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	02/06/2025

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

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on closed record review and interviews, the facility failed to provide an appropriate transfer notice with Ombudsman notifications to either the resident or designated representative. This affected one resident (Resident #5) out of three residents reviewed for facility discharge. The facility census was 40. Findings include: Closed Record Review of Resident #5 on 02/04/25 at 11:21 A.M. revealed this resident was admitted to the facility on [DATE] and discharged to the hospital on 01/20/25 with the following medical diagnoses: chronic kidney disease, GERD, chronic pain, altered mental status, osteoarthritis, fatigue, irritable bowel syndrome, neuralgia and neuritis, gout, hyperglycemia, depression, anxiety, arthritis, shortness of breath, difficult ambulation, and aspirin use. Review of the Minimum Data Set (MDS) assessment completed on 11/26/24 revealed Resident #5 was alert and oriented to name only and had severe cognitive impairment. Review of facility transfer and discharge information revealed no ombudsman notifications were completed. Review of facility notifications for this resident revealed the State Ombudsman was not notified of the transfer. Interview with the Administrator on 02/04/25 at 10:37 A.M. verified that one of the Ombudsman had informed the facility in the past that a notification was not necessary, and they did not need to be notified of each transfer. The Administrator verified the facility has not been submitting this information to the Ombudsman.

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

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on record review and interview, the facility failed to complete a significant change Pre Admission Screening and Resident Review (PASARR) for Resident #7 and failed to ensure the admission PASARR was completed accurately for Resident #31. This affected two (Resident #7 and Resident #31) of four residents reviewed for PASARR. The facility census was 40. Findings include: 1. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including unspecified dementia with psychotic disturbance, diabetes mellitus type two, peripheral vascular disease, visual hallucinations, auditory hallucinations, depressive disorder and bipolar disorder. Review of the physician order dated 11/20/23 revealed Resident #31 was ordered Celexa (antidepressant/antianxiety medication) 20 milligrams (mg) by mouth one time daily for anxiety. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #31 had intact cognition with no mood or behaviors. Resident #31 had diagnosis of dementia, depression and bipolar disorder. Resident #31 received antidepressant medication. Review of the plan of care for Resident #31 revealed Resident #31 had a behavioral problem exhibited being rude, demanding and verbally abusive to staff, and had a history of visual and auditory hallucinations. The goal was to have no increase in behavior problems through review date. the interventions included to administer medications as ordered, monitor for side effects/effectiveness of medications, attempt gradual dose reductions as ordered by physician, attempt to anticipate and meet the residents needs in timely manner, encourage and allow time to voice needs and concerns, attempt to use alternative interventions to medications to manage behaviors and attempt to determine/eliminate the underlying cause, intervene as necessary to protect the rights and safety of others, and consult behavioral health as needed. Review of the admission PASARR dated 11/15/23 revealed Resident #31 had indications of serious illness such as mood disorder and had dementia. Resident #31 had not been prescribed any psychotropic medications such as anti-psychotics, anti-depressants, anti-anxiety or mood stabilizers. Interview on 02/05/25 at 1:43 P.M. with Social Services Director #106 confirmed the admission PASARR dated 11/15/23 did not include the anti-depressant medication Celexa. 42728 2. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Parkinsonism, Post Traumatic Stress Disorder (PTSD), and anxiety disorder. Review of the physicians order, dated 03/15/24, revealed the resident was admitted to hospice services. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Significant Change Minimum Data Set (MDS) assessment, dated 03/20/24, revealed the resident was receiving hospice services. Further record review for Resident #7 revealed a significant change PASARR assessment was not completed following the resident being newly admitted to hospice services or the completion of the Significant Change MDS assessment. Interview with Social Services Director #106 on 02/05/25 at 1:43 P.M. confirmed a significant change PASARR assessment had not been completed following Resident #7 beginning hospice services on 03/15/24 or after the Significant Change MDS assessment was completed on 03/20/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34299 Based on interview and record review, the facility failed to invite Resident #31 to attend quarterly care conferences. This affected one resident of 12 reviewed for care planning and care conference. The facility census was 40. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including unspecified dementia with psychotic disturbance, diabetes mellitus type two, peripheral vascular disease, visual hallucinations, auditory hallucinations, depressive disorder and bipolar disorder. Review of the physician orders dated 02/25 revealed several changes in medication since Resident #31 was admitted . Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #31 had intact cognition with no mood or behaviors. Resident #31 required partial to moderate assistance from staff to complete activities of daily living. Resident #31 had diagnosis of dementia, depression and bipolar disorder. Resident #31 received antidepressant medication. Review of the progress notes from 11/20/23 through 02/04/25 revealed no documentation that Resident #31 was invited or attended his quarterly care conferences. Review of the plan of care note dated 11/06/24 at 5:02 P.M. revealed the plan of care meeting was held with the plan of care team and Resident #31 sister via phone. The current plan of care, medications, code status and other orders were reviewed. All questions and concerns were addressed during the meeting. There was no indication Resident #31 was invited or attended. Review of the plan of care note dated 08/08/24 at 11:56 A.M. revealed the plan of care meeting was held with the plan of care team and Resident #31 daughter via phone on 08/07/24. The current plan of care, medications, code status, and other orders were reviewed. All questions and concerns were addressed during the meeting. There was no indication Resident #31 was invited or attended. Review of the plan of care for Resident #31 revealed no concerns. An interview on 02/04/25 at 8:11 A.M. revealed Resident #31 was not sure if he had went to any kind of meetings to talk about his care. An additional interview on 02/05/25 at 8:35 A.M. revealed Resident #31 stated he was sure he had not attended any meetings with the nurse or social worker about his care. Resident #31 also stated he did not recall anyone inviting him to attend such meetings. Resident #31 stated he would like to be involved in his care and make decisions about what he would like. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/05/25 at 1:55 P.M. with Social Services #105 and MDS nurse #157 stated any resident below the intact cognition line per the Resident Assessment Instrument (RAI) were not invited to care conferences due to not being able to make decisions about their care. Resident #31 last Brief Interview of Mental Status (BIMS) score was 12, and prior to that it was three. Resident #31 fluctuates with his cognition. Social Services #105 confirmed Resident #31 was not invited to attend any of his care conferences. Social Services #105 also stated Resident #31 sister or daughter attended. Social Services #105 confirmed Resident #31 had the right to attend and that Resident #31 did not have a Power of Attorney or Guardian appointed.

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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** 33023 Based on record review and interviews, the facility failed to provide an ordered psychiatric consult following a gradual dose reduction (GDR) recommendation. This affected one (Resident #35) out of five residents reviewed for unnecessary medications. The facility census was 40. Findings include: Record review of Resident #35 on 02/04/25 at 2:06 P.M. revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: Parkinson's disease, altered mental status, physical debility, hallucinations, osteoporosis, anxiety, depression, hyperlipidemia, GERD, constipation, dysphagia, edema, depression, and glossodynia. Review of the Minimum Data Set (MDS) assessment completed on 01/22/25 revealed resident was alert and oriented to name only and had minimal cognitive impairment Review of physician orders revealed this resident is receiving the following medications: Venlafaxine 150 milligrams (mg) 1 tablet by mouth twice daily for anxiety; Clozapine 100 mg 1 tablet by mouth daily at bedtime for hallucinations; Clozapine 25 mg 1/2 tablet by mouth daily at bedtime for hallucinations; and Pimavanserin 34 mg 1 tablet by mouth daily for depression. Review of the medication regimen review dated 12/01/24 revealed a recommendation was made for Clozapine, Pimavanserin, and Venlafaxine to use per current standards of practice for GDR consideration. Review of physician response dated 12/03/24 was to follow up with Ohio State University ([NAME]) psychiatric services for management of psychiatric medications. Review of physician orders and consult results revealed Resident #35 was not seen by the ordered psychiatric service which was written as the GDR response. No evidence of the ordering physician being notified was provided for the deviation of the order. Facility provided a new order for the resident to follow up with [NAME] psych was obtained on 02/04/25, which was not carried out previously. Interview with the Director of Nursing on 02/04/25 at 4:10 P.M. verified the facility had a breakdown in communication in regards to the consultation for psychiatric services for this resident. She verified instead of making an appointment with the written provider, the resident was seen in-house by the facility service, and the physician was not notified of this change to the order. She verified an appointment with the ordered provider was obtained on 02/04/25.