 since the copier was repaired on 03/09/25. Observation on 09/24/25 at 3:17 P.M. revealed a stack of medical records copied for Resident #37 that had not been distributed to Resident #37. Review of the facility policy titled Release of Information dated September 2021 confirmed a resident has the right to access his/her medical records at any time.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, family and staff interviews, review of the grievance log, and policy review, the facility failed to complete thorough investigations for complaints of missing items. This affected one (#76) of two residents sampled for missing items. The facility census was 96. Findings include: Review of the medical record revealed Resident #76 was admitted to the facility on [DATE]. Diagnoses included morbid obesity, type II diabetes, unspecified anxiety disorder, and stage III chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #76 had no documented inventory list. Review of facility grievance log dated January 2025 to September 2025 revealed no entries for resident concerns or grievances. Review of handwritten document titled Clothing Inventory dated April 2025, updated May 2025, revealed a list of clothing including four (4) 2X long sleeved blouses, four (4) 2X solid-colored T-shirts, five (5) 2X with printed shirts with short sleeves, two (2) (2X solid-colored 3/4 sleeve shirts, four (4) 3X patterned shirts with 3/4 sleeves, three (3) 3X patterned gowns, six (6) white bras 42C, ten (10) pairs of socks, two (2) pairs solid-colored cotton capris, two (2) 2X leggings, one (1) 3X pair Mauve leggings, three (3) pairs jeans, six (6) sets 2X patterned pajamas, and one (1) Navy cable-knit sweater. Check marls were noted beside items including each of three (3) gowns and one (1) 2X pair of leggings described as gray with purple flowers. Review of handwritten document titled Woman Within 1(800) [PHONE NUMBER] Order Missing Clothing, no date, revealed a list of clothing items described by color and size, catalog order numbers, prices, tax, and shipping information. The ten items listed totaled \$319.49. Review of handwritten document titled New Clothing Inventory revealed clothing items including five (5) bras, one (1) pair black capris with floral pattern, one (1) pajama set with moon and stars pattern, and four (4) 1X pairs leggings of various solid colors and patterns. Beside each item was a date ranging from 08/12/25 to 09/17/25. Review of handwritten document titled Missing Clothing, no date revealed items with dates including 08/12/25 Playtex 18-hour bra and 08/20/25 PJ top French blue with moon and stars. During an interview on 09/22/2025 at 3:18 P.M. Resident #76 stated she first noticed she had clothing missing while she was residing in the locked unit. The resident stated she [NAME] all her clothing from Woman Within catalog and had about \$600 of stuff disappear. Resident #76 stated she reported the missing items to Social Services (SS) In April, who stated the items were sent home with family. The resident denied sending the items home and stated the facility did nothing further to investigate and refused to reimburse or replace the items. Resident #76 stated she provided SS a list of missing items and a list of items the facility could purchase to replace the missing items. Resident #76 stated since the incident has kept an inventory of clothing and continues to have items missing. Resident #76 stated she had a brand new white bra and a pajama top described as blue with [NAME] and stars pattern missing since August. Resident #76 stated the facility did her laundry and all clothing items were labeled with her full name. She described clothing items missing since April including one (1) Blue sweater, one (1) set pajamas mixed with love, one (1) set pajamas purple coffee please with coffee cups, one (1) set pajamas pink and blue flowers, three (3) nightgowns - spring colors, one (1) blouse tan with white insert, one (1) blouse lilac floral design, one (1) blouse Navy with stars, one (1) blouseshort-sleeved with navy and aqua bulbs, one (1) blouse lavender with purple flowers, four (4) solid-colored leggings, and one (1) leggings with floral pattern. During an interview on 09/23/2025 at 4:24 P.M. the Administrator confirmed Resident #76's family had reported clothing items were missing. The facility asked Resident #26's spouse to provide a list of missing items and never received a list. The Administrator stated the spouse continued to visit several times a week and never mentioned the missing items again. The administrator stated he did not follow up any further. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/2025 at 11:41 A.M. SS #231 verified she had six (6) copies of Resident #76's list of missing items. SS #231 stated Resident #231 approached her in May with a list of missing clothing items and gave a different list every day for three days. SS #231 looked in Resident #76's room and laundry and found some of the clothing. SS #231 marked off what was found on the list. SS #231 advised Resident #76 to speak to her husband about items potentially sent home or recently donated. SS #231 stated she never heard anything else about the remaining items and never followed up with Resident #76 or her husband to ensure the issue was resolved. SS #231 stated she assumed the issue was resolved since it was not mentioned again. During an observation on 09/25/2025 at 12:01 P.M. SS #231 showed Resident #76 the handwritten list titled Missing Items Resident #76 reviewed the list and verified to SS #231 the unchecked items on the list were still missing. During a telephone interview on 09/25/2025 at 12:10 P.M. revealed Resident #76's spouse stated he had purchased a bunch of clothing for Resident #76 from Woman Within, due to her size. The family labeled her clothing with her name. The facility did her laundry, and items kept coming up missing. The spouse stated he talked to the Administrator a few months ago, and he said they would check on it. The spouse stated Resident #76 had provided the facility a list of the missing clothing items. The family did not hear anything back, and the next time the spouse spoke to the Administrator, he said the facility would not reimburse for the clothing. The spouse stated the facility had always done Resident #76's laundry. He denied taking large amounts of clothing home with him and stated he had taken home a blouse and a pair of shoes to spot clean them since they did not provide stain removal services. The family had to replace all of Resident #76's missing clothing, worth around \$600. During an interview on 09/25/2025 at 3:02 P.M. the Director of Nursing (DON) confirmed Resident #76 did not have a list of personal items and her concerns for missing items was absent but should have been listed on the grievance log. Review of policy titled Resident Grievances and Concerns dated 09/2021 revealed residents had the right to make complaints and voice grievances about any concern regarding the resident's stay. Upon receipt of any oral, written, or anonymous grievance submitted, the facility took immediate action to complete a timely investigation and prevent further potential violations. This deficiency represents noncompliance investigated under Complaint Numbers 2630213, 2618777, 2574379, 1260775 (OH00165907), 1260773 (OH00165246) and 1260770 (OH00163975).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, and policy review, the facility failed to develop comprehensive person-centered care plans. This affected two (#49 and #76) residents out of 23 residents reviewed for comprehensive person-centered care plans. The facility census was 96. Findings include: 1. Review of the medical record for Resident #49 revealed an admission date of 02/04/25 with medical diagnoses of cerebral infarction, diabetes mellitus (DM), psychotic disorder with delusions, vascular dementia and hypertension (HTN). Review of the medical record for Resident #49 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/13/25, which indicated Resident #49 was cognitively intact and was independent with eating, bed mobility, and transfers, and required partial/moderate staff assistance with toilet hygiene and bathing. Review of the medical record for Resident #49 revealed a Smoking assessment dated [DATE], which indicated resident #49 was an unsupervised smoker. Review of the medical record for Resident #49 revealed a care plan, dated 07/27/25 which stated Resident #49 was a smoker and interventions included to monitor the resident's safety during smoking. The care plan did not have documentation to support Resident #49 was an independent smoker or where smoking materials are to be kept. Interview on 09/25/25 at 12:15 P.M. with Registered Nurse (RN) #194 confirmed Resident #49's smoking care plan did not include documentation to support Resident #49 was independent with smoking or where smoking supplies should be kept. 2. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE]. Diagnoses included morbid obesity, type II diabetes, unspecified anxiety disorder, and stage III chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #76 required maximum assistance with bathing. Review of care plan dated 04/01/2025 revealed Resident #76 had an ADL self-care performance deficit. Interventions included assisting with ADL's as needed. Resident #76 was independent with eating and bed mobility and required two-person assistance with toileting and transfers. There was nothing specific to level of assistance needed with bathing or personal hygiene in the care plan. During an interview on 09/25/2025 at 10:24 A.M. RN #194 verified Resident #76's care plan did not specify Resident #76's level of assistance needed for bathing. Review of policy titled Care Plans, Comprehensive Person-centered dated 09/2021 revealed care plans described services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observations, resident and staff interviews, and policy review, the facility failed to ensure residents received showers. This affected three (#76, #37, and #92) of ten residents sampled for bathing assistance. The facility census was 96. Findings include: 1. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE]. Diagnoses included morbid obesity, type II diabetes, unspecified anxiety disorder, and stage III chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #76 required maximum assistance with bathing. Review of care plan dated 04/01/2025 revealed Resident #76 had an ADL self-care performance deficit. Interventions included assisting with ADL's as needed. Resident #76 was independent with eating and bed mobility and required two-person assistance with toileting and transfers. There was nothing specific to level of assistance needed with bathing or personal hygiene in the care plan. Review of task report dated June 2025 revealed Resident #76 had three showers documented in the month of June on 06/21/25, -6/25/25, and 06/28/25. Review of task reports dated April and May 2025 revealed Resident #76 no documentation related to bathing or showers. Review of shower sheets revealed Resident #76 received assistance with bathing on 04/02/25, 04/20/25, 06/28/25, 07/02/25, 07/09/25, 07/12/25, 07/16/25, 07/23/25, 07/26/25, 07/30/25, 08/02/25, 08/06/25, 08/12/25, and 08/15/25. During an interview on 09/22/2025 at 3:31 P.M. Resident #76 stated she had an issue, while she resided in the locked unit, during which she went 12 weeks without a shower. Resident #76 stated two young men on night shift repeatedly refused to give her a shower. Resident #23 stated she reported her concerns to the DON, but nothing changed until she was moved to a new unit. During an interview on 09/24/2025 at 10:14 A.M. the Director of Nursing (DON) stated Resident #76 complained to her in the beginning of May of not getting showers. The DON verified there were no shower sheets or documentation showing that Resident #76 received showers from 04/20/25 to 06/20/25. 2. Review of medical record for Resident #37 revealed admission date of 08/06/24. The resident was admitted with diagnoses including Multiple Sclerosis, Morbid Obesity, Chronic Obstructive Pulmonary Disease Asthma, urinary retention and major depressive disorder. The resident remained at the facility. The annual Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. No behaviors were documented. She required set up assistance with toileting hygiene and was independent with eating, bed mobility and transfers. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the electronic charting revealed documentation of independent bathing for Resident #37 on 09/07/25. Review of the shower sheet documentation revealed a shower was completed for Resident #37 on 09/05/25 and 09/19/25. A shower was documented as refused on 09/23/25. Interview on 09/29/25 at 1:52 P.M. with Resident #37 revealed she was scheduled for showers twice a week and voiced a concern did not always receive them. Interview on 09/29/25 at 3:24 P.M. with the Director of Nursing (DON) verified Resident #37 should receive bathing assistance twice weekly. The DON acknowledged the facility had documentation Resident #37 had received three showers and refused one from 09/01/25 through 09/29/25. 3. Review of the medical record for Resident #92 revealed an admission date of 01/29/25 with medical diagnoses of necrotizing fasciitis, chronic obstructive pulmonary disease, left spastic hemiplegia, cerebral infarction, and bipolar disorder. Review of the medical record for Resident #92 revealed a quarterly MDS assessment, dated 08/07/25, which indicated Resident #92 was cognitively intact and required substantial/maximum staff assistance with bathing/showers, partial/moderate staff assistance with transfers, and was dependent upon staff for toilet hygiene. Review of the medical record for Resident #92 revealed the August 2025 shower sheets which indicated Resident #92 did not receive his shower as scheduled on 08/07/25 due to short staffed. Review of Resident #92's shower sheets for September revealed documentation to support Resident received showers as scheduled. The shower sheets did not contain documentation to support the if facility staff shaved Resident #92. Interview with observation on 09/22/25 at 10:00 A.M. with Resident #92 stated he didn't get his showers as scheduled and they don't shave his face with showers. Resident #92 stated his face had not been shaved in several days. Observation of Resident #92 revealed facial hair stubble. Interview on 09/25/25 at 2:59 P.M. with Director of Nursing confirmed Resident #92 did not receive a shower as scheduled on 08/07/25. Review of the facility policy titled, Activities of Daily Living (ADLs) stated residents who are unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy stated hygiene included bathing, dressing, grooming, and oral care. This deficiency represents non-compliance investigated under Complaint Numbers 2618777, 2582623, 1260777 (OH00167022), 1260775 (OH00165907), 1260770 (OH00163975), 1260768 (OH00163266), 1260767 (OH00163258) and 1260766 (OH00162690).		