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	07/02/2024

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to manage his or her financial affairs. 39333 Based on review of resident funds management authorizations and staff interview, the facility failed to ensure authorizations from a resident or resident representative were attested to by a witness not affiliated with the facility. This affected three residents (#10, #34 and #57) of five residents reviewed for resident funds accounts. The facility census was 90. Findings include: 1. Review of the authorization to manage funds for Resident #10 dated 02/15/24 revealed no non facility affiliated witness signature was obtained as required. 2. Review of the authorization to manage funds for Resident #34 dated 07/17/23 revealed no non facility affiliated witness signature was obtained as required. 3. Review of the authorization to manage funds for Resident #57 dated 08/30/22 revealed no non facility affiliated witness signature was obtained as required. Interview on 06/25/24 at 8:23 A.M. with Business Office Manager #522 verified the lack of witness signatures for all three residents.

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: 365317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on medical record review, review of resident fund records and staff interview, the facility failed to ensure resident funds were conveyed timely upon resident discharge from the facility. This affected one (#148) of one resident reviewed for funds conveyance. The facility census was 90. Findings include: Resident #148 was admitted to the facility on [DATE] with a readmitted [DATE]. Resident #148 was discharged [DATE]. Review of a progress note dated [DATE] revealed Resident #148 was transferred to the hospital. Review of a progress note dated [DATE] revealed the hospital informed the facility that Resident #148 expired. Review of Resident #148's resident funds records revealed on [DATE], a check in the amount of $1193.46 was dispersed to the state and one for $527.18 was dispersed to the funeral home handling Resident #148's arrangements. Interview on [DATE] at 7:17 A.M. with Business Office Manager (BOM) #522 verified Resident #148's funds were not conveyed within the required timeframe of 30 days post discharge.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on medical record review and staff interview, the facility failed to ensure residents and/or resident representatives received written transfer notices when transferring to the hospital. This affected two residents (#11 and #51) of three residents reviewed for hospitalization . The facility census was 90. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, chronic diastolic (congestive) heart failure and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had impaired cognition and required substantial/maximum assistance from staff for bed mobility and was dependent on staff for transfers. Review of the Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Forms dated 03/27/24, 05/13/24, and 06/04/24 revealed Resident #11 was transferred to the hospital on those dates. Review of the Transfer/Discharge Notices dated 03/27/24, 05/13/24, and 06/04/24 revealed the notices were reviewed by phone with Resident #11's responsible party. Interview on 06/27/24 at 10:35 A.M. with the Administrator verified the transfer notices were reviewed with Resident #11's responsible party over the phone. The Administrator stated social services was responsible for the transfer and discharge notices and she was unsure if written notices were provided to the resident and/or the resident's responsible party. Telephone interview on 06/27/24 at 10:58 A.M. with Social Services Designee)SSD) #611 revealed she was responsible for providing transfer/discharge notices. SSD #611 verified she did not provide the transfer/discharge notice forms in writing to Resident #11 or the resident's responsible party. 44457 2. Review of the medical record for Resident #51 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included diabetes mellitus, end stage renal disease, atrial fibrillation, hypoxemia, metabolic encephalopathy, and lobar pneumonia. Review of Transfer Form dated 06/10/24 revealed Resident #51 was transferred to the hospital for shortness of breath and generalized discomfort. Review of the medical record revealed no evidence Resident #51 was given a written transfer notice upon transfer to the hospital on 06/10/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/24 at 11:13 A.M. with Administrator confirmed Resident #51 was not given a written transfer notice. The Administrator indicated transfer notices were reviewed over the phone and residents were not provided with a copy in writing.

