

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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 - 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 observation, medical record review, hospital record review, review of radiological studies, interview, and policy review, the facility failed to ensure appropriate care, services and interventions were in place to prevent the development of an avoidable pressure ulcer for Resident #8. Actual Harm occurred on 10/24/25 when Resident #8 developed an avoidable suspected deep tissue injury (DTI) (a severe pressure-related wound damaging skin and underlying soft tissues, often starting under intact skin as a bruise-like purple or maroon area, that rapidly deteriorates to reveal significant tissue death-necrosis) to the left heel following a fall with a fracture to the right fibula, which impaired the resident's mobility and increased her dependence and need for assistance with activities of daily living (ADL). The wound evolved to an unstageable pressure ulcer with eschar (a full-thickness skin loss where the wound's true depth is hidden by yellow, tan, gray, black, or brown tissue-slough and/or eschar, making it impossible to stage until the covering is removed) which required manual debridement (the removal of damaged tissue or foreign objects from a wound). The facility also failed to ensure air mattress settings were correct for Resident #7. This affected two residents (Resident #7 and Resident #8) of four residents reviewed for pressure ulcers. Findings include: 1. Review of Resident #8's medical record revealed an admission date of 09/16/22 with diagnoses including dementia without behavioral disturbances, anxiety, major depressive disorder, and unspecified intellectual disabilities. Review of the care plan for Resident #8 dated 02/11/25 revealed the resident was at risk for impaired skin integrity related to incontinence and impaired mobility. Interventions including to apply protective barrier cream after incontinence episodes and as needed (PRN), assist resident with turning and repositioning as needed, complete Braden Scale (pressure ulcer risk assessment) PRN, complete skin inspection every seven to ten days and PRN, assist as needed, encourage resident to reposition self if able, if resident refuses intervention, medication/treatment per physician/NP/PA orders, notify nurse of any new areas of skin breakdown noted during bathing or daily care (redness, blisters, bruises, discoloration), notify physician/NP/physician assistant (PA) of new areas of impaired skin integrity, pressure redistribution mattress to bed, provide a non-irritating surface to reduce friction or shearing forces, and provide incontinence care PRN. Resident #8 had care plan for activities of daily living (ADL) initiated on 03/27/25 with a focus on ADL needs to be met and interventions to include assist with ADLs (i.e. dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed. Additionally, a care plan focus of the musculoskeletal status related to osteoporosis was initiated on 09/11/25 with interventions to include provide assistance with turning and repositioning as needed and allow ample time to reduce pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] stated Resident #8 used a walker for mobility and was a partial to moderate assistance for personal hygiene, dressing her upper body, and for personal care. The assessment noted the resident had no current pressure ulcers (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	but was at risk for pressure ulcers. Review of the Braden Scale which scores a patient's risk for pressure ulcers from six (severe risk) to 23 (no risk), with lower scores indicating higher risk, based on six factors: Sensory Perception, Moisture, Activity, Mobility, Nutrition, and Friction & Shear. Total scores categorize risk as: 19-23 (No Risk), 15-18 (Mild Risk), 13-14 (Moderate Risk), 10-12 (High Risk), and less than nine (Very High/Severe Risk), guiding preventive interventions like repositioning, skin care, and nutrition support). The Braden Scale for Resident #8 dated 09/10/25 revealed a score of 17, mild risk. Review of Resident #8's functional tasks from 10/01/25 to 10/15/25 revealed Resident #8 was independent but also required staff supervision for transfers at times. Review of Resident #8's shower sheets dated 10/14/25, 10/17/25, 10/21/25, 10/22/25 and 10/24/25 revealed no documented evidence of any deep tissue injury (DTI) to the left heel or any redness or softness to the left heel. Review of the Fall Incident Report dated 10/15/25 at 10:00 P.M. revealed Resident #8 was standing with her rollator in her room and was heading towards the bathroom when she stopped, shook, and fell to the floor. The fall was witnessed and immediate bruising to the affected lower extremity was noted. Three staff members helped Resident #8 to bed. Review of Resident #8's functional tasks for 10/16/25 and 10/17/25 revealed Resident #8 was totally dependent on staff for transfers and refused breakfast. The functional task dated 10/17/25 revealed Resident #8 was not getting out of bed and refused breakfast. Review of the skin inspection dated 10/17/25 noted no new observed skin issues for Resident #8. Review of the X-ray findings for Resident #8's right ankle dated 10/17/25 revealed an oblique nondisplaced fracture of the distal fibula. Review of the emergency room documentation dated 10/17/25 revealed Resident #8 had a fall on 10/15/25 and had not been ambulatory for the past two days, with significant swelling and bruising with tenderness over the medial malleolus noted to the right ankle. The plan for discharge included orders for a sugar-tong splint, minimal weight-bearing, and to follow up with orthopedics. Review of the progress note dated 10/17/25 at 6:22 P.M. revealed Resident #8 returned from emergency room at 4:30 P.M. with a splint on the right leg. The nurse documented Resident #8 was non-weight bearing on the right leg and there was a referral to orthopedics dated 10/29/25. Review of Resident #8's medical record revealed there was no documented evidence of an updated Braden Scale completed after Resident #8 had the fracture and she was non-weight bearing. Review of Resident #8's medical record revealed there was no documented evidence of pressure ulcer interventions in place after Resident #8 became non-weight bearing after the fall with fracture until 10/22/25 when the resident received a new order for the heels to be elevated. Review of Resident #8's physician orders dated 10/22/25 revealed an order for the resident's heels to be elevated at all times as the patient will allow to prevent pressure ulcer due to increased immobility for prevention. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #8's care plan for ADLs initiated on 10/22/25 and 10/23/25 revealed interventions to include one person assistance for bed mobility and toileting, independence with eating, staff to offer assistance with meal set-up if needed, and may use mechanical lift and two person assistance for transfers. Review of the Wound Evaluation dated 10/24/25 revealed Resident #8 had a new unstageable pressure ulcer noted to the left heel that measured 2.5 centimeters (cm) in length and four cm in width and it had unknown depth. The pressure ulcer was in-house acquired, there was no drainage, it was fragile and intact, and new orders were received. Review of Resident #8's care plan initiated on 10/24/25 revealed a care plan for impaired skin integrity as evidenced by a DTI to left heel related to impaired mobility with interventions for treatments per physician orders, wound consult PRN, complete Braden Scale PRN, complete wound evaluation to monitor progress of the resident's skin condition, and heel medix boot (a specialized medical device designed to prevent and treat pressure injuries in bedridden and non-ambulatory patients) to the left foot. Review of Resident #8's physician orders dated 10/24/25 revealed orders for a heel medix boot to the left foot with instructions for the medix boot placement to be checked twice a day. An order was also received to cleanse Resident #8's left heel, apply skin prep (protective barrier), then pad with an abdominal dressing (ABD) (a thick highly absorbent gauze dressing used for large or heavily draining wounds, offering padding, protection, and moisture absorption to prevent infection and promote healing) and wrap with a gauze bandage twice a day. Review of the physician order dated 10/27/25 revealed Resident #8 was to be repositioned frequently twice a day to off load (removing or significantly reducing pressure and weight from a specific body part, especially a foot or heel, to allow wounds or injuries to heal, prevent further tissue damage, infection, and complications by improving blood flow and tissue regeneration). The orders also stated Resident #8 was to be turned and repositioned with incontinence care and as needed. Review of the wound care progress note dated 11/07/25 by Wound Nurse Practitioner (WNP) #210 revealed the wound was still a DTI and measured three cm in length by three cm in width. The wound bed was closed with purple discoloration. Review of the significant change MDS assessment dated [DATE] revealed Resident #8 used a wheelchair for mobility and required substantial to maximum assistance for personal care, dressing her upper body, and for personal hygiene. The assessment noted the resident also had one unstageable pressure ulcer. Review of the wound care progress note dated 11/14/25 by WNP #210 revealed the improved DTI measured 2.5 cm in length by 1.5 cm in width. The wound bed was closed and necrotic. Review of the wound care progress note dated 11/21/25 by WNP #210 revealed the deteriorating DTI measured 2.8 cm in length by 1.8 cm in width. The wound bed was closed and necrotic. Review of the wound progress note dated 11/28/25 by WNP #210 revealed the improved DTI measured 2.5 cm in length by 1.5 cm in width. The wound bed was closed and necrotic. Review of the wound progress note dated 12/05/25 by WNP #210 revealed the unchanged DTI (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	