| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366475 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Smiths Mill Health Campus | 7320 Smiths Mill Road<br>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.

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, medical record review and interviews, the facility failed to ensure one resident who was dependent on staff for eating was provided a dignified dining experience when his meal tray was left for an extended period of time before staff returned to feed him. This affected one resident (#22) of six sampled residents. The facility census was 49. Findings Include:Review of the medical record for Resident #22 revealed an initial admission date of 02/06/25 with the diagnoses including but not limited to Guillain-Barre syndrome, dysphagia, retention of urine, diabetes mellitus, hyperlipidemia, hypertension and functional quadriplegia. Review of the plan of care dated 02/20/25 revealed the resident required staff dependence to complete self-care and mobility functional tasks completely and safely. Review of resident's functional abilities dated 02/10/26 revealed the resident was dependent on staff for eating. On 02/11/26 at 11:55 A.M., an interview/observation with Resident #22 revealed the resident's lunch tray was sitting untouched on the resident's bedside table. The resident revealed the staff comes to feed him once all meal trays have been delivered. He revealed he could wait from eight minutes to 30 minutes before a staff member came to feed him. He stated, I have to sit and look at it. On 02/11/26 at 12:10 P.M., observation of the meal tray revealed the meal tray remained untouched and staff had not come to feed the resident. On 02/11/16 at 1:00 P.M., an interview with the Director of Nursing (DON) verified staff leaving the meal tray and unable to feed himself was undignified meal experience. This deficiency represents non-compliance investigated under Complaint Number 2740077. |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, open and closed medical record review, hospital record review, and interview, the facility failed to ensure physician ordered treatments were provided to non-pressure skin impairments. Additionally, the facility failed to identify a change in condition timely. This affected one resident (#19) of three residents reviewed for skin breakdown and one resident (#50) of three residents reviewed for change in condition. The facility census was 49. Findings Include:1. Review of the medical record for Resident #19 revealed an initial admission date of 02/01/26 with the diagnoses including but not limited to infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, toxic encephalopathy, cellulitis of right lower limb, myositis, right thigh, peripheral vascular disease, anemia, atrial fibrillation, hypertension, congestive heart failure, retention of urine, cardiac arrythmia, left below the knee amputation, dementia, insomnia, chronic pain syndrome, benign prostatic hyperplasia and hypothyroidism. Review of the resident's Brief Interview for Mental Status (BIMS) score dated 02/02/26 revealed a score of 8 out of 15 indicating the resident had a moderate cognitive deficit. Review of the progress note dated 02/04/26 at 9:03 A.M. revealed two skin tears were prevent to the left upper arm measuring 5.0 centimeters (cm) by 2.5 cm and 3.5 cm by 2.1 cm. The nurse cleansed the site and applied a dressing. A new order was obtained for a daily dressing change and as needed. Review of the resident's monthly physician orders for February 2026 identified an order dated 02/05/26 cleanse the skin tears to the left upper arm with normal saline (NS), pat dry gently, apply xeroform dressing, ABD pad and wrap with Kerlix every Monday, Wednesday, Friday and as needed. Review of the resident's February 2026 Treatment Administration Record (TAR) revealed the physician ordered treatment was to be administered on 02/06/26 and 02/09/26. On 02/11/26 at 9:35 A.M., observation of Resident #19 revealed a dressing to his left upper arm dated 02/04/26 with a large amount of dark red dried blood on the dressing. On 02/11/26 at 2:40 P.M., observation of Resident 19 revealed the soiled dressing remained to his left upper arm dated 02/04/26 with a large amount of dark red dried blood on the dressing. On 02/11/26 at 2:44 P.M., an interview with Licensed Practical Nurse (LPN) #100 verified the dressing to the resident's left upper arm was not changed on 02/06/26 and 02/09/26 as physician ordered. 2. Review of the closed medical record for Resident #50 revealed an initial admission date of 01/29/26 with the diagnoses including but not limited to displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, effusion of right knee, anemia, cerebral ischemia, retention of urine, Alzheimer's disease, dementia, unspecified fall, adult failure to thrive, constipation, osteoarthritis, other specified disorder of right middle ear and mastoid and personal history of malignant neoplasm of prostate and tongue. The resident was discharged to an acute care hospital on [DATE]. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the progress note dated 02/07/26 at 1:50 P.M., authored by LPN #180 revealed the resident was drowsy and won't fully wake up. Took vitals (not recorded) and he was having tachycardia. Family wanted nurse to send him out to get evaluated. Called Certified Nurse Practitioner (CNP) on call who gave order to send him out. Review of the medical record revealed no evidence LPN #180 obtained an assessment or vital signs prior to the resident being transferred to the acute care hospital. Review of Critical Care Ambulance Service run report dated 02/07/26 revealed the resident was found lying in bed on arrival. The resident was skin was found to be hot, dry and pale. His respirations were even with no increased effort. His lung sounds were coarse with a dry infrequent unproductive cough. The resident's pulse was rapid and strong. The resident's pupils were pin-point and non-reactive. The<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medic administered 2 milligrams (mg) of Naloxone (a medication used to reverse the effects of opioids) with the resident improved. The resident was also infusion 500 milliliters (ml) of normal saline (NS). A sepsis alert was initiated to the receiving acute care hospital. Further review revealed the resident's blood pressure was 159/96, Temperature 102.4 axillary, pulse 117 and respirations 12. Review of the resident's February 2026 Medication Administration Record (MAR) revealed the resident received two doses of Oxycodone 5 mg by mouth on 02/07/26 at 4:21 A.M. and 8:26 A.M. for pain. Review of the resident's discharge physician orders identified an order dated 01/29/26 Oxycodone 5 mg by mouth every four hours as needed for pain. Review of the emergency department (ED) progress note dated 02/07/26 revealed the resident presented with altered mental statue, elevated temperature and tachycardia. The resident's vital signs were documented as blood pressure 157/85, temperature 103.1, pulse 119 and respirations 19 in the ED. The resident was admitted for left femoral neck fracture after multiple falls at the extended care facility, sepsis present on admission with the source of infection unknown at that time, acute encephalopathy, elevated alkaline phosphatase, elevated troponin and right lower extremity clearance. Review of the CT with contract results dated 02/07/26 revealed the resident was found to have an acute fracture at the subcapital and transcervical region of the left femoral neck with 1.6 centimeters (cm) of impaction 9a type of femoral neck fracture where the femoral head is impinged against the femoral neck often due to fall or trauma). On 02/12/26 at 11:39 A.M., interview with the Certified Nursing Assistant (CNA) #185 revealed on 02/07/26 CNA #185 delivered the resident's meal tray and he was sleeping. She revealed she had not seen the resident again prior to being transferred to the hospital due to her workload. The CNA revealed she had a 200 hallway and four room on the 300 hallway. On 02/12/26 at 11:32 A.M., an interview with Registered Nurse (RN) #133 revealed Resident #50's daughter came to her looking for LPN #180 due to feeling there was something wrong with her father. RN #133 revealed she couldn't find his nurse so she went back and obtained a set of vital signs. She said she remembers his pulse was in the 120's to 130's and irregular. She said LPN #180 then entered the room and she reported her findings and LPN #180 took over. She revealed she doesn't remember if the resident had an elevated temperature or not. On 02/12/26 at 12:03 P.M., an interview with LPN #180 revealed his daughter reported he was drowsy, however she received in report he was up all night. The LPN revealed she obtained a set of vital signs and assessed him and found no negative findings that morning. She revealed she had no reason to reassess the resident until RN #133 reported the increased heart rate. She revealed a temperature was not obtained so she was unaware the resident had an increased temperature. The LPN verified she charted no assessment or vital signs in the residents electronic medical record. LPN #133 stated, I must have forgotten. On 02/17/26 at 9:30 A.M., an interview with the Director of Nursing (DON) verified the medical record contained no assessment or vital signs of the resident and the change in condition was not identified by the nurse timely. This deficiency represents non-compliance investigated under Complaint Number 2740077. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, hospital summary review, review of staffing schedules and facility policy review, the facility failed to provide adequate supervision and /or assistive devices to prevent falls and/or injury for those residents with a cognitive deficit. Additionally, the facility failed to ensure one resident was assisted in bed mobility in a manner to prevent falls from bed. This affected three residents (#19, #50 and #51) of three residents reviewed for falls. The facility census was 49. Findings Include:1. Review of the closed medical record for Resident #50 revealed an initial admission date of 01/29/26 with the diagnoses including but not limited to displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, effusion of right knee, anemia, cerebral ischemia, retention of urine, Alzheimer's