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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 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** 42011 Based on medical record review, observation and staff interview, the facility failed to ensure dependent residents received nail care. This affected one resident (#89) of three residents reviewed for podiatry care. The facility census was 90. Findings include: Record review for Resident #89 revealed an admitted [DATE]. Diagnoses included unspecified dementia, muscle weakness and need for assistance with personal care. Review of the Admission Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 was severely cognitively impaired. Resident #89 had impairment to one side of the upper extremity and required substantial maximum assistants with personal hygiene. Further review of Resident #89's medical record revealed no evidence of an identified need for toenail care or that the resident received toenail care. Observation on 06/24/24 at 9:49 A.M. revealed Resident #89 was lying in bed. Resident #89's feet were sticking out from under the blanket at the end of the bed. Further observation revealed Resident #89's toenails on both feet were very long, thick and curling under his toes. Interview on 06/27/24 at 1:01 P.M. with the Director of Nursing (DON) confirmed Resident #89's toenails were very long, thick and curling under his toes. The DON revealed Resident #89's toenails were too thick and long for staff to trim them. The DON confirmed there was no documentation in Resident #89's medical record pertaining to the resident's toenails or need for care. Additionally, the DON stated staff should notify Social Services if podiatry care was needed and they would arrange a podiatry visit. The DON verified there was no evidence Resident #89 had been assessed for toenail care or referred for podiatry services. Interview on 06/27/24 at 1:06 P.M. with Registered Nurse (RN) #562 confirmed podiatry was not notified until 06/26/24 of Resident #89's need for toenail care. RN #562 confirmed there were no previous podiatry visits scheduled for Resident #89.

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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 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 42011

Based on observation, medical record review, review of hospital records, staff interview and review of facility policy, the facility failed to ensure all fall interventions were implemented. This affected two (#41 and #45) of three residents reviewed for falls. In addition, the facility failed to follow procedures following a fall to prevent further injury. This affected one (#41) of three residents reviewed for falls. The facility census was 90.

Findings include:

1. Record review for Resident #41 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side, subsequent encounter epilepsy, and epilepticus pseudobulbar affect vascular dementia. An additional diagnosis of displaced simple supracondylar fracture of right the humerus was added on 05/16/24.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was severely cognitively impaired. Resident #41 had no impairment to the upper or lower extremities, required supervision or touch assistance with transfers and the resident was frequently incontinent of urine and always incontinent of bowels.

Review of the Fall Risk Assessment, dated 05/04/24 at 6:17 P.M. and completed by Restorative Registered Nurse (RRN) #562, revealed Resident #41 was at risk for falls.

Review of a Change in Function Assessment, dated 05/12/24 at 12:55 P.M. and completed by RRN #562, revealed Resident #41 was more unsteady when ambulating and had an increase in confusion.

Review of an updated Fall Risk assessment dated [DATE] at 1:45 P.M. and completed by RRN #562 revealed Resident #41 was alert and oriented times two, was continent, had unsteady gait and transferred with no assistance. Resident #41 was identified as higher risk for falls and two assist/handheld for transfers was implemented.

Review of a safety note, dated 05/15/24 at 9:25 P.M. and completed by RRN #562 revealed on 05/15/24 at 1:45 P.M., Resident #41 was in the dining room eating lunch and the activity aide was in the dining room with her. Resident #41 had a fall while in the dining room at 1:45 P.M. Resident #41 indicated she tripped over her wheelchair and stated her right shoulder hurt and she was lifted into the wheelchair. Resident #41 had pain in the right elbow with range of motion. Resident #41's physician was notified at 3:30 P.M. and it was recommended Resident #41 be sent to the emergency room (ER). A new fall intervention was implemented for two person assist/handheld and for Occupational Therapy (OT) to evaluate and treat.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of hospital records, dated 05/16/24, revealed Resident #41 had x-rays completed to include the right forearm and right humerus. The x-ray results revealed Resident #41 had an acute fracture of the distal humerus, displacement of the fat pads of the elbow, indicating an elbow effusion (build up of fluid)/hemarthrosis (joint bleeding) and soft tissue swelling around the elbow. Resident #41 discharged back to the facility with an order for oxycodone five milligrams (mg) by mouth every six hours for 12 doses. Review of the care plan dated 06/11/24 for Resident #41 revealed Resident #41 had an activity of daily living self-care deficit. Interventions included a wheelchair for mobility and two person assist/handheld assist for transfers. During observation on 06/25/24 at 11:41 A.M. of medication administration with Registered Nurse (RN) #569, Resident #41 was observed to propel herself up the