STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365269	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Court	1076 Coshocton Ave Mount Vernon, OH 43050

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interviews, and review of facility policy, the facility failed to report an allegation of an injury of unknown origin to the State Survey Agency as required. This affected one (Resident #49) of three residents reviewed for abuse. The facility census was 48.|Findings include: Review of the medical record for Resident #49 revealed an admission date of 02/03/17 with diagnoses including Alzheimer's Disease with late onset, protein calorie malnutrition, major depressive disorder and chronic kidney disease.Review of Resident #49's care plan last revised on 07/15/24 revealed the resident had difficulty integrating information during conversation due to cognitive problems and she was extensive/dependent for all care. Interventions included monitor for skin concerns during care. Report all found.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, which indicated severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with eating and bed mobility and dependent on staff for showering/bathing, hygiene, and transfers.Review of facility incident report dated 02/26/26, revealed a bruise to Resident #49's right cheek. The incident report indicated daughter in reporting seeing light purple bruising to right cheek. No nature of incident was indicated in the report. Further review of the incident report, completed by the DON revealed the area could have been a line created if her right cheek had rested on a side rail during incontinence care. Interviews conducted with staff members revealed no evidence of Resident #49's face coming in contact with the bed rail.Further review of the medical record revealed no mention of the bruise to the resident's right cheek. No skin assessment was completed on 02/26/26, after the area was identified.Review of the February 2026 incident/accident log revealed no documentation of the resident's bruising to her right cheek. Review of the Self-Reported Incidents located on the Enhanced Information Dissemination Collection (a database used to report information, including facility self-reportable incidents, directly to the state survey agency) for February 2026 through March 2026 revealed no self-reported incidents were generated by the facility related to Resident #49 and the discoloration to her right cheek.On 03/18/26 at 10:18 A.M. Resident #49 was observed lying in bed. No areas of discoloration were noted to the resident's right cheek.Interview on 03/18/26 at 1:30 P.M. with Family member #160 revealed she visited Resident #49 on 02/26/26. Upon entering the room, a staff member was assisting Resident #49 with lunch and Family member #160 noticed a bruise on Resident #49's right cheek. She stated she took a picture then spoke to Registered Nurse (RN) #102, who stated to the family member it appeared to be an age spot. The Director of Nursing (DON) came to assess the area and stated to the family member the area could have been caused by the bedrail during care. The DON told Family member #160 she would perform an investigation and provide staff education for Resident #49 to require two staff members for all care.Interview on 03/19/26 at 9:46 A.M. with RN #102 revealed she was working the day Resident #49's daughter came in and stated she saw a bruise on Resident #49's face. The area was discolored, and the RN reported it to the DON. The RN denied noticing the area earlier in the day. Interview on 03/19/26 at 9:54 A.M. with Family member #170 revealed the DON had contacted her on 02/26/26 (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the potential bruise and she would perform an investigation, but no information was provided how the facility planned to prevent further incidents.Interview on 03/19/26 at 3:00 P.M. with the DON verified no self-reported incident (SRI) was submitted by the facility related to the discoloration/bruise noted to the resident's right cheek as an allegation of an injury of unknown origin.Review of facility policy titled Abuse policy, last revised 04/12, revealed Investigation will be completed by social services and/or Director of Nurses, and Ohio Department of Health will be notified within 24 hours and investigation completed by five days.This deficiency represents non-compliance investigated under Complaint Number 2733229.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, facility policy review, and interview, the facility failed to complete a thorough investigation following an allegation of an injury of unknown origin. This affected one (#49) of three residents reviewed for abuse. The facility census was 48.Findings include: Review of the medical record for Resident #49 revealed an admission date of 02/03/17 with diagnoses including Alzheimer's Disease with late onset, protein calorie malnutrition, major depressive disorder and chronic kidney disease.Review of Resident #49's care plan last revised on 07/15/24 revealed the resident had difficulty integrating information during conversation due to cognitive problems and she was extensive/dependent for all care. Interventions included monitor for skin concerns during care. Report all found.