disease, dementia, unspecified fall, adult failure to thrive, constipation, osteoarthritis, other specified disorder of right middle ear and mastoid and personal history of malignant neoplasm of prostate and tongue. Review of the fall risk assessment dated [DATE] revealed a score of 22 indicating the resident was at high risk for falls. Review of the plan of care dated 01/29/26 revealed the resident was at risk for falls related to impaired mobility, medication side effects and history of falls. Interventions implemented on 01/29/26 was to assure the floor was free of liquids and foreign objects, encourage/assist resident to assume a standing position slowly, keep call light within reach, keep personal items and frequently used items within reach, provide nonskid footwear, staff to assist resident with transfers as needed and therapy evaluation and treatment as needed. Further review of the care plan revealed on 02/05/26 the facility implemented the interventions dycem to wheelchair and resident to be in common area after family leaves in the evening. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate difficulty hearing and utilized hearing aides. The resident also had impaired vision and wore glasses. The assessment indicated the resident had a severe cognitive deficit. The assessment indicated the resident required substantial/maximum with transfers. The assessment indicated the resident had had falls prior to admission resulting in fractures. Review of the progress note dated 02/02/26 at 7:53 P.M. revealed the resident was found on the floor in his room. No injuries were observed and the facility implemented dycem to his wheelchair. Review of the post fall investigation tool dated 02/02/26 at 7:52 P.M. revealed the resident was found on the floor in his room. The investigation determined the resident was anxious following his family leaving for the day and attempted to self-transfer. The facility implemented the intervention of dycem to wheelchair. Review of the progress note dated 02/03/26 at 8:20 P.M. revealed the resident was again found on the floor in the hallway. The resident had hit his head and was sent to the local emergency room (ER) for an evaluation. The entry documented the staff witnessed the fall from the wheelchair and the resident hitting his head. Review of the post fall investigation tool dated 02/03/26 at 8:30 P.M. revealed the resident was observed falling from his wheelchair in the hallway. The resident was sent to the local ER due to striking his head. The facility implemented to keep the resident at the nurse's station for supervision. Review of the progress note dated 02/06/26 at 12:38 A.M. revealed the resident sustained a third fall when he was found on the floor in his room. The note indicated the resident had painful/limited ROM in the lower extremity. Review of the post fall investigation tool dated 02/06/26 at 12:16 A.M. revealed the resident was found on the floor in his room. The facility brought the resident to common area for supervision. Further review of the medical record revealed the resident was not assessed following the falls for further injury including vital signs. Review of the emergency department (ED) progress note dated 02/07/26 revealed the<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident presented with altered mental statue, elevated temperature and tachycardia. The resident's vital signs were documented as blood pressure 157/85, temperature 103.1, pulse 119 and respirations 19 in the ED. The resident was admitted for left femoral neck fracture after multiple falls at the extended care facility, sepsis present on admission with the source of infection unknown at that time, acute encephalopathy, elevated alkaline phosphatase, elevated troponin and right lower extremity clearance. Review of the staffing schedule for 02/02/26 revealed the facility scheduled three Certified Nursing Aides (CNA) from 6:00 P.M. to 6:00 A.M. shift and two nurses from 7:00 P.M. to 7:00 A.M. for 47 residents. On 02/03/26 the facility again scheduled three Certified Nursing Aides (CNA) from 6:00 P.M. to 6:00 A.M. shift and two nurses from 7:00 P.M. to 7:00 A.M. for 47 residents. On 02/06/26 the facility scheduled once again scheduled three Certified Nursing Aides (CNA) from 6:00 P.M. to 6:00 A.M. shift and two nurses from 7:00 P.M. to 7:00 A.M. for 48 residents indicating each nurse would be responsible for two hallways and each CNA would be responsible for one hallway plus four additional rooms on another hallway. On 02/12/26 at 11:39 A.M., interview with the CNA #185 revealed the facility's usual staffing pattern was three CNA and when in a room or on another hallway resident's who require increased supervision cannot be adequately supervised. 