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	04/28/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on resident and staff interview, review of the Almanac Weather History, medical record review, and review of the facility policy, the facility failed to ensure a resident's room maintained a comfortable temperature for Resident #97. This affected one (Resident #97) of three residents reviewed for safe environment. The facility census was 89. Findings include: Record review for Resident #97 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included diabetes mellitus, depression, and anxiety disorder. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 was cognitively intact. Review of the census history revealed Resident #97 was admitted to [room [ROOM NUMBER]] on 03/20/25. On 03/24/25, Resident #97 was transferred to [room [ROOM NUMBER]]. Review of the Almanac Weather History for [NAME] Ohio revealed on 03/20/25, the outdoor temperature ranged from 35 to 71 degrees Fahrenheit (F); On 03/21/25, the temperature ranged from 28 to 63 degrees F; On 03/22/25, the temperature ranged from 28 to 51.1 degrees F; On 03/23/25, the temperature ranged from 21 to 46 degrees F; and on 03/24/25, the temperature ranged from 37 to 50 degrees F. Interview on 04/28/25 at 10:40 A.M. with Resident #97 revealed on 03/20/25, when he was admitted to room [ROOM NUMBER], it was cold, there was no heat in that room. Resident #97 told staff and they said they wrote something up, and they gave me a blanket. His wife and daughter had to wear a coat to visit him. Resident #97 said it really got colder at night. Resident #97 said the blanket the staff provided didn't really help because the whole room was so cold. Resident #97 stated maintenance came in, looked at the heater, and said he couldn't fix it. and had to get part so they moved me. Resident #97 stated he was so cold and miserable while in the room and he and did not understand why they did not do something about it right away. Resident #97 confirmed he was not offered a room change over the weekend. Interview on 04/28/25 between 9:27 A.M. and 11:00 A.M. with Registered Nurse (RN) #292 confirmed she worked on Saturday 03/22/25 and Sunday 03/23/25 with Resident #97. RN #292 revealed Resident #97 expressed concerns on those days about his room temperature and said his room was cold. RN #292 revealed she put a Maintenance ticket in and gave him an extra blanket. RN #292 revealed she did not recall how cold the room was. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/28/25 at 10:01 A.M. with Maintenance Assistant #254 revealed each room had baseboard heating that was used during the winter months. Maintenance Assistant #254 revealed he was aware of the room temperature concern with Resident #97. When he returned to work Monday, 03/24/25, he was told about the concern and revealed the heater in the room went out and stated It was a little chill but he didn't know why Resident #97 stayed in room [ROOM NUMBER] during the weekend. Maintenance Assistant #254 confirmed the Maintenance department did not routinely work the weekends. Interview on 04/28/25 at 10:56 A.M. with RN Unit Manager #301 revealed he did not work the weekend of 03/22/25 or 03/23/25 but he did work 03/24/25 and assisted in moving Resident #97 to a different room. RN Unit Manager #301 stated the room he was in was cold, and he didn't know why Resident #97 was not moved to a different room when the room got cold. Nursing put it in a work order through the maintenance electronic messaging system); However, maintenance doesn't work over the weekend. RN Unit Manager #302 confirmed staff could have offered Resident #97 a room change over the weekend and didn't know why the didn't do this. Interview on 04/28/25 at 11:15 A.M. with the Administrator revealed if a resident room was cold and there was a problem with the heat, the staff can move the resident to a different room. Interview on 04/28/25 at 11:15 A.M. with Maintenance Director #255 revealed the facility had an HVAC system. When the temperature outside gets cold, the facility supplements the heat with baseboard heating. In [room [ROOM NUMBER]], the thermocouple went out, unsure when, so the baseboard heating was not working. Reviewed the work orders with Maintenance Director #255 revealed on Saturday, 03/22/25, Certified Nursing Assistant (CNA) #256 placed a maintenance ticket for [room [ROOM NUMBER]] with a summary Please turn on heat, resident says room is cold. On 03/24/25 at 5:32 A.M. CNA #259 placed a maintenance ticket for [room [ROOM NUMBER]] with a summary, Room too cold patient complaining. Review of the facility's undated policy titled Safe Environment revealed the resident has the right to a safe, clean, comfortable, and home-like environment, comfortable and safe temperature levels, must maintain a temperature of 71 to 81 degrees F. This deficiency represents non-compliance investigated under Complaint Number OH00165134.