measured 2.5 cm in length by 1.5 cm in width. The wound bed was closed and necrotic. Review of the psychiatry progress note dated 12/09/25 by NP #280 revealed when Resident #8 was asked about her overall wellbeing, she reported feeling bad and attributed this to her legs, specifically pointing to bilateral heel wounds. Review of the Braden Scale dated 12/11/25 revealed a score of 15 which indicated Resident #8 was at moderate risk for pressure ulcers. Review of the progress note dated 12/16/25 at 3:02 P.M. revealed a conversation with Resident #8's family. Staff stated that Resident #8 had experienced a decline in overall functional status. Therapy services reported little progress in treatment and there was a recent weight loss. Resident #8 refused meals, care, and to get out of bed or chair frequently. Hospice was discussed and the resident's family was agreeable. Review of the wound care progress note dated 12/19/25 by WNP #210 revealed the deteriorating DTI measured 2.5 cm length by 1.5 cm in width. A Bioburden debridement (process of removing microorganisms such as bacteria and fungi and the slimy film they create on the surface of a wound) was performed for the DTI. During an interview on 12/17/25 at 10:26 A.M., Registered Nurse (RN) #120 stated when she came in for the night shift on 10/16/25, an unknown Certified Nursing Assistant (CNA) told her that Resident #8 was complaining of pain. RN #120 stated she noticed Resident #8 had swelling and bruising to her right ankle, so she called the on-call physician and received an order for an x-ray. The x-ray was completed on 10/17/25 which revealed an acute fibula fracture to the right ankle. Additionally, RN #120 stated she had not observed Resident #8 getting up out of bed or walking on her own since the fall on 10/15/25. During an interview on 12/17/25 at 11:18 A.M., Licensed Practical Nurse (LPN) #169 stated after the fall, Resident #8 was fearful and refused to leave her room because her right leg was swollen and painful. During an interview on 12/18/25 at 3:31 P.M., NP #200 stated she was not notified of any redness or softness to Resident #8's left heel until she was first notified of a deep tissue injury (DTI) on 10/24/25. During an interview on 12/18/25 at 4:03 P.M., NP #210 stated she examined Resident #8 on 10/24/25 and noted a DTI which, without a diagnosis of blood clots or decreased circulation, would be considered avoidable. During an interview on 12/22/25 at 8:37 A.M., CNA #175 stated Resident #8 did not want to be touched after the fall and required two-person assistance, when previously, Resident #8 had been independent with walking. CNA #175 stated the pressure ulcer was probably just from the way Resident #8 was lying because pillows were only being used under the resident's feet to elevate them before the pressure ulcer was noticed. After the pressure ulcer was noticed, Resident #8's foot was wrapped and a boot was used. During an interview on 12/22/25 at 8:51 A.M., CNA #90 stated Resident #8's mobility changed significantly after the fall and Resident #8 would not let anyone touch the right broken extremity. CNA (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	#90 stated Resident #8 was independent with walking and would go to the dining room and participate in activities and now she did not walk or go to activities at all but sat in her recliner watching television. CNA #90 stated Resident #8 did not get out of bed for at least a week after the fall. During an interview on 12/22/25 at 9:32 A.M., the Director of Nursing (DON) verified there was no documentation that Resident #8's heels were offloaded and that the resident was turned every two hours, from after the fall on 10/15/25, leading up to the wound on 10/24/25. During interview on 12/22/25 at 10:17 A.M. with Regional RN #320 verified Resident #8's mattress was just a regular mattress, and not a pressure redistribution mattress per the care plan dated 02/11/25. During an observation on 12/22/25 at 10:22 A.M., Resident #8 had a foam mattress on her bed. At the time of the interview, the Assistant Director of Nursing (ADON) confirmed the observation and stated a foam redistribution mattress was a soft foam mattress which had firm foam at the sides and soft foam in the middle which went from top to bottom. The ADON stated that if a resident had a pressure ulcer that was Stage 3 or higher, then the resident would have an air mattress (pressure redistribution mattress). The ADON confirmed Resident #8's mattress was a foam redistribution mattress and not a pressure redistribution mattress. During an interview on 12/22/25 at 11:14 A.M., the ADON stated she had mentioned an air mattress several times for Resident #8 to the DON and to the person who ordered the supplies, but that she never received one for Resident #8. The ADON stated she knew a DTI was unstageable and required an air mattress. The ADON verified that Resident #8 did not have a diagnosis of blood clots or decreased circulation. The ADON confirmed Resident #8 had a significant decline since her fall. During an interview on 12/22/25 at 12:03 P.M., the DON verified Resident #8's DTI was unstageable and the resident should have an air mattress. The DON stated she just ordered an air mattress. During an observation on 12/16/25 at 3:28 P.M., Resident #8's left heel had a DTI that was black and round, and approximately the size of a fifty-cent piece. During an interview on 12/22/25 at 2:52 P.M., the Medical Director (MD) stated Resident #8 was independent before the fall in October 2025 and had declined over the last few months and was just admitted to hospice last week. The Medical Director stated the most significant decline after the fall included skin breakdown and the resident's overall decline escalated after the fall. During an interview on 12/23/25 at 3:07 P.M., CNA #116 stated Resident #8 did not move her legs in bed and she would try to move her upper body, but Resident #8 could not turn herself. CNA #116 stated that most of the time Resident #8 did not have a pillow under her feet or feet elevated when she was lying in bed after her fall. Review of the facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, undated, revealed the nursing staff will assess and document an individual's significant risk factors for developing pressure sores. Staff will review and modify the care plan as appropriate. 2. Review of the medical record revealed Resident #7 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hypertensive heart disease with heart failure, displaced fracture of right femur, severe-protein-calorie malnutrition, and anxiety. The record indicated the (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident weighed 151 pounds. Review of Resident #7's physician order dated 10/21/25 at 3:47 P.M. revealed Resident #7 was admitted to hospice with the diagnosis of hypertensive heart disease with heart failure. Review of Resident #7's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had cognitive impairment. The MDS also revealed Resident #7 was dependent on staff for rolling from lying on back, to left and right side, and returning to lying on back on the bed. Review of Resident #7's physician order dated 11/03/25 at 5:05 P.M. revealed an air mattress was ordered and the function was to be checked every shift. Review of Resident #7's plan of care dated 11/05/25 revealed Resident #7 was at risk for impaired skin integrity related to limited mobility secondary to a history of right hip fracture, incontinence, and requiring hospice services. An intervention included an air mattress was ordered by hospice. Observations on 12/15/25 at 2:56 P.M., 12/16/26 at 10:50 A.M., and 12/18/25 at 8:35 A.M. revealed Resident #7's air mattress was on the firm setting. An interview on 12/18/25 at 8:20 A.M. hospice Registered Nurse (RN) #240 verified Resident #7's air mattress should only be on the firm setting when care, such as incontinence care, was provided while the resident was in bed. An interview on 12/18/25 at 8:33 A.M. Director of Nursing (DON) verified Resident #7's air mattress was on the firm setting. The DON verified the air mattress should be set based on the resident's weight of 151 pounds.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, review of facility policy, and review of the United States Department of Agriculture (USDA) website, the facility failed to store and serve food under sanitary conditions. This had the potential to affect all 59 residents residing in the facility, who ate food from the kitchen. Findings Include: 1. Observation of the kitchen on 12/15/25 from 8:55 A.M. to 9:14 A.M. revealed in the over the tray foodservice serving area, there were two dirty exhaust fans with a large amount of a brown and gray fuzzy substance on them. The white paint on the ceiling over the food serving area was also chipping and bulging from the ceiling. An interview with [NAME] #117 on 12/15/25 at 9:06 A.M. confirmed the presence of a brown and gray fuzzy substance on the exhaust fans and the presence of chipping ceiling paint over the food serving area. An interview with Dietary Director #74 on 12/15/25 at 9:08 A.M. confirmed the presence of a brown and gray fuzzy substance on the exhaust fans and the presence of chipping ceiling paint over the food serving area. 2. Observation of the internal temperature on the tray line prior to food service on 12/18/25 at 10:17 A.M. revealed that the plain chicken holding temperature was 130 degrees Fahrenheit. The holding temperature of the mechanical soft chicken was 153 degrees Fahrenheit. A follow up observation of the internal temperature on the tray line prior to food service on 12/18/25 at 11:55 A.M. revealed that the holding internal temperature for the plain chicken was 110 degrees Fahrenheit. The holding internal temperature for the mechanical soft chicken was 128 degrees Fahrenheit. An interview with [NAME] #117 on 12/18/25 at 11:55 A.M. confirmed that the holding temperatures for the plain chicken and mechanical soft chicken were in the temperature danger zone. Review of the September 2021 facility policy titled, Food Handling, revealed that the temperature danger zone for potentially hazardous foods is 41 degrees to 135 degrees Fahrenheit. Review of the USDA Food and Inspection Service webpage revealed that leaving food out too long at room temperature can cause bacteria to grow at dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40 degrees and 140 degrees Fahrenheit. This range of temperatures is called the Danger Zone. Food placed in preheated steam tables or warming trays should be kept above 140 degrees Fahrenheit.