STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithville Western Care Center	4110 East Smithville Western Road Wooster, OH 44691

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on closed medical record, interview, and policy review, the facility failed to notify the physician and/or nurse practitioner of abnormal lab results for Resident #78. This affected one resident (#78) of 17 residents reviewed for abnormal lab results. The census was 77. Findings include: Review of the closed medical record for Resident #78 revealed an admitted [DATE] with diagnoses of acute ischemia (reduced blood flow) of small intestine, status post right hemicolectomy (removal of part of the large intestine), infectious gastroenteritis (inflammation of the lining of the stomach), acute respiratory failure with hypoxia, diastolic heart failure, hypothyroidism, and need for personal care. Resident #78 was discharged to the hospital on 10/09/24. Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #78 was cognitively intact, needed setup or clean-up assistance with eating, and needed partial/moderate assistance with toileting. Review of the physician/nurse practitioner progress note dated 08/29/24 authored by Nurse Practitioner (NP) #603 revealed Resident #78 was admitted to the facility on [DATE] from the hospital where she was treated for ischemic small bowel perforation, septic shock, acute kidney injury and acute hypoxemic respiratory failure. Resident #78 had gone to the emergency department on 08/20/24 complaining of severe abdominal pain and nausea and was found to have small bowel ischemia with perforation and was taken to the operating room for right hemicolectomy with re-anastomosis. On 08/21/24, Resident #78 experienced hypotensive shock requiring pressors (medication). There was concern for further bowel ischemia and Resident #78 was transferred to a larger hospital. Labs from 08/27/24 to 08/28/24 included sodium 131 (low), potassium 4.0 (normal), BUN 7 (normal) and creatinine 0.66 (normal). Review of symptoms revealed Resident #78 was eating well and anxious. A physical exam indicated Resident #78 was ambulatory with assist and walker since hospitalization and alert and oriented to person, place, time and situation. The assessment/plan indicated infectious gastroenteritis and colitis status post right hemicolectomy. Follow up with surgeon (Physician #608) on 09/06/24 as scheduled. Regarding hypothyroidism the note indicated to continue levothyroxine and monitor labs. Recheck basic metabolic panel (BMP) in one week. Review of the health status note dated 09/05/24 timed 6:54 A.M. revealed Resident #78 had complaints of nausea off and on all night. Abdomen was soft, not distended, and not painful. Bowel sounds were active throughout. Labs were drawn. Resident #78 also had a single loose stool. The note further indicated the nurse practitioner was aware and would assess that day. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the BMP lab result dated 09/05/24 revealed Resident #78's sodium was 129 (normal 136 to 145), potassium 3.7 (normal 3.5 to 5.1), blood urea nitrogen (BUN) was 5 (normal 7 to 18) and creatinine was 0.79 (normal 0.55 to 1.02). Review of the fluid volume deficit care plan updated 09/10/24 revealed Resident #78 had potential for fluid volume deficit with an intervention to monitor labs as ordered. Review of the BMP lab result dated 09/09/24 revealed Resident #78's sodium was 128 (low) and creatinine was 1.16 (high). Review of the physician order dated 09/10/24 revealed Resident #78 was ordered a 2000 milliliter (mL) fluid restriction, to encourage salt intake and BMP in one week. Review of the BMP lab result dated 09/17/24 revealed Resident #78's sodium was 128 (low) and creatinine was 2.19 (high). Review of the physician orders dated 09/17/24 revealed Resident #78's fluid restriction was discontinued, two liters of intravenous (IV) sodium chloride 0.9% at 75 mL/hour was ordered, a BMP was to be rechecked in one week, and if Resident #78's nausea and vomiting continued to worsen, could send to emergency department. Review of the health status note dated 09/23/24 timed 10:00 P.M. revealed Resident #78 complained of ongoing nausea with emesis of bile and saliva. Ginger ale and as needed Zofran (used to treat nausea and vomiting) was administered at 7:40 P.M. and was not effective. On call physician was notified and order given for an additional dose of Zofran 4 mg. Resident #78 was aware of order and medication administered. Resident #78 refused part of bedtime medications due to nausea. Primary care physician (PCP) notified of continued nausea and medication refusal. No diarrhea was noted that shift. Review of the physician order dated 09/24/24 revealed Resident #78 was ordered omeprazole oral tablet delayed release 20 mg once a day at bedtime for indigestion and if nausea and vomiting worsened could send to emergency room for CAT scan. Review of BMP lab results dated 09/24/24 revealed Resident #78's sodium was 127 (low), potassium 3.3 (low), and creatinine was 2.09 (high). Review of the nursing progress notes and assessments from 09/24/24 to 10/09/24 revealed there was no evidence Resident #78's physician (Physician #600) and/or NP (NP #603) was notified of Resident #78's 09/24/24 abnormal lab results. Interview on 10/21/24 at 2:40 P.M. with the Director of Nursing (DON) verified Resident #78's labs were abnormal on 09/24/24 and verified there was no evidence that Resident #78's physician and/or NP was notified of the resident's 09/24/24 abnormal labs. Interview on 10/22/24 at 9:45 A.M. with Physician #600 revealed Resident #78 was dehydrated on 09/17/24 resulting in the new order of the two liters of IV fluids being administered. Physician #600 verified he was not aware of Resident #78's abnormal labs on 09/24/24 and if he would have been notified of the abnormal potassium and sodium values, Physician #600 would have likely ordered oral potassium and another round of IV fluids to correct the sodium value. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/22/24 at 3:15 P.M. with NP #603 for Physician #600 revealed she could not recall if she was notified of Resident #78's 09/24/24 abnormal labs. Normally when NP #603 received a lab, she reviewed the lab then wrote orders or consulted with Physician #600. Review of the facility's Notification of Change in Resident Condition policy updated January 2022 revealed the facility would ensure that the resident, physician, resident representative and/or the resident responsible party or family member (unless otherwise directed by resident, where the resident did not want family member informed) was notified when the following occurred, involving the resident: significant change in the resident's physical, mental or psychological status. This deficiency represents non-compliance investigated under Complaint Number OH00158806.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, open and closed medical record review, fax sheet review, policy review, and interview, the facility failed to ensure all residents received adequate, timely and necessary care and treatment. The facility failed to ensure Resident #78 received timely and adequate treatment and care and medical intervention to treat a change in condition. Resident #78 was admitted to the facility on [DATE] following a hospitalization for acute ischemia (reduced blood flow) of small intestine with perforation status post right hemicolectomy (removal of part of the large intestine), septic shock and gastroenteritis (inflammation of the lining of the stomach). Between 09/05/24 and 09/18/24 Resident #78 exhibited increased nausea/vomiting, diarrhea and abdominal pain. In addition, Resident #78 had orders for levothyroxine (used to treat thyroid disorders) with concerns the medication was not ordered/provided at an appropriate dose to meet the resident's needs. During this time, the facility failed to take appropriate action by updating the physician on a change of condition which included abnormal laboratory values and meal refusals for Resident #78. On 09/18/24, Resident #78's thyroid stimulating hormone (TSH) level was elevated at 44.9 (0.358 to 3.740 normal). Upon notification of the abnormal TSH level, the physician, who was unaware Resident #78 was already receiving levothyroxine, ordered levothyroxine at a lower dose. This resulted in Immediate Jeopardy and actual harm with the potential for serious impairment and/or death beginning on 09/24/24 when Resident #78's laboratory testing obtained on this date was abnormal with sodium of 127 (normal 136-145), potassium 3.3 (normal 3.5-5.1) and creatinine 2.09 (normal for woman 0.55 -1.02) without evidence the physician was notified. From 09/24/24 through 10/09/24, Resident #78 continued to have nausea, vomiting, diarrhea, abdominal pain, decreased appetite with refusal of meals and supplements, weight loss and weakness. On 10/09/24, Resident #78 presented with coffee ground emesis, exhibited (abdominal) pain rated a 10 out of 10 and low blood pressure (hypotension) and was transferred to the emergency room . Resident #78 was subsequently admitted to the hospital with severe dehydration, severe malnutrition and abnormal TSH which was noted to possibly be a contributing factor of the resident's gastrointestinal (GI) issues. The resident's sodium was noted to be abnormally low at 120, blood urea nitrogen (BUN) was abnormally high at 70 (normal 7-18) and her TSH level was abnormally high at 85.7 (normal 0.358 -3.740). The resident required intravenous fluids and intravenous levothyroxine. In addition, a concern that did not rise to Immediate Jeopardy occurred when the facility failed to ensure Resident #25 was transported to scheduled appointments to ensure continuity care and failed to assess Resident #71 timely related to an elevated blood sugar. This affected three residents (#78, #25 and #71) of 12 residents reviewed for change in condition and/or continuity of care/transportation. The facility census was 77. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/28/24 at 5:27 P.M., the Administrator, Director of Nursing (DON), Regional Clinical Registered Nurse (RCRN) #605, Regional Director of Operations (RDO) #606 and [NAME] President of Operations (VPO) #612 were notified Immediate Jeopardy began on 09/24/24 when the facility failed to identify a change in Resident #78's condition and provide physician notification of continued abnormal laboratory testing. Between 09/24/24 and 10/09/24 the facility failed to provide adequate medical/nursing intervention to ensure the resident received timely and necessary treatment. On 10/09/24, Resident #78 was admitted to the hospital intensive care unit (ICU) with severe dehydration, severe malnutrition and abnormal TSH level. The resident was hospitalized until 10/16/24 and did not return to the facility. Prior to the hospitalization , the resident exhibited increased nausea/vomiting, diarrhea, abdominal pain and weight loss without evidence of adequate intervention or communication to the physician for necessary and adequate treatment. The Immediate Jeopardy was removed on 10/29/24 when the facility implemented the following corrective actions. On 10/09/24 Resident #78 was transferred to the emergency room and did not return to the facility. On 10/28/24 by approximately 3:00 P.M., the DON conducted a whole house audit to ensure all resident labs in the last 30 days had documented evidence of physician notification. On 10/28/24 by approximately 7:00 P.M., the DON conducted a whole house audit to ensure any resident who refused meals in the last 72 hours had physician and registered dietitian (RD) notification and documentation. On 10/28/24 at approximately 8:00 P.M., the DON educated Registered Dietitian (RD) #613 on communicating meal refusals with the facility nursing management. On 10/28/24 by approximately 7:30 P.M., Licensed Practical Nurse (LPN) #578/Unit Manager conducted a whole house audit for all resident's nursing progress notes from the previous 72 hours (since 10/26/24) to ensure any change in condition had proper notification and documentation. On 10/28/24 by approximately 8:15 P.M., the DON educated all nurses on the proper process for reporting labs, observing new orders and ensuring appropriate documentation of all notifications and new orders. The education also included current medications related to lab values should be relayed to the physician at the time of notification. On 10/28/23 by approximately 8:30 P.M., the DON completed verbal education to all facility physicians and nurse practitioners regarding verifying the current dose of any medication related to a lab value before changing the dose. On 10/28/24 by approximately 8:30 P.M., the DON completed education for all nurses on notification of change in condition policy and recognizing signs and symptoms of a change in condition. On 10/28/24 by approximately 8:30 P.M., Registered Nurse (RN) #583/Unit Manager conducted a whole house audit for all residents ordered levothyroxine to ensure labs within the last 30 days were managed appropriately. All orders were verified for accuracy. Any concerns were addressed and documented. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/28/24 at approximately 8:30 P.M., Physician #600, who was the Medical Director, was notified of the concern related to Resident #78 and notified of the facility current corrective action plan. On 10/28/24 at approximately 8:30 P.M., an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Administrator, DON, RDO #606, VPO #612, RCRN #605, LPN #593/Minimum Data Set Nurse, RN #583/Unit Manager, LPN #578/Unit Manager, and with Physician #600 via telephone. Discussion included requirements of visits, labs, notifications, communication, current orders, and resident conditions. Beginning on 10/29/24, the DON/designee would audit all labs for results, notifications and documentation every business day for four weeks then randomly thereafter for a total of two months. Quality Assurance (QA) would review the results of the audits weekly. Beginning on 10/29/24, the DON/designee would audit all nurses' notes for a change in condition and proper notification and documentation each business day for four weeks, then randomly thereafter for a total of two months. QA would review the results of the audits weekly. Beginning on 10/29/24, the DON/designee would audit meal intakes on five residents each business day for four weeks, then randomly thereafter for a total of two months. QA would review the results weekly. Beginning on 10/29/24, the DON/designee would audit four residents on Levothyroxine each week to check for notification of physician as warranted, if new orders were reviewed and were appropriate, documentation of labs, new order notification to family, and if any needed follow up was completed immediately for four weeks, then randomly thereafter for a total of two months. QA would review the results weekly. Although the Immediate Jeopardy was removed on 10/29/24, the deficiency remained at Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action and monitoring for effectiveness and on-going compliance. Findings include: 1. Review of the closed medical record for Resident #78 revealed the resident was admitted to the facility on [DATE] with diagnoses of acute ischemia of small intestine, status post right hemicolectomy, infectious gastroenteritis, acute respiratory failure with hypoxia, diastolic heart failure, hypothyroidism, and need for personal care. The resident was transferred/discharged to the hospital on 10/09/24 and did not return to the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the physician/nurse practitioner progress note dated 08/29/24 authored by Nurse Practitioner (NP) #603 revealed Resident #78 was admitted to the facility on [DATE] from the hospital where she was treated for ischemic small bowel perforation, septic shock, acute kidney injury and acute hypoxemic respiratory failure. Resident #78 had gone to