STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365368	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jamestown Place Health and Rehab	4960 US 35 East Jamestown, OH 45335

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure dignity and respect were shown to residents who needed help to eat. This affected three (#25, #26, #7) of three residents reviewed for assistance with eating. The census was 34.Findings Included:1.Medical record review for Resident #25 was admitted on [DATE]. Medical diagnoses included encephalopathy and non-Alzheimer's dementia.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #25 was severely cognitively impaired. Her functional status was dependent for eating, toileting, bathing and bed mobility. She was non-applicable for transfers. 2.Medical record review for Resident #26 revealed an admission date of 05/27/21. Medical diagnoses included quadriplegia, neurogenic bladder, diabetes, and cerebrovascular attack.Review of Resident #26's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and non-applicable for transfers. She was always incontinent for bowel and bladder.3. Medical record review revealed Resident #7 was admitted on [DATE]. Medical diagnoses included cancer, anemia, and hypertension.Review of the quarterly MDS assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment and required a helper to set up and clean meals.Observation of the dining room on 09/11/25 at 11:00 A.M. revealed Resident #3, #20, and #7 among unidentified residents sitting at the dining table waiting for lunch. At 11:10 A.M. lunch was given to these residents, and they started eating. Observation of Resident #25 on 09/11/25 at 11:01 A.M. revealed she was brought to the dining room table and wasn't served lunch and assisted to eat until 11:46 A.M. Observation of Resident #26 on 09/11/25 at 11:03 A.M. she was in the dining room and waiting to be fed and then at 11:10 A.M. revealed the resident was getting fed. Observation of Resident #7 on 09/11/25 from 11:10 A.M. to 11:45 A.M. revealed she was not sitting close enough to the table and had to be cued to eat. At 11:50 A.M. this resident was cued to eat her lunch and slid up to the table so she could reach her meal. Interview with Certified Nursing Aide (CNA) #106 on 09/11/25 at 12:16 P.M., verified she was the only aide in the dining area and had two people to assist with eating and another one had to be cued to eat. She confirmed it took a while for Resident #25 to be fed while the other residents were eating and stated it wasn't a dignified experience for the residents. Review of the policy titled Resident Rights dated 2001 revealed employees shall treat all residents with kindness, respect, and dignity.This was an incidental finding under Complaint Number 2593977.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of the resident council minutes, staff and resident interviews, and policy review the facility failed to ensure resident council concerns had a resolution. This affected two (#13 and #29) of two residents reviewed for resident council. The facility identified not all of the residents were able to attend resident council. The facility census was 34.Findings Included:Review of Resident Council Minutes revealed:On 06/23/25 there was a complaint noted about the facility driveway needed the cracks fixed.On 07/21/25 there was a complaint noted about the facility driveway still needed fixed. On 08/25/25 there was a complaint noted a resident's wheelchair got stuck in a hole out front and the resident could hardly get out of the hole. The resident's voiced in this resident council meeting they felt like nothing was done about their concerns when the administration was made aware of the concerns. Interview with the Resident Council President #13 on 09/15/25 at 10:32 A.M., revealed the resident council does not receive timely answers to their complaints, if they even answer them at all. The Resident Council President #13 said there were cracks in the black top driveway and she gets tumbled around when driving around in her electric wheelchair. She further revealed Resident #29 was stuck in their wheelchair out in a crack in the black top driveway. Interview with the Activity Director (AD) #38 on 09/15/25 at 1:21 P.M., revealed she conducted the council meetings and if there were any concerns she gave them to the Administrator. She verified the resident council complaints were not addressed timely if answered at all. Interview with Resident #16 on 09/15/25 at 1:33 P.M., revealed she was stuck in the cracks of the blacktop driveway once but was able to get herself unstuck. Resident #16 could not remember when this happened. Interview with Resident #29 on 09/15/25 at 1:53 P.M., revealed he had gotten stuck in the cracks in the driveway before unsure when it was. He revealed he had told the facility numerous times about it and had not received a resolution.Review of the policy titled Resident Council dated 02/01/21 revealed the facility supports residents' rights to organize and participate in the resident council. The quality assurance and performance improvement (QAPI) committee will review information and feedback from the resident council as part of their quality review. Issues documented on council response forms maybe referred to the QAPI committee, if applicable. This deficiency represents an incidental finding investigated under Complaint Number 2580867 and 2593977.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, staff and resident interview, and policy review the facility failed to ensure there was a homelike environment. This affected 11 (# 20, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18) out of 11 reviewed for the environment. The facility census was 34.Findings Included: Observation of Resident #13's room on Winter Hall on 09/15/25 at 8:16 A.M., revealed the bathroom light made a loud screeching noise, the faucet leaked in the sink, and the hot water temperature was 82.7 degrees Fahrenheit. Interview with Resident #13 on 09/15/25 at 8:17 A.M., revealed the light in her bathroom had been screeching for about five or six days, and an aide knew about it, however the resident could not remember her name. Resident #13 reported the water in her bathroom had not been hot for about three weeks and the aides would give her washcloths that were lukewarm, and they would apologize for it when they had to provide care when the washcloth wasn't hot. Review of the following resident's rooms on Winter Hall on 09/15/25 at 8:30 A.M., revealed:Resident #9's bathroom hot water temperature was 88 degrees Fahrenheit and the faucet leaked.Resident #10's bathroom hot water temperature was 85 degrees Fahrenheit and the faucet leaked. Resident #11's bathroom hot water temperature was 85 degrees Fahrenheit. Resident #12's bathroom hot water temperature was 85.5 degrees Fahrenheit, and the faucet leaked. Resident #14's bathroom hot water temperature was 85.2 degrees Fahrenheit. Resident #15's bathroom hot water temperature was 88.3 degrees Fahrenheit, and the faucet was leaking. Resident #16's bathroom hot water temperature was 85.2 degrees Fahrenheit, and the faucet was leaking. Resident #17's bathroom hot water temperature was 85 degrees Fahrenheit. Resident #18's bathroom hot water temperature was 85 degrees Fahrenheit.Observation of Residents #20's room revealed the bathroom sink was leaking. There was a potential trip hazard that went from the bedroom to the bathroom that looked like it had been repaired with a cement room divider that was raised off the floor approximately 3/4's of an inch. Interview and observations with the Maintenance Man (MM) #117 on 09/15/25 at 8:45 A.M., verified all the above-mentioned residents' room environment concerns. He reported he had been off sick for two weeks and returned on 09/15/25. He revealed he had received text messages about the water temperatures while he was off sick but could not remember who he told about them. Interview with Resident #18 on 09/15/25 at 1:43 P.M., revealed she had not had hot water in her bathroom in a while. She said when the aides gave her a washcloth or provided care the washcloth was lukewarm.Observation of the black top parking lot on 09/15/25 at 12:00 P.M., revealed there were cracks in the cement. Observation of the sidewalk coming out of the facility on the right-hand side revealed the sidewalk was broken up and had chunks of cement laying on the walk. Interview on 09/15/25 at 12:15 P.M., with the Corporate Registered Nurse (CRN) #300 revealed the parking lot should have been taken care of and verified the cracks in the black top and the chunks of cement on the sidewalk. There was a policy requested but the facility said they go by standard protocol which was never provided. This deficiency represents non-compliance investigated under Complaint Number 2580867 and 2593977