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, and record review, the facility failed to ensure interventions to prevent the worsening of contracture's were implemented. This affected one resident (#7) out of the two residents reviewed for limited range of motion during the annual survey. The facility census was 40. Findings include: Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] and had diagnoses including Parkinsonism, Post Traumatic Stress Disorder (PTSD), and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/21/24, revealed the resident was assessed to have mildly impaired cognition and limited range of motion to bilateral upper extremities. Review of the Occupational Therapy Discharge Progress Note, signed 08/13/24, revealed recommendations skilled Occupational Therapy (OT) services indicated to promote skin integrity and Passive Range of Motion to left hand for application of therapy carrot daily for left hand stiffness. Review of the care plan, revised 08/15/24, revealed Resident #7 had potential for skin breakdown due to hand contracture's. Interventions included palm protector to right hand as ordered and staff to apply therapy carrot to left hand daily for four to six hours as indicated. Review of the active and discontinued physicians orders for Resident #7 revealed no orders for a palm protector or therapy carrot had been implemented. Review of the progress notes, dated 08/15/24 through 02/06/25, revealed no documentation related to the placement or refusal of therapy carrots or palm protectors. Observation on 02/03/25 at 1:35 P.M. revealed Resident #7 was lying in bed with no devices in place to the left or right hand. Both hands were observed to be contracted. A therapy carrot was lying on the bedside table next to the residents bed and a palm guard was lying on the nightstand in the corner of the room. Interview with Resident #7 at the time of the observation confirmed staff were supposed to place a therapy carrot and palm guard in her hands but frequently did not. Observation on 02/04/25 at 9:25 A.M. revealed Resident #7 was sitting up in a geri-chair in the dining area. The resident did not have any devices in place to the left or right hand. Observation on 02/05/25 at 2:55 P.M. revealed Resident #7 was lying in bed. The resident did not have any devices in place to the left or right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Occupational Therapist (OT) #222 on 02/06/25 at 10:20 A.M. confirmed Resident #7 had received Occupational Therapy services due to contracture's of the left hand. OT #222 confirmed a therapy carrot had been recommended upon discharge from therapy services to prevent worsening of contracture's. OT #222 confirmed nursing staff were to provide the specific details and orders for the application of devices after discharge from therapy services. Observation with OT #222 on 02/06/25 at 10:26 A.M. confirmed there was not a therapy carrot or palm guard in place to Resident #7's left or right hand. OT #222 pulled open the fingers of Resident #7 and the residents skin was intact with no visible alterations. Interview with Certified Nursing Assistant (CNA) #158 on 02/06/25 at 10:32 A.M. confirmed there were no orders or tasks in place for a therapy carrot, palm guard, or other device for Resident #7. CNA #158 confirmed she was not aware of Resident #7 requiring a palm guard or therapy carrot to be placed in her hands and was unsure if any other staff placed any devices in her hands. Interview with Licensed Practical Nurse (LPN) #125 on 02/06/25 at 10:38 A.M. confirmed there were no orders in place for a therapy carrot, palm guard, or other device to be placed in the hands of Resident #7. Interview with the Director of Nursing (DON) on 02/06/25 at 1:10 P.M. confirmed orders for the placement of a therapy carrot and a palm guard had not been put into place for Resident #7 following the residents discharge from OT services. The DON confirmed there was no evidence the resident had a therapy carrot or palm guard placed her in hands per the plan of care.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews and interviews, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify causes and triggers for trauma. This affected one resident (#7) reviewed for PTSD during the annual survey. The facility identified one resident having a diagnosis of PTSD. The facility census was 40. Findings include: Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Parkinsonism, PTSD, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/21/24, revealed the resident was assessed to have mildly impaired cognition. Review of the care plans for Resident #7 revealed there was not a plan of care in place addressing the residents PTSD or trauma. Further record review for Resident #7 revealed there was not an assessment of the cause of the residents PTSD or potential triggers for PTSD. Interview with Social Services employee #105 on 02/05/25 at 3:20 P.M. confirmed an assessment of the cause and triggers for Resident #7's PTSD had not been conducted and there was no plan of care in place to address the PTSD.

