STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365995	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Lawn Ctr for Rehab	10608 Navarre Road SW Navarre, OH 44662

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record, and interview with staff the facility failed to maintain privacy for Resident #44 during medication administration. This affected one resident (Resident #44) of seven residents observed for medication administration. The facility census was 79. Findings included: Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included nontraumatic subarachnoid hemorrhage, respiratory failure, hydrocephalus, aneurysm, need for personal care, aphonia, right cerebral shunt, encephalopathy, chronic obstructive pulmonary disease, hypothyroidism, gastrostomy, tracheostomy, dysphagia, major depression disorder, cachexia, incontinence, protein-calorie malnutrition, bipolar disorder, anxiety disorder, rheumatoid arthritis, insomnia, nystagmus, cataract, and pseudobulbar affect. An observation was conducted on 06/26/24 at 11:35 A.M. with Registered Nurse (RN) #186 who entered into the room of Resident #44 to administer medications via the percutaneous endoscopic gastrostomy (PEG) tube for Resident #44. RN #186 did not close the door to the room or pull the privacy curtain and proceeded to pull up the residents hospital gown exposing her bare abdomen and incontinence brief. RN #186 then proceeded to administer Resident #44's medications via per PEG tube. RN #186 verified at this time she had not provided privacy and should have closed the room door and/or pulled the privacy curtain before exposing the resident.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 Based on record review, observation and interviews the facility failed to develop a comprehensive care plan for Resident #15, #23, #31, #42 and #68. This affected five residents (#15, #23, #31, #42 and #68) of 20 residents reviewed for care plans. The facility census was 79. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included delusional disorder, dementia with behavioral disturbance, anxiety disorder and restlessness and agitation. Review of the Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 was cognitively impaired. Her behaviors were marked as worse indicating she had physical and verbal behaviors and was resistive to care one to three days a week. Review of the progress noted dated 02/08/24 and timed at 7:01 P.M. and authored by Registered Nurse (RN) #201 revealed Resident #23 was combative and striking out at other residents. A noted dated 02/09/24 at 10:35 A.M. and authored by RN #105 revealed Resident #23 grabbed a glass plate and started hitting a State Testing Nursing Assistant. Review of the care plan initiated 02/14/23 for Resident #23 revealed she had the behavior of wandering. Interview on 06/25/24 at 5:00 P.M. with MDS #193 verified the care plan was not revised to include physical behaviors therefore no interventions for physical behaviors were included in the care plan. Interview on 06/25/24 at 5:15 P.M. with MDS #193 and Regional Nurse Consultant (RNC) #114 verified the progress notes dated 02/08/24 and 02/09/24 revealed Resident #23 had episodes of physical behaviors leading to her being hospitalized . Review of the facility policy titled Care Plan-Use of, dated 11/2016 revealed documentation in the medical record must be consistent with the resident's care plan. 42015 2. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included end stage renal disease, heart failure, and diastolic congestive heart failure. Interview on 06/26/24 at 9:55 A.M. with Resident #15 revealed she attended dialysis three times a week, utilized a port but recently received a fistula (an access point for dialysis) in her right arm, and once the fistula healed it will be used for her dialysis treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's care plan revealed she did not have a comprehensive care plan indicating she was receiving dialysis treatment. Review of Resident #15's physician orders dated 01/31/24 revealed an order for Dialysis every Tuesday, Thursday, and Saturday. Interview on 06/26/24 at 4:05 P.M. Regional Nurse Consultant #115 confirmed the facility did not implement a care plan regarding Resident #15 receiving dialysis treatment. 3. Review of Resident #42's medical record revealed an admitted [DATE]. Diagnosis included vascular dementia, atrial fibrillation, and diastolic heart failure. Review of Resident #42's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident was cognitively intact and received anticoagulant medication. Review of Resident #42's June 2024 physician orders revealed an order for Eliquis (anticoagulant also known as blood thinning medication) five milligrams twice daily for chronic atrial fibrillation. Continued review revealed the facility had no orders in place to monitor the resident for side effects related to the high-risk medication. Review of Resident #42's Comprehensive Care Plan revealed the facility had not developed a care plan related to the residents atrial fibrillation and need for anticoagulant medication. Interview on 06/27/24 at 10:33 A.M. with Regional Nurse Consultant #114 confirmed the facility had not developed a comprehensive care plan indicating the resident had atrial fibrillation and required an anticoagulant medication. 35765 4. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE]. Diagnoses included peritonitis, gastrointestinal hemorrhage, anemia, congestive heart failure, end stage renal disease, atrial fibrillation, dependent on renal dialysis, pulmonary hypertension, anxiety, dermatitis , respiratory failure, Parkinson's disease, and obstructive sleep apnea. Review of the Five-Day Medicare Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #68 had intact cognation. Review of the June 2024 physician's orders revealed Resident #68 had orders for calamine lotion to be applied to her rash four times daily dated 06/07/24, Eucerin cream to be applied to her rash twice daily dated 06/18/24, and hydroxyzine (antihistamine) 10 milligrams three times daily for itching dated 06/11/24. Review of the progress note dated 05/15/24 at 9:30 A.M. revealed Resident #68 arrived to the facility by ambulance. She was alert and oriented with no complaints of distress or discomfort. She had a red rash to the trunk of her body, her arms and her legs with an unknown cause. Review of the progress note dated 05/31/24 at 11:57 A.M. revealed Resident #68 was