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on medical record review, staff interview, and policy review revealed the facility failed to ensure a resident elopement was reported to the state agency. This affected one (#20) of two residents reviewed for elopement. The facility census was 34.Findings Included: Medical record review for Resident #20 revealed an admission date of 10/13/23. Medical diagnoses included non-Alzheimer's dementia, seizure disorder, and schizophrenia.Review of the progress notes dated 05/01/24 revealed Resident #20 had a history of eloping from home.Review of the care plan dated 04/03/25 revealed Resident #20 was identified as an elopement risk and would be wearing a wander guard alarming device. Interventions to prevent elopement included: to monitor placement and function of the wander guard alarming device every shift, provide redirection from the lobby area when visitors were leaving, and redirect the resident from the doors.Review of the medical record dated 04/12/25 revealed Resident #20 eloped from the facility at approximately 7:45 A.M., went to a gas station 0.2 miles away, got into a truck with a man, the gas station manager knew, who asked him to take her to the other side of town. The station manager discovered the resident was from the facility and asked the man driving the resident across town to take her back to the facility. Resident #20 was taken back to the facility at approximately 8:25 A.M. Interview with the Administrator on 09/15/25 at 3:00 P.M., verified she had not filed a Self-Reported Incident (SRI) because she felt there was no neglect for Resident #20, even though the resident was cognitively impaired. She reported the resident left the facility. Review of the policy titled Abuse Policies and Procedures dated 04/01/21 revealed to report any allegations within timeframes required by federal requirements. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.This deficiency represents non-compliance investigated under Complaint Number 2583977.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interviews, and policy review the facility failed to ensure residents received two showers a week. This affected five (#25, #29, #20, #8 and #3) of five residents reviewed for bathing. The facility census was 34. Findings Included:1.Medical record review revealed Resident #25 was admitted on [DATE]. Medical diagnoses included encephalopathy and non-Alzheimer's dementia.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #25 was severely cognitively impaired. Her functional status was dependent for eating, toileting, bathing and bed mobility. She was non-applicable for transfers. Review of the shower sheets for Resident #25 revealed out of eight shower opportunities the resident received one on 08/21/25 and 09/08/25. The resident had not been out to the hospital. 2.Medical record review for Resident #29 revealed an admission date of 04/03/24. Medical diagnoses included aftercare following joint replacement surgery, neurogenic bladder, and diabetes. Review of the quarterly MDS dated [DATE] revealed Resident #29 was cognitively intact. His functional status was set up or clean-up assistance for eating, toileting, and transfers. He was independent for bed mobility, and he needed supervision or touching assistance for bathing.Review of shower sheets for Resident #29 revealed out of 11 shower opportunities he received one on 08/16/25 and on 09/06/25. He refused one on 08/09/25 and on 08/13/25. He had not been out to the hospital. Interview and observation with Resident #29 on 09/15/25 at 1:53 P.M., revealed there was not enough aides to give him a shower especially at night. He said he received his showers on Wednesdays and Saturday nights if there were enough aides. He didn't have any specific days his showers weren't given. Resident #29 had an odor of urine and was unkempt at this time.3.Medical record review for Resident #8 revealed an admission date of 11/05/20. Medical diagnoses included end stage renal disease, and heart failure. Review of the quarterly MDS dated [DATE] revealed Resident #8 was moderately cognitively impaired. Functional status was dependent for eating, substantial/maximal assistance for toileting and bathing. She was set up or clean-up assistance for bed mobility, and transfers.Review of bathing sheets for Resident #8 revealed out of 11 opportunities she received five baths on 08/12/25, 08/19/25, 08/22/25, 09/10/25, and 09/13/25. She had not been out to the hospital. 4.Medical record review for Resident #3 revealed an admission date of 07/15/25. Medical diagnoses included aftercare for a fracture. Review of the admission MDS dated [DATE] revealed Resident #3 was severely cognitively impaired. His functional status was dependent for eating, substantial/maximal for toileting and bathing. He was partial/moderate assistance for bed mobility, and transfers. Review of the shower sheet for resident #3 revealed out of eight shower opportunities he received five on 08/12/25, 08/19/25, 08/22/25, 09/05/25, and on 09/06/25. The resident had not been out to the hospital. 