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, which indicated severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with eating and bed mobility and dependent on staff for showering/bathing, hygiene, and transfers.Review of facility incident report dated 02/26/26, revealed a bruise to Resident #49's right cheek. The incident report indicated daughter in reporting seeing light purple bruising to right cheek. No nature of incident was indicated in the report. Further review of the incident report, completed by the DON revealed the area could have been a line created if her right cheek had rested on a side rail during incontinence care. Interviews conducted with staff members revealed no evidence of Resident #49's face coming in contact with the bed rail. Further review of the information provided by the facility revealed Certified Nursing Assistant (CNA) #116, #117, #119, #120, #121, #122 and #123's interviews did not indicate dates or times of their interviews; CNA #358's witness statement (conducted via phone by the Director of Nursing) did not contain her last name or title; and no physical assessments for abuse were conducted of non-interviewable residents to ensure no other residents were affected.Review of the facility's incident/accident log revealed no evidence of a bruise to Resident #49's cheek.Further review of the medical record revealed no mention of the bruise to the resident's right cheek. No skin assessment was completed on 02/26/26, after the area was identified.On 03/18/26 at 10:18 A.M. Resident #49 was observed lying in bed. No areas of discoloration were noted to the resident's right cheek.Interview on 03/18/26 at 1:30 P.M. with Family member #160 revealed she visited Resident #49 on 02/26/26. Upon entering the room, a staff member was assisting Resident #49 with lunch and Family member #160 noticed a bruise on Resident #49's right cheek. She stated she took a picture then spoke to Registered Nurse (RN) #102, who stated to the family member it appeared to be an age spot. The Director of Nursing (DON) came to assess the area and stated to the family member the area could have been caused by the bedrail during care. The DON told Family member #160 she would perform an investigation and provide staff education for Resident #49 to require two staff members for all care.Interview on 03/19/26 at 9:46 A.M. with RN #102 revealed she was working the day Resident #49's daughter came in and stated she saw a bruise on Resident #49's face. The area was discolored, and the RN reported it to the DON. The RN denied noticing the area earlier in the day. Interview on 03/19/26 at 9:54 A.M. with Family member #170 revealed the DON had contacted her on 02/26/26 regarding the potential bruise and she would perform an investigation, but no information was provided how the facility planned to prevent further incidents.Interview on 03/19/26 at 3:00 P.M. with the DON verified the incident report provided by the facility was the full investigation, no other residents were assessed for injuries, no written education was provided to staff for further prevention of re-occurrence, and no documentation was in Resident #49's medical record related to the discoloration/bruise noted to the resident's right cheek. Review of facility policy titled Abuse policy, last revised 04/12, revealed all investigations of abuse will be thoroughly investigated. Request written statements from all persons involved in reporting, witnessing and intervening in abuse situations. All statements must be returned to the DON office within 24 hours. Investigation will be (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed by social services and/or Director of Nurses. This deficiency represents non-compliance investigated under Complaint Number 2733229.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 record review, review of facility policy and interviews, the facility failed to ensure showers were provided to dependent residents as scheduled and/or per plan of care. This affected two residents (Resident #38 and #49) of three residents reviewed for activities of daily living. The census was 48.Findings include: 1. Review of the medical record for Resident #38 revealed an admission date of 01/06/26 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, tremors, anxiety disorder, and major depressive disorder.