STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365317	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithville Western Care Center	4110 East Smithville Western Road Wooster, OH 44691

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review and review of the facility policy the facility failed to ensure Resident #86 directed his own medical care. This affected one resident (Resident #86) out of three residents reviewed for resident rights. The facility census was 85. Findings include: Review of Resident #86's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included pneumonia, acute respiratory failure with hypoxia and hypercapnia, morbid obesity, bacteremia and type two diabetes mellitus with hyperglycemia. Review of Resident #86's care plan dated 12/01/24 included Resident #86 had the potential for altered respiratory status related to pneumonia, acute respiratory failure with hypoxia and hypercapnia history of PE (pulmonary embolus) and other diagnoses. Resident #86 would have breathing comfort with no dyspnea. Interventions included to assess respiratory status, assess breath sounds, position to facilitate breathing and comfort, suction as needed, administer oxygen as ordered; report difficulty breathing to charge nurse. Resident #86 had an infection related to sepsis and pneumonia. Resident #86 would be free of signs and symptoms of infection with no complications. Interventions included to report any abnormalities to the physician; administer medications as ordered, monitor for side effects and effectiveness, monitor for adverse reactions. Review of Resident #86's Admission Minimum Data Set assessment dated [DATE] revealed Resident #86 was cognitively intact. Resident #86 was dependent for toileting, upper and lower body dressing, and the ability to bathe self was not attempted due to medical condition or safety concerns. Resident #86 received oxygen therapy and used a non-invasive mechanical ventilator. Review of Resident #86's History and Physical dated 12/06/24 and completed by Physician #202 included Resident #86 was admitted to the facility for acute, chronic hypoxic and hypercapnic respiratory failure, pneumonia and other diagnoses. Resident #86 had a cough, dyspnea (difficult or labored breathing) and was on oxygen therapy. Review of Resident #86's progress notes including physician notes dated 12/06/24 through 12/15/24 did not reveal evidence Resident #86 was examined and evaluated by Physician #202. Review of Resident #86's progress notes dated 12/11/24 at 9:07 P.M. included Resident #86 used six liters of oxygen per minute and his breath sounds were cta (clear throughout). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's progress notes dated 12/12/24 at 10:40 A.M. included Resident #86 stated I feel like my pneumonia is back, I was running a fever off and on, pulse ox was 88 percent with my CPAP on. Lab results from today compared to previous results, and oxygen saturation was 92 to 93 percent on CPAP. Lung sounds clear with diminished bases. Temperature 99.1 degrees Fahrenheit. Physician #202 was notified of today's lab results and past CO2 and WBC results, lung sounds, oxygen saturation reading and Resident #86's complaints. Physician #202 was notified of Resident #86 requesting chest x-ray, but portable not able to be performed due to resident size. The physician replied no to hospital x-ray and to use CPAP during the day. Review of Resident #86's progress notes dated 12/12/24 at 6:29 P.M. included Resident #86's oxygen saturation was monitored throughout the day and readings were 90 to 93 percent with oxygen on at six liters via nasal cannula or 10 liters while on CPAP. Resident #86 continued to report his oxygen saturation was 88 to 90 percent. Resident #86's respirations were even and unlabored, with no respiratory distress noted. Resident #86's skin was pink, warm and dry. Review of Resident #86's progress notes dated 12/13/24 at 8:32 A.M. included assessment completed due to Resident #86 continued to state I know I have pneumonia. Resident #86's skin color was pink, warm and dry, respirations were even and unlabored. CPAP in place as ordered and oxygen saturations was 96 percent. Resident #86's physician was in the facility and updated on Resident #86's vital signs. Review of Resident #86's progress notes dated 12/13/24 at 3:13 P.M. included the nurse was called to Resident #86's room to evaluate and speak to him. Resident #86 inquired what could be done in the facility versus what was done in the hospital for treatment of pneumonia. Resident #86 was told the facility could administer all the same medications that were ordered as in the hospital setting if they were ordered by the physician. Resident #86 stated he got aerosols around the clock in the hospital. The nurse explained the facility could do the same if the aerosols were ordered. Resident #86 was not short of breath during the conversation, did not have to stop talking to breathe, nor was he sitting straight up at the time. Resident #86 was advised if he felt shortness of breath, the nurse could see what medications were available. The nurse also suggested Resident #86 sit upright and use proper