5.Medical record review for Resident #20 revealed an admission date of 10/13/23. Medical diagnoses included non-Alzheimer's dementia, seizure disorder, and schizophrenia. Review of the quarterly MDS dated [DATE] revealed Resident #20 was moderately cognitively impaired. Her functional status was setup or clean-up for eating, toileting, bed mobility, and transfers. She was occasionally incontinent for bladder and bowel.Review of shower sheets for Resident #20 revealed out of 13 opportunities she received eight showers on 08/05/25, 08/15/25, 08/22/25, 08/26/25, 08/29/25, 09/02/25, 09/09/25, and 09/16/25. The resident had not been out to the hospital. Interview with the Corporate Registered Nurse (CRN) #300 on 09/15/25 at 12:58 P.M., verified there wasn't any more shower sheets to review and the residents had not received their two showers a week. Review of the policy titled Bathing dated 2001 revealed the purpose of bathing was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.This deficiency represents non-compliance investigated under Complaint Number OH002593977

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the activity calendar, observation, staff and resident interview, medical record review, and policy review the facility failed to ensure meaningful activities were provided as scheduled. This affected three (#13, #16, #26) of three residents reviewed for activities. This had the potential to affect all of the residents who participated in activities. The facility census was 34. Findings Included:Review of the activity calendar dated 09/01/25 through 09/30/25 revealed on 09/11/25:10:30 A.M. pass mail11:30 A.M. lunch1:30 P.M. bingo 3:30 P.M. manicuresFurther review of the activity calendar for the month of September 2025 revealed every day at 10:30 A.M., was mail and 11:30 A.M., was lunch. Observation on 09/11/25 at 10:30 A.M., revealed no one was passing mail to the residents. At 11:30 A.M., lunch was served to the residents. At 1:30 P.M., bingo was held by a resident who called out the numbers for the game. The Activity Director (AD) #38 walked around the bingo area for a while and then sat down to help a resident who was unable to mark her bingo cards. At 3:30 P.M. to 3:43 P.M., there was no residents who received manicures. 1.Medical record review for Resident #26 revealed an admission date of 05/27/21. Medical diagnoses included quadriplegia, neurogenic bladder, diabetes, and cerebrovascular attack.Review of Resident #26's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and non-applicable for transfers. She was always incontinent for bowel and bladder. Review of Resident #26's activity care plan dated 06/20/25 revealed due to inability to enjoy physical activities of choice due to physical condition please help her with the activities she chooses to participate in. Invite her to her favorite activities, or try new things she may be interested in, and introduce her to others with similar interests. Interview with Resident #26 on 09/16/25 at 3:35 P.M., revealed she wished there were more activities offered than just two days a week. 2.Medical record review for Resident #13 revealed an admission date of 12/14/19. Medical diagnoses included cerebrovascular accident. Review of the activity care plan dated 04/15/25 revealed she enjoyed playing bingo, and making beaded jewelry, she enjoyed group or independent activities.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident # 13 was cognitively intact. Interview with the Resident #13 on 09/11/25 at 3:48 P.M., revealed she was the council president and the caller for the bingo activity. She revealed the residents could use more activities and the residents would like to have activities on the weekends. She said the facility had been without an activity helper for a while until recently the facility got one.3.Medical record review for Resident #16 revealed an admission date of 09/15/23. Medical diagnoses included osteoporosis and respiratory failure. Review of the annual MDS dated [DATE] revealed Resident #16 was cognitively intact. Her functional status was set up or clean-up for eating, partial/moderate assistance for toileting, bed mobility, and transfers. Review of activities care plan dated 07/07/25 for Resident #16 revealed she preferred independent activities but would like to be invited to group activities and she would attend ones that interest her. Interview with Resident #16 on 09/15/25 at 1:33 P.M., revealed there wasn't activities every day and she was unable to think of any they have on the weekends. Interview with the AD #28 on 09/11/25 at 4:11 P.M., revealed she designed the activity calendar and agreed the calendar had activities that weren't meaningful and weren't doing enough activities for the residents and agreed passing mail every day wasn't meaningful to the resident in a way of activity. She verified she had not completed activities on 09/11/25 because the helper for activities was not working on 09/11/25. She had been without a helper for quite some time and weekends were not being done for the residents.The facility identified they didn't have an activity policy, and they follow standard practice for the activities. This deficiency represents non-compliance investigated under Complaint Number 2593977.