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	04/23/2026

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 closed record review, review of self reported incidents (SRI), staff interview, and policy review, facility failed to ensure a concern of resident neglect was reported to the State agency. This affected one resident (#50) of three reviewed for resident death. The facility census was 48. Findings include:Review of the medical record for Resident #50 revealed an admission date of [DATE]. Diagnoses included nonalcoholic steatohepatitis (NASH), diabetes, ascites, and obesity. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition.Review of the plan of care dated [DATE] revealed Resident #50 had a full code advanced directive with interventions to call nine-one-one (911) in the event the resident's heart stopped and start Cardiopulmonary Resuscitation (CPR) if the resident was not breathing or had no pulse, and to start oxygen and or life-saving breaths via an artificial manual breathing unit (ambu) bag if the resident stopped breathing. It also included interventions to keep a copy of the resuscitation wishes in the medical record and to notify the physician and family if the resident stopped breathing or her heart stopped. Review of the care plan dated [DATE] revealed Resident #50 was at risk for alteration in skin integrity related to diabetes, incontinence, self mobility problems and long term use of steroids with interventions to be turned and repositioned every two hours. Review progress notes dated [DATE] at 5:30 A.M. from Licensed Practical Nurse (LPN) #79 revealed during morning medication pass, Resident #50 was found to be nonresponsive with no communication. The nurse at bedside noted the resident to be cool to touch and attempted to take vital signs. No blood pressure, pulse or respirations were identified. A second nurse (Registered Nurse (RN) #75) verified. No heartbeat or breath sounds were noted. A text message was sent to the Director of Nursing (DON) and the Nurse Practitioner #225 and spouse were made aware. Review of the medical record found no evidence of any identified change in condition for Resident #50 prior to her death and documentation did not state the last time resident was checked on and last seen or cared for.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) revealed no self-reported incidents were generated by the facility notifying the State agency of an allegation of neglect related to Resident #50's death.Interview on [DATE] at 10:19 A.M. with Certified Nursing Assistant (CNA) #94 revealed she worked night shift on [DATE] and stated an Agency Aide working on another hall was not taking care of residents appropriately. She revealed the CNA was sitting down at the desk or missing frequently and was difficult to find. She reported she offered to help on a few occasions, and either was unable to locate the CNA or found him sitting and not providing care. She revealed LPN #79 informed her of Resident #50 being found unresponsive and she was trying to find the nurse (RN #75) to confirm the lack of vital signs. At this time CNA #94 asked the assigned CNA when he last saw her and he reported [DATE] at 11:20 P.M. She stated that CNA had not worked since this incident. Interview on [DATE] at 10:40 A.M. and 11:30 A.M. with the Director of Nursing (DON) revealed Agency CNA #103 was the CNA working on night shift from [DATE] into [DATE]. She confirmed Agency CNA (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	#103 was Resident #50's assigned CNA. The DON reported she identified the facility staff did not check on Resident #50 timely and it was unknown how long Resident #50 was unresponsive before being found at 5:30 A.M. She revealed when she was alerted by phone on [DATE] around 7:00 A.M. she asked the nurse when she last saw resident alive and LPN #79 informed her around 12:00 midnight was her last observation of Resident #50 before she was found unresponsive at 5:30 A.M. and the nurse informed the DON she was unsure when CNA #103 last cared for the resident prior to her death. The DON confirmed facility staff did not follow up to confirm with CNA #103 about the last time he saw her alive and well. The DON confirmed her expectation of staff checking on residents at least every two hours and laying eyes on residents to confirm safety. The DON confirmed Resident #50 was not cared for and checked on in a timely manner. Interview on [DATE] at 11:49 A.M. with Hospitality Aide (HA) #98 revealed she had worked part of the shift with CNA #103 and reported he was not tending to resident's needs and was not following up timely with requests for resident care. She reported concerns related to lack of care and monitoring and the residents' unforeseen death. Interview on [DATE] at 6:40 A.M. with CNA #131 and CNA #135 revealed they worked night shift and confirmed the facility expectation for residents to be observed and checked on every one to two hours, including on the night shift. Interview on [DATE] at 11:00 A.M. with the DON confirmed the facility had not placed Agency CNA #103 on the do not return list from his agency, but reported he would not be returning. She also verified the investigation had not been completed for Resident #50's death and/or allegation of neglect due to lack of timely care. The DON stated she would begin an investigation on this date.Interview on [DATE] at 1:55 P.M. with Agency CNA #103 revealed the previous aide left her