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42011 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure and maintain accurate and complete drug records for the residents. This affected four (Residents #38, #84, #95 and #99) of four residents reviewed for pharmacy services. The facility census was 89. Findings include: 1. Record review for Resident #38 revealed an admitted [DATE]. Diagnosis included Alzheimer's dementia, chronic pain syndrome, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was rarely or never understood. Review of the physician orders for Resident #38 revealed an order for Ativan (a controlled medication) oral tablet 0.5 milligrams (mg) one tablet by mouth every eight hours as needed for anxiety/restlessness for 14 days. The order was initiated 01/10/25 to be discontinued after 01/23/24. Review of the Controlled Drug Record for Resident #38 revealed Ativan 0.5 mg dated 11/26/24 take one tablet by mouth every 12 hours as needed for 14 days. The Controlled Drug Record was initiated 11/27/24 signed by Licensed Practical Nurse (LPN) #251. The same controlled drug record continued through 03/26/25. Review of the Controlled Drug Record revealed on 01/25/25 at 8:22 P.M. Registered Nurse (RN) #306 signed the Controlled Drug Record for the removal of an Ativan 0.5 mg from Resident #38's controlled medications. Review of the medication administration record (MAR) for Resident #38 revealed for the order for the Ativan 0.5 mg, the box dated 01/25/25 (where the nurse initials she administered the medication to the resident) had an x in the box indicating the order was no longer active. The medical record for Resident #38 revealed no indication (or physician order) indicating Resident #38 had an order for or received the Ativan 0.5 mg on 01/25/25. Review of the physician orders for Resident #38 revealed an order for Norco (a controlled medication) oral tablet 5-325 mg give one tablet by mouth every eight hours as needed for pain initiated 01/22/25. Review of the Controlled Drug Record for Resident #38 revealed on 01/26/25 at 5:23 A.M., RN #306 dated and signed the Controlled Drug Record for the Norco oral tablet 5-325 mg. RN #306 then drew one line through the date, time and signature (indicating an error, the medication was not administered). Review of the MAR for Resident #38 for the order for the Norco oral tablet 5-325 mg revealed on 01/26/25 at 5:23 A.M., Resident #38 had a pain level of seven. RN #306 administered the Norco 5-325 mg and the medication was effective. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/28/25 at 12:41 P.M. with Director of Nursing (DON) revealed the nurses sign the controlled drug record when they remove a resident's controlled medication. Each controlled medication is numbered with the amount delivered from the pharmacy and the amount remaining. The nurses (oncoming and off going) count each controlled drug together at the beginning and end of each shift to ensure the controlled medications are accurate. DON revealed the nurse would sign the controlled drug record when they removed a controlled drug from the secured storage area; once the medication was signed out as removed by the nurse, they would then sign the MAR indicating the medication was administered to the resident it was ordered for. DON confirmed Resident #38's Ativan removed from the secured drug box by RN #306 on 01/25/25 was not documented in Resident #38's medical record or MAR as administered to that resident. In addition, the Ativan was discontinued on 01/25/25 so there was no order to administer the drug. The controlled drug audit for the Norco tablet 5-325 mg was signed by RN #306 on 01/26/25 at 5:23 A.M. then errored off. The MAR was documented as the medication was given for pain and effective but it couldn't have been given because the count was accurate on the controlled drug record reflecting the medication was not given when both nurses counted at the end of the shift. 