hallway in her wheelchair, towards her room (medication administration occurred directly across from the resident's room). Continued observation revealed Resident #41 entered her room, stood up from the wheelchair, independently ambulated into the bathroom and shut the bathroom door. Concurrent interview with RN #569 confirmed Resident #41 had a recent fall, resulting in an arm fracture. RN #569 verified the observation of Resident #41 ambulating independently into the bathroom and closing the door. As RN #569 watched Resident #41 ambulating independently, she stated She takes herself to the bathroom all the time. She's not supposed to, but she does it anyway. RN #569 did not intervene or ask any staff to assist Resident #41. RN #569 continued her task and did not monitor or address the safety of Resident #41. Interview on 06/26/24 at 3:38 P.M. with the Director of Nursing (DON) and RRN #562 confirmed Resident #41 had a fall with a fracture on 05/15/24 while in the dining room. The DON confirmed Resident #41 complained of pain to the right arm immediately following the fall and staff proceeded to pick Resident #41 up and transfer her to a wheelchair. The DON verified if a resident experienced a fall and had complaints of pain, the resident should not be moved, the physician should be notified immediately and the resident sent to the hospital to prevent further injury. Interview on 06/27/24 at 4:19 P.M. with Physical Therapist (PT) #926 confirmed Resident #41 continued to be unsteady and required two persons to assist with ambulation to prevent falls. 39333 2. Review of the medical record for Resident #45 revealed an admitted [DATE]. Diagnoses included, but not limited to, epilepsy, anxiety disorder and muscle weakness. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #45 had intact cognition and required maximal assistance with activities of daily living. (ADLs). No Falls were noted on the MDS. Review of the progress note dated 05/08/24 at 9:45 P.M. revealed the aide was assisting Resident #45 to bed when the resident requested another pillow and towel. The staff member reached for the pillow and towel and threw them on the bed, while still having a hand on the resident. Resident #45 lost his balance and started to fall. The staff member tried to break the fall and obtained scratched on her right arm. Resident #45 fell back on the bedside table and hit the trash can. Resident #45 did not hit his head but obtained two large abrasions on his back and a bruise to his right elbow. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's fall investigation dated 05/08/24 revealed the current intervention of nonskid footwear was in place and the new immediate intervention for Resident #45 would be a two person assist with a front wheeled walker (FWW) for stand pivot transfer only. There was no statement from the aide on duty the night of the fall. Review of the statement dated 05/09/24 by RRN #562 revealed the fall investigation was completed this day and the Interdisciplinary Team (IDT) agreed to the intervention of two person assist with FWW for stand pivot transfer only. Review of the progress note dated 05/13/24 at 9:15 P.M. revealed the aide alerted the nurse that Resident #45 had fallen while she was transferring him into bed. Both the aide and the resident stated the resident did not hit his head. Resident #45 stated he had lost his balance. Resident #45 was assessed for range of motion at which time resident complained of left hip pain. The nurse obtained orders to have a portable x-ray of the resident's left hip. The DON and physician were notified. Review of the facility's fall investigation dated 05/13/24 revealed no notation of whether the fall intervention of two staff for transfers was in place. The new immediate intervention was for OT to evaluate Resident #45. There was no statement from the aide on duty the night of the fall. Review of the statement dated 05/14/24 by RRN #562 revealed the fall investigation was completed this day, and the Interdisciplinary Team (IDT) agreed to the intervention of OT to evaluate and treat. Interview on 06/25/24 at 4:53 P.M. with RRN #562 revealed she completed the fall investigations for Resident #45's falls on 05/08/24 and 05/13/24. RRN #562 stated that the new intervention that was put in place for 05/08/24 was transfers would be done with two staff with a FWW. The fall on 05/13/24 occurred while being transferred to bed and documentation was verified by RRN #562 that there was only reference to one aide being in the room during the transfer. RRN #562 could not state who the aide was on duty was. Further review of Resident #45's medical record revealed the x-ray came back negative for a hip fracture. Review of the facility policy titled, Fall Management and Incident Intervention Protocol, updated July 2022, revealed any new interventions would be communicated to the relevant nursing staff. In addition, movement of the resident from the original site and position of the fall should only take place after assessment finding reveal that it will not cause further injury to do so. The physician and family will be made aware of the incident as soon as possible.