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of the facility investigation statements, staff interview and policy review the facility failed to provide adequate interventions and/or supervision to ensure a resident who was assessed as being at risk for elopement did not elope from the facility. This affected one (#20) of three residents reviewed for elopement. The facility census was 34. Findings Included:Medical record review for Resident #20 revealed an admission date of 10/13/23. Medical diagnoses included non-Alzheimer's dementia, seizure disorder, and schizophrenia. Review of the progress notes dated 05/01/24 revealed Resident #20 has a history of eloping from home. Review of the physician orders dated 05/28/24 revealed to place a wander guard alarming device to alert staff of attempt to elope. Check function and placement every shift.Review of the physician orders dated 08/09/24 revealed to check the wander guard alarming device placement and function every day.Review of the elopement assessment dated [DATE] revealed Resident #20 was at risk for elopement rated as three. Review of the elopement drills revealed there was one on 03/14/25.Review of the Treatment Administration Record (TAR) dated 04/01/25 through 04/12/25 revealed Resident #20's wander guard alarming device was checked every day shift for functionality. Also, during this time, the wander guard was checked for placement every shift. There was a new order dated 04/14/25 for a wander guard alarming device in place and working every shift. Review of the care plan dated 04/03/25 revealed she had been identified as an elopement risk and would be wearing a wander guard alarming device. Interventions included: to monitor placement and function of wander guard alarming device every shift, provide redirection from the lobby area when visitors were leaving, and redirect the resident from the doors.Review of the progress notes dated 04/12/25 at 8:15 A. M. revealed Resident #20 was not in the facility. The resident was brought back into the facility and head to toe assessment was completed, no areas of injury were documented. Vital signs were assessed within normal limits. The Director of Nursing (DON), the Medical Director (MD), and the guardian were notified. Review of a progress note dated 04/12/25 at 12:30 P.M., documented the resident said witches made her elope and concerns over four cats. Review of the statement from Certified Nursing Aide (CNA) #42 revealed she had not heard the alarm go off because she was in a room helping feed a resident. She stated she gave Resident #20 her breakfast tray around 7:15 A.M. Review of the statement by Licensed Practical Nurse (LPN) #75 dated 04/12/25 revealed she heard the alarm go off at the front door and went to check it. She reported she went outside to see if anyone was out in the parking lot and did not see anyone.Review of the statement from Registered Nurse (RN) #71 dated 04/12/25 revealed she got a call from the gas station at around 8:10 A.M. to 8:15 A.M. and said Resident #20 was in a truck with a person the gas station manager knew and Resident #20 wanted to go to the other side of town, so the man was enroute to take her to the other side of town when the gas station manager called the facility and discovered Resident #20 was from the facility. The man was called to bring Resident #20 back to the facility and the driver arrived to the facility at 8:25 A.M., with Resident #20.Interview with LPN #75 on 09/11/25 at 7:47 A.M., revealed she was in the kitchen on 04/12/25 when she heard the front door alarm go off. She reported she went to the door and disarmed the alarm and went outside and didn't see anyone, so she came back into the facility and continued with her work. She stated there was a call made to the facility that Resident #20 had been at the gas station 0.2 miles down the road and was now traveling across town with a man the gas station manager knew. She stated he was notified to bring her back to the facility and she retuned back and was not hurt in anyway. She confirmed the resident eloped and the door was functioning properly for the wander guard on the resident's ankle. She said there had been audits of the door functionality