2. Record review for Resident #84 revealed an admitted [DATE]. Diagnoses included paraplegia, contracture of unspecified muscle, and low back pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 was cognitively intact and received scheduled pain medications. Review of the physician orders for Resident #84 dated 01/19/25 revealed an order for Oxycodone HCL (controlled medication) oral tablet five milligrams (mg) give one tablet by mouth every six hours as needed for pain score of seven to 10 for three days. Review of the Controlled Drug Record for Resident #84 revealed on 01/12/25, there was an order for Oxycodone HCL oral tablet five mg give one tablet by mouth every six hours as needed for pain score of seven to 10 (from pain level of zero no pain to 10 most severe pain) for three days. On 01/26/25 at (unreadable time), Registered Nurse (RN) #306 signed out Resident #84's Oxycodone from the secured medication storage. Review of the medication administration record (MAR) for Resident #84 revealed Oxycodone had a start date of 01/19/25 and an end date of 01/22/25 (four days). The box dated 01/25/25 (where the nurse initialed she administered the medication to the resident) had an x in the box indicating the order was no longer active. The medical record for Resident # 84 revealed no indication (or physician order) indicating Resident #84 had an order for or received the Oxycodone HCL five mg on 01/26/25. Interview on 04/28/25 at 12:41 P.M. with the Director of Nursing (DON) confirmed on 01/26/25 at (unreadable time), RN #306 signed out Resident #84's Oxycodone from the secured medication storage. DON confirmed there was no order to administer the medication and the medication was not documented in Resident 84's medical record as administered. 3. Record review for Resident #95 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included cerebral infarction and dysarthria following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was cognitively intact and received scheduled pain medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders for Resident #95 revealed an order for an admission to hospice ordered 01/24/25. Additional orders dated 01/24/25 included morphine sulfate (controlled medication) oral solution 20 milligrams (mg) per milliliter (ml) give 0.5 ml by mouth every two hours as needed for pain/shortness of breath (SOB). Review of the Controlled Drug Record for Resident #95 with the Director of Nursing (DON) on 04/28/25 at 12:45 P.M. revealed the controlled drug record did not indicate the name of the controlled drug (morphine sulfate oral solution 20 mg per ml) with directions for use. DON confirmed this was the controlled drug record for Resident #95's morphine sulfate oral solution 20 mg per ml. The controlled drug record indicated the drug was initiated for Resident #95 on 01/25/25. The Controlled Drug Record revealed RN #306 documented morphine sulfate 0.5 ml was removed on 01/26/25 at 10:00 P.M., 01/27/25 at 12:30 A.M. and 4:00 A.M. Review of the MAR and medical record for Resident #95 with the DON confirmed no documentation Resident #95 received the morphine on 01/26/25 at 10:00 P.M. or 01/27/25 at 4:00 A.M.; The MAR indicated on 01/27/25 Resident #95 received morphine sulfate 0.5 ml at 1:00 A.M. administered by Registered Nurse (RN) #306. 4. Record review for Resident #99 revealed an admitted [DATE]. Diagnosis included toxic encephalopathy. Review of the physician orders for Resident #99 revealed an order for Hydrocodone -Acetaminophen oral tablet 5-325 milligrams (mg) give one tablet every six hours as needed for pain with a start date of 08/09/24. Review of the Controlled Drug Record for Resident #99 with the Director of Nursing (DON) on 04/28/25 at 12:47 P.M. revealed the Hydrocodone -Acetaminophen oral tablet 5-325 mg was signed on 02/03/25 by Registered Nurse (RN) #306 at 8:35 P.M.; RN #306 signed again on 02/03/25 (unreadable time) directly under the 8:35 P.M. that the medication was again removed; To the left of the documented dates and times was a hand written wasted dropped. DON confirmed there was no second nurse signature to verify the medication was wasted. DON revealed if a controlled medication was wasted, two nurses were required to waist the medication, and both nurses sign the controlled drug form verifying the medication was wasted. Review of the MAR revealed on 02/03/25 at 8:58 P.M., Resident #99 received one dose of Hydrocodone -Acetaminophen oral tablet 5-325. Review of the facility's undated policy titled Managing Controlled Substances revealed immediately after a dose of a controlled drug is administered, the licensed nurse administering the drug is to enter all of the following information on the proof-of-use record: a) Date and time of administering b) Dose administered c) Signature of the nurse administering the dose d) Remaining doses e) The controlled substance administration must also be recorded on the Medication Administration Record (MAR). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If a dose is removed from the container for administration but refused by the patient or not given for any reason, it should not be put back into the container. Rather, it is to be destroyed in the presence of two (2) licensed nurses. The disposal must be documented on the proof-of-use record on the line presenting the dose. This deficiency represents non-compliance investigated under Control Number OH00164423.