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	08/15/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, policy review, and interview, the facility failed to notify physician and family of abnormal radiology results. This affected one resident (#14) of three residents reviewed for notification. The facility census was 89.Findings Include:Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, heart failure, and other toxic encephalopathy. Review of an admission minimum data set (MDS) assessment dated [DATE] revealed Resident #14's cognition remained intact, and she had no behaviors.Review of nursing notes from 07/25/25 through 07/27/25 revealed no documented evidence of Resident #14 having a fall or being lowered to the ground. Review of a staff statement dated 07/27/25 by certified nurse aide (CNA) #140 revealed after Resident #14 finished using the bathroom, she stood up but was having trouble standing from the low toilet. CNA #140 helped Resident #14 up and the resident was standing very well while her pants were pulled up. After pants were up, Resident #14 became unstable and CNA #140 instructed her to sit back on the toilet but the resident began to fall. CNA #140 guided Resident #14 to the floor. CNA #140 pulled the call light and CNA #133 came in. CNA #133 stated the resident needed to get up, so CNA #140 and #133 got Resident #14 up and the resident did really well walking to bed. Resident #14 denied pain while walking but once in bed stated she may have hurt her foot. CNA #140 let the nurse know and asked when vitals should be taken. CNA #140 stated the nurse did not seem to care and went on a break.Review of a nursing note dated 07/28/25 at 7:08 P.M. by licensed practical nurse (LPN) #103 revealed Resident #14's physician gave new orders for a left ankle x-ray related to pain, a mobile x-ray company was called, and all parties were aware. Review of a nursing note dated 07/29/25 at 3:46 P.M. by LPN #105 revealed the note was a late entry for 07/26/25 at 6:20 P.M. LPN #105 was informed by Resident #14's spouse he took her to the bathroom and Resident #14 became dizzy so he put the wheelchair under her. Resident #14 was denying pain.Review of an order dated 07/29/25 revealed Resident #14 needed an orthopedic appointment due to left ankle fracture. An additional order dated 07/29/25 revealed Resident #14's left ankle/foot was to be wrapped with ace wrap and she was non-weight bearing for left ankle fracture.Review of an x-ray dated 07/29/25 revealed Resident #14 had an acute, minimally displaced fracture at the distal fibula with adjacent soft tissue swelling.Interview on 08/13/25 at 11:10 A.M. with Resident #14 and the resident's spouse revealed the resident was not made aware of the abnormal x-ray results until an aide let it slip to her. Resident #14's spouse could not recall if he was notified.Interview on 08/13/25 at 2:03 P.M. with the Administrator confirmed there was no evidence Resident #14, or her family were notified of the abnormal X-ray results. The Administrator verified there was no documented evidence Resident #14's physician was notified of the resident's fall on 07/26/25 with subsequent complaints of pain.Review of a policy titled Change in Condition (undated) revealed the nurse will notify physician when there has been an accident or incident involving the resident, discovery of injuries of an unknown source, or other change in condition. Prior to notifying the physician, the nurse will make detailed observations and gather relevant information and pertinent information for the provider. Unless otherwise instructed by the residents, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status.This deficiency represents non-compliance investigated under Complaint Number 2583218.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, policy review and interview, the facility failed to provide timely diagnostic services and treatment when Resident #14 complained of pain to her ankle after a fall. This affected one resident (#14) of three residents reviewed for change in condition. The facility census was 89. Findings include:Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, heart failure, and other toxic encephalopathy. The resident was discharged from the facility on 08/01/25. Review of a care plan dated 07/14/25 revealed Resident #14 was at risk for falls, goals included to be free of minor injuries and major injuries during her stay. Interventions included but were not limited to anticipate and meet resident's needs, call light in reach, education on safety reminders and what to do if a fall occurs, ensure proper footwear, and therapy as needed.Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14's cognition remained intact, and she had no behaviors.Review of nursing notes from 07/25/25 through 07/27/25 revealed no documented evidence Resident #14 had a fall or was lowered to the ground during this time period.Review of a skilled nursing note dated 07/25/25 at 12:26 A.M. by Licensed Practical Nurse (LPN) #101 revealed Resident #14's pain level was 0 (1-10 pain scale).Review of a skilled nursing note dated 07/25/25 at 11:16 P.M. by LPN #107 revealed Resident #14 had a pain level of 0 (1-10 pain scale).Review of the medication administration record (MAR) for 07/2025 revealed Resident #14 had a physician order for tramadol (narcotic pain medication) oral tablet 50 milligrams (mg) give 50 mg by mouth every eight hours as needed for pain starting on 07/21/25. Resident #14 received this medication on 07/27/25 at 6:35 A.M. for a pain level of five (5) (on a 1-10 pain scale with 10 being the most severe pain) and again on 07/27/25 at 5:30 P.M. for a pain level of six (6) (1-10 pain scale). However, there was no evidence comprehensive assessments of the resident's pain to include location, quality, intensity, onset, duration, aggravating/alleviating factor were completed on 07/27/25 related to the use of the as needed narcotic pain medication. Review of a skilled nursing note dated 07/27/25 at 11:05 P.M. by LPN #107 revealed Resident #14 had a pain level of two (2) (1-10 pain scale).Review of a staff statement dated 07/27/25 by (CNA) #140 revealed after Resident #14 finished using the bathroom on 07/26/25, she stood up but was having trouble standing from the low toilet. CNA #140 helped Resident #14 up and the resident was standing very well while her pants were pulled up. After her pants were up, Resident #14 became unstable, and CNA #140 instructed the resident to sit back on the toilet but the resident began to fall. The statement included CNA #140 guided Resident #14 to the floor, CNA #140 pulled the call light and CNA #133 came in. CNA #133 stated the resident needed to get up, so CNA #140 and #133 got Resident #14 up and (per the statement) the resident did really well walking to bed. Resident #14 denied pain while walking but once in bed stated she may have hurt her foot. The statement included the CNA #140 let the nurse know and asked the nurse when vitals should be taken. CNA #140 stated the nurse did not seem to care and went on a break. (The statement did not specify which nurse the incident was reported to.) Review of Resident #14's medical record revealed no written documentation/evidence the resident was lowered to the floor during a transfer on 07/26/25. Review of a nursing note dated 07/28/25 at 7:08 P.M. by LPN #103 revealed Resident #14's physician gave new orders for a left ankle x-ray related to pain, a mobile x-ray company was called, and all parties were aware. Review of the MAR for 07/2025 revealed Resident #14 received tramadol oral tablet 50 milligrams (mg) on 07/29/25 at 12:48 A.M. for a pain level of four (4) (1-10 pain scale). Review of the MAR for 07/2025 revealed Resident #14 received tramadol oral tablet 50 milligrams (mg) on 07/29/25 at 11:34 P.M. for a pain level of three (3) (1-10 pain scale).However, there was no evidence comprehensive assessments of the resident's pain to include location, quality, intensity, onset, duration, aggravating/alleviating factor were completed on 07/29/25 related to the use of the as needed narcotic pain medication. Review of a nursing note dated 07/29/25 at 3:46 P.M. by LPN #105 revealed the note was a late entry for 07/26/25 at 6:20 P.M. when LPN #105 was informed by Resident #14's spouse he took her to the bathroom and Resident #14 became dizzy so he put the wheelchair under her. The late entry note revealed Resident #14 denied pain. Review of an x-ray report dated 07/29/25 revealed Resident #14 had an acute, minimally displaced fracture at the distal fibula with adjacent soft tissue swelling. Review of an order dated 07/29/25 revealed Resident #14 needed an orthopedic appointment due to left ankle fracture. An additional order dated 07/29/25 revealed Resident #14's left ankle/foot was to be wrapped with an ace wrap and she was non-weight bearing for left ankle fracture. There was nothing documented in the resident's