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, and review of facility policy, the facility failed to ensure smoking regulations were being adhered to in accordance with NFPA 101 - 2012 Edition, Section 19.7.4 per the regulations. This deficient practice had the potential to affect all 59 residents residing in the facility. Findings Include: Observation on 12/18/25 during a tour of the facility at 8:56 A.M. with the Director of Maintenance (DM) #131 noted the designated smoking area in the central enclosed courtyard was not being properly maintained. Thirty-seven cigarette butts were on the ground. Three butts were in a pine bush and had burned some of the needles. A cigarette receptacle was also present. An interview with the DM #131 verified the findings at the time of observation. An interview with the Administrator on 12/17/25 at 3:23 P.M. revealed that smokers were expected to use the two available fireproof cigarette receptacles to dispose of their cigarette butts after smoking. Review of the facility policy dated September 2022 titled, Smoking Policy, revealed that the smoking area will comply with applicable Federal, State and local laws regarding smoking and smoking safety.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interviews, review of the National Institutes of Health (NIH) instructions on how to use a nebulizer, and facility policy review, the facility failed to ensure Resident #7's oxygen was administered as ordered. This affected one (Resident #7) out of six residents reviewed for respiratory care. The facility also failed to ensure oxygen tubing was dated for Resident #6, Resident #26, Resident #27, Resident #44, and Resident #70. This affected five (Resident #6, #26, #27, #44, and #70) out of six residents reviewed for respiratory care. The facility census was 59. Findings include: 1. Review of the medical record revealed Resident #7 was admitted on [DATE] and 08/27/25 with diagnoses including hypertensive heart disease with heart failure, displaced fracture of right femur, severe-protein-calorie malnutrition, and anxiety. Review of a plan of care dated 08/19/25 revealed Resident #7 had impaired respiratory status. Interventions included to monitor vital signs and pulse oximetry, and provide oxygen as needed when resident exhibits signs and symptoms of difficulty breathing such as shortness of breath, cyanosis, and low oxygen saturation levels. Review of vital sign documentation revealed Resident #7's last oxygen saturation recorded was on 10/21/25. Review of the physician order dated 10/25/25 at 4:41 P.M. revealed Resident #7 was ordered oxygen at two to four liters per minute via nasal cannula as needed to maintain oxygen saturation at 90% or greater and/or shortness of breath. Review of the medication administration record (MAR) for December 2025 revealed no documentation of oxygen being used as needed and no documentation of Resident #7's oxygen saturation levels. An observation on 12/15/25 at 2:56 P.M. and 12/16/26 at 10:50 A.M. revealed oxygen was being administered to Resident #7 at three liters per minute via nasal cannula. An interview on 12/18/25 at 8:37 A.M. with the Director of Nursing (DON) verified oxygen was being administered without documentation on the MAR. The DON verified there was no documentation of Resident #7's oxygen saturation level before and after the use of oxygen and how many liters of oxygen was being administered. Review of the Oxygen Administration policy, dated September 2021, revealed problems may occur if the patient fails to comply with the doctor's orders or receives inadequate instruction. The initial need is determined by documented hypoxemia or a physician order. 2. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic kidney disease, and anxiety disorder. Review of Resident #6's care plan dated 03/21/25 revealed that Resident #6 was at risk for impaired respiratory status related to COPD. Interventions included administering oxygen as needed. Review of Resident #6's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicative of intact cognition. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She was assessed as receiving oxygen. Review of Resident #6's physician orders dated 12/01/25 revealed that she had orders for four liters of oxygen per minute via nasal cannula, may titrate to keep saturations at or above 91%. Resident #6's physician order dated 12/07/25 revealed that oxygen tubing should be changed on a weekly basis. Observation on 12/15/25 at 9:43 A.M. revealed that Resident #6's oxygen tubing was not dated. An interview with Registered Nurse (RN) #92 on 12/15/25 at 10:41 A.M. confirmed that Resident #6's oxygen tubing was not dated. 3. Review of the medical record for Resident #26 revealed an admission date of 12/29/23 with diagnoses including COPD, type two diabetes mellitus, iron deficiency anemia, anxiety disorder, hypertension, dementia, depressive disorder, dysphagia, and polyneuropathy. Review of an order dated 06/04/25 for Resident #26 stated oxygen: may use two to four liters per minute at bedtime via Continuous Positive Airway Pressure (CPAP) machine as needed, to maintain oxygen saturations above 92% until assessed by respiratory. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #26 had a BIMS score of 13 out of 15, indicating the resident had no cognitive deficit. Observation on 12/15/2025 at 11:11 A.M. revealed Resident #26 in his room sitting on his bed with oxygen in his nose via nasal cannula. Licensed Practical Nurse (LPN) #135 confirmed there was no date on the oxygen tubing at the time of the observation. 4. Review of the medical record for Resident #27 revealed an admission date of 11/01/24 with diagnoses including COPD, acute and chronic respiratory failure with hypoxia, heart failure, chronic kidney disease stage four, supraventricular tachycardia, hypertension, cardiomyopathy, atrial fibrillation, and need for assistance with personal care. Review of an order dated 12/08/24 for Resident #27 stated change oxygen tubing and set up weekly every night shift every Sunday. Review of an order dated 07/29/25 for Resident #27 stated oxygen at two liters per minute via nasal cannula every shift related to COPD and acute and chronic respiratory failure with hypoxia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #27 had a BIMS score of 15 out of 15, indicating the resident had no cognitive deficit. Observation on 12/15/2025 at 11:11 A.M. of Resident #27 lying in his bed receiving oxygen via nasal cannula. LPN #135 confirmed there was no date on the oxygen tubing at the time of the observation. 5. Review of the medical record for Resident #44 revealed an admission date of 06/14/22 with diagnoses including COPD, dementia, iron deficiency, hyperlipidemia, chronic respiratory failure with hypoxia, hypertension, gastro-esophageal reflux disease, major depressive disorder, and obstructive sleep apnea. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #44 had a BIMS score (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 12 out of 15, indicating the resident had a moderate cognitive deficit. Review of an order dated 12/04/25 for Resident #44 stated oxygen at two liters per minute via nasal cannula as needed for shortness of breath. Observation on 12/15/2025 at 11:12 A.M. of Resident #44 lying in bed with her oxygen on via nasal cannula and no date on the tubing. LPN #135 confirmed there was no date on the oxygen tubing at the time of the observation. 6. Review of the medical record for Resident #70 revealed an admission date of 04/14/24 with diagnoses including COPD, cerebral infarction, morbid obesity, hyperlipidemia, obstructive sleep apnea, hypertension, atrial fibrillation, congestive heart failure, asthma, gastro-esophageal reflux disease, chronic kidney disease stage three, and acute respiratory hypercapnia. Review of an order dated 02/18/25 for Resident #70 stated Bilevel Positive Airway Pressure (BiPAP) at home settings (11/seven) at bedtime and with naps as needed. Additionally, there was an order dated 02/19/25 for Resident #70 which stated BiPAP: remove in morning. Clean the mask and equipment after use in the morning. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #70 had a BIMS score of 15 out of 15, indicating the resident had no cognitive deficit. Review of an order dated 12/11/25 stated DuoNeb solution 0.5-2.5 3 milligrams/3milliliters (mL) (Ipratropium-Albuterol) one vial inhale orally via nebulizer every eight hours as needed for cough, wheezing, or shortness of breath. Observation on 12/15/2025 9:45 A.M. of Resident #70 sitting up in bed, with her bedside tray in front of her. Resident #70's nebulizer mask and tubing were lying on the nightstand beside her bed attached to the nebulizer machine. and the tubing had no date on it. Resident #70's BiPAP facemask was lying on top of the BiPAP machine, and there was no date on the tubing, and the BiPAP facemask was not covered. LPN #135 confirmed there was no date on the nebulizer tubing or the BiPAP tubing at the time of the observation and verified the BiPAP facemask was not covered. LPN #135 stated the facemask should be stored in a plastic bag when not in use. Review of the National Institutes of Health (NIH) https://www.nhlbi.nih.gov/sites/default/files/publications/How-to-Use-a-Nebulizer-21-HL-8163.pdf publication number 21-HL-8163 titled How to use a nebulizer, dated October 2021, stated in between uses to store the nebulizer parts in a dry, clean plastic storage bag. Keep each person's medicine cup, mouthpiece or mask, and tubing in a separate labeled bag to prevent the spread of germs.		

