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	04/30/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to properly store drugs and biologicals in the medication storage rooms and ensure all medications were properly stored in a secured location. This affected two of two medication rooms reviewed for medication storage. This affected Resident #31 and had the potential to affect all 49 residents in the facility.Findings include:1. An observation on [DATE] at 10:49 A.M. revealed in both of the facility's medication storage rooms, in the cabinets, multiple boxes containing 100 three milliliter (ml) syringes with expiration date of [DATE]. The medication storage areas also revealed multiple boxes containing tuberculin syringes with an expiration date of [DATE]. Observation in the freezer in the storage room revealed a single serve Vanilla Ensure (nutritional supplement), with an expiration date of [DATE]. The storage room's refrigerator revealed a 25 milligram (mg) Promethazine (anti-nausea) suppository with an expiration date of [DATE].During a subsequent interview on [DATE] at 10:57 A.M., Assistant Director of Health Services #165 confirmed the presence of the expired syringes, Ensure and Promethazine suppositoryReview of the facility's policy titled Medication Storage effective [DATE] revealed outdated medication must be immediately pulled from the active inventory.2. Review of Resident #31's medical record revealed the resident was admitted to the facility on [DATE]. Observation on [DATE] at 2:50 P.M. revealed lidocaine 4.0 percent (%) patches (over the counter topical anesthetic) on Resident #27's open bedside shelves.Interview on [DATE] at 3:05 P.M. with Registered Nurse (RN) #159 confirmed the lidocaine 4.0% patches were a medication and should be kept in locked storage, not at the bedside.

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

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	04/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to conduct care plan conferences at regular intervals for residents. This affected four (Residents #19, #50, #61, and #62) of four residents reviewed for care planning. The facility census was 49 residents.Findings include:1. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included unspecified dementia, chronic obstructive pulmonary disease, hypertension, depression, and dependence on wheelchair. Further review of Resident #50's medical record revealed the last documented care conference was 05/08/25. Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and was dependent for oral hygiene, toileting hygiene, shower or bathe self, lower body dressing, putting on or taking off footwear, and personal hygiene. Interview on 04/27/26 at 11:37 A.M. with Resident #50's representative revealed the facility has not been conducting care conferences since the previous social worker left six months ago. Interview conducted on 04/28/26 at 11:08 A.M. with Regional Social Services (RSS) #200 revealed the previous social worker had been absent from the facility for at least two months. RSS #200 stated the Administrator had been completing social services responsibilities during that time. RSS #200 stated care conferences were expected to be conducted within five to seven days following admission, quarterly thereafter, with significant changes in condition, or upon request. Interview conducted on 04/28/26 at 3:18 P.M. with the Executive Director (ED) revealed concerns related to completion of Resident First Meetings (RFMs) were identified by the facility in March 2026 and addressed through the Quality Assurance and Performance Improvement (QAPI) program. The ED stated the facility implemented education and audits; however, not all required care conferences had been completed at the time of the survey. The ED reported uncertainty regarding the last date a Resident First Meeting was conducted and confirmed the social worker position had been vacant since approximately November 2025. Follow-up interview conducted on 04/29/26 at 9:27 A.M. with the ED confirmed that required care conferences had not been completed for multiple residents listed on the facility's quarterly RFM tracking log, including Resident #50. The ED stated the facility planned to utilize the existing tracking list to complete outstanding care conferences until the facility returned to compliance. Review of the policy 'Resident's First Meeting Guidelines' undated revealed the facility requires interdisciplinary care conferences to be completed upon admission, quarterly, with significant change in condition, and as needed to evaluate and revise the resident's plan of care with participation from the resident and/or resident representative. 2. Review of Resident #61's medical record revealed an original admission date of 12/12/19 and had diagnoses that included Alzheimer's disease, anxiety disorder, and history of urinary tract infections. Further review of Resident #61's medical record revealed the last documented care conference was 07/31/25. (continued on next page)

