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	09/19/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 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 record review, observations, and interviews, the facility failed to ensure timely services were provided for a head injury as ordered by the physician, notification to the family of the incident, and ensure fall interventions in place. This affected one (Resident #22) of three residents reviewed for falls. The facility census was 44. Findings include:Record review revealed Resident #22 admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, and fatigue. Review of a care plan dated 11/18/24 revealed Resident #22 was at risk for falls related to deconditioning. The goal was to have less incidents of falls with injuries through the review date. Interventions included but were not limited to anticipate and meet resident's needs, call light in reach, dycem to wheelchair seat, non-skid strips to the floor on the left side of bed, visual cues to remind resident to use call lights, and a safe environment. Review of a physician order from Physician #101 dated 04/10/25 revealed staff should verify fall precautions are in place every day and night shift for Resident #22. Review of a Fall Risk Evaluation dated 07/15/25 revealed Resident #22 had no falls in the past three months, had intermittent confusion, had a balance problem while standing and walking, and required the use of assistive devices. Review of a minimum data set (MDS) dated [DATE] revealed Resident #22 had mildly impaired cognition, no behaviors, and had no falls since admission. Review of a nursing note dated 08/10/25 at 10:15 A.M. by Licensed Practical Nurse (LPN) #107 revealed Resident #22 was found on the floor in her room next to her bed and stated she was reaching for a remote and rolled off the bed onto the floor. During assessment of Resident #22, a laceration to the left side of her head was identified and Resident #22 stated she hit it on the bedside table. No other injuries were noted and all extremities were moving as usual for resident. Resident #22 was assisted off the floor by two staff members into her wheelchair, the wound on her head was cleansed and bacitracin was applied to the injury. LPN #107 documented Resident #22's daughter was made aware of the fall, and the on-call physician was made aware. Neurochecks were initiated and within normal limits and resident was educated to use her call light to ask for help reaching items she had dropped. Review of a nursing note dated 08/10/25 at 4:07 P.M. by LPN #107 revealed at around 3:15 P.M., a scheduled neurocheck was completed and Resident #22 was noted to have a fixed left eye and all previous neurochecks had been within normal limits. Resident #22 was noted to have confusion, and her words were jumbled and did not make sense. The physician was made aware the family requested Resident #22 go to the emergency department and 911 was called at 3:26 P.M. Resident #22 left the facility in the ambulance at 4 P.M. Report was called to the emergency department. Review of a nursing note dated 08/10/25 at 8:35 P.M. by LPN #102 revealed Resident #22 returned to the facility with four staples to her head and no new orders. Review of a triage note dated 08/10/25 at 11:59 P.M. by Nurse Practitioner (NP) #105 an electronic communication between NP #105 and LPN #107 which revealed the following:- LPN #107: Resident #22, vital signs were 97.2 degrees Fahrenheit temperature, 55 beats per minute, 21 breaths per minute, blood pressure of 144/62 and oxygen of 95% on room air. Resident #22 was found on the floor next to the bed, stated she was reaching for the remote, did hit head when fell on bedside table handle causing a 4 (four) centimeter (cm) laceration to the left side of her head, cleansed and applied bacitracin, no other injuries noted, resident is not on blood thinners and neurochecks are within normal limits. - NP #105 responded with: any change in mental status? Is patient able to recall the event? Any complaints of pain anywhere? Any cuts, abrasions, bruising, or open areas due to fall or any bleeding? How is range of motion (ROM)? Is patient able to flex and bend extremity? Any swelling to extremity or joint? Is patient on a blood thinner? How is pupil reactivity to light? Any difficulty breathing or shortness of breath? Any sweats, nausea, headache or chest pain?- LPN #107: No changes in mental status, able to recall event, ROM is per resident's normal, extremities move well, pupil reactions is good, no other symptoms and not on a blood thinner.- NP #105: New order for laceration, cleanse site with warm water and soap daily, pat dry, apply steri-strips to area, monitor vital signs every 4 hours for 24 hours, neurochecks per facility protocol, notify of any increase in lethargy, change in mental status or difficulty with following commands, continue to monitor patient and vital signs, continue to follow facility protocol and follow up with primary care provider. Interview on 09/19/25 at 12:51 P.M. with Certified Nursing Assistant (CNA) #113 revealed Resident #22 had an incident where she was not sent out to the hospital until after six hours after her head was injured and still bleeding. CNA #113 stated she had been assigned to the memory care unit but she was taking her residents out to church then helped the aides on the long term unit when she heard screaming. CNA #113 stated there