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	08/07/2024

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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34298 Based on observation, record review, family interview, resident interview, and staff interviews, the facility failed to provide residents that required assistance from staff with activity of daily living (ADL) with the care and services with nail hygiene and dressing. This affected four (Residents #5, #12, #19, and #39) of seven residents reviewed for ADL care. The facility census was 46. Findings include: 1. Review of the medical record revealed Resident #5 was admitted on [DATE]. Diagnoses included abdominal aortic aneurysm, gangrene bilateral toes, and peripheral vascular disease. Review of Resident #5's profile care guide revealed the care included showers scheduled Monday and Thursday on day shift and use of a mechanical lift with two staff assist for transfers. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact and was dependent on staff for bathing. Review of the plan of care dated 07/03/24 revealed Resident #5 required staff assistance to complete self-care and mobility functional tasks completely and safely. Interventions included to provide nail care on shower days and as needed. Review of the bathing documentation for 07/04/24 to 08/05/24 revealed Resident #5 received a partial bed bath on 07/04/24 and nail care was marked as not completed. The next bathing documentation dated 07/21/24 (16 days later) only revealed nails were trimmed and cleaned. Bathing documentation dated 07/29/24 revealed Resident #5 received a bed bath, and nails were clipped and cleaned. Bathing documentation dated 08/01/24 and 08/05/24 revealed no documentation of what type of bathing or care was provided. Observation on 08/06/24 at 8:44 A.M. revealed Resident #5 had long fingernails with a dark substance under the nails. Interview on 08/06/24 at 9:12 A.M. with the Director of Health Services (DHS) verified Resident #5 had long, dirty fingernails. 2. Review of the medical record revealed Resident #12 was admitted on [DATE]. Diagnoses included heart failure, chronic kidney disease, Alzheimer's disease, and severe protein-calorie malnutrition. (continued on next page)

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 - Some	Review of the profile care guides for Resident #12 revealed the care included showers on Wednesday and Saturday on evening shift and nail care to be provided with showers and as needed. Resident #12 required extensive assistance with eating and a mechanical lift with the assistance of two staff for transfers. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had severe cognitive impairment. Resident #12 required assistance from staff for upper body dressing. Review of the bathing documentation from 07/19/24 to 08/03/24 revealed Resident #12 received a partial bed bath on 07/19/24. Bathing documentation dated 07/24/24 and 07/27/24 revealed Resident #12 had nails cleaned but did not reveal if Resident #12 received a bed bath or a shower. Bathing documentation dated 07/31/24 and 08/02/24 revealed no documentation of what type of bathing or care was provided. Observation on 08/05/24 at 9:27 A.M. revealed Resident #12 was lying in bed and had long, jagged fingernails with a dark substance under and around the fingernails. Observation again on 08/06/24 at 8:33 A. M. revealed Resident #12 had long, jagged fingernails with dark substance under and around the fingernails. Interview on 08/06/24 at 9:14 A.M. with the Director of Health Services (DHS) verified Resident #12 had long, jagged, and dirty fingernails. 3. Review of the medical record revealed Resident #19 was admitted on [DATE]. Diagnoses included a brain injury, anxiety, and dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had severe cognitive impairment. Observation on 08/05/24 at 1:03 P.M. revealed Resident #19 was sitting in her room wearing a blue shirt and a long-beaded necklace. Subsequent observation on 08/06/24 at 8:39 A.M. revealed Resident #19 was lying in bed with the same blue shirt and beaded necklace that Resident #19 was observed wearing on 08/05/24. Interview on 08/06/24 at 8:42 A.M. the spouse of Resident #19 verified Resident #19 should not be wearing the same clothes from 08/05/24. Interview on 08/06/24 at 8:59 A.M. with State tested Nursing Aide (STNA) #57 revealed Resident #19 liked to stay in bed until 10:00 A.M. STNA #57 verified they had not provided any care for Resident #19 that morning and Resident #19 should not be wearing a long-beaded necklace at night. Interview on 08/06/24 at 9:01 A.M. with STNA #58 verified Resident #19 did not like to get up until 10:00 A. M. and STNA #58 verified they had not changed Resident #19's clothes the morning of 08/06/24. Interview and observation on 08/06/24 at 9:06 A.M. with Resident #19 and Director of Health Services (DHS) stated the resident stated they liked to wear pajamas to bed. The DHS verified Resident #19 was wearing a blue shirt and a necklace. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record revealed Resident #39 was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis, parkinsonism, dementia, and type II diabetes mellitus. Review of the profile care guide for Resident #39 dated 11/13/23 revealed care included showers Monday and Thursday on evening shift and Resident #39 was transferred with a sit-to-stand lift. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had some cognitive impairment. Review of the bathing documentation from 07/04/24 to 07/02/24 revealed on 07/04/24, 07/08/24, and 07/11/24, Resident #39 had nails cleaned but did not reveal if Resident #39 received a bed bath or shower. The next bathing documentation dated 07/25/24 (13 days later) revealed Resident #39 received a bed bath and refused nail care. Bathing documentation dated 07/29/24 and 08/01/24 revealed no documentation of what type of bathing or care was provided. Interview and observation on 08/05/24 at 1:03 P.M. with Resident #39 stated they were not showered very often. Resident #39 was dressed and sitting in a wheelchair and had long fingernails with a dark substance under the nails. Observation on 08/06/24 at 8:42 A.M. revealed Resident #39 had long fingernails with a dark substance under the nails. Interview on 08/06/24 at 9:08 A.M. with Director of Health Services (DHS) verified Resident #39 had long, dirty fingernails. This deficiency represents non-compliance investigated under Master Complaint Number OH00156112 and Complaint Number OH00155831. This deficiency is an example of continued non-compliance from complaint survey dated 07/03/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, medical record review, staffing schedule review, review of the facility assessment, and family, resident, and staff interviews, the facility failed to ensure there was adequate staffing to provide activities of daily living (ADL) care for Residents #5, #12, #19, and #39. This affected four residents (#5, #12, #19, and #39) of seven residents reviewed for ADL care with the potential to affect all 46 residents. The facility census was 46. Findings include: 1. On 08/05/24 at 5:40 A.M., observation of staff revealed there were three licensed nurses, four State tested Nursing Assistants (STNAs) and two STNAs in training on duty to provide care for 46 residents currently residing in the facility. The facility identified 15 residents that required assistance or were dependent on staff for feeding and 29 residents that required the assistance of two staff for toileting and transfers. 2. The following family and resident concerns were lodged during the investigation related to facility staffing. 2a. Interview on 08/05/24 at 9:11 A.M. with a family member of Resident #15 revealed the facility was short staffed. A family member or a family hired a caregiver who visited Resident #15 for the breakfast and dinner meals to ensure Resident #15 was fed. The family member stated there was not enough staff to ensure all the residents were assisted with meals. Resident #15 had a camera in the room and the family member stated they had observed staff eating Resident #15's sandwich at lunch time and not assisting Resident #15 with lunch. Resident #15 would be observed in bed without the head of bed raised when a lunch tray was provided. The family member stated they had observed two residents with feces on their body and staff would just close the resident's doors until they had time to provide care. The family member stated there had been multiple medication errors due to the staff working long hours. The family member stated they just wanted Resident #15 fed, provided incontinence care, and repositioned. There were times Resident #15 was not provided incontinence care or repositioning from the time someone left after breakfast until they returned for the dinner meal. The family hired caregivers to provide showers for Resident #15 due to the lack of staffing. 2b. Interview on 08/05/24 at 12:26 P.M. with a family member of Resident #7 revealed Resident #7 had aspirated on medications within the last week. A nurse brought medication in and then left before Resident #7 had swallowed the pills. An STNA happened to come in and found Resident #7 choking and rendered aid. The family member stated Resident #7 was not getting regular showers but now received hospice services and should receive regular bathing. Resident #7 was provided incontinence care before breakfast, around 4:00 P.M. and when put to bed in the evening. The family member stated there was a camera in the room and there were many nights a staff member never checked on Resident #7 after Resident #7 was put to bed. The family member stated a family member visited every day at lunch and dinner to ensure Resident #7 was fed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2c. Interview on 08/05/24 at 1:03 P.M. with Resident #39 revealed they were not showered very often because there was not enough help. Resident #39 stated they needed assistance with eating and had gone without a meal because there was not enough staff to feed Resident #39. 2d. Interview on 08/06/24 at 7:28 A.M. with Resident #11 revealed there were not enough staff to provide care. Some residents required assistance with eating and there was not always a staff member in the dining room when residents were eating. Resident #11 stated visitors came in to feed residents in the dining room and staff feed those residents that stayed in their rooms for meals. Resident #11 stated the Director of Health Services (DHS) had to work the floor a lot and also had to perform DHS duties. Resident #11 stated there were four or five families concerned about the care the residents were receiving. 2e. Interview on 08/06/24 at 8:44 A.M. with Resident #5 revealed call lights could be answered anywhere from five minutes to one hour. 2f. Interview on 08/06/24 at 5:03 P.M. with a family member of Resident #33 revealed there were not enough staff to provide adequate care. There were times when there was only one STNA working. Resident #33 had been left on the toilet for an hour. The family stated call lights were not answered for long periods of time. Staff were leaving the facility and those that continued to work at the facility were overworked. 3. The following staff concerns were lodged during the investigation related to facility staffing. 