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	04/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #61's MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and was dependent for toileting hygiene, shower or bathe self, putting on or taking off footwear, and personal hygiene. Interview on 04/27/26 at 12:04 P.M. with Resident #61's representative revealed facility has not been conducting care conferences since the previous social worker left. Interview conducted on 04/28/26 at 11:08 A.M. with RSS #200 revealed the previous social worker had been absent from the facility for at least two months. RSS #200 stated the Administrator had been completing social services responsibilities during that time. RSS #200 stated care conferences are expected to be conducted within five to seven days following admission, quarterly thereafter, with significant changes in condition, or upon request. Interview conducted on 04/28/26 at 3:18 P.M. with the ED revealed concerns related to completion of Resident First Meetings (RFMs) were identified by the facility in March 2026 and addressed through the Quality Assurance and Performance Improvement (QAPI) program. The ED stated the facility implemented education and audits; however, not all required care conferences had been completed at the time of the survey. The ED reported uncertainty regarding the last date a Resident First Meeting was conducted and confirmed the social worker position had been vacant since approximately November 2025. Follow-up interview conducted on 04/29/26 at 9:27 A.M. with the ED confirmed that required care conferences had not been completed for multiple residents listed on the facility's quarterly RFM tracking log, including Resident #61. The ED stated the facility planned to utilize the existing tracking list to complete outstanding care conferences until the facility returned to compliance. Review of the policy 'Resident's First Meeting Guidelines' undated revealed the facility requires interdisciplinary care conferences to be completed upon admission, quarterly, with significant change in condition, and as needed to evaluate and revise the resident's plan of care with participation from the resident and/or resident representative. 3. Review of Resident #62's medical record revealed that he was admitted to the facility on [DATE] and had diagnoses that included dementia, dysphagia, wedge compression fracture and need for assistance with personal care. Review of Resident #62's MDS 3.0 assessment dated [DATE] revealed that Resident #62 had a Brief Interview for Mental Status score of 03, indicative of severe cognitive impairment. He was assessed as being dependent for toileting hygiene and needing partial to moderate assistance with transfers. Review of Resident #62's medical chart revealed that Resident #62 had not had a care planning meeting since admission. An interview with RSS #200 on 04/28/26 at 11:08 A.M. revealed that care planning meetings were held within the first week of admission to the facility and then quarterly, with a significant change in condition, or upon request. An interview with the ED on 04/29/26 at 9:27 A.M. confirmed that Resident #62 had not had a care planning meeting since admission. (continued on next page)

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	04/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Review of the clinical record for Resident #19 revealed the resident was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, type two diabetes mellitus with peripheral angiopathy, atrial fibrillation, pulmonary hypertension, morbid obesity, and chronic obstructive pulmonary disease (COPD). Review of MDS-related documentation, including comprehensive assessments used to guide the resident's plan of care, indicated care planning should be driven by interdisciplinary input and ongoing reassessment of the resident's needs. Review of progress notes and documentation records revealed no documented evidence that care conferences were completed for Resident #19. Further review of facility tracking documentation for required Resident First Meetings (RFMs) and quarterly care conferences indicated multiple residents were listed as needing conferences that had not been completed. Resident #19 was identified on the facility's list of residents requiring a quarterly care conference. Interview conducted on 04/28/26 at 11:08 A.M. with Regional Social Services (RSS) #200 revealed the previous social worker had been absent from the facility for at least two months. RSS #200 stated the Administrator had been completing social services responsibilities during that time. RSS #200 stated care conferences were expected to be conducted within five to seven days following admission, quarterly thereafter, with significant changes in condition, or upon request. Interview conducted on 04/28/26 at 3:18 P.M. with the ED revealed concerns related to completion of Resident First Meetings (RFMs) were identified by the facility in March 2026 and addressed through the Quality Assurance and Performance Improvement (QAPI) program. The ED stated the facility implemented education and audits; however, not all required care conferences had been completed at the time of the survey. The ED reported uncertainty regarding the last date a Resident First Meeting was conducted and confirmed the social worker position had been vacant since approximately November 2025. Follow-up interview conducted on 04/29/26 at 9:27 A.M. with the ED confirmed that required care conferences had not been completed for multiple residents listed on the facility's quarterly RFM tracking log, including Resident #19. The ED stated the facility planned to utilize the existing tracking list to complete outstanding care conferences until the facility returned to compliance. Review of the facility policy titled Care Planning (policy date not specified) revealed the facility requires interdisciplinary care conferences to be completed upon admission, quarterly, with significant change in condition, and as needed to evaluate and revise the resident's plan of care with participation from the resident and/or resident representative.

