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	02/25/2025

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 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** 47059 Based on record review, resident interview, staff interview and policy review, the facility failed to provide transportation to a scheduled medical appointment. The affected one Resident (#17), of three residents reviewed for transportation to medical appointments. The facility census was 42. Findings include: Resident #17 was admitted on [DATE] with diagnoses that included acute embolism and thrombosis of femoral vein, acute respiratory failure with hypoxia, Systemic Inflammatory Response Syndrome (SIRS) of non-infectious origin without acute organ dysfunction, pneumonia, sepsis, pressure ulcer of sacral region, atherosclerotic heart disease, chronic kidney disease, lymphedema, neutropenia, metabolic encephalopathy, chondrocalcinosis of left knee, urinary tract infection, tachycardia, dysphagia, altered mental status, and localized edema. Review of quarterly minimum data set (MDS) 3.0 dated 01/23/25 revealed Resident #17 was cognitively intact with a brief interview of mental status score (BIMS) of 13 out of 15. Resident #17 has no impairment of range of motion in upper extremities but had impairment noted in both lower extremities. Resident #17 used a walker for transfers and a wheelchair for mobility. Review of wound care appointment notes indicated resident attended wound clinic at an outside appointment on 12/16/24, 12/23/24, and 12/30/24 for a pressure ulcer on the coccyx. On 12/30/24 the wound physician sent Resident #17 to the emergency room for increased swelling in her legs, general lethargy and feeling unwell. Resident #17 was hospitalized from 12/30/24 to 01/02/25 and was seen by the wound physician prior to discharge. The resident was then seen in the wound clinic 01/06/25, 01/13/25, 01/20/25 and 01/27/25. Resident #17 was due to be seen 02/02/25 but was hospitalized from 02/02/25 to 02/05/25 and was seen by the wound physician while an in-patient. The resident missed the appointment on 02/10/25 and was seen 02/17/25 and 02/24/25. Interview on 02/09/25 at 4:30 P.M. with the administrator confirmed the 02/10/25 appointment was missed and stated the van driver was tied up with another outside appointment and couldn't make it back in time. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy Transportation Guidelines last review date 08/31/17 revealed transportation may be provided from the hospital to the campus, to medical appointments by bus or car, for campus outings and various trips. The Transportation Assistant (TA) is required to complete all required training before operating a vehicle. Any campus without a TA position should arrange transports through an outside agency. Then a TA is not doing transports they should assist with life enrichment activities. There should be a master transportation schedule. Contracts with local vendors are also appropriate for resident wheelchair/stretcher transportation. This deficiency represents an example of continued non compliance investigated under the complaint survey completed on 01/17/25 and represents non-compliance investigated under Complaint Number OH00162536.

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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** 47059 Based on record review, staff interviews, and policy review, the facility failed to keep one, Resident (#23), of three reviewed for fall risk, free from a fall during care. The facility census was 42. Findings Include: Resident #23 was admitted [DATE] with the most recent re-admitted [DATE], diagnoses included metabolic encephalopathy, dysphagia, severe protein-calorie malnutrition, hyperosmolality and hypernatremia, hypokalemia, adult failure to thrive, low back pain, major depressive disorder, anxiety disorder, neurocognitive disorder with Lewy bodies, Vitamin D deficiency, and hallucinations. Review of the admission minimum data set (MDS) 3.0 dated 11/11/24 revealed the resident was unable to be interviewed, Resident #23 is rarely understood. Staff reported Resident #23 had both short-term and long-term memory problems. Resident #23 was dependent on staff for eating, personal hygiene, all activities of daily living and mobility. Resident #23 received no high-risk medications and no special treatments or programs. Review of a Significant Change MDS dated [DATE] indicated it was still in progress but initiated because the responsible party had agreed to place Resident #23 in Hospice care. Review of the Admission Observation and Data Collection tool dated 11/05/24 for Resident #23 revealed Resident #23 had weakness in all four extremities, had no contractures, had full weight bearing, and used a wheelchair for mobility. Recommended care plan interventions included providing assistance as needed for bed mobility, eating, toileting, transfers, and providing assistance to ensure safe completion of activities of daily living (ADL) tasks. Review of the Admission Observation and Data Collection tool dated 12/10/24 for Resident #23 revealed Resident #23 had weakness in all four extremities, had contractures of right and left lower legs, was