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	01/27/2026

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete Minimum Data Set (MDS) assessments per RAI guidelines. This affected five (#02, #04, #17, #19, and #29) out of sixteen residents reviewed. The facility census was 30. 1)Review of the medical record for Resident #02 revealed an admission date of 11/05/20 with medical diagnoses of end stage renal disease (ESRD), congestive heart failure (CHF), anxiety disorder, hypertension (HTN), and dementia. Review of the medical record for Resident #02 revealed a quarterly MDS assessment, with assessment reference date (ARD) 11/01/25. Review of the MDS assessment revealed the assessment was completed on 11/17/25. 2) Review of the medical record revealed Resident #04 was admitted on [DATE]. Diagnoses included type II diabetes mellitus (DM II), atrial fibrillation, major depressive disorder, and peripheral vascular disease (PVD). Review of the Quarterly MDS assessment dated [DATE] revealed Resident #04 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require setup with eating, dependent with toileting and transfers, partial assistance with bathing, and substantial assistance with dressing. The MDS assessment was not completed until 01/14/26. Interview on 01/21/26 at 3:30 P.M., MDS-Registered Nurse (RN) #159 verified the MDS assessment was not completed within 14 days after the ARD for Resident #04 due to working in two buildings. 3) Review of the medical record for Resident #17 revealed an admission date of 10/13/23. Diagnoses included dementia, epilepsy, schizoaffective disorder, bipolar type, and schizophrenia. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #17 had severe cognitive impairment as evidenced by a BIMS score of five. This resident was assessed to require setup with eating, toileting, dressing, and transfers, and partial assistance with bathing. The MDS assessment was not completed until 01/08/26. Interview on 01/21/26 at 3:30 P.M., MDS RN #159 verified MDS assessment was not completed within 14 days after the ARD for Resident #17 due to working in two buildings. 4) Record review of Resident #19 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident # 19 include dementia, dysphagia, hypertension, adult failure to thrive, and history of venous thrombosis. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #19 had severely impaired cognition and was dependent on staff for all activity of daily living skills. Review of the (continued on next page)

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

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's MDS completion log, revealed the resident's quarterly MDS start date was 10/06/25 and completion date was to be 10/30/25. The actual MDS completion date was 11/17/25. Interview on 01/22/26 at 3:30 P.M. the MDS RN #159 verified Resident #19 MDS should have been completed on 10/30/25 and was completed on 11/17/25, 18 days after the due date. 5) Record review of Resident #29 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #29 included diabetes, dysfunction of heart disease, chronic kidney disease, malnutrition, and coronary graft. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #29 had intact cognition and required-set assistance for eating and partial assistance for mobility. The resident received a carbohydrate controlled and no added salt diet. Review of Resident #29 MDS completion log, revealed the resident's quarterly MDS start date was 12/29/25 and completion date was to be 01/12/26. The actual MDS completion date was 01/15/26. Interview on 01/21/26 at 3:02 P.M. with MDS RN #159 confirmed the assessments for Residents #02, #04, #17, #19, and #29 were not completed timely as per RAI guidelines. MDS RN #159 stated she used the RAI manual as the procedural guide for MDS completion. Review of the Long-Term Care Facility RAI 3.0 User's Manual, Version 1.20.1, dated October 2025, pages 2-17 through 2-34, stated the MDS completion dates must be no later than 14 days after the ARD (ARD plus 14 days).

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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 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 medical record review, family interview, and staff interview, the facility failed to ensure care conferences were completed as required. This affected three (#07, #22, and #29) of three residents reviewed for care conferences. The facility also failed to ensure care plans were updated in a timely manner. This affected one (Resident #06) of one resident reviewed for advanced directives. The facility census was 30. 1) Review of the medical record of Resident #07 revealed an admission date of [DATE]. Diagnoses included dementia with agitation, senile degeneration of brain, schizoaffective disorder, bipolar type, chronic obstructive pulmonary disease, repeated falls, depression, gastro-esophageal reflux disease, prostate cancer. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #07 had severely impaired cognition. The resident required setup/cleanup assistance with eating, partial/moderate assistance with bed mobility and transfers, substantial/maximal assistance with toileting, and bathing. Interview on [DATE] at 12:24 P.M., Resident #07's wife stated she did not recall having a recent care conference. Review of the medical record on [DATE] at 9:55 A.M., revealed Resident #07 had care conferences completed on [DATE], [DATE], and [DATE]. There was no additional care conferences recorded. Interview on [DATE] at 9:55 A.M., Social Services (SS) #154 verified Resident #07 had not had a care conference since [DATE]. SS #154 stated care conferences should be completed at least every three months. 2) Review of the medical record for Resident #22 revealed an admission date of [DATE]. Diagnoses included cerebral palsy, protein-calorie malnutrition, major depressive disorder, hypothyroidism, and colon cancer. Review of the comprehensive MDS assessment for Resident #22 dated [DATE] revealed the resident had moderately impaired cognition. The resident required setup/cleanup assistance with eating, substantial/maximal assistance with bathing, bed mobility, transfers, and was dependent on staff for toileting. Review of the medical record for Resident #22 on [DATE] at 9:55 A.M. revealed the resident had care conferences on [DATE], [DATE], and [DATE]. There was no further care conferences documented. Interview on [DATE] at 9:55 A.M. SS #154 verified Resident #22 had not had a care conference since [DATE]. SS #154 stated care conferences should be completed at least every 3 months. 3) Record review of Resident #29 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #29 included diabetes, dysfunction of heart disease, chronic kidney disease, malnutrition, and coronary graft. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #29 had intact cognition and required set-up assistance for eating and partial assistance for mobility. The resident received a carbohydrate controlled and no added salt diet. Review of Resident #29's care conference log revealed the resident had no record of a care conference since [DATE]. Interview on [DATE] at 9:56 A.M. Resident #29 stated he had not had a care conference in awhile. He could not remember when he had a care conference meeting. Interview on [DATE] at 9:50 A.M., Social Service Designee, (SSD) #154 verified Resident #29 had no (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care conference since [DATE]. SSD #154 verified a care conference should be offered to the resident and responsible party each quarter of the year. 4) Review of the medical record for Resident #06 revealed an admission date of [DATE]. Diagnosis included arthropathy (joint pain), hypertension, chronic kidney disease stage 1, and muscle weakness. Review of the admission MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. She required supervisory assistance with dressing her upper body, toileting, transferring from her bed or chair, and walking with her walker. She required moderate hands-on assistance with dressing her lower body and sit-to-stand transfers. Further review of the electronic and physical medical records revealed Resident #06 was identified as having a Do Not Resuscitate – Comfort Care (DNR-CC) order in place, indicating she did not want any extraordinary life-saving interventions implemented if her heart or breathing stopped. The DNR-CC order was signed on [DATE]. The signed order was not uploaded into Resident #06's electronic record. Review of Resident #06's care plan revealed a focus initiated on [DATE] stating the resident has an advanced directive of Full Code with interventions including performing cardio-pulmonary resuscitation (CPR). Interview on [DATE] at 2:52 P.M. with MDS Registered Nurse (RN) #159 confirmed the discrepancy between Resident #06's code status in the medical record and the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure care-planned fall interventions were in place and failed to implement appropriate fall interventions following an unwitnessed fall. This affected one (Resident #07) of five residents reviewed for falls. The facility also failed to ensure neurological (neuro) checks were completed following unwitnessed falls. This affected five Residents (#06, #07, #19, #25, and #29) of five residents reviewed for falls. The facility census was 30. 1) Review of the medical record of Resident #07 revealed an admission date of 10/09/24. Diagnoses included dementia with agitation, senile degeneration of brain, chronic obstructive pulmonary disease, repeated falls, and prostate cancer. Review of a physician order for Resident #07 dated 01/22/25 revealed the resident was ordered to have a fall mat on the floor next to the left side of the bed. Review of the fall investigation dated 09/10/25 revealed Resident #07 had an unwitnessed fall in his room when he attempted to self-transfer unassisted. The resident was noted to be non-compliant with the use of his call light. Intervention implemented after the fall was education on the importance of using the call light when assistance was needed. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #07 had severely impaired cognition. The resident required setup/cleanup assistance with eating, partial/moderate assistance with bed mobility and transfers, substantial/maximal assistance with toileting and bathing. Review of the fall risk assessment for Resident #07 dated 12/10/25 revealed the resident was at a moderate risk for falls. Review of the plan of care for Resident #07 revised on 01/08/26 revealed the resident was at risk for falls related to a dementia, history of falls, use of medication, lack of safety awareness, noncompliance with ambulation and transfers, and noncompliance with fall interventions. Interventions included a fall mat to the left side of the bed. Observation on 01/20/26 at 9:43 A.M. revealed Resident #07 was lying in bed with his tray table over the bed in front of him. The fall mat was on the floor approximately four feet away from the bed. Interview on 01/20/26 at 10:03 A.M., Certified Nursing Assistant (CNA) #106 verified the fall mat was situated away from the bed and not in an appropriate position to be effective. Observation on 01/21/26 at 12:15 P.M. revealed Resident #07 was lying in bed with the tray table over the bed in front of him. The fall mat was not observed anywhere in the vicinity of the bed. Interview on 01/21/26 at 12:15 P.M., CNA #111 verified the fall mat was not next to the bed. CNA #111 stated the fall mat was probably pulled away when the tray table was placed in front of the resident; however, it should have been placed directly next to the bed once the tray table was in place. Interview on 01/21/26 at 4:13 P.M., the Director of Nursing (DON) verified education on the importance of using a call for Resident #07 was not an appropriate intervention after the unwitnessed fall on 09/10/25 due to his severely impaired cognition. Review of the facility policy titled, Managing Falls and Fall Risk, dated 03/2018, revealed a resident-centered fall prevention plan would be implemented. Staff would identify and implement relevant interventions to try to minimize serious consequences of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Review of the medical record for Resident #06 revealed an admission date of 11/09/25. Diagnoses included arthropathy (joint pain), hypertension, chronic kidney disease, and muscle weakness. Review of the Fall Risk Evaluation for Resident #06 dated 11/09/25 revealed a score of 11, which indicated the resident was at moderate risk for falls. Review of a physician progress note dated 01/07/26 revealed Resident #06 saw the facility's nurse practitioner (NP) on 01/06/26 for an acute visit presenting with a bruise on the right side of her scalp, swelling of her upper left lip, and a skin tear on her left wrist. When asked, Resident #06 reported that she had hit her hand on a screen door but could not recall any head trauma. Resident #06 reported she was up walking around the facility but did not remember falling. Resident #06 denied headaches, changes to her vision, or facial pain. The NP ordered for monitoring of the bruise for signs of worsening, start neuro checks; monitor lip swelling for any signs of infection or worsening; and implement measures to reduce the risk of falls and to continue with close monitoring and routine follow-up. Review of the MDS assessment for Resident #06 dated 01/15/26 revealed a Brief Interview of Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. Review of medical record for Resident #06 on 01/22/26 at 10:07 A.M., revealed no documented evidence of ordered neuro checks being completed after the resident was discovered with bruises on her scalp, swelling of her upper left lip and skin tear on her left wrist first documented on 01/06/26. Interview on 01/22/26 at 10:09 A.M., the DON verified there was no documented evidence of the ordered neuro checks being completed after Resident #06 was discovered with bruises on her scalp, swelling of her upper left lip and skin tear on her left wrist which was first documented on 01/06/26. 3) Review of the medical record of Resident #07 revealed an admission date of 10/09/24. Diagnoses included dementia with agitation, senile degeneration of brain, chronic obstructive pulmonary disease, repeated falls, and prostate cancer. Review of the fall investigation dated 08/26/25 revealed Resident #07 was found on the floor from an unwitnessed fall. The resident stated he attempted to self-transfer to go to the bathroom and fell. Further review of the medical record revealed no documented evidence of neuro checks being completed following the unwitnessed fall on 08/26/25. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #07 had severely impaired cognition. The resident required setup/cleanup assistance with eating, partial/moderate assistance with bed mobility and transfers, substantial/maximal assistance with toileting and bathing. Review of the fall risk assessment for Resident #07 dated 12/10/25 revealed the resident was at a moderate risk for falls. Review of the plan of care for Resident #07 revised on 01/08/26 revealed the resident was at risk for falls related to dementia, history of falls, use of medication, lack of safety awareness, noncompliance with ambulation and transfers, and noncompliance with fall interventions. Interventions included a fall mat to the left side of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/26 at 4:10 P.M., Regional Clinical Nurse (RCN) #160 verified there was no documented evidence of neuro checks being completed after Resident #07's unwitnessed fall on 08/26/25. RCN #160 stated neuro checks should be completed on any resident following any unwitnessed fall. 4) Review of the medical record for Resident #19 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, dysphagia, hypertension, adult failure to thrive, and history of venous thrombosis. Review of fall investigation dated 04/02/25 revealed Resident #19 had an unwitnessed fall on 04/02/25. On 04/05/25, a bruise was reported on the left ankle. There was no documented evidence that neuro checks were completed for the fall on 04/02/25 and no documentation of a thorough investigation completed related to the resident's left ankle bruises. Review of the MDS comprehensive assessment for Resident #19 dated 11/17/25 revealed the resident had severely impaired cognition and was dependent on staff for all activity of daily living skills. Interview on 01/22/26 at 1:35 P.M. the DON verified Resident #19 should have had neuro checks started for 72 hours after the unwitnessed fall of 04/02/25. The DON also verified there was no documented evidence of a thorough investigation being completed after the bruises on the resident's left ankle were discovered. 5) Review of the medical record revealed Resident #25 was admitted to the facility on [DATE]. Diagnoses included fracture of orbital floor on the right side, fracture of other specified skull and facial bones on the right side, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, generalized anxiety disorder, oropharyngeal dysphagia (difficulty swallowing), muscle weakness, seizures, and underweight status. Review of the fall investigations for Resident #25 revealed the resident experienced unwitnessed falls on 07/16/25, 07/17/25, 07/28/25, 07/30/25, 10/03/25, 10/27/25, 12/10/25, and 01/04/26. Review of the care plan for Resident #25's dated 01/09/26 revealed the resident was identified as a high risk for falls due to a history of falls, right sided hemiplegia/hemiparesis, impaired gait, poor safety awareness and recent subdural hemorrhage and subarachnoid hemorrhage, in addition to poor safety awareness. Review of Resident #25's medical record on 01/21/26 at 4:07 P.M. revealed no documented evidence that neuro checks were completed following any of Resident #25's unwitnessed falls on 07/16/25, 07/17/25, 07/28/25, 07/30/25, 10/03/25, 10/27/25, 12/10/25, and 01/04/26. Interview on 01/21/26 at 4:08 P.M., the DON verified the facility had no documented evidence that neuro checks were completed following any of Resident #25's unwitnessed falls on 07/16/25, 07/17/25, 07/28/25, 07/30/25, 10/03/25, 10/27/25, 12/10/25, and 01/04/26. 6) Review of the medical record for Resident #29 revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes, dysfunction of heart disease, chronic kidney disease, malnutrition, and coronary graft. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of fall investigation dated 12/28/25 revealed Resident #29 had an unwitnessed fall. There was no documented evidence that neuro checks were completed. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #29 had intact cognition and required set assistance for eating and partial assistance for mobility. The resident received a carbohydrate controlled and no added salt diet. Interview on 01/22/26 at 1:35 P.M. the DON verified Resident #29 should have had neuro checks for 72 hours following the unwitnessed fall on 12/28/25. The DON verified there was no documentation the Resident #29 had neuro checks after the fall. Review of the facility policy titled, Managing Falls and Fall Risk, dated 03/2018, revealed a resident-centered fall prevention plan would be implemented. Staff would identify and implement relevant interventions to try to minimize serious consequences of falling.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the facility policy, the facility failed to implement appropriate infection control practices for residents on transmission-based precautions. This affected four (Residents #06, # 07, #09, and #29) of five residents reviewed for transmission-based precautions (TBP.) The facility also failed to ensure staff performed appropriate hand hygiene after performing catheter care. This affected one (Resident #04) of one resident reviewed for catheter-use. The facility census was 30 residents.Findings include:Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to implement appropriate infection control practices for residents on transmission-based precautions. This affected four (Residents #6, # 7, #9, and #29) of five residents reviewed for transmission-based precautions (TBP.) The facility also failed to ensure staff performed appropriate hand hygiene after performing catheter care. This affected one (Resident #4) of one resident reviewed for catheter-use. The facility census was 30 residents. Findings include: 1) Review of the medical record for Resident #7 revealed an admission date of 10/09/24 with diagnoses including dementia, chronic obstructive pulmonary disease, and prostate cancer. Review of the Minimum Data Set (MDS) assessment for Resident #7 dated 10/15/25 revealed the resident had severely impaired cognition and required assistance with activities of daily living (ADLs.) Review of physician's orders for Resident #7 revealed an order dated 01/20/26 for the staff to maintain enhanced barrier precautions (EBP) related to the presence of a suprapubic catheter. Observation on 01/20/26 at 11:44 A.M. revealed Assistant Director of Nursing (ADON) #109 entered Resident #7's room with his lunch tray, placed the tray on the overbed table, and called down the hall for assistance with pulling the resident up in bed. The door to Resident #7's room indicated he was to be under contact precautions. Certified Nursing Assistant (CNA) #112 applied gloves and entered Resident #7's room. ADON #109 and CNA #112 then pulled Resident #7 up in bed. CNA #112 and ADON #109 did not don gowns prior to pulling Resident #7 up in bed, and ADON #109 did not don gloves before pulling Resident #07 up in bed. Interview on 01/20/26 at 11:53 A.M. with ADON #109 confirmed she was the facility's infection control designee and verified she did not wear a gown nor gloves when pulling Resident #7 up in bed. ADON #109 verified the door to Resident #7's room indicated he was on transmission-based precautions and staff should apply a gown and gloves upon any entrance to the room. Interview on 01/21/26 at 2:40 P.M. with Regional Clinical Nurse (RCN) #160 verified the signage on Resident #7's room was incorrect, as the sign said he was supposed to be contact precautions, and the physician's order indicated the resident