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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 record review, observations, staff interviews, review of the Centers for Disease Control and Prevention (CDC) guidance, and review of the facility policy, the facility failed to follow infection control procedures while serving food to residents under contact precautions. This affected two (Residents #21 and 26) out of five residents reviewed for infection control. Also, the facility failed to properly clean the glucometer and place a barrier between the glucometer and a potentially contaminated surface. This affected one (Resident #60) of one resident observed for blood glucose check on the Sycamore hallway and had the potential to affect the five additional (Residents #4, #5, #17, #32, and #54) identified by the facility that had blood glucose checks on Sycamore hallway. Additionally, the facility failed to have proper personal protective equipment (PPE) in place for Resident #13 under enhanced barrier precautions (EBP). This affected one (Resident #13) of three residents under EBP in the Sycamore hallway and had the potential to affect 13 additional (Residents #2, #3, #4, #8, #12, #13, #16, #36, #37, #45, #49, #51, and #58) identified by the facility with orders for EBP. The facility census was 59. Findings include: 1. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] and had diagnoses that included Clostridioides difficile (C. diff) infection. Review of Resident #21's care plan dated 12/15/25 revealed that Resident #21 had a recurrent C. diff infection. Interventions included contact isolation, which included all meals to be provided in her room. Review of Resident #21's physician orders dated 12/15/25 revealed that they were under contact isolation precautions for C. diff infection. Observation of lunch meal pass on 12/17/25 at 11:53 A.M. revealed that Certified Nursing Aide (CNA) #73 did not don PPE to enter Resident #21's room, and CNA #73 was observed to be within one foot of Resident #21 while setting up her meal tray. An interview with CNA #73 on 12/17/25 at 11:54 A.M. confirmed that CNA did not don any PPE prior to entering Resident #21's room and getting within one foot of Resident #21. 2. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] and had diagnoses that included C. diff infection. Review of Resident #26's physician orders dated 12/10/25 revealed that he was under contact isolation related to C. diff infection. Observation of lunch meal pass on 12/15/25 at 11:55 A.M. revealed that CNA #117 did not don gloves or a gown when entering Resident #26's room to deliver his meal. CNA #117 was observed to be within one foot of Resident #26 while setting up his lunch meal. An interview with CNA #117 on 12/15/25 at 11:58 A.M. confirmed that he did not wear PPE to enter Resident #26's room and that he was within one foot of Resident #26. Review of an undated facility policy titled, Isolation-Initiating Transmission-Based Precaution, revealed that transmission-based precautions include contact precautions. Transmission-based precautions will be implemented by ensuring that PPE is available so that everyone entering the room (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	can access what they need. Review of the CDC's Infection Control website revealed that wearing a gown and gloves for all interactions that may involve contact with the patient is recommended. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. 3. Review of the medical record revealed Resident #60 was admitted on [DATE] with diagnoses that included type II diabetes and chronic pain. Review of the plan of care dated 11/29/25 revealed Resident #60 had an impaired metabolic status related to diabetes. Interventions included administering medications and treatments as indicated by the physician, monitoring labs/diagnostic testing per physician orders, and monitoring glucose levels per physician orders. Review of a physician order dated 12/03/25 revealed Resident #60 was to have blood glucose levels checked before meals and bedtime. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #60 was cognitively intact. An observation on 12/17/25 at 8:11 A.M. revealed Licensed Practical Nurse (LPN) #169 went into Resident #60's to check the resident's blood glucose levels. LPN #169 laid the blood glucose monitoring device on Resident #60's overbed table without a barrier. After checking Resident #60's blood glucose, LPN #169 took the blood glucose monitoring device back out and laid it directly on the medication cart. LPN #169 ripped off half a bleach wipe and wiped off the blood glucose monitoring device and laid it back on the medication cart without a barrier. LPN #169 stated the wipes were very wet and the blood glucose monitoring device needed to be wet for two minutes. On 12/17/25 at 8:18 A.M. LPN #169 verified the directions on the bleach wipes revealed the blood glucose monitoring device was to be visible wet for three minutes. LPN #169 also verified she laid the blood glucose monitoring device on Resident #60's overbed table and medication cart without a barrier. Review of the undated policy titled Obtaining a Fingerstick Glucose Level policy revealed the blood glucose monitoring device is to be placed on a clean field. Following the manufacturer's instructions, clean and disinfect reuseable equipment, parts, and/or devices after each use. 4. Review of the medical record revealed Resident #13 was admitted on [DATE] with diagnoses including alcohol dependence, dysphagia, anxiety, schizophrenia, and chronic viral hepatitis C. An observation on 12/17/25 at 8:57 A.M. revealed emergency (rain) ponchos were located in the PPE cart outside Resident #13's room. A sign hanging outside Resident #13's room revealed the resident was on EBP. LPN #169 and CNA #73 verified the emergency ponchos did not cover the staff's arms and were not appropriate PPE. Review of the facility policy titled Enhanced barrier Precautions (EBP) dated 01/2024, revealed EBPs are an infection control method used in the facility to reduce transmission of multi-drug-resistant organisms (MDROs). EBP refers to the use of gown and gloves during high-contact care activities for residents with any of the following known infection or colonization with a resistant organism when contact precautions do not otherwise apply, chronic wounds, or indwelling medical devices.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure privacy was maintained while Resident #17 was being taken to the shower room. This affected one (Resident #17) out of one reviewed for dignity and respect. Facility census was 59. Findings include: Review of the medical record revealed Resident #17 was admitted on [DATE] with diagnoses that included Parkinson's disease, diabetes, and anxiety disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact and required substantial/maximal assistance for showering and bathing. An observation on 12/16/25 at 1:44 P.M. revealed Certified Nursing Assistant (CNA) #124 was transporting Resident #17 from his room to the shower room in a shower chair. Resident #17 was wearing a gown that covered the front of the resident, though a side view of Resident #17 revealed the resident's buttocks and genitals were able to be seen below the hole in the seat in the shower chair. An interview on 12/16/25 at 1:44 P.M. with CNA #124 verified Resident #17's buttocks and genitals were able to be seen when Resident #17 was observed from the side. Review of the Shower/Tub Bath policy dated 09/2021 revealed when transporting the resident to and from the bath area ensure that the resident is covered and his or her privacy is maintained.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a safe environment. This affected one resident (#4) of four sampled for environment. The facility census was 59. Findings Include: Review of Resident #4's medical record revealed an admission date of 07/20/22, a re-entry date of 07/07/24 and diagnoses including but not limited to diabetes, dysphagia, heart failure, chronic obstructive pulmonary disease, osteomyelitis, schizoaffective disorder, schizophrenia, peripheral vascular disease, anxiety disorder, major depressive disorder and hypertension. Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. Further review of the MDS revealed the resident was independent or required set up assistance with eating, bed mobility, transfers and wheelchair mobility, required partial/moderate assistance with toilet hygiene and showering or bathing, had an indwelling catheter and was occasionally incontinent of bowel. An observation on 12/17/25 at 9:10 A.M. revealed Resident #4's bed was positioned to the left of the door with the head of the bed against the same wall as the door and a space between the left side of the bed and the wall of about six inches. The resident's call light was attached to the call light box positioned on the wall at the foot of the resident's bed. The call light box was partially covered by a plastic cover with approximately a third of the call light box uncovered and unused wires covered by a wire nut and electrical tape was visible in the open area of the call light box. In an interview on 12/17/25 at 9:14 A.M. with Certified Nursing Assistant (CNA) #73 confirmed that Resident #4's call light was attached to the call light box at the foot of the resident's bed and the call light box was partially covered by a plastic cover with approximately a third of the call light box uncovered and unused wires covered by a wire nut and electrical tape visible in the open area of the call light box.		