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	04/30/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to ensure the call light was in reach for residents. This affected three (Resident #9, #27, and #50) of five residents reviewed for environment. The facility census was 49 residents.Findings include:Findings include:1.Review of Resident #9's medical record revealed the resident was originally admitted to the facility on [DATE] and had diagnoses including unspecified dementia, major depressive disorder, anxiety disorder, weakness, history of falling, feeding difficulties, unsteadiness on feet, and muscle weakness.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively impaired and required substantial or maximal assistance to roll left or right and to move from lying to sitting on the side of the bed.Review of Resident #9's plan of care for falls revealed a intervention to keep call light within reach with a start date of 12/16/20.Observation on 04/27/26 at 9:46 A.M. of Resident #9's call light revealed the call light was hanging below the railing on the left side of the bed.Observation on 04/29/26 at 8:01 A.M. of Resident #9's call light revealed the call light was hanging below the railing on the left side of the bed.Interview on 04/29/26 at 8:01 A.M. with Resident #9 revealed the resident did not know where the call light was located.Interview on 04/29/26 at 8:10 A.M. with Certified Resident Care Associate (CRCA) #300 confirmed Resident #9's call light was not within reach. 2. Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, depression, and cerebral atherosclerosis.Review of Resident #27's MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and was dependent for bed to chair transfer.Review of Resident #27's plan of care for falls revealed an intervention to keep call light in reach with a start date of 06/06/25.Observation on 04/27/26 at 9:31 A.M. of Resident #27 revealed the resident was up to a specialized wheelchair and situated on the right side of the bed. Resident #27's call light was hanging over the arm of a recliner chair positioned on the left side of the bed which was out of reach of the resident.Interview on 04/27/26 at 9:43 A.M. with Registered Nurse (RN) #159 confirmed Resident #27's call light was not within reach. 3. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease, hypertension, depression, and dependence on wheelchair.Review of Resident #50's MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and was dependent for oral hygiene, toileting hygiene, shower or bathe self, lower body dressing, putting on or taking off footwear, and personal hygiene.Review of Resident #50's plan of care for falls revealed an intervention to keep call light in reach with a start date of 07/18/23.Observation on 04/27/26 at 9:33 A.M. of Resident #50's call light revealed the call light was hanging below the railing on the right side of the bed.Interview on 04/27/26 at 9:43 A.M. with RN #159 confirmed Resident #50's call light was not within reach.Review of the policy ?Guidelines for Answering Call Lights' effective 05/11/26 revealed staff should ensure the call light is plugged in securely to the outlet and in reach of the resident.