non-weight bearing, and used a wheelchair for mobility. Recommended care plan interventions included providing assistance as needed for bed mobility, eating, toileting, transfers, and use of a mechanical lift for all transfers. Review of the medical record for Resident #23 revealed there were no other falls risks assessments completed prior to the incident on 01/31/25. Review of nursing documentation dated 01/31/25 at 6:11 A.M. revealed the Certified Nursing Assistant (CNA) #447 reported to the Registered Nurse (RN) #448 that Resident #23 slid out of bed during incontinence care. The CNA reported Resident #23 slid to the floor slowly and did not hit her head. RN #448 entered the room to find Resident #23 sitting on the floor up against the night stand. Resident appeared to have no pain and had no visible injuries. Resident #23 was assisted back to bed. Resident #23's responsible party and provider were both notified and there were no new orders noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a therapy referral observation form for the requested incident report for the fall Resident #23 had on 01/31/25 from her bed during incontinent care. Review of the Therapy Referral Observation dated 02/03/24 for Resident #23 revealed a physical therapy review in response to a fall. Physical Therapists #502 noted Resident #23 had increased assistance needed for turning side to side and increased assistance needed for sitting up on the edge of the bed. Additional physical therapy was not indicated at this time because it was not approved by Hospice. Review of the interdisciplinary progress note dated 02/10/25 revealed Resident #23 is at risk for falling related to impaired mobility, impaired cognition, incontinence and pain. At the time of the even on 01/31/25 the immediate intervention was to ensure Resident #23's safety that was accomplished by returning Resident #23 to be, completing a head-to-toe assessment, and assuring there were no visible or audible signs of pain. The ongoing intervention was as of 02/10/25, Resident #23 is to be a two person assist for all cares and transfers. Interview on 02/20/25 at 3:35 P.M. with CNA #480 confirmed when incontinence care is provided the resident should always be rolled towards a staff member not away from the staff member or there is a chance they could roll out of bed. CNA #480 also stated a resident who was bedridden and was not mobile would not be someone considered a falls risk. Interview on 02/24/25 at 7:50 A.M. with LPN #467 confirmed they would not perform incontinence care on a resident dependent on staff for mobility without a second staff member present. Interview with the Administrator on 02/25/25 at 1:30 P.M. confirmed Resident #23 had an event resulting in a fall to the floor on 01/31/25 at 6:11 A.M. The interdisciplinary team reviewed the event and recommended changing Resident #23 from a one person assist care to a two person assist care. Resident #23 was dependent on staff for mobility and care before the event and after the event. Interview on 02/25/25 at approximately 1:35 P.M. with the Director or Nursing regarding the incident with Resident #23 on 01/31/25 confirmed the facility had performed a root cause analysis and implemented to have two staff provide incontinence care for the resident and stated the intervention was put in place to fix the cause of the fall from the bed, the DON was asked if the resident was rolled off the bed by the staff and the DON refused to answer. Review of policy Falls Management Program Guidelines last review date 12/17/24 revealed a fall is considered to be an unintentional coming to rest on the ground, floor, or other lower level. The policy outlines all residents should have a falls risk assessment as part of the admission and quarterly nursing observation including care planning to address risks. Should the resident experience a fall a Fall Event should be completed to investigate the circumstance surrounding the fall, to determine the cause, identify contributing factors, and identify interventions to decrease the risk of another fall. There should be a review by the IDT team to evaluate the thoroughness of the investigation and appropriateness of the interventions. The provider and the responsible party should be notified. Any orders received should be carried out and the resident's care plan should be updated. Nursing staff will monitor and continue to document resident's response and effectiveness of interventions for 72 hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents continued non compliance investigated under the complaint survey completed on 01/17/25 and represents non-compliance investigated under Complaint Number OH00162581 and OH00162485.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47059 Based on record review and staff interviews, the facility failed to staff a registered nurse eight hours a day, seven days a week. The facility census was 42. Findings include: Review of staffing sheets and the staffing tool from 02/11/25 to 02/17/25, there was no registered nurse scheduled for 02/16/25. Interview on 02/24/25 at 10:30 A.M. with the Administrator confirmed there was no registered nurse on the assignment sheet for Saturday 02/16/25.