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview, and policy review, the facility failed to provide activities designed to meet resident needs. This affected one (#29) resident of one resident reviewed for activities. The facility census was 96. Findings include: Review of the medical record for Resident #29 revealed an admission date of 08/20/18 with medical diagnoses of major depression, chronic obstructive pulmonary disorder, vascular dementia, and right sided spastic hemiplegia. Review of the medical record for Resident #29 revealed an annual Minimum Data Set (MDS) assessment, dated 07/11/25, which indicated Resident #29 had severely impaired cognition and was dependent upon staff for all activities of daily living. Further review of the MDS revealed Resident #70's indicated it was somewhat important to have books, newspapers, magazines to read, and to listen to music and it was very important to keep up with the news, do things with groups of people and do his favorite activity. Review of the medical record for Resident #29 revealed an at risk for altered activity [NAME] care plan related to bedfast, decreased in activity participation. The care plan indicated Resident #29 preferred independent activities but did not include the activities. Review of the medical record for Resident #29 revealed the August 2025 activity log which indicated Resident #29 refused one-on-one activity and group activities on 08/08/25 and participated with group activity on 08/12/25. Review of the August activity log revealed no other documentation to support Resident #29 was offered or participated in any other activities throughout the month. Review of Resident #29's September 2025 activity log revealed documentation to support Resident #29 was offered and participated with activities on 09/09/25, 09/10/25, 09/12/25, and 09/19/25. Review of the September activity log revealed no other documentation to support Resident #29 was offered or participated in any other activities throughout the month. Random observations made on 09/22/25 between 8:00 A.M. and 3:00 P.M. revealed Resident #29 had remained in bed, and no activities were noted. The observations revealed Resident #29 did not have the television on or music playing, no magazines, books or newspapers were present. Random observations made on 09/23/25 between 8:00 A.M. and 2:30 P.M. revealed Resident #29 remained in bed, and no activities were noted. The observations revealed Resident #29 did not have the television on or music playing, no magazines, books or newspapers were present. Observation on 09/23/25 at 3:00 P.M. revealed Resident #29 sitting in his wheelchair at the nurse's station. Interview on 09/25/25 at 8:19 A.M. with Activity Director (AD) #199 stated Resident #29 preferred independent activities and at times Resident #29 would sit at the nurse's station or sit in on group activities. AD #199 confirmed Resident #29 had severely impaired cognition and that Resident #29's preferences on the annual MDS assessment dated [DATE] were taken from past MDS assessments. AD #199 confirmed she had not contacted Resident #29's family to obtain activity preferences. AD #199 confirmed the facility did not have documentation to support Resident #29 was offered activities daily in August or September 2025. AD #199 also confirmed the activity staff are to offer one-on-one activities when residents refuse group activities. Review of the facility policy titled, Activities stated the facility would provide, based on comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. The policy stated for residents who have dementia preferences would be determined through communication with the residents, family, friends, and caregivers.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and review of facility timeline documentation, the facility failed to provide adequate interventions and/or supervision to ensure a resident who was assessed as being at risk for elopements did not elope from the facility. This affected one (#70) resident out of three residents reviewed for accidents. The facility census was 96. Findings include: Review of the medical record for Resident #70 revealed an admission date 06/20/25 with medical diagnoses of schizoaffective disorder, hypertension, dementia without behavioral disturbances, and bipolar disorder. The medical record indicated Resident #70 was sent to the hospital on [DATE] for behavior issues and returned to the facility on [DATE]. The medical record indicated Resident #70 discharged to another nursing facility on 09/12/25. Review of the medical record for Resident #70 revealed an admission Minimum Data Set (MDS) assessment, dated 06/26/25, indicated Resident #70 had severely impaired cognition and required supervision with bathing, toilet hygiene, and transfers. The MDS did not indicate Resident #70 had any behaviors. Review of the medical record for Resident #70 revealed a physician order dated 06/23/25 which stated resident had a mental disorder with behavioral disturbance and met the criteria for placement on the mental health unit and would benefit from the structure and activity-based care philosophy. Review of the medical record for Resident #70 revealed an elopement evaluation dated 08/06/25 which indicated Resident #70 was a high risk for elopement. Review of the medical record for Resident #70 revealed an at risk for elopement care plan related to exit seeking behaviors dated 07/14/25. The interventions included to calmly redirect, to distract resident, to promptly check when the alarm system goes off to ensure resident was safe and remained in the facility, resident was not to be taken off the unit for activities, and to encourage resident's family to not take resident off the unit. Review of the medical record for Resident #70 revealed a nurses' note dated 