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	04/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to report an allegation of injury of unknown origin. This affected one (Resident #27) of two residents reviewed for abuse. The facility census was 49 residents.Findings include:1. Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, depression, and cerebral atherosclerosis.Review of Resident #27's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making. Resident #27 required substantial or maximal assistance to roll left and right, move from sitting to lying, and move from lying to sitting on the side of bed. Resident #27 was dependent for bed to chair transfer and tub or shower transfer.Review of Resident #27's plan of care for falls revealed an intervention to provide an air mattress with bolsters to the bed with a start date of 06/17/25.Review of Resident #27's progress notes revealed a note dated 11/04/25 at 8:23 P.M. indicating a bruise was found on the resident's forehead at 8:00 A.M. and noted the resident's bumper pads and floor mats were in place prior to bruise being found. Further review of the progress note revealed the hospice nurse was notified at 8:44 A.M.Review of the Ohio Department of Health Application Gateway was silent for a Facility Reported Incident (FRI) for Resident #27.Review of Resident #27's Event Report dated 11/5/25 at 2:11 P.M. revealed documentation of an unwitnessed bruise and was linked to the progress note dated 11/04/25 that revealed the bruise was located on Resident #27's forehead. Further review of the event report revealed padding to grab bars was a preventative measure in place for the resident. Notifications of Resident #27's bruise were performed on 11/05/25 at 2:18 P.M.Further review Resident #27's progress notes revealed a note dated 11/05/25 at 2:24 P.M. that stated per Director of Health Services (DHS), resident might have bumped her head on the grab bars. Bruise measuring four centimeters long and four centimeters wide. Padding to grab bars in place.Further review of Resident #27's progress notes revealed a late entry note recorded on 11/26/25 for 11/05/25 at 3:22 P.M. revealed the Interdisciplinary Team (IDT) met regarding the bruise on the resident's forehead. The progress note stated based on appearance and location of the bruise, a possible root cause was Resident #27 bumped her head on the enabler bar while turning in bed.Interview on 04/26/26 with the Interim Director of Health Services #207 confirmed the bruise was not reported by staff timely. The Interim Director of Health Services #207 confirmed staff did not notify the Interim Director of Health Services until the following day on 11/05/25. When asked for the time of notification, the Interim Director of Health Services stated at the times documented in the progress note and referred to the progress notes documented on 11/05/25 at 2:24 P.M. and 11/05/25 at 3:22 P.M. Interim Director of Health Services #207 revealed the Executive Director and Regional Staff were notified of the bruise at that time. Further interview with the Interim Director of Health Services #207 revealed that normally an injury of unknown origin would be reported as a FRI; however, this injury of unknown origin was not reported because they suspected the possible cause was Resident #27 bumped her head on the enabler bar while turning in bed.Interview on 04/28/26 at 3:18 P.M. with the Executive Director confirmed only hospice was notified when the bruise was discovered. The Executive Director revealed he was probably told about the bruise in a CCM meeting. Further interview with the Executive Director revealed the injury of unknown origin was not reported as a FRI because the facility came to the conclusion that the bruise was from the enabler bar. The Executive Director stated there would not be a FRI if they knew where the bruise came from. The Executive Director was not aware of a formal investigation being completed for the bruise and did not know if Resident #27 had a history of bumping her head on the enabler bars.Interview on 04/28/26 at 3:18 P.M. with the Director of Health Services (DHS) who stated Resident #27 has not been observed bumping her head on the enabler bars.Interview on (continued on next page)

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	04/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/28/26 at 5:20 P.M. with Licensed Practical Nurse (LPN) #204 revealed she was alerted to the presence of a bruise on Resident #27's forehead. LPN #204 confirmed Resident #27 was unable to report where the injury came from because the resident was confused. LPN #204 was unable to provide a date or time of notification to facility management. LPN #204 confirmed hospice was notified of the bruise upon discovery.Review of the policy ?Abuse, Neglect and Exploitation Procedural Guidelines' effective 01/2019 and reviewed 11/19/25 revealed staff should ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source or misappropriate of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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	04/30/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to investigate an allegation of injury of unknown origin for Resident #27. This affected one (Resident #27) of two residents reviewed for abuse. The facility census was 49 residents.Findings include:Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, depression, and cerebral atherosclerosis.Review of Resident #27's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making. Resident #27 required substantial or maximal assistance to roll left and right, move from sitting to lying, and move from lying to sitting on the side of bed. Resident #27 was dependent for bed to chair transfer and tub or shower transfer.Review of Resident #27's plan of care for falls revealed an intervention to provide an air mattress with bolsters to the bed with a start date of 06/17/25.Review of Resident #27's progress notes revealed a note dated 11/04/25 at 8:23 P.M. revealed a bruise was found on the resident's forehead at 8:00 A.M. and noted the resident's bumper pads and floor mats were in place prior to bruise being found. Further review of the progress note revealed the hospice nurse was notified at 8:44 A.M.Review of Resident #27's Event Report dated 11/5/25 at 2:11 P.M. revealed documentation of an unwitnessed bruise and was linked to the progress note dated 11/04/25 that revealed the bruise was located on Resident #27's forehead. Further review of the event report revealed padding to grab bars was a preventative measure in place for the resident. Notifications of Resident #27's bruise were performed on 11/05/25 at 2:18 P.M.Further review Resident #27's progress notes revealed a note dated 11/05/25 at 2:24 P.M. that stated per Director of Health Services (DHS), resident might have bumped her head on the grab bars. Bruise measuring 4 centimeters long and 4 centimeters wide. Padding to grab bars in place.Further review of Resident #27's progress notes revealed a late entry note recorded on 11/26/25 for 11/05/25 at 3:22 P.M. revealed the Interdisciplinary Team (IDT) met regarding the bruise on the resident's forehead. The progress note stated based on appearance and location of the bruise, a possible root cause was Resident #27 bumped her head on the enabler bar while turning in bed.Interview on 04/26/26 with the Interim Director of Health Services #207 confirmed the bruise was not reported in a timely manner by staff as the bruise was not reported to management until the following day on 11/05/26 at the times documented in the progress notes. Further interview with the Interim Director of Health Services #207 revealed that normally an injury of unknown origin would be reported as a Facility Reported Incident (FRI); however, this injury of unknown origin was not reported because they suspected the possible cause was Resident #27 bumped her head on the enabler bar while turning in bed. The Interim Director of Health Services #207 stated she thinks she interviewed staff and looked at other residents but does not recall if this was investigated.Interview on 04/28/26 at 3:18 P.M. with the Executive Director revealed he was not aware of a formal investigation being completed for the injury of unknown origin.Interview on 04/29/26 at 11:25 A.M. with the Director of Health Services (DHS) revealed the DHS had discovered a file on the abuse investigation for Resident #27. Further interview with the Director of Health Services (DHS) revealed Interim Director of Health Services #207 had put some stuff together for the abuse investigation at the time it happened.Review 04/29/26 at 11:25 A.M. of the abuse investigation for Resident #27 provided by the facility revealed an Event Report dated 11/05/26 and shower sheets for like residents examined at the time of the event.Interview on 04/29/26 at 2:03 P.M. with DHS confirmed the investigation was not thorough as the investigation did not include witness statements from staff or any resident interviews. Review of the policy ?Abuse, Neglect and Exploitation Procedural Guidelines' effective 01/2019 and reviewed 11/19/25 revealed the investigation includes identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.