body alignment. The nurse offered to get assistance to help Resident #86 properly align self. Resident #86 refused the medication check, but did raise the head of the bed and straighten self in alignment with the bed without assistance. Resident #86 was not using accessory muscles when breathing. Review of Resident #86's late entry progress note dated 12/15/24 at 9:06 A.M. revealed on 12/13/24 at 4:55 P.M. the DON had a discussion with Resident #86's primary care provider and it was okay to start an antibiotic (Levaquin) as a precaution to pneumonia. It was explained to Resident #86 that if he had pneumonia the antibiotic was the appropriate treatment. Resident #86 stated he lived three hours from the nearest hospital and he wanted the chest x-ray to make sure he was getting better, not that he felt like he had pneumonia currently. It was explained to Resident #86 that he would need to be sent through the ED and then admitted per the hospital protocol, and that a preventive x-ray was not really an emergency so would have to schedule transport via non emergency transportation. Resident #86 became angry and started swearing, and Resident #86 was given his space. Resident #86's wife called and stated the antibiotic was fine and Resident #86 was worried for when he returned home. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's progress notes dated 12/15/24 at 2:13 A.M. included Resident #86 had a cough and wanted to go to the hospital for a chest x-ray (could not be done at the facility due to body habitus). Resident #86 was started on Levaquin and was unhappy about not being evaluated at the hospital. When his pin care was completed at 1:00 A.M. Resident #86 noted redness around the pins and wanted to go to the hospital right then. Review of Resident #86's progress notes dated 12/15/24 at 7:21 A.M. included around 1:00 A.M. Resident #86 verbalized dissatisfaction that he had not gone to the hospital for a chest x-ray. Resident #86 was reminded he was on Levaquin just in case and he took his first dose. Resident #86 had his mind set that he should have gone out for an x-ray and wanted the facility to call the physician and go to the hospital for an evaluation at this time. Resident #86 was sent to the ER per his request and his physician, wife and on-call nurse were notified. Interview on 01/09/25 at 11:09 A.M. of Resident #86 and Family Member (FM) #200 revealed Resident #86 developed a respiratory infection that started about a week after he was admitted to the facility. Resident #86 stated staff came in the room without face masks and had hoarse, deep coughs, and after that he developed a cough. FM #200 stated facility staff argued with her and said they could not do a portable chest x-ray at the facility because Resident #86 was too big, and they would not even try. FM #200 stated she did not know if an x-ray was ever ordered. Resident #86 and FM #200 stated Resident #86 definitely asked for a chest x-ray because he had a respiratory infection. Resident #86 stated he did not talk to and was not examined by a physician or nurse practitioner after he thought he had pneumonia was definitely upset about the situation. Interview on 01/13/25 at 3:44 P.M. of the Director of Nursing (DON) revealed Resident #86 was unable to have a portable chest x-ray at the facility due to body habitus, and was not sent to the hospital for a chest x-ray. The DON confirmed Physician #202 did not order a chest x-ray for Resident #86 and told the nurses not to send him to the hospital where he could have a chest x-ray. The DON indicated even if Resident #86 had a chest x-ray at the hospital and it showed he had pneumonia, the treatment with the antibiotic Levaquin would be the same as what he was already receiving at the facility. The DON confirmed Physician #202 did not examine Resident #86 or talk to him from 12/06/24 until he went to the hospital on 12/15/24 and stated she could not make Physician #202 see Resident #86. The DON indicated she had a discussion with Resident #86 and told him the hospital protocol was he could not have a chest x-ray if he went to the ER, and he would have to be admitted if a chest x-ray was ordered. Review of the Ohio Health Care Association policy titled Resident Rights and Facility Responsibilities included the facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The resident had the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including the resident had a right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part. This deficiency represents non-compliance investigated under Complaint Number OH00160965.