08/07/25 at 9:00 P.M. which stated Resident #70 was found in the lounge pushing on the courtyard door setting off the alarm while he was trying to get out. The note stated Resident #29 succeeded in opening the door and started to go outside but staff were able to get Resident #70 back into the facility. Further review of a nurse's note, dated 08/08/25 at 2:00 P.M., stated the Administrator was alerted that Resident #70 went out the front door and was walking down the sidewalk with two staff members directly behind him. The note stated the police were called and able to get Resident #70 back into the facility. Review of the nurses' note dated 08/11/25 at 11:25 A.M. stated Resident #70 was observed kicking on the exit door and staff attempted to redirect the resident. The note stated staff sat with Resident #70 in the courtyard and supervised Resident #70 smoking. Review of a nurses' note dated 08/11/25 at 1:12 P.M. stated Resident #70 pushed his way out the smoking exit door several times during the morning and Resident #70 tried to jump the fence in the smoking area. The note stated Resident #70 was redirected with extra smoke breaks but continued to exit seek. The note stated new orders for Ativan (antianxiety medication) 0.5 milligram (mg) one time along with Zyprexa (antipsychotic medication) 5 mg one time only were given. Review of a note dated 08/11/25 at 4:15 P.M. stated Resident #70 continued to aggressively exit seek by pushing on doors. The note stated non-pharmacological interventions and medications were not effective. The note stated an order was received to pink slip Resident #70 to a behavioral hospital. Review of a nurse's note dated 08/11/25 at 7:51 P.M. stated at 5:45 P.M. staff were alerted by an alarm going off at the end of the unit and that Resident #70 had exited the building. The note stated staff members did not see which direction Resident #70 went and staff began looking for Resident #70. The note stated the Administrator and police were notified. The note continued to state Resident #70 was found within 50 feet of the facility hiding behind bushes. Resident #70 was placed on one-on-one supervision, skin assessment was completed with no injuries noted, and no complaints of pain noted. A note dated 08/12/25 at 2:52 A.M. stated Resident #70 was sent to a behavioral hospital. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER New Lebanon Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Mills Place New Lebanon, OH 45345	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility timeline for Resident #70's elopement on 08/11/25 revealed the Resident #70 eloped from the mental health unit at 5:45 P.M. and was found at 6:45 P.M. The timeline indicated Resident #70 was evaluated by Emergency Medical Services at 6:50 P.M. and returned to the facility at 7:15 P.M. The timeline indicated Resident #70 was placed on one-on-one supervision at 7:15 P.M. and discharged to the behavioral hospital on [DATE] at around 3:00 A.M. Interview on 09/29/25 at 9:46 A.M with Licensed Practical Nurse (LPN) #212 confirmed she was the nurse on the Mental Health Unit on 08/11/25 and that she was notified by staff that Resident #70 had eloped from the unit. LPN #212 confirmed Resident #70 had tried to leave the facility multiple times during the day on 08/11/25. LPN #212 stated the interventions in place at the time of Resident #70's elopement was for staff to provide redirection and for staff to keep a close eye on him. LPN #212 confirmed Resident #70 was not placed on one-on-one supervision until after his return to the facility on [DATE]. Interview on 09/29/25 at 10:06 A.M. with Administrator and Director of Nursing (DON) stated Resident #70 was on frequent staff checks on 08/11/25 due to his increase in behaviors. DON confirmed Resident #70 had not been placed on one-on-one supervision until after his elopement on 08/11/25. DON confirmed Resident #70 eloped from the facility on 08/11/25 at 5:45 P.M. and stated staff were unable to determine which direction he had gone because Resident #70 was fast and ran out of their site. DON confirmed Resident #70 was found on 08/11/25 at 6:45 P.M. in the bushes about 50 feet behind the building. DON confirmed Resident #70 was assessed and had no injuries noted. Administrator confirmed the facility elopement policy only indicated the process to following a resident elopement. This deficiency represents non-compliance investigated under Complaint Number 2574379.