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on medical record review, resident interview and staff interview, the facility failed to ensure residents were free of unnecessary medication increases. This affected one (#74) of six residents reviewed for unnecessary medications. The facility census was 90. Findings include: Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included end stage renal disease, depression, insomnia and anxiety disorder. Further review of census information revealed Resident #74 was moved to a new room on 03/19/24. Review of the plan of care revised 01/04/24 revealed Resident #74 had altered sleep pattern and difficulty falling asleep. Interventions included identifying regular sleep schedule, give measures of comfort including turn out lights, provide quiet and darkness and turn off television, give hypnotics per orders, and report complaints of sleeplessness to the charge nurse. Review of a physician's order dated 03/18/24 revealed Resident #74 had an order for Trazodone (an anti-depressant medication that can be used off-label for patients with insomnia) 50 milligram (mg) by mouth at bedtime for sleep aid. Review of a Psychiatric Nurse Practitioner (PNP) note dated 05/14/24 revealed Resident #74 reported feeling frustrated at times. It was quoted Resident #74 reported I can not sleep due to my roommate making noise. Resident #74 reported a hard time sleeping on most nights. It was noted staff were aware of Resident #74's concerns. PNP gave a new order to increase Resident #74's Trazodone 75 milligrams by mouth at bedtime. Review of a nurses note dated 05/15/24 at 10:19 P.M. revealed staff were called to Resident #74's room. Resident #74 asked the staff to turn down his roommate's television. Resident #74's roommate indicated I don't care if you don't like it. Resident #74 was noted to kick over the wheelchair and dart out of bed. Staff attempted to de-escalate the situation and encouraged Resident #74's roommate to turn down the television. It was noted the problem would be addressed in the morning. Further review of Resident #74's medical record revealed no evidence of follow-up to the nursing note on 05/15/24. Review of a PNP note dated 06/03/24 revealed Resident #74 continued to report issues with sleep. Resident #74 reported having a hard time staying asleep. PNP gave an order to increase Resident #74's Trazodone to 100 milligrams by mouth at bedtime. Interview on 06/24/24 at 11:40 A.M. with Resident #74 revealed he was moved to his current room following a hospitalization . Resident #74 indicated his roommate kept the television on all night, was constantly making noises and moving the bed up and down, preventing him from sleeping. Resident #74 reported dissatisfaction with current roommate. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/26/24 at 3:45 P.M. with Registered Nurse (RN) #564 revealed she was aware Resident #74 was not getting along with his roommate. RN #564 indicated there were open rooms and a room move could easily be made. RN #564 indicated she should notify the Unit Manager (UM) or Director of Nursing (DON) of the concern. Interview on 06/26/24 at 3:50 P.M. with the Administrator revealed she was unaware Resident #74 was not getting along with his roommate. Interview on 06/26/24 at 3:57 P.M. with the DON and RN #562 revealed RN #562 was the UM for Resident #74's hallway. RN #562 indicated she was aware of a situation of tension between Resident #74 and his roommate regarding television volume; however, she believed the situation to be resolved. Trazodone medication increases in Resident #74's medical record were reviewed with the DON and RN #562. The DON and RN #562 stated they were unaware of the reasoning for medication increases for Resident #74. While the DON stated she was aware the medication was increased, she had not read the PNP notes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42011 Based on observation, medical record review, staff interview and review of the facility policy, the facility failed to store medications in a safe manner. This affected one (#79) resident, with the potential to affect nine additional residents (#14, #28, #41, #52, #54, #62, #89, #197, and #198) who were identified by the facility as being independently mobile and cognitively impaired residing on the memory care unit. The facility census was 90. Findings include: Record review for Resident #79 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, altered mental status, depression, alcohol dependence and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 was severely cognitively impaired. Resident #79 had no impairment to the upper or lower extremities. Resident#79 used a walker/wheelchair for mobility. Observation on 06/25/24 at 11:26 A.M. of medication administration on the secured memory care unit with Registered Nurse (RN) #569 revealed the nurse placed Resident #22's medications in a medication cup and sat the cup on the medication cart. The medications in the cup included aspirin 81 milligrams (mg), benztropine (used to treat involuntary movements) 0.5 mg, duloxetine (anti-depressant) 30 mg, and omeprazole 20 mg. Resident #79 was observed to be within a few feet of the medication cart, observing RN #569. RN #569 left the medications in the cup, unsupervised, on the medication cart and entered Resident #22's room. While RN #569 assessed Resident #22's blood sugar in the resident's room, the medication cart was out of RN #569's view and no other staff were present to monitor Resident #79, who was still standing next to the cart and observing the items on the cart. Interview on 06/25/24 at 11:31 A.M. with RN #569 verified she left the medication cup containing Resident #22's medications on top of the medication cart, unsupervised. RN #569 confirmed Resident #79 was standing near the cart when she left the medications. RN #569 stated, Oh yea, he could have taken them. I thought about taking them in, but I didn't. Review of the facility policy titled Medication Storage Policy, revised August 2021. revealed medication and other supplies are received by the facility and are either stored in a locked medication cart or in the locked overflow area until those items are ready for use.

