STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365418	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Manor Nursing and Rehabilitation LLC	1865 Countryside Drive 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)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure services required by the state-designated mental health authority were provided to residents. This affected one (#18) of two residents reviewed for pre-admission screening and resident review (PASARR) requirements. The facility census was 69. Findings include: Review of the medical record revealed Resident #18 was admitted to the facility on [DATE]. Diagnoses included anxiety, depression, bipolar disorder, and psychophysiologic insomnia. Review of Resident #18's PASARR results, dated 12/16/24, revealed the resident was referred for a level II evaluation. Review of Resident #18's PASARR level II evaluation results dated 01/13/25 revealed a determination was made that the resident was approved for a nursing facility with specialized services. The nursing facility was required to provide the resident with specialized behavioral health services including a comprehensive psychiatric assessment in order to identify behavioral health supports and services that would help mitigate psychiatric decompensation and improve quality of life, and was required to provide mental health counseling. Further review of the medical record revealed no evidence a psychiatric assessment was completed for Resident #18, until 04/03/25 in response to a resident-to-resident altercation and ongoing aggression. There was also no evidence Resident #18 was ever seen, assessed for, or referred to mental health counseling. Interview on 05/28/25 at 11:21 A.M. with the Director of Social Services (DSS) #558 verified there was no evidence Resident #18 had ever been seen for mental health counseling. DSS #558 was unaware of whether the resident ever had a comprehensive psychiatric assessment. A follow-up interview on 05/28/25 at 4:16 P.M. with the DSS #558 revealed Resident #18 did have a psychiatric assessment in April 2025 and verified it was in response to a resident-to-resident altercation and not due to the resident requiring specialized services as indicated by the resident's PASARR level II determination. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, admission Criteria_PASARR_OH, revised April 2007, revealed all residents admitted to the facility were screened for mental disorders, intellectual disabilities, or related disorders. If a level I PASARR screening indicated a possible serious mental illness, a level II evaluation was required to be completed before admission to a nursing facility. Upon completion of the level II evaluation, the state PASARR representative determined if the individual had a physical or mental condition, what specialized or rehabilitative services were needed, and whether placement in the facility was appropriate. The state PASARR representative then provided a copy of the report to the facility. The interdisciplinary team then determined whether the facility was capable of meeting the needs and services of the potential resident as outlined in the evaluation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of a facility policy, the facility failed to to ensure residents who required staff assistance with activities of daily living received adequate and timely care to maintain appropriate personal hygiene including nail care. This affected one (#46) of four residents reviewed who required assistance with nail care and personal hygiene. The facility census was 69. Findings include: Review of Resident #46's medical record revealed an admission date of 10/27/21. Diagnoses included profound intellectual disability, cerebral palsy, seizures, scoliosis, lactose intolerance, and gluten sensitivity. Review of Resident #46's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #46 was cognitively intact. Resident #46 required supervision or touching assistance with toilet use, bathing, dressing, and personal hygiene. Resident #46 displayed no behaviors during the review period. Review of Resident #46's care plan revised 04/07/25 revealed support and interventions for behavior problems, potential for verbal aggression, required a private room related to intellectual disabilities and psychosocial needs, and self-care deficit. Resident #46's supports for bathing included checking nail length and trim and clean on bath day and as necessary. Observation on 05/27/25 at 9:39 A.M. of Resident #46 found him to have long fingernails which were tinged brown on his left hand. Coinciding interview with Resident #46 revealed the staff members are who cut his fingernails and they had not cut them in a while. Observation on 05/28/25 at 8:08 A.M. of Resident #46 found him walking up and down the hallway. Resident #46's fingernails on his left hand appeared less brown but continued to be untrimmed. Interview on 05/28/25 at 8:51 A.M. with Certified Nurse Aide (CNA) #581 verified Resident #46 required staff assistance with trimming his fingernails and his nails were to be trimmed on shower days and as needed. Observation on 05/28/25 at 8:54 A.M. of Resident #46 found him in his room and his nails continued to be untrimmed. Coinciding interview with CNA #581 verified Resident #46's fingernails appeared to have not been trimmed for several weeks. CNA #581 stated Resident #46's nails would be trimmed that day. Review of the facility policy titled, Care of Fingernails/Toenails, revised October 2010, revealed the purposed of the policy was to clean resident nail beds, keep nails trimmed, and to prevent infections.