STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366475	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smiths Mill Health Campus	7320 Smiths Mill Road New Albany, OH 43054

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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** 41266 Based on observations, resident and staff interviews, medical record review, review of shower sheets, and facility policy review, the facility failed to provide showers as scheduled for one resident (Resident #29). This affected one resident (Resident #29) of three reviewed for showers. The facility census was 46. Findings Include: Review of the medical record for Resident #29 revealed an admitted on 04/28/24. Medical diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic kidney disease stage III, adjustment disorder, depression, legal blindness, unsteadiness on feet, abnormalities of gait and mobility, and need for assistance with personal care. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had intact cognition and scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The resident had impairments on both sides of both the upper and lower extremities. Resident #29 required substantial assistance from staff to complete bathing, dressing, bed mobility, and transfer tasks. Resident #29 was occasionally incontinent of bladder and frequently incontinent of bowel. Review of the shower schedule revealed Resident #29 was scheduled for showers twice a week. Review of the shower documentation dated from 06/01/24 through 07/03/24 revealed Resident #29 received a shower on 06/01/24 and 06/11/24. Additionally, the resident received a bed bath on 06/18/24 and 06/25/24 and partial bed baths on 06/28/24, 07/01/24, and 07/03/24. Review of shower sheets dated from 06/01/24 through 06/30/24 revealed Resident #29 was noted as refused on each shower sheet. The shower sheets were not signed by the resident, aide, or nurse. Review of progress notes dated from 06/01/24 through 06/30/24 revealed there was not any evidence of Resident #29 refusing showers or bed baths. Additionally, there was not any evidence of Resident #29 requesting a bed bath instead of a shower. Observations on 06/27/24 at 10:39 A.M. and 2:20 P.M. with Resident #29 revealed the resident was laying in bed with his head on a pillow. Upon raising his head, Resident #29's hair appeared to be greasy and stuck to the back of his head where he had been laying on the pillow. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 06/27/24 at 10:39 A.M. and 2:20 P.M. with Resident #29 revealed he had received bed baths once a week but he would prefer to have a shower. Resident #29 stated he thought he would receive a shower more frequently. The resident stated he had not received a shower in approximately two weeks and would like to have a shower. Resident #29 stated he had not been offered a choice between a shower or a bed bath. The resident stated, there is not enough staff to give me a shower. Resident #29 had not received a full bed bath or shower yet this week. The resident stated he received partial bed baths (staff washed his armpits, genital area, and face) once a week. Resident #29 confirmed he had not had his hair washed with partial bed baths. Resident #29 stated he had requested staff get him out of bed this morning at approximately 9:45 A.M. and also requested a shower today but staff had not followed up with him yet. Interview on 06/27/24 at 2:25 P.M. with Licensed Practical Nurse (LPN) #215 and Resident #29 confirmed Resident #29 had requested to be assisted out of bed at approximately 9:45 A.M. this morning and had requested a shower and no staff had followed up with the resident. Interview on 07/03/24 at 11:56 A.M. with the Director of Health Services (DHS) confirmed if a resident refused a shower, the refusal should be documented on a shower sheet, the aide should notify the nurse of the refusal, and the nurse should also attempt to offer a shower to the resident. If the resident continued to refuse, then both the aide and the nurse should sign the shower sheet that noted the refusal. The DHS stated if a resident refused a shower or bed bath on a scheduled day, the staff should continue to offer on the next shift as well as on another day and attempts should be documented in the medical record. The DHS confirmed Resident #29 had not received showers as scheduled. The DHS also confirmed the shower sheets that noted a refusal had not been signed by the aide or the nurse. The DHS also confirmed there was no evidence in Resident #29's medical record of a history of refusing showers or bed baths nor evidence of any additional attempts made with the resident to offer a shower or bed bath on various days or shifts. Review of the facility policy, Guidelines for Bathing Preference, dated 12/31/23, revealed the policy stated, bathing should occur at least twice a week unless resident preference states otherwise. This deficiency represents non-compliance investigated under Complaint Number OH00154581