shift at 11:00 P.M. and that was when he assumed care for Resident #50. He revealed Resident #50 had been on her call light all evening requesting incontinence care, a drink, and to be repositioned as she had reported being uncomfortable. He revealed he had checked her last on [DATE] between midnight and 1:00 A.M. as she had stopped pressing the call light. CNA revealed the resident appeared to be sleeping during this observation check. He acknowledged he did not check in with her again prior to Resident #50 being found unresponsive in her room at 5:30 A.M. CNA #103 revealed LPN #79 and RN #75 went into the room to assess her and check her vital signs after Resident #50 was found unresponsive and he revealed he stepped into the room as well, but the nurses were already in there and there was nothing for him to do. Interview on [DATE] at 4:55 P.M. with RN #75 revealed LPN #79 came to her on [DATE] during morning medication administration and stated Resident #50 was found unresponsive. RN #75 reported LPN #79 had mentioned CNA #103 was making himself scarce during the shift and was hard to locate. She stated the outcome may have been different with more frequent monitoring or checks.Interviews on [DATE] at 2:00 P.M. and at 4:15 P.M. with the DON acknowledged not checking on a resident for an extended period of time would be considered neglect and the DON confirmed no self-reported incident (SRI) had been initiated and reported to the State agency related the Resident #50's care the night of her death. Review of the undated facility policy titled Policy and Procedure on Abuse, Neglect, Exploitation, and Misappropriation of Resident Property revealed Policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries from an unknown source. Additionally, the facility should immediately report all such allegations to the administrator and/or designee. The administrator/designate will report the allegations to the State agency. Mistreatment of a resident is defined as inappropriate treatment or exploitation of a resident. Neglect was defined as the willful failure of the facility, its employees, or the facility service providers, to provide goods and services to a resident to avoid physical harm, pain, mental anguish, or emotional distress. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Additionally, this policy notes in response to allegations of abuse, neglect, exploitation, or mistreatment, the administrator and/or designee of the facility will report to the State agency in accordance with state law and they also must have evidence that the alleged violations are thoroughly investigated and they (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must report the results of all investigations to the administrator and/or his designated representative and to the other officials in accordance with state law including the State survey agency within five working days of the incident.This deficiency represents an example of continued noncompliance from the survey dated [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 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 closed record review, review of facility self reported incidents (SRI), staff interview, and policy review, facility failed to ensure a concern of resident neglect was thoroughly investigated. This affected one resident (#50) of three reviewed for resident death. The facility census was 48. Findings include:Review of the medical record for Resident #50 revealed an admission date of [DATE]. Diagnoses included nonalcoholic steatohepatitis (NASH), diabetes, ascites, and obesity. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition.Review of the plan of care dated [DATE] revealed Resident #50 had a full code advanced directive with interventions to call nine-one-one (911) in the event the resident's heart stopped and start Cardiopulmonary Resuscitation (CPR) if the resident was not breathing or had no pulse, and to start oxygen and or life-saving breaths via an artificial manual breathing unit (ambu) bag if the resident stopped breathing. It also included interventions to keep a copy of the resuscitation wishes in the medical record and to notify the Physician and family if the resident stopped breathing or her heart stopped. Review of the care plan dated [DATE] revealed Resident #50 was at risk for alteration in skin integrity related to diabetes, incontinence, self mobility problems and long term use of steroids with interventions to be turned and repositioned every two hours. Review progress notes dated [DATE] at 5:30 A.M. from Licensed Practical Nurse (LPN) #79 revealed during morning medication pass, Resident #50 was found to be nonresponsive with no communication. The nurse at bedside noted the resident to be cool to touch and attempted to take vital signs. No blood pressure, pulse or respirations were identified. A second nurse (Registered Nurse (RN) #75) verified. No heartbeat or breath sounds were noted. A text message was sent to the Director of Nursing (DON) and the Nurse Practitioner #225 and spouse were made aware. Review of the medical record found no evidence of any identified change in condition for Resident #50 prior to her death and documentation did not state the last time resident was checked on and last seen or cared for.Review of facility investigation documents and 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) revealed no documented evidence of an investigation into Resident #50's death or