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and interview, medical record review, review of a facility policy, and review of the Facility Assessment, the facility failed to provide an individualized activity program designed to meet the interests and care needs of residents with intellectual disabilities. This affected one (#46) of one residents reviewed for activities. The facility census was 69. Findings include: Review of Resident #46's medical record revealed an admission date of 10/27/21. Diagnoses included profound intellectual disability, cerebral palsy, seizures, scoliosis, lactose intolerance, and gluten sensitivity. Review of Resident #46's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #46 was cognitively intact. Resident #46 required supervision or touching assistance with toilet use, bathing, dressing, and personal hygiene. Resident #46 displayed no behaviors during the review period. Review of Resident #46's care plan revised 04/07/25 revealed support and interventions for behavior problems of yelling, screaming, cursing at staff, non-compliant with wearing appropriate footwear, taking office supplies, sitting on the floor, and forgetting to take his walker when ambulating. In addition, Resident #46 had supports and interventions for self-care deficit, potential for verbal aggression, resistance to care, impaired thought process, required a private room related to intellectual disabilities and psychosocial needs and was dependent on staff for meeting his emotional, intellectual, physical, and social needs. Interventions included assisting with arranging community activities and arranging transportation and to ensure activities Resident #46 was attending were compatible with his physical and mental capabilities. Interview on 05/27/25 at 9:39 A.M. with Resident #46 revealed he did not go anywhere and did not do anything. Resident #46 stated he wanted to go out and he wanted to make money. Observation on 05/27/25 at 10:23 A.M. of Resident #46 found him dressed in an off-white tank top, shorts, and thong sandals. Resident #46 was aimlessly walking up and down the hallways of the third floor. Observation on 05/27/25 at 12:18 P.M. of Resident #46 found him wandering around the main dining room with his walker. Staff and other residents directed him away from their tables and to his seat at the table on the left side of the room. Resident #46 continued to wander until 12:27 A.M. when his meal was placed at his table. Observation on 05/27/25 at 1:52 P.M. of Resident #46 found him wandering the halls on the third floor going in and out of his room. Observation on 05/28/25 at 8:06 A.M. of Resident #46 found him wearing the same clothes as he was observed wearing on 05/27/25 and wandering around the hallway. At 8:08 A.M., Resident #46 walked to the nurses cart for his medications. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/28/25 at 8:11 A.M. with Registered Nurse (RN) #523 revealed Resident #46 had intellectual disabilities and did not attend any day program or workshop for individuals with intellectual disabilities. RN #523 stated Resident #46 would benefit from a work program or day program for individuals with intellectual disabilities. RN #523 she was not sure why he did not attend. RN #523 reported Resident #46 would wander the halls, go into others rooms, and hoard items. RN #523 reported Resident #46 could be redirected but verified Resident #46 appeared board and looking for something to do. Interview on 05/28/25 at 8:32 A.M. with Activities Director (AD) #562 revealed Resident #46 had intellectual disabilities and used to attend work shop prior to his admission to the facility. AD #562 reported she was not sure why he no longer attended, but reported Resident #46 had been admitted during the time of the COVID-19 pandemic and that may have had something to do with it. AD #562 stated Resident #46 attended some of the activities the facility provided and was driven by prizes for completion of the activities. Interviews on 05/28/25 at 1:34 P.M. with eight (#3, #4, #17, #41, #47, #51, #53, and #62) resident representatives of the Resident Council all reported concerns with Resident #46's and the facility not meeting his activity and involvement needs. The eight residents reported Resident #46 was left to wander and would often go into other resident's rooms and went through their things, stood over them while they were sleeping, and wandered into places like the kitchen. Review of the Facility Assessment, last reviewed on 12/20/24, revealed conditions the facility admitted and managed included residents who were diagnosed with cerebral palsy and seizures. The facility did not identify developmental disabilities as a diagnosis accepted and managed by the facility. The Facility Assessment indicated the facility was to support community integration if resident desired and provided opportunities for social activities and life enrichment including individual, small group and community. The Facility Assessment indicated new hire orientation topics included dementia care and dealing with behaviors but did not include working with individuals with intellectual disabilities. Review of the facility policy titled, Activities and Social Services, revised December 2006, revealed residents who wished to meet with or participate in activities of social, religious, and other community groups, at or away from the facility, would be encouraged to do so. As much as possible the facility would help the individual arrange to reach these outside activities but the facility may not necessarily provide the transportation.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure pressure ulcer prevention interventions were implemented as ordered by the physician. This affected one (#39) of three residents reviewed for pressure ulcer care and treatment in a facility census of 69. Findings include: Review of Resident #39's medical record revealed the resident admitted to the facility on [DATE] with the diagnoses including, Parkinson's disease with dyskinesia, transient ischemic attack, contracture of the right and left lower leg, vascular dementia, major depressive disorder, and normal pressure hydrocephalus. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was assessed with severe cognitive impairment, had resistive behaviors interfering with care, was assessed with delusions and hallucinations, had bilateral upper and lower extremity range of motion impairment, was dependent on staff for the completion of activities of daily living, was incontinent of bowel and bladder, was at risk for pressure ulcer development with no skin breakdown, and received antianxiety, antidepressant, diuretic, antiplatelet, and anticonvulsant medications. Review of a nursing plan of care dated 07/31/24 revealed the plan of care was revised to address Resident #39's risk for developing complications secondary to potential or actual impairment to skin integrity related to fragile skin, incontinence, and dementia. Interventions included to avoid scratching and keep the resident's hands and body parts from excessive moisture, keep fingernails short, follow facility protocols for treatment of injury, identify and document potential causative factors and eliminate and resolve where possible, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of an assessment dated [DATE] revealed Resident #39 was assessed at high risk for pressure ulcer development. Review of physician orders for Resident #39 revealed on 07/15/24 the resident was ordered to off load his heels while in bed as tolerated, every shift for pressure relief. On 01/08/25, weekly skin checks on Wednesday on day shift were ordered and for staff to document in the weekly skin assessment. Further review of the physician orders revealed on 04/04/25, Resident #39 was ordered barrier cream after each incontinence episode with instructions that certified nurse aides (CNAs) may apply the cream and keep it at the resident's bedside. Review of the medical record revealed the most recent documented skin assessment for Resident #39 was on 05/14/25 and no skin breakdown was identified. Observation on 05/27/25 at 10:51 A.M., and on 05/28/25 at 6:07 A.M., 7:39 A.M., 8:30 A.M., and 9:50 A.M. noted Resident #39 in bed on a standard pressure relief mattress (non-inflatable) with his heels and feet resting on the mattress and the bottoms of his feet against the bed foot board and an adult brief applied. The resident's heels were not off loaded. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at 6:22 A.M., interview with CNA #538 revealed she assumed care of Resident #39 at 7:00 P.M. on 05/28/25 and was finishing her shift at 7:00 A.M. CNA #538 stated she provided a final bed check of Resident #39 for incontinence and repositioning at 5:00 A.M. On 05/28/25 at 8:09 A.M., interview with CNA #582 and CNA #602 noted they assumed care of Resident #39 at 7:00 A.M. and were unaware when Resident #39 was last checked and changed for incontinence or repositioning. On 05/28/25 at 8:30 A.M., surveyor inquiry noted Unit Manager Licensed Practical Nurse (LPN) #516 repositioned Resident #39 on his back and pulled him up in bed. Unit Manager LPN #516 checked the front of the resident's adult brief and stated the resident was dry. There was no heel or lower extremity elevation to off load them provided for Resident #39. Interview with CNA #582 on 05/28/25 at 11:25 A.M. revealed she attempted to check Resident #39 at approximately 10:15 A.M. but the resident was combative and she did not provide care. CNA #582 confirmed she did not notify the nurse (LPN #528) she was unable to provide care to Resident #39. CNA #582 proceeded to obtain wash cloths, a new adult brief, and towel. LPN #528 came to the room due to the call light accidentally being activated and proceeded to assist with positioning Resident #39. CNA #582 removed the front of the brief and provided incontinence care. LPN #528 positioned Resident #39 to the right side and discovered the resident to be heavily soil with urine extending through a folded bath blanket and a mattress top sheet onto the surface of the mattress. CNA #582 removed the back of the brief and Resident #39's buttock was assess with redden skin and his left heel was observed with redden skin. LPN #528 verified she did not observe Resident #39 with redden skin to the buttock or heels when assessed on 05/26/25. LPN #528 also confirmed she was not informed of Resident #39 refusal of care or combativeness. LPN #528 and CNA #582 proceeded to change Resident #39's bed linens and placed a new adult brief onto the resident. Additional interview with LPN #528 verified Resident #39's heels were not elevated to provide off loading and his feet were pressed against the foot board. CNA #582 was unaware Resident #39 required his feet to be elevated. LPN #528 obtained a heel elevation device and place it to the foot of the bed. On 05/29/25 at 9:55 A.M., interview during review of the medical record with the Assistant Director of Nursing (ADON) verified no documentation was available indicating a weekly skin assessment was completed since 05/14/25 for Resident #39. The ADON confirmed skin assessments were to be obtained on 05/21/25 and 05/28/25, and were not contained in the medical record. Review of the Prevention of Pressure Ulcer/Injuries policy, revised July 2017, revealed the purpose of the procedure was to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Staff are to review the resident's care plan and identify the risk factors as well as interventions designed to reduce or eliminate those considered modifiable. Staff were to assess the resident on admission for existing pressure/injury risk factors and repeat the risk assessment weekly and upon any changes in condition. Staff should inspect the skin daily when performing or assisting with personal care or activities of daily living (ADL) and reposition the resident as indicated on care plan. Staff should keep the skin clean and free of exposure to urine or fecal matter. and at least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more. At least every two hours, staff should reposition residents who are reclining and dependent on staff for repositioning. Staff should also provide support devices and assistance as needed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of therapy documentation, the facility failed to ensure an individualized restorative program was implemented to ensure residents maintained range of motion and mobility. This affected one (#35) of one residents reviewed for limited range of motion and mobility. The facility census was 69. Findings include: Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure, acute on chronic diastolic (congestive) heart failure, depression, and hemiplegia and hemiparesis following unspecified cerebrovascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], the quarterly MDS assessment dated [DATE], the quarterly MDS assessment dated [DATE], the significant change MDS assessment dated [DATE], and the quarterly MDS assessment dated [DATE], revealed Resident #35 