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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. 44457 Based on observations, staff interview and review of facility policy, the facility failed to maintain a clean and sanitary kitchen area and ensure foods were properly stored. This had the potential to affect all 90 residents who received meals from the kitchen. The facility census was 90. Findings include: Observation on 06/24/24 at 8:22 A.M. with Dining Services Director (DSD) #505 of the facility's kitchen revealed a plastic storage container with oats in the dry storage room. A scoop was resting on top of the oats inside the container. Continued observation of the walk-in refrigerator revealed a box of cucumbers, with two molded cucumbers touching non-molded cucumbers, a quarter-full pan of tomato soup covered with plastic wrap without label or date, a pitcher of red juice without label or date, a pitcher of grape juice dated 06/13/24 and a pitcher of sweet tea dated 06/13/24. Concurrent interview with DSD #505 indicated pitchers of juices should be kept for no more than seven days in the cooler (the pitchers of grape juice and sweet tea were on day 11). Further observation of the deep fryer revealed the oil was dark and had food debris floating in the oil. The floor around the deep fryer had significant oil build-up and food debris, including French fries. The front of the deep fryer had drips of oil build-up. There was a three-tiered cart next to the deep fryer that was coated in fryer oil and food debris. On the cart was a metal half pan with burned food debris, used tongs, and a used fryer scoop. Additional observations of the ovens revealed food build-up and crumbs on the front of each of the three double ovens and the flat top grill revealed dark grease build up on the grill top and surrounding guards. Observation of the dish machine area revealed food debris on the clean side of dish machine. The rubber mats and floors were greasy and slippery in the dish machine area. A fan, with a cart below the fan in the dish machine area, were covered in dust build-up. The three trash cans in the dish machine area had drips of an unidentified dried substance down sides and the lids had a layer of food build-up. Lastly, the ceilings in the kitchen area and dish machine area had dust build-up around lights and air vents. Interview on 06/24/24 at 9:12 A.M. with DSD #505 verified the above findings in kitchen areas. Observation on 06/25/24 at 2:58 P.M. of the kitchen revealed a hand sink next to the coffee machine with significant food debris in the sink. Concurrent interview with DSD #505 confirmed the finding. Review of the facility policy titled Sanitation and Food Handling Policy, dated January 2021, revealed sanitary conditions would be maintained in the storage, preparation, and distribution of food. The Dietary Manager was responsible for ensuring cleaning assignments were carried out. Review of the facility policy titled Food Stock Rotation Policy, dated January 2021, revealed any item in a pan or open item would be covered and dated with current date and use by date.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 44457 Based on observation, staff interview and review of facility policy, the facility failed to ensure garbage was properly disposed of. This had the potential to affect all 90 residents of the facility. The facility census was 90. Findings include: Observation on 06/24/24 at 9:13 A.M. of the outside trash area, with Dining Services Director (DSD) #505, revealed two dumpsters. There were various plastic wrappers, gloves, plastic spoons and cigarette butts on the ground surrounding the dumpsters. Interview at the time of the observation with DSD #505 verified the findings. Review of the facility policy titled Dumpster/Trash Policy, dated January 2022, revealed the area around the dumpsters would be free from any debris and each employee was responsible for keeping the area clean and free of debris.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, medical record review, family interview and staff interview, the facility failed to ensure accurate documentation on the Treatment Administration Record (TAR). This affected one resident (#8). Additionally, the facility failed to ensure accurate care conference documentation for two residents (#41 and #79). This affected three residents (#8, #41, and #79) of three residents reviewed fo accuracy of medical records. The facility census was 90. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnoses included quadriplegia, polyneuropathy and morbid (severe) obesity due to excess calories. Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE] revealed Resident #8 had intact cognition and was dependent on staff for bed mobility and transfers. Review of the physician orders for June 2024 revealed orders for a low air loss (LAL) with perimeter overlay mattress and to check the function of the LAL every shift. Both orders had a start date of 06/04/24 and a discontinued date of 06/24/24. Review of the Treatment Administration Record (TAR) for June 2024 revealed the orders were signed off as completed on each day from 06/04/24 through 06/24/24. Further review of Resident #8's medical record revealed no evidence of when Resident #8 was switched from a LAL mattress to a bariatric mattress. Interview on 06/24/24 at 2:26 P.M. with Resident #8 revealed she had a history of bed sores but no current skin issues. Resident #8 stated she used to have a LAL mattress but it was switched to a bariatric mattress. Concurrent observation confirmed Resident #8 had a regular bariatric mattress. Follow-up interview on 06/25/24 at 4:13 P.M. with Resident #8 revealed the LAL mattress was switched out for a bariatric mattress earlier this year, but she could not recall exactly when. Interviews on 06/25/24 at 4:18 P.M. and 4:30 P.M. with Wound Nurse (WN) #587 revealed Resident #8 had no skin issues and currently had a pressure reducing bariatric mattress. WN #587 stated he was not sure when Resident #8's mattress was switched from a LAL mattress to a bariatric pressure reducing mattress but he had seen the resident had orders for a LAL mattress, which were discontinued on 06/24/24. WN #587 verified the orders had been signed off as completed from 06/04/24 through 06/24/24, but was not able to say when the LAL mattress was discontinued. Interview on 06/25/24 at 4:53 P.M. with State tested Nurse Aide (STNA) #543 revealed he routinely cared for Resident #8. STNA #543 stated it had been at least a few months since Resident #8 had a LAL mattress. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/25/24 at 4:54 P.M. with Licensed Practical Nurse (LPN) #603 revealed it had been at least a month since Resident #8 had a LAL mattress. Interview on 06/26/24 at approximately 4:45 P.M. with the Director of Nursing (DON) revealed she was unable to determine when the LAL mattress had been discontinued for Resident #8. The DON stated she had seen there were orders related to the LAL, which were revised on 06/04/24. The DON verified the LAL mattress orders had been inaccurately signed off as completed from 06/04/24 through 06/24/24. 39333 2. Review of the medical record for Resident #79 revealed an admitted [DATE]. Diagnoses included, but not limited to, altered mental status, depression and anxiety disorder. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #79 had severe impaired cognition and required moderate assistance with activities of daily living (ADLs). Review of the care plan meeting documentation, completed by Social Services Designee (SSD) #900 with an effective date of 01/29/24 at 4:19 P.M., revealed a care conference meeting was held on 01/29/24 at 12:00 A. M. and the resident and resident representative attended. Review of the care plan meeting documentation, completed by Social Services Designee (SSD) #611 with an effective date of 04/29/24 at 10:32 P.M., revealed a care conference meeting was held on 01/29/24 at 12:00 A.M. and the resident and resident representative attended. Interview on 06/27/24 at 11:02 A.M. with Director of Nursing (DON) verified the care conferences dated 01/29/24 and 04/29/24 were both documented as being completed on 01/29/24 at 12:00 A.M. 42011 3. Record review for Resident #41 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side, subsequent encounter epilepsy and epilepticus pseudobulbar affect vascular dementia. Review of the quarterly MDS dated [DATE] revealed Resident #41 was severely cognitively impaired. Review of the Family Meeting/Plan of Care, dated 06/17/24 at 10:01 A.M. and completed by SSD #611, revealed the meeting was held on 06/17/2024 at 10:00 A.M. The documentation indicated Resident #41, Registered Nurse (RN) #587, SSD #611, and Resident #41's daughter/Representative/Power of Attorney (POA) all attended the care plan meeting and review of resident representative and advanced directives was completed with the POA. The summary indicated resident goals were reviewed and the care plan was signed by the resident/resident representative and a copy was given. Further reviewed revealed a family meeting summary, which stated the team met with the resident's daughter via phone for the care conference. The resident was invited, but refused to attend. The care plan was reviewed with the family and the plan was for the resident to remain in long term care. The SSD reviewed the advanced directives and ancillary services. The resident's family stated their satisfaction with