STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Lane Gardens Rehab & Nursing Ctr	7820 Pleasantville Road Pleasantville, OH 43148

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on record review, interview, review of the Ohio Department of Health (ODH) Gateway and facility policy review, the facility failed to report an allegation of resident-to-resident sexual abuse to the state agency. This affected two residents (#26 and #70) of four residents reviewed for sexual abuse. The facility census was 91. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disorder, congestive heart failure, benign prostrate hypertrophy and bipolar disorder. Resident #26 was his own person with no designated power of attorney (POA). Review of the plan of care initiated on 03/24/25 revealed Resident #26 had a behavior problem as evidenced by making sexually inappropriate comments to the staff. The goal stated Resident #26 would have fewer episodes by the review date. The interventions included administering medications as ordered, anticipating and meeting resident needs, caregivers to provide opportunity for positive interaction, and attention, explaining all procedures to Resident #26 before starting and allowing time to adjust to changes, if reasonable, discuss Resident #26's behavior, and intervene as necessary to protect the rights and safety of others. Review of the progress notes revealed a note authored by Licensed Practical Nurse (LPN) #151 dated 04/01/25 at 3:41 A.M. revealed another resident reported that Resident #26 was given oral sex while in their room. Resident #26 denied any contact with the other resident and stated no penetrative or oral sex was received. The physician was notified and new orders for labs were received. The Unit Manager, Assistant Director of Nursing (ADON), and Director of Nursing (DON) were notified. Review of the medical record revealed Social Service Director (SSD) #270 completed a wellness visit with Resident #26 on 04/01/25 at 2:32 P.M. Resident #26 denied any sexual behaviors happened and no one gave him oral sex. Resident #26 was educated on safe sex practices and aware condoms would be supplied when needed. Resident #26 was provided education on not entering female resident's rooms while they were naked. Discussed best practice would be for Resident #26 to talk with female residents in the lobby area and Resident #26 agreed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a note authored by SSD #270 dated 04/01/25 at 3:43 P.M. revealed Resident #26 had been given printed education as well as verbal education on sexually transmitted disease risk factors, symptoms and prevention. Resident #26 was also educated on condom use, why it was important, and the risk versus benefits of not using a condom. No issues or concerns were noted at this time. Review of the plan of care initiated on 04/01/25 revealed Resident #26 would be on every 15-minute checks for possible sexually inappropriate behavior -another resident reported oral sex. Review of the behavior assessment dated [DATE] revealed Resident #26 had socially disruptive behaviors, inappropriate sexual behaviors, agitation and irritability. Resident #26 was not a threat to self or others. A note authored by Registered Nurse (RN) #170 dated 04/06/25 at 3:05 P.M. revealed Resident #26 was attempting to get into female rooms and was currently on 15-minute checks. Resident #26 needed numerous reminders to not go into female rooms. Resident #26 attempted earlier to go into female room and this nurse educated Resident #26 once again to where he said he was not going. This nurse went into another resident room, came out and Resident #26 once again was trying to get into a female room. Resident #26 did turn around and stop; however, stated he was allowed to do what he wanted. Resident #26 was observed rubbing on a female resident's legs and was told to stop, which he did when staff was present. It was reported by other resident that Resident #26 continued to rub this particular female resident legs. This nurse reported off to on call nurse, the DON, regarding CF Review of a note authored by LPN #160 dated 04/07/25 at 10:59 A.M. revealed Resident #26 and female resident came to author to discuss sexual behaviors that have been reported. Resident #26 stated that nothing was happening between himself and the female resident, they were just friends. Resident #26 stated he did rub her leg and that was all. Discussed importance of not touching the female resident, and Resident #26 voiced understanding. Resident #26 stated if he wanted to do something, he knew where to go and wouldn't do it in his room. Review of the plan of care revealed a revision on 04/07/25 stating Resident #26 was noted to be attempting to go into another female resident's room, and rubbing another female resident's leg after the female pulled her pants legs. The goal stated Resident #26 would be monitored every 15-minute to ensure whereabouts and behaviors through the review date. The interventions included in the event of negative behavior, Resident #26 would be monitored until appropriate staff were notified, notify administrative staff in event of behaviors, provide redirection when noted to be going into other female resident rooms, report changes in behaviors that affect others to the physician and administrative staff and continue to monitor Resident #26's whereabouts and behaviors every 15 minutes. Review of a note authored by SSD #270 dated 04/09/25 at 2:25 P.M. revealed Resident #26 was educated on a behavior contract. The behavior contract was for sexual behaviors with a female resident. Resident #26 was aware he was not to have any sexual contact with the other resident per her guardian. If a violation occurred, it would lead to a 30-day discharge notice. Resident #26 voiced understanding of the contract, agreed, and signed. Review of the behavior contract signed on 04/09/25 revealed Resident #26 was not to have any sexual contact with Resident #70 per her guardian. If a violation occurred, a 30-day discharge notice would be issued. Resident #26 understood the contract, and the Ombudsman was aware. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a note authored by LPN #151 dated 04/10/25 at 7:08 A.M. revealed Resident #26 was observed by the Certified Nursing Assistant (CNA) kissing another resident in room B-9-B. Both were redirected successfully. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. Resident #26 had physical and verbal behaviors and other behaviors directed towards others. Resident#26 required minimal assistance with activities of daily living (ADL), had impaired range of motion to one side of upper extremities and was mobile using a wheelchair. Resident #26 had no restraints or alarms. Review of the behavioral counseling notes dated 04/01/25, 04/08/25 and 04/15/25 revealed Resident #26 was frustrated with his current situation, was processing relationships and had inappropriate behaviors. Review of a note authored by LPN #151 dated 04/18/25 at 1:56 P.M. revealed Resident #26 was observed by other residents to have his hands in resident B-9-B pants and that resident had her legs wrapped around Resident #26. The nurse observed the residents sitting next to each other. The nurse separated the two residents successfully. 15-minute checks will continue. Review of the physician orders dated 04/25 revealed Resident #26 had an order for 15-minute checks for safety. Interview on 04/28/25 at 1:24 P.M. Resident #26 stated he did not like living at the facility because he was accused of messing with one of the ladies that live there. Resident #26 stated he did not touch the resident except when she asked him to rub her leg because she had a cramp in it. 2. Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including anoxic brain damage, dementia, bipolar disorder, depression, anxiety, post-traumatic stress disorder, viral Hepatitis C, and opioid abuse with induced psychotic disorder. Review of the admission MDS assessment dated [DATE] revealed Resident #70 had BIMS score of 13 indicating intact cognition. Resident #70 had behaviors directed towards others and wandering. Resident #70 required set up assistance with ADL, had no impaired range of motion and ambulated per self. Resident #70 had no alarms or restraints. Review of the elopement assessment completed 02/17/25 revealed Resident #70 was a high risk for elopement. Review of the SSD admission assessment dated [DATE] revealed Resident #70 had history of depression, anxiety, adjusting to environment, wandering and inappropriate sexual behaviors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care initiated on 02/18/25 and revised on 04/04/25 revealed Resident #70 had a behavior problem of yelling at others, calling them names and argumentative. The goal stated Resident #70 would have fewer episodes by the review date. Interventions included administering medications as ordered, educating the resident on successful coping and interaction strategies, explaining all procedures to Resident #70 prior to starting, and allowing her time to adjust to changes, if reasonable discuss behavior, explaining why behavior was unacceptable or inappropriate and intervene as necessary to protect the rights and safety of others. Review of the plan of care initiated on 02/18/25 and revised on 04/07/25 revealed Resident #70 could be sexually inappropriate with others per guardian and previous facility. On 04/01/25, the resident's guardian was okay with Resident #70 having one partner but not multiple. On 04/07/25, Resident #70 was noted to be pulling her pants legs up and allowing male resident to rub her legs. The goal stated Resident #70 would not display inappropriate sexual behaviors through the review date. The interventions included administering medications as ordered, behavioral health services as indicated if sexually inappropriate behaviors occurred, removing Resident #70 from the situation and place on one-to-one, monitoring for wandering into other resident rooms, notifying the administrator immediately if sexually inappropriate behavior occurred, providing safe practice information to Resident #70, and removing Resident #70 from the situation if inappropriate behavior was occurring. Review of progress notes revealed a note authored by SSD #270 dated 04/01/25 at 2:25 P.M. revealed Resident #70 was unable to sit still. Resident #70 promised she would not harm herself and confirmed she told the Nurse Practitioner she wanted to slit her wrists. Resident #70 was placed on suicide watch and sent to local emergency room for psychiatric evaluation. Resident #70 stated she gave a male resident two blow jobs and now had a sore mouth. SSD #270 educated Resident #70 on safe sex practices with oral sex and condoms would be supplied. SSD #270 discussed with Resident #70 to not have male residents in her room while she was naked, and she agreed. A note authored by SSD #270 on 04/01/25 at 2:22 P.M. revealed the SSD spoke to Resident #70's guardian about her sexual behaviors. Resident #70's guardian was okay with Resident #70 having one partner/boyfriend but not several. According to the guardian, Resident #70 had several at the previous facility, and Resident #70 had her tubes tied. The guardian wanted to keep all male residents out of Resident #70's room. A note authored by SSD #270 dated 04/01/25 at 3:46 P.M. revealed Resident #70 was provided with written education as well as verbal education on sexually transmitted disease risk factors, symptoms and prevention. Also, condom use and why it was important and the risk versus benefits of not using a condom. The centers for Disease Control and Prevention (CDC) guidelines on how to apply a condom were reviewed with Resident #70. Resident #70 was informed that condoms would be available for her use. Review of psychiatric visit note dated 04/01/25 revealed Resident #70 was currently paranoid, hyperverbal, elevated, restless and tangential. Resident #70 was sexually preoccupied and reported that she had not slept in days. Resident #70 shared she was previously a heroin addict and endorsed suicidal ideation with a plan to cut her wrists. Resident #70 was placed on one-to-one suicide watch and ordered to be sent out for evaluation. Resident #70 was unaware of current events as evidenced by age-appropriate responses to questions. Insight and judgement were grossly impaired as evidenced by age appropriate awareness of the problem, denial/blamed others and understanding cause and effect. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a note authored by LPN #171 dated 04/06/25 at 2:59 P.M. revealed Resident #70 was rolling up her pant legs in common areas for another resident to rub her legs. The nurse asked Resident #70 to roll her pants back down. Resident #70 rolled her pant legs down then back up when staff walked away. The guardian was notified and was okay with Resident #70 having a partner/boyfriend and did not want them separated. However, the guardian did not want the two residents to be alone together. The nurse reported the behavior to the on call nurse, the DON. Review of a note authored by LPN #160 dated 04/07/25 at 11:02 A.M. revealed Resident #70 and another male resident came to talk about sexual interactions that have been observed. Both stated nothing was going on and they were just friends. When asked about previous incidents, Resident#70 stated nothing ever occurred, and she gets cold sores on her mouth often. Review of a note authored by LPN #151 dated 04/10/25 at 7:25 A.M. revealed Resident #70 was observed kissing resident in room B-3-B, and both were redirected successfully. Review of a note authored by LPN #151 dated 04/18/25 at 2:11 A.M. revealed Resident #70 was observed by other residents to have resident from room B-3-B hands in her pants, and that Resident #70 had her legs wrapped around the male resident. The nurse observed the two residents sitting next to each other and separated them. 15-minute checks would continue. Review of a note authored by LPN #265 dated 04/21/25 at 1:12 P.M. revealed Resident #70's guardian gave consent for room change. Interview on 04/28/25 at 1:12 P.M. Resident #70 denied any sexual behavior or interactions between her and Resident #26 or anyone else at the facility. Review of the ODH Gateway revealed there was not a self-reported incident (SRI) submitted to state agency related to sexual inappropriate behaviors between Residents #26 and #70. Interview with the DON, Regional Nurse, Administrator and Regional Administrator on 04/28/25 at 2:40 P.M. revealed the facility moved Resident #70 to the secure unit for her safety and best interest. Interview with the Administrator 04/29/25 at 12:35 P.M. verified the facility did not complete an SRI into the sexual abuse allegation between Resident #26 and Resident #70. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of resident property, dated 11/01/19, revealed the Administrator or his/her designee will notify ODH of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, ad soon as possible, but in no event later than 24 hours from the time of the incident/allegation was made known to a staff member. This deficiency represents non-compliance investigated under Complaint Number OH00165092.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on record review, interview, and facility policy review, the facility failed to thoroughly investigate an allegation of resident-to-resident sexual abuse. This affected two residents (#26 and #70) of four residents reviewed for sexual abuse. The facility census was 91. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disorder, congestive heart failure, benign prostrate hypertrophy and bipolar disorder. Resident #26 was his own person with no designated power of attorney (POA). Review of the plan of care initiated on 03/24/25 revealed Resident #26 had a behavior problem as evidenced by making sexually inappropriate comments to the staff. The goal stated Resident #26 would have fewer episodes by the review date. The interventions included administering medications as ordered, anticipating and meeting resident needs, caregivers to provide opportunity for positive interaction, and attention, explaining all procedures to Resident #26 before starting and allowing time to adjust to changes, if reasonable, discuss Resident #26's behavior, and intervene as necessary to protect the rights and safety of others. Review of the progress notes revealed a note authored by Licensed Practical Nurse (LPN) #151 dated 04/01/25 at 3:41 A.M. revealed another resident reported that Resident #26 was given oral sex while in their room. Resident #26 denied any contact with the other resident and stated no penetrative or oral sex was received. The physician was notified and new orders for labs were received. The Unit Manager, Assistant Director of Nursing (ADON), and Director of Nursing (DON) were notified. Review of the medical record revealed Social Service Director (SSD) #270 completed a wellness visit with Resident #26 on 04/01/25 at 2:32 P.M. Resident #26 denied any sexual