sent out to the hospital for altered mental status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note dated 06/01/24 at 12:07 A.M. revealed Resident #68 was admitted to the hospital with diagnoses of rash and altered mental status. Review of the progress note dated 06/08/24 at 5:44 A.M. revealed Resident #68's skin was reddened with a tough texture to touch. Review of the progress note dated 06/08/24 at 4:40 P.M. revealed Resident #68 was resting in bed with her eyes closed. She had edema to her bilateral forearms and wrists, and her skin was red tinted all over. Review of the progress note dated 06/23/24 at 2:27 P.M. revealed Resident #68's skin was bright red, dry, and scaly. Review of the plan of care for Resident #68 revealed no evidence of addressing her itching or rash. Observation on 06/24/24 at 11:05 A.M. revealed the skin of Resident #68 was bright red and peeling in large pieces on her face, neck and arms. An interview at this time with Resident #68 revealed she had an allergic reaction at the hospital. She stated the rash itched alot. On 06/26/24 at 2:55 P.M. an interview with Regional Nurse Consultant # 114 confirmed there was no plan of care for the rash which covered most of Resident #68's body. Review of the facility policy titled Care Plan-Use of, dated 11/2016 revealed documentation in the medical record must be consistent with the resident's care plan. 5. Review of the medial record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, rhabdomyolysis, pancreatitis, need for assistance, sepsis, elevated white blood, pyelonephritis, kidney failure, abdominal pain, major depressive disorder, psychotic disorder, cerebral infarction, chronic pain syndrome, anemia, osteoporosis, impulse disorder, obstructive and reflux uropathy and protein-calorie. Review of the June 2024 physician's orders revealed Resident #31 had an order for a indwelling catheter to straight drain for malignant neoplasm of the prostate. Review of the Admission Minimum Data Set 3.0 assessment dated [DATE] reveled Resident #31 was cognitively intact and had an indwelling catheter. On 06/27/24 at 11:24 A.M. an interview with Regional Nurse Consultant # 115 confirmed there was no indwelling catheter plan of care for Resident #31. Review of the facility policy titled Care Plan-Use of, dated 11/2016 revealed documentation in the medical record must be consistent with the resident's care plan.

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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** 35765 Based on observations, review of the medical record and interview with facility staff the facility failed to provide assistance with shaving for Resident #31 and #77. This affected two residents (Resident #31 and #77) of 20 residents reviewed for activities of daily living (ADL). The facility census was 79. Findings include: 1. Review of the medial record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, rhabdomyolysis, pancreatitis, need for assistance, sepsis, elevated white blood, pyelonephritis, kidney failure, abdominal pain, major depressive disorder, psychotic disorder, cerebral infarction, chronic pain syndrome, anemia, osteoporosis, impulse disorder, obstructive and reflux uropathy. Review of the progress notes from 05/02/24 to 06/26/24 revealed no evidence Resident #31 refused to be shaved. Review of the Admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #31 was cognitively intact and required substantial assistance with personal hygiene/care. Observation on 06/24/24 at 3:25 P.M. revealed Resident #31 had long beard hairs. An interview with Resident #31 at this time revealed he had not been shaved for awhile and would like to be shaved. On 06/26/24 at 2:55 P.M. an interview with Registered Nurse # 118 revealed the male residents were shaved on shower days or as needed. On 06/26/24 at 3:21 P.M. an interview with Registered Nurse #170 confirmed Resident #31 needed shaved. 2. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE]. Diagnoses included severe sepsis, need for assistance with personal care, dysphagia, respiratory failure, metabolic acidosis, atrial fibrillation, Brown-Sequard syndrome, cerebellar ataxia, hydronephrosis, benign prostatic hyperplasia, moderate protein-calorie malnutrion, anxiety disorder, Review of the Admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #77 had intact cognation and required substantial assistance for personal hygiene. Review of the progress notes from 05/02/24 to 06/26/24 revealed no evidence Resident #77 refused to be shaved. Observation on 06/25/24 at 10:50 A.M. revealed Resident #77 had long beard hairs. Observation on 06/26/24 at 9:40 A.M. revealed Resident #77 still had not been shaved. On 06/26/24 at 11:00 A.M. an interview with Resident #77 revealed he wanted shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/24 at 2:55 P.M. an interview with Registered Nurse # 118 revealed the male residents were shaved on shower days or as needed. On 06/26/24 at 3:21 P.M. an interview with Registered Nurse #170 confirmed Resident #31 needed shaved.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on interview and record review the facility failed to adequately monitor the use of an anticoagulant medication for side effects for Resident #42. This affected one resident (Resident #42) out of five residents reviewed for unnecessary medication. The facility census was 79. Findings include: Review of Resident #42's medical record revealed an admitted [DATE]. Diagnosis included vascular dementia, atrial fibrillation, and diastolic heart failure. Review of Resident #42's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident was cognitively intact and received anticoagulant medication. Review of Resident #42's June 2024 physician orders revealed an order for Eliquis (anticoagulant also known as blood thinning medication) five milligrams twice daily for chronic atrial fibrillation. Continued review revealed the facility had no orders in place to monitor the resident for side effects related to the high-risk medication. Continued review of the resident's medical record including Point of Care system for State tested Nursing Aides and the residents care plan revealed the facility did not have any evidence for monitoring for the resident's anticoagulant medication. Interview on 06/27/24 at 10:33 A.M. with Regional Nurse Consultant #114 confirmed the facility was not monitoring for side effects related to Resident #42's anticoagulant medication.