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	01/17/2025

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 - 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** 41271 Based on medical records review, shower sheet review, and staff interview, this facility failed to ensure residents received a bath or shower as scheduled and failed to provided supporting documents for provided shower sheets. This affected one (Resident #49) of the five residents reviewed for hygiene care. The facility census was 46. Findings include: Review of the medical record for Resident #49 revealed an initial admitted [DATE] and a reentry date of 01/02/2025. Diagnoses included acute embolism and thrombosis of femoral vein bilateral, pulmonary embolism, stage two pressure ulcer of sacral region, and a history of urinary tract infections. Review of Resident #49's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #49 was noted to have an impairment to one lower extremity and required the use of a wheelchair for mobility. Resident required setup or clean up assistance for eating, oral hygiene, and personal hygiene. Resident #49 was dependent for toileting hygiene, and dressing and substantial to maximal assistance for bathing, bed mobility, and toilet transfers. Resident #49 was noted to be frequently incontinent of bowel and bladder . Continued review of Resident #49's medical record revealed this resident was to receive a bath or shower on Tuesday and Friday evenings. Review of Resident #49 electronic medical record revealed under the bathing Activity of Daily Living (ADL) task from 10/23/2024 through 01/14/2025 that this resident was documented to either receive a partial bed bath or complete bed bath at least twice a week except for one week in December 2024. Out of the 27 days a bath was documented to be completed, 13 of those days indicated a complete bed bath was completed and the other 14 days indicated that a partial bed bath was provided. Review of the plan of care dated 11/13/24 revealed Resident #49 demonstrates non-compliance with physician orders and or plan of care as evidenced by refusing to turn and repositioning at times, refuses care at times, refuses showers at times, refuses lab draws at times. Interventions include to honor residents' preference to the extent that non-compliance with physician orders will not result in injury to self or others. Assess for need for a guardian or other legal oversight as needed. Monitor ability to give informed consent and fluctuation in decision making, encourage to participate in decision making by offering choices and discussion of advance directives, educate, encourage. (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	Interview on 01/15/2025 with State tested Nursing Assistant (STNA) #142 revealed she has worked with Resident #49 on multiple occasions and confirmed she will refuse care including showers from time to time but it was not very common. STNA #142 claimed residents received partial bed baths daily with their morning care and this is documented in their electronic medical records. A partial bed bath is not considered the same as a completed bed bath or shower. When a complete bed bath or shower is completed a shower or skin sheet is also completed and given to the nurse to review and sign. Review of provided shower sheets revealed multiple shower sheet that appeared to have similar documentation included name of staff providing care, nurse signing off on this care, and exact care provided including nail care. Some of these shower sheets were noted to have a line where the date was at then the next similar document had all the same information but the line that was present for the date was now gone and a different date was put there. Multiple sheet reviewed appeared to have signs of being altered or changed. Requested facility to provide time sheets for staff who were noted to complete these shower sheets for the dates the showers were noted to be provided. Facility Administrator claimed this information could not be provided and was not available for review. Attempted to contact STNA #200 on 01/17/2024 at 2:30 P.M. who was noted to provide most of these showers with similar documentation but was unable to reach staff member. A voice message was left with a return phone number which a return phone call was never received. Interview with the Administrator and Director of Nursing on 01/13/2025 revealed the facility only uses shower/skin sheet to document baths or showers provided and they did not chart this information in the electronic ADL task on the residents' medical records. Requested information to support staff noted to complete these shower sheets were working dates noted revealed no documents could be provided including staff time sheets. This deficiency represents non-compliance investigated under Complaint Number OH00160855.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, wound clinic order review, and staff interview, this facility failed to ensure orders for lymphedema pumps were implemented as ordered. This affected one (Resident #49) of the five residents reviewed for physician orders. The facility summary was 46. Findings include: Review of the medical record for Resident #49 revealed an initial admitted [DATE] and a reentry date of 01/02/2025. Diagnoses included acute embolism and thrombosis of femoral vein bilateral, pulmonary embolism, stage two pressure ulcer of sacral region, and a history of urinary tract infections. Review of Resident #49's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #49 was noted to have an impairment to one lower extremity and required the use of a wheelchair for mobility. Resident required setup or clean up assistance for eating, oral hygiene, and personal hygiene. Resident #49 was dependent for toileting hygiene, and dressing and substantial to maximal assistance for bathing, bed mobility, and toilet transfers. Resident #49 was noted to be frequently incontinent of bowel and bladder. Review of Resident #49's physician orders from 10/19/2024 through 01/17/2025 revealed no current or past order for lymphedema pumps (a medical device that uses compression to apply pressure to a swollen limb helping to reduce swelling). Review of the after-visit summary from the wound clinic dated 12/16/2024 and again on 12/23/2024 revealed under the section titled, Instructions revealed for edema control, use lymphedema pumps two times a day for one hour at a time for both legs. Review of the after-visit summary dated 12/30/2024 revealed Resident #49 was not seen in the office that day and was instead send directly to the emergency room for treatment. Review of the after-visit summary from the wound clinic dated 01/06/2025 and 01/13/2025 revealed edema pumps were currently on hold due to recent diagnosis of bilateral lower extremity blood clots. Interview on 01/15/2025 at 3:00 P.M. with the Director of Nursing and Administrator confirmed there was not an order in place for the use of the lymphedema pumps twice a day for an hour each time. The Director of Nursing and Administrator also confirmed the wound clinics after visit summary dated 12/16/2024 indicated under instructions for the use of these pumps. Interview with Wound Clinic Nurse #247 on 01/16/2025 at 3:00 P.M. revealed confirmed Resident #49's daughter had updated them on her medical history which included cancer treatment which damaged the lymph nodes in her lower extremities which she required the use of lymphedema pumps daily to help with her circulation. The wound clinic nurse confirmed the use of lymphedema pumps daily was added to the care instructions after her visit on 12/16/2024. This deficiency represents non-compliance investigated under Complaint Number OH00160855.

