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	07/02/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, non-facility staff interview, and facility policy review, the facility failed to ensure accurate/clear advanced directives were in place at the time of a resident's death. This affected one, (Resident #90), of three resident reviewed for advanced directives. The census was 88. Findings Include: Resident #90 was admitted to the facility on [DATE]. His diagnoses were encephalopathy, waldenstrom macroglobulinemia, atrial fibrillation, dementia, dysphagia, schizophrenia, hypertension, anemia, catatonic disorder, restlessness and agitation, encounter for palliative care, hallucinations, psychosis, and colostomy status. Review of his minimum data set (MDS) assessment, dated [DATE], revealed he had a severe cognitive impairment. Review of Resident #90's physician orders found he was placed on hospice services on [DATE]. Review of Resident #90's medical records, dated [DATE] to [DATE], revealed no hospice records. There was no hospice documentation on site, including no hospice plan of care, no hospice progress notes, and no resident code status. Interview with Administrator and Director of Nursing (DON) on [DATE] at 10:30 A.M. confirmed they did not have Resident #90's hospice documentation at the facility. They confirmed hospice had not sent any of the needed documents to them. They confirmed they should have had the documents in the facility, but hospice had not sent them since he was admitted to the facility. This included his change in advanced directive, which went from full code status to do not resuscitate - comfort care arrest (DNR-CCA). They confirmed during his death incident, the facility staff was confused as to whether to perform CPR or not, due to not having the updated advance directive documentation in the facility. (continued on next page)

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
	366199	A. Building B. Wing	07/02/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #101 on [DATE] at 5:01 P.M. and [DATE] at 10:56 A.M. revealed she was the nurse for Resident #90 the evening of [DATE] and early morning of [DATE]. She confirmed she was told by the out-going nurse they were waiting for an updated advance directive order for Resident #90 from hospice; they were waiting for the physician to sign the change from full code status to DNR-CCA. She confirmed they never received the the updated advance directive by the morning of [DATE], when she was informed by a Certified Nursing Assistant (CNA) that Resident #90 was without vital signs. She ensured there was nothing in the electronic medical records to contradict the existing full code status order; which she did not find. So they started CPR. While her and LPN #102 were completing CPR, hospice staff called her and told her to stop CPR due to the change in his code status that was signed by the physician. She confirmed she stopped CPR until EMS arrived; which EMS started CPR again because they did not have documented evidence of a code status change. She confirmed they did not have all the needed hospice documentation in the facility to adequately provide the care and dignity to Resident #90. Interview with LPN #102 on [DATE] 3:25 P.M. and [DATE] at 11:10 A.M. revealed she was working an adjacent hallway when she heard someone yell for assistance in Resident #90's room. She went to get the crash cart as LPN #101 checked his code status. There was nothing in the electronic medical records to dispute he was a full code status, even though they had been told it was going to be changed to a DNR-CCA the night prior. She confirmed they started CPR; she confirmed she continued chest compressions as LPN #101 took a phone call from hospice staff who stated they should stop CPR. LPN #102 confirmed she continued chest compressions and then stopped as EMS was walking into the room to take over the care of Resident #90. She confirmed there was confusion that morning because they did not know Resident #90 code status for certain, and there was no documentation in the facility to refute that it had changed from a full code to DNR-CCA. Interview with Hospice Staff #175 on [DATE] at 8:17 A.M. confirmed they received the change in advance directive status for Resident #90 on [DATE] at approximately 10:00 P.M. He confirmed he did not receive notification that the nurse practitioner had signed it until the next day. He confirmed the facility did not receive a copy of the change of code status until after Resident #90 expired. He confirmed hospice had the ability to immediately send the change of code status to the facility when he was aware the physician had signed it. Given that it was very late on a Friday night when it was signed, it was an oversight to get it sent to the facility. Review of facility Advance Directive policy, dated [DATE], revealed information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. Changes or revocation of a directive must be submitted to the Administrator. The Administrator may require new documents if changes are extensive. The Director of Nursing Services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and care plan. Review of facility Do Not Resuscitate Order policy, dated [DATE], revealed do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. A DNR order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law), and placed in the front of the resident's medical record. DNR orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. Verbal orders to cease the DNR will be permitted when two staff members witness such request. (continued on next page)

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	07/02/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00166766.

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	07/02/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, non-facility staff interview, and facility policy review, the facility failed to ensure all resident medical records were complete. This affected one (Resident #90) of three resident medical records reviewed. The census was 88. Findings Include: Resident #90 was admitted to the facility on [DATE]. His diagnoses were encephalopathy, waldenstrom macroglobulinemia, atrial fibrillation, dementia, dysphagia, schizophrenia, hypertension, anemia, catatonic disorder, restlessness and agitation, encounter for palliative care, hallucinations, psychosis, and colostomy status. Review of his minimum data set (MDS) assessment, dated [DATE], revealed he had a severe cognitive impairment. Review of Resident #90 progress notes, dated [DATE], revealed two notes that stated, expired and body released to funeral home. There was no documentation in any portion of his medical record to explain how he expired, what happened prior to his expiration, and what was done (if anything) to provide life sustaining measures. Interview with Administrator and Director of Nursing (DON) on [DATE] at 10:30 A.M. confirmed there was no documentation to explain or describe the incident/death on [DATE] to Resident #90. They confirmed there should have been a full description of what happened prior, during, and after the incident/death. They also confirmed there should have been documentation to support what the nurse did and who she contacted. They confirmed the record did not contain the required information. Interview with Licensed Practical Nurse (LPN) #101 on [DATE] at 5:01 P.M. and [DATE] at 10:56 A.M. revealed she was the nurse for Resident #90 the evening of [DATE] and early morning of [DATE]. She confirmed she was the lead nurse for Resident #90's hallway, and was the person responsible for documenting all the aspects of the incident/death that occurred on [DATE]. She confirmed there was no documentation in Resident #90's medical record regarding the incident/death. She stated she thought she had documented it, but confirmed that it was not in his medical record as it should have been. Review of facility Change in a Resident's Condition or Status policy, dated [DATE], revealed the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number OH00166766.

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	07/02/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure hospice records were in the facility for full access and review. This affected one, (Resident #90), of one resident reviewed for hospice services. The census was 88. Findings Include: Resident #90 was admitted to the facility on [DATE]. His diagnoses were encephalopathy, waldenstrom macroglobulinemia, atrial fibrillation, dementia, dysphagia, schizophrenia, hypertension, anemia, catatonic disorder, restlessness and agitation, encounter for palliative care, hallucinations, psychosis, and colostomy status. Review of his minimum data set (MDS) assessment, dated 04/22/25, revealed he had a severe cognitive impairment. Review of Resident #90's physician orders found he was placed on hospice services on 05/01/25. Review of Resident #90's medical records, dated 05/01/25 to 05/10/25, revealed no hospice records were included in the record. There was no hospice documentation on site, including no hospice plan of care, no hospice progress notes, and no resident code status. Interview with Administrator and Director of Nursing (DON) on 06/24/25 at 10:30 A.M. confirmed they did not have the hospice documentation for Resident #90 in the facility. They confirmed hospice had not sent any of the needed documents to them. This deficiency represents non-compliance investigated under Complaint Number OH00166766.