the emergency department on 08/20/24 complaining of severe abdominal pain and nausea and was found to have small bowel ischemia with perforation and was taken to the operating room for right hemicolectomy with re-anastomosis. On 08/21/24, Resident #78 experienced hypotensive shock requiring pressors (medication). There was concern for further bowel ischemia and Resident #78 was transferred to a larger hospital. Labs from 08/27/24 to 08/28/24 included sodium 131 (low), potassium 4.0 (normal), BUN 7 (normal) and creatinine 0.66 (normal). Review of symptoms revealed Resident #78 was eating well and anxious. A physical exam indicated Resident #78 was ambulatory with assist and walker since hospitalization and alert and oriented to person, place, time and situation. The assessment/plan indicated infectious gastroenteritis and colitis status post right hemicolectomy. Follow up with surgeon (Physician #608) on 09/06/24 as scheduled. Regarding hypothyroidism the note indicated to continue levothyroxine and monitor labs. Recheck basic metabolic panel (BMP) in one week. Review of the physician orders from August 2024 revealed Resident #78 was ordered potassium chloride extended-release oral tablet 20 milliequivalent (mEq) one tablet by mouth two times a day for hypokalemia, spironolactone (a diuretic) oral tablet 50 milligrams (mg) by mouth in the morning for hypertension, meclizine HCl oral tablet 25 mg give one tablet by mouth every six hours as needed for dizziness, levothyroxine sodium oral tablet 75 micrograms (mcg) give one tablet by mouth in the morning evening Monday, Tuesday, Wednesday and Thursday and levothyroxine sodium oral tablet 75 mcg give 1.5 tablets by mouth in the morning on Friday, Saturday and Sunday for hypothyroidism. Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #78 was cognitively intact, required setup or clean-up assistance with eating, needed partial/moderate assistance with toileting, and was always continent of bowel. Review of a fax sheet from the facility to Physician #600's office dated 09/04/24 authored by RN #581 revealed Resident #78 had complaints of nausea most of the day and had dry heaved off and on. The fax noted the resident was here (at the facility) after bowel surgery. Abdomen was soft, nondistended and not painful. Bowel sounds active throughout. She also had a soft/loose stool this evening. On 09/05/24, the resident refused all medications due to nausea. The NP wrote on the fax sheet dated 09/05/24 to complete a Kidney, Ureter and Bowel (KUB) x-ray. Review of the health status note dated 09/05/24 timed 6:54 A.M. revealed Resident #78 had complaints of nausea off and on all night. Staff documented the resident's abdomen was soft, not distended, and not painful. Bowel sounds were active throughout. Resident #78 also had a single loose stool. Labs were drawn. The note further indicated the nurse practitioner was aware and would assess that day. Review of the results of the BMP dated 09/05/24 revealed Resident #78's sodium was 129 (low), potassium 3.7 (normal), (BUN) was 5 (low) and creatinine was 0.79 (normal). Review of the nurse's note dated 09/05/24 revealed Resident #78 continued to complain of nausea. The nurse practitioner was in for a visit and gave order for Zofran (anti-nausea medication) and KUB x-ray. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the physician orders dated 09/05/24 revealed Resident #78 was ordered ondansetron (Zofran) oral tablet disintegrating four mg one table by mouth every six hours as needed for nausea and vomiting, Stat (immediate) KUB x-ray and BMP on 09/09/24. Review of the nutritional status care plan dated 09/05/24 revealed Resident #78 was at risk for decreased nutritional status and dehydration due to septic shock, required pressors, ischemic bowel status post right hemicolectomy, colitis, acute kidney injury, respiratory failure, morbid obesity. The care plan included nausea was currently affecting intakes and Resident #78 was at risk for malnutrition. Interventions included monitor for signs and symptoms of dehydration and monitor oral intakes. Review of the surgical physician, Physician #608's progress note dated 09/06/24 revealed Resident #78 had a laparotomy (an incision into the abdominal cavity performed to examine the abdominal organs and aid diagnosis of any problems) on 08/20/24. Resident #78 reported nausea and not tolerating much of a diet. She was having liquid stool. The progress note indicated Resident #78 could return in two weeks for a follow-up. Review of the fluid volume deficit care plan updated 09/10/24 revealed Resident #78 had potential for fluid volume deficit with an intervention to monitor labs as ordered. Review of the altered comfort level care plan updated 09/10/24 revealed Resident #78 had potential for altered comfort level related to gastrointestinal discomfort, hemicolectomy related to ischemic necrosis of small bowel and colitis with interventions to report abdominal pain, report episodes of diarrhea and vomiting and report complaints of nausea. Review of the BMP lab result dated 09/09/24 revealed Resident #78's sodium was 128 (low) and creatinine was 1.16 (high). Review of the physician order dated 09/10/24 revealed Resident #78 was ordered a 2000 milliliter (mL) fluid restriction, to encourage salt intake and BMP in one week. Review of the BMP lab dated 09/17/24 revealed Resident #78's sodium was 128 (low) and creatinine was 2. 