

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Country Lane Gardens Rehab & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</p> <p>Based on interview and medical record review, the facility failed to care plan and document on Resident #43's behaviors and ensure the physician or Certified Nurse Practitioner (CNP) addressed his behaviors. This affected one resident (#43) of four residents reviewed for abuse. The facility census was 90.</p> <p>Findings includes:</p> <p>Review of Resident #43's medical record revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic heart failure, bipolar disorder, and presbyopia.</p> <p>Review of Resident #43's physician order dated 04/01/25 to 05/16/25 revealed an order for 15-minute checks.</p> <p>Review of Resident #43's progress notes dated 04/01/25 at 3:41 A.M. revealed Resident #43 was accused of sexual behaviors. Social Service Director (SSD) #168 revealed they met to discuss allegations, which Resident #43 denied. He was also educated on not entering female's rooms while they are naked.</p> <p>Review of Resident #43's progress note dated 04/06/25 at 3:05 P.M. revealed Resident #43 had been attempting to enter females' rooms on multiple occasions and had been caught rubbing a female residents' legs.</p> <p>Review of Resident #43's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. During one to three days of the lookback period he had physical and verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed towards others.</p> <p>Review of Resident #43's progress note dated 04/10/25 7:08 A.M. and 04/18/25 at 1:56 A.M. revealed he experienced sexual behaviors towards another resident.</p> <p>Review of Resident #43's progress note dated 04/16/25 at 12:03 P.M. revealed he entered a female resident's room without permission.</p> <p>(continued on next page)</p>

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: 366199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Country Lane Gardens Rehab & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #43's physician order dated 05/08/25 revealed an order for one-on-one supervision.</p> <p>Review of the facilities self-reported incident (SRI) dated 05/08/25 revealed Resident #27 had accused Resident #43 of touching her inappropriately. Resident #27 reported Resident #43 had entered her room, touched her chest, put his hand inside her brief and put his fingers inside her. Resident #43 was placed on one-on-one supervision following this incident. This allegation was unsubstantiated by the facility.</p> <p>Review of Resident #43's medical record from 05/08/25 to 05/19/25 revealed no documentation related to the 05/08/25 incident and no documentation related to the reason for one-on-one supervision.</p> <p>Review of Resident #43's plan of care revealed it did not address sexual behaviors directed towards others.</p> <p>Review of Resident #43's progress notes from 04/01/25 to 05/18/25 revealed the physician or CNP #144 reviewed the resident on 04/01/25, 04/18/25, and 05/07/25. These notes did not indicate they were aware of the residents' behaviors and did not address them at all.</p> <p>Interview on 05/19/25 at 10:57 A.M. with CNP #144 revealed she was aware of Resident #43's sexual behaviors. The facility had kept her up to date on interventions they put in place. CNP #144 reported the facility stated Resident #43 declined any medications to curb sexual desires.</p> <p>Interview on 05/19/25 at 11:28 A.M. with Registered Nurse (RN) #133 revealed residents have told her Resident #43 asks for sexual favors.</p> <p>Interview on 05/19/25 at 12:27 P.M. and 1:48 P.M. with the Administrator verified the 05/08/25 allegation was not in Resident #43's medical record. She additionally verified his care plan did not address his behaviors towards other residents. The Administrator verified the physician and CNP notes did not address Resident #43's behaviors. She reported they had not attempted any medications related to his behaviors because they did not think he would take them.</p>		