behaviors happened and no one gave him oral sex. Resident #26 was educated on safe sex practices and aware condoms would be supplied when needed. Resident #26 was provided education on not entering female resident's rooms while they were naked. Discussed best practice would be for Resident #26 to talk with female residents in the lobby area and Resident #26 agreed. Review of a note authored by SSD #270 dated 04/01/25 at 3:43 P.M. revealed Resident #26 had been given printed education as well as verbal education on sexually transmitted disease risk factors, symptoms and prevention. Resident #26 was also educated on condom use, why it was important, and the risk versus benefits of not using a condom. No issues or concerns were noted at this time. Review of the plan of care initiated on 04/01/25 revealed Resident #26 would be on every 15-minute checks for possible sexually inappropriate behavior -another resident reported oral sex. Review of the behavior assessment dated [DATE] revealed Resident #26 had socially disruptive behaviors, inappropriate sexual behaviors, agitation and irritability. Resident #26 was not a threat to self or others. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note authored by Registered Nurse (RN) #170 dated 04/06/25 at 3:05 P.M. revealed Resident #26 was attempting to get into female rooms and was currently on 15-minute checks. Resident #26 needed numerous reminders to not go into female rooms. Resident #26 attempted earlier to go into female room and this nurse educated Resident #26 once again to where he said he was not going. This nurse went into another resident room, came out and Resident #26 once again was trying to get into a female room. Resident #26 did turn around and stop; however, stated he was allowed to do what he wanted. Resident #26 was observed rubbing on a female resident's legs and was told to stop, which he did when staff was present. It was reported by other resident that Resident #26 continued to rub this particular female resident legs. This nurse reported off to on call nurse, the DON, regarding CF Review of a note authored by LPN #160 dated 04/07/25 at 10:59 A.M. revealed Resident #26 and female resident came to author to discuss sexual behaviors that have been reported. Resident #26 stated that nothing was happening between himself and the female resident, they were just friends. Resident #26 stated he did rub her leg and that was all. Discussed importance of not touching the female resident, and Resident #26 voiced understanding. Resident #26 stated if he wanted to do something, he knew where to go and wouldn't do it in his room. Review of the plan of care revealed a revision on 04/07/25 stating Resident #26 was noted to be attempting to go into another female resident's room, and rubbing another female resident's leg after the female pulled her pants legs. The goal stated Resident #26 would be monitored every 15-minute to ensure whereabouts and behaviors through the review date. The interventions included in the event of negative behavior, Resident #26 would be monitored until appropriate staff were notified, notify administrative staff in event of behaviors, provide redirection when noted to be going into other female resident rooms, report changes in behaviors that affect others to the physician and administrative staff and continue to monitor Resident #26's whereabouts and behaviors every 15 minutes. Review of a note authored by SSD #270 dated 04/09/25 at 2:25 P.M. revealed Resident #26 was educated on a behavior contract. The behavior contract was for sexual behaviors with a female resident. Resident #26 was aware he was not to have any sexual contact with the other resident per her guardian. If a violation occurred, it would lead to a 30-day discharge notice. Resident #26 voiced understanding of the contract, agreed, and signed. Review of the behavior contract signed on 04/09/25 revealed Resident #26 was not to have any sexual contact with Resident #70 per her guardian. If a violation occurred, a 30-day discharge notice would be issued. Resident #26 understood the contract, and the Ombudsman was aware. Review of a note authored by LPN #151 dated 04/10/25 at 7:08 A.M. revealed Resident #26 was observed by the Certified Nursing Assistant (CNA) kissing another resident in room B-9-B. Both were redirected successfully. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. Resident #26 had physical and verbal behaviors and other behaviors directed towards others. Resident#26 required minimal assistance with activities of daily living (ADL), had impaired range of motion to one side of upper extremities and was mobile using a wheelchair. Resident #26 had no restraints or alarms. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the behavioral counseling notes dated 04/01/25, 04/08/25 and 04/15/25 revealed Resident #26 was frustrated with his current situation, was processing relationships and had inappropriate behaviors. Review of a note authored by LPN #151 dated 04/18/25 at 1:56 P.M. revealed Resident #26 was observed by other residents to have his hands in resident B-9-B pants and that resident had her legs wrapped around Resident #26. The nurse observed the residents sitting next to each other. The nurse separated the two residents successfully. 15-minute checks will continue. Review of the physician orders dated 04/25 revealed Resident #26 had an order for 15-minute checks for safety. Interview on 04/28/25 at 1:24 P.M. Resident #26 stated he did not like living at the facility because he was accused of messing with one of the ladies that live there. Resident #26 stated he did not touch the resident except when she asked him to rub her leg because she had a cramp in it. 2. Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including anoxic brain damage, dementia, bipolar disorder, depression, anxiety, post-traumatic stress disorder, viral Hepatitis C, and opioid abuse with induced psychotic disorder. Review of the admission MDS assessment dated [DATE] revealed Resident #70 had BIMS score of 13 indicating intact cognition. Resident #70 had behaviors directed towards others and wandering. Resident #70 required set up assistance with ADL, had no impaired range of motion and ambulated per self. Resident #70 had no alarms or restraints. Review of the elopement assessment completed 02/17/25 revealed Resident #70 was a high risk for elopement. Review of the SSD admission assessment dated [DATE] revealed Resident #70 had history of depression, anxiety, adjusting to environment, wandering and inappropriate sexual behaviors. Review of the plan of care initiated on 02/18/25 and revised on 04/04/25 revealed Resident #70 had a behavior problem of yelling at others, calling them names and argumentative. The goal stated Resident #70 would have fewer episodes by the review date. Interventions included administering medications as ordered, educating the resident on successful coping and interaction strategies, explaining all procedures to Resident #70 prior to starting, and allowing her time to adjust to changes, if reasonable discuss behavior, explaining why behavior was unacceptable or inappropriate and intervene as necessary to protect the rights and safety of others. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care initiated on 02/18/25 and revised on 04/07/25 revealed Resident #70 could be sexually inappropriate with others per guardian and previous facility. On 04/01/25, the resident's guardian was okay with Resident #70 having one partner but not multiple. On 04/07/25, Resident #70 was noted to be pulling her pants legs up and allowing male resident to rub her legs. The goal stated Resident #70 would not display inappropriate sexual behaviors through the review date. The interventions included administering medications as ordered, behavioral health services as indicated if sexually inappropriate behaviors occurred, removing Resident #70 from the situation and place on one-to-one, monitoring for wandering into other resident rooms, notifying the administrator immediately if sexually inappropriate behavior occurred, providing safe practice information to Resident #70, and removing Resident #70 from the situation if inappropriate behavior was occurring. Review of progress notes revealed a note authored by SSD #270 dated 04/01/25 at 2:25 P.M. revealed Resident #70 was unable to sit still. Resident #70 promised she would not harm herself and confirmed she told the Nurse Practitioner she wanted to slit her wrists. Resident #70 was placed on suicide watch and sent to local emergency room for psychiatric evaluation. Resident #70 stated she gave a male resident two blow jobs and now had a sore mouth. SSD #270 educated Resident #70 on safe sex practices with oral sex and condoms would be supplied. SSD #270 discussed with Resident #70 to not have male residents in her room while she was naked, and she agreed. A note authored by SSD #270 on 04/01/25 at 2:22 P.M. revealed the SSD spoke to Resident #70's guardian about her sexual behaviors. Resident #70's guardian was okay with Resident #70 having one partner/boyfriend but not several. According to the guardian, Resident #70 had several at the previous facility, and Resident #70 had her tubes tied. The guardian wanted to keep all male residents out of Resident #70's room. A note authored by SSD #270 dated 04/01/25 at 3:46 P.M. revealed Resident #70 was provided with written education as well as verbal education on sexually transmitted disease risk factors, symptoms and prevention. Also, condom use and why it was important and the risk versus benefits of not using a condom. The centers for Disease Control and Prevention (CDC) guidelines on how to apply a condom were reviewed with Resident #70. Resident #70 was informed that condoms would be available for her use. Review of psychiatric visit note dated 04/01/25 revealed Resident #70 was currently paranoid, hyperverbal, elevated, restless and tangential. Resident #70 was sexually preoccupied and reported that she had not slept in days. Resident #70 shared she was previously a heroin addict and endorsed suicidal ideation with a plan to cut her wrists. Resident #70 was placed on one-to-one suicide watch and ordered to be sent out for evaluation. Resident #70 was unaware of current events as evidenced by age-appropriate responses to questions. Insight and judgement were grossly impaired as evidenced by age appropriate awareness of the problem, denial/blamed others and understanding cause and effect. Review of a note authored by LPN #171 dated 04/06/25 at 2:59 P.M. revealed Resident #70 was rolling up her pant legs in common areas for another resident to rub her legs. The nurse asked Resident #70 to roll her pants back down. Resident #70 rolled her pant legs down then back up when staff walked away. The guardian was notified and was okay with Resident #70 having a partner/boyfriend and did not want them separated. However, the guardian did not want the two residents to be alone together. The nurse reported the behavior to the on call nurse, the DON. Review of a note authored by LPN #160 dated 04/07/25 at 11:02 A.M. revealed Resident #70 and another male resident came to talk about sexual interactions that have been observed. Both stated nothing was going on and they were just friends. When asked about previous incidents, Resident#70 stated nothing ever occurred, and she gets cold sores on her mouth often. (continued on next page)

