STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366013	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Court Care Center	250 Delaware St Lexington, OH 44904

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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366013	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Court Care Center	250 Delaware St Lexington, OH 44904

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 0744 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility Self-Reported Incident (SRI), facility investigation review, police report review, interviews, review of the facility assessment, training review and policy review, the facility failed to ensure Resident #44 was provided appropriate and dignified dementia care to meet Resident #44's total care needs. This resulted in actual harm on 08/24/25 when Resident #44, who was identified with severe cognitive impairment with a diagnosis of dementia and required one staff assistance with activities of daily living (ADLs), received bruising to her bilateral wrists and lower forearms after her hands and wrists were held while she was combative with personal care provided by Certified Nursing Assistants (CNA) #204, #233 and #251. The staff failed to follow facility procedure related to care of a resident with dementia and failed to respect her right to refuse care during times of combativeness, agitation and duress resulting in bruising that measured four centimeters by four centimeters to her wrists and lower forearms. Subsequently, Resident #44 received X-rays of her bilateral wrists and hands due to complaints of pain. This affected one (Resident #44) of three residents reviewed for dementia care. The facility census was 69. Findings include: Review of Resident #44's medical record revealed an admission date of 03/27/17 with diagnoses including Alzheimer's disease, unspecified dementia without behavioral disturbances, diabetes, hypothyroidism, depression, and a history of urinary tract infections.Review of Resident #44's care plan, dated 06/26/18, revealed the resident had care plans in place for verbal behaviors and resisting care. Approaches included accepting the resident's right to refuse and show respect for the resident's decision, maintaining a calm environment and calm approach to the resident, and when the resident begins to resist care, stop and try tasks later. Do not force the resident to do a task.Further review of the care plan revealed Resident #44 had a care plan dated 02/18/21 for severe cognitive impairment related to diagnosis of Alzheimer's disease with approaches including to allow the resident time to absorb and respond to information and to explain all procedures and treatments to the resident prior to initiating them. Resident #44 also had a care plan dated 02/18/21 to monitor the resident for bruising and bleeding related to receiving aspirin daily as a blood thinning medication. Approaches included attempting to protect the resident from injury or trauma.Review of Resident #44's five-day minimum data set (MDS), dated [DATE], revealed a brief interview for mental status (BIMS) score of five (out of a possible score of 15) indicating the resident had severe cognitive impairment. Further review of the MDS revealed Resident #44 was dependent on the facility staff for toileting hygiene and bathing or showering needs and the resident was occasionally incontinent of bladder and frequently incontinent of her bowels. No behaviors were documented on the MDS.Review of current physician orders revealed Resident #44 was ordered aspirin 81 milligrams daily.Review of the resident's progress notes, dated 08/24/25 at 11:26 A.M. and written by Registered Nurse (RN) #164, revealed Resident #44 was alert and oriented times two. The resident was pleasant and cooperative with care. Resident #44 required the assistance of one staff with activities of daily living (ADL), bed mobility, and with stand and pivot transfer from bed to wheelchair using bed rails to transfer. Resident #44 was incontinent of bowel and bladder and required check and change every two hours and required the assistance of one staff with transferring to toilet, using the grab bars in the bathroom. The resident was able to self-propel in a wheelchair. Resident #44 was in her wheelchair in the dining room and denied any needs at this time. Review of Resident #44's nurse progress notes, dated 08/24/25 at 5:36 P.M. and written by Licensed Practical Nurse (LPN) #250, revealed LPN #250 had received a phone call from Resident #44's daughter requesting an update because her brother had visited earlier (that date) and Resident #44 had hit him. Resident #44's daughter requested the resident's urine be tested for a urinary tract infection (UTI).Review of the behavior monitoring log revealed no evidence of resident behaviors prior to 08/24/25 at 8:00 P.M.Review of Resident #44's behavior log flow sheet revealed on 08/24/25 at 8:00 P.M. Resident #44 displayed behaviors of refusing care, frustration/escalation of behavior, being argumentative, scratching, biting, kicking, hitting and pinching. Prior to the behaviors being displayed, the resident was incontinent of her bladder. The behaviors took place in the resident's room and bathroom. The staff attempted the following interventions: approaching the resident calmly and quietly from the front, offering food/drink, assessing her for pain and treating it if indicated, offering or assisting her to the bathroom, offering rest, repositioning, redirecting to a quiet area, approaching 1:1, offering care later, having a different caregiver approach her, and using two caregivers. The interventions were not effective in calming the resident. Further review of the log revealed the nurse was