care provided. SSD will continue to follow up with the resident and family as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 06/26/24 at 5:43 P.M. with Resident #41's daughter (Representative/POA) revealed she requested a care plan meeting but the facility told her they would get back to her and never did. The resident's daughter denied being involved in a care conference on 06/17/24 or having any telephone conversation with anyone at the facility regarding the resident's care. Interview on 06/27/24 at 10:03 A.M. with RN #587 revealed he did not attended Resident #41's care plan meeting on 06/17/24. RN #587 reviewed the plan of care meeting documentation dated 06/17/24 at 10:01 A. M., located in the resident's electronical medical record (EMR), and stated he was not in attendance as indicated in the documentation. Telephone interview on 06/27/24 at 11:04 A.M. with SSD #611 revealed she documented who was in attendance for care plan meetings. Review of the care plan meeting documentation dated 06/17/24 at 10:01 A.M. with SSD #611 revealed she documented the meeting information while she was attemping to contact Resident #41's daughter on the phone. SSD #611 stated the resident's daughter did not answer the phone and she accidentally locked and saved the note and forgot to go back in to correct it. SSD #611 confirmed Resident #41's care plan meeting was not held on 06/17/24, as the medical record indicated. SSD #611 stated, at times, she wrote the meeting summary before the actual meeting. Interview on 06/27/24 at 11:14 A.M. with the Administrator revealed the care plan meeting documented for Resident #41 on 06/17/24 should not have been documented since it did not occur. The Administrator stated SSD #611 should have errored out the meeting immediately after accidently signing and saving it.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Hire a qualified full-time social worker in a facility with more than 120 beds. 39969 Based on review of the Certification and Licensure System (CALS), review of personnel records, review of the key personnel list and staff interview, the facility failed to employ a full-time, qualified Social Worker. This had the potential to affect all 90 residents of the facility. The facility census was 90. Findings include: Review of CALS revealed the facility had 127 certified and licensed beds. Review of the personnel file for Social Services Designee (SSD) #611 revealed a hire date of 03/28/21. SSD #611's application indicated she had attended a four college, but did not earn a degree. SSD #611's work history included being a restaurant manager and a caregiver. There was no documented history of long-term care experience. Further review revealed on 03/18/21, SSD #611 signed the Social Services Employee job description. The job description indicated the qualifications included two years experience in long term care and a Licensed Social Worker (LSW) was preferred. Essential job functions included document all interactions with resident and/or family in the assessment and care plan as required by state standard, document the social and emotional needs of residents, oversee the coordination of referrals for ancillary services (dentist, eye doctor, podiatrist, psychologist, psychiatrist and audiology) and participate in plan of care meetings. Review of the key personnel list revealed Activities Director (AD) #502 was identified as Social Services. Review of the personnel file for AD #502 revealed a hire date of 07/25/22 for the position of Activities Director. AD #502's application indicated she had a four year degree (bachelor's degree) in healthcare administration and a minor in business administration. The application indicated no social services experience. Interviews on 06/27/24 at 10:35 A.M. with the Administrator revealed Corporate Social Services Designee (CSSD) #902 was over the social services department and SSD #611 moved to a corporate position around the end of April 2024/beginning of May 2024. The Administrator stated SSD #611 was over admissions and social services at the facility for several years and AD #502 was training to fill that position. Since moving to her new position, SSD #611 had been coming to the facility twice weekly to assist with meeting social services needs, with CSSD #902 assisting once every week or every other week. Additionally, the Administrator stated Licensed Social Worker (LSW) #900 worked at a sister facility and, initially, had assisted once a week, but was now only helping as needed. The Administrator confirmed AD #502 and SSD #611 were not LSWs and did not hold a related degree. Follow-up interview on 06/27/24 at 12:13 P.M. with the Administrator revealed most social services related tasks were completed by SSD #611. The Administrator verified CSSD #902, who provided oversight to the Social Services Department, was not an LSW.