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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 resident record review, staff interview, and review of facility policy, the facility failed to provide a bed hold letter to a resident and failed to notify the Ombudsman when the resident discharged to the hospital. This affected one resident (Resident #3) out of three residents reviewed for discharges. The facility census was 59 residents. Findings Include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] and had diagnoses that included vascular dementia, and displaced fracture of neck of right femur. Review of Resident #3's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was assessed as having a Brief Interview for Mental Status (BIMS) score of 14, indicative of intact cognitive status. Review of Resident #3's nursing progress notes dated 08/20/25 revealed that he had a fall and was discharged to the hospital for an evaluation. Review of Resident #3's medical record revealed that he was hospitalized from [DATE] to 08/24/25. There was no documented evidence of a bed hold letter provided or evidence of Ombudsman notification in the medical chart. An interview with Business Office Manager #71 on 12/18/25 at 11:33 A.M. confirmed there was no evidence that a bed hold notice letter had been given to Resident #3 or their representative, nor was there evidence that the Ombudsman had been notified about Resident #3's hospitalization. Review of a facility policy dated September 2021 titled, Bed-Holds and Returns, revealed that prior to a transfer, written information will be given to the residents and the resident representatives that explains the bed hold policy.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure Resident #7's fingernails were trimmed and cleaned. This affected one (Resident #7) out of three reviewed for activities of daily living. Facility census was 59. Findings included: Review of the medical record revealed Resident #7 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hypertensive heart disease with heart failure, displaced fracture of right femur, severe-protein-calorie malnutrition, and anxiety. Review of Resident #7's plan of care dated 08/06/25 revealed Resident #7 had an activity of daily living (ADL) self-care performance deficit. Interventions included to assist the resident with activities of daily living such as dressing, grooming, personal hygiene, locomotion, and oral care. Review of Resident #7's physician order dated 10/21/25 at 3:47 P.M. revealed Resident #7 was admitted to hospice with diagnosis of hypertensive heart disease with heart failure. Review of Resident #7's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had cognitive impairment. The MDS also revealed Resident #7 was dependent on staff for personal hygiene. Review of Resident #7's bathing documentation dated 12/03/25 and 12/06/25 revealed Resident #7's fingernails were not trimmed. Bathing documentation dated 12/10/25 revealed hospice bathed Resident #7 and trimmed his fingernails. Bathing documentation dated 12/10/25 revealed Resident #7's fingernails were not trimmed. An observation on 12/15/25 at 2:56 P.M. and 12/16/26 at 10:50 A.M. revealed Resident #7 had long fingernails. An interview on 12/18/25 at 8:20 A.M. with Hospice Triage Registered Nurse (RN) #240 revealed hospice aides did not trim resident fingernails as part of activities of daily living care. An interview on 12/18/25 at 8:37 A.M. with the Director of Nursing verified Resident #7 had long fingernails that needed trimmed. An interview on 12/18/25 at 9:01 A.M. with Hospice RN #242 verified hospice aides could not trim resident fingernails. Review of the undated policy titled Activities of Daily Living revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently including appropriate support and assistance with hygiene.		

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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 observation, record review, interviews, and policy review, the facility failed to ensure timely care and services were provided to Resident #8 who had a fall which resulted in a fracture. This affected one resident (#8) out of five reviewed for accidents. Additionally, the facility failed to ensure appropriate catheter care was provided for Resident #7 when the resident's indwelling urinary catheter drainage bag was not properly positioned or secured in accordance with facility policy and accepted catheter care standards. This deficient practice affected one resident (#7) of two residents reviewed for catheter care. The facility reported ten residents with indwelling urinary catheters. Facility census was 59. Findings include: 1. Review of Resident #8's medical record revealed an admission date of 09/16/22 with diagnoses including, but not limited to dementia without behavioral disturbances, anxiety, major depressive disorder, and unspecified intellectual disabilities. Review of Resident #8's care plan dated 02/11/25 revealed the resident had impaired communication related to intellectual disabilities, dementia and usually understood with slurred and mumbled speech. Interventions included to allow the resident ample time to comprehend what is being said and allow for a response, pay attention to the residents body language, and use simple and direct communication (yes/no questions) to promote understanding. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] stated Resident #8 used a walker independently for mobility and required partial to moderate assistance for personal hygiene, dressing her upper body, and for personal care. Review of the Fall Risk Evaluation dated 09/10/25 revealed Resident #8 was at a high risk for falls. Review of the Fall Incident Report dated 10/15/25 at 10:00 P.M. revealed Resident #8 was standing with her rollator in her room and was heading towards the bathroom when she stopped, shook, and fell to the floor. The fall was witnessed and immediate bruising to the affected lower extremity was noted. Three staff members helped Resident #8 to bed. Review of the Fall Risk Evaluation dated 10/15/25 revealed Resident #8 was at a high risk for falls. Review of the bed mobility functional tasks for October 2025 revealed Resident #8 went from being independent/one person supervision to extensive staff assistance after the fall on 10/15/25, and total staff dependence that required two-person assistance with transfers on 10/16/25. Resident #8 was independent with walking ten feet on 10/15/25 prior to the fall, and after 10/16/25, Resident #8 did not walk again according to the task report. Resident #8 remained an extensive staff assist or dependent on staff for transfers since the fall on 10/15/25. Review of the progress note dated 10/16/25 by Nurse Practitioner (NP) #200 revealed she was asked to examine Resident #8 for bilateral lower extremity edema related to a recent fall. NP #200 stated Resident #8 had Thrombo-Embolic Deterrent (TED) hose on her feet during the examination and ordered Furosemide (a diuretic) 20 milligrams (mg) for swelling. Review of the progress note dated 10/17/25 at 5:50 A.M. revealed Resident #8 was favoring her right ankle and did not want to stand to transfer. Resident #8 fell on [DATE] and there was a concern for a possible fracture. The on-call physician was notified, and an order was received for a right ankle x-ray. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 10/17/25 at 6:06 A.M. revealed Resident #8 had limited range of motion to the right foot and ankle, and it was painful to stand. Review of the X-ray findings for Resident #8's right ankle dated 10/17/25 revealed an oblique nondisplaced fracture of the distal fibula. Review of the emergency room documentation dated 10/17/25 revealed Resident #8 had a fall on 10/15/25 and had not been ambulatory for the past two days, with significant swelling and bruising with tenderness over the medial malleolus noted to the right ankle. The plan for discharge included orders for a sugar-tong splint, minimal weight-bearing, and to follow up with orthopedics. Review of the progress note dated 10/17/25 at 6:22 P.M. revealed Resident #8 returned from emergency room at 4:30 P.M. with a splint on the right leg. The nurse documented Resident #8 was non-weight bearing on the right leg and there was a referral to orthopedics dated 10/29/25. Review of the orthopedic note dated 10/29/25 revealed due to limited mobility, the quality of the images was suboptimal, making it a challenge to determine if there was an additional fracture in the medial malleolus bone. A computed tomography (CT) scan of the ankle will be ordered to provide a more comprehensive view of the bone structure. This would guide the decision on weight-bearing restrictions and whether the boot could be removed. Resident #8 was to be non-weight bearing in the boot. Review of the CT scan dated 10/31/25 revealed Resident #8 had a right tri-malleolar ankle fracture which consisted of three fractures to include the distal fibula, posterior malleolus, and medial malleolus bones. During an interview on 12/17/25 at 10:26 A.M., Registered Nurse (RN) #120 stated when she came in for the night shift on 10/16/25, an unknown Certified Nursing Assistant (CNA) told her that Resident #8 was complaining of pain. RN #120 stated she noticed Resident #8 had swelling and bruising to her right ankle, so she called the on-call physician and received an order for an x-ray. The x-ray was completed on 10/17/25 which revealed an acute fibula fracture to the right ankle. Additionally, RN #120 stated she had not observed Resident #8 getting up out of bed or walking on her own since the fall on 10/15/25. During an interview on 12/17/25 at 11:18 A.M., Licensed Practical Nurse (LPN) #169 stated after the fall, Resident #8 was fearful and refused to leave her room because her right leg was swollen and painful. Interview on 12/17/25 at 12:36 P.M. with NP #200 revealed she saw Resident #8 on 10/16/25 because she had a fall and had some swelling to her legs. NP #200 confirmed Resident #8 had on TED hose at the time of the examination and stated she looked at Resident #8's forefoot and noted some bruising. Additionally, NP #200 confirmed she only examined the forefoot and not the ankle visibly as she did not remove the TED hoses. NP #200 stated Resident #8 did not communicate in a clear way that she was in pain or hurting. Furthermore, NP #200 stated if she had known that Resident #8 had swelling, bruising and was non-weight bearing, then she would have ordered an x-ray on 10/16/25 instead of on 10/17/25. Observation and interview on 12/17/25 at 12:31 P.M. with Resident #8 revealed she was lying in bed. Resident #8 was asked if she remembered when she fell and she nodded yes. Resident #8 was asked (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if her leg hurt when she fell and she nodded yes. Resident #8 was asked if she told the nurse her leg was hurting right after the fall, and she nodded her head yes while she moaned and pointed to her right leg. Review of the facility Falls policy dated September 2021 which stated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific tasks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 2. Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses that included hypertensive heart disease with heart failure, chronic diastolic congestive heart failure, chronic kidney disease stage three-B, benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, paroxysmal atrial fibrillation, anemia, and anxiety disorder. Review of Resident #7's physician orders revealed an order dated 08/28/25 for an indwelling Foley catheter. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was moderately cognitively impaired and required substantial to maximal assistance with toileting hygiene and transfers and was unable to independently manage catheter care, indicating reliance on staff for proper catheter management. Review of Resident #7's care plan dated 11/10/25 identified interventions related to the management of an indwelling Foley catheter, including ensuring proper positioning and securing of the urinary drainage bag to reduce the risk of infection, catheter tension, and other complications. The care plan also addressed the resident's extensive functional dependence and need for staff assistance with all catheter-related care. On 12/16/25 at 10:48 A.M., observation of Resident #7 revealed the resident was in bed with an indwelling urinary catheter. The urinary drainage bag was observed hung on the bedside adjustable bed rail, rather than secured on a stationary hook or stand. The drainage bag was positioned on the side of the bed facing the door and was not covered. On 12/18/25 at 10:20 A.M., a subsequent observation of Resident #7 revealed the urinary drainage bag remained hung on the adjustable bed rail and continued to be positioned on the side of the bed facing the door, without a cover. At the time of this observation, the resident's door was open, increasing the visibility of the drainage bag from the hallway. On 12/18/25 at 9:37 A.M., an interviewed the Director of Nursing (DON) confirmed the drainage bag was hung on the bed rail and stated this placement was not consistent with facility policy. The DON further confirmed the catheter drainage bag was not properly hung or stored as required. The DON stated the facility currently had ten residents with indwelling urinary catheters. Review of the facility's undated catheter care policy required urinary drainage bags to be properly secured, kept off the bed, positioned below bladder level, and managed in a manner that reduces the risk of complications, including infection, catheter tension, and contamination.		