neglect.Interview on [DATE] at 10:19 A.M. with Certified Nursing Assistant (CNA) #94 revealed she worked night shift on [DATE] and stated an Agency Aide working on another hall was not taking care of residents appropriately. She revealed the CNA was sitting down at the desk or missing frequently and was difficult to find. She reported she offered to help on a few occasions, and either was unable to locate the CNA or found him sitting and not providing care. She revealed LPN #79 informed her of Resident #50 being found unresponsive and she was trying to find the nurse (RN #75) to confirm the lack of vital signs. At this time, CNA #94 asked the assigned CNA when he last saw her and he reported [DATE] at 11:20 P.M. Interview on [DATE] at 10:40 A.M. and 11:30 A.M. with the Director of Nursing (DON) revealed an Agency CNA #103 was the CNA working on night shift from [DATE] into [DATE]. She confirmed Agency CNA #103 was Resident #50's assigned CNA. The DON reported she identified the facility staff did not check on Resident #50 timely and it was unknown how long Resident #50 was unresponsive before being found at 5:30 A.M. The DON confirmed an investigation was not completed. She revealed when she was alerted by phone on [DATE] around 7:00 A.M. she asked the nurse when she last saw resident alive and LPN #79 informed her around 12:00 midnight was her last observation of Resident #50 before she was found unresponsive at 5:30 A.M. and the nurse informed the DON she was unsure when CNA #103 last cared for the resident prior to her death. The DON confirmed facility staff did not follow up to confirm with CNA #103 about the last time he saw her alive and well. The DON confirmed her expectation of staff checking on residents at least every two hours and laying eyes on residents to confirm safety. The DON confirmed Resident #50 was not cared for and checked (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on in a timely manner. Interview on [DATE] at 11:49 A.M. with Hospitality Aide (HA) #98 revealed she had worked part of the shift with CNA #103 and reported he was not tending to resident's needs and was not following up timely with requests for resident care. She reported concerns related to lack of care and monitoring and the residents' unforeseen death. Interview on [DATE] at 11:00 A.M. with the DON confirmed the facility had not placed Agency CNA #103 on the do not return list from his agency, but reported he would not be returning. She also verified the investigation had not been completed for Resident #50's death and/or allegation of neglect due to lack of timely care. The DON stated she would begin an investigation on this date.Interview on [DATE] at 1:55 P.M. with Agency CNA #103 revealed the previous aide left her shift at 11:00 P.M. and that was when he assumed care for Resident #50. He revealed Resident #50 had been on her call light all evening requesting incontinence care, a drink, and to be repositioned as she had reported being uncomfortable. He revealed he had checked her last on [DATE] between midnight and 1:00 A.M. as she had stopped pressing the call light. CNA #103 revealed the resident appeared to be sleeping during this observation check. He acknowledged he did not check in with her again prior to Resident #50 being found unresponsive in her room at 5:30 A.M. CNA #103 revealed LPN #79 and RN #75 went into the room to assess her and check her vital signs after Resident #50 was found unresponsive and he revealed he stepped into the room as well, but the nurses were already in there and there was nothing for him to do. Interview on [DATE] at 4:55 P.M. with RN #75 revealed LPN #79 came to her on [DATE] during morning medication administration and stated Resident #50 was found unresponsive. RN #75 reported LPN #79 had mentioned CNA #103 was making himself scarce during the shift and was hard to locate. She stated the outcome may have been different with more frequent monitoring or checks.Interviews on [DATE] at 2:00 P.M. and at 4:15 P.M. with the DON acknowledged not checking on a resident for an extended period of time would be considered neglect.Review of the undated facility policy titled Policy and Procedure on Abuse, Neglect, Exploitation, and Misappropriation of Resident Property revealed Policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries from an unknown source. Additionally, the facility should immediately report all such allegations to the administrator and/or designee. Mistreatment of a resident is defined as inappropriate treatment or exploitation of a resident. Neglect was defined as the willful failure of the facility, its employees, or the facility service providers, to provide goods and services to a resident to avoid physical harm, pain, mental anguish, or emotional distress. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Additionally, this policy notes in response to allegations of abuse, neglect, exploitation, or mistreatment, the administrator and/or designee of the facility will report to the State agency in accordance with state law and they also must have evidence that the alleged violations are thoroughly investigated and they must report the results of all investigations to the administrator and/or his designated representative and to the other officials in accordance with state law including the State survey agency within five working days of the incident.This deficiency represents an example of continued noncompliance from the survey dated [DATE].

