| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365418 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Countryside Manor Nursing and Rehabilitation LLC | 1865 Countryside Drive<br>Fremont, OH 43420 |

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) |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, staff interview, and review of facility policy, the facility failed to ensure an adequate supply of clean linen was available to meet the residents' needs. This had the potential to affect all 46 (#32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, and #78) residents who resided on the third floor. The facility census was 76. Findings include:Interview on 02/26/26 at 7:27 A.M. with Certified Nursing Assistant (CNA) #137 revealed there was no linen available to wash the residents. CNA #137 revealed, at times, towels were used instead of wash cloths. Interview on 02/26/26 at 7:33 A.M. with CNA #189 revealed it was common to not have linens available and stated pillowcases have been used to wash residents. Observation on 02/26/26 at approximately 7:40 A.M. of the third floor linen storage revealed there were six towels and no wash cloths available for 46 residents. Interview on 02/26/26 at 8:04 A.M. with CNA #197 verified there were no linens available at the start of their shift at 6:45 A.M. to wash and get residents up. CNA #197 stated it was a daily concern and linens were typically not brought up from laundry until 8:30 A.M. to 9:00 A.M.Interview on 02/26/26 at 8:14 A.M. with Laundry Aide (LA) #176 revealed she was the only laundry aide and worked from 5:00 A.M. to no later than 2:30 P.M. and at times they ran out of linens before laundry could wash and restock. Interview on 02/26/26 at 8:19 A.M. with Housekeeping/Laundry Supervisor (HLS) #170 revealed there was sufficient linen but no one at the facility to keep the linen clean. Review of the facility policy titled, Quality of Life, dated May 2017, revealed residents were provided with a safe, clean, comfortable and homelike environment. The facility staff and management shall maximize the characteristics of the facility that reflect a personalized homelike setting, including clean bed and linens that were in good condition. This was an incidental finding discovered during the complaint investigation. |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (#47) of two residents reviewed for medication administration. The facility census was 76.Findings include:Review of the medical record revealed Resident #47 was admitted on [DATE]. Diagnoses included multiple sclerosis, Alzheimer's disease with late onset, essential hypertension, and hypertensive heart disease with heart failure. Review of the Minimum Data Set (MDS) assessment, dated 01/07/26, revealed the resident was moderately cognitively impaired and did not receive insulin. Review of a nursing progress note, dated 10/18/25 at 9:09 P.M., revealed the resident was given 15 milligram (mg) of glargine Lantus (long acting insulin) and it was not prescribed. The Nurse Practitioner (NP) was notified and gave an order to check the residents bp (not specified what this meant) every hour for six hours. The resident's current blood sugar was 109 milligrams per deciliter (mg/dl). Review of a NP progress note, dated 10/19/25, revealed notification was made by nursing that Resident #47 mistakenly received 15 units of Lantus and was not diabetic. Vitals were assessed and glucose was 107 mg/dl. Physician order entered for glucose check every hour for 12 hours and to notify provider for glucose less than 70 (mg/dl). Glucagon as needed ordered as well as needed glucose tabs. Nursing instructed to notify the Director of Nursing (DON). Ensure the resident eats breakfast and encourage snacks. Recheck vitals in four hours. Interview on 02/26/26 at 10:35 A.M. with the DON verified Resident #47 received insulin when it was not prescribed. Review of the facility policy titled, Administering Medications, dated April 2019, revealed medications were administered in a safe and timely manner, and as prescribed. The individual administering medications verified the resident's identity before giving the resident his/her medications. Methods of identifying the resident included checking the identification band, checking photograph attached to the medical record, and if necessary, verifying the resident identification with other facility personnel. This was an incidental findings discovered during the complaint investigation. |