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39969 Based on observation and staff interview, the facility failed to ensure residents rooms were maintained in a clean/sanitary manner and were in good repair. This affected 10 (#16, #17, #20, #21, #23, #33, #36, #39, #66, and #85) of 10 residents reviewed for physical environment. The facility census was 90. Findings include: Observation on 06/24/24 at 11:24 A.M. of Residents #33 and #66's room revealed the closet doors were hanging at a slant and off the track. Observation on 06/24/24 at 11:40 A.M. of Residents #17 and #39's room revealed several black markings and gashes across wall between the two residents' beds. Further observation of Resident #39's bed remote revealed the wiring was exposed and the bottom drawer of the resident's nightstand was off the track. Observation on 06/24/24 at 12:15 P.M. of Resident #85's room revealed several gashes and black marking along the wall that extended to bed two, which was unoccupied. Observation on 06/24/24 at 2:13 P.M. of Residents #16 and #23's room revealed the cover of the heating unit was missing, exposing the heating element. Continued observation on 06/24/24 at 2:40 P.M. of Residents #17 and #39's room revealed the light fixture above each bed was covered with heavy dust with what appeared to be dead bugs inside the fixture. Additionally, the closet doors were off the track and the call light panels were not affixed to wall. Observation on 06/24/24 at 02:43 P.M. of Residents #20 and #36's room revealed a large gash in wall to the right side of Resident #36's bed. Continued observation revealed several black markings and gashes in wall between the residents' beds and Resident #20's bed remote had exposed wiring. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/25/24 from 11:38 A.M. through 11:55 A.M. with Director of Maintenance (DOM) #538 verified the above identified finding. Concurrent observations with DOM #538 revealed the exposed wiring on Resident #39's bed remote had been covered with a material that was similar to black electrical tape. At the time of the observation, Resident #39 stated her roommate had fixed it. DOM #538 indicated the repair was okay. Further observation of Residents #16 and #23's room revealed the heating unit now had a cover. DOM #538 verified it had been off and he put a cover on the heating unit this morning. The cover had an unknown dried substance on it. DOM #538 verified the observation and stated it needed to be cleaned. During the observation of Resident #85's room with DOM #538, the resident's bathroom was observed to have an unknown dried substance on the floor and along the baseboard, two floor tiles were cracked and there was an odor of urine. DOM #538 verified the findings and stated the bathroom needed cleaned and he would get the floor tiles fixed. Additional observations with DOM #538 revealed in Resident #21's bathroom, the light over the sink was missing the light cover, the baseboard was coming off the wall behind the toilet, the wall behind toilet appeared stained, the floor and baseboard were dirty and the wall around the soap dispenser was dirty and needed painting. DOM #538 verified the findings.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44457 Based on observation, staff interview, review of pest control reports and review of facility policy, the facility failed to maintain a kitchen area free of pests. This had the potential to affect all 90 residents who received meals from the kitchen. The facility census was 90. Findings include: Observation on 06/24/24 at 8:22 A.M. of the kitchen, with Dining Services Director (DSD) #505, revealed large amounts of drain flies in the dish machine area. The drain flies were seen on the walls and equipment in the area and flying around the area. Interview on 06/24/24 at 9:12 A.M. with DSD #505 confirmed the findings of drain flies. DSD #505 indicated maintenance was aware of the drain flies and was supposed to have it treated. DSD #505 indicated it had been two weeks and nothing had been done yet. Interview on 06/27/24 at 11:07 A.M. with Maintenance Director (MD) #538 revealed he was unaware of the drain flies until 06/24/24, after the observation was made with DSD #505. Review of Pest Control Service Inspection Reports from 01/16/24, 02/09/24, 03/12/24, 04/08/24, 05/09/24, and 06/11/24 revealed the kitchen had not been treated for drain flies. Review of the facility policy titled Pest Control Policy, dated December 2024, revealed when an issue with pest control arises, the pest control company would be contacted and appropriate services would be provided.