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13. The resident was assessed to require assistance with all activities of daily living (ADL's).Review of Resident #38's care plan last revised on 02/11/26 revealed resident required assistance with bathing, hygiene and dressing. Interventions included shower days were Mondays and Fridays.Review of the shower schedule provided by the facility revealed Resident #38's shower days were scheduled Mondays and Fridays.Review of the shower sheets revealed Resident #38 received showers on 01/09/26, 02/06/26, 02/09/26, 02/20/26, 02/23/26 and 03/06/26.Review of the Certified Nursing Assistant (CNA) Point of Care (POC) revealed no evidence Resident #38 received showers since her admission to the facility.Interview on 03/18/26 at 10:24 A.M. with Resident #38 revealed she did not get her showers as scheduled. She reported she was lucky getting one once a week and stated it upset her that she didn't get her two showers per week as planned on Mondays and Fridays.Interview on 03/23/26 at 11:30 A.M. with the Director of Nursing (DON) verified the missing shower documentation for Resident #38. The DON verified showers are to be provided to the residents as care planned, requested and as needed unless refusals are documented. 2. Review of the medical record for Resident #49 revealed an admission date of 02/03/17 with diagnoses including Alzheimer's Disease with late onset, protein calorie malnutrition, major depressive disorder and chronic kidney disease.Review of Resident #49's care plan last revised on 07/15/24 revealed resident required increased assistance with care. Interventions included resident is totally/nearly dependent on staff for bathing, hygiene, and dressing.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00. The resident was assessed to require substantial/maximal assistance with eating and bed mobility and dependent on staff for showering/bathing, hygiene, and transfers.Review of the shower schedule provided by the facility revealed Resident #49's shower days were scheduled on Tuesdays and Saturdays.Review of shower documentation revealed no shower being provided on 01/06/26, 01/13/26, 01/17/26, 01/24/26, 01/27/26, and 01/31/26, 02/10/26, 02/17/26, 02/21/26, 02/24/26, 02/28/26 and 03/03/26.Review of the nurse progress notes revealed no documentation to support the resident's refusal of her showers or the facility's attempt again later.Interview on 03/18/26 at 1:30 P.M. with Resident #49's daughter stated the staff tell her the resident refuses showers but the resident doesn't speak and the daughter was confused as to how the resident would refuse her showers. The daughter stated the resident needed showered her planned two times a week to maintain hygiene. Interview on 03/23/26 at 11:30 A.M. with the DON verified the missing shower documentation Resident #49. The DON verified showers are to be provided to the residents as care planned, requested and as needed unless refusals are documented. Review of facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities, not dated, revealed It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each residents preferences, choices, values and beliefs.This deficiency represents non-compliance investigated under Complaint Number 2733229.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review the facility failed to ensure meal intakes were documented to ensure residents maintained appropriate nutritional parameters to prevent potential weight loss and meet nutritional needs. This affected three residents (Resident #44, #49 and #53) of three residents reviewed for nutrition. The facility census was 48.|Findings include: 1. Review of the medical record for Resident #44, revealed an initial admission date of 11/22/23 and a readmission date of 10/31/25 with diagnoses including Huntington's disease, dysphagia, abnormal weight loss, bipolar disorder and adult failure to thrive.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15. The resident was assessed to require dependent on staff for eating, toileting hygiene, shower/bathing, all ADLs, bed mobility, and transfers.Review of Resident #44's care plan last revised on 03/05/26 revealed resident is at nutrition risk, risk for altered fluid maintenance/dehydration risk for significant weight loss, related to Huntington's disease, anemia, anxiety, history of abnormal weight loss. She consumes less than 75% of diet at times, uses mechanically altered diet, needs assistance with meals, Low body mass index (BMI), and abnormal labs. Interventions included monitoring percentages of meals consumed and documenting each meal.Review of the resident's meal percentage for January 2026 revealed no documented meal percentage intakes for 01/02/26, 01/08/26, 01/26/26, 01/27/26 for dinner; 01/09/26 for breakfast and 01/13/26 for lunch and dinner.Review of the resident's meal percentages for February 2026 revealed no documented meal percentage intakes for 02/04/26, 02/05/26, 02/06/26, 02/10/26, 02/17/26, 02/19/26 for dinner; 02/11/26 for lunch and dinner; 02/20/26 for breakfast and