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review, Self-Reported Incident (SRI) review, and review of facility policy the facility failed to ensure Resident #88's privacy was maintained. This affected one resident (Resident #88) out of three residents reviewed for privacy. The facility census was 88. Findings Include: Review of Resident #88's medical record revealed an admitted [DATE], a re-entry date of 05/01/23 and a discharge date of [DATE]. Diagnoses included paraplegia, type two diabetes mellitus with diabetic neuropathy, morbid obesity, bipolar disorder and anxiety disorder. Review of Resident #88's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #88 was cognitively intact. Resident #88 was dependent for toileting and personal hygiene, and upper and lower body dressing. Review of Resident #88's care plan dated 02/09/23 included Resident #88 had the potential for altered behavior patterns, disruptive interactions, disruptive verbally, resistive to care, violence, anger, agitation and, or anxiety. Resident #88 was verbally abusive to staff, cursed at staff, and was rude and demanding. Resident #88 made sexually inappropriate comments to staff at times, used inappropriate language including racial slurs. Resident #88 would be calm in a secure environment. Resident #88 would cope with routine, occurrences were minimized and Resident #88 would interact with staff and others appropriately. Interventions included to removed from public area when behavior was unacceptable, keep environment calm and relaxed, convey acceptance of resident during periods of inappropriate behavior and obtain help if resident became abusive or resistive; praise positive behavior, watch for signs of increasing anxiety and, or agitation, keep voice soft, establish routines and redirect as needed. Review of Resident #88's progress notes dated 10/05/24 through 10/08/24 did not reveal documentation regarding an incident on 10/07/24 involving Resident #88, Licensed Practical Nurse (LPN) #204 and other staff members. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a SRI Form tracking number 252783 dated 10/08/24 revealed on 10/08/24 Certified Nursing Assistant (CNA) #208 reported LPN #204 was allegedly arguing with Resident #88 and allegedly had her phone out and was possibly recording the conversation. LPN #204 was immediately removed from the schedule and suspended until the facility investigation was completed. CNA #208 stated she did not witness the allegations but heard it from CNA #205. CNA #205 allegedly witnessed LPN #204 and Resident #88 in a heated verbal exchange in Resident #88's room. CNA #205 alleged seeing LPN #204's cell phone on the treatment cart recording the altercation and witnessed CNA #209 with her phone out recording the altercation. CNA #209 was suspended pending the facility investigation outcome. Interview of staff revealed Resident #88 was yelling at LPN #204 and calling her racial names throughout the night. The interviews revealed LPN #204 voice recorded the conversation she had with Resident #88 with his permission. Review of the recording revealed no identifying information. The interviews revealed CNA #209 did not have her phone out in Resident #88's room and was not recording. Staff would be educated on cell phone use, abuse policy, and call light policy. LPN #204 would complete additional education for customer service. Resident #88 experienced no change in condition and remained at his baseline. Abuse was not suspected. Review of a witness statement dated 10/08/24 revealed after the altercation between Resident #88 and LPN #204, CNA #210 saw LPN #204 sitting at the nurses station playing a voice recording that she said she took in room [ROOM NUMBER] (Resident #88's room). CNA #210 stated she could hear the recording but could not tell what was being said. Review of a statement from CNA #205 to Director of Human Resources and Corporate Compliance (DHRCC) #211 dated 10/09/24 at 4:40 A.M. revealed on 10/07/24 at approximately 1:58 A.M. CNA #205 heard yelling and screaming from the hall Resident #88 resided on, and walked down the hall to see what the commotion was. CNA #205 stated she heard LPN #204 and Resident #88 having a heated verbal exchange, and observed LPN #204's cell phone on the treatment cart, and it was recording the altercation. CNA #205 also witnessed CNA #209 recording the altercation with her cell phone. CNA #205 stated it looked like abuse and intimidation of a resident and also a HIPPA violation. CNA #205 stated she reported the situation to Unit Manager (UM) #212. Review of a witness statement undated and written by UM #212 revealed CNA #205 reported chaos happening out into the 300 hall and she went to investigate the situation. UM #212 stated she heard Resident #88 yelling and asking staff for their names and license number and things like that, and was able to calm Resident #88 down. UM #212 stated she heard staff arguing with each other in the hall and at the nurses station. UM #212 stated she did not see or hear any form of abuse. Interview on 01/09/25 at 2:34 P.M. with CNA #205 revealed she made a formal complaint when she witnessed the incident between Resident #88 and LPN #204 and other staff members, and the incident happened on 10/07/24. CNA #205 stated she told the staff members involved in the incident that she was going to file a complaint and the staff members started screaming at her, things escalated and almost became physical. CNA #205 indicated she witnessed a verbal altercation between Resident #88 and LPN #204 and they were screaming at each other. CNA #205 stated it was so loud it could be heard all the way to the other side of the building. CNA #205 stated she saw LPN #204 and CNA #209 recording the heated verbal exchange with Resident #88. