

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Nhc Healthcare, Smithville		STREET ADDRESS, CITY, STATE, ZIP CODE 825 Fisher Ave Smithville, TN 37166	

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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to resubmit a Pre-Admission Screening and Resident Review (PASRR) to include an active mental health condition present upon admission for 1 resident (Resident #74) of 7 residents reviewed for PASRR.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR), revised 11/2016, revealed .all centers to screen patients before admission to determine if they have Mental Illness, Intellectual or Developmental Disability or related condition .It must be determined whether this individual requires the level of services provided by a health care center or whether they need specialized treatment .Center should refer any patient for a Level II resident review upon a significant change in status/condition such as newly evident or possible serious mental disorder .</p> <p>Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Dementia, Anxiety, and Psychotic Disorder with Delusions.</p> <p>Review of a Physician's Order for Resident #74 dated 1/6/2025, revealed .Rexulti [anti-psychotic medication] 0.5 mg [milligram] po [by mouth] daily for Psychotic Disorder with Delusions .</p> <p>Review of the Notice of PASRR Level I Screen Outcome for Resident #74 dated 1/6/2025, revealed .No PASRR Level II Required .DIAGNOSIS .Anxiety Disorder .Dementia/Neurocognitive Disorder . Further review revealed Psychotic Disorder with Delusions was not included as an active mental health diagnosis.</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #74 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident had active diagnoses of Dementia, Anxiety, and Psychotic Disorder.</p> <p>Review of the comprehensive care plan for Resident #74 dated 1/17/2025, revealed .Psychiatric conditions . at risk for complications r/t [related to] Psychotic Disorder with Delusions .</p> <p>(continued on next page)</p>

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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/2025 at 2:02 PM, the Assistant Director of Nursing (ADON) stated she was responsible for resubmitting the PASRRs at the facility. The ADON confirmed the mental health condition of Psychotic Disorder with Delusions was active upon admission and was not included as a diagnosis on the PASRR dated 1/6/2025. The ADON stated a new PASRR for Resident #74 should have been resubmitted after admission to include the diagnosis of Psychotic Disorder with Delusions.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003</p> <p>Based on facility policy review, medical record review, and interviews, the facility failed to ensure the medical record was accurate for 1 resident (Resident #37) of 25 residents reviewed for accurate medical records.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Introduction to Documentation For Inpatient Medical Records, dated 11/2023, revealed .It is the responsibility of each health care center to establish and maintain comprehensive records which accurately reflect all aspects of the organization .Professional Standards of Documentation . Observations .assessments/evaluations .are accurately recorded .</p> <p>Review of the medical record revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Hypertensive Heart Disease with Heart Failure, Neoplasm of Respiratory System, Major Depression, Peripheral Vascular Disease, and Malnutrition.</p> <p>Review of a comprehensive care plan for Resident #37 dated 2/12/2024, revealed .Nutrition .At risk for malnutrition .Pt [patient] at risk for wt [weight] fluctuations r/t [related to] CHF [congestive heart failure] .Hx [history] of wt fluctuations w/ [with] significant wt loss [2/2025] w/ decreased intakes and refusal of meals . Obtain weights as ordered and observe for significant change .</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #37 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment.</p> <p>Review of the medical record for Resident #37 revealed the resident weighed 170.9 pounds (lbs.) on 1/27/2025; 221 lbs. on 1/30/2025; 159.4 lbs. on 2/6/2025; 158.8 on 2/24/2025.</p> <p>During an interview on 2/26/2025 at 2:00 PM, the Registered Dietician (RD) stated she felt the documented weight of 221 lbs. on 1/30/2025 for Resident #37 was inaccurate. The RD stated the resident's weights had consistently been in the 170's until the end of January and the resident's weight was currently stable.</p> <p>During an interview on 2/26/2025 at 2:30 PM, the Restorative Nurse stated she felt the documented weight of 221 lbs. on 1/30/2025 for Resident #37 was inaccurate.</p> <p>During a telephone interview on 2/26/2025 at 3:05 PM, Licensed Practical Nurse (LPN) A stated the electronic documentation system gave a pop-up warning if the weight was out of range and the staff had the capability to look at previous weights for comparison. LPN A stated if Resident #37's weight was flagged as out of range, she would have requested a reweigh. LPN A stated .sounds like the one [Resident #37's weight on 1/30/2025] was incorrect .there are multiple weights documented, so I could have documented someone else's weight .</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 3:40 PM, Family Nurse Practitioner (FNP) stated the weight of 221 lbs. on 1/30/2025 for Resident #37 was .an inaccurate weight .no way .[weight gain] would not even happen with fluid overload .</p> <p>During an interview on 2/26/2025 at 3:53 PM, the Assistant Director of Nursing (ADON) stated her expectation was the staff would accurately enter documentation in the medical record and confirmed Resident #37's recorded weight for 1/30/2025 was inaccurate.</p> <p>During a telephone interview on 2/27/2025 at 9:15 AM, Certified Nursing Assistant (CNA) B stated he recalled obtaining a weight of 221 lbs. for Resident #37. CNA B stated he entered Resident #37's weight in the computer, then reported the resident's weight to the day shift and night shift nurse. CNA B stated the nurses looked at Resident #37's previous weights and stated the weight was .off quite a bit . CNA B stated he reweighed Resident #37, but could not recall the re-weight value, but it was close to his baseline (150's to 170's). CNA B stated the weight was amended in the electronic documentation system to reflect the new weight. CNA B stated .it [new weight] .must not have taken [saved in the electronic documentation system] .</p>		