was to be on enhanced barrier precautions. RCN #160 stated Resident #07 was on EBP, and staff should have worn a gown and gloves when pulling Resident #07 up in bed. 2) Review of the medical record for Resident #6 revealed an admission date of 11/09/25 with diagnoses including hypertension, chronic kidney disease, and muscle weakness. Review of the MDS assessment for Resident #6 dated 11/24/25 revealed the resident had moderately impaired cognition required partial/moderate assistance with ADLs. Review of a progress note for Resident #6 dated 01/12/26 revealed the resident tested positive for Coronavirus (COVID-19.) The resident was noted with a non-productive cough and sinus congestion. Review of the physician's orders for Resident #6 revealed an order dated 01/12/26 for transmission-based precautions: contact/droplet isolation in private room with all services provided in room related to COVID-19 for 10 days (until 01/22/26.) Observation on 01/20/26 at 9:58 A.M. revealed Resident #6's room had no signage indicating the resident was to be on droplet precautions. CNA #115 and Resident #6 exited the resident's room both wearing masks and walked down the hall to the common shower room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/20/26 at 10:06 A.M. revealed CNA #115 and Resident #6 exited the shower room both wearing surgical masks and walked back to the resident's room. Interview on 01/20/26 at 10:07 A.M. with CNA #115 confirmed she wore a surgical mask into the shower room and performed Resident #6's shower while wearing a surgical mask. CNA #115 verified she did not don a gown to care for Resident #6 and verified the resident was positive for COVID-19. Further interview with CNA #115 confirmed the resident was on contact and droplet precautions and the aide should have worn an N-95 mask and gown while tending to Resident #6. Interview on 01/21/26 at 2:40 P.M. with RCN #160 stated residents who were positive for COVID-19 should be bathed in their room or masked, if going to the shower room, and staff should wear an N-95 mask and gown when tending to the COVID-19-positive resident. 3) Review of the medical record for Resident #29 revealed the resident was admitted to the facility on [DATE] with diagnoses including diabetes, heart disease, and chronic kidney disease. Review of the MDS assessment for Resident #29 dated 12/29/25 revealed the resident had intact cognition and required assistance with ADLs. Review of physician's orders for Resident #29 revealed an order for EBP. Observation on 01/20/26 at 10:30 A.M. revealed there was a sign on Resident #29's door which indicated the resident was EBP and staff should wear a gown, a mask, and gloves for any direct care. ADON #154 applied oxygen via nasal cannula into Resident #29's nose, touching the resident's face, nose and ears. ADON #154 was not wearing a gown or gloves. Interview on 01/20/26 at 10:31 A.M. with ADON #154 verified she should have donned a gown and gloves while providing direct care to Resident #29 because he was on EBP. Interview on 01/22/26 at 1:35 P.M. with the Director of Nursing (DON) confirmed ADON #109 should have worn a gown and gloves when applying the oxygen tubing directly to Resident #29. 4) Review of the medical record for Resident #9 revealed an admission date of 07/18/25 with diagnoses including dementia, COVID-19, and diabetes. Review of the MDS assessment for Resident #9 dated 10/17/25 revealed the resident had intact cognition and required assistance with ADLs. Review of the physician's orders for Resident #9 revealed and order for transmission-based contact/ droplet precautions for 10 days starting on 01/12/26 and ending on 01/21/26 on night shift due to COVID-19 diagnosis. Observation on 01/21/26 at 7:41 A.M. revealed there was a sign on Resident #9's door indicating the resident was on droplet precautions and everyone must ensure their eyes, nose and mouth were fully covered before entering the room and to remove face protection before leaving the room. Hands must be cleaned before entering and when leaving the room. The sign had an image of face shield and a mask. CNA #133 entered Resident #9's room wearing a surgical mask. CNA #133 then exited the room without washing hands and wearing the same mask walked down the resident-occupied hallway. Interview on 01/21/26 at 7:43 A.M. with CNA #133 verified she did not wash her hands upon leaving Resident #9's room. CNA #133 verified she wore a surgical mask into Resident #9's room and exited the room with the same surgical mask. CNA #133 confirmed she should have worn a rated mask and (continued on next page)

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	365368	A. Building B. Wing	01/27/2026

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded it prior to exiting the room and she should have washed her hands. Interview on 01/22/26 at 1:36 P.M. with the DON verified CNA #133 should have worn a rated mask and should have washed her hands after care and removed the mask prior to exiting the room. 5) Review of the medical record for Resident #4 revealed an admission date of 09/24/24 with diagnoses including diabetes mellitus, atrial fibrillation, major depressive disorder, and peripheral vascular disease (PVD). Review of the physician's orders for Resident #4 revealed an order dated 07/10/25 for indwelling catheter care every shift. Review of the care plan for Resident #4 dated 07/15/25 revealed the resident had an indwelling catheter due to obstruction and reflux uropathy. Interventions included the following: catheter care per order, enhanced barrier precautions due to increased risk of infection, monitor for changes in color, odor, appearance of urine and notify nurse if noted. Review of the MDS assessment for Resident #4 dated 12/16/25 revealed the resident had moderate cognitive impairment and required assistance with ADLs. Observation on 01/22/26 at 9:10 A.M. of catheter care for Resident #4 per CNAs #110 and #113 revealed CNA #110 did not change gloves during and/or after catheter care and then touched clean linens, bed controls, bedside table, and Resident #4 with soiled gloves. Interview on 01/22/26 at 9:21 A.M. with CNA #110 verified she did not change her gloves after providing care and touched the above items. Review of the facility policy titled Handwashing/Hand Hygiene dated October 2023 revealed the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene should be completed immediately before touching a resident, before moving from work on a soiled body site to a clean body site on the same resident, and after contact with blood, body fluids, or contaminated surfaces.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, family interview, staff interview, and review of facility policies regarding significant changes in resident health status and weight assessment, the facility failed to notify residents' responsible parties of significant changes. This affected two residents (#25 and #07) out of five residents reviewed for notification of changes in status. The facility census was 30. Findings include: 1) Review of the medical record for Resident #25 revealed the resident was admitted to the facility on [DATE]. Diagnoses included fracture of orbital floor on the right side, fracture of other specified skull and facial bones on the right side, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, generalized anxiety disorder, oropharyngeal dysphagia (difficulty swallowing), muscle weakness, seizures, and underweight status. Review of the weight summary for Resident #25 ' s revealed the resident weighed 164.4 pounds (lbs.) on 07/15/25 (admission). The resident experienced a weight loss of 45 pounds (27 percent [%] weight loss) in less than six months when the resident ' s weight decreased from 164 pounds at admission to 119 pounds on 01/02/26. The weight summary indicated Resident #25 had a rapid weight loss between 07/22/25 and 08/01/25, when Resident #25 lost 32 pounds or approximately 20 % of his weight in a span of 11 days. Additionally, Resident #25 lost approximately eight % of his body weight from 12/02/25 (129 lbs.) to 01/02/26 (119 lbs.). Review of the progress notes for Resident #25 between 07/15/25 and 08/08/25 revealed there was no documented notification of any of Resident #25 ' s family or other authorized representatives regarding the significant weight loss the resident sustained. Interview via telephone on 01/22/26 at 11:40 A.M., Resident #25 ' s daughter stated she did not recall being notified of her father ' s weight loss at any point before visiting her father around the time of the Thanksgiving holiday in November, when she noticed he was considerably thinner than the last time she had seen him. Interview on 01/27/26 at 11:35 A.M., Regional Clinical Nurse #166 verified there was no documented evidence that the facility notified Resident #25 ' s family regarding the weight loss he sustained during July and August 2025. 2) Review of the medical record for Resident #07 revealed an admission date of 10/09/24. Diagnoses included dementia with agitation, senile degeneration of brain, schizoaffective disorder, bipolar type, chronic obstructive pulmonary disease, depression, gastro-esophageal reflux disease, and prostate cancer. Review of Resident #07 ' s weights revealed the following: a.On 02/18/25 the resident weighed 208.5 lbs. b.On 03/02/25, the resident weighed 209 lbs. c.On 04/02/25, the resident weighed 200.5 lbs. d.On 05/02/25, the resident weighed 194.5 lbs. e.On 06/02/25, the resident weighed 196 lbs. f.On 07/02/25, the resident weighed 195 lbs. g.On 08/02/25, the resident weighed 184 lbs. h.On 09/02/25, the resident weighed 178.5 lbs. i.On 10/02/25, the resident weighed 175.7 lbs. j.On 10/06/25, the resident weighed 175 lbs. k.On 10/13/25, the resident weighed 174.5 lbs. l.On 11/02/25, the resident weighed 179 lbs. m.On 12/01/25, the resident weighed 174 lbs. n.On 01/02/26, the resident weighed 174 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The weights indicated the resident experienced an 11.7 % weight loss between February 2025 and August 2025 and a 14.5 % weight loss between March 2025 and September 2025. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #07 had severely impaired cognition. The resident weighed 175 pounds (lbs.) and had a weight loss of five percent (%) or more in the last month or 10 % or more in the last 6 months. Interview via telephone on 01/20/26 at 12:30 P.M., Resident #07 ' s wife stated Resident #07 appeared to have lost weight; however, nobody from the facility had notified her of the weight loss. Review of the medical record on 01/21/26 at 10:14 A.M., revealed no documented evidence of Resident #07 ' s responsible party being notified of Resident #07 ' s significant weight loss. Interview on 01/21/26 at 10:15 A.M., Registered Dietitian (RD) #600 verified Resident #07 experienced an 11.7 % weight loss in August 2025 and 14.5 % weight loss in September 2025. RD #600 verified there was no documented evidence of Resident #07 ' s responsible party being notified of the significant weight loss. RD #600 stated the nurses were responsible for notifying responsible parties of significant weight loss. Interview on 01/21/26 at 3:48 P.M., the DON verified Resident #07 ' s significant weight loss and there was no documented evidence the resident ' s responsible party was notified. The DON stated that weight loss notifications should be completed by the nurses on the floor Review of the facility policy titled, Weight Assessment and Intervention, dated 03/2022, revealed a weight loss of 5% in one month is significant and greater than 5% is severe and a weight loss of 10% in six months is significant and greater than 10% is severe. Review of the facility policy titled, Change in a Resident's Condition or Status, revision date February 2021 revealed a significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, (is not self-limiting), that impacts more than one area of the residents ' health status, that requires interdisciplinary review and/or revision to the care plan; and ultimately is based on the judgement of clinical staff and the guidelines outlined in the resident assessment instrument. Further review of this policy revealed unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. In addition to notifying the resident's representative when there is any significant change in status, the facility is to notify the resident's representative if the resident is involved in any accident or incident that results in injury, including injuries of an unknown source.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record reviews, staff interviews, and policy reviews, the facility failed to implement the abuse policy upon the discovery of an injury of unknown origin. This affected one (Resident #06) of the one resident reviewed for abuse. The facility census was 30. Review of the medical record for Resident #06 revealed an admission date of 11/09/25. Diagnoses included arthropathy (joint pain), hypertension, chronic kidney disease, and muscle weakness.Review of the admission Minimum Data Set (MDS) assessment for Resident #06 dated 01/15/25 revealed a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. Review of a physician progress note dated 01/07/26 revealed Resident #06 saw the facility's nurse practitioner (NP) on 01/06/26 for an acute visit presenting with a bruise on the right side of her scalp, swelling of her upper left lip, and a skin tear on her left wrist. When asked, Resident #06 reported that she had hit her hand on a screen door but could not recall any head trauma. Resident #06 reported she was up walking around the facility but did not remember falling. Resident #06 denied headaches, changes to her vision, or facial pain. The NP recommended monitoring the bruise for signs of worsening and neurological (neuro) checks per the facility's protocol; monitoring lip swelling for any signs of infection or worsening; and implement measures to reduce the risk of falls and to continue with close monitoring and routine follow-up.Review of a nursing note dated 01/10/26 at 6:46 A.M. (created as a late entry 01/12/26 3:47 P.M.) revealed the staff observed bruising on Resident #06's upper forehead near her hairline and cheek. When the staff asked about her injury, Resident #06 said she had a fall in her room and did not tell anyone. The resident could not recall the date or time of the fall, only that she had fallen. A full skin assessment was completed and two bruises, one on each hip, were also identified. Resident #06's range of motion, vital signs, and neuro checks were within normal limits, and Resident #06 denied any pain or discomfort. Resident #06's physician and family were notified of the incident. Additionally, the facility's therapy department was notified to evaluate and treat as needed. An intervention was suggested to move Resident #06 from her room at the end of her hallway to one that is closer to the nurse's station for closer monitoring and supervision.Interview on 01/22/26 at 10:09 A.M., the Director of Nursing (DON) stated Resident #06's injuries were identified on 01/10/25 by the nursing staff. When asked, Resident #06 stated she fell but did not remember when or where the fall occurred. The DON stated the fall was determined to have happened recently based on the condition of the injuries. The DON confirmed Resident #06 was not a reliable historian but appeared to be lucid when discussing her injuries. The DON confirmed an investigation was not done because Resident #06 reported she had fallen.Interview on 01/22/26 at 12:47 P.M., Certified Nurse Practitioner (CNP) stated Resident #06 was seen on 01/06/26 for an acute care visit due to the staff identifying facial injuries. CNP #06 stated Resident #06 did not tell her the injuries were from a fall. CNP #06 stated she does not consider Resident #06 to be a reliable historian.Interview on 01/27/26 at 10:21 A.M., The Administrator stated if a resident had injuries of an unknown origin, the abuse policy should be followed until abuse and/or neglect was ruled out. The Administrator stated if the cause of the injuries was not determined, the facility should submit a self-reported incident (SRI) report to the state agency and start an investigation. The Administrator stated he was unsure if an SRI was submitted upon identification of Resident #06's injuries. Review of the policy titled Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, revised 09/2022, stated that all reports of resident abuse, including injuries of unknown origin, are to be reported to local, state, and federal agencies as required by regulations and are thoroughly investigated by facility management. The policy stated the Administrator was responsible for initiating the investigation.

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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 record reviews, staff interviews, review of Self-Reported Incidents (SRIs), and policy reviews, the facility failed to report an injury of unknown origin to the state agency. This affected one (Resident #06) of the four residents reviewed for falls. The facility census was 30. Review of the medical record for Resident #06 revealed an admission date of 11/09/25. Diagnoses included arthropathy (joint pain), hypertension, chronic kidney disease, and muscle weakness.Review of the admission Minimum Data Set (MDS) assessment for Resident #06 dated 01/15/25 revealed a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. Review of a physician progress note dated 01/07/26 revealed Resident #06 saw the facility's nurse practitioner (NP) on 01/06/26 for an acute visit presenting with a bruise on the right side of her scalp, swelling of her upper left lip, and a skin tear on her left wrist. When asked, Resident #06 reported that she had hit her hand on a screen door but could not recall any head trauma. Resident #06 reported she was up walking around the facility but did not remember falling. Resident #06 denied headaches, changes to her vision, or facial pain. The NP recommended monitoring the bruise for signs of worsening and neurological (neuro) checks per the facility's protocol; monitoring lip swelling for any signs of infection or worsening; and implement measures to reduce the risk of falls and to continue with close monitoring and routine follow-up.Review of a nursing note dated 01/10/26 at 6:46 A.M. (created as a late entry 01/12/26 3:47 P.M.) revealed the staff observed bruising on Resident #06's upper forehead near her hairline and cheek. When the staff asked about her injury, Resident #06 said she had a fall in her room and did not tell anyone. The resident could not recall the date or time of the fall, only that she had fallen. A full skin assessment was completed and two bruises, one on each hip, were also identified. Resident #06's range of motion, vital signs, and neuro checks were within normal limits, and Resident #06 denied any pain or discomfort. Resident #06's physician and family were notified of the incident. Additionally, the facility's therapy department was notified to evaluate and treat as needed. An intervention was suggested to move Resident #06 from her room at the end of her hallway to one that is closer to the nurse's station for closer monitoring and supervision.Review of facility SRIs on 01/27/26 at 10:20 A.M. revealed the facility did not report the injury of unknown origin first documented on 01/06/26. Interview on 01/22/26 at 12:47 P.M., Certified Nurse Practitioner (CNP) stated Resident #06 was seen on 01/06/26 for an acute care visit due to the staff identifying facial injuries. CNP #06 stated Resident #06 did not tell her the injuries were from a fall. CNP #06 stated she does not consider Resident #06 to be a reliable historian. Interview on 01/27/26 at 10:21 A.M., The Administrator stated if a resident had injuries of an unknown origin, the abuse policy should be followed until abuse and/or neglect was ruled out. The Administrator stated if the cause of the injuries was not determined, the facility should submit an SRI to the state agency and start an investigation. The Administrator stated he was unsure if an SRI was submitted upon identification of Resident #06's injuries. The Administrator verified that an SRI was not created upon identification of the injuries first documented on 01/06/26.Review of the policy titled Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, revised 09/2022, stated that all reports of resident abuse, including injuries of unknown origin, are to be reported to local, state, and federal agencies as required by regulations and are thoroughly investigated by facility management. The policy stated an injury of unknown origin must be immediately reported to the Administrator and other officials according to state law. The policy stated the Administrator or the individual making the allegation must immediately (within two hours if the allegation involves abuse or results in serious bodily injury; or within 24 hours if the allegation does not involve abuse or does not result in serious bodily injury) report suspicions to the state licensing/certification agency; the resident's representative; adult protective services; and the resident's attending physician. The policy stated the Administrator was responsible for initiating the investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews, staff interviews, review of Self-Reported Incidents (SRIs) and policy reviews, the facility failed to thoroughly investigate an injury of unknown origin. This affected one (Resident #06) of four residents reviewed for falls. The facility census was 30 Review of the medical record for Resident #06 revealed an admission date of 11/09/25. Diagnoses included arthropathy (joint pain), hypertension, chronic kidney disease, and muscle weakness.Review of the admission Minimum Data Set (MDS) assessment for Resident #06 dated 01/15/25 revealed a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. Review of a physician progress note dated 01/07/26 revealed Resident #06 saw the facility's nurse practitioner (NP) on 01/06/26 for an acute visit presenting with a bruise on the right side of her scalp, swelling of her upper left lip, and a skin tear on her left wrist. When asked, Resident #06 reported that she had hit her hand on a screen door but could not recall any head trauma. Resident #06 reported she was up walking around the facility but did not remember falling. Resident #06 denied headaches, changes to her vision, or facial pain. The NP recommended monitoring the bruise for signs of worsening and neurological (neuro) checks per the facility's protocol; monitoring lip swelling for any signs of infection or worsening; and implement measures to reduce the risk of falls and to continue with close monitoring and routine follow-up.Review of a late-entry nursing note dated 01/10/26 at 6:46 A.M. (created 01/12/26 3:47 P.M.) revealed staff observed bruising on Resident #6's right upper forehead near her hairline and cheek. When staff asked about her injury, Resident #06 said she had a fall in her room and did not tell anyone. She could not recall the date or time of the fall, only that she had fallen. A full skin assessment was completed and two bruises, one on each hip, were also identified. Resident #06's range of motion, vital signs, and neurological checks were within normal limits, and Resident #06 denied any pain or discomfort. Resident #06's physician and family were notified of the incident. An intervention was suggested to move Resident #06 from her room at the end of her hallway to one that is closer to the nurse's station for closer monitoring and supervision.Interview on 01/22/26 at 12:47 P.M., Certified Nurse Practitioner (CNP) stated Resident #06 was seen on 01/06/26 for an acute care visit due to the staff identifying facial injuries. CNP #06 stated Resident #06 did not tell her the injuries were from a fall. CNP #06 stated she does not consider Resident #06 to be a reliable historian.Review of facility SRIs on 01/27/26 at 10:20 A.M. revealed the facility did not report the injury of unknown origin first documented on 01/06/26. Interview on 01/27/26 at 10:21 A.M., The Administrator stated if a resident had injuries of an unknown origin, the abuse policy should be followed until abuse and/or neglect was ruled out. The Administrator stated if the cause of the injuries was not determined, the facility should submit a self-reported incident (SRI) report to the state agency and start an investigation. The Administrator verified the injuries of unknown first documented on 01/06/26 was not thoroughly investigated. Review of the policy titled Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, revised 09/2022, stated that all reports of resident abuse, including injuries of unknown origin, are to be reported to local, state, and federal agencies as required by regulations and are thoroughly investigated by facility management. The policy stated the administrator is responsible for initiating the investigation. The policy states the follow-up investigation report must provide sufficient information to describe the results of the investigation

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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 staff interviews and record reviews, the facility failed to provide bed hold notices to hospitalized residents. This affected two Residents (#29 and #32) of the four residents reviewed for discharges. The facility also failed to notify the State Ombudsman Agency of a resident's discharge. This affected one (Resident #36) of the four residents reviewed for discharges. The facility total census was 30. 1) Record review for Resident #29 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #29 included diabetes, dysfunction of heart disease, chronic kidney disease, malnutrition, and coronary graft. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed Resident #29 had intact cognition and required set assistance for eating and partial assistance for mobility. Review of hospitalization log revealed the Resident #29 was hospitalized on [DATE], 07/14/25 and 10/22/25. Interview on 01/22/26 at 1:35 P.M., Regional Clinical Nurse, (RCN) #160 verified Resident #29 should have had a bed-hold notice during hospitalizations on 07/04/25, 07/14/25 and 10/22/25. RCN #160 verified there was no documentation the Resident #29 received the required bed hold notices. 2) Record review for Resident #32 revealed the resident was admitted to the facility on [DATE] and 12/20/25. Diagnoses for Resident #32 include respiratory failure with atrial fibrillation, hypoxia and hypercapnia, incontinence, and obesity. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #32 had intact cognition and required maximum assistance with mobility and required set up assistance for meals. Review of hospitalization log on 01/22/26 at 1:35 P.M., with RCN #160 revealed Resident #32 was hospitalized on [DATE]. Interview with RCN #160 at the same time, verified Resident #32 should have received the required bed hold notice. Review of facility policy, Bed Hold and Returns, dated 2001, revealed all residents are provided written information which addresses reserving a resident's bed during hospitalization. 3) Review of the medical record for Resident #36 revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, repeated falls, and unspecified cerebrovascular disease amongst other diagnoses. Resident #36 was discharged from the facility due to hospitalization on 11/12/25. Interview on 01/21/26 at 9:40 A.M., Social Services Manager #154 stated the facility used email to notify the Ombudsman's Office of all resident transfers and discharges from the facility. Observation on 01/21/26 at 9:44 A.M. revealed no documented evidence available to verify that an email or other form of notification had been sent to the Ombudsman regarding Resident #36's discharge from the facility on 11/12/25. Interview on 01/21/26 at 9:45 A.M. with Social Services Manager #154 revealed the facility was unable to provide any documented evidence that the Ombudsman was notified of Resident #36's discharge from the facility on 11/12/25.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure significant change Minimum Data Set (MDS) assessments were completed in a timely manner. This affected one (Resident #07) of one resident reviewed for hospice services. The facility census was 30. Review of the medical record of Resident #07 revealed an admission date of 10/09/24. Diagnoses included dementia with agitation, senile degeneration of brain, schizoaffective disorder, bipolar type, chronic obstructive pulmonary disease, depression, and prostate cancer. Review of the significant change MDS assessment dated [DATE], revealed Resident #07 had severely impaired cognition. The resident required setup/cleanup assistance with eating, partial/moderate assistance with bed mobility and transfers, substantial/maximal assistance with toileting, and bathing. The assessment was not completed until 11/21/25. Review of the medical record on 01/22/26 at 3:45 P.M., revealed the resident began receiving hospice services on 10/06/25. Interview on 01/22/26 at 3:50 P.M., Registered Nurse (RN) #159 verified Resident #07's significant change assessment was not completed until 11/21/25. RN #159 stated the MDS assessment should have been completed by 10/19/25.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure a dental care plan was created timely. This affected one (Resident #04) of three residents reviewed for dental services. The facility census was 30.Review of the medical record revealed Resident #04 was admitted on [DATE]. Diagnoses included type II diabetes mellitus (DM II), atrial fibrillation, major depressive disorder, and peripheral vascular disease (PVD).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #04 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require setup with eating, dependent with toileting and transfers, partial assistance with bathing, and substantial assistance with dressing.Review of the physician order dated 07/10/25 revealed Resident #04 was ordered to see podiatrist, dentist, audiologist, and ophthalmologist. Interview on 01/21/26 at 3:55 P.M. with the Director of Nursing (DON) verified Resident #04 did not have a dental care plan until 01/21/26 when the Surveyor questioned the whereabouts. Review of the facility policy titled, Resident Participation - Assessment/Care Plans, dated February 2021 revealed the resident and his or her representative were encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. A comprehensive care plan was developed within seven days of completing the resident assessment.

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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** Based on review of the medical record, staff interviews, observations, and policy review, the facility failed to ensure dressing changes were changed as ordered. This affected one (Resident #04) of three residents reviewed for skin concerns. The facility census was 30. Review of the medical record revealed Resident #04 was admitted on [DATE]. Diagnoses included type II diabetes mellitus (DM II), atrial fibrillation, major depressive disorder, and peripheral vascular disease (PVD).Review of the physician order dated 11/25/25 revealed Resident #04 was ordered a continuous wound vacuum-assisted closure (Wound Vac) (therapeutic technique using a suction pump, tubing, and a dressing [usually foam] to apply sub-atmospheric pressure to a wound) at 125 millimeters of mercury (mmHg) to be changed every Monday, Wednesday, and Friday every shift.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #04 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require setup with eating, dependent with toileting and transfers, partial assistance with bathing, and substantial assistance with dressing.Review of the care plan dated 12/19/25 revealed Resident #04 had surgical wounds to the right foot with treatment in place. Interventions included encourage proper nutrition, in-house wound physician for wounds, outside wound clinic for amputation site, low air loss mattress to bed, medication and treatments as ordered by physician, and wound vac orders to right foot wound three times weekly and as needed Tuesdays, Thursdays, and Sunday.Review of the progress note dated 01/12/26 at 1:52 P.M. revealed Resident #04's wound vac to right foot changed without incidence.Observation on 01/20/26 at 12:24 P.M. revealed Resident #04's wound vac dressing had a date of 01/12/26.Interview on 01/20/26 at 12:29 P.M. with Registered Nurse (RN) #157 verified Resident #04's dressing had not been changed since 01/12/26, which revealed Resident #04 missed three dressing changes.Review of the facility policy titled, Wound Care, revised October 2010 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Verify that there was a physician's order for the procedure. Review the resident's care plan to assess for any special needs of the request. Assemble the equipment and supplies as needed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to thoroughly assess a resident's pressure wound upon admission and readmission. This affected one (Resident #32) of one resident reviewed for wound assessment. The facility total census was 30. Record review of Resident #32 revealed the resident was admitted to the facility on [DATE], discharged to the hospital on [DATE] and was readmitted to the facility on [DATE]. Diagnoses for Resident #32 included Stage IV pressure ulcer, respiratory failure with atrial fibrillation, hypoxia and hypercapnia, incontinence, and obesity. Review of the census information for Resident #32 revealed the resident was admitted to the facility on [DATE], discharged to the hospital on [DATE] and was readmitted to the facility on [DATE].Review of the Admissions Data Collection document for Resident #32 dated 12/19/25 (admission) revealed the resident had an open area on the sacrum. The document had no measurement of the pressure wound. Review of the Resident #32 readmissions Data Collect document for Resident #32 dated 01/03/26, revealed the resident was readmitted to the facility with an open area on the sacrum. The document had no measurement of the pressure wound other than the resident was noted to have a stage IV pressure wound on her sacrum. Review of the Weekly Pressure Ulcer documentation for Resident #32 dated 01/08/26, revealed the sacrum pressure wound measured 2.5 centimeters (cm) length by 3.0 cm width by 2.5 cm depth stage IV. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #32 had intact cognition and required maximum assistance with mobility and required set up assistance for meals.Review of Wound Evaluation Summary dated 01/15/26 revealed Resident #32's coccyx pressure wound measured 2.3 cm length by 3.0 cm width by 2.5 cm depth.Interview on 01/22/26 at 8:30 A.M. Registered Nurse (RN) #151 identified as being the facility's wound nurse, verified Resident #32 should have had wound measurements documented upon admission on [DATE] and the readmission from the hospital on [DATE] by the nurse who completed admission assessments. Interview on 01/22/26 at 8:45 A.M., RN #151, verified Resident #32's pressure area on the coccyx was measured by the Wound Care Physician #700 on 01/15/26 and decreasing in size. Interview on 01/27/26 at 10:50 A.M. the Director of Nursing, (DON), verified Resident #32 sacral pressure wound should have been measured upon admission on [DATE] and on readmission from the hospital on [DATE]. The DON verified the pressure wound measurements were not obtained. The DON verified there were no hospital documents available to verify the measurements of the pressure wound prior to admission and readmission. Review of the facility policy, Wound Care, dated 2001, revealed all assessment data, including size, is to be obtained when inspecting the wound and documented in the resident's medical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to implement and execute physician orders to ensure maintenance of acceptable nutrition status parameters. This affected one (Resident #25) out of five residents (#25, #02, #19, #07, and #29) reviewed for weight loss. The facility census was 30. Review of the medical record for Resident #25 revealed the resident was admitted to the facility on [DATE]. Diagnoses included fracture of orbital floor on the right side, fracture of other specified skull and facial bones on the right side, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, generalized anxiety disorder, oropharyngeal dysphagia (difficulty swallowing), muscle weakness, seizures, and underweight status.Review of the weight summary for Resident #25's revealed the resident weighed 164.4 pounds (lbs.) on 07/15/25 (admission). The resident experienced a weight loss of 45 pounds (27 percent [%] weight loss) in less than six months when the resident's weight decreased from 164 pounds at admission to 119 pounds on 01/02/26. The weight summary indicated Resident #25 had a rapid weight loss between 07/22/25 and 08/01/25, when Resident #25 lost 32 pounds or approximately 20 % of his weight in a span of 11 days. Additionally, Resident #25 lost approximately eight % of his body weight from 12/02/25 (129 lbs.) to 01/02/26 (119 lbs.).Review of the physician orders dated 07/15/25 for Resident #25 revealed an order for weekly weight measurements to occur each Tuesday morning for four weeks. Physician orders dated 08/08/25 revealed the resident was ordered to receive Med Pass 120 milliliters (mL) three times daily related to weight loss.Review of a dietary progress note for Resident #25 dated 08/08/25 and authored by Registered Dietician (RD) #600, revealed a weight warning noted due to weight loss from 163 lbs. on 07/22/25 to 131 lbs. on 08/01/25. Resident #25 received Speech Therapy (ST) services, and the dietary staff recommended addition of a nutritional supplement of Med Pass 120 mL to be given three times per day and to reweigh Resident #25. Review of Resident #25's medical record revealed no documentation to support the facility obtained a reweight on Resident #25 until 09/01/25 when Resident #25 was noted to weigh 128.9 lbs. Further review of Resident #25's weights revealed no documentation to support the facility obtained weekly weights per physician orders in July or August 2025.Review of the August and September 2025 medication administration records (MAR) and treatment administration records (TAR) for Resident #25, revealed the Med Pass supplement was marked as administered as ordered; however, there was no documentation of the intake/administered amounts of the supplement recorded from the start date of the order on 08/08/25 until 09/17/25. Interview on 01/21/26 at 10:15 A.M., RD #600 stated the facility was aware of Resident #25's significant weight loss and RD #600 stated interventions to prevent further weight loss included oral nutritional supplements, including a med pass supplement of 120 milliliters three times daily, a magic cup nutritional supplement given with lunch, and most recently a health shake nutritional supplement given with lunch and dinner. RD #600 stated the health shakes were recommended on 01/09/26 after Resident #25's weight loss was still present as of the nutritional risk assessment conducted on 01/09/26 which identified Resident #25 as high risk from a nutritional standpoint, and noted he was still losing weight despite other interventions.Review of active physician orders for Resident #25 on 01/21/26 at 12:53 P.M. revealed no documented evidence of a health shake nutritional supplement ordered to be given with lunch and dinner, as RD #600 had described. Interview on 01/21/26 at 3:50 P.M., the Director of Nursing (DON) stated the expectations were for the staff to obtain re-weights for residents who had a significant weight loss or if the recorded weight measurement was questionable. The DON confirmed Resident #25's weight measurements had not been obtained or recorded as ordered for July and August 2025. Interview via telephone on 01/22/26 at 2:35 P.M., RD #600 stated she did not know why Resident #25 lost so much weight since admission to the facility, especially from 07/22/25 to 08/01/25. RD #600 stated if a resident experienced significant weight loss, the facility staff should obtain weekly weight measurements until the resident's weight became stable. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RD #600 confirmed the facility had not obtained a reweight as requested after Resident #25's significant weight loss in August 2025 nor had the facility staff documented the amount of Med Pass nutritional supplements consumed by Resident #25 from 08/08/25 to 09/17/25. RD #600 also stated accurate records of the percentage of nutritional supplements consumed and accurate weight measurements are important pieces of information to help the monitor nutritional status and guide nutrition planning for residents in their care. RD #600 confirmed the health shake supplement was reordered on 01/21/26 because the order had not been obtained when recommended on 01/09/25.Review of a March 2022 facility policy titled Weight Assessment and Intervention revealed resident weights are monitored for undesirable or unintended weight loss or gain. The residents are weighed upon admission and at intervals established by the interdisciplinary team and interventions will be implemented for undesirable weight loss based on careful consideration by the care team.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, staff interview, review of the dialysis contract, and policy review, the facility failed to ensure pre/post dialysis communication forms were completed consistently and thoroughly and failed to ensure pre/post dialysis vital signs and weights were obtained as per physician orders. This affected one (Resident #02) resident who received dialysis. The facility census was 30. Review of the medical record for Resident #02 revealed an admission date of 11/05/2020 with medical diagnoses of end stage renal disease (ESRD) with dependency on dialysis, congestive heart failure (CHF), anxiety disorder, hypertension (HTN), and dementia.Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, which indicated Resident #02 had severe cognitive impairment and required substantial/maximum staff assistance for showers, bed mobility, and transfers and was dependent upon staff for toilet hygiene. The MDS indicated Resident #02 received dialysis. Review of the physician orders for Resident #02 dated 10/29/25 revealed the resident was ordered to receive pre-dialysis and post-dialysis vital signs and weights. Further review revealed a physician order dated 10/22/25 for dialysis at a dialysis center every Monday, Wednesday, and Friday with a chair time of 12:00 P.M.Review of the medical record for Resident #02 on 01/21/26 at 11:10 A.M. revealed no documentation to support the facility obtained post-dialysis weights or vital signs on 12/01/25, 12/08/25, 12/12/25, 12/26/25, or 12/26/25. Continued review revealed no documentation to support pre-dialysis weights or vital signs were obtained on 12/08/25, 12/22/25, and 12/26/25. Further review of the medical record revealed no documentation to support the facility ensured pre/post dialysis communication forms were completed thoroughly on 12/12/25, 12/19/25, 12/26/25, 12/29/25, and 12/31/25. The facility did not have documentation to support pre/post dialysis communication from was completed on 12/01/25. Interview on 01/21/26 at 11:11 A.M. with Regional Clinical Nurse (RCN) #160 confirmed Resident #02's medical record did not have documentation to support the facility obtained pre/post dialysis vital signs and weights or completed dialysis communications consistently or thoroughly in December 2025. Review of the facility dialysis contract, signed 05/19/24, stated in order to provide for continuity of care the ESRD facility would ensure current clinical data, events during dialysis, and other pertinent data would be supplied to the long-term care facility via a document agreed upon by both parties. The policy stated the facility shall ensure that all appropriate medical, social, administrative, and other information accompany all residents at the time of the transfer to the Center.Review of the facility policy titled, Care of a Resident with ESRD, revised September 2010 stated the agreements between the facility and the contracted ESRD would include how information would be exchanged between the facilities.