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview, review of the Emergency Medical Services (EMS) run report, review of hospital records, review of the death certificate, review of staff witness statements, and review of facility policy, the facility failed to ensure residents were served foods in the correct texture to meet individual needs and further failed to ensure residents were accurately assessed for supervision needs during meals. This resulted in Immediate Jeopardy on 01/16/26 for one (#77) resident who experienced serious life-threatening harm and negative health outcomes resulting in death when Certified Nursing Assistant (CNA) #151 served Resident #77, who had a physician ordered mechanical soft texture diet (foods are ground, chopped, or naturally soft), a regular texture sandwich during an evening snack. Subsequently, Resident #77 choked, lost consciousness, and required staff intervention to perform the Heimlich maneuver (a first-aid method for choking that includes abdominal thrusts), cardiopulmonary resuscitation (CPR), and EMS response to remove the food from the trachea where it was preventing air flow to and from the lungs. Consequently, Resident #77 died at the hospital on [DATE]. This affected one (#77) of three residents reviewed for mechanically altered diets. The facility identified 13 residents (#63, #73, #39, #42, #60, #46, #41, #37, #50, #33, #43, #68, #66) who had physician ordered mechanically altered diets. The facility census was 71. On 02/25/26 at 4:14 P.M., the Administrator, the Director of Nursing (DON), Regional Director of Operations (RDO) #201, Regional Clinical Director (RCD) #202, and Licensed Practical Nurse Unit Manager (LPN/UM) #135 were notified Immediate Jeopardy began on 01/16/26 when CNA #151 served Resident #77 a regular texture ham sandwich during the evening snack, contrary to the resident's physician ordered mechanical soft texture diet, and no supervision was provided while the resident consumed the sandwich. At approximately 9:30 P.M., Registered Nurse (RN) #134 observed Resident #77 in the doorway of his room with his hands up to his throat and inserting his finger into his mouth to make himself gag. RN #134 approached Resident #77 and asked if he was choking and Resident #77 nodded yes. Resident #77 was unable to cough and dislodge the food item. RN #134 called for assistance and attempted the Heimlich maneuver, which was unsuccessful. CNA #111, CNA #151, CNA #117, and Respiratory Therapist (RT) #185 responded and attempted the Heimlich maneuver, with each attempt being unsuccessful at dislodging the foreign object. Subsequently, Resident #77 lost consciousness, suffered cardiac arrest, and CPR was initiated and continued until EMS arrived and assumed care, which included the use of a laryngoscopy (specialized medical instrument used to view the larynx and surrounding structures), [NAME] forceps (specialized, angled surgical instrument primarily used for airway management), CPR, defibrillation, suctioning, intravenous (IV) epinephrine (used to treat severe, acute conditions by rapidly stimulating the heart and opening the airways), and intubation (placement of a flexible tube through the mouth or nose and into the trachea to maintain an open airway). EMS removed a large piece of meat that was completely covering Resident #77's trachea and preventing the flow of air to the lungs and at 9:48 P.M., and the resident had a pulse. Resident #77 was transferred to the hospital and subsequently died on [DATE] due to anoxic brain death (death occurring after the brain has been completely and irreversibly deprived of oxygen - signifies the permanent cessation of all brain functions), cardiac arrest, and choking on food. The Immediate Jeopardy was removed on 01/19/26 when the facility implemented the following corrective actions: -On 01/16/26, RN #134 responded to Resident #77, EMS was called, and the resident was subsequently transferred to the hospital. Resident #77 did not return to the facility. -On 01/16/26, RN #134 notified Resident #77's physician of the incident. -On 01/16/26, the DON reviewed Resident #77's diet order for accuracy. -On 01/16/26, the DON initiated an investigation of events surrounding Resident #77's choking incident. -On 01/18/26, the DON conducted a root cause analysis and determined Resident #77 choked when CNA #151 provided Resident #77 with the incorrect diet texture<br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | during the evening snack. -On 01/18/26, the DON reviewed all facility residents' care plans to ensure they accurately reflected current diet orders. -On 01/18/26, the DON conducted a full house audit to ensure no additional residents received incorrect diet consistency or improper feeding assistance, with no issues identified. -On 01/18/26, the DON educated CNA #151 on ensuring each resident received their diet as ordered. -On 01/18/26, the DON educated all nursing staff and Dietetic Technician (DT) #203 on ensuring resident care plans accurately reflected current diet needs. -On 01/18/26, the DON educated all nursing staff on the facility policy to ensure each resident received their diet as ordered and where to verify a resident's diet order. -On 01/18/26, the Administrator, the DON, LPN/UM #135, RDO #201, and RCD #202 reviewed facility policies on assisting residents with in-room meals, snack serving, and therapeutic diets. No changes were made to the policies. -On 01/19/26, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to