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) or call emergency medical services (EMS) for a resident with advance directives for a Full Code (indication for healthcare providers to perform all possible life-saving measures in the event of a cardiac or respiratory arrest). This resulted in Immediate Jeopardy and Actual Harm/Subsequent Death on [DATE] at 5:30 A.M. when Resident #50 was found unresponsive without vital signs and Licensed Practical Nurse (LPN) #79 and Registered Nurse (RN) #75 failed to initiate CPR or contact EMS. LPN #79 and RN #75 did not review Resident #50's code status and determined Resident #50 was deceased at 5:30 A.M. On [DATE] at 10:11 A.M., the Administrator and Registered Nurse (RN) #162 were notified Immediate Jeopardy began on [DATE] at 5:30 A.M. when Resident #50 was found unresponsive and without vital signs, and Licensed Practical Nurse (LPN) #79 and Registered Nurse (RN) #75 failed to initiate CPR or summon EMS services. The resident, who had advance directive for a Full Code was pronounced deceased at the facility. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions-On [DATE] at 9:05 A.M., the Medical Director #150 was notified of the incident. -On [DATE], the Director of Nursing (DON) completed a review of the event to determine potential areas of improvement as in when you determine the absence of vital signs to initiate CPR, and came up with a plan for educating nursing staff regarding the problem.-On [DATE] all licensed staff were in-serviced by the DON on the facility policy for identifying and responding appropriately to code status.-On [DATE], Corporate Registered Nurse (RN) #201 completed a whole house audit of all residents to verify code status, care plans and signed Do Not Resuscitate (DNR) forms were correctly documented in the health record as applicable. No concerns were identified. Audits were completed for all new admissions through [DATE].-LPN #79 was no longer employed at the facility. RN #75 received Code Status education on [DATE], which was related to the facility policy on identifying and responding appropriately to code status.-On [DATE], RN #162 audited the crash cart, and any expired equipment was removed and replaced with valid equipment by [DATE]. -On [DATE], the DON, RN #162, Corporate RN #201, and RN #191 began additional education of all nursing staff on the facility policy on advance directives, location of advanced directives, change of condition, notification of change, rounding protocols (every two hours and as needed if the resident's condition warrants) and immediate response when CPR is required. The education was provided to all nursing staff that were in-house and those not in-house received training via phone. All staff were educated by [DATE] except for those on vacation or leave. No nursing staff will be permitted to work until they receive the above education. Agency staff will review the above education prior to working a shift at the facility.-On [DATE], Business Office Manager #105 reviewed all nursing staff files to verify cardiopulmonary resuscitation (CPR) certifications were valid. All certifications were valid and up to date.-Beginning on [DATE], the DON, Administrator and/or designee will conduct record review audits for all resident deaths going forward for at least the next three months to validate advanced directives were implemented appropriately. The QAPI committee will review the audits and determine if additional follow up is needed.-On [DATE], an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was completed to review the incident investigation, action plans, and applicable policies on CPR and advanced directives. Attendees included Administrator, DON, Corporate RN #201, RN #162, President #250. The Medical Director (Physician #150) provided input via phone. -On [DATE], the DON completed a comprehensive Root Cause Analysis and it was determined that the nurses did not implement CPR because the absence of vital signs was presumed to have occurred a considerable length of time prior. -On [DATE], the Administrator and DON were educated on investigating adverse events, including unexpected deaths, by Corporate Nurse #201. -Beginning on [DATE], the DON and/or (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	designee will conduct Code Drills on alternating shifts to evaluate nurse competency with code procedures. Code drills will be completed three times weekly for four weeks, and then once a month for two months as directed by the QAPI committee.