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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 medical record review, family interview, and staff interview, the facility failed to ensure care conferences were completed as required. This affected three (#07, #22, and #29) of three residents reviewed for care conferences. The facility also failed to ensure care plans were updated in a timely manner. This affected one (Resident #06) of one resident reviewed for advanced directives. The facility census was 30. 1) Review of the medical record for Resident #04 revealed an admission date of 07/10/25 with medical diagnoses of diabetes mellitus (DM), morbid obesity, hypertension (HTN), chronic kidney disease Stage III, and depression. Review of a physician order for Resident #04 dated 07/10/25 revealed the resident was ordered to receive Trulicity pen-injector (used to improve blood sugar levels) 0.75 milligram (mg) per 0.5 milliliter (ml) to inject 0.5 ml subcutaneously (SQ) one time weekly on Sunday and an order dated 09/09/25 for insulin glargine (long acting insulin) SQ pen-injector 100 units per ml to inject 17 units SQ every evening for diabetes mellitus. Review of the physician note dated 10/20/25 which stated Resident #04's blood glucose levels have been well-controlled on current medications of Trulicity and insulin glargine. The note stated to discontinue sliding scale insulin due to consistent glucose control and to monitor blood glucose levels and adjust treatment as needed. Further review of the medical record revealed a physician note dated 01/21/26 which stated to continue current medications and to monitor blood glucose levels regularly. Review of the medical record for Resident #04 revealed no documentation to support the facility staff obtained Resident #04 blood glucose levels since 10/30/25. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #04 had severe cognitive impairment and required partial/moderate staff assistance with showers, supervision with bathing, and was dependent upon staff for toileting hygiene and transfers. The MDS indicated Resident #04 received seven days of insulin. Interview on 01/27/26 at 8:56 A.M., the Director of Nursing (DON) stated she would expect staff to monitor Resident #04's blood glucose at least daily because Resident #04 still received insulin daily. The DON confirmed the medical record for Resident #04 did not contain any documentation to support the facility obtained blood sugar levels after 10/30/25. Interview on 01/27/26 at 1:13 P.M., Nurse Practitioner (NP) #500 stated the expectation for a resident who received insulin daily that the blood glucose levels would be checked daily also. NP #500 was not aware that Resident #04 did not have blood glucose levels checked since 10/30/25. 2) Review of the medical record of Resident #07 revealed an admission date of 10/09/24. Diagnoses included dementia with agitation, senile degeneration of brain, chronic obstructive pulmonary disease, and prostate cancer. Review of the medical record revealed the most recent valproic acid level was completed on 10/16/24. Review of a physician order dated 08/18/25 revealed Resident #07 was ordered to receive divalproex (Depakote) sodium oral capsule delayed release (DR) sprinkle 125 milligrams (mg)-give two capsules (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(250 mg) by mouth two times a day for unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and an order dated 03/24/25 for routine laboratory (lab) tests, including valproic acid (Depakote) level, to be completed every six months. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had severely impaired cognition. Interview on 01/27/26 at 10:00 A.M., the DON verified the last valproic acid was completed 10/16/24 and was to be completed every 6 months.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observations, staff interviews, and policy review, the facility failed to ensure medication error rate was less than five percent (%) during medication administration pass. This affected two Residents (#31 and #33) of four residents observed for medication administration. The facility census was 30. 1) Review of the medical record for Resident #33 revealed an admission date of 12/09/24. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and emphysema. Review of the physician order dated 07/15/25 revealed Keppra 500 milligrams (mg), give one tablet by mouth two times a day for seizures. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require setup with eating, toileting, and transfers, and partial assistance with bathing and dressing.Observation on 01/21/26 at 8:00 A.M. revealed Licensed Practical Nurse (LPN) #144 was unable to administer Keppra 500 mg to Resident #33 because the medication was unavailable. Interview on 01/21/26 at 8:07 PM with LPN #144 verified Keppra 500 mg was not available to be administered and had to be ordered from pharmacy.2) Review of the medical record for Resident #31 revealed an admission date of 08/01/22. Diagnoses included Parkinson's disease, moderate intellectual disabilities, and major depressive disorder.Review of the physician order dated 02/05/25 revealed Resident #31 was ordered Potassium Chloride Extended Release (ER) 10 milliequivalents (mEq) by mouth one time a day for hypokalemia. Review of the MDS assessment dated [DATE] revealed Resident #31 had moderate cognitive impairment as evidenced by a BIMS score of 11. This resident was assessed to require dependent with eating, substantial assistance with toileting and bathing, supervision with dressing, and setup with transfers.^Observation on 01/21/26 at 8:14 A.M. revealed Registered Nurse (RN) #157 crushed Potassium Chloride ER 10 mEq for Resident #31. Observations on 01/21/26 at 8:30 A.M. revealed 28 medications were observed for four residents (#16, #30, #31, and #33) were administered by two nurses (LPN #144 and RN #157) with two medication errors for a medication error rate of 7.14 %.Interview on 01/21/26 at 8:17 A.M. with RN #157 revealed she was unsure if she could crush Potassium Chloride but would find out and let me know.Subsequent interview on 01/21/2026 11:38 AM with RN #157 verified she was not supposed to crush Potassium Chloride. RN #157 notified the physician and got an order for liquid Potassium Chloride.Review of the facility policy titled, Administering Medications, dated April 2019 revealed medications were administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by the state to prepare, administer and document the administration of medications may do so. Medications were administered in accordance with prescriber orders including any required timeframe.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to notify the physician of abnormal laboratory (lab) results/values. This affected one (Resident #29), of one resident reviewed for labs. The total facility census was 30. Record review of Resident #29 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #29 included diabetes, dysfunction of heart disease, chronic kidney disease, malnutrition, and coronary graft. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed Resident #29 had intact cognition and required set-up assistance for eating and partial assistance for mobility. The resident received a carbohydrate controlled and no added salt diet.Review of physician orders dated 02/19/25 revealed the Resident #29 had orders for weekly potassium levels drawn every Wednesday and to fax the results to a designated nephrology practice physician. Review of potassium level lab tests dated 12/24/25, 12/31/25 and 01/14/26, revealed the potassium levels were above normal levels. There was an error documented for the potassium test dated 01/07/26 and there were no results available.Review of the nursing progress notes from 12/91/25 through 01/21/26 revealed no documented evidence that the results for the potassium levels were faxed to the nephrology physician.Review of the progress notes and entries by the Nurse Practitioner (NP) #500 from 12/19/25 through 01/21/26 revealed no notification acknowledgement for elevated potassium levels. Interview on 01/21/26 at 7:50 A.M., Registered Nurse, (RN) # 157 verified there was no nursing notes or other documentation the nephrology physician and the facility physician were notified. There was no return response documentation from the physicians to the elevated potassium levels. Interview on 01/22/26 at 9:39 A.M. NP #500 verified she had no evidence the facility had contacted her related to the elevated potassium levels for Resident #29. She had reviewed the lab values on her own when she assessed Resident #29 weekly and was unaware the 01/07/26 potassium level was unable to be obtained. The NP #500 verified she had ordered the potassium results be faxed to the nephrology physician so the nephrology physician could assist in monitoring the resident's elevated potassium changes. NP #500 was unaware if the nephrology physician ever received the resultsInterview on 01/22/26 at 2:00 P.M. Medical Records Staff #650 with the designated nephrology physician group verified the facility did not submit any potassium levels dated 12/24/25,12/31/25, 01/14/26, including the missed laboratory results of 01/07/26. Interview on 01/22/26 at 1:35 P.M. the Director of Nursing, (DON) verified there was no documented evidence that the facility notified the designated nephrology physician and the facility physician of Resident #29's elevated potassium laboratory results on 12/24/25,12/31/25, and 01/14/26, and the 01/07/26 missed laboratory results. The DON stated there should have been documentation that the nephrology physician was notified, including documentation in the nursing progress notes of the results being sent via facsimile (fax), a fax receipt and documentation of the physician response to the abnormal results. The DON verified there should have also been documentation the facility notified the facility NP #500 or the physician of the elevated potassium results.Review of facility policy, Change in a Resident's Condition or Status, dated 2001, the nurse will notify the physician when there has been a change in the resident's status and medical condition. The physician will be notified when there are specific instructions to notify the physician of changes in the resident condition.