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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 medical record review, review of resident diet slips, interview, and observation, the facility failed to ensure timely initiation of nutritional supplement recommendations and failed to ensure nutritional supplements were available and received as ordered. This affected two residents (#3 and #8) of three residents reviewed for nutrition. Findings include: 1. Review of Resident #8's medical record revealed an admission date of 09/16/22 with diagnoses including, but not limited to dementia without behavioral disturbances, anxiety, major depressive disorder, and unspecified intellectual disabilities. Review of Resident #8's care plan dated 01/03/25 revealed the resident was at risk for altered nutritional status related to dementia, anxiety, communication problems, and on 11/07/25 it was updated to include an altered diet texture, unplanned weight loss and poor intakes. Interventions included provide feeding/dining assistance as needed and provide nutritional supplements as ordered by the physician. Review of the Nutritional assessment dated [DATE] revealed Resident #8 had a regular diet, with thin liquids and consumed 50 percent (%) to 100% of meals. Resident #8 came to the dining room to eat, there were no meal issues, and no nutrition recommendations noted at this time. Review of Resident #8's Nutritional progress note dated 10/24/25 revealed a skin alteration was present and the treatment nurse was following with a treatment in place. Med pass (liquid supplement) was added to aid in wound healing, the residents weight stable, and the resident was receiving weekly weights for close monitoring. Review of Resident #8's order dated 10/24/25 revealed an order for House Supplement (med pass) 120 milliliters (ml) two times a day for prevention. Review of Resident #8's weekly weights revealed on 10/03/25, Resident #8 weighed 163.4 pounds (lbs.), on 11/01/25 she weighed 162.6 lbs., on 11/08/25 she weighed 147.1 lbs., on 11/15/25 she weighed 146.6 lbs., on 11/22/25 she weighed 142.8 lbs., and on 12/16/25 she weighed 132.8 lbs. Review of the Speech evaluation for Resident #8 dated 10/28/25 recommended a puree diet, thin liquids, and close supervision. Review of Resident #8's physician orders revealed an order dated 10/28/25 for a puree diet texture, thin liquids consistency, encourage small bites, and recommend the dining room for meals. Additional orders dated 11/08/25 revealed orders for a Magic Cup (a specific brand of high calorie, high protein nutritional frozen dessert) two times a day for nutrition due at 7:00 A.M. and 7:00 P.M. Review of Resident #8's nutritional progress note dated 12/04/25 stated Resident #8's weight loss was expected as the resident had had inadequate intakes, required total dependence on staff for the Magic Cup and house supplements, and would recommend increasing house supplements and an appetite stimulant. Review of Resident #8's medical record revealed orders for increasing house supplements and an appetite stimulant were not initiated from 12/04/25 through 12/17/25. Review of Resident #8's nutritional progress note dated 12/12/25 recommended Remeron (an appetite (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stimulant) for Resident #8. Review of Resident #8's medical record revealed an order for Remeron was not initiated. Review of the progress note dated 12/16/25 at 3:02 P.M. revealed a conversation with Resident #8's family. Staff stated that Resident #8 had experienced a decline in overall functional status. Therapy services reported little progress in treatment and there was a recent weight loss. Resident #8 refused meals, care, and to get out of bed or chair frequently. Hospice was discussed and the resident's family was agreeable. Review of Resident #8's nutritional progress noted dated 12/17/25 revealed a 18.73% weight loss since October 2025, no Remeron and a hospice consult was noted. The note, again, recommend increasing supplements. Review of the physician orders dated 12/18/25 revealed Resident #8 was ordered House Supplement 120 milliliters (ml) three times a day for supplement/wound healing. Review of the Medication Administration Record for December 2025 revealed the Magic Cup two times a day (at 7:00 A.M. and 7:00 P.M.) was checked off as received at 7:00 A.M. on 12/01/25, 12/02/25, 12/03/25, 12/06/25 through 12/18/25, 12/20/25, and 12/22/25. Additionally, the 7:00 P.M. order was checked off as received on 12/02/25, 12/03/25, 12/04/25, 12/06/25, 12/08/25, 12/09/25, 12/12/25, 12/14/25, 12/15/25, and 12/22/25. Observation on 12/18/25 at 8:22 A.M. revealed Resident #8 sitting in her wheelchair in the dining room with her meal tray present. Resident #8 had no Magic Cup on her tray and there was no substitution present for the absence of the Magic Cup. Interview on 12/18/25 at 8:22 A.M. with Certified Nursing Assistant (CNA) #119 confirmed Resident #8 did not get Magic Cup at breakfast per orders. Interview with [NAME] #117 on 12/18/25 at 12:10 P.M. confirmed that the facility did not have any Magic Cups in the building and no substitution was sent out in its place. [NAME] #117 stated that the facility had been out of Magic Cups for a while. Observation on 12/23/25 at 8:24 A.M. revealed Resident #8 was sitting in her recliner in her room with her meal tray in front of her. There was no Magic Cup on her tray and there was no substitution present for the absence of the Magic Cup. Interview on 12/23/25 at 11:00 A.M. with Registered Dietician (RD) #300 confirmed Resident #8 was supposed to be receiving house supplements three times per day, that it was initially recommended on 12/04/25, and the Magic Cup was to be received twice a day. RD #300 stated that the nurses gave the house supplement with medication pass and if there was no Magic Cup, the nurses could replace it with an appropriate stock supplement. RD #300 stated the truck did not send Magic Cups for the last two weeks. Additionally, RD #300 stated she had recommended Remeron, but was told the Nurse Practitioner (NP) wanted to wait and see what hospice recommended. Interview on 12/23/25 at 2:11 P.M. with the Director of Nursing revealed if there were no Magic Cups, then the staff would offer a pudding or rice of the same texture and that an alternative should always be offered if there was no house supplement or Magic Cup. Additionally, the Director of Nursing stated (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff would put in a progress note to indicate that there was an alternative offered to Resident #8. She confirmed there was no evidence in the medical record from October, November, or December 2025 indicating that Resident #8 had been offered an alternative for the lack of Magic Cups. Review of Resident #8's actual diet order/slip for the kitchen on 12/23/25 revealed no Magic Cup on the diet slip for Resident #8. Interview on 12/23/25 at 2:44 P.M. with Dietary Director #74 revealed the Magic Cup order was on Resident #8's diet order in the kitchen and the staff placed it on the tray for meals. Dietary Director #74 confirmed he did not know when the facility ran out of Magic Cups and verified that there were no Magic Cups in the facility at this time. Dietary Director #74 then verified Resident #8's Magic Cup order was no on the diet order/slip and that if it was not on the diet order/slip, then the kitchen staff had not been sending it on Resident #8's meal tray. Interview on 12/23/25 at 3:05 P.M. with CNA #116 revealed that most CNA's did not go to the kitchen and get a Magic Cup for Resident #8 if it was not on her meal tray. 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] and had diagnoses that included vascular dementia, cerebral infarction, and type two diabetes mellitus. Review of Resident #3's nutrition care plan dated 04/16/25 revealed that Resident #3 was at risk for altered nutritional status related to diabetes mellitus, unplanned weight loss and malnutrition. Interventions included providing nutritional supplements as ordered by the physician. Review of Resident #3's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that he was assessed as needing setup or clean-up assistance with his meals. He was assessed as having a Brief Interview for Mental Status (BIMS) score of 14, indicative of intact cognitive status. Review of Resident #3's physician orders dated 10/28/25 revealed that he had a Magic Cup supplement ordered three times daily for supplement with his meals. Review of Resident #3's Medication Administration Records (MAR) dated 11/21/25, 11/28/25, 12/05/25, 12/08/25, 12/12/25, and 12/13/25 revealed the resident did not have the Magic Cup supplement for other reasons. Review of Resident #3's weights revealed that his weight on 10/20/25 prior to the ordering of the Magic Cup was 221.3 pounds (lbs.) and that his weight on 12/02/25 had remained stable at 222.2 lbs. Review of Resident #3's nursing progress notes dated 11/21/25, 11/28/25, and 12/12/25 revealed that the kitchen did not send out Resident #3's Magic Cups. Observation on 12/18/25 at 8:03 A.M. revealed that Resident #3 did not receive his Magic Cup as ordered and no substitution was sent in its place. Observation on 12/18/25 at 12:08 P.M. revealed that Resident #3 did not receive his lunch Magic Cup as ordered. An interview with Certified Nursing Aide (CNA) #90 on 12/18/25 at 12:08 P.M. confirmed that Resident #3 did not receive his lunch Magic Cup as ordered. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with [NAME] #117 on 12/18/25 at 12:10 P.M. confirmed that the facility did not have any Magic Cups in the building and no substitution was sent out in its place. [NAME] #117 stated that the facility had been out of Magic Cups for a while. An interview with Registered Dietitian #300 on 12/18/25 at 12:22 P.M. revealed that Resident #3's weight had been stable since Magic Cups were ordered. The interview revealed that if the Magic Cup was out of stock in the facility, she would expect that a substitute would be sent in lieu of the Magic Cup if it was not available, such as a milk shake. An interview with Dietary Director #74 on 12/22/25 at 2:15 P.M. revealed that he was uncertain of when the facility had run out of Magic Cups, but that he had ordered some Magic Cups, which were expected on the next delivery.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews and review of a facility policy, the facility failed to have parameters in place for as needed pain medications. This affected one (Resident #3) out of two residents reviewed for pain management. The facility census was 59. Findings include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses of vascular dementia and displaced fracture of the base of the neck of the right femur. Review of Resident #3's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that he was assessed as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicative of intact cognitive status. Review of Resident #3's physician orders dated 08/24/25 revealed that he had an order for Tylenol, a non-narcotic analgesic oral tablet 325 milligram (mg), give 650 mg by mouth every four hours as needed for pain. There were no specified parameters in place for the medication. Review of Resident #3's physician orders dated 08/26/25 revealed that he had an order for Oxycodone with Acetaminophen, an opioid analgesic 5-325 mg oral tablet, give one tablet by mouth every four hours as needed for pain. There were no specified parameters in place for the medication. Review of Resident #3's Medication Administration Record (MAR) revealed that he received as needed Oxycodone-Acetaminophen oral tablet 5-325 mg as needed for pain for a pain level of three on a pain scale of zero to ten, ten being the worst pain, on 10/10/25, on 10/11/25 for a pain level of five, on 11/17/25 for a pain level of five, on 11/22/25 for a pain level of five, 11/30/25 for a pain level of five, 12/07/25 for a pain level of four, 12/09/25 for a pain level of five, and 12/18/25 for a pain level of five. Review of Resident #3's MAR revealed that he received as needed Tylenol oral tablet 325 mg, 650 mg by mouth for a pain on 10/15/25 for a pain level of six, and on 12/04/25 for a pain level of six. An interview with Licensed Practical Nurse (LPN) #169 on 12/17/25 at 2:41 P.M. revealed that for residents who were prescribed two as needed pain medications, she would expect to quantify the pain level using a pain level scale from one to ten. She would expect the order to specify when to give each as needed pain medication based on the pain level scale and the parameters set forth in the order. An interview with the Director of Nursing (DON) on 12/17/25 at 2:51 P.M. confirmed that Resident #3 did not have parameters for pain levels in his two as needed pain medications. The DON revealed that she would expect the non-opioid analgesic to be used typically for a pain scale of one to five and the opioid analgesic to be typically prescribed for a pain scale of six to ten; however, the orders for the pain parameters would come from the physician. Review of the September 2021 facility policy titled Administering Medications revealed that medications shall be administered in a safe manner as prescribed. An interview with the Administrator on 12/17/25 at 3:01 P.M. revealed that the facility did not have a pain medication management policy.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement pharmacy recommendations signed by the provider in a timely manner. This affected one resident (#49) of five reviewed for unnecessary medications. The facility census was 59. Findings include: Review of Resident #49's medical record revealed an admission date of 07/27/23 and diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction on the right dominant side, chronic pain, hyperlipidemia, hypertension, mood disorder due to known physiological condition, and alcohol abuse uncomplicated. Review of Resident #49's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed Resident #49 required a wheelchair for mobility and was independent with wheelchair mobility, was continent of both bladder and bowel, had occasional pain of five out of ten on the pain scale (zero was no pain and ten was the worst pain the resident could imagine), and received opioid pain medication. Review of Resident #49's physician's orders revealed an order dated 12/03/24 for trolamine salicylate external cream 10% (a pain relieving cream) with instructions to apply topically to left wrist every eight hours as needed for left wrist pain and an order dated 02/10/25 for diclofenac sodium external gel 1% (a pain relieving gel) with instructions to apply 4 grams to the affected area topically every six hours as needed for pain. Review of Resident #49's pharmacy note to the attending physician/prescriber dated 12/05/25 revealed the pharmacist recommended the trolamine salicylate external cream 10% and diclofenac sodium external gel 1% be evaluated for continued need or discontinuation as they had not been used in the past 60 days. Further review of the pharmacy note to the attending physician/prescriber revealed the note was signed by Nurse Practitioner (NP) #200 and marked to indicate the NP agreed with the pharmacist and the trolamine salicylate external cream 10% and diclofenac sodium external gel 1% should be discontinued. NP #200's signature was undated. The note was made available to surveyors on 12/18/25. Review of Resident #49's medication administration record (MAR) and treatment administration record (TAR) for December 2025 revealed the orders for trolamine salicylate external cream 10% (a pain relieving cream) with instructions to apply topically to left wrist every eight hours as needed for left wrist pain and an order dated 02/10/25 for diclofenac sodium external gel 1% (a pain relieving gel) with instructions to apply 4 grams to the affected area topically every six hours as needed for pain were present and active on the MAR and TAR as of 12/22/25. In an interview on 12/22/25 at 3:37 P.M. the Director of Nursing (DON) confirmed Resident #49's pharmacy note to the attending physician/prescriber dated 12/05/25 was signed by NP #200 and indicated the trolamine salicylate external cream 10% and diclofenac sodium external gel 1% should be discontinued. The DON stated that she did not recall when NP #200 had signed the pharmacy note since NP #200 did not date the note when she signed it. The DON further confirmed the trolamine salicylate external cream 10% and diclofenac sodium external gel 1% had not been discontinued.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility investigations, interview, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected three residents (#28, #50, and #69) out of nine residents reviewed for medication administration. Facility census was 59. Findings include: 1. Review of the medical record revealed Resident #28 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included mononeuropathy of the right lower leg, pain in right knee, and type two diabetes. Review of Resident #28's physician order dated 11/24/25 revealed Resident #28 was ordered Pregabalin (a medication used to treat nerve pain) 150 milligrams (mg) capsules three times a day, due at 6:00 A.M., 2:00 P.M., and 10:00 P.M. Review of Resident #28's controlled drug record revealed on 11/26/25 at 4:00 A.M. Licensed Practical Nurse (LPN) #96 signed out five Pregabalin 150 mg capsules. Review of Resident #28's Medication Administration Record (MAR) revealed on 11/26/25 at 6:00 A.M., Pregabalin was not documented as administered. Review of Resident #28's facility medication error report dated 11/26/25 at 10:05 A.M. revealed a nurse reported that five Pregabalin 150 mg capsules were signed out of the controlled drug record on 11/26/25 at 4:00 A.M. Review of Resident #28's nursing note dated 11/26/25 at 7:27 P.M. revealed on 11/26/25 at approximately 10:00 A.M. Registered Nurse (RN) #123 was at the medication cart when Resident #28 reported not feeling well. Resident #28 stated she thought the increased dose of Pregabalin might be the culprit. Resident #28 had been taking Pregabalin 100 mg three times a day and