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, interview and facility policy review the facility failed to ensure residents were free from significant medication errors. This affected two residents (#8, #19) of three residents reviewed for medication errors. The facility census was 46. Findings Include: Review of Resident #8 revealed Resident #8 was admitted on [DATE] with the diagnoses including Alzheimer's Disease, depressive disorder, anxiety disorder, and high blood pressure. Resident #8 required extensive assistance from staff for activities of daily living (ADL) tasks including medication administration. Resident #8 had severely impaired cognition and was receiving hospice services for end stage Alzheimer's Disease. Review of Resident #8's progress notes dated 05/11/24 at 11:00 P.M. authored by the Director of Health Services (DHS) revealed Resident #8 had been administered the wrong medication. Resident #8 was assessed; vitals were stable and did not exhibit any adverse effects. Review of Resident #8's Interdisciplinary Team (IDT) progress note dated 05/13/24 at 12:26 P.M. authored by Registered Nurse (RN) #204 revealed on 05/11/24 during the evening medication administration Resident #8 had been administered the roommate's medications including the following medications: Tylenol 650 milligrams (mg); Depakote (antiseizure medication) 125 mg, Morphine (pain medication) 10 mg, and Trazodone (antidepressant/sedative) 25 mg. The error had been identified at 10:45 P.M. The physician and family were notified concerning the medication error. Review of Resident #8's Safety Events - Medication Error Event dated 05/20/24 at 10:00 P.M. authored by the DHS revealed Resident #8 had again received the roommate's evening medications in error. The medications included: Tylenol 650 mg, Depakote 125 mg, Morphine 10 mg, and Trazodone 25 mg. Resident #8 was assessed for any adverse reactions to the medication. The physician and family were notified of the medication error. Review of Resident #8's IDT progress note dated 06/07/24 at 3:01 P.M. authored by RN #204 revealed the root cause of the medication error on 05/20/24 at 10:00 P.M. for Resident #8 was Resident #8 was not correctly identified prior to the medication administration by the DHS. The intervention implemented was to label each side of the rooms either A or B. Resident #8 did not experience any adverse reactions to the medications. Review of Resident #8's physician orders dated 05/01/24 to 06/30/24 revealed there were no orders for Resident #8 to receive the following medications: Tylenol 650 mg; Depakote 125 mg; Morphine 10 mg, and Trazodone 25 mg. Interview on 06/27/24 at 3:30 P.M. with the Administrator confirmed Resident #8 had been administered the roommate's evening medications in error on 05/11/24 and again on 05/20/24 by the DHS. The Administrator stated the facility had identified the root cause of the medication errors and implemented an intervention by identifying the sides of the rooms as either A or B for easier identification of the residents. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the closed medical record for former Resident #19 revealed an admitted on 05/22/24. Resident #19 was hospitalized on [DATE] and did not return to the facility. Medical diagnoses included vesicointestinal fistula, acute cystitis without hematuria, asthma, chronic kidney disease Stage III, anxiety disorder, irritable bowel syndrome, depression, personal history of urinary tract infections (UTI), and personal history of malignant neoplasms of cervix and bladder. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 had intact cognition. The resident required assistance from staff to complete Activities of Daily Living (ADLs) ranging from supervision to substantial assistance. Review of the progress notes revealed on 06/06/24 at 7:04 P.M., Licensed Practical Nurse (LPN) #202 mistakenly administered another resident's medications to Resident #19. LPN #202 immediately informed Resident #19 of the error. LPN #202 also notified the Certified Nurse Practitioner (CNP) and Director of Health Services (DHS) of the medication error. LPN #202 assessed Resident #19 and found the resident in stable condition with no new signs or symptoms. Review of the written statement completed on 06/27/24 by Regional Nurse (RGN) #350 revealed Licensed Practical Nurse (LPN) #202 notified the Nurse Practitioner (NP) on 06/06/24 at 2:40 P.M. of a medication error that had occurred for Resident #19. LPN #202 reported Resident #19 was administered another resident's medications. Resident #19 was administered Tylenol 325 mg and Propafenone (a medication to treat atrial fibrillation) 150 mg by mistake. The NP ordered labs which were completed and reviewed by the NP without any new orders provided. LPN #202 reported Resident #19's blood pressure on 06/06/24 at 4:52 P.M. was 128/67 millimeters of mercury (mmHg) and within normal limits. Interview on 06/26/24 at 4:33 P.M. with LPN #202 confirmed she administered another resident's medications to