had limited mobility on one side in both the upper and lower extremities. The resident did not receive physical therapy, occupational therapy, range of motion exercises, or restorative services. The resident also did not have splint/brace assistance. Review of the physician progress notes dated 07/28/24 revealed Resident #35 had a right-hand contracture. Review of Resident #35's current comprehensive plan of care revealed no evidence of a plan of care for limited range of motion/contractures. Review of Resident #35's current physician orders revealed no evidence the resident ever had an order for a splint, brace, or restorative therapy. Review of Resident #35's therapy documentation for 07/01/25 through 05/28/25 revealed no evidence the resident was seen, evaluated, or screened regarding limited mobility in the right extremity and/or the right-hand contracture. Interview and observation with Resident #35 on 05/27/25 at 1:06 P.M. revealed the resident's right hand was contracted. The resident demonstrated she was unable to open her right hand. Resident #35 stated she had not received therapy, splints, or any type of treatment or device to prevent her hand from getting worse while residing in the facility. An interview on 05/29/25 at 10:42 A.M. with the Director of Therapy Services verified there was no evidence Resident #35 had been screened or evaluated regarding limited mobility in her right upper and lower extremities and the contracture in her right hand from 07/01/24 through 05/28/25. The Director of Therapy Services reported the resident was screened on 06/21/24 and declined services at that time. The Director of Therapy Services confirmed if a resident refused services, they should be screened on a quarterly basis following the refusal.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on medical record review, resident and staff interview, review of a facility investigation, review of hospital documentation, policy review, and review of facility corrective action documentation, the facility failed to ensure the appropriate level of care and assistance was utilized during resident bathing which resulted in an avoidable fall. Actual harm occurred when Resident #22 was being bathed by one staff member when the resident's care plan indicated the resident required a two-person assist for bathing and the resident's abilities were known to fluctuate. Resident #22 was rolled to her side while in bed and was rolled onto the floor which necessitated the resident to be sent to the hospital for an evaluation. Resident #22 was determined to have sustained a left hip fracture which required surgical intervention. This affected one (#22) of five residents reviewed for falls. The facility census was 69. Findings include: Review of Resident #22's medical record revealed an admission date of 02/27/20. Diagnoses include unspecified dementia, obstructive sleep apnea, severe protein-calorie malnutrition, chronic atrial fibrillation, anxiety, essential hypertension, corneal ulcer of the left eye, chronic pain, inflammatory spondylopathy of the lumbar region, chronic kidney disease, presence of a cardiac pacemaker, and neuromuscular dysfunction of the bladder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact. The resident was dependent for bathing and required the assistance of two staff. Further review revealed the resident required extensive assistance of one to two staff for bed mobility. Review of the most recent quarterly MDS assessment dated [DATE] revealed Resident #22 had no falls since admission or the previous assessment. Review of a care plan initiated on 03/10/20, and revised on 05/18/21, revealed Resident #22 had an activities of daily living (ADLs) self-care performance deficit related to disease process. Resident #22 required staff assistance to complete daily ADLs and fluctuations in abilities were expected due to the resident's diagnoses. Review of an intervention initiated on 02/21/23 revealed Resident #22's need for assistance and additional staff support may fluctuate from day to day and hour to hour. Review of an intervention most recently revised on 10/18/23 revealed Resident #22 was dependent with assistance from two staff members for bathing and showers. Review of an additional intervention for bed mobility most recently revised on 10/18/23 revealed Resident #22 required extensive assistance of one to two staff members with her usual performance being dependent to roll from left to right. Review of the care plan dated 07/03/24 revealed Resident #22 was dependent and required two staff members to assist with bathing/bed baths. An intervention revealed Resident #22 required extensive assistance from one to two staff members for bed mobility. Review of the fall risk assessment dated [DATE] revealed Resident #22 was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the fall risk assessment dated [DATE] revealed Resident #22 was a low fall risk. Review of Resident #22's nursing progress notes dated 09/01/24 revealed the resident slid out of bed while getting a bed bath early in the morning. Resident #22 indicated she hit her head. Vital signs were obtained, and neurological checks were completed. Resident #22 was sent to the emergency room (ER) due to facility policy since the resident hit her head. The provider was notified after Resident #22 was sent out to the hospital and the care team was updated. Review of the medical record for Resident #22 revealed she was admitted to the hospital on [DATE] and returned to the facility on [DATE]. Review of Resident #22's hospital documentation dated 09/02/24 revealed the resident reported she was receiving a bed bath while at the nursing facility and she fell off the end of the bed while they were putting powder on her back. The resident landed on her left side as well as hit her head with no loss of consciousness. Resident #22 was complaining of severe aching pain to the left hip that was worse with any type of motion, and she did not receive anything for the pain prior to arrival. An x-ray was completed on 09/01/24 and revealed a comminuted displaced proximal left femoral, likely intertrochanteric, fracture (left hip fracture). The fracture required surgery and Resident #22 underwent surgical repair