-Beginning on [DATE], the DON, Administrator and/or designee will conduct management rounds (observation and interview audits) throughout the facility on alternating shifts to validate the staff are meeting residents' needs in regard to their specific needs and concerns. Audits will be completed three times weekly for four weeks as directed by the QAPI committee. Although the Immediate Jeopardy was removed on [DATE], the deficiency remains at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Findings include:Review of the medical record for Resident #50 revealed an admission date of [DATE]. Diagnoses included nonalcoholic steatohepatitis (NASH), diabetes, ascites, and obesity. Review of physician orders for [DATE] revealed an advanced directive order for Full Code. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact.Review of the plan of care dated [DATE] revealed Resident #50 had a full code advanced directive with interventions to call nine-one-one (911) in the event the resident's heart stopped and start CPR if the resident was not breathing or had no pulse, and to start oxygen and or life-saving breaths via an artificial manual breathing unit (ambu) bag if the resident stopped breathing. It also included interventions to keep a copy of the resuscitation wishes in the medical record and to notify the Physician and family if the resident stopped breathing or her heart stopped.Review of the progress notes dated [DATE] at 5:30 A.M. by LPN #79 revealed during morning medication pass, Resident #50 was found nonresponsive with no communication. The nurse at the bedside noted the resident was cool to the touch and attempted to take vital signs. No blood pressure, pulse or respirations were identified. A second nurse (RN #75) verified Resident #50 had no heartbeat or breath sounds. A text message was sent to the Director of Nursing (DON) and Nurse Practitioner (NP) #225 and spouse were made aware. Review of the progress note dated [DATE] at 5:52 A.M. documented Resident #50 had expired.Review of the medical record found no evidence of any identified change in condition for Resident #50 prior to her death. The record also did not document CPR was initiated or EMS was contacted when Resident #50 was found unresponsive without vital signs. The record also did not document Resident #50 had been deceased for an extended period of time.During an interview on [DATE] at 10:19 A.M., Certified Nursing Assistant (CNA) #94 stated she worked night shift on [DATE] and stated an Agency CNA (CNA #103) working on another hall was not taking care of residents appropriately. She stated CNA #103 was sitting down at the desk or was difficult to find. She offered to help on a few occasions, and either was unable to locate CNA #103 or found him sitting and not providing care. She stated LPN #79 informed her of Resident #50 being found unresponsive and she was trying to find the nurse (RN #75) to confirm the lack of vital signs. At this time CNA #94 asked CNA #103 when he last saw her and he reported he saw her at [DATE] at 11:20 P.M. She stated CNA #103 had not worked since this incident. During an interview on [DATE] at 10:40 A.M., the DON stated Agency CNA #103 was the CNA working on night shift from [DATE] into [DATE] and he was Resident #50's assigned CNA. The DON reported she identified the facility staff did not check on Resident #50 timely and it was unknown how long Resident #50 was unresponsive before being found at 5:30 A.M. The DON confirmed staff should have performed CPR and called 911 for emergency services as Resident #50 was a full code. During an interview on [DATE] at 11:30 A.M., the DON again confirmed the nursing staff should have performed CPR on Resident #50. The DON also reported the assigned nurse working [DATE] only worked two more shifts and then left her employment after her shift on [DATE]. She confirmed an investigation was not completed. She said when she was alerted about Resident #50's death by phone on [DATE] around 7:00 A.M. she asked the nurse when she last saw the resident alive. LPN #79 informed her around 12:00 A.M. was her last observation of Resident #50 before she was found unresponsive at 5:30 A.M. and the nurse informed the DON she was unsure when Agency CNA #103 last cared for the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident prior to her death. The DON confirmed her expectation of staff checking on residents at least every two hours and laying eyes on residents to confirm safety. The DON confirmed if staff were unable to obtain vital signs on a resident, code status should be verified, and CPR should be initiated along with calling 911 for anyone unresponsive. The DON revealed she was unsure if 911 was contacted and stated she did not believe they were contacted. She confirmed Resident #50's body was sent directly from the facility to