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/25 at 3:58 P.M. with Resident #88 revealed he transferred to another facility because he had a lot of problems at the facility, most of the problems were with LPN #204, he told the Administrator but nothing went anywhere. Resident #88 stated he had many arguments with LPN #204, confirmed he had an argument with LPN #204 on 10/07/24, and said she recorded me and I did not say she could record me. Resident #88 indicated there were witnesses who saw LPN #204 recording him, and CNA #205 stuck up for me and they fired her. The DON told Resident #88 nothing was found to be true. Resident #88 stated this whole situation caused him to be very upset, overwhelmed, stressed and he could not sleep, and this was all because of the way he was treated and yelled at while he was at the facility, and he never had problems sleeping before. Interview on 01/13/25 at 10:32 A.M. with the Director of Nursing (DON) confirmed on 10/07/24 there was a situation between Resident #88 and LPN #204 was voice recording the altercation. The DON stated LPN #204 was reprimanded for recording Resident #88. The DON indicated it was not okay for staff to yell at residents and no staff were yelling at Resident #88, but Resident #88 was yelling at the staff. The DON stated CNA #205 heard Resident #88 yelling, and CNA #205 was not fired and chose to leave her position. The DON indicated CNA #205 did not observe or hear anything because she was standing at the top of the hall by the nurses station. The DON stated LPN #204 was suspended and staff were educated about cell phone use. Review of a witness statement dated 10/11/24 written by LPN #204 revealed LPN #204 entered Resident #88's room to provide a treatment and Resident #88 yelled for about ten minutes. When Resident #88 began yelling LPN #204 asked him if she could record him and he said I don't care. LPN #204 had a CNA in the room with her as a witness. Review of a witness statement undated written by CNA #209 revealed CNA #205 said she was going to file abuse claims on all of us. CNA #209's statement stated LPN #204 voice recorded all of this when Resident #88 started yelling at her. CNA #209 stated she never had her phone out recording. Review of LPN #204's Review Discussion Form created on 10/16/24 revealed the date of the conversation was 10/11/24. LPN #204 had her phone out in a resident room and call lights were on too long. LPN #204 would not have her phone out in any resident area at anytime. LPN #204 would ensure resident call lights were answered in a timely manner. Additional customer service education to be completed. LPN #204 responded that she took her phone out of her pocket to use as a flashlight to meet resident needs. LPN #204 stated sometimes she needed to pick something up for a resident and additional light was needed, and sometimes need a better look at a wound, and sometimes residents ask for phone number to a restaurant etcetera. Further violations of policy might lead to disciplinary action up to and including termination. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Use of Cellular Phones, Cameras and Other Similar Devices undated included cellular telephones including smart phones such as iphones, blackberries etcetera, cameras, tablets, and similar devices such as audio or video recorders (Personal Handheld Device) may not be worn, carried or used during working time unless the device was used for the business purposes of the facility. You may not carry a Personal Handheld Device during working time unless you receive specific authorization from your facility administrator or corporate human resources. You must report to your supervisor any improper usage of a Personal Handheld Device in the workplace or on work time. Taking, viewing, showing, or otherwise distributing photographs, videos or other content of a lewd, indecent, or discriminatory nature during working time or on the facility property was strictly prohibited. All other company policies, including anti-harassment and violence in the workplace policies apply to use of Personal Handheld Devices on working time and on the facility premises. The deficient practice was corrected on 10/16/24 when the facility implemented the following corrective actions: On 10/09/24 staff were educated that cell phone use while on company time was for emergency use only. The education was provided by the DON and signed by all staff members. On 10/09/24 staff were educated that call lights were to be answered in a timely manner. The education was provided by the DON and signed by all staff members including nurses and aides. On 10/16/24 staff were educated on the facility abuse policy, cell phone use policy and call light policy. The education was provided by the DON and signed by all staff members. Interview on 01/13/25 at 10:32 A.M. of the DON revealed she did random audits on all three shifts and found no concerns related to cell phone use, abuse, or call lights being answered. This deficiency represents non-compliance investigated under Master Complaint Number OH00160965, Complaint Number OH00160980, and Complaint Number OH00160438.