Resident #19 by mistake. The nurse stated she identified the error right away and notified the resident and the NP. LPN #202 followed the NP's orders and continued to monitor Resident #19 with no signs of any negative outcome noted. Review of the Medication Administration General Guidelines policy dated 11/18 revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient personnel and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Medication preparation includes the five rights of medication administration: Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration: 1. when the medication is selected, 2. when the dose is removed from the container, and finally 3. just after the dose is prepared and the medication put away. Medications are administered in accordance with written orders of the prescriber. Residents are identified before medication is administered. Methods of identification include: checking a photograph attached to the medical record; calling resident by name (except in residents with cognitive impairment); having the resident verify his/her last name; if necessary, verifying resident identification with other facility personnel. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00154766 and Complaint Number OH00154005.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, medical record review, interview, and review of the manufacture guidelines the facility failed to ensure the glucometer was properly disinfected after use. This affected one resident (Resident #4) of five residents observed for medication administration. The facility census was 46. Findings include: Review of Resident #4's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, unspecified dementia, and anxiety. Resident #4 required assistance from staff to complete activities of daily living (ADL) tasks including obtaining blood glucose readings and medication administration. Review of Resident #4's physician orders dated 04/15/24 revealed an order to obtain blood glucose readings before meals and at bedtime. Observation on 06/27/24 at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #200 was completing morning medication administration for Resident #4. LPN #200 removed the glucometer from a drawer in the medication cart and placed it on the top of the medication cart (the glucometer was stored loosely in the drawer with blood glucose monitoring supplies including alcohol pads, glucometer testing strips and lancets). LPN #200 then gathered the supplies needed to obtain Resident #4's blood glucose (sugar) reading (a lancet to [NAME] the residents finger, a test strip and alcohol pad) and entered the resident's room. LPN #200 placed the supplies, including the glucometer, on Resident #4's bedside table without a barrier between the glucometer and the resident's bedside table. LPN #200 donned gloves and obtained the blood sample by piercing the resident's finger with the lancet and placing a sample of blood on the test strip that was inserted into the glucometer. LPN #200 exited the room and placed the glucometer directly on the top of the medication cart without a barrier between the glucometer and the medication cart. LPN #200 removed the test strip from the glucometer and disposed of the test strip in the sharp's container and then doffed their gloves. LPN #200 unlocked the medication cart and placed the glucometer back into the drawer of the medication cart without cleaning or sanitizing the glucometer following the use for Resident #4. Interview and observation on 06/27/24 at 8:05 A.M. with LPN #200 confirmed the glucometer was not disinfected prior to or following use for Resident #4. LPN #200 stated the glucometer should have been cleaned prior to and following the use of the glucometer. During the interview with LPN #200, the LPN was observed to remove the glucometer from the drawer of the medication cart and obtain an alcohol pad, opened the alcohol pad, and without donning gloves, began to partially wipe the glucometer with the alcohol pad. LPN #200 then placed the glucometer back into the drawer of the medication cart and disposed of the alcohol pad in the trash can on the medication cart. After completion, LPN #200 confirmed the glucometer had been partially wiped with an alcohol pad instead of the approved disinfecting wipes and the LPN verified gloves were not worn during the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer guidelines for Assure Prism multi Blood Glucose Monitoring System dated 12/17 revealed, Guidelines for cleaning and disinfecting the Assure Prism multi: Always wear appropriate protective gear, including disposable gloves; open disinfectant package; Wipe the entire surface of the meter using the disinfectant wipe at least three times vertically and three times horizontally to clean blood and other body fluids from the meter.; Dispose the disinfectant wipe; Allow the exterior to remain wet for one minute, then wipe the meter dry using a dry cloth. This deficiency represents non-compliance investigated under Complaint Number OH00154383.