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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** 41271 Based on medical records review, incident investigation review, and staff interview, this facility failed to ensure residents were free from injury when receiving assistance and transportation from facility staff. This affected one (Resident #49) of the five residents reviewed for accidents and injuries. The facility census was 46. Findings include: Review of the medical record for Resident #49 revealed an initial admitted [DATE] and a reentry date of 01/02/2025. Diagnoses included acute embolism and thrombosis of femoral vein bilateral, pulmonary embolism, stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without bruising or slough) of sacral region, and a history of urinary tract infections. Review of Resident #49's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #49 was noted to have an impairment to one lower extremity and required the use of a wheelchair for mobility. Resident required setup or clean up assistance for eating, oral hygiene, and personal hygiene. Resident #49 was dependent for toileting hygiene, and dressing and substantial to maximal assistance for bathing, bed mobility, and toilet transfers. Resident #49 was noted to be frequently incontinent of bowel and bladder. Review of the incident investigation summary dated 12/20/2024 revealed that on 12/16/2024 at 3:15 P.M. during transportation to a wound clinic for appointment, Resident #49's foot slipped off the wheelchairs foot pedal causing a small bruise with scant amount of serosanguineous drainage (a thin, watery fluid that contains both blood and serum). Immediate action taken including staff being interviewed, resident being interviewed, physician notified, resident representative notified. Timeline of events included that around 3:10 PM as Resident #49 was getting off the bus she hit her leg prior to going into the wound clinic, clinic staff fixed wheelchair pedal. Summary of investigation- root cause: Wheelchair pedal tipping. Immediate intervention taken included wheelchair pedal fixed, first aid provided at wound clinic, education provided to transportation aide to notify clinical/therapy immediately of concerns regarding functioning of assistive devices. Request of education reveled no physical evidence of education could be provided and that education was provided verbally by the Director of Nursing (DON) to Transportation Associate #118. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/2025 at 2:30 P.M. with Transportation Associate #118 revealed the facility has two vehicles for transportation. One is a bus like and the other is a rental that is a mini van that can hold two wheelchairs. Transportation Associate #118 claims she takes Resident #49 to a wound clinic appointment every Monday around the same time. Claimed there was one day when she was transporting Resident #49 and while driving there, Resident #49 claimed her foot peddle was not staying in place and her foot would fall down. When they arrived at the wound clinic, Transportation Associate #118 claimed she tried fixing the peddle and even tried placing both feet on the other peddle but that did not work. After lowering the ramp and taking Resident #49 off the ramp, she went to push her forward and the resident yelled out and she ran over her foot. After looking at the wheelchair and where the wheels were at, that could not be possible because the wheels were set so far off to the sides. Transportation Associate #118 claimed she thinks it was caused by the foot peddle but could not identify exactly where or how since she was pushing the resident forward the peddle should not have hit her like that. When she looked at the leg, it looked just like a small scratch where the very top layer of skin was pulled up. Almost like if you had a sunburn and started to peel. That very small, thin layer of skin. No bruising or bleeding or swelling was noted. She took the resident into the appointment and afterwards was told that the wound doctor looked at the area and put a bandage on it. Resident #49's daughter took photos and when she showed her it appeared the area had bruising around it which was not what she saw when it first happened. The wound clinic nurse was able to tighten the foot peddle up so there were no further issues. Transportation Associate #118 claimed she notified the facility when she returned but they were already made aware due to the daughter calling and telling them about it. It was late that day so the DON requested her to write up a statement and place it in her mailbox to be reviewed the following day. No education was provided or anything else that she could recall. This deficiency represents non-compliance investigated under Complaint Number OH00160855.