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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** 34299 Based on record reviews and interviews, the facility failed to ensure parameters for the monitoring and reporting of hypoglycemia (low blood sugar) were in place. This affected one resident (#31) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 40. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including unspecified dementia with psychotic disturbance, diabetes mellitus type two, peripheral vascular disease, visual hallucinations, auditory hallucinations, depressive disorder and bipolar disorder. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #31 had intact cognition with no mood or behaviors. Resident #31 required partial to moderate assistance from staff to complete activities of daily living. Resident #31 had diagnosis of dementia, depression and bipolar disorder. Resident #31 received antidepressant medication and insulin. Review of the physician orders dated 02/25 revealed Resident #31 received the following medications for treatment of diabetes mellitus type two. Metformin 500 milligrams (mg) by mouth two times daily, Basaglar Kwik-pen 100 units (u) per milliliter (ml) subcutaneously two times daily and Novolog Flex-pen injector 100u/ml subcutaneously before meals per sliding scale of blood sugar 151-200 give two units, 201-250 give four units, 251-300 give six units, 301-350 give eight units, 351-400 give 10 units, 401-450 give 12 units and 451-500 give 15 units and notify provider. The physician orders did not include orders for low blood sugars or parameter of what constitutes a low blood sugar. Review of the nursing progress notes dated 11/20/23 through 02/05/25 revealed no concerns related to low blood sugars. Review of the plan of care revealed Resident #31 had diabetes mellitus with hyperglycemia (high blood sugar) with a goal to free from signs and symptoms of hyperglycemia through the next review date. The interventions included to administer diabetes medication as ordered, monitor for side effects and effectiveness of medications, dietary consult as needed, educate resident regarding medications and importance of compliance, fasting serum blood sugar/fingersticks as ordered, insulin per sliding scale orders, monitor/document and report as needed any signs and symptoms of hyperglycemia including increased thirst and appetite, frequent urination, weight loss fatigue, dry skin, poor wound healing, muscle cramps, Kussamaul breathing, acetone breath, stupor or coma, monitor and report any signs and symptoms of infection to open areas, offer substitute for foods not eaten, refer to podiatry as needed and nurse to wash feet daily with mild soap and water and dry thoroughly. There was no plan of care addressing hypoglycemia or low blood sugar. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/05/25 at 8:41 A.M. with Registered Nurse (RN) #165 revealed if a resident had a low blood sugar,(unable to identify exact number for a low blood sugar) the nurse would follow the standing orders in the book located at the nursing station. The standing order stated if a resident had a low blood sugar (no parameter or number) and the resident was able to swallow, administer six ounces of orange juice and recheck the blood sugar in 15 minutes. If the blood sugar remained low, repeat and notify the physician. RN #165 confirmed the order did not have a parameter or number of what was a low blood sugar. Interview on 02/05/25 at 3:28 P.M. with the Director of Nursing (DON) #128 confirmed Resident #31 did not have parameters for a low blood sugar or orders to treat hypoglycemia (low blood sugar) including glucagon.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview and record review, the facility failed to ensure Resident #25 had the appropriate diagnosis for an antipsychotic medication. This affected one (Resident #25) of five residents reviewed for unnecessary medications. The facility census was 40. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, unspecified dementia with behavioral disturbance, insomnia, chronic pain, and diabetes mellitus with hyperglycemia. Review of the physician orders dated 02/25 revealed Resident #25 was ordered and received Risperdal 0.5 milligrams (mg) by mouth at bedtime for unspecified dementia with other behavioral disturbance. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #25 had moderate cognitive impairment with disorganized thinking. Resident #25 had physical behavioral symptoms, verbal behavioral symptoms, rejection of care and wandering. Resident #25 required partial to moderate assistance of one staff for activities of daily living. Resident #25 had diagnoses including dementia with behavioral disturbance, insomnia, metabolic encephalopathy, chronic pain and diabetes mellitus. Resident #25 received an antipsychotic medication. Review of the nursing progress notes from 12/12/24 through 02/05/25 revealed several notes related to Resident #25 behaviors. Review of the Certified Nursing Assistants (CNA) documentation revealed Resident #25 had episodes of behaviors daily. Review of the plan of care revealed Resident #25 had a behavior problem related to dementia and impaired cognition with a goal to exhibit less behaviors through the review date. The interventions included to administer medications as ordered, monitor for side effects and effectiveness, attempt a gradual dose reduction as ordered by physician, attempt to anticipate and meet resident needs, attempt to use alternative interventions to mediations to manage behavior episodes, intervene as necessary to protect the rights and safety of others, refer to psych services as needed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care revealed Resident #25 used a psychotropic medication related to behavior management with a goal to remain free of psychotropic drug related complications including movement disorders, discomfort, hypotension, gait disturbance or constipation through review date. The interventions. included to administer psychotropic medications as ordered, monitor for side effects and effectiveness, consult with pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly, discuss with physician and family ongoing need for use of medication, review behaviors/interventions for effectiveness per facility policy, education resident/family about risks, benefits and side effects, and monitor/document and report any adverse reactions of psychotropic medications. Interview on 02/05/25 at 3:28 P.M. with the Director of Nursing (DON) #128 confirmed Resident #25 received Risperdal, an antipsychotic medication, for treatment of dementia with behavioral disturbance. DON #128 confirmed this was not an appropriate diagnosis for use of antipsychotic medication. The facility did not have a policy related to unnecessary medications.