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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** 42013 Based on observation, interview, record review, and review of the facility policy the facility failed to ensure Resident #81's physician's orders were followed to ensure proper diabetic insulin management, and failed to ensure Resident #86's open area to his abdominal fold was evaluated and treated. This affected two resident's (Resident #81 and Resident #86) out of three residents reviewed for quality of care. The facility census was 85. Findings include: 1. Review of Resident #81's medical record revealed an admitted [DATE] and diagnoses included type one diabetes mellitus with hyperglycemia, type two diabetes mellitus with hypoglycemia without coma, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #81's care plan dated 05/14/24 included Resident #81 had the potential for hyperglycemia and hypoglycemia related to type one diabetes mellitus. Resident #81's blood sugars would remain stable, skin would remain intact, and resident would be compliant with diet. Interventions included to check accu checks per D.O. (doctors orders) and as needed; administer insulin per order; observe for hypoglycemia, hyperglycemia including symptoms of thirst, urination, hunger, shaking, sweating, blurred vision; monitor food intake. Review of Resident #81's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #81 was cognitively intact. Resident #81 required set-up and clean-up assistance with eating. Resident #81 received insulin injections. Review of Resident #81's physician orders dated 09/27/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject 6 units subcutaneously with meals related to type one diabetes mellitus with hyperglycemia, hold for blood sugar less than 120. Review of Resident #81's physician orders dated 09/27/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject per sliding scale, subcutaneously after meals for hyperglycemia: if blood sugar 200 to 250 inject 2 units, if blood sugar 251 to 300 inject 4 units, if blood sugar 301 to 350 inject 6 units, it blood sugar 351 to 400 inject 8 units, if blood sugar 401 to 450 inject 10 units, if blood sugar is above 450 call the physician. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject 6 units subcutaneously with meals, hold for blood sugar less than 120, scheduled to be administered at 8:00 A.M. with meals was administered at 7:24 A.M. Review of Resident #81's Medication Administration Record (MAR), progress notes, and blood sugars dated 10/03/24 did not reveal evidence a blood sugar was checked prior to the administration of insulin aspart 6 units at 7:24 A.M. The insulin was ordered to be held if Resident #81's blood sugar was less than 120. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #81's blood sugars dated 10/03/24 revealed blood sugars were checked at 9:10 A.M., 11:18 A.M., 1:52 P.M., 4:02 P.M., and 7:42 P.M. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject 6 units subcutaneously with meals, hold for blood sugar less than 120, scheduled to be administered at 12:00 P.M. with meals was administered at 11:19 A.M. and Resident #81's blood sugar was 359. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject per sliding scale, subcutaneously after meals for hyperglycemia, was scheduled to be administered after meals, and 8 units was administered at 11:18 A.M. for a blood sugar of 359. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed Resident #81's insulin aspart was administered at 11:18 A.M., but the physician orders were for insulin aspart 6 units to be administered with meals, hold for blood sugar less than 120, and a sliding scale of insulin aspart was ordered to be given after meals. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject 6 units subcutaneously with meals, hold for blood sugar less than 120, scheduled to be administered at 5:00 P.M. with meals was administered at 4:02 P.M. and Resident #81's blood sugar was 429. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed insulin aspart flexpen subcutaneous solution pen-injector 100 units per ml, inject per sliding scale, subcutaneously after meals for hyperglycemia, was scheduled to be administered after meals, and 10 units was administered at 4:02 P.M. for a blood sugar of 429. Review of Resident #81's Medication Administration Audit Report dated 10/03/24 revealed Resident #81's insulin aspart was administered at 4:02 P.M., but the physicians orders were for insulin aspart 6 units to be administered with meals, hold for blood sugar less than 120, and a sliding scale of insulin aspart was ordered to be given after meals. Interview on 01/14/25 at 1:19 P.M. of the Director of Nursing (DON) revealed blood sugars should be checked per physician order, and if a resident was exhibiting any signs and symptoms of high or low blood sugar a blood sugar check should be completed. The DON stated nursing judgement and critical thinking were important for the overall picture. The DON confirmed on 10/03/24 Resident #81 did not receive insulin per physician orders. Interview on 01/14/25 at 2:37 P.M. of Licensed Practical Nurse (LPN) #207 revealed on the nursing unit Resident #81 resided on the dinner meal was served at 5:00 P.M. or later. LPN #207 stated the nursing unit was the last nursing unit to be served at all the meals. LPN #207 stated Resident #81's blood sugars alternate between high and low a lot and she usually tried to check Resident #81's blood sugars before meals. LPN #207 indicated if Resident #81 did not eat her blood sugar dropped quickly. LPN #207 confirmed on 10/03/24 she checked Resident #81's blood sugar at 4:02 P.M. and gave her insulin pretty soon after that and confirmed she administered both insulin injections at the same time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365317	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithville Western Care Center	4110 East Smithville Western Road Wooster, OH 44691

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/14/25 at 2:56 P.M. of Resident #81 revealed she was sitting in a wheelchair in her room watching television. Resident #81 was alert and answered questions pleasantly. Resident #81 remembered she was transported to the hospital Emergency Department on 10/03/24 but could not remember any details about what happened. Resident #81 stated her blood sugar goes up and down a lot. Interview on 01/15/24 at 11:41 A.M. of Physician #202 revealed Resident #81 was living at home, became hypoglycemic, fell and had a fracture of her arm. Physician #202 stated Resident #81 was taken to the hospital and after her hospital stay was admitted to the facility. Physician #202 indicated Resident #81 was a brittle diabetic, her blood sugars could be very low or very high, and she was always eating snacks and drinks. Physician #202 stated multiple variables could impact Resident #81's blood sugars including stress and diet. Physician #202 confirmed Resident #81's blood sugars should be checked with meals and held if less than 120 and after meals according to a sliding scale. Physician #202 stated it was important to stick to scheduled times for insulin administration and she worked with an endocrinologist to manage Resident #81's blood sugars. Review of an email sent on 01/15/25 at 1:00 P.M. from the DON confirmed on 10/03/24 Resident #81's two orders for insulin aspart were given at the same time for the lunch meal and the dinner meal and not as ordered which was to give 6 un insulin aspart with meals after checking a blood sugar to make sure Resident #81's blood sugar was not below 120 before administering. The second order was to administer insulin aspart per sliding scale after Resident #81's meal. The email also confirmed there was no blood sugar checked before 6 units insulin aspart was administered to Resident #81 for the breakfast meal. The email stated Resident #81 consumed 100 percent of her meals for breakfast, lunch, dinner. Review of the facility policy titled Blood Glucose Testing Protocol undated included it was the facility policy to ensure residents blood glucose levels were tested and recorded appropriately and accurately. Check physician's order for specific instructions. Record blood sugar in the resident's medical record. Review of the facility policy titled Medication Administration Policy undated included it was the policy to the facility to ensure medications were administered in a safe and sanitary manner. Licensed nurses would ensure the six medication rights were followed, the right resident, the right drug, the right dose, the right time, the right route and the right documentation. 