2. Review of the medical record for Resident #19 revealed an initial admission date of 02/01/26 with the diagnoses including but not limited to infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, toxic encephalopathy, cellulitis of right lower limb, myositis, right thigh, peripheral vascular disease, anemia, atrial fibrillation, hypertension, congestive heart failure, retention of urine, cardiac arrythmia, left below the knee amputation, dementia, insomnia, chronic pain syndrome, benign prostatic hyperplasia and hypothyroidism. Review of the resident's fall risk assessment dated [DATE] revealed a score of five indicating the resident was at a low risk for falls. Review of the resident's Brief Interview for Mental Status (BIMS) score dated 02/02/26 revealed a score of 8 out of 15 indicating the resident had a moderate cognitive deficit. Review of the plan of care dated 02/02/26 revealed the resident was at risk for falls related to impaired mobility and medication side effects. Interventions implemented on 02/02/26 assure the floor is free of liquids and foreign objects, encourage/assist resident to assume a standing position slowly, keep call light in reach, keep personal items and frequently used items within reach, provide nonskid footwear, staff to assist resident with transfers as needed and therapy evaluation and treatment as needed. On 02/05/26 the facility implemented encourage/assist resident to toilet after meals and at bedtime and on 02/09/26 the facility implemented the fall intervention of bilateral floor mats. Review of the progress note dated 02/04/26 at 1:52 A.M. revealed the resident was found in his room sitting on floor on his buttocks with his right leg extended in the bathroom. The resident reported he was going to the bathroom. The resident was noted to have no injuries at the time of the fall. Review of the post fall investigation tool dated 02/04/26 revealed the fall occurred at 12:10 A.M. when the resident attempted to self-transfer. The facility implemented to toilet the resident at bedtime. Review of the progress note dated 02/05/26 at 4:20 P.M. revealed the resident was found sitting on the floor in his bathroom between his wheelchair and the toilet when asked he stated he was trying to transfer from his wheelchair to the toilet and he slid on the floor. No injuries were found. Review of the post fall investigation tool dated 02/05/26 revealed the fall occurred at 10:14 A.M. wen the resident was again attempting to self-transfer for toileting. The facility implemented to toilet resident after meals. Review of the progress note dated 02/08/26 at 4:59 A.M. revealed the resident was found on the floor in his room at 4:00 A.M. No injuries were found and the facility implemented to keep door open at all times except with care. Review of the post fall investigation tool dated 02/05/26 revealed the resident<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was found in his room on the floor at 4:00 A.M. The resident was attempting to self-transfer out of his bed. The staff brought the resident to the common area for supervision. Review of the progress note dated 02/09/26 at 5:35 P.M. revealed During meal pass, resident was noted on the floor underneath the bed. Resident stated he was working and trying to fix the bed. Review of the post fall investigation tool dated 02/09/26 revealed the resident was found on the floor under the bed during meal pass. The resident was assisted up and brought to the dining for the dinner meal. Review of the resident's progress note dated 02/13/26 at 9:09 P.M. revealed on 02/13/26 at 8:25 P.M. the nurse was walking in the hall passing medication and seen the resident slide out of his wheelchair onto the floor. The staff member educated the resident on using the call light despite his cognitive deficit. Review of the post fall investigation tool dated 02/13/26 revealed the facility determined no root cause of the fall or implemented an intervention to prevent further falls. Review of the progress note dated 02/14/26 at 10:19 P.M. revealed the nurse was in hall on 200 unit while passing medication and heard the resident screaming for help. The resident was found sitting on the floor in front of bed B in the room. The resident said he was attempting to get into bed. Review of the post fall investigation tool dated 02/14/26 revealed the facility positioned the resident's bed against the wall to optimize room layout and allow efficient use of space. On 02/12/26 at 11:39 A.M., interview with the CNA #185 revealed the facility's usual staffing pattern was three CNA and when in a room or on another hallway resident's who require increased supervision cannot be adequately supervised. Further review of the medical record revealed the resident was not assessed following the falls for further injury including vital signs. On 02/17/26 at 8:45 A.M., an interview with the Administrator verified the facility had an issue with falls and had been taken to Quality Assessment and Performance Improvement (QAPI). The Administrator verified the facility had a pattern when the falls occur. 