lunch; 02/21/26 for breakfast, lunch and dinner and 02/22/26 for lunch and dinner. Review of the resident's meal percentages for March 2026 revealed no documented meal percentage intakes for 03/04/26, 03/08/26, 03/10/26 and 03/17/26 for dinner; 03/05/26 for breakfast, lunch and dinner and 03/06/26 for breakfast.Interview on 03/19/26 at 9:58 A.M with Certified Nursing Assistant (CNA) #122 revealed meal intakes are recorded after the meal is complete and she does not leave her shift until her documentation is completed.Interview on 03/23/26 at 11:30 A.M. with the Director of Nursing (DON), revealed the aides are expected to do charting daily, including the meal percentages. The DON verified meal percentages are used to monitor a resident's nutritional status.2. Review of the medical record for Resident #49 revealed an admission date of 02/03/17 with diagnoses including Alzheimer's Disease with late onset, protein calorie malnutrition, major depressive disorder and chronic kidney disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00. The resident was assessed to require substantial/maximal assistance with eating and bed mobility and dependent on staff for showering/bathing, hygiene, and transfers.Review of Resident #49's care plan last revised on 12/31/25 revealed resident is at malnutrition risk, altered fluid maintenance /dehydration, and significant weight loss related to diagnoses of malnutrition, Alzheimer's disease, chronic kidney disease stage two, anxiety, dementia with delusions, depression, needs assistance with meals, and use of mechanically altered diet. Interventions included monitoring percentages of meals consumed and document each meal.Review of the resident's meal percentage for January 2026 revealed no documented meal percentage intakes for 01/02/26 for breakfast.Review of the resident's meal percentages for February 2026 revealed no documented meal percentage intakes for 02/04/26, 02/11/26, 02/16/26, and 02/17/26 for dinner; 02/19/26 for breakfast and dinner and 02/22/26 and 02/24/26 for lunch and dinner.Review of the resident's meal percentages for March 2026 revealed no documented meal percentage intakes for 03/08/26 for dinner.Interview on 03/19/26 at 9:58 A.M with CNA #122 revealed meal intakes are recorded after the meal is complete and she does not leave her shift until her documentation is complete.Interview on 03/23/26 at 11:30 A.M. with the Director of Nursing (DON), revealed the aides are expected to do charting daily, including the meal percentages.(continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON verified meal percentages are used to monitor a resident's nutritional status.3. Review of the medical record for Resident #53, revealed an admission date of 06/29/24 with diagnoses including non-traumatic subdural hemorrhage, visual hallucinations, Down syndrome, chronic pain syndrome, and left foot drop. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00. The resident was assessed to require dependent on eating, all ADL's and transfers.Review of Resident #53's care plan last revised on 12/31/25 revealed resident is at malnutrition risk, altered fluid maintenance /dehydration, and significant weight loss related to diagnoses of seizure-like activity, Down syndrome, consumes less than 75% of meals and needs assistance with meals. Interventions included monitoring percentages of meals consumed and document each meal.Review of the resident's meal percentage for January 2026 revealed no documented meal percentage intakes for 01/02/26, 01/09/26, 01/23/26, 01/26/26 and 01/27/26 for dinner and 01/08/26 for lunch and dinner.Review of the resident's meal percentages for February 2026 revealed no documented meal percentage intakes for 02/04/26, 02/05/26, 02/06/26, 02/18/26, 02/23/26, and 02/24/26 for dinner; 02/10/26, 02/21/26, and 02/22/26 for breakfast, lunch and dinner; 02/11/26, 02/17/26 and 02/19/26 for breakfast and dinner and 02/20/26 for breakfast and lunch.Review of the resident's meal percentages for March 2026 revealed no documented meal percentage intakes for 03/04/26 for breakfast and dinner; 03/08/26 and 03/10/26 for dinner and 03/17/26 for breakfast, lunch and dinner.Interview on 03/19/26 at 9:58 A.M with CNA #122 revealed meal intakes are recorded after the meal is complete and she does not leave her shift until her documentation is complete.Interview on 03/23/26 at 11:30 A.M. with the Director of Nursing (DON), revealed the aides are expected to do charting daily, including the meal percentages. The DON verified meal percentages are used to monitor a resident's nutritional status.Review of facility policy titled Nutrition Documentation Overview, not dated, revealed Nutrition documentation shall be completed on all residents in accordance with state and federal regulations and meet standards of practice.This deficiency represents non-compliance investigated under Complaint Number 2733229.