STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365431	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jenkins Memorial Health Facility	142 Jenkins Memorial Road Wellston, OH 45692

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement pressure ulcer prevention precautions for Resident #206 identified as having a facility acquired deep tissue injury (DTI) (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue). This affected one (Resident #206) of three residents reviewed for skin impairment. The facility census was 43.Findings include: Review of the closed medical record for Resident #206 revealed an admission date of 02/27/25 and was discharge to the hospital on [DATE]. Resident #206 diagnoses included aftercare following joint replacement surgery, dysphagia, non-rheumatic aortic valve stenosis, left bundle branch block, hypertension, urinary retention and recent gastrointestinal hemorrhage.Review of the Braden scale assessment dated [DATE] revealed Resident #206 was at a high risk for pressure ulcers with a score of 17. Review of the nursing admission assessment dated [DATE] revealed Resident #206 had bruising noted to right and left inner forearm and top of left hand related to intravenous sites during hospital stay. Resident #206 left medial midfoot had a small scab and left hip had surgical incision measuring 13 centimeters (cm) in length, zero cm in width and depth. Review of the admission five day Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #206 was cognitively intact with feelings of depression noted and no behaviors. Resident #206 had impaired range of motion to one side of lower extremities and used a wheelchair for mobility. Resident #206 required a set up for meals and substantial to maximum assistance from staff with toileting hygiene, bathing, bed mobility, sit to stand and transfers. The resident had an indwelling foley catheter and was occasionally incontinent of bowels. Resident #206 received scheduled and as needed pain medications along with non-pharmacological interventions. She had frequent pain that interfered with therapy and day to day activities at a moderate level. The only fall noted on assessment happened prior to admission resulting in recent hip replacement surgery. Resident #206 had no skin impairments noted except for surgical incision to left hip and had a pressure reducing device to bed. Review of the plan of care dated 03/03/25 revealed Resident #206 had the potential for impairment to skin integrity related to decreased mobility. The interventions included to encourage good nutrition and hydration to promote healthier skin, follow facility protocols for treatment of injury, identify and document any potential causative factors and eliminate or resolve when possible, resident required pressure relieving/reducing mattress, use caution during transfers and bed mobility to prevent striking arms, legs and hands against any hard surfaces, and weekly treatment documentation.Review of the initial pressure ulcer assessment by the wound nurse dated 04/03/25 revealed Resident #206 had a deep tissue injury to left heel that measured three centimeters (cm) by three cm by 0.1cm in depth. The deep tissue injury was intact with calloused skin noted on surrounding area/tissue. There was no odor or drainage noted. The left heel was cleansed with wound cleanser, skin prep applied, covered with non-adherent pad and wrapped in kerlix. The nurse noted the son stated he noticed Resident #206 rubbing her foot on the back nylon strap of her wheelchair pedal when sitting up in the wheelchair. Resident #206 was educated on the importance of reducing friction and placing feet further forward when feet were resting on the pedals. The nurse offered to pad the straps on the pedals and the resident and son declined. Resident #206 was educated to elevate bilateral lower extremities on pillows with heels floating off the bed while in bed and when resting in recliner. Resident #206 was encouraged to have good food and fluid intake to aid in healing the skin.Review of the physician orders and Treatment Administration Record (TAR) for Resident #206 revealed no orders to float heels or wear heal protectors while in bed. A new order on 03/29/25 to cleanse area to left heel with wound cleanser, pat dry, cover with calcium alginate, non-adherent gauze, pad with ABD pad, wrap with kerlix and ace wrap. Dressing changed every day and as needed. Staff to offload Resident #206 bilateral heels when in bed every shift. On 04/02/25 the order was changed to cleanse the left heel with wound cleanser, apply skin prep, non-adherent pad and wrap with kerlix. Dressing changed daily until healed.Review of the plan of care dated 04/04/25 revealed Resident #206 had a pressure ulcer to left heel related to decreased mobility. The interventions included to educate resident and family as to cause of skin breakdown including transfers and positioning requirement, importance of taking care during ambulation/mobility, good nutrition, frequent repositioning, follow facility policies for prevention and treatment of skin breakdown, monitor/document/report any changes in skin status and educate resident and family of the importance of changing positions for prevention of pressure ulcers Review of the Certified Nursing Assistant (CNA) history of documentation for

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a complete and accurate medical record affecting Resident #206. This affected one (Resident #206) of nine resident medical record reviews. The facility census was 43.Findings include:Review of the closed medical record for Resident #206 revealed an admission date of 02/27/25 and was discharged to the hospital on [DATE]. Resident #206 diagnoses included aftercare following joint replacement surgery, dysphagia, non-rheumatic aortic valve stenosis, left bundle branch block, hypertension, urinary retention and recent gastrointestinal hemorrhage. Review of the admission five day Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #206 was cognitively intact with feelings of depression noted and no behaviors. Resident #206 had impaired range of motion to one side of lower extremities and used a wheelchair for mobility. Resident #206 required a set up for meals and substantial to maximum assistance from staff with toileting hygiene, bathing, bed mobility, sit to stand and transfers. The resident had an indwelling foley catheter and was occasionally incontinent of bowels. Resident #206 received scheduled and as needed pain medications along with non-pharmacological interventions. She had frequent pain that interfered with therapy and day to day activities at a moderate level. The only fall noted on assessment happened prior to admission resulting in recent hip replacement surgery. Resident #206 was assessed to hold food in her mouth, have coughing/choking during meals and complained of difficulty or pain when swallowing. The resident received a mechanically altered diet with no weight loss. Current weight was 124 pounds. Resident #206 had no skin impairments noted except for surgical incision to left hip and had a pressure reducing device to bed.Review of the progress notes revealed on 04/06/25 Resident #206 was not acting herself. The Nurse Practitioner ordered chest X-ray, breathing treatments, oxygen and laboratory testing. Resident #206 was later sent to the emergency room for evaluation and treatment. However, the nursing progress notes were silent related to resident condition, date and time resident was sent to the emergency room, report called to emergency room, any follow up with the hospital and no order to send resident to the emergency room for evaluation and treatment. An interview 08/06/25 at 8:30 A.M. with the Assistant Director of Nursing (ADON) confirmed the medical record for Resident #206 was incomplete. The record did not include an order to send resident to emergency room, documentation of signs and symptoms of illness, report called to emergency room, time and date of the squad pick up or any follow up related to emergency room visit.