review the choking incident and the facility's corrective action. In attendance were the Administrator, DON, LPN/UM #135, Business Office Manager (BOM) #102, Human Resources (HR) #103, Maintenance Director (MD) #105, Minimum Data Set Coordinator (MDSC) #158, Dietary Manager (DM) #160, Housekeeping/Laundry Director (HLD) #170, Activities Director (AD) #177, Social Services Director (SSD) #181, Admissions #101, Marketing #100, Respiratory Therapy Director (RTD) #183, and Medical Records (MR) #157. -On 01/19/26, DM #160 posted a list of mechanical soft approved foods in the nutrition rooms on each floor of the facility. -On 01/19/26, DM #160 posted a list of residents with mechanically altered diets in the nutrition rooms on each floor of the facility. DM #160 and/or designee will be responsible for monitoring and updating the lists as diet orders change, with new admissions, and as needed. -On 01/19/26, DM #160 placed separate bins identifying regular snacks and mechanically altered snacks in the nutrition rooms. DM #160 and/or designee, will be responsible for ensuring appropriate food items are placed in each bin, based on safe foods for each diet texture. -Beginning on 01/19/26, the DON would audit four nursing staff three times a week for four weeks to ensure understanding of mechanically altered diets. The results of the audits would be reported to the QAPI committee. -Beginning on 01/19/26, the DON would audit two residents three times per week for four weeks to ensure meals and snacks being served are appropriate based on the ordered diet. The results of the audits would be reported to the QAPI committee. -On 02/25/26, the DON audited all Nutrition and Hydration Status Assessments to ensure accuracy regarding residents' feeding capabilities, including supervision and assistance (if applicable). Any inaccuracies were corrected immediately by DT #203. -On 02/25/26, the DON reviewed all residents' care plans to ensure they accurately reflected the residents' feeding and eating capabilities, including supervision and assistance (if applicable). -On 02/25/26, the DON educated all nursing staff on following the care plan and Kardex (summary of a resident's care plan, used as a quick reference) to identify a resident's level of assistance required when eating. -On 02/25/26, Registered Dietitian (RD) #204 educated DT #203 on the completion of Nutrition and Hydration Status Assessments to accurately reflect a resident's level of assistance required when eating. -Beginning on 02/25/26, the DON would audit two residents three times a week for four weeks to ensure they are receiving feeding assistance and supervision as needed. The results of the audits would be reported to the QAPI committee. -Beginning on 02/25/26, the DON would complete random audits of three resident charts for the most recent admission, quarterly, and change of condition Nutrition and Hydration Status Assessments for accuracy of the resident's level of assistance required when eating for four weeks. The results of the audits would be reported to the QAPI committee. -Observations on 02/25/26 of the nutrition rooms verified bins were maintained for regular and mechanically altered diets. -Interviews on 02/25/26 and 02/26/26 with RN #134, CNA #151, RN #129, and DT #203 confirmed the facility provided education regarding dietary orders, textures, and meal supervision. Although the Immediate Jeopardy was removed on 01/19/26, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility had not yet audited the 13 residents currently residing in the facility, identified to have physician ordered<br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | mechanical soft diets, to ensure the Nutrition and Hydration Assessments and care plans were reviewed and updated for accuracy, that staff education was completed related to appropriate supervision during meals, and 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 closed medical record for Resident #77 revealed an admission date of 02/14/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominate side, facial weakness following cerebral infarction, and phantom limb syndrome with pain. Resident #77 transferred to the hospital on [DATE] and was discharged from the facility on 01/20/26. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/06/25, revealed Resident #77 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. The assessment indicated Resident #77 required set-up assistance with eating, supervision with toileting, partial assistance with showers, and supervision with transferring. Review of the care plan focus area initiated 02/27/25 revealed Resident #77 had an Activities of Daily Living (ADLs) self-care performance deficit related to disease process. Resident #77 required staff assistance to complete ADL tasks daily. Fluctuations were expected related to diagnoses, and the resident was at risk for decline in physical function. Interventions included: usual performance with meals was set up/clean up assistance and provide milkshakes or liquid food supplements when the resident refused or had difficulty with solid food or provide nutritious foods that could be taken from a cup or a mug, where appropriate. Additionally, fluctuations were expected related to diagnosis/condition. Allow for increased support as necessary related to tiredness/weakness, respiratory status, time of day, post-therapy, et cetera (etc.). Further review revealed a focus area revised on 06/12/25 for a mechanically altered diet that may affect appetite. Interventions included provide and serve a low concentrated sweet (LCS), no added salt (NAS), mechanical soft, thin liquid diet as ordered. Review of the physician orders revealed an order dated 06/12/25 for a LCS, NAS, mechanical soft texture, regular (thin) consistency liquids, and a divided plate with meals. Review of the Nutrition and Hydration Status Assessment, dated 11/09/25, revealed Resident #77 had the following diagnoses with nutritional significance: cardiovascular accident, aphasic pneumonia due to food inhalation, below the knee amputation, hypertension, hemiplegia, and hemiparesis. Resident #77 had a chewing problem and fed self with supervision. Review of the Speech Therapy (ST) Discharge summary, dated [DATE], revealed Resident #77 had a medical history of aspiration (food/liquid enters the trachea and lungs instead of being swallowed into the esophagus and stomach), cerebrovascular disease, hypertension, and muscle weakness. Goals included skilled treatment instructing and training Resident #77 in safe swallowing strategies in order to increase safety and independence during daily living tasks and meals. Upon discharge from ST services, Resident #77 exhibited difficulty with oral containment and secretions zero to 25 percent (%) of the time and required supervision/assistance at mealtime due to swallow safety zero to 25% of the time. Resident #77 had a Dysphagia Outcome and Severity Scale ([DOSS] clinical tool used to rate the functional severity of a person's swallowing difficulty) of five out of seven, meaning one or two diet consistencies were restricted and distant supervision was required (caregiver within earshot or nearby to check in periodically). Discharge recommendations included mechanical soft/chopped textures, sit upright, alternate between food/liquid, and take small bites. Review of the late entry nursing progress note dated 01/16/26 at 9:30 P.M. revealed RN #134 observed Resident #77 in his room at 9:06 P.M. during medication administration. At 9:30 P.M., RN #134 saw Resident #77 in his wheelchair at the door of his room, clutching his throat with two hands, and then saw Resident #77 inserting his finger into his mouth making himself gag. RN #134 asked Resident #77 if he was choking and he nodded but could not speak. RN #134 instructed Resident #77 to cough but he couldn't. RN #134 visually inspected Resident #77's mouth for any visible objects, such as food, but none was seen. RN #134 called for help down the hallway while staying with Resident #77. After calling for help, RN #134 immediately attempted the Heimlich maneuver and was not successful. Other staff members were present including an RT<br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | (#185), CNAs (#111, #117 and #151), and another RN (#129). The CNAs and the RT each attempted the Heimlich maneuver and were not successful at expelling the foreign object. At this time, another RN (#129) called nine-one-one (911). At 9:32 P.M., despite repeated Heimlich maneuver attempts, the obstruction was not relieved and the resident lost consciousness. RN #134 instructed the CNA to get the CPR board, another RN secured the crash cart, a second CNA secured the oxygen tank, and a third CNA secured oxygen tubing. At 9:33 P.M., Resident #77 went unresponsive. RN #134 assessed for a carotid pulse and found the pulse was absent. Staff immediately transferred Resident #77 to the bed from the wheelchair, utilizing the backboard to support the resident. The backboard was kept in place with the resident on the bed. At 9:34 P.M., RN #134 initiated chest compressions while RT #185 provided ventilation using a bag-valve mask (Ambu bag) connected to oxygen in coordination with chest compressions. The staff continued CPR without interruption, monitoring for signs of breathing, pulse, and/or expulsion of the foreign object. CPR was maintained until EMS arrived on the scene. At 9:37 P.M., EMS arrived. Upon EMS arrival, RN #134 provided report detailing the choking event, loss of consciousness, initiation of CPR and duration of care rendered. EMS was successful with utilizing the laryngoscope and [NAME] forceps to extract the object from Resident #77's throat. EMS continued CPR, started intravenous (IV) fluid, epinephrine (used to treat severe, acute conditions by rapidly stimulating the heart and opening the airways), suctioning, defibrillation, and intubation. At 10:00 P.M., Resident #77 was sent to