for her left hip fracture on 09/02/24. Review of the fall risk assessment dated [DATE] revealed Resident #22 was a high fall risk. Interview on 05/27/25 at 10:51 A.M. with Resident #22 revealed she was receiving a bed bath given by one certified nurse aide (CNA), CNA #595, when CNA #595 turned Resident #22 to apply powder to her back and her legs went over the side of the bed causing her to fall onto the floor. Resident #22 confirmed she sustained a broken hip as a result. Review of the investigation conducted by the facility revealed a witness statement dated 09/01/24 from CNA #600 which revealed Resident #22 was getting a bed bath and during the turn the resident slipped out of bed. Further review of the witness statement revealed the incident happened in Resident #22's room and CNA #600 became aware of the situation when she was called to help by CNA #595. The witness statement revealed Resident #22 indicated she turned too far and slipped out of bed. Review of the witness statement dated 09/01/24 from CNA #595 revealed she was giving Resident #22 a bed bath and turned the resident on her side to put powder on her back. Resident #22's feet started to go down off the bed and CNA #595 tried to catch her, but she could not. CNA #595 indicated Resident #22 fell off and slid down the opposite side of the bed. Resident #22 indicated she rolled too far and slipped out of the bed. Interview on 05/28/25 at 3:45 P.M. with the Assistant Director of Nursing (ADON) verified it was not proper nursing care to roll a resident away from the caregiver when there was only one person completing a bed bath. Furthermore, the ADON confirmed Resident #22's care plan specified two caregivers were required to be present for bathing/showering and confirmed there was only one staff member providing the bed bath on 09/01/24 when the resident was rolled out of bed and sustained the hip fracture. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled, Falls-Clinical Protocol, revised September 2012, revealed based on preceding assessments of a resident's falls and fall risks, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature category of falling, until falling reduces or stops, or until a reason is identified for its continuation. As a result of the incident, the facility implemented the following corrective actions to correct the deficient practice by 09/04/24: • On 09/01/24, Resident #22 was immediately assessed for pain, neurological impairment, skin integrity, and range of motion by Respiratory Therapist (RT)/LPN #557. • On 09/01/24, Resident #22 was transferred to the ER via emergency medical services upon assessment findings. The provider was notified on 09/01/24 by RT/LPN #557. • On 09/01/24, Resident #22's power of attorney (POA)/guardian was notified of the incident by RT/LPN #557. • On 09/01/24, all residents were assessed for the need for a bariatric bed based on their body shape by the ADON. Resident #1's fall risk care plan was updated on 09/01/24 to include an intervention for a bariatric bed. • Beginning on 09/02/24, the DON/designee audited two bariatric and immobile residents' bed baths to ensure bed baths were being completed properly per the protocol. The audits continued weekly for four weeks occurring on 09/06/24, 09/09/24, 09/13/24, 09/16/24, 09/20/24, 09/23/24, and 09/27/24 with no additional concerns identified. • On 09/03/24, a bariatric bed was ordered by Receptionist #553 for Resident #22 and was applied to the resident's bed. • On 09/03/24, all nursing staff were educated on bed mobility and bed positioning during bed baths by the ADON and subsequently, no staff were permitted to work on the floor prior to receiving the education. Review of the staff in-service sign-in sheets revealed all staff were trained by 09/03/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	• On 09/04/24, all residents who were bariatric and immobile had an occupational and physical therapy screening sent for bed mobility on various days. All resident screenings were completed by Therapy Director #590 on 09/04/24. • On 09/04/24, all residents who were bed-bound had their care plans reviewed and were updated by the ADON to require two people to assist when repositioning and for bed baths. • On 09/04/24, Resident #22's care plan was revised by the ADON to include an intervention for the resident to require two people to assist when repositioning and when providing bed baths. • On 05/29/25, four (#17, #42, #44, and #57) additional residents were reviewed for falls with no concerns identified. • On 05/29/25, interviews between 7:30 A.M. and 8:00 A.M. with CNA #582, CNA #547, LPN #516, and Transportation Aide #515 all verified they were provided education regarding residents who were bed-bound requiring a two person assist with bed mobility and bed baths and were able to demonstrate proficiency in the training. • On 05/29/25, the facility incident log was reviewed from January to May 2025 with no additional incidents of residents falling from the bed while being provided care by staff. There were no trends or patterns of incidents identified.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure timely incontinence care was provided. This affected one (#39) of three residents reviewed for incontinence care and treatment in a facility census of 69. Findings include: Review of Resident #39's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia, transient ischemic attack, contracture of the right and left lower leg, vascular dementia, major depressive disorder, and normal pressure hydrocephalus. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was assessed with severe cognitive impairment, had resistive behaviors interfering with care, had delusions and hallucinations, had bilateral upper and lower extremity range of motion impairment, was dependent on staff for the completion of activities of daily living, was incontinent of bowel and bladder, was at risk for pressure ulcer development with no skin breakdown, and received antianxiety, antidepressant, diuretic, antiplatelet, and anticonvulsant medications. Review of a nursing plan of care dated 10/09/23 revealed the plan of care was revised to address Resident #39's bowel and bladder incontinence related to activity intolerance and dementia. Interventions included for Resident #39 to remain free from skin breakdown due to incontinence and brief use through the review date, the resident used adult disposable briefs for comfort and dignity, for staff to clean the resident's peri-area with each incontinence episode, staff to check as needed and required for incontinence and wash, rinse and dry perineum, staff to change clothing as needed after incontinence episodes, check the resident, during rounds and as required for incontinence, and utilize moisture barrier cream as ordered. Further review revealed no specific time frame for checking Resident #39 for incontinence was listed on the plan of care. Review of Resident #39's physician orders noted on 04/04/25 barrier cream was ordered to be used after each incontinence episode and noted certified nurse aides (CNAs) may apply the cream and keep it at the resident's bedside. Observations on 05/28/25 at 6:07 A.M., 7:39 A.M., 8:30 A.M., and 9:50 A.M. noted Resident #39 in bed on a standard pressure relief mattress (non-inflatable) with his heels and feet resting on the mattress with the bottom of his feet against the foot board and an adult brief applied. On 05/28/25 at 6:22 A.M. interview with CNA #538 revealed she assumed care of Resident #39 at 7:00 P.M. on 05/28/25 and was finishing her shift at 7:00 A.M. CNA #538 stated she provided a final bed check of Resident #39 for incontinence and repositioning at 5:00 A.M. On 05/28/25 at 8:09 A.M. interview with CNA #582 and CNA #602 noted they assumed care of Resident #39 at 7:00 A.M. and were unaware when Resident #39 was last checked and changed for incontinence or repositioning. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at 8:30 A.M. surveyor inquiry noted Unit Manager Licensed Practical Nurse (LPN) #516 repositioned Resident #39 on his back and pulled him up in bed. Unit Manager LPN #516 checked the front of the resident's adult brief and stated the resident was dry. Interview with CNA #582 on 05/28/25 at 11:25 A.M. revealed she attempted to check Resident #39 at approximately 10:15 A.M. but the resident was combative and she did not provide care. CNA #582 confirmed she did not notify the nurse (LPN #528) she was unable to provide care to Resident #39. CNA #582 proceeded to obtain wash cloths, a new adult brief, and towel. LPN #528 came to the room due to the call light accidentally being activated and proceeded to assist with positioning Resident #39. CNA #582 removed the front of the resident's incontinence brief and provided incontinence care. LPN #528 positioned Resident #39 to the right side and discovered the resident to be heavily soil with urine extending through a folded bath blanket and mattress top sheet onto the surface of the mattress. CNA #582 removed the back of the brief and Resident #39's buttock was assess with reddened skin. LPN #528 verified she did not observe Resident #39 with red skin to the buttock when the resident was assessed on 05/26/25. LPN #528 also confirmed she was not informed of Resident #39's refusal of care or combativeness. LPN #528 and CNA #582 proceeded to change Resident #39's bed linens and placed a new adult brief onto the resident. Review of facility urinary incontinence clinical protocol, revised September 2012, revealed the staff will identify environmental interventions and assistive devices that facilitate toileting. This deficiency represents non-compliance investigated under Master Complaint Number OH00165012.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, dialysis communication documentation, and facility policy, the facility failed to ensure residents received physician ordered medication for residents receiving hemodialysis. This affected one (#38) of two residents reviewed for the administration of hemodialysis in a facility census of 69. Findings include: Review of Resident #38's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including end stage renal disease, dependence on renal dialysis, chronic anemia, heart failure, hypotension, chronic pain, asthma, hypertension, and cardiac defibrillator. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #38 with intact cognition and required partial to moderate assistance with activities of daily living. Review of the nursing plan of care dated 07/25/24 revealed the plan of care was revised to address Resident #38's risk for developing complications secondary to needing hemodialysis related to end stage renal disease (ESRD). An intervention included on Monday, Wednesday, Friday the resident had out-patient dialysis. Further review of the nursing plan of care revealed it was revised on 07/25/24 to address Resident #38's potential for dehydration and fluid deficit related to diuretic use and ESRD with dialysis. Interventions included to administer medications as ordered and monitor/document for side effects and effectiveness. On 05/27/25 at 10:35 A.M., observation and interview with Resident #38 revealed the facility frequently runs out of her phosphate binder medication and do not notify the resident or dialysis center to re-order it. The resident stated she was currently not receiving the medication and when she does not receive the medication she felt nauseous and sick. Review of Resident #38's medical record revealed a physician order dated 01/13/25 for the medication used to reduce high levels of phosphorus in the blood Xphozah oral tablet 30 milligrams (mg) with instructions to give one tablet by mouth two times a day for a phosphate absorption inhibitor. Further revealed revealed the mail order pharmacy supplies in bottle in the cart and to please let the resident know when low on the medicine. On 05/28/25 at 10:38 A.M. interview with Licensed Practical Nurse (LPN) #528, during observation of the medication cart contents, discovered an empty medication bottle marked as Xphozah oral tablet 30 mg for Resident #38. Review of Resident #38's medical record at the time of the observation revealed no documentation indicating the dialysis center or Resident #38's nephrologist had been informed of the medication not being given or available for administration. Further review of the medical record noted Resident #38 had not received Xphozah 30 mg since 05/09/25. On 05/28/25 at 10:59 A.M., Resident #38 was observed to be returned to her room following dialysis. The resident stated she spoke with her nephrologist at dialysis and he was not aware the Xphozah 30 mg was not available or being provided as ordered. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at 12:50 P.M. additional interview with LPN #528, during review of Resident #38's dialysis communication book and dialysis communication forms between 05/09/25 and 05/28/25, confirmed documentation did not indicate Resident #38 was lacking or needed Xphozah 30 mg to be reordered. Review of a care of a resident with ESRD policy, revised September 2010, revealed the residents comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. Review of the facility's administering medications policy, version 02/14/24, revealed medications are administered in a safe and timely manner, and as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, review of pharmacy documentation, and facility policy review, the facility failed to store resident insulin in a safe and sanitary manner. This affected nine of (#16, #22, #36, #41, #44, #53, #56, #59, and #272) 14 residents identified by the facility to receive insulin administration in a facility census of 69. Findings include: 1. Observation on 05/27/25 at 12:29 P.M. with Licensed Practical Nurse (LPN) #525 during review of medication storage of the third floor C medication cart discovered two insulin pens. One Lantus insulin pen prescribed to Resident #16 was open with no date when it was opened. A second insulin aspart pen prescribed for Resident #41 was marked as opened on 04/01/25. Interview with LPN #525 at the time of the observation identified pharmacy guidance documentation on the medication cart binder. The pharmacy guidance listed medications with shortened expiration dates. This included instructions indicating Lantus insulin and aspart insulin expired 28 days after opening or removing from refrigerator. LPN #525 confirmed the insulin for Resident #16 was not dated when it was opened and Resident #41's insulin remained in use after the opened expiration date. 2. On 05/27/25 at 12:57 P.M. observation with LPN #533 during review of the second floor A-C medication cart noted insulin storage contained on the cart. A vial of Lantus insulin prescribed to Resident #53 was opened with no date indicating when it was opened on the vial. A lispro insulin pen prescribed to Resident #272 was also discovered to be open with no date when opened. A vial of Semglee insulin dated 04/15 and a lispro pen dated 04/18 was prescribed to Resident #22. Interview with LPN #533 at the time of the observation identified pharmacy guidance documentation on the medication cart binder. The pharmacy guidance listed medications with shortened expiration dates. This included instructions indicating Lantus insulin, lispro insulin, and Semglee insulin expired 28 days after opening or removing from refrigerator. LPN #533 confirmed Resident #53 and Resident #272's insulin was not dated when it was opened and Resident #22's insulin remained in use after the opened expiration dates. 3. Observation with Registered Nurse (RN) #521 on 05/27/25 at 1:05 P.M. during review of medication storage of the Skilled medication cart revealed a lispro insulin pen opened without a date when it was opened prescribed for Resident #36. In addition, a vial of glargine insulin prescribed to Resident #56 was opened with a open date of 04/19/25 and a Lantus insulin pen prescribed to Resident #59 was opened without a date when it was opened. Interview with RN #521 at the time of the observation identified pharmacy guidance documentation on the medication cart binder. The pharmacy guidance listed medications with shortened expiration dates. This included instructions indicating Lantus/glargine insulin and lispro insulin expired 28 days after opening or removing from refrigerator. RN #521 confirmed Resident #36's insulin was not dated when it was opened and the insulins for Resident #59 were not dated when opened and also the glargine insulin was kept in use after the opened expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/27/25 at 1:13 P.M. with the Director of Nursing (DON verified insulin vials and pens are to be marked when opened to ensure expired medications are not administered to residents. 4. Observation on 05/28/25 at 6:34 A.M. with Unit Manager LPN #516 during review of the third floor medication storage room discovered a vial of Lantus insulin prescribed to Resident #44 open with no open date on the vial. Interview with Unit Manager LPN #516 at the time of the observation verified the facility policy was to mark insulin vials and pens with the date open. Review of a storage of medication policy, revised April 2019, revealed the nursing staff was responsible for maintaining medication storage and preparation areas are clean, safe, and sanitary. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of an administering medications policy, version 02/14/24, revealed the expiration/beyond use date on the medication label was to be checked prior to administering. When opening a multi-dose container, the date opened was to be recorded on the container.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, and therapy documentation review, the facility failed to ensure residents received timely rehabilitation services. This affected one (#272) of three residents reviewed for rehabilitation services. The facility census was 69. Findings include: Review of the medical record for Resident #272 revealed an admission date of 05/15/25 with diagnoses of type II diabetes mellitus, bipolar disorder, and depression. Review of the comprehensive admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #272 had intact cognition, had limited range of motion to both sides of her lower extremities, was dependent for transfers and toileting, and required partial/moderate assistance for bed mobility. Review of the physician order dated 05/15/25 revealed Resident #272 should receive a physical therapy (PT), occupational therapy (OT), and speech therapy (ST) evaluation and treatment as needed. Review of Resident #272's PT evaluation and plan of treatment dated 05/16/25 revealed PT was recommended three