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record. staff interview and review of guidelines from the National Institute of Health, the facility failed to ensure non-rebreather masks were used according to professional standards. This affected one (#108) of one residents sampled for respiratory services. The facility census was 96. Findings include: Review of the medical record revealed Resident #108 was admitted to the facility on [DATE] and expire in the facility on 02/27/25. Diagnoses included type II diabetes, stage III kidney disease, and unspecified dementia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #108 had moderately impaired cognition, had verbal behaviors, did not wander, and did not reject care. Review of care plan dated 12/16/2021 revealed Resident #108 had impaired respiratory status. Interventions included administer medications as ordered, change oxygen tubing weekly, monitoring for symptoms of respiratory distress, monitoring vital signs with pulse oximetry every shift and as needed, provide oxygen as ordered and titrate to keep saturation rates higher than 90%. Review of the medical record revealed Resident #108 had a physician order dated 02/27/205 at 6:34 P.M. for oxygen at 5 Liters per minute via non-rebreather mask. Review of progress note dated 02/27/25 at 1:11 P.M. while passing trays, a Certified Nursing Assistant (CNA), unspecified, notified Licensed Practical Nurse (LPN) #173 that Resident #108 looked unwell. LPN #173 assessed vital signs and found Resident #108 had oxygen saturation levels in the 60% range on 2 Liters of oxygen per minute via nasal cannula. Management was called to assist and the provider was notified. Nurse Practitioner (NP) #83 gave verbal orders for oxygen at 5 Liters per minute through a non-rebreather mask. LPN #173 documented the non-rebreather mask did not fit Resident #108 properly and saturation levels came up to 85%. Resident #108 was sent to the hospital via emergency services. Review of progress note dated 02/27/25 at 6:38 P.M. revealed Resident #108 returned to the facility. Admitting orders included oxygen at 5 Liters per minute via non-rebreather mask. During an interview on 09/25/25 at 3:17 P.M. LPN #210 stated she was called into the room to assist LPN #173 with Resident #108. LPN #210 stated Resident #108 was never completely unresponsive. LPN #210 stated she was aware a non-rebreather mask required high flow oxygen from at least 10 to 12 Liters of oxygen per minute. She stated the facility had concentrators that accommodated high flow oxygen up to 10 liters. LPN #210 verified Resident #108's order on 02/27/25 was for a non-rebreather mask at 5 Liters per minute and that the mask had been placed on the resident as ordered. During a telephone interview on 09/29/2025 at 9:23 A.M. LPN #173 stated she was floor nurse. LPN #173 stated an aide told her around lunchtime resident was not doing well. LPN #173 stated she assessed and had the aide get LPN #210 while she spoke to NP #83 who ordered the non-rebreather mask at 5 LPM. LPN #173 stated she was unaware what oxygen levels were standard of care for non-rebreather mask, and she followed the providers order. LPN #173 stated the non-rebreather mask did not fit properly around the resident's chin due to multiple skin folds in the neck. Staff had to hold the mask in place. During an interview on 09/29/2025 at 11:36 A.M. NP #83 initially stated he would an order for a non-rebreather max at the flow rate that was the maximum flow for Resident #108's concentrator which he believed was 6 liters per minute. He was not aware the facility had concentrators that supported 10 liters of oxygen per minute. He stated he asked the staff how high Resident #108's oxygen concentrator went and would have issued the order for the non-rebreather mask at the highest flow rate his concentrator would allow to raise his saturation levels. The facility did not have a policy specific to Non-rebreather masks. Review of guidelines from National Institute of Health: National Library of Medicine website at https://www.ncbi.nlm.nih.gov/books/NBK593208/table/ch11oxytherapy.T.settings_of_oxygenation/ revealed standard practice demonstrated a non-rebreather mask is to be used with a flow rate of 10 to 15 Liters per minute of oxygen. This deficiency represents non-compliance investigated under Complaint Number 1260767 (OH00163258).		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to administer medications as ordered. This affected one (#70) out of four residents reviewed for medication administration. The facility census was 96. Findings include: Review of the medical record for Resident #70 revealed an admission date 06/20/25 with medical diagnoses of schizoaffective disorder, HTN, dementia without behavioral disturbances, and bipolar disorder. The medical record indicated Resident #70 was sent to the hospital on [DATE] for behavior issues and returned to the facility on [DATE]. The medical record indicated Resident #70 discharged to another nursing facility on 09/12/25. Review of the medical record for Resident #70 revealed an admission Minimum Data Set (MDS) assessment, dated 06/26/25, indicated Resident #70 had severely impaired cognition and required supervision with bathing, toilet hygiene, and transfers. Review of the medical record for Resident #70 revealed physician orders dated 08/08/25 for lorazepam (antianxiety) 1 milligram (mg) one tablet by mouth at bedtime and an order for trazadone (antidepressant) 50 mg one tablet by mouth at bedtime. Review of the medical record for Resident #70 revealed the August 2025 Medication Administration Record (MAR) which indicated Resident #70 did not receive the lorazepam on 08/08/25 through 08/10/25 and did not receive the trazadone on 08/08/25 and 08/09/25. Interview on 09/29/25 at 1:24 P.M. with Director of Nursing (DON) confirmed Resident #70's medical record did not have documentation to support Resident #70 received the lorazepam on 08/08/25 through 08/10/25 or trazadone on 08/09/25 or 08/09/25 as ordered. Review of the facility policy titled, Administering Medications, stated medications shall be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Numbers 1260777 (OH00167022) and 1260763 (OH00161296).