3. Review of the closed medical record for Resident #51 revealed an initial admission date of 12/31/25 with the diagnoses including but not limited to cellulitis of left lower limb, MRSA, ASHD, atrial fibrillation, pulmonary hypertension, obesity, congestive heart failure, asthma, interstitial pulmonary disease, lymphedema, pleural effusion, migraine, PVD and acromegaly and pituitary gigantism. The resident was discharged home on [DATE]. Review of the resident's comprehensive MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident was dependent on staff for toileting, dressing lower half of body, bed mobility, required substantial/maximal assistance with showers and sit to standing position. The assessment indicated the resident had one fall with injury since admission. Review of the progress note dated 01/05/26 at 9:05 A.M. revealed the resident rolled and fell out of bed while the CNA was turning the resident away from her while providing incontinence care. The resident stuck her head on the closet next to her bed when she roll out of the bed. The resident was found to have an abrasion to the back of her head that was actively bleeding. The resident was transported to the local ER for an evaluation. Review of the occurrence progress note dated 01/05/26 at 9:05 P.M. revealed the resident had a fall to the floor in her room. The resident complained of pain to the back of her head at an intensity level of eight out of 10, with zero being no pain and 10 being the worst pain felt. The resident was sent to the local ER for an evaluation. The facility implemented the intervention of two assistants with turning or transfers. Review of the medical record revealed Resident #51 returned from the ER with abrasion that did not require any sutures. On 02/17/26 at 1:27 P.M., an interview with the DON verified the CNA rolled the resident away from her causing the resident to roll out of the bed and onto the floor. She verified no resident should be rolled away from the staff member when working alone. Review of the facility policy titled, Fall Management Program Guidelines, last revised on 05/31/17 revealed the facility strives to<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The facility recognizes even the most vigilant efforts may not prevent falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours. This deficiency represents non-compliance investigated under Complaint Number 2740077. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and daily assignment sheet review, the facility failed to ensure sufficient levels of staffing to supervise to prevent falls. This affected one resident (#50) of three residents reviewed for falls. The facility census was 49. Findings Include:. Review of the closed medical record for Resident #50 revealed an initial admission date of 01/29/26 with the diagnoses including but not limited to displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, effusion of right knee, anemia, cerebral ischemia, retention of urine, Alzheimer's disease, dementia, unspecified fall, adult failure to thrive, constipation, osteoarthritis, other specified disorder of right middle ear and mastoid and personal history of malignant neoplasm of prostate and tongue. Review of the fall risk assessment dated [DATE] revealed a score of 22 indicating the resident was at high risk for falls. Review of the plan of care dated 01/29/26 revealed the resident was at risk for falls related to impaired mobility, medication side effects and history of falls. Interventions implemented on 01/29/26 was to assure the floor was free of liquids and foreign objects, encourage/assist resident to assume a standing position slowly, keep call light within reach, keep personal items and frequently used items within reach, provide nonskid footwear, staff to assist resident with transfers as needed and therapy evaluation and treatment as needed. Further review of the care plan revealed on 02/05/26 the facility implemented the interventions dycem to wheelchair and resident to be in common area after family leaves in the evening. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate difficulty hearing and utilized hearing aides. The resident also had impaired vision and wore glasses. The assessment indicated the resident had a severe cognitive deficit. The assessment indicated the resident required substantial/maximum with transfers. The assessment indicated the resident had had falls prior to admission resulting in fractures. Review of the progress note dated 02/02/26 at 7:53 P.M. revealed the resident was found on the floor in his room. No injuries were observed and the facility implemented dycem to his wheelchair. Review of the post fall investigation tool dated 02/02/26 at 7:52 P.M. revealed the resident was found on the floor in his room. The investigation determined the resident was anxious following his family leaving for the day and attempted to self-transfer. The facility implemented the intervention of dycem to wheelchair. Review of the progress note dated 02/03/26 at 8:20 P.M. revealed the resident was again found on the floor in the hallway. The resident had hit his head and was sent to the local emergency room (ER) for an evaluation. The entry documented the staff witnessed the fall from the wheelchair and the resident hitting his head. Review of the post fall investigation tool dated 02/03/26 at 8:30 P.M. revealed the resident was observed falling from his wheelchair in the hallway. The resident was sent to the local ER due to striking his head. The facility implemented to keep the resident at the nurse's station for supervision. Review of the progress note dated 02/06/26 at 12:38 A.M. revealed the resident sustained a third fall when he was found on the floor in his room. The note indicated the resident had painful/limited ROM in the lower extremity. Review of the post fall investigation tool dated 02/06/26 at 12:16 A.M. revealed the resident was found on the floor in his room. The facility brought the resident to common area for supervision. Further review of the medical record revealed the resident was not assessed following the falls for further injury including vital signs. Review of the staffing schedule for 02/02/26 revealed the facility scheduled three Certified Nursing Aides (CNA) from 6:00 P.M. to 6:00 A.M. shift and two nurses from 7:00 P.M. to 7:00 A.M. for 47 residents. On 02/03/26 the facility again scheduled three Certified Nursing Aides (CNA) from 6:00 P.M. to 6:00 A.M.<br><br>(continued on next page) |