2. Review of Resident #86's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included pneumonia, acute respiratory failure with hypoxia and hypercapnia, morbid obesity, bacteremia and type two diabetes mellitus with hyperglycemia. Review of Resident #86's physician orders dated 11/27/24 revealed orders for miconazole external powder 2 percent (miconazole nitrate topical), apply to abdominal folds, armpits, groin topically every morning and at bedtime for fungal infection for 14 days. This order was discontinued on 12/11/24. Review of Resident #86's care plan did not reveal a care plan related to Resident #86's open area on his right lower abdomen. Review of Resident #86's Admission Minimum Data Set assessment dated [DATE] revealed Resident #86 was cognitively intact. Resident #86 was dependent for toileting, upper and lower body dressing, and the ability to bathe self was not attempted due to medical condition or safety concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's Weekly Skin Check dated 12/11/24 included skin was not intact, skin area noted was chronic. Resident #86 had redness, mild, open, in right lower abdominal fold, and folds were treated with antifungal powder and none were red but this one spot. Review of Resident #86's progress notes dated 12/11/24 through 12/15/24 did not reveal evidence Resident #86's open, reddened area to the right lower abdominal fold was evaluated and treated. Review of Resident #86's physician orders dated 12/11/24 through 12/15/24 did not reveal treatment orders for Resident #86's open, reddened area to his right lower abdominal fold. Review of Resident #86's assessments from 12/11/24 through 12/15/24 did not reveal a Wound Track assessment. Interview on 01/09/25 at 11:09 A.M. with Resident #86 and Family Member (FM) #200 revealed he was discharged from the facility after he was transported to the Emergency Department and was at home now. Resident #86 stated one of the issues he had at the facility was that an unidentified aide roughed me up, but he did not know the name of the aide. Resident #86 stated the aide was rough with him and used tremendous force causing an open area on his abdomen. The open area was not charted or treated timely, and an unidentified aide put a sheet in the abdominal fold and left it for a couple days, took it out and placed another sheet in the fold. Resident #86 stated when the sheet was taken out it was covered with blood. Resident #86 revealed he told the unidentifed aide that the spot on his abdomen was sensitive to touch and was hurting and no one had looked at it or treated it, but no one came in to check the area or treat it. Resident #86 stated he told a nurse he had an area on his right lower abdomen that needed evaluated, and the nurse looked at it, but he could not remember what day this occurred. Resident #86 indicated care was sporadic and no one looked at his wounds every day. Interview on 01/13/25 at 10:49 A.M. of Registered Nurse (RN) #201 revealed Resident #86 was frequently yeasty and would not keep a pillow case in the folds. RN #201 indicated if a resident had heavy skin on skin she always put something in the area. RN #201 stated on 12/11/25 an area to Resident #86's right pannus opened up, it was not a huge open wound, and it freaked him out. RN #201 stated she cleaned the area with soap and water, patted it dry, put nystatin powder (treats fungus infections) on the area and placed an ABD (abdominal pad) in the fold where the open area was to get skin off skin to help avoid a yeast infection and skin friction. RN #201 stated she did not call the physician or obtain a treatment order because a treatment was already in place. RN #201 indicated she found the open area on Resident #86's abdomen during routine care. RN #201 stated Resident #86 complained and said someone washed him too hard causing the area to open up, but when she looked at the area it did not look like it was scrubbed raw, it just looked yeasty and yeast infections could cause the skin to be sensitive. Interview on 01/13/25 at 2:53 P.M. of the Director of Nursing (DON) revealed Resident #86 had a yeast infection and was ordered miconazole powder for treatment. The DON confirmed the miconazole powder was discontinued on 12/11/24, but stated the treatment would be the same for the open area on Resident #86's lower abdominal fold because it was yeast related. The DON did not provide evidence of additional orders, treatments or documentation of Resident #86's open area on his lower right abdominal fold. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Wound Prevention and Management Policy revised 10/2022 included an appropriate treatment would be implemented for any existing skin breakdown. A Wound Track Assessment would be documented at the time of discovery of the skin breakdown and then weekly thereafter. A care plan would be initiated and updated as necessary until the area was resolved. Weekly skin checks would be performed by licensed nurses. CNA's would monitor resident's skin during care, for signs of breakdown and notify the charge nurse. This deficiency represents non-compliance investigated under Master Complaint Number OH00160965, Complaint Number OH00160980, and Complaint Number OH00160438.