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews and review of facility policy, the facility failed to ensure medications were stored appropriately. This affected two (#15 and #97) of five residents reviewed for medication storage. The facility census was 96. Findings include: Review of medical record for Resident #15 revealed admission date of 03/15/24. The resident was admitted with diagnoses including paraplegia, paranoid schizophrenia, depression, encephalopathy, and hypotension. The resident remained at the facility. The annual Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. He was independent with eating, dependent upon staff with toileting hygiene, bed mobility and transfers. He was documented to have four stage four pressure areas, two were present on admission. Review of Resident #15's medical record revealed there was no physician order, assessment, care plan or other documentation supporting the resident could keep medications at the bedside. Observation on 09/22/25 at 9:58 A.M. in Resident #15's room revealed the bedside table was placed diagonally over his bed. On top of the table a medicine cup was observed containing two round, lightly colored tablets. Observation on 09/22/25 at 10:05 A.M. with Licensed Practical Nurse (LPN) #198 verified the medication was at bedside. LPN #198 asked Resident #15 if the tablets were his TUMS (antacid) and Resident #15 acknowledged they were. LPN #198 informed Resident #15 the medication could not be left on the bedside table and removed the medication cup. Review of the facility policy, Storage of Medication dated 09/01/21 documented drugs would be stored in the packaging, containers, or other dispensing system in which they are received. 2. Review of the medical record for Resident #97 revealed an admission date of 08/21/25 with medical diagnoses of encephalopathy, chronic obstructive pulmonary disease, diabetes mellitus, and psychosis. Review of the medical record for Resident #97 revealed an admission Minimum Data Set (MDS) assessment, dated 08/27/25, which indicated Resident #97 had modified independence with decision making and was independent with eating, bed mobility, and toileting. The MDS indicated Resident #97 required supervision with bathing and received insulin. Review of the medical record for Resident #97 revealed a physician order dated 09/22/25 for Novolog solution 100 unit per ml (insulin Aspart) per sliding scale: if 201-250 = 3 units; 251-299=6 units; 301-350= 9 units; 351-400=12 units; 401-450=15 units, if over 450 to call the physician. Inject subcutaneously before meals and at bedtime. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/23/25 at 8:00 A.M. of the North Front medication cart revealed an insulin ASPA (aspart) injection flexpen was unopened and in the top drawer of the medication cart. The insulin flexpen was labeled for Resident #97 and was in a pharmacy bag with a label to refrigerate until it was opened. Interview on 09/23/25 at 8:02 A.M. with Licensed Practical Nurse (LPN) #140 confirmed Resident #97's Insulin flexpen was unopened and not refrigerated. Review of the facility policy titled, Storage of Medications, dated 09/01/21, stated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy stated the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals and all drugs should be returned to the dispensing pharmacy or destroyed. The policy stated each medication requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location. This deficiency represents non-compliance investigated under Complaint Number 1260763 (OH00161206).		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, observations, and resident and staff interviews, the facility failed to maintain a pest free environment. This affected three (#49, #61, and #96) residents out of six residents reviewed for pest control. The facility census was 96. Findings include: 1. Review of the medical record revealed Resident #61 was admitted to the facility on [DATE]. Diagnoses included unspecified psychosis, unspecified schizophrenia, and narcolepsy without catatonia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had moderately impaired cognition, had verbal behaviors, did not wander, and routinely rejected care. Observation on 09/22/25 at 10:16 A.M. revealed Resident #61 lay in bed in a hospital gown with a sheet covering him. There were two flying insects observed on the the bed sheet, and one flying insect had landed on the privacy curtain. During an interview in 09/22/25 at 10:16 A.M. Activities Director #199 verified Resident #61 had three flying insects flying around his room and landing on the sheet covering his body as he lay in bed. 2. Review of the medical record revealed Resident #96 was admitted to the facility on [DATE]. Diagnoses included unspecified alcohol-induced pancreatitis, essential tremor, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #96 was cognitively intact, had no behaviors, did not wander and did not reject