and she received education on the elopement policy and elopement drills. Interview with LPN #69 on 09/11/25 at 2:49 P.M., revealed she was helping feed a resident on 04/12/25 and heard the door alarm go off at the front door and heard someone turn it off. She went back to feeding her resident. She said the gas station manager called the facility a short time later and said Resident #20 had been at the station and asked a man, the manager knew, to give her ride to the other side of town. As he was driving Resident #20 to the other side of town the station manager figured out Resident #20 was from the facility and asked him to return the resident to the facility. She confirmed she only heard the door alarm go off and not the wander guard alarm. She stated apparently the wander guard alarm was only going off on one side of the door. She said there had been audits of the

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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Jamestown Place Health and Rehab	4960 US 35 East Jamestown, OH 45335

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, observation, and policy review the facility failed to ensure fresh water was passed out during the day. This affected four Residents (#26, #19, #24, #29) out of four residents reviewed. The facility identified residents who received nothing by mouth. In addition, the facility failed to ensure a resident with significant weight loss was given his ordered supplement. This affected one resident (#3) of two residents reviewed for weight loss. The facility census was 34. Findings Included:1. Medical record review for Resident #26 revealed an admission date of 05/27/21. Medical diagnoses included quadriplegia, neurogenic bladder, diabetes, and cerebrovascular attack.Review of Resident #26's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and non-applicable for transfers. She was always incontinent for bowel and bladder. Review of the care plan for Resident #26 dated 06/20/25 revealed she was at risk for pressure ulcers due to quadriplegia and provide hydration support. Observation on 09/16/25 at 3:47 P.M., revealed Resident #26 had a Styrofoam cup dated 09/09/25 sitting on the table. 2.Medical record review for Resident #19 revealed an admission date of 08/04/25. Medical diagnoses included metabolic encephalopathy, coronary artery disease, and peripheral vascular disease. Review of the admission MDS dated [DATE] revealed Resident #19 was cognitively intact. Her functional status was setup or clean-up assistance for eating and bed mobility, and she was supervision or touching assistance for toileting and transfers. Review of the care plan dated 08/10/25 for Resident #19 revealed she had peripheral vascular disease related to diabetes and the staff were to encourage good hydration. Observation and interview on 09/16/25 at 3:48 P.M., revealed the resident had a Styrofoam cup dated 09/09/25 sitting on her bedside table. Resident #19 stated that was the last time the cup had been filled with fresh water.3.Medical record review for Resident #24 revealed an admission date of 11/29/24. Her medical diagnoses included cerebral palsy, cancer, and coronary artery disease.Review of the quarterly MDS dated [DATE] revealed Resident #24 was cognitively intact. Her functional status was setup or cleanup assistance for eating, partial/moderate assistance for toileting, supervision or touching assistance for bed mobility, and transfers. Review of the care plan dated 07/28/25 revealed Resident #24 was at risk for altered skin integrity related to adult failure to thrive. Intervention was to provide hydration support. Observation and interview with Resident #24 on 09/16/25 at 3:50 P.M., revealed the resident had an empty dirty pink glass in her room. Resident #24 stated the glass had not been filled up today and the staff don't always fill them every day. 4.Medical record review for Resident #29 revealed an admission date of 04/03/24. Medical diagnoses included aftercare following joint replacement surgery, neurogenic bladder, and diabetes. Review of the quarterly MDS dated [DATE] revealed Resident #29 was cognitively intact. His functional status was set up or clean-up assistance for eating, toileting, and transfers. He was independent for bed mobility, and he needed supervision or touching assistance for bathing.Review of the care plan dated 08/22/25 revealed Resident #29 was at risk for alteration in kidney function and to follow the hydration program interventions. Interview with Resident #29 on 09/16/25 at 3:53 P.M., revealed he had an empty glass on his bedside table and said the staff does not provide fresh water every day. Interview with the