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	365368	A. Building B. Wing	01/27/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure dental services were provided as required. This affected one (Resident #04) of three residents reviewed for dental services. The facility census was 30 residents.Findings include: Review of the medical record for Resident #04 was admitted on [DATE] diagnoses including diabetes mellitus, atrial fibrillation, major depressive disorder, and peripheral vascular disease (PVD).Review of the medical record for Resident #04 revealed the resident was seen by a dentist in August 2024. There were no subsequent dental visits.Review of the physician's orders for Resident #04 revealed an order dated 07/10/25 for the resident to receive dental services.Review of the Minimum Data Set (MDS) assessment for Resident #4 dated 12/16/25 revealed the resident had moderate cognitive impairment and required assistance with activities of daily living (ADLs.)Interview on 01/21/26 at 2:45 P.M. with Regional Clinical Nurse (RCN) #160 verified Resident #04 had not been seen by a dentist since August 2024.Review of the facility policy titled Dental Consultant dated April 2007 revealed dental care should be provided through the services of a consultant dentist retained by the facility.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to follow therapeutic diets as ordered by the physician. This affected three (Residents #02, #29 and #32) of three residents reviewed for therapeutic diets. The facility census was 30 residents.Findings include: 1.Review of the medical record for Resident #02 revealed an admission date of 11/05/20 with diagnoses including end stage renal disease, congestive heart failure, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 12/17/25 revealed the resident had severely impaired cognition and required maximum assistance with activities of daily living (ADLs.)Review of the physician's orders for Resident #02 revealed orders for dialysis three times a week and a renal diet. Review of the physician's orders for Resident #02 revealed an order dated 01/21/26 for a fluid restriction of 1500 cubic centimeters (cc) of fluid per day with 720 cc for dietary in 24 hours and a 300cc limit for breakfast. The nursing restriction was 720cc per nursing staff per 24 hours.Review of the care plan for Resident #02 dated 01/21/26 revealed the fluid restriction was updated to include the division of amounts between nursing and dietary. Observation on 01/22/26 at 7:40 A.M. revealed Resident #02 was in bed eating breakfast which included 240 cc milk, 120 cc of juice and 720 cc of water in a tumbler on the bedside table. There was no nutritional supplement. Resident #02's meal ticket revealed the breakfast meal should have had a limit of 300 cc including a nutritional supplement.Interview on 01/22/26 at 7:40 A.M. with Resident #02 confirmed she drank most of the water in the water tumbler two times a day from both nursing shifts and all drank the fluids the facility sent at meals. Resident #02 confirmed she was unaware she had orders to be on a fluid restriction.Interview on 01/22/26 at 7:42 A.M. with Certified Nursing Assistant (CNA) #106 verified Resident #2's tray had no nutritional supplement, and the breakfast fluids were over the 300 cc limit. The CNA #106 verified the water tumbler contained the full amount of fluid allotted for nursing, not including medication fluids and nursing second shift fluid allotment. CNA #106 stated she did not know Resident #02 was on a fluid restriction.Interview on 01/22/26 at 7:50 A.M. with Registered Nurse (RN) #157 confirmed she did not know Resident #02 was on a 1500 cc fluid restriction per day. She stated the physician orders were not listed until 01/21/26. RN #157 stated in order to stay within the nursing fluid limit, there should not be a water tumbler on the bedside table.Interview on 01/22/26 at 2:15 P.M. with CNA #133 confirmed she was not aware Resident #02 was on a fluid restriction and should not have a water tumbler on her bedside table. The CNA #133 verified she had provided the resident with water tumbler two times a day of 720 cc and the resident would drink at least half of the contents.Interview on 01/22/26 at 2:30 P.M with Registered Dietitian (RD) # 600 verified Resident #02 had not been on a fluid restriction since 09/29/25. The RD #600 verified Resident #2 should have been on a fluid restriction since 09/29/25 and the previous 1500 cc restriction should have been reordered after the hospitalization readmission on [DATE]. The RD #600 verified she restarted the 1500cc restriction on 01/21/26 after surveyor had questioned the fluid restriction.Interview on 01/22/26 at 1:35 P.M with the Director of Nursing (DON) verified Resident #02 should have been on a 1500cc fluid restriction since September 2025 as a part of dialysis protocol. She stated there should not be fluids at accessible at bedside when a resident is on fluid restrictions. There should be ordered limits of fluids for dietary and nursing.2.Review of the medical record for Resident #29 revealed an admission date of 04/03/24 with diagnoses including diabetes, heart disease, and chronic kidney disease. Review of nursing note for Resident #29 dated 10/22/25 revealed the resident had diuresis at the hospital and remained on an 1800 cc fluid restriction and diuretic medication. Review of the physician's orders for Resident #29 revealed an order dated 10/29/25 for an 1800 cc fluid restriction with no dietary and nursing limits listed. Review of the MDS assessment for Resident #29 dated (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/29/25 revealed the resident had intact cognition and required assistance with ADLs. Review of the physician's orders for Resident #29 revealed an order dated 01/21/26 for an 1800 cc fluid restriction with a dietary total of 1320 cc and nursing total of 480 cc per 24 hours. Observation on 01/22/26 at 7:15 A.M. revealed there was a care plan dated 01/15/26 located on the inside of Resident 29's closet door indicating staff should encourage the resident to drink fluids. There was no documentation of an 1800 cc fluid restriction.Observation on 01/21/26 and 01/22/26 at random times of the day revealed Resident #29 had a 720 cc water tumbler at the bedside and fluids at breakfast of 840 of fluids, including two cups of coffee. The CNAs provided the coffee for Resident #29 when he requested coffee. Interview on 01/22/26 at 7:40 A.M. with Resident #29 confirmed he did not know he was on a fluid restriction. He stated the CNAs give him coffee when he asks and he gets two water tumble containers provided by the CNAs. Interview on 01/22/26 at 7:40 A.M. with CNA #106 confirmed she did not know Resident #29 was on a fluid restriction at meals and throughout the day. She verified she provided the resident coffee upon request and brought water to his bedside twice a shift. CNA #106 further verified the resident had cans of soda in his refrigerator which he could access. The CNA #106 verified she did not know the plan of care was behind the closet door for reference, and verified it stated to encourage fluids without restriction. She stated she would have attempted to redirect the resident when he asked for fluids if she had known he was on a fluid restriction. Interview on 01/22/26 at 2:30 P.M with RD # 600 confirmed Resident #29 had been on a fluid restriction since 10/22/25 without limits for dietary and nursing department. The RD #600 verified Resident #29 should have been on a limited dietary and nursing restrictions so the departments could monitor the limits and provide the resident guidance on the fluid restriction. RD #600 stated she had no knowledge the resident had soda in his room refrigerator and verified there was no documentation of fluid restriction counseling for the resident. Interview on 01/22/26 at 1:35 P.M the DON verified the Resident #29 should have been on a 1800cc fluid restriction with limits of dietary and nursing departments. She stated there should not be fluids at accessible at bedside when a resident is on fluid restrictions. 3. Review of the medical record for Resident #32 revealed an admission date of 12/19/25 with diagnoses including respiratory failure with atrial fibrillation, hypoxia, and hypercapnia. Review of the physician's orders for Resident #32 revealed an order dated 01/05/26 for a 2000cc fluid restriction starting There were no fluid limits for dietary or nursing. Review of the MDS assessment for Resident #32 dated 01/09/26 revealed the resident had intact cognition and required assistance with ADLs. Observation on 01/22/26 at 2:40 P.M. of Resident #32's room revealed the care plan dated 01/15/26 located inside of the resident's closet door revealed it did not include documentation of a 2000 cc fluid restriction.Observation on 01/21/26 and 01/22/26 at random times revealed there was a 720 cc tumbler full of water accessible at Resident #32's bedside. Interview on 01/21/26 at 2:42 P.M. with Resident #32 confirmed she did know she was on a fluid restriction and verified she received a water tumbler provided by the nursing assistants twice a day. The resident denied having any counseling regarding the fluid restriction order. Interview on 01/22/26 at 7:40 A.M. with CNA #106 confirmed she did not know Resident #32 was on a fluid restriction at meals and throughout the day. She verified she provided the resident 720cc of water at her bedside twice a shift. CNA #106 verified she did not know the plan of care was behind the closet door for reference, and verified it stated no fluid restriction listed. CNA #106 stated she would not have provided water tumbler at bedside if she had known the resident was on a fluid restriction. Interview on 01/22/26 at 2:30 P.M with the RD # 600 verified Resident #32 was on a fluid restriction since 01/05/26 without limits for dietary and nursing department. The RD #600 verified Resident #32 should have been on limited dietary and nursing restrictions so the departments could monitor the limits and provide the resident guidance on fluid restrictions. The RD #600 verified there was no documentation of fluid restriction counseling for the resident. Interview on 01/22/26 at 1:35 P.M the DON confirmed Resident #32 should have been on a 2000cc fluid restriction since 01/05/26 with ordered limits of fluids for dietary and nursing. The DON stated there should not be fluids accessible at the bedside when a resident was on fluid restriction (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the plan of care should be accurate.Review of facility policy titled Encouraging and Restricting Fluids dated 2001 revealed when a resident was on fluid restricted fluids staff should remove the water pitcher and cup from the room and accurately record the resident's fluid intake.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were provided education on benefits and risks of the Coronavirus (COVID-19) vaccination. This affected two (Residents #02 and #25) of five residents reviewed for vaccinations. The facility census was 30 residents.Findings include:1.Review of the medical record for Resident #02 revealed an admission date of 11/05/20 with diagnoses including end stage renal disease (ESRD), congestive heart failure (CHF), anxiety disorder, hypertension (HTN), and dementia. Review Minimum Data Set (MDS) assessment for Resident #2 dated 12/17/25 revealed the resident had severe cognitive impairment and required substantial/maximum staff assistance with activities of daily living (ADLs.) Review of the medical record for Resident #02 revealed the resident had refused COVID-19 vaccination. The medical record did not include documentation regarding resident education on the risks and benefits of the vaccination. Interview on 01/22/26 at 12:09 P.M. with Regional Clinical Nurse #160 confirmed the medical record for Resident #02 did not include documentation of resident and/or resident representative education regarding the risks and benefits of the COVID-19 vaccine nor did the record include a signed declination form to support refusal of the COVID-19 vaccination. 2. Review of the medical record for Resident #25 revealed an admission date of 07/15/25 with diagnoses including hemiplegia and hemiparesis following cerebral infarction and generalized anxiety disorder. Review of the medical record for Resident #25 revealed the record did not include documentation of administration of a COVID-19 vaccine nor did the record include documentation of resident and/or resident representative education regarding risks and benefits of the vaccine. Interview on 01/27/26 at 8:52 A.M. with the Director of Nursing (DON) confirmed Resident #25's medical record did not include documentation regarding administration of the COVID-19 vaccine, nor did the record include documentation of resident/resident representative education of the risks and benefits of the vaccine. Review of the facility policy titled Coronavirus Disease (COVID-19)-Vaccination of Residents revealed each resident should be offered the COVID-19 vaccine unless the immunization was medically contraindicated or the resident was fully vaccinated. Before the COVID-19 vaccine was offered the resident was provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. Review of the facility policy titled Coronavirus Disease (COVID-19)- Vaccination of Residents revealed each resident should be offered the COVID-19 vaccine unless the immunization was medically contraindicated or the resident was fully vaccinated. Before the COVID-19 vaccine was offered the resident was provided with education regarding the benefits, risks, and potential side effects associated with the vaccine.