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	04/30/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, staff interviews and review of facility policy, the facility failed to issue a bed hold letter for a resident upon discharging to the hospital. Additionally, the facility failed to notify the Ombudsman of the discharge status of two residents. This affected two residents (#64 and 66) out of two residents reviewed for discharge. The facility census was 49 residents.Findings include: 1. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE] and had diagnoses including wedge compression fractures, type two diabetes mellitus and chronic kidney disease. Review of Resident #64's Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed intact cognitive status and receiving opioid medication.Review of Resident #64's nursing progress notes dated 03/16/26 revealed Resident #64 wanted to leave the facility. Resident #64 expressed a desire for his pain medications to be changed. Resident #64 was given options to stay at the facility to allow time to plan for a safe discharge, to leave the facility against medical advice or to discharge to the hospital to be evaluated for possible altered mental status changes. Resident #64 chose to be discharged to the hospital. Review of the discharge observation report dated 03/16/26 revealed that Resident #64 was transferred to the hospital and that the transfer was necessary to meet the resident's welfare and the resident's needs could not be met at the facility. The discharge observation revealed that the Ombudsman would be notified of the discharge monthly. Review of Resident #64's medical record revealed that there was not proof that a notification had been made to the long term care Ombudsman and there was not proof that a bed hold letter had been given to Resident #64 or his representative. An interview with Regional Social Services Support #200 on 04/29/26 at 10:25 A.M. confirmed that the facility did not have proof that a bed hold letter had been sent to or given to Resident #64 or his resident representative. The interview also confirmed that the facility had not yet sent the long term care Ombudsman notification that Resident #64 had been sent to the hospital on [DATE]. 2. Review of the medical record revealed that Resident #66 was admitted to the facility on [DATE] and had diagnoses including acute respiratory disease, cirrhosis of the liver and chronic diastolic heart failure. Review of Resident #66's admission observation report dated 02/18/26 revealed that Resident #66 was admitted for therapy and had intact cognition. Review of Resident #66's MDS 3.0 assessment dated [DATE] revealed that Resident #66 had a BIMS score of 15, indicative of intact cognitive status. Review of Resident #66's nursing progress notes dated 02/19/26 revealed that Resident #66 left the facility against medical advice. Review of Resident #66's medical record revealed that there was not proof that the long term care Ombudsman had been notified of Resident #66's discharge from the facility on 02/19/26. An interview with Regional Social Services Support #200 on 04/29/26 at 10:35 A.M. confirmed that the facility had not sent the long-term care Ombudsman notification that Resident #66 had been discharged from the facility on 02/19/26. Review of the facility policy titled, Guidelines for Transfer and Discharge, reviewed on 12/08/25, revealed that before the facility transfers a resident to a hospital, nursing staff should provide written information to the resident and a family member or representative of the bed hold and admission policies. Review of the facility discharge observation report revealed that the facility would notify the long term care Ombudsman of discharges monthly.