3a. Interview on 08/05/23 at 5:52 A.M. with STNA #50 revealed they were an employee at a sister facility and were part of the flex program that helped cover shifts that this facility. STNA #50 stated they worked at this facility four days a week. 3b. Interview on 08/05/23 at 5:55 A.M. with Licensed Practical Nurse (LPN) #51 revealed it could take staff five minutes to an hour to answer call lights depending on staffing and what was going on at the time. 3c. Interview on 08/05/24 at 5:58 A.M. with STNA #52 revealed some nights there were not enough staff to provide adequate care for residents. STNA #52 stated they had found residents that appeared to have been soiled for a long period of time. 3d. Interview on 08/05/24 at 6:16 A.M. with STNA #53 revealed sometimes there were not enough staff to provide adequate care for residents. 3e. Interview on 08/05/24 at 7:39 A.M. with LPN #55 revealed there was not enough staff. Staff were unhappy and felt they were working in unsafe conditions due to the workload. LPN #55 stated showers and daily weights were not done due to lack of staffing. 4. During the staffing investigation concerns were identified that residents were not provided routine showers/baths, nail care, and clothing changed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4a. Review of the medical record revealed Resident #5 was admitted on [DATE]. The profile care guide for Resident #5 dated 06/25/24 included showers scheduled Monday and Thursday on day shift and use of a mechanical lift with two staff assist for transfers. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was dependent on staff for bathing. The plan of care dated 07/03/24 revealed Resident #5 required staff assistance to complete self-care and mobility functional tasks completely and safely. Interventions included to provide nail care on shower days and as needed. Review of the bathing documentation dated 08/01/24 and 08/05/24 revealed no documentation of what type of bathing or care was provided. Observation on 08/06/24 at 8:44 A.M. revealed Resident #5 had long fingernails with a dark substance under the nails. Interview on 08/06/24 at 9:12 A.M. with the DHS verified Resident #5 had long, dirty fingernails. 4b. Review of the medical record revealed Resident #39 was admitted on [DATE]. The profile care guide dated 11/13/24 for Resident #39 included showers Monday and Thursday on evening shift. Review of the bathing documentation dated 07/29/24 and 08/01/24 revealed no documentation of what type of bathing or care was provided. Interview and observation on 08/05/24 at 1:03 P.M. with Resident #39 revealed they were not showered very often. Resident #39 was dressed and sitting in a wheelchair and had long fingernails with a dark substance under the nails. Subsequent observation on 08/06/24 at 8:42 A.M. revealed Resident #39 had long fingernails with a dark substance under the nails. Interview on 08/06/24 at 9:08 A.M. with the DHS verified Resident #39 had long, dirty fingernails. 4c. Review of the medical record revealed Resident #12 was admitted on [DATE]. The profile care guide dated 03/29/24 for Resident #12 included showers on Wednesday and Saturday on evening shift and nail care to be provided with showers and as needed. Resident #12 required extensive assistance with eating and a mechanical lift with the assistance of two staff for transfers. Review of the bathing documentation dated 07/31/24 and 08/02/24 revealed no documentation of what type of bathing or care was provided. Observation on 08/05/24 at 9:27 A.M. revealed Resident #12 was lying in bed and had long, jagged fingernails with a dark substance under and around the fingernails. Observation again on 08/06/24 at 8:33 A.M. revealed Resident #12 had long, jagged fingernails with dark substance under and around the fingernails. Interview on 08/06/24 at 9:14 A.M. with the DHS verified Resident #12 had long, jagged, and dirty fingernails. 4d. Review of the medical record revealed Resident #19 was admitted on [DATE]. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/05/24 at 1:03 P.M. revealed Resident #19 was sitting in her room wearing a blue shirt and a long-beaded necklace. Subsequent observation on 08/06/24 at 8:39 A.M. revealed Resident #19 was lying in bed with the same blue shirt and beaded necklace that Resident #19 was observed wearing on 08/05/24. Interview on 08/06/24 at 8:42 A.M. with the spouse of Resident #19 verified Resident #19 should not be wearing the same clothes from 08/05/24. Interview on 08/06/24 at 8:59 A.M. with STNA #57 revealed Resident #19 liked to stay in bed until 10:00 A. M. STNA #57 verified they had not provided any care for Resident #19 that morning and Resident #19 should not be wearing a long-beaded necklace at night. Interview on 08/06/24 at 9:01 A.M. STNA #58 verified Resident #19 did not like to get up until 10:00 A.M. and STNA #58 verified they had not changed Resident #19's clothes the morning of 08/06/24. Interview on 08/06/24 at 9:06 A.M. with Resident #19 stated they liked to wear pajamas to bed. DHS verified at that the time of the interview with Resident #19, that Resident #19 was wearing a blue shirt and a necklace. 5. Review of the Facility assessment dated [DATE] revealed the staffing plan of full-time employees per day was six nurses and nine STNAs based on a daily census of 47. Review of the schedules for July 2024 revealed the staffing was three to five nurses and five to six STNAs each day. Interview on 08/06/24 at 4:20 P.M. with Clinical Support #56 revealed the facility was budgeted for 3.2 hours for staffing and were trying to get more staff. The facility was currently using two flex staff. Hiring events were scheduled and the facility was doing employee recognition to try to reduce staff turnover. The Administrator was involved in the hiring process and the facility was offering STNA training to help with the hiring process. Clinical Support #56 verified the DHS did have to work the floor about once a week. This deficiency represents non-compliance investigated under Complaint Number OH00155831.