19 (high). Review of a fax sheet from the facility to Physician #608 dated 09/17/24 revealed Resident #78 continued to have frequent nausea and vomiting. Currently ordered Zofran as needed and effective short term. Recent KUB negative. Please advise. Physician #608's office responded with, Resident #78 to follow up next with Physician #608. If worsening symptoms, patient will need to go to the emergency room . Appointment on 09/23/24 at 3:00 P.M. Review of Resident #78's physician orders dated 09/17/24 revealed orders to discontinue fluid restriction and administer two liters of sodium chloride 0.9% at 75 mL/hour intravenously, recheck BMP in one week, and if resident's nausea and vomiting continue to worsen, may send to emergency department. Review of the TSH lab result dated 09/18/24 revealed Resident #78's TSH was 44.9 (high). Physician #600 wrote on the lab sheet, start Synthroid 50 micrograms (mcg) by mouth one a day in the morning by itself for one hour (no other food or pills). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Surgical Physician #608's progress notes dated 09/23/24 revealed Resident #78 was still complaining of nausea, vomiting and diarrhea. The assessment and plan indicated diarrhea. The note further indicated unsure as to the reason for the vomiting, but Resident #78 would require a CAT scan which the physician would rather have done at the emergency room if the resident was having acute vomiting. The resident's abdomen was not distended, and it was soft. The physician wanted to check/test the resident for Clostridium difficile (a bacterium that can cause diarrhea). Review of the nursing progress notes from 09/23/24 to 09/24/24 revealed there was no evidence of an order to obtain a Clostridium difficile culture for Resident #78 and no evidence the testing was completed. Review of the health status note dated 09/23/24 timed 10:00 P.M. revealed Resident #78 complained of ongoing nausea with emesis of bile and saliva. Ginger ale and as needed Zofran administered at 7:40 P.M., not effective. On call physician notified and order given for an additional dose of Zofran 4 mg. Resident aware of order and medication administered. Resident #78 refused part of bedtime medications due to nausea. The primary care physician (PCP) was notified of continued nausea and medication refusal. Resident #78 with no diarrhea noted this shift. Review of the fax sheet from the facility to Physician #600/NP dated 09/23/24 revealed Resident #78 with complaints of frequent nausea with emesis of bile and saliva. Resident #78 was medicated with Zofran 4 mg at 7:40 P.M. without relief. On call physician notified and additional order given for repeat administration of Zofran 4 mg. Continued to complain of nausea. Refused medications due to nausea. Resident #78 had been having more frequent bouts of nausea. The fax indicated Resident #78 had an order for Zofran 4 mg every six hours and asked if the physician/nurse practitioner would consider increasing dose or frequency or additional medication. NP #603 responded on 09/24/24 with direction to start omeprazole (reduces the amount of acid the stomach makes) 20 mg once a day at night. Review of the physician order dated 09/24/24 revealed Resident #78 was ordered omeprazole oral tablet delayed release 20 mg once a day at bedtime for indigestion and if nausea and vomiting worsened could send to emergency room for CAT scan. Review of BMP lab results dated 09/24/24 revealed Resident #78's sodium was 127 (low), potassium 3.3 (normal 3.5-5.2) and creatinine was 2.09 (high). Review of the nursing progress notes and assessments from 09/24/24 to 10/09/24 revealed there was no evidence Resident #78's physician (Physician #600) and/or NP (NP #603) were notified of Resident #78's 09/24/24 abnormal lab results. In addition, there was no evidence Resident #78's physician and/or NP was notified from 09/26/24 to 10/07/24 regarding Resident #78's ongoing nausea, vomiting, diarrhea, refusal of meals and abdominal pain. Review of the health status note dated 09/25/24 timed 11:57 A.M. revealed Resident #78 refused to go to the dining room during the shift and refused to eat meals. Review of the nutrition progress note dated 09/25/24 timed 1:01 P.M. revealed Resident #78 had refused 24 meals and nausea and vomiting was noted in Resident #78's chart. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the pharmacy review note dated 09/25/24 authored by Pharmacist #611 revealed Pharmacist #611 reviewed Resident #78's medication regimen and noted any irregularities and/or observations on a separate report to the DON and prescriber. Review of the Consultant Pharmacist's Medication Regimen Review sheet dated 09/30/24 revealed Resident #78 was reviewed during the consultant pharmacist's visit between 09/01/24 and 09/30/24 with no irregularities noted and no pharmacist recommendations. Review of the late-entry Medicare Skilled Assessment note dated 09/27/24 timed 9:48 P.M. revealed Resident #78 had abdominal cramping with nausea and stomach cramping. Review of the Medicare Skilled Assessment note dated 09/28/24 timed 10:08 P.M. revealed Resident #78 complained of abdominal pain, nausea and stomach cramping. Review of the health status note dated 09/29/24 timed 