the funeral home. During an interview on [DATE] at 1:06 P.M., Funeral Home Staff #140 confirmed they had a copy of the death certificate which listed Resident #50's cause of death as sudden cardiac death and acute liver failure with the manner of death listed as natural and the date/time of death was [DATE] at 5:30 A.M. During an interview on [DATE] at 2:34 P.M., Physician #150 stated Resident #50 was very ill and was a newer admission to the facility. He was not informed of any changes in her condition leading up to her death and was informed by staff she had been found deceased . He reported staff did not perform any CPR or life-saving measures to his knowledge. He would expect staff to perform CPR if they observed her go unresponsive, but if she was found down for an unknown period of time, he would not have expected staff to perform CPR. He revealed the resident was found already deceased .During an interview on [DATE] at 11:00 A.M., the DON confirmed the facility had not completed an investigation for Resident #50's death and/or allegation of neglect due to lack of timely care. The DON stated she would begin an investigation on this date.During an interview on [DATE] at 1:55 P.M., Agency CNA #103 revealed the previous aide left her shift at 11:00 P.M. and that was when he assumed care for Resident #50. He stated Resident #50 had been on her call light all evening requesting incontinence care, a drink, and to be repositioned as she had reported being uncomfortable. He stated he had checked her last on [DATE] between midnight and 1:00 A.M. as she had stopped pressing the call light. CNA#103 revealed the resident appeared to be sleeping during this observation check. He acknowledged he did not check in with her again prior to Resident #50 being found unresponsive in her room at 5:30 A.M. Agency CNA #103 stated LPN #79 and RN #75 went into the room to assess her and check her vital signs after Resident #50 was found unresponsive and he revealed he stepped into the room as well, but the nurses were already in there and there was nothing for him to do. The nursing staff did not request his assistance and did not ask him to get any documentation or equipment related to Resident #50. He walked out of the room and went to care for other residents, and he did not really see Resident #50 and had no information on what she looked like or felt like upon finding her unresponsive. During an interview on [DATE] at 4:55 P.M., RN #75 stated she had never seen or cared for Resident #50 during her admission at the facility. LPN #79 came to her on [DATE] during morning medication administration and stated Resident #50 was found unresponsive, and she was unsure of the resident's code status and was unable to find it. RN #75 stated she went to Resident #50's room to check her vital signs and confirmed she did not check or verify the resident's code status and did not attempt to check the code status in the medical record. She confirmed CPR was not completed and 911was not contacted and she was unable to state why. She was asked to check the resident's vital signs and Resident #50 was lying on her side in bed. She used her stethoscope to check for vital signs and signs of life and did not move the resident during this assessment. RN #75 was unsure if Resident #50 was cold or stiff as she did not touch her or move her. She did not observe the bedside LPN #79 move the resident and was quickly in and out of the room because she was busy with medication pass. Resident #50 was grayish looking. LPN #79 was the one to call the doctor, the DON, and the family, and she was not around when the calls took place. She confirmed the nurse called time of death, then corrected herself stating the physician would have to call the time of death, but the nurse would put the time for the death certificate. LPN #79 mentioned Agency CNA #103 was making himself scarce during the shift and was hard to locate. RN #75 verified if a resident was a full code, CPR should be initiated and 911 should be contacted if they were found unresponsive without a heartbeat. RN #75 stated the outcome may have been different with more frequent monitoring or checks but revealed she was unsure if CPR would have been effective.During an interview on [DATE] at 4:15 P.M., the (continued on next page)

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	04/23/2026

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