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	04/30/2026

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** Based on review of resident medical record, review of resident hospital records, and staff interviews, the facility failed to accurately transcribe a diet order for a resident. This affected one resident (#67) out of four residents reviewed for food. The facility census was 49 residents. Findings include: Review of a resident medical record revealed that Resident #67 was admitted to the facility on [DATE] and had medical diagnoses that included traumatic brain injury, dysphagia, and acute respiratory failure with hypoxia. Review of Resident #67's hospital medical record dated 04/24/26 revealed that Resident #67 had hypoxia, which was possibly related to bouts of aspiration pneumonitis due to pocketing food. The hospital notes dated 04/24/26 indicated that Resident #67 was started on a soft and bite sized diet with mildly thickened liquids. Review of Resident #67's hospital after visit summary dated 04/24/26 revealed that Resident #67 was prescribed a discharge diet of soft and bite sized foods with mildly thickened liquids. Review of Resident #67's facility admission assessment dated [DATE] revealed that Resident #67 had no swallowing problems. The baseline care plan goal dated 04/24/26 revealed that goal was for Resident #67's weight to remain stable, and the approach was to follow Resident #67's diet per physician orders. Review of Resident #67's diet orders revealed that on 04/24/26 through the survey end date of 04/30/26, Resident #67's physician orders in his electronic medical chart included a consistent carbohydrate diet, pre-cut meats, regular/ thin liquids, with special instructions to include Styrofoam cups. Review of Resident #67's nursing progress notes dated 04/24/26 through 04/27/26 were silent for indications of communications with the facility physician regarding switching Resident #67's diet orders. Review of Resident #67's Brief Interview for Mental Status assessment dated [DATE] revealed that Resident #67 had a score of 4, indicative of severe cognitive impairment. Review of Resident #67's speech therapy assessment dated [DATE] at 1:32 P.M. revealed that Resident #67 was assessed as having mild to moderate oropharyngeal dysphagia, characterized by prolonged mastication, incomplete bolus formation, pocketing and diffuse oral residue as well as incomplete airway protection; however, he was assessed to be safe to consume regular textures with thin liquids with compensatory feeding strategies in place. Review of Resident #67's nutrition assessment dated [DATE] at 3:16 P.M. revealed that Resident #67 was on a consistent carbohydrate diet and thin liquids. Dietitian #250 indicated in the assessment that Resident #67's hospital records indicated that Resident #67 was receiving a soft and bite sized diet with mildly thick liquids at the hospital. The current diet order was pre-cut meats on a regular diet texture with thin liquids. Speech therapy was reviewing the diet textures and liquid thickness. Observation of Resident #67 on 04/27/26 at 9:31 A.M., 04/28/26 at 5:10 P.M., and 04/29/26 A.M. revealed that Resident #67 was consuming a consistent carbohydrate diet with pre-cut meats with thin liquids. An interview with the Director of Health Services on 04/28/26 at 5:37 P.M. confirmed that Resident #67's physician diet orders starting 04/24/26 did not match the hospital discharge diet orders of soft and bite sized food with mildly thick liquids. An interview with Area Director of Food Services #106 on 04/29/26 at 8:24 A.M. revealed that the electronic medical charting system is tied live to the tray card system, so the orders in the electronic medical charting system would be consistent with the diet that the resident received. An interview with Speech Therapist #210 on 04/30/26 at 10:07 A.M. revealed that she assessed Resident #67's swallowing function at the lunch meal on 04/27/26 and determined Resident #67 to be safe to swallow regular textures and thin liquids. Speech Therapist #210 confirmed that the diet order from the hospital after visit summary was not implemented into Resident #67's admission orders on 04/24/26.