the dosage had been increased to 150 mg when the doctor visited on 11/24/25. RN #123 checked the controlled drug record and saw five Pregabalin had been signed out on 11/26/25 at 4:00 A.M. The Nurse Practitioner (NP) was notified, and new orders were received for a completed blood count and comprehensive metabolic panel to be completed. Resident #28's vitals were to be checked every hour for four hours, then every two hours times two, and every four hours times four. The resident was also ordered normal saline intravenously at 30 milliliter (ml) an hour. The resident's level of consciousness was to be monitored and the afternoon and bedtime doses of Pregabalin on 11/26/25 were to be held. Resident #28 reported being dizzy and was assisted to bed. An interview on 12/22/25 at 10:08 A.M. with the Director of Nursing (DON) verified on 11/26/25 at 4:00 A.M. Resident #28 was administered 750 mg of Pregabalin instead of ordered 150 mg. The DON stated LPN #96 was unsure why she administered five capsules of Pregabalin to Resident #28. The DON also verified the Pregabalin was not scheduled to be administered at 4:00 A.M. and that it was also not signed off as administered. Review of the undated policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication shall contact the resident's attending physician or the facility's medical director to discuss the concerns. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 2. Review of the medical record revealed Resident #50 was admitted on [DATE] with diagnoses that included vascular dementia, anxiety disorder, idiopathic peripheral autonomic neuropathy, polyneuropathy, and polyarthritis. Review of Resident #50's plan of care dated 02/21/25 revealed Resident #50 had the potential for pain related to chronic pain syndrome. Interventions included to administer medications per physician orders and to monitor for side effects and effectiveness. Review of Resident #50's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact. Review of physician orders revealed Resident #50 was ordered Tramadol (to treat moderate to moderately severe pain) 50 milligrams (mg) twice a day at 7:00 A.M. and 7:00 P.M., Levaquin (antibiotic) 500 mg daily at 7:00 A.M., and Prednisone (corticosteroid) 40 mg daily at 7:00 A.M. Review of Resident #50's progress noted dated 11/26/25 at 8:30 A.M. revealed the nurse administered medications during the morning medication pass. The nurse (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noticed that night shift nurse (Registered Nurse (RN) #155) had signed out the narcotics (Tramadol) but there was not a time documented. This resulted in medication errors. Review of Resident #50's medication administration record (MAR) revealed the day shift nurse administered Resident #50's Tramadol, Levaquin, and Prednisone on 11/26/25 at the 7:00 A.M. administration time. Review of the controlled drug record revealed Resident #50 was administered Tramadol 50 mg on 11/26/25 at 5:50 A.M. by Registered Nurse (RN) #155 and at 8:23 A.M. by Licensed Practical Nurse (LPN) #163. The facility investigation dated 11/26/25 revealed RN #155 stated she thought she had signed of the medication on the MAR. RN #155 was educated on ensuring the appropriate documentation was completed with medication administration. The root cause of the medication error was RN #155 failed to sign the MAR which caused the oncoming nurse to administer the medication for an additional dose. The Certified Nursing Practitioner (CNP) was notified, and new orders were received for Resident #50's level of consciousness and vital signs to be monitored every hour for four hours, then every two hours times two, and then every four hours times two. An electrocardiogram (test that records the electrical activity of the heart) was ordered to be completed on 11/26/25. A comprehensive blood count and basic metabolic panel were also ordered to be completed on 11/26/25 and 11/28/25. An interview on 12/22/25 at 10:08 A.M. with the Director of Nursing (DON) verified Resident #50 was administered Levaquin, Prednisone, and Tramadol by the nightshift nurse, RN #155, and day shift nurse, LPN #163, on 11/26/25. 3. Review of the medical record revealed Resident #69 was admitted on [DATE] with diagnoses that included osteogenesis imperfecta, fracture of lower end of right femur, chronic pain syndrome, and osteoarthritis. Review of Resident #69's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 was cognitively intact. The MDS also revealed Resident #69 received scheduled pain medications and no as needed pain medication. Review of physician orders revealed Resident #69 was ordered Pregabalin (used to treat nerve pain) 200 milligrams (mg) twice a day at 7:00 A.M. and 7:00 P.M. Resident #69 was also ordered Tramadol 50 mg twice a day at 7:00 A.M. and 7:00 P.M. Review of the Medication Administration Record (MAR) revealed Resident #69 was administered Pregabalin 200 mg and Tramadol 50 mg by Licensed Practical Nurse (LPN) #94 on 11/26/25 at the scheduled 7:00 A.M. time. Review of the controlled drug record revealed Resident #69's Pregabalin 200 mg and Tramadol 50 mg were administered on 11/26/25 at 6:10 A.M. by Registered Nurse (RN) #155 and at 8:26 A.M. by LPN #94. Review of Resident #69's progress note dated 11/26/25 at 8:30 A.M. revealed the nurse (LPN #94) was administering medications during the morning medication pass. LPN #94 noticed that night shift nurse (RN #155) had signed out the narcotics at 6:10 A.M. resulting in medication errors since the medication was not signed off on the MAR. New orders received to monitor Resident #69's level of consciousness and vitals every hour for four hours, then every two hours times two, then every four hours times two. Review of the facility investigation dated 11/26/25 revealed the nurse (LPN #94) was administering medications during the morning medication pass and noticed the night shift nurse (RN #155) had signed out narcotics at 6:10 A.M. for Resident #69. RN #155 did not sign the MAR that the medications were administered. The root cause of the medication error was the nurse failed to sign the MAR which in turn caused the oncoming nurse to administer the medication for an additional dose. An interview on 12/22/25 at 10:08 A.M. with the Director of Nursing (DON) verified on 11/26/25, Resident #69 was administered Tramadol and Pregabalin by the nightshift nurse, RN #155, and by the day shift nurse, LPN #163. Review of the undated policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. The individual administering the medication must initial the resident's MAR after giving the medication.		

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NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interviews, review of the menu spreadsheet, and review of facility policy, the facility failed to provide and serve pureed bread as planned on the menu. This affected two out of two residents (Resident #8 and #13) who received pureed diets in the facility. The facility census was 59 residents. Findings include: Review of the planned pureed diet spreadsheet for 12/18/25 revealed that a #16 scoop of pureed bread was to be served with the lunch meal on 12/18/25. Observations of the preparation of the pureed diets on 12/18/25 from 10:02 A.M. to 10:17 A.M. revealed that no pureed bread was prepared for the pureed diets. An interview with [NAME] #117 on 12/18/25 at 11:51 A.M. confirmed that no pureed bread was made for the pureed diets on 12/18/25 for lunch, and no pureed bread substitute was served. [NAME] #117 stated that it does not work well. An interview with Registered Dietitian #300 on 12/18/25 at 12:22 P.M. revealed that if bread was unable to be prepared properly, she would expect a pureed bread substitute to be served instead.		

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NAME OF PROVIDER OR SUPPLIER Roscoe Gardens Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident #42's call light was within reach. This affected one (Resident #42) out of 28 residents observed for call lights within reach. Facility census was 59. Findings include: Review of the medical record revealed Resident #42 was admitted on [DATE] with diagnoses that included dementia, atrial fibrillation, asthma, and generalized anxiety disorder. Review of Resident #42's care plan dated 02/20/25 revealed the resident was at risk for falls related to impaired cognition and the use of psychotropic medications. Interventions included to maintain the call light within reach. Review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 02 which indicated severe cognitive impairment. The MDS also revealed Resident #42 was independent with mobility. An observation on 12/15/25 at 3:03 P.M. revealed Resident #42's call light was between the resident's bed and the wall. An observation on 12/16/25 at 7:18 A.M. revealed Resident #42's call light was under Resident #42's bed under the foot board. An interview on 12/16/25 at 7:59 A.M. Certified Nursing Assistant (CNA) #146 verified Resident #42's call light was underneath the resident's bed and could not be reached by Resident #42.		