8:47 P.M. revealed the author discussed with Resident #78 the importance of eating foods with medications due to frequent complaints of nausea, that food intake could help neutralize acids, and taking multiple medications could increase the chance of nausea. Review of the Medication Administration Record (MAR) from September 2024 revealed Resident #78 received the as needed Zofran 4 mg on 09/05/24 at 8:10 P.M., 09/06/24 at 1:19 P.M. and 8:45 P.M., 09/07/24 at 8:38 A.M., 09/08/24 at 10:04 P.M., 09/09/24 at 10:33 P.M., 09/10/24 at 7:14 A.M. and 8:05 P.M., 09/11/24 at 7:49 A.M., 09/12/24 at 7:42 A.M. and 8:28 P.M., 09/13/24 at 7:52 A.M. and 3:35 P.M., 09/14/24 at 7:48 A.M. and 5:37 P.M., 09/15/24 at 12:14 A.M., 9:06 A.M. and 4:54 P.M., 09/16/24 at 8:00 A.M. and 4:17 P.M., 09/17/24 at 5:21 A.M. and 4:21 P.M., 09/18/24 at 1:19 A.M., 7:41 A.M. and 4:40 P.M., 09/19/24 at 9:12 A.M. and 8:26 P.M., 09/20/24 at 5:51 P.M. and 8:55 P.M., 09/21/24 at 5:32 P.M. and 8:46 P.M.,09/22/24 at 6:01 A.M. and 7:55 P.M., 09/23/24 at 5:44 A.M., 7:44 P.M. and 10:00 P.M., 09/24/24 at 4:22 A.M. at 4:43 P. M., 09/25/24 at 2:50 A.M., 09/26/24 at 1:47 A.M. and 3:25 P.M., 09/27/24 at 8:39 A.M. and 9:09 P.M., 09/28/24 at 7:16 A.M. and 5:23 P.M.,09/29/24 at 6:17 A.M. and 8:14 P.M., and 09/30/24 at 7:28 A.M. and 10:24 P.M. Review of the MAR from September 2024 revealed Resident #78 received the as needed meclizine 25 mg on 09/04/24 at 8:11 P.M., 09/11/24 at 7:49 A.M., 09/14/24 at 9:13 P.M., 09/15/24 at 10:58 P.M., 09/18/24 at 11:51 A.M. and 9:13 P.M., 09/20/24 at 3:34 P.M., 09/21/24 at 7:15 P.M., 09/23/24 at 1:30 P.M. and 8:37 P.M. , 09/25/24 at 5:49 A.M. and 7:34 P.M., 09/26/24 at 6:09 A.M. and 7:17 P.M., 09/27/24 at 5:20 A.M. and 4:38 P.M.,09/28/24 at 2:48 A.M., 11:48 A.M. and 9:26 P.M., 09/29/24 at 5:28 P.M., and 09/30/24 at 3:53 A.M. Review of the September 2024 meal intake documentation in the tasks tab of the electronic medical record (EMR) revealed Resident #78 refused meals on 09/07/24 at breakfast, 09/08/24 at breakfast, 09/09/24 at lunch, 09/10/24 at breakfast, lunch and dinner, 09/11/24 at breakfast and dinner, 09/12/24 at breakfast and dinner, 09/13/24 at breakfast and dinner, 09/14/24 at breakfast and dinner, 09/15/24 at breakfast and lunch, 09/16/24 at breakfast and lunch, 09/18/24 at breakfast, 09/19/24 at breakfast and lunch, 09/20/24 at breakfast and lunch, 09/21/24 at breakfast, 09/22/24 at breakfast and lunch, 09/23/24 at lunch, 09/24/24 at breakfast, lunch and dinner, 09/25/24 at breakfast and lunch, 09/26/24 at breakfast, lunch and dinner, 09/27/24 at breakfast, lunch and dinner, 09/28/24 at breakfast, 09/29/24 at breakfast and lunch, and 09/30/24 at breakfast. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithville Western Care Center	4110 East Smithville Western Road Wooster, OH 44691

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the September 2024 bowel continence documentation in the tasks tab of the EMR revealed Resident #78 had loose stools or diarrhea on 09/05/24, 09/07/24, 09/09/24, 09/10/24, 09/11/24, 09/12/24, 09/13/24, 09/14/23, 09/15/24, 09/16/24 (two episodes), 09/17/24 (three episodes), 09/19/24, 09/22/24 (two episodes), 09/23/24, 09/24/24, 09/26/24 (two episodes), 09/27/24 (two episodes), 09/28/24, and 09/29/24. Review of the Medicare Skilled Assessment note dated 10/01/24 timed 9:26 P.M. revealed Resident #78 had mild abdominal pain and complaints of nausea frequently. Review of the nutrition progress note dated 10/03/24 timed 9:54 A.M. revealed Resident #78 had refused 27 meals, and nausea and vomiting continued with treatments in place. Resident #78 was independent to set up assistance with some increased assistance from helper at times. Resident #78 was still at risk for malnutrition. The goal indicated meal intakes greater than or equal to 50% once nausea was resolved. Review of the health status note dated 10/08/24 timed 6:11 P.M. revealed Resident #78 had a small coffee ground emesis this evening. The physician notified. The note further indicated to see new orders. Review of the health status note dated 10/09/24 timed 7:11 A.M. revealed Resident #78 was noted to have additional coffee ground emesis and complained of intense left upper quadrant and left lower quadrant abdominal pain. Resident #78 stated, worse than before I had my surgery. The note indicated Resident #78 had a bowel obstruction when she was hospitalized prior to the nursing home admission. Physician #600 was notified. Review of the eINTERACT Transfer Form assessment dated [DATE] timed 7:14 A.M. revealed Resident #78 had an unplanned transfer to the hospital for abdominal pain with a blood pressure of 95/66 (hypotensive) and a pain level rated a 10 out of 10 (with 10 being the most severe pain). Resident #78 had complaints of achy pain, stated constant for the last hour and also had coffee ground emesis. Review of the MAR from October 2024 revealed Resident #78 received as needed Zofran 4 mg on 10/01/24 at 4:53 A.M. and 8:07 P.M., 10/02/24 at 5:43 A.M. and 7:55 P.M., 10/03/24 at 5:10 P.M.,10/04/24 at 10:12 A.M. and 8:01 P.M., 10/05/24 at 3:08 A.M.,10/06/24 at 12:10 P.M. and 6:10 P.M., 10/07/24 at 1:16 A.M., 12:49 P.M. and 11:25 P.M.,10/08/24 at 9:59 A.M. and 4:44 P.M., and 10/09/24 at 4:38 A.M. Review of the MAR from October 2024 revealed Resident #78 received as needed meclizine 