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	04/30/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to change oxygen tubing as ordered by the physician and facility policy. This affected one (Resident #30) of two residents reviewed for oxygen services. The facility census was 49.Findings include:Review of Resident #30's medical record revealed an admission date of 11/22/25 and diagnoses included chronic obstructive pulmonary disease.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was cognitively intact and received oxygen therapy.Review of Resident #30's physician orders dated 01/02/26 revealed an order to change oxygen tubing monthly.Observation on 04/27/26 at 10:22 A.M. revealed Resident #30's oxygen tubing was dated as last changed on January 20 (no year).Interview on 04/27/26 at 10:30 A.M. with Registered Nurse (RN) #159 confirmed Resident #30's oxygen tubing was dated as last changed on January 20 (no year) and should have been changed sooner.Review of the facility's policy titled 'Administration of Oxygen' effective 05/2018 revealed oxygen tubing should be changed monthly and as needed. This deficiency represents non-compliance investigated under Complaint Number 2989132.

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	04/30/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the monthly pharmacy recommendations, staff interviews, and review of facility policy, the facility failed to address pharmacy recommendations in a timely manner for the residents. This affected three (#11, #27, and #54) of five residents reviewed for unnecessary medications. The facility census was 49.Findings include: 1. Review of the resident medical record revealed Resident #54 was admitted to the facility on [DATE].Diagnoses included abdominal aortic aneurysm and posthemorrhagic anemia. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 had intact cognition. Review of the care plan dated 01/09/26 revealed Resident #54 had potential for experiencing symptoms of fatigue, weakness and confusion related to anemia. A goal was for Resident #54 to be free from complications associated with anemia. An intervention was to monitor labs as ordered. Review of Resident #54's complete blood count on 01/21/26 revealed she had a hemoglobin level of 7.8 grams per deciliter, with a normal range being between 11.1 and 15.9 grams per deciliter, and a hematocrit level of 25 percent (%), with a normal range indicated as 34 to 46.6%. Review of Resident #54's pharmacist drug regimen review dated 02/12/26 revealed Resident #54 had a low hemoglobin level in January 2026. The pharmacist recommended to review and consider if any additional follow up or additional treatment would be beneficial. The provider response to the recommendation was to accept the recommendation on 02/26/26. The pharmacy recommendation was reviewed with the nurse practitioner and the facility would redraw a complete blood count. There was no documentation of a complete blood count completed for Resident #54 from 02/26/26 to 03/12/26. Review of Resident #54's pharmacist drug regimen review dated 03/12/26 revealed the pharmacist again recommended rechecking a complete blood count. The undated provider response was to accept the recommendation. Review of the laboratory results revealed Resident #54 had a complete blood count redrawn on 03/25/26 in response to the recommendations from the pharmacist on 02/12/26 and 03/12/26. The hemoglobin level was 8.0 grams per deciliter, indicating a low level of hemoglobin. An interview with the Director of Heath Services on 04/29/26 at 4:01 P.M. confirmed the pharmacy recommendations to complete a complete blood count for Resident #54 on 02/12/26 were not completed in a timely manner. 2. Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety disorder, depression, and cerebral atherosclerosis. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had severely impaired cognitive skills for daily decision making and received scheduled and as needed pain medications. (continued on next page)

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	04/30/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's physician orders dated 06/02/25 revealed an order for morphine solution 20 milligrams (mg) per five milliliters (mL) (four mg per mL) give 0.25 orally every four hours as needed. Review of the Pharmacist Drug Regimen Review dated 07/28/25 noted an order for morphine 20 mg per five mL with instructions to take 0.25 every four hours as needed. The recommendation was to review and verify or clarify product concentration and specify directions as the ordered strength of morphine does not match the resident's orders from assisted living. There was no noted response by the physician. The physician orders dated 08/03/25 revealed an order for morphine concentrate 100 mg per five mL (20 mg per mL) give 0.25 mL orally three times a day. Review of the Pharmacist Drug Regimen Review dated 08/21/25 revealed an order for morphine 20 mg per five mL with instructions to take 0.25 every four hours as needed in addition to a routine order for morphine concentrate 100 mg per five mL (20 mg per mL). The recommendation to review and verify or clarify product concentration for the as needed order as this could be potential for a medication error. There was no noted response by the physician. Review of the Medication Administration Records (MARs) from July 2025 to April 2026 revealed Resident #27 received multiple administrations of morphine solution as needed pain. Interview on 04/29/26 at 12:16 P.M. with Licensed Practical Nurse (LPN) #101 confirmed the only strength of morphine available for Resident #27 was morphine 100 mg per five mL (20 mg per mL) and was being used for both scheduled and as needed administrations. Interview on 04/29/26 2:03 P.M. with the Director of Health Services confirmed the order for 20 mg per five mL (four mg per mL) should have been clarified on 06/02/25 because the pharmacy will not send that strength of morphine. The Director of Health Services confirmed pharmacy recommendations should be completed within 14 days of receipt but were not being completed by the facility. The facility initiated a Quality Assurance and Performance Improvement (QAPI) plan and was in the process of completing audits and deciding who will be responsible for each part of the pharmacy recommendation process. 3. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic medical and psychiatric conditions requiring ongoing medication management and monitoring. The Minimum Data Set (MDS) assessment revealed Resident #11 had active diagnoses requiring routine clinical monitoring, placing the resident at risk for adverse outcomes if medication-related issues were not addressed. Review of the Pharmacist Drug Regimen Review dated 07/21/25 revealed additional recommendations, including laboratory monitoring, with no documented response or evidence the recommendations were reviewed or implemented. There was no evidence the physician responded to the recommendation in the medical record. Interview with the Director of Nursing on 04/29/26 at 2:03 P.M. revealed pharmacy recommendations were not being completed when she started at the facility. The Director of Nursing stated the facility is addressing this through a Quality Assurance and Performance Improvement (QAPI) plan, including (continued on next page)