the hospital and, at 10:01 P.M., RN #134 called report to the hospital, Nurse Practitioner (NP), emergency contact, and the DON. Review of the respiratory therapy note dated 01/16/26 at 10:08 P.M. revealed RT #185 was called to the code, assisted Resident #77 to sit up with the nurse's help in the chair and did five Heimlich maneuvers with nothing coming out. Resident #77 was transferred to his bed with the help of an aide and began CPR on resident at 9:30 P.M. until EMS came around 9:38 P.M., then EMS took over CPR duties. Review of the EMS run report dated 01/16/25 revealed a call was placed to 911 on 01/16/25 at 9:25 P.M. with a chief complaint of he was totally normal, then started choking and went unresponsive. EMS was at bedside at 9:34 P.M. and Resident #77 was found supine (on back) in bed and effective CPR was in progress by staff. Resident #77 was pulseless and apneic (not breathing), with reported full airway obstruction. Further review of the EMS run report revealed at 9:37 P.M., EMS inserted [NAME] forceps under video laryngoscopy, a large piece of meat was noted to be completely obstructing the trachea and was removed without incident, and Resident #77 was subsequently intubated. At 9:48 P.M., Resident #77 had a pulse. At 10:05 P.M., Resident #77 was placed in the ambulance and transferred to the hospital. Review of CNA #151's witness statement, dated 01/16/26, revealed CNA #151 gave Resident #77 ice water and snacks at 9:00 P.M. At 9:30 P.M., CNA #151 was asked to help with Resident #77, who was in the wheelchair clutching his throat. CNA #151 was asked to get help and call 911. At 9:32 P.M., CNA #151 helped with the Heimlich maneuver and helped with the oxygen tank for Resident #77. At 9:37 P.M., EMS arrived and took over. At 10:00 P.M., EMS took Resident #77 to the hospital. Review of CNA #117's witness statement revealed on 01/16/26 at 9:30 P.M., CNA #117 was motioned by another aide (CNA #111) from the other end of the hall. CNA #117 noticed the way CNA #111 was motioning was a serious manner, so CNA #117 ran down the hall. CNA #151 was giving Resident #77 the Heimlich, then the nurse tried, then CNA #117 tried. CNA #151 tried once more, then the nurse (RN #134), then CNA #117, then CNA #117 asked where the RT was. The nurse tried again, and CNA #117 ran to get the RT. CNA #117 and RT #185 returned to Resident #77 and tried again, then transferred Resident #77 to the bed. While staff were trying on the bed (CPR), EMS came and CNA #117 left the room and waited in the hallway. Review of CNA #111's witness statement revealed on 01/16/26, CNA #111 observed Resident #77 was choking in his chair. The nurse (RN #134) was assisting in the Heimlich maneuver and yelled for more help. CNA #111 was instructed to grab the CPR board, while RN #129 retrieved the crash cart, CNA #151 grabbed the oxygen, and CNA #117 got the oxygen tube. In the midst of that, CPR continued until the ambulance arrived on scene and took over. CNA #111 returned to CNA duties in the hallway. Review of RN #129's witness statement revealed on 01/16/26, (continued on next page) |

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|---|---|
| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | RN #129 was working on the skilled hall. While doing medication pass at around 9:30 P.M., the CNAs were yelling for help from Resident #77's room. RN #129 ran and saw that Resident #77 was choking and his nurse, RN #134, was doing the Heimlich maneuver. RN #129 ran towards the (nurses') station to call 911 for emergency procedure and called code blue on the radio. RN #129 took the crash cart, and the CNAs secured the oxygen tank, tube and CPR board. RN #129 set up the suction machine, while RT #185 was bagging (provide air to the lungs) and RN #134 was doing compressions. At 9:37 P.M., EMS arrived with a stretcher. RN #134 informed EMS of what happened while doing compressions. EMS took over the compressions and bagging. At 10:00 P.M., Resident #77 was transported via stretcher while bagging and with an IV line. Review of RT #185's witness statement revealed on 01/16/26, RT #185 was called to the code. RT #185 got Resident #77 to sit up with the nurse's help in the chair. RT #185 did five Heimlich maneuvers with nothing coming out, transferred Resident #77 to bed with the help of an aide, and began CPR on Resident #77 at 9:30 P.M. until EMS came around 9:38 P.M., then EMS took over CPR duties. Review of a written staff interview with CNA #151, conducted by the DON, revealed CNA #151 was questioned if she knew that Resident #77 was on an altered diet of mechanical soft and CNA #151 stated yes. CNA #151 admitted to giving Resident #77 a ham sandwich (regular texture) and thought it was ok because the ham was very thinly sliced and not a big hunk of meat. One-on-one education was provided to CNA #151 on mechanical soft diets. Review of the Hospitalist History and Physical (H&P), dated 01/17/26, revealed Resident #77 was a nursing home resident who was