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|---|---|---|---|
| | 366475 | A. Building<br>B. Wing | 02/18/2026 |

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

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | shift and two nurses from 7:00 P.M. to 7:00 A.M. for 47 residents. On 02/06/26 the facility scheduled once again scheduled three Certified Nursing Aides (CNA) from 6:00 P.M. to 6:00 A.M. shift and two nurses from 7:00 P.M. to 7:00 A.M. for 48 residents indicating each nurse would be responsible for two hallways and each CNA would be responsible for one hallway plus four additional rooms on another hallway. On 02/12/26 at 11:39 A.M., interview with the CNA #185 revealed the facility's usual staffing pattern was three CNA and when in a room or on another hallway resident's who require increased supervision cannot be adequately supervised. On 02/12/26 at 12:33 P.M., an interview with Resident #50's family revealed the facility had inadequate staffing to prevent their loved one from falling. The family member revealed the family stayed all day and assisted with care. The family member revealed it was difficult to find a CNA or nurse responsible for the resident's care as they always had rooms on another hallway as well as the resident's hallway. On 02/17/26 at 8:45 A.M., an interview with the Administrator verified the facility had an issue with falls and had been taken to Quality Assessment and Performance Improvement (QAPI). The Administrator verified the facility had a pattern when the falls occur. The Administrator revealed all staff assist with managing staff. The Administrator gave no answer when asked about less staff on evenings and weekends. This deficiency represents non-compliance investigated under Complaint Number 2740077. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on medical record review, interview and review of after care summary, the facility failed to ensure physician orders were implemented in a timely manner. This affected one resident (#19) of six sampled residents. The facility census was 49. Findings Include:Review of the medical record for Resident #19 revealed an initial admission date of 02/01/26 with the diagnoses including but not limited to infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, toxic encephalopathy, cellulitis of right lower limb, myositis, right thigh, peripheral vascular disease, anemia, atrial fibrillation, hypertension, congestive heart failure, retention of urine, cardiac arrythmia, left below the knee amputation, dementia, insomnia, chronic pain syndrome, benign prostatic hyperplasia and hypothyroidism. Review of the resident's Brief Interview for Mental Status (BIMS) score dated 02/02/26 revealed a score of 8 out of 15 indicating the resident had a moderate cognitive deficit. Review of the resident's after visit summary dated 02/13/25 revealed the resident attended an appointment related to open wounds to the right lower leg and right great toe. Further review revealed the resident was to start Doxycycline 100 milligrams (mg) by mouth twice daily for seven days. Review of the progress note dated 02/17/26 at 3:59 A.M. revealed an order was observed in the copy room that was faxed from the pharmacy that physician faxed directly to the pharmacy for Doxycycline 100 milligrams (mg) by mouth twice daily for seven days. The order was transcribed to the Medication Administration Record (MAR). Review of the resident's monthly physician orders identified an order dated 02/17/26 for Doxycycline 100 mg by mouth twice daily for seven days for infection. Review of the resident's February 2026 Medication Administration Record (MAR) revealed the resident received the first dose of Doxycycline 100 mg by mouth on 02/17/26 during the morning medication administration. On 02/17/26 at 10:36 A.M., an interview with Licensed Practical Nurse (LPN) #100 revealed he was unsure why the resident was on the antibiotic medication Doxycycline 100 mg but knew the order came from the appointment he attended on 02/13/26. On 02/17/26 at 11:15 A.M., an interview with the Director of Nursing (DON) verified the medication Doxycycline 100 mg was not implemented in a timely manner. This deficiency represents non-compliance investigated under Complaint Number 2740077. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to ensure a complete and accurate electronic medical record (EMR). This affected two residents (#19 and #50) of six sampled residents. The facility census was 49. Findings Include:1. Review of the medical record for Resident #19 revealed an initial admission date of 02/01/26 with the diagnoses including but not limited to infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, toxic encephalopathy, cellulitis of right lower limb, myositis, right thigh, peripheral vascular disease, anemia, atrial fibrillation, hypertension, congestive heart failure, retention of urine, cardiac arrythmia, left below the knee amputation, dementia, insomnia, chronic pain syndrome, benign prostatic hyperplasia and hypothyroidism. Review of the resident's Brief Interview for Mental Status (BIMS) score dated 02/02/26 revealed a score of 8 out of 15 indicating the resident had a moderate cognitive deficit. Review of the progress note dated 02/04/26 at 9:03 A.M. revealed two skin tears were prevent to the left upper arm measuring 5.0 centimeters (cm) by 2.5 cm and 3.5 cm by 2.1 cm. The nurse cleansed the site and applied a dressing. A new order was obtained for a daily dressing change and as needed. Review of the resident's monthly physician orders for February 2026 identified an order dated 02/05/26 cleanse the skin tears to the left upper arm with normal saline (NS), pat dry gently, apply xeroform dressing, ABD pad and wrap with Kerlix every Monday, Wednesday, Friday and as needed. Review of the resident's February 2026 Treatment Administration Record (TAR) revealed on 02/06/26 Licensed Practical Nurse (LPN) #180 documented the treatment was provided and 02/09/26 LPN #100 documented the treatment was provided to the left upper arm wounds as physician ordered despite the fact the dressing on his arm was dated 02/04/26 when the skin tears occurred. On 02/11/26 at 9:35 A.M., observation of Resident #19 revealed a dressing to his left upper arm dated 02/04/26 with a large amount of dark red dried blood on the dressing. On 02/11/26 at 2:40 P.M., observation of Resident 19 revealed the soiled dressing remained to his left upper arm dated 02/04/26 with a large amount of dark red dried blood on the dressing. On 02/11/26 at 2:44 P.M., an interview with LPN #100 verified the dressing to the resident's left upper arm was not changed on 02/06/26 and 02/09/26 as physician ordered, however the TAR was documented as being provided verifying the TAR was inaccurate. 2. Review of the closed medical record for Resident #51 revealed an initial admission date of 01/29/26 with the diagnoses including but not limited to displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, effusion of right knee, anemia, cerebral ischemia, retention of urine, Alzheimer's disease, dementia, unspecified fall, adult failure to thrive, constipation, osteoarthritis, other specified disorder of right middle ear and mastoid and personal history of malignant neoplasm of prostate and tongue. The resident was discharged to an acute care hospital on [DATE]. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit Review of the progress note dated 02/07/26 at 1:50 P.M., authored by LPN #180 revealed the resident was drowsy and won't fully wake up. Took vitals and he was having tachycardia. Family wanted nurse to send him out to get evaluated. Called Certified Nurse Practitioner (CNP) on call who gave order to send him out. Review of the medical record revealed no evidence LPN #180 obtained an assessment or vital signs prior to the resident being transferred to the acute care hospital. On 02/12/26 at 11:32 A.M., an interview with Registered Nurse (RN) #133 revealed Resident #50's daughter came to her looking for LPN #180 due to feeling there was something wrong with her father. RN #133 revealed she couldn't find his nurse so she went back and obtained a set of vital signs. She said she remembers his<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | pulse was in the 120's to 130's and irregular. She said LPN #180 then entered the room and she reported her findings and LPN #180 took over. She revealed she doesn't remember if the resident had an elevated temperature or not. On 02/12/26 at 12:03 P.M., an interview with LPN #180 revealed his daughter reported he was drowsy, however she received in report he was up all night. The LPN revealed she obtained a set of vital signs and assessed him and found no negative findings that morning. She revealed she had no reason to reassess the resident until RN #133 reported the increased heart rate. She revealed a temperature was not obtained so she was unaware the resident had an increased temperature. The LPN verified she charted no assessment or vital signs in the residents electronic medical record. LPN #133 stated, I must have forgotten. On 02/17/26 at 9:30 A.M., an interview with the Director of Nursing (DON) verified the medical record contained no assessment or vital signs of the resident and the change in condition was not identified by the nurse timely. Review of the facility policy titled, Guidelines for General Wound and Skin Care, last revised 02/23/23 revealed perform wound treatments. Date, time and initial all dressings at time of application. This deficiency was an incidental finding discovered during the course of this complaint investigation. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to maintain appropriate infection control practices to prevent the potential spread of infection during a pressure ulcer dressing change. This affected one resident (#16) of three residents reviewed for skin breakdown. The facility census was 49. Findings Include:Review of the medical record for Resident #16 revealed an initial admission date of 11/19/25 with the diagnoses including but not limited to sepsis, urinary tract infection, osteomyelitis of vertebra, stage four pressure ulcer to sacral region, moderate protein calorie malnutrition, hypertension, congestive heart failure, encounter for palliative care, neuromuscular dysfunction of bladder, dementia, hyperlipidemia, hypothyroidism, cerebral infarction, adult failure to thrive and dysphagia. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent on staff for all activities of daily living (ADL). The assessment indicated the resident was at risk for skin breakdown and had one stage IV pressure ulcer that was present on admission and four unstageable pressure ulcers that were present on admission. The facility implemented the interventions of pressure reducing device to bed/chair pressure ulcer/injury care and applications of ointments/medications. Review of the plan of care dated 11/25/25 revealed the resident had a stage IV pressure ulcer to her sacrum, an unstageable to right scapula, right upper back, right calf and left heel. Interventions included administer analgesics as physician ordered, air mattress to bed, assess and record the condition of the skin surrounding the pressure ulcer, encourage fluids, observe and report signs of infection, observe and report signs of pain related to pressure ulcers, obtain a dietary consult, pressure reducing cushion to wheelchair, provide diet, supplements vitamins and minerals as ordered, treatments per physician order and notify physician if ineffective and weekly skin assessment, measurement and observation of the pressure ulcer and record. Review of the resident's physician orders for February 2026 identified orders dated 11/21/25 staff to use enhanced barrier precautions (EBP), wearing a gown and gloves at minimum during high-contact care activities, 11/24/25 cleanse left heel with normal saline, pat dry, paint with Betadine, leave open to air daily every Monday, Wednesday and Friday and as needed, 12/29/25 cleanse wound to right scapula with damp normal saline gauze and allow to dry, place calcium alginate over wound and cover with bordered foam dressing daily and as needed, 01/06/26 cleanse wound to sacrum with NS, pat dry, spray peri-wound skin with no sting barrier film, fill wound bed with calcium alginate, cover with foam dressing twice daily and as needed, 01/09/26 cleanse wound to right flank with NS gauze and allow to dry, place calcium alginate over wound and cover with border foam dressing daily and as needed and 02/11/26 cleanse wound to right posterior calf with NS, apply calcium alginate to wound bed and cover with bordered foam dressing daily and as needed. On 02/11/26 at 3:12 P.M., observation of Registered Nurse (RN) #183 and RN #133 provide the physician ordered treated to Resident #16's multiple pressure ulcers revealed staff sanitized their hands and donned gown and gloves as enhanced barrier precautions (EBP). RN #183 sanitized the bedside table, washed his hands and set up the required supplies. RN #183 removed the soiled dressing from the resident's right calf dated 02/09/26. The wound was pink in color with no necrotic tissue. RN #183 stated the current treatment to the wound was no longer appropriate and an order for calcium alginate and a bordered foam dressing would be obtained. The RN then removed the soiled dressings from the sacrum, right upper back and the right scapula using the same gloves. The RN then washed his hands and donned a pair of gloves and cleansed the right upper back and the right scapula with normal saline (NS), applied calcium alginate and covered the wounds with bordered foam dressing using the same gloves. The RN<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | then cleansed the wound to sacrum with NS and a split drain sponge, then packed the wound with calcium alginate and covered the wound with a bordered foam dressing. The RN then washed his hands due to leaving the room for additional supplies to complete the treatment to the resident's right posterior calf. The RN cleansed the wound to the right posterior calf with NS, pat dry, applied calcium alginate and covered the wound with a bordered foam dressing. The RN then obtained a betaine swap using the same gloves and painted the unstageable pressure ulcer to the left heel with the betadine swab. On 02/11/26 at 4:02 P.M., an interview with RN #183 verified the treatments to the five pressure ulcers were not separated introducing the potential to spread infection from wound to wound. Review of the facility policy titled, Guidelines for General Wound and Skin Care, last revised 02/23/23 revealed wash hands before and after resident contact. Dress chronic wounds using clean technique since all chronic wounds are contaminated. This deficiency was an incidental finding discovered during the course of this complaint investigation. |