25 mg on 10/02/24 at 12:02 P.M., 10/03/24 at 3:00 A.M. and 12:44 P.M.,10/04/24 at 12:55 P.M. on 10:26 P.M., 10/05/24 at 2:29 P.M. and 8:46 P.M.,10/06/24 at 2:58 P.M.,10/07/24 at 5:10 A.M. and 7:44 P.M., and 10/08/24 at 5:38 A.M., 2:23 P.M. and 11:29 P.M. Review of the October 2024 meal documentation in the tasks tab in the EMR revealed Resident #78 refused meals on 10/01/24 at breakfast and lunch,10/02/24 at breakfast, lunch and dinner,10/03/24 at breakfast, 10/04/24 at breakfast, lunch and dinner,10/05/24 at breakfast, lunch and dinner,10/06/24 at breakfast, lunch and dinner,10/07/24 at breakfast and lunch, and 10/08/24 at breakfast and dinner Review of the October 2024 bowel continence documentation in the tasks tab of the EMR for Resident #78 revealed Resident #78 had loose stools or diarrhea on 10/02/24, 10/03/24 (two episodes), 10/05/24, and 10/07/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the weights in the weights/vitals tab of the EMR revealed Resident #78 sustained weight during her facility admission with the following weights obtained: On 09/03/24 the resident weighed 267.4 pounds, on 09/10/24 the resident weighed 255.4 pounds, on 09/17/24 the resident weighed 253.3 pounds, on 09/24/24 the resident weighed 246.8 pounds, on 10/01/24 the resident weighed 245.5 pounds and on 10/07/24 the resident weighed 239.1 pounds. From 09/03/24 to 10/07/24 the resident experienced a 28. 3-pound weight loss. Review of the emergency department physician summary dated 10/09/24 revealed Resident #78 presented from a nursing home with dark brown coffee-ground emesis that she stated she had for the past week without any bloody or red discoloration and left-sided abdominal pain that started in the morning (10/09/24). She stated she had been vomiting like this for six weeks or so, but she had not had any abdominal pain until this morning. Labs showed acute renal failure .and with her BUN of almost 70 and actively vomiting intravenous fluids were warranted. The resident was noted to be hyperkalemic presumably from the acute renal failure .Labs from 10/09/29 at 8:36 A.M. showed BUN 68 and creatinine 4.78 (reflective of acute renal failure). Review of the hospitalist physician's history and physical exam dated 10/09/24 timed 11:45 A.M. revealed family assisted with Resident #78's history, and they told the hospitalist that she had a Pneumovax vaccine three weeks ago and since that point in the time she had nausea and vomiting, diarrhea and intermittent abdominal pain. Her oral intake had declined, and Resident #78 reported profuse watery diarrhea. Resident #78 stated she had been able to take her medicines, but she was unsure what was coming back up when she vomited and was not clear on absorption. Given her ongoing decline and ongoing issues with vomiting and concern or hematemesis (bloody emesis) she was sent to the emergency department. TSH was 85.7. The plan indicated abnormal TSH with history of hypothyroidism. TSH was markedly elevated. Paperwork from nursing facility noted the resident was on (levothyroxine) 50 mcg daily but per documentation she had been on 125 mcg daily. Hold home oral thyroid replacement therapy and give intravenous (thyroid replacement therapy) 75 mcg. The note indicated this could have been confounding the resident's digestive issues. The resident was admitted to the intensive care unit. Review of Physician #608's hospital progress note dated 10/10/24 revealed Resident #78 was having severe dehydration as she also had an elevated TSH. Resident #78 was receiving a low-dose of Synthroid at her nursing home so she was receiving intravenous to replete. Continue hydration and observation. Resident #78 had been very dehydrated and not eating or drinking at the nursing home. Resident #78 said she had been having a lot of nausea. Labs shown on 10/09/24 at 8:36 A.M. that TSH was 85.7 (0.358 to 3.740 normal). Review of a hospital discharge summary dated 10/16/24 revealed Resident #78 had acute gastroenteritis, acute cystitis (urinary tract infection that causes inflammation of the bladder), diffuse abdominal pain, acute kidney failure, and acidosis and severe malnutrition related to inadequate oral intake as evidenced by 10% unintentional weight loss in 1.5 months and oral intake meeting less than 50% of estimated needs for three weeks. Interview on 10/21/24 at 2:15 P.M. with LPN #536 revealed the evening of 10/08/24, Resident #78 had a small coffee ground emesis, so LPN #536 notified the on-call physician who ordered labs to be drawn the morning of 10/09/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/21/24 at 2:40 P.M. with the DON verified Resident #78's labs were abnormal on 09/24/24 and verified there was no evidence Resident #78's physician and/or nurse practitioner was notified of the resident's 09/24/24 abnormal labs. Interview on 10/21/24 at 3:00 P.M. with RN #574 revealed Resident #78 had been at the facility for approximately a month and a half and stated she believed the resident was medically in poor condition when she arrived from the hospital as she was weak and not eating much. Resident #78 began to progress and get better; however, Resident #78 began to have nausea and vomiting and was not eating well. Resident #78 was given Zofran and meclizine. RN #574 stated she would question the day shift nurses about how the medication