to five times per week for 29 days to address her ability to transfer, increase her lower extremity strength, and improve standing. Review of the current care plan for Resident #272 revealed a discharge care area, initiated 05/23/25, indicating Resident #272 was at the facility for short-term rehabilitation and would have a safe discharge to the community after completing rehabilitation with skilled nursing care and therapy. Interview and observation on 05/27/25 at 10:16 A.M. revealed Resident #272 was lying in bed. Resident #272 stated she wanted PT so she could walk and stated she had not seen therapy since she was admitted to the facility. Interview on 05/28/25 at 8:51 A.M. with Therapy Director (TD) #590 stated Resident #272 was evaluated by PT on 05/16/25 and treatment was recommended. TD #590 stated treatment was not started because Resident #272's insurance information was not accepted. TD #590 stated she referred the concern to the Business Office Manager. Interview on 05/28/25 at 9:03 A.M. with Business Office Manager (BOM) #554 confirmed the facility had difficulty confirming Resident #272's primary payor source was Medicaid, but attempted to bill for rehabilitation services through Resident #272's Medicare supplemental insurance. BOM #554 stated the facility did not have an accurate insurance member number to pursue billing for rehabilitation services. BOM #554 stated the facility asked Resident #272 if she had a copy of her insurance card and Resident #272 did not have a copy; therefore, the facility had not yet offered rehabilitation services despite the recommendation from physical therapy dated 05/16/25 for Resident #272 to receive treatment. Observation on 05/28/25 at approximately 2:00 P.M. revealed Resident #272 being wheeled via wheelchair by staff to the therapy gym. Resident #272 stated excitedly, I am going to therapy for the first time. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/29/25 at 8:45 A.M. with BOM #554 stated the facility started rehabilitation services for Resident #272 by billing through Medicaid. Follow-up interview on 05/29/25 at 9:07 A.M. with BOM #554 stated the corporate office and the Administrator determined therapy could be billed through Medicaid for Resident #272. BOM #554 stated Resident #272 was very happy to receive therapy because Resident #272 said she was able to stand. This deficiency represents non-compliance investigated under Complaint Number OH00164093.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on medical record review, staff interview, review of a McGeer criteria checklist, and policy review, the facility failed to ensure the facility's antibiotic stewardship program was appropriately implemented with use of antibiotic medications. This affected two (#22 and #59) of three residents reviewed for antibiotic use. The facility census was 69. Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 02/27/20 with diagnoses of dementia, hypertension, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, revealed Resident #22 was cognitively intact. Review of the urine culture obtained on 03/19/25, and reported on 03/22/25, revealed Resident #22's urine was positive for 10-15,000 colony forming units (CFU) per milliliter (ml) of Pseudomonas aeruginosa and 10-15,000 CFU/ml of Enterococcus faecalis. Interview on 05/29/25 at 11:31 A.M. with the Assistant Director of Nursing (ADON) revealed Resident #22 received the antibiotic doxycyline to treat a urinary tract infection (UTI) identified on 03/19/25. Follow up interview on 05/29/25 at 12:43 P.M. with the ADON confirmed Resident #22 urine culture did not meet McGeer criteria (a set of standardized definitions used for surveillance of healthcare-associated infections (HAIs) in long-term care facilities) to define a UTI. The ADON confirmed the criteria indicated the number of organisms should have been at least 100,000 CFU/ml. The ADON stated she believed the criteria was met because two organisms were present in Resident #22's urine. 2. Review of the medical record for Resident #59 revealed an admission date of 01/12/25 with diagnoses of chronic respiratory failure, type II diabetes mellitus, and morbid obesity. Review of the quarterly MDS assessment completed 04/11/25 revealed Resident #59 had intact cognition, was dependent on staff for toileting, and was frequently incontinent of urine and bowel. Review of the urine culture obtained on 02/05/25, and reported on 02/07/25, revealed Resident #59's urine was positive for 70-99,000 CFU/ml of Escherichia coli and 50-60,000 CFU/ml of Proteus mirabilis. Review of the urine culture obtained on 03/26/25, and reported on 03/29/25, revealed Resident #59's urine was positive for 60-70,000 CFU/ml of Escherichia coli. Interview on 05/29/25 at 11:31 A.M. with the ADON revealed Resident #59 received Bactrim (an antibiotic) to treat the UTI identified on 02/07/25. Further, the ADON revealed Resident #59 received cefazolin (an antibiotic) to treat the UTI identified on 03/29/25. (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 B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Manor Nursing and Rehabilitation LLC	1865 Countryside Drive 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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow up interview on 05/29/25 at 12:43 P.M. with the ADON confirmed Resident #59's urine cultures received 02/07/25 and 03/29/25 did not meet McGeer criteria to define a UTI. The ADON confirmed the criteria indicated the number of organisms should have been at least 100,000 CFU/ml before treating Resident #59 with an antibiotic. Review of the undated document titled, Revised McGeer Criteria for Infection Surveillance Checklist, used by the facility to monitor and document compliance with meeting criteria for antibiotic use in the facility, revealed residents without a urinary catheter must have reported and documented symptoms AND at least 100,000 CFU/ml of no more than two species of organisms in a voided urine sample or at least 100 CFU/ml of any organism in a specimen collected by an in-and-out catheter. Review of the policy titled, Antibiotic Stewardship, revised 2016, revealed no guidance regarding the implementation of any criteria to monitor the use of antibiotics.