Certified Nursing Assistant (CNA) #106 on 09/16/25 at 3:53 P.M., revealed she was taking care of the above-mentioned residents and reported if the cup in the room was dated 09/09/25 that was the last time it was filled with fresh water. She stated if the resident asked for water she would get it for the resident, then and that was the only time.5.Medical record review for Resident #3 revealed an admission date of 07/15/25. Medical diagnoses included aftercare for a fracture, atrial fibrillation, peripheral vascular disease, renal insufficiency, diabetes, and cerebrovascular accident. Resident #3 had a significant weight loss but was stabilizing. Review of the admission MDS dated [DATE] revealed Resident #3 was severely cognitively impaired. His functional status was dependent for eating, substantial/maximal for toileting and bathing. He was partial/moderate assistance for bed mobility, and transfers.Review of the care plan updated 07/29/25 revealed Resident #3 was at risk for malnutrition as evidenced by chronic disease, peripheral vascular disease, gastroenteritis, bronchitis, depression, hypertension and dysphagia. Interventions were to monitor weights as ordered, provide diet as ordered-mechanical soft diet. Review of the orders dated 09/05/25 revealed to provide a magic cup supplement during lunch for Resident #3.Observation of Resident #3 on 09/11/25 at 11:34 A.M., the lunch meal revealed the resident was eating his meal independently, there was no magic cup supplement on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365368	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jamestown Place Health and Rehab	4960 US 35 East Jamestown, OH 45335

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the daily staffing, observation and staff interview the facility failed to ensure there was enough staff to assist residents to eat. This affected three (#25, #26, and #7) of three residents reviewed for staffing. The facility census was 34. Findings Included:Review of the daily staffing dated 09/11/25 revealed there were two nurses, and three Certified Nursing Assistants (CNA)'s to take care of 34 residents. There was one CNA who was out of the facility taking a resident to dialysis. The affected three (#25, #26, and #7) of three residents reviewed for assistance with eating.1.Medical record review for Resident #25 was admitted on [DATE]. Medical diagnoses included encephalopathy and non-Alzheimer's dementia.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #25 was severely cognitively impaired. Her functional status was dependent for eating, toileting, bathing and bed mobility. She was non-applicable for transfers. 2.Medical record review for Resident #26 revealed an admission date of 05/27/21. Medical diagnoses included quadriplegia, neurogenic bladder, diabetes, and cerebrovascular attack.Review of Resident #26's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and non-applicable for transfers. She was always incontinent for bowel and bladder.3. Medical record review revealed Resident #7 was admitted on [DATE]. Medical diagnoses included cancer, anemia, and hypertension.Review of the quarterly MDS assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment and required a helper to set up and clean meals.Observation of the dining room on 09/11/25 at 11:00 A.M., revealed Resident #3, #20, and #7 among unidentified residents sitting at the dining table waiting for lunch. At 11:10 A.M. lunch was given to these residents, and they started eating. Observation of Resident #25 on 09/11/25 at 11:01 A. M. revealed she was brought to the dining room table and wasn't served lunch and assisted to eat until 11:46 A.M. Observation of Resident #26 on 09/11/25 at 11:03 A.M. she was in the dining room and waiting to be fed and then at 11:10 A.M. revealed the resident was getting fed. Observation of Resident #7 on 09/11/25 from 11:10 A.M. to 11:45 A.M. revealed she was not sitting close enough to the table and had to be cued to eat. At 11:50 A.M. this resident was moved closer to the table so she could reach her meal and cued to eat her lunch. Interview with Certified Nursing Aide (CNA) #106 on 09/11/25 at 12:16 P.M., verified she was the only aide in the dining area and had two residents who required assistance with eating and another one had to be cued to eat. She reported there was not enough staff to feed the residents timely, and it was like this every day. She said the other aides had to feed residents down the halls. Attempted to get a staffing policy the Regional Director of Clinical Services revealed they followed standard practice. This deficiency represents non-compliance investigated under Complaint Number 2593977.