was not fixing Resident #78's nausea and vomiting. Interview on 10/22/24 at 7:15 A.M. with RN #581 revealed on the evening of 10/08/24, Resident #78 had nausea and vomiting and a coffee ground emesis during LPN #536's shift. The physician ordered labs for 10/09/24, and the nurses thought Resident #78 was possibly in lactic acidosis (a condition where there is too much lactic acid in the body). The RN stated Resident #78 was fine through the night of 10/08/24 into 10/09/24 then at 6:20 A.M., Resident #78 started complaining of abdominal pain. Interview on 10/22/24 at 9:45 A.M. with Physician #600 revealed Resident #78 was dehydrated on 09/17/24 resulting in the new order of two liters of intravenous fluids being administered. Physician #600 revealed he was not aware of Resident #78's abnormal labs on 09/24/24 and stated if he had been notified of the abnormal potassium and sodium values, Physician #600 would have likely ordered oral potassium and another round of intravenous fluids to correct the sodium value. Physician #600 also revealed he was not aware Resident #78 had consistently refused 27 meals during her stay in the facility. Interview on 10/22/24 at 10:10 A.M. with Physician #608's office representative revealed during Resident #78's office visit on 09/23/24, Resident #78 was sent back to the facility with orders to obtain a lab culture for Clostridium difficile and to send the resident to the emergency department if the vomiting continued. Physician #608's office representative stated the Clostridium difficile culture should have been obtained at the nursing home. Interview on 10/22/24 at 12:00 P.M. with the DON and RCRN #605 revealed the facility did not have a policy regarding meal refusals and notifying the physicia [TRUNCATED]

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure residents were seen by their physician once at least every 30 days for the first 90 days after an admission. This affected four residents (#9, #10, #78 and #84) of seven residents reviewed for physician visits. The facility census was 77. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including necrotizing fasciitis (a bacterial infection that results in the death of the body's soft tissue), sepsis, paraplegia and fracture of the left tibia. Review of the nursing progress notes (where the physician and nurse practitioner progress notes were also located) dated 08/24/24 through 10/29/24 revealed Resident #9 was not seen by his physician while at the facility. Resident #9 was seen by Nurse Practitioner (NP) #603 on 08/27/24, 09/19/24, 10/08/24 and 10/17/24. Interview on 10/29/24 at 1:55 P.M. with Resident #9 verified he had never seen Physician #600 while at the facility. He stated he had seen NP #603 and had also went out of the facility to see his surgeon and the wound clinic physician. Interview on 10/29/24 at 2:22 P.M. with Regional Clinical Registered Nurse (RCRN) #605 verified Resident #9 had not been seen by Physician #600 while at the facility. 2. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including aftercare following joint replacement surgery, diabetes mellitus and chronic kidney disease. Review of the nursing progress notes dated 08/30/24 through 10/29/24 revealed Resident #10 was not seen by her physician while at the facility. Resident #10 was seen by NP #603 on 09/05/24, 09/10/24 and 10/17/24. Interview on 10/29/24 at 2:22 P.M. with RCRN #605 verified Resident #10 had not been seen by Physician #600 while at the facility. 3. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including acute ischemia (decreased blood flow) of the small intestine, chronic obstructive pulmonary disease, acute respiratory failure, infectious gastroenteritis (inflammation of the stomach and intestines) and hypothyroidism (condition where the thyroid does not produce enough hormone). Resident #78 was discharged to the hospital on 10/09/24 for an emergent health condition. Review of the nursing progress notes dated 08/28/24 through 10/09/24 revealed Resident #78 was not seen by her physician while at the facility. She was seen by NP #603 on 08/29/24. Interview on 10/28/24 at 11:43 A.M. with RCRN #605 verified Resident #78 had not been seen by Physician #600 while at the facility. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #84 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, malignant neoplasm (cancer) of the lung and heart failure. Resident #84 was discharged to the hospital on 08/26/24. Review of the nursing progress notes dated 07/03/24 through 08/26/24 revealed Resident #84 was seen by Physician #600 on 08/25/24. There was no other documentation that Resident #84 saw a physician at the facility prior to this date. Resident #84 was seen by NP #603 on 08/01/24 and 08/20/24. Interview on 10/29/24 at 10:40 A.M. with the Director of Nursing (DON) revealed Physician #600 had seen Resident #84 on 08/25/24. The DON provided a physician progress note for Resident #84 dated 08/25/24 that indicated late entry. However, the effective date indicated 08/25/24 and there were no other dates listed on the progress note. The DON verified Resident #84 had not been seen by a physician within 30 days of admission. The DON stated she had spoken to Physician #600 and he could not recall the date he had seen Resident #84 other than the indicated date on the progress note.