brought to the emergency department (ED) after sustaining cardiac arrest in the nursing home after choking. Resident #77 was intubated, ventilated mechanically, and received norepinephrine infusion (medication to raise blood pressure in patients with severe, acute low blood pressure). Resident #77 was comatose and given medication for intubation. The physician assessment and plan revealed Resident #77 had acute hypoxic respiratory failure due to choking, followed by cardiac arrest, and was successfully resuscitated after postcardiac arrest shock state. Resident #77 had aspiration pneumonia in the left lung. Resident #77 was to continue supportive care with mechanical ventilation and medications. Review of the Certificate of Death, certified 01/26/26, revealed Resident #77 died in the hospital on [DATE]. The immediate cause of death was anoxic brain death due to cardiac arrest and choking on food. An interview on 02/25/26 at 10:38 A.M. with DT #160 revealed a mechanical soft sandwich would be soft food items, such as egg salad, or chopped ham, turkey or tuna salad. DT #160 stated Resident #77 was ordered a mechanical soft diet but was given a regular texture ham sandwich on the day he choked at the facility. An interview on 02/25/26 at 11:18 A.M. with the DON revealed she received a telephone call on 01/16/26 from RN #134 about Resident #77's choking incident and the details on how staff responded. The DON verified CNA #151 provided Resident #77 with a regular texture deli ham sandwich because the resident asked for a sandwich and she thought it was okay because the ham was thinly sliced. The DON confirmed the ham was not chopped, or the appropriate texture for a mechanical soft diet. The DON stated CNA #151 had one-on-one training on mechanically altered diets and appropriate snacks and meals. The DON confirmed Resident #77 was not supervised during the snack, stating he only required set-up assistance for meals. Further interview, and concurrent review of the Nutrition and Hydration assessment dated [DATE], revealed the resident was assessed to require supervision during meals. The DON stated supervision on the assessment only meant set-up assistance. An interview on 02/26/26 at 9:52 A.M. with RN #134 revealed on 01/16/26 at approximately 9:00 P.M., she gave Resident #77 his medication. RN #134 stated she continued to pass medications and at approximately 9:30 P.M., she saw Resident #77 clenching his neck. RN #134 asked Resident #77 if he was choking, and Resident #77 shook his head yes. RN #134 stated she looked in Resident #77's mouth and did not see any obstruction and she began doing the Heimlich maneuver and back blows. RN #134 stated she yelled for help and CNA #151 was the first to respond. RN #134 stated she was unsure of what Resident #77 was choking on and further stated the resident had difficulty swallowing and had incidents with swallowing before. An interview on 02/26/26 at 11:18 A.M. with CNA #151 verified on<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365418 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Countryside Manor Nursing and Rehabilitation LLC | 1865 Countryside Drive<br>Fremont, OH 43420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 01/16/26, she gave Resident #77 a regular texture ham sandwich. CNA #151 confirmed she was aware Resident #77 was on a mechanical soft diet but thought the ham sandwich was safe. CNA #151 stated Resident #77's choking incident was over one month ago, and she could not recall specifics. Interview on 02/26/26 at 11:06 A.M. with DT #203 revealed she completed the Nutrition and Hydration Assessment on 11/06/25 that indicated Resident #77 required supervision during meals. DT #203 stated she was called by the facility on 02/25/26 regarding her assessment. DT #203 confirmed Resident #77's assessment indicated twice that he required supervision with meals, but this was human error and the resident only required set-up assistance. DT #203 stated she generally left that section blank if supervision was not required. Review of the facility policy titled, Nutritional Assessment, revised October 2017, revealed as part of the comprehensive assessment, the nutritional assessment would be a systematic, multidisciplinary process that included gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. Review of the facility policy titled, Assisting the Resident with In-Room Meals not dated, revealed check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. Review the residents' care plan and provide for any special needs of the residents. Review of the facility policy titled, Resident Nutrition Services, undated, revealed nursing personnel would inspect food trays as they were delivered to ensure that the correct meal had been delivered. Review of the facility policy titled, Therapeutic Diets, undated, revealed snacks would be compatible with the therapeutic diet. This deficiency represents non-compliance investigated under Master Complaint Number 2785441. |