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON confirmed no staff had reported any signs that rigor mortis had set in when Resident #50 was found unresponsive on [DATE]. Review of the facility policy titled Additional Code status/Change in condition education points, dated [DATE], revealed when checking for code status's staff should check the active order profile first. The code status shall also be published onto the point of care dashboard for nurses. When a resident has a Code status of Do-Not Resuscitate Comfort Care (DNRCC) or DNRCC-Arrest (DNRCCA) the provider signed document shall be scanned into the medical record. In the absence of a signed DNR document, the resident shall be considered a Full Code. A resident who was Full Code shall have resuscitation attempts started immediately upon noting absence of vital signs. Resuscitation attempts shall be initiated regardless of temperature or lividity of the body. Staff shall promptly call 911, the provider assigned and the emergency contact for the resident. Staff must round at a minimum every two hours to check on residents for any possible changes in condition which include, but are not limited to change in breathing, new onset pain, altered mental status, vomiting, bleeding, fever, chills, sweating, or other abnormal changes from baseline. Changes must be promptly reported to the nurse, and the nurse will promptly assess the resident and report abnormal findings to the medical provider. Review of facility policy titled Code Status Education, dated [DATE], revealed Code status's included Full Code, DNRCC and DNRCCA. The Full Code status included all medical interventions including CPR, defibrillation, and artificial ventilation shall be performed to keep the resident alive. Any resident who was a Full Code shall have resuscitation attempts started immediately upon absence of vital signs. The code status can be revoked or changed by the resident or representative at any time. Residents without a designated signed DNR shall be considered a Full Code. In Ohio, CPR must continue until trained medical professionals take over, the patients is resuscitated, or a valid DNR order is presented. This deficiency represents non-compliance investigated under Complaint Number 2983896.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of facility crash cart (a mobile cart utilized in emergency situations that contains emergency medications and equipment), review of the crash cart binder, interview, and review of facility policy, the facility failed to maintain emergency patient care medications and equipment in safe operating condition. This had the potential to affect all residents. The census was 48.Findings Include:Observation of the facility crash cart on [DATE] at 3:47 P.M. revealed the following expired items: suction machine with a sticker indicating the next inspection was due on 02/2026, five packets of iodine with an expiration date of 02/2025, one bottle of aspirin with an expiration date of 08/2025, one biohazard spill kit with an expiration date [DATE], 11 airway tubes with expiration dates of [DATE], one suction tip with a use by year of 2024, suction tubing with use by year of 2024, small bore extension kits with expiration years of 2025, one central line dressing kit with an expiration year of 2023, and a heat pack with an expiration date of 08/2025. During observation of crash cart, an interview with the Director of Nursing (DON) confirmed that the suction machine was past due for the next inspection and confirmed the above listed expired supplies. The DON stated that she believed the expiration dates were the manufacturing dates. The DON stated that the facility completed monthly checks of the contents of the crash cart. The DON stated that she kept a binder with a checklist of all the equipment that was supposed to be housed on the crash cart.Review of the crash cart binder revealed three crash cart checklists dated [DATE], [DATE] and February 2025. Review of the crash cart checklist dated [DATE] revealed check marks documented for all equipment on the checklist. No expiration dates were noted on the crash cart checklist.On [DATE] at 8:56 A.M. a policy for crash cart maintenance was requested from Office Manager #105. Interview with Office Manager #105 on [DATE] at 9:43 A.M. confirmed that the facility had no policy regarding the crash cart, crash cart audits, or crash cart maintenance.Review of the undated facility policy titled Crash Cart Audit Policy and Procedure revealed the facility will ensure that all crash carts are maintained in a state of readiness at all times. The policy stated that any missing, expired, or damaged items will be replaced promptly and that a trained staff member will maintain a running inventory of expiration dates for all applicable crash cart supplies. The trained staff member will monitor upcoming expiration dates routinely and identify items that are nearing expiration.