care. Observation on 09/22/2025 at 10:51 A.M. revealed Resident #96 had fly paper hanging from ceiling which contained the bodies of 7 dead insects. Resident #96 had a plastic fly swatter on his bed. During an interview on 09/22/25 at 10:51 A.M. Resident #96 stated the facility was so overloaded with flies, one of the nurses was kind enough to bring that in the sticky fly trap about a month ago. The resident stated also had fly swatter in bed, and he called the area under his bed the graveyard because that was where he flung the dead bodies after swatting them. During interview conducted on 09/29/2025 from 10:38 A.M. to 10:40 A.M. with Housekeeper # 79, Registered Nurse (RN) #176 and the Administrator each verified Resident #96 had a fly paper hanging from ceiling near he bed which had several bodies of dead insects attached to it. The Administrator stated the fly paper was not there on 09/28/25 and he did not know from where it came since the facility did not carry that type of pest control device. 3. Review of the medical record for Resident #49 revealed an admission date of 02/04/25 with medical diagnoses of cerebral infarction, diabetes mellitus (DM), psychotic disorder with delusions, vascular dementia and hypertension (HTN). Review of the medical record for Resident #49 revealed a quarterly Minimum Data Set (MDS) (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, dated 08/13/25, which indicated Resident #49 was cognitively intact and was independent with eating, bed mobility, and transfers, and required partial/moderate staff assistance with toilet hygiene and bathing. Observation with interview on 09/22/25 at 10:59 A.M. revealed Resident #49 sitting on the side of his bed in his room. The observation revealed multiple gnats flying around his room. Resident #49 stated he always has flies or gnats in his room. Observation on 09/22/25 at 11:22 A.M. revealed Resident #49 sleeping in bed. The observation revealed three flies on Resident #49's comforter and two gnats on his pillow. Interview on 09/22/25 at 11:24 A.M. with Housekeeper #125 confirmed Resident #49 had three flies on his comforter and two gnats on his pillow.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews and review of facility policy the facility failed to ensure smoking items were properly stored according to policy. This affected two (#49 and #16) of four residents reviewed for smoking. The facility census was 96. Findings include: Review of medical record for Resident #16 revealed admission date of 07/29/25. The resident was admitted with diagnoses including hemiplegia right dominant side following stroke, type two diabetes mellitus, dementia without behavior, anxiety, depression and congestive heart failure. The resident remained at the facility. The admission Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. He was independent with eating and required moderate assistance from staff with toileting hygiene, bed mobility Observation on 09/22/25 at 10:51 A.M. revealed an unopened pack of cigarettes located on the bedside table during an interview with Resident #16. Observation on 09/22/25 at 11:06 A.M. with Certified Nursing Assistant (CNA) #132 verified there was an unopened pack of cigarettes on Resident #16's bedside. At the time of the observation CNA #132 informed Resident #16 smoking supplies were to be kept in a locked box and removed the cigarettes from the table. 2. Review of the medical record for Resident #49 revealed an admission date of 02/04/25 with medical diagnoses of cerebral infarction, diabetes mellitus (DM), psychotic disorder with delusions, vascular dementia and hypertension (HTN). Review of the medical record for Resident #49 revealed a quarterly Minimum Data Set (MDS) assessment, dated 08/13/25, which indicated Resident #49 was cognitively intact and was independent with eating, bed mobility, and transfers, and required partial/moderate staff assistance with toilet hygiene and bathing. Review of the medical record for Resident #49 revealed a smoking evaluation, dated 09/08/25, which indicated Resident #49 was an unsupervised smoker. Observation with interview on 09/22/25 at 11:15 A.M. revealed Resident #49 open his nightstand and remove a pack of cigarettes and a lighter. Resident #49 stated he was allowed to smoke independently. Observation with interview on 09/22/25 at 11:29 A.M. with Director of Nursing (DON) revealed Resident #49 had one pack of cigarettes and two lighters in his bedside table. DON confirmed smoking materials are to be locked up in either a locked box or at the nurse's station even if the resident was an independent smoker. Review of the facility policy titled, Smoking, dated September 2022, stated upon admission all residents who smoke would have a smoking assessment completed. The policy stated for the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who were deemed safe to smoke independently, per the smoking assessment, they may smoke at any time the resident chooses in the designated smoking areas. The policy continued to state the resident smoking materials would be retained and distributed by the facility staff to the residents during the designated smoking times and/or when independent resident chooses to smoke.		