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	366199	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Lane Gardens Rehab & Nursing Ctr	7820 Pleasantville Road Pleasantville, OH 43148

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a note authored by LPN #151 dated 04/10/25 at 7:25 A.M. revealed Resident #70 was observed kissing resident in room B-3-B, and both were redirected successfully. Review of a note authored by LPN #151 dated 04/18/25 at 2:11 A.M. revealed Resident #70 was observed by other residents to have resident from room B-3-B hands in her pants, and that Resident #70 had her legs wrapped around the male resident. The nurse observed the two residents sitting next to each other and separated them. 15-minute checks would continue. Review of a note authored by LPN #265 dated 04/21/25 at 1:12 P.M. revealed Resident #70's guardian gave consent for room change. Interview on 04/28/25 at 1:12 P.M. Resident #70 denied any sexual behavior or interactions between her and Resident #26 or anyone else at the facility. Interview with the DON, Regional Nurse, Administrator and Regional Administrator on 04/28/25 at 2:40 P.M. revealed the facility moved Resident #70 to the secure unit for her safety and best interest. Interview with the Administrator 04/29/25 at 12:35 P.M. verified the facility did not complete an investigation into the sexual abuse allegation between Resident #26 and Resident #70. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of resident property, dated 11/01/19, revealed once the Administrator and the Ohio Department of Health (ODH) are notified, an investigation of the alleged violation will be conducted. The investigation must be completed within five working days. The investigation protocol included interviewing the residents, the accused and all witnesses. Witnesses include anyone who witnessed or heard about the incident. This deficiency represents non-compliance investigated under Complaint Number OH00165092.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on record review, review of a self-reported incident (SRI), facility policy review, and interview, the facility failed to accurately and timely identify and address sexually oriented behaviors involving cognitively impaired residents (#71 and #32) to ensure the residents were able to consent to sexual activity and to prevent potential incidents of resident to resident sexual abuse. This affected two residents (#71 and #32) of four residents reviewed for sexual abuse. The facility census was 91. Findings include: Review of Resident #71's medical record revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes mellitus type two, morbid obesity, unspecified mood disorder, depression, and dementia. Record review revealed Resident #71 was her own person with no designated power of attorney (POA). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment and no behaviors. Resident #71 had impaired range of motion to one of lower extremity, was dependent on staff for most activity of daily living (ADL) care and was independently mobile in wheelchair. Resident #71 had no restraints or alarms. Review of a progress notes revealed a note authored by the Director of Nursing (DON) dated 03/20/25 at 4:44 P.M. which indicated Resident #71 was observed in the common area with another resident (Resident #32) touching inappropriately through full clothing. The staff were able to easily redirect and separate the residents. Skin assessment implemented with no new areas noted. Review of SRI tracking number 258458 submitted to State agency on 03/20/25 at 5:19 P.M. revealed Resident #32 and Resident #71 had been spending time talking with each other. On 03/20/25, staff noted the two residents sharing a kiss with closed mouth, and he had his hand over her private area above her clothing. When interrupted, both became upset and yelled obscenities at the nurse. The nurse then asked them to separate and both were agreeable. Resident #32 was monitored with every 15-minute check. The primary care provider and Resident #32's spouse were notified and agreed to a care conference on 03/21/25. Resident #71 was her own person and had no emergency contact. An investigation was initiated that consisted of interviews of both residents involved as well as staff present with knowledge of the occurrence. Skin assessments were completed for both residents without signs of injury noted. The facility unsubstantiated the allegation (of sexual abuse) through investigation. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SRI included although both residents had cognitive impairment, both recalled and expressed during later interviews the occurrence to be of a mutual decision. Both residents were agreeable to interventions implemented by the facility. A care conference was held the next day on 03/21/25 with Resident #32 and his wife. Resident #32's wife was unable to drive at this time and requested Resident #32 be moved closer to her in [NAME]. Resident #32 agreed he would like to move closer to her. Social Services Director (SSD #270) was going to be sending referrals. The facility continued to monitor for any negative psychosocial impact and would update care planning accordingly. Both the Ombudsman and the psychological services provider were updated. Review of the plan of care revised on 03/20/25 revealed Resident #71 had behavior problem with history of biting self, verbal and physical aggression towards others, and periods of hallucination and delusions. On 03/20/25, Resident #71 was noted to be refusing medications, care, food related to wanting to be a brat due to being separated from the male resident (Resident #32). The goal was to have fewer episodes by the review date, and Resident #71 will allow care, food, etcetera when upset about being removed from the male resident through the review date. The interventions included administering medications as ordered, anticipating and meeting the resident's needs, caregivers to provide opportunity for positive interaction and attention, explaining all procedures before starting and allowing time to adjust to changes, if reasonable, discuss Resident #71's behavior, explain/reinforce why the behavior was inappropriate and/or unacceptable, intervene as necessary to protect the rights and safety of others, monitor behavior episodes and attempt to determine underlying cause, and will remove from male resident when touching/holding hands. Review of the behavioral assessment dated [DATE] revealed Resident #71 had depression and was not a threat to self or others. A note authored by the Administrator dated 03/24/25 at 4:16 P.M. revealed the Administrator spoke to the Ombudsman regarding Resident #71's interaction with another resident (Resident #32). The Ombudsman was informed both residents were seeking out the other and both enjoy each other's company. The Ombudsman wanted to confirm that neither was resisting each other. The Ombudsman suggested if the relationship progresses, they educate both resident's on sexually transmitted diseases and contraception. Review of the psychiatric visit note dated 03/25/25 revealed Resident #71 reported her mood was good, she was depressed and irritated because she was not able to leave when she wanted to. Resident #71 was easily distracted and sexually preoccupied. Per the nursing report, Resident # 71 refused care, had times of irritability and inappropriate sexual behavior. Resident #71 was unaware of the current events as evidenced by age-appropriate responses to questions. Resident #71 had poor insight and judgement as evidenced by age-appropriate awareness of problems and denied or blamed others. The note failed to contain any assessment or information related to the resident's ability to consent to sexual activity. Review of the physician orders dated 04/2025 revealed Resident #71 had an order for expert evaluation by a physician to determine cognitive function and decision-making ability. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note authored by Licensed Practical Nurse (LPN) #151 dated 04/02/25 at 9:49 P.M. revealed Resident #71 was observed to be in another resident's room (Resident #32) shirtless, and the other resident was naked. Both residents stated nothing happened; they just got naked. Both residents were redirected, and both residents put their clothing back on and left the room. 15-minute checks were initiated. The DON, Unit Manager, Assistant Director of Nursing (ADON) and Administrator were notified. A note authored by Social Service Director (SSD) #270 dated 04/08/25 at 11:33 A.M. revealed Resident #71 was aware and agreed to room move and to a new roommate. There were no issues or concerns at this time. A note authored by SSD #270 dated 04/09/25 at 4:25 P.M. revealed Resident #71 had been given printed education as well as verbal education on sexually transmitted diseases risk factors, symptoms, prevention, and condom use. She was also informed about why it was important and the risk versus benefits of not using a condom. The Centers for Disease Control (CDC) guidelines on how to apply a condom were reviewed. Resident #71 was aware that condoms would be available for her to use. No note revealed no other issues or concerns were noted at this time. The note failed to include an assessment and/or information related to the resident's understanding of the sexually based education and/or resident's ability to consent to sexual activity. Review of a care plan initiated 04/10/25 revealed Resident #71 was noted to have consensual sexual relations with another resident, explain to not do anything in common areas or around others and to be in private area. The goal was to not display inappropriate sexual behavior through the review date. The interventions included administering medications as ordered, behavioral health services as indicated, if sexually inappropriate behaviors occur, remove the residents from the situation, remind Resident #71 of private area for sexual relations with consenting partner, and remove Resident #71 from the situation if an inappropriate behavior was occurring. The care plan failed to contain evidence of how it was determined Resident #71 had the ability to consent to the sexual activity/relationship. Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses of unspecified dementia, diabetes mellitus type two, anxiety, and traumatic brain injury. Resident #32 had a medical power of attorney (POA) designated. Review of the behavioral assessment dated [DATE] revealed Resident #32 had unrealistic demands, agitation and irritability. Resident #32 was not a threat to self or others. Review of the annual MDS assessment dated [DATE] revealed Resident #32 had a Brief Interrview Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Resident #32 had no behaviors and required minimal assistance from the staff to complete activities of daily living (ADL) and was mobile using a wheelchair. Resident #32 had no alarms or restraints. Review of the progress notes revealed a nursing note authored by the Director of Nursing (DON) dated 03/20/25 at 2:44 P.M. (late entry) Resident #32 was observed in the common area with another resident (Resident #71) touching her inappropriately over clothes. The staff were easily able to redirect and separate the residents. Skin assessments were completed with no new areas noted. Review of the physician orders dated 04/2025 revealed Resident #32 had an order for every 15-minute checks by staff. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care created on 04/03/25 revealed Resident #32 would be on every 15-minute checks for sexually inappropriate behavior. The goal stated Resident #32 would be monitored every 15 minutes to ensure whereabouts and behaviors through the review date. The interventions included in the event of negative behaviors, the resident will be monitored until appropriate staff was notified, notify administrative staff in the event of behaviors identified, report changes in behaviors that affect others to the physician and administrative staff, staff would monitor the residents whereabouts and behaviors every 15 minutes, and when noted to be in contact with residents, remove from situation and remind him that was inappropriate. The plan of care did not include what the inappropriate behaviors were or address the reisdent's ability to engage in consensual sexual activity with other residents. Review of the behavioral assessment dated [DATE] revealed Resident #32 had unrealistic demands, agitation, irritability, and inappropriate sexual behaviors. Resident #32 was not a threat to self or others. A nursing note authored by Licensed Practical Nurse (LPN) #151 dated 04/02/25 at 9:19 P.M. revealed Resident #32 was observed to be in his room naked with another resident (Resident #71) who had taken her shirt off. Both residents stated nothing happened; they just got naked. Both residents put their clothing back on and left the room. Every 15-minutes checks were initiated. The DON, Administrator, Unit Manager and Assistant Director of Nursing (ADON) were notified. A note authored by SSD #270 dated 04/06/25 at 4:24 P.M. revealed Resident #32 had been given printed off education as well as verbal education on sexually transmitted disease risk factors, symptoms, and prevention. Condom use and why it was important and risk versus benefits of not using condoms. Also, the Center for Disease Control (CDC) guidelines on how to apply a condom. Resident #32 was aware that condoms would be available for him to use. No note included there were no issues or concerns at this time. However, the note failed to assess the resident's ability to engage or consent to sexual activity with other residents Review of a psychiatric visit note dated 04/08/25 revealed Resident #32 reported his mood was okay. Resident #32 was recently started on Rivastigmine (medication to treat mild dementia) and Tagamet (medication to reduce stomach acid also used to reducing sexual desires) was increased for behaviors related to dementia. Resident #32 had an increase in inappropriate sexual behaviors However, the note did not describe what these behaviors were. The resident's Sertraline (antidepressant) was stopped, and Resident #32 was put on Lexapro (antidepressant) as he was previously taking. Resident #32 tolerated the medication changes without side effects or adverse reactions. Resident #32 denied depression, sadness, irritability, and anxiety. The nursing staff reported an increase in inappropriate sexual behaviors. It was noted Resident #32 had poor insight and judgment as evidenced by age-appropriate awareness of problem, acceptance of help, and understanding cause and effect. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care revised on 04/10/25 revealed Resident #32 was noted to have sexually inappropriate behavior with another female resident (Resident #71). On 04/09/25, Resident #32 had consensual sexual relations with another resident (Resident #71). Resident #32 was instructed that needed to be in a private area. The goal stated Resident #32 would not display inappropriate sexual behaviors through the review date. The interventions included administering medications as ordered, behavioral health services as indicated, monitoring Resident #32 for wandering into the room of others, notifying the administrator immediately if sexually inappropriate behavior occurs between Resident #32 and another, remind Resident #32 the need to be in a private area when having sexual contact with consented partner, and remove Resident #32 from the situation if an inappropriate behavior was occurring. Interview on 04/28/25 at 11:51 A.M. with Certified Nursing Assistant (CNA) #120 revealed the CNA was unaware of any residents who had a sexual relationship at this time as administration had separated residents (#32 and #71) when they moved the lady (Resident #71) upstairs. Attempted telephone interview on 04/28/25 at 1:47 P.M with LPN #151, who documented reported inappropriate sexual behavior; however the LPN could not be reached. Interview on 04/28/25 at 1:01 P.M. with Resident #71 revealed the resident denied any sexual behavior or interaction between her and Resident #32 or anyone else at the facility. Interview on 04/28/25 at 1:18 P.M. with Resident #32 revealed staff liked to accuse him of having a girlfriend and having sex with her. Resident #32 stated he did not, and he was accused of being naked with her and was not. Resident #32 stated he had a wife and did not cheat. Interview with the DON, Regional Nurse, Administrator, and Regional Administrator on 04/28/25 at 2:40 P.M. revealed the facility moved Resident #71 to the secure unit for her safety and best interest. Following the move, no further inappropriate sexual behavior had been reported or observed. Interview with the Administrator on 04/29/25 at 12:35 P.M. confirmed sexual interaction between Residents #32 and #71 did occur and was reported to the State agency. This deficiency represents non-compliance investigated under Complaint Number OH00165092.