Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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	03/10/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42733 Based on record review, observation and interview the facility failed to implement Resident #3's care plan in regards to percutaneous endoscopic gastrostomy (PEG) tube insertion site care. This affected one resident (#3) of two residents observed for PEG tube care. The facility census was 74. Findings include: Review of Resident #3's medical records revealed an admitted [DATE]. Diagnoses included respiratory failure, throat cancer, and percutaneous endoscopic gastrostomy (feeding) tube. Review of the care plan dated 02/18/25 revealed Resident #3 received tube feeding related to having a nothing by mouth (NPO) status. Interventions included administer skin treatments to PEG tube site as ordered. Review of Resident #3's physician orders for February 2025 through March 2025 revealed an order to cleanse tube (PEG) site with normal saline and apply a T-sponge twice daily. Observation on 03/06/25 at 10:24 A.M. with Licensed Practical Nurse (LPN) #849 revealed Resident #3 had a PEG tube with nutritional formula infusing. Observation of the the PEG tube insertion site revealed a split gauze dressing that was dated 02/28/25. Interview with LPN #849 at time of observation confirmed the split gauze dressing was dated 02/28/25. LPN #849 stated the dressing was to be changed daily. At 11:10 A.M. the Director of Nursing entered Resident #3's room to assist with care and also confirmed the split gauze dressing was dated 02/28/25.

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