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	04/30/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	auditing pharmacy recommendations and assigning responsibility for completion. The Director of Nursing confirmed pharmacy recommendations should be completed within 14 days of receipt. Review of the facility policy titled Pharmacy Recommendations Standard Operating Procedure (revised 12/16/24) revealed the facility is responsible to ensure pharmacy recommendations are reviewed by the provider, acted upon as appropriate, documented in the medical record, and completed within an expected timeframe.

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	04/30/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to implement non-pharmacological interventions in the management of a resident's pain. This affected one (Resident #27) of five residents reviewed for unnecessary medications. The facility census was 49.Findings include:Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia and anxiety disorder.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had severely impaired cognitive skills for daily decision making and received scheduled and as needed pain medications.Review of the physician orders dated 06/02/25 revealed an order for morphine solution as needed for pain.Review of Resident #27's care plan for pain revealed an intervention to attempt non-pharmacological interventions with a start date of 07/10/25.Review of the Medication Administration Records (MARs) from July 2025 to April 2026 revealed Resident #27 received multiple administrations of morphine solution as needed pain. Further review of Resident #27's MARs and progress notes for this time period were absent for documentation of non-pharmacological interventions attempted in the management of Resident #27's pain.Interview on 04/29/26 at 4:01 P.M. with the Director of Health Services confirmed non-pharmacological interventions were not attempted in the management of Resident #27's pain.Review of the policy titled Guidelines for Pain Observation and Management with a revision date of 12/16/25 revealed care plan approaches should be implemented to assist with pain management.

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	04/30/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and review of facility policy, the facility failed to maintain a proper containment system for soiled personal protective equipment for a resident. This affected one (Resident #26) of five residents reviewed for infection control. The facility census was 49. Findings include: Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included severe sepsis with septic shock, recurrent enterocolitis due to clostridium difficile, and encounter for attention to colostomy. Review of the comprehensive Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #26 required substantial to maximal assistance from staff with toileting hygiene. Review of Resident #26's hospital record dated 04/15/26 revealed Resident #26 had clostridium toxin B detected, but not active infection, and she was a carrier of clostridium toxin. In response, Resident #26 was on oral vancomycin, an antibiotic. Review of Resident #26's care plan dated 04/27/26 revealed Resident #26 required contact precautions during high contact care related to being a carrier of clostridium difficile and colostomy status. A goal was to minimize the risk of transmission of infection. An approach listed was to don and doff and dispose of personal protective equipment systematically and appropriately per policy. An observation of Resident #26's room on 04/27/26 at 10:00 A.M. revealed there was not a containment system to dispose of soiled personal protective equipment present in the room nor outside the resident's door. An interview with Licensed Practical Nurse (LPN) #101 on 04/27/26 at 10:02 A.M. confirmed there was not a containment system for soiled personal protective equipment in Resident #26's room. Review of the facility policy titled Contact Precautions revised on 02/28/24, revealed personal protective equipment such as gown and gloves, should be disposed of in a biohazard container before leaving the resident's room.