

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 10/15/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on review of Resident Council Meeting Minutes and staff interview, the facility failed to act promptly upon the grievances concerning issues of resident care voiced by residents at resident council meetings. This affected nine (9) residents who attended the resident council meeting (Residents #7, #24, #49, #72, #74, #76, #80, #85, and #92). The facility census was 94. Findings include: Review of Resident Council Meeting Minutes from 08/13/25 revealed Residents #7, #24, #49, #72, #74, #76, #80, #85, and #92 attended the meeting. Concerns were voiced by unnamed residents regarding not receiving medications timely, staffing, and continuity of care. The page said to see back. However, there was nothing on the back of the form. There were no further specifics given as to what the resident concerns were regarding staffing and continuity of care. There was no evidence of any follow up by the facility to determine specifically what the concerns were. There was no evidence of any action taken by the facility regarding the concerns. Evidence of what the specific concerns were and what action was taken by the facility was requested from the Administrator on 09/16/25 at 3:30 P.M., 09/17/25 at 3:00 P.M., and 09/18/25 at 7:45 A.M. with no response. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number 2623748.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 366199	Facility ID: 366199 If continuation sheet Page 1 of 44

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

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, staff interview, and family interview, the facility failed to notify the resident's representative when there was a significant change in the resident's physical status and when the resident was transferred to the hospital for treatment. This affected one (#32) of 17 sampled residents. The facility census was 94. Findings include: Review of the medical record for Resident #32 revealed an admission date of 07/10/23. The resident was [AGE] years old and had diagnoses including cerebral infarction, glaucoma, vascular dementia, and anxiety disorder. Review of nursing progress notes dated 09/19/25 at 7:45 P.M. revealed Licensed Practical Nurse (LPN) #248 documented Resident #32 was approved to go outside to the courtyard by social service assistant. Resident was noted by staff to be slumped in wheelchair. Staff applied sternal rub with no response noted. Resident was brought into the building and taken to her room. Temperature 107.5 temporal. Ice packs applied to underarms, groin area. Moved placement of bed to air conditioned area. Pulse ox was 88 percent on room air. Oxygen applied via nasal cannula at two liters. After about 125 minutes, resident began to moan and slightly open eyes. Management was present in room. Resident code status is do not resuscitate. Another nursing progress note regarding the incident by LPN #169 on 09/20/25 at 1:57 A.M. stated the nursing assistant informed the nurse that the resident had multiple blistered areas on her arms and legs. Upon assessment, resident had multiple blisters to bilateral forearms and bilateral lower extremities. Areas measured and assessed. Blisters appear to be intact without any drainage. Resident states, they tell me I fell out of my wheelchair but I don't remember doing that. Cleansed areas with normal saline and patted dry. Covered with dressings and wrapped with Kerlix. Med One contacted. Spoke with certified nurse practitioner (this was approximately 12 hours after the incident). New order obtained to cleanse areas with normal saline and pat dry. Cover with dressing and wrap with Kerlix every shift. Review of a nursing progress note dated 09/20/25 at 1:52 P.M. revealed an order was received per Certified Nurse Practitioner (CNP) #202 to send Resident #32 to the emergency room for evaluation. (This was approximately 24 hours after the incident). A nursing progress note dated 09/21/25 at 2:01 A.M. indicated the resident returned to the facility. A nursing progress note dated 09/21/25 at 3:10 A.M. stated the resident was to follow up with a hospital burn unit on 09/24/25. Review of the hospital records revealed Resident #32 arrived on 09/20/25 at 3:46 P.M. The noted stated she arrived via emergency medical services (EMS) for burns on arms and legs due to being out in the sun for an extended period of time at the nursing home she resides in. Patient unable to provide history secondary to her underlying dementia. Per EMS, facility staff called EMS due to concerns for blistering on arms and legs. Per EMS, patient was out in the sun for extended period of time yesterday. Multiple blisters noted to bilateral upper and lower extremities. Notably, a dime size blister on dorsum of left hand. One blister has ruptured with mild serous drainage. The records indicated to see pictures. The differential diagnosis included superficial burn, partial thickness burn, cellulitis. Given multiple blisters, it was discussed with hospital burn team. They recommend local wound care/dressing and outpatient follow up with their burn clinic on 09/24/25. There was no evidence Resident #32's daughter, who was listed in the medical record as an emergency contact, was notified of the resident sustaining burns from being outside in the sun on 09/19/25 or that the resident was transferred to the hospital on [DATE]. Interview with Resident #32's daughter on 09/24/25 at 4:10 P.M. revealed she was not notified of the incident on 09/19/25 or the fact that the resident was transferred to the hospital on [DATE]. She stated the only way she knew about the incident and transfer to the hospital was the hospital contacted her to notify her that they were referring the resident to the burn clinic. Review of the facility policy titled Change in a Resident's Condition or Status which was revised December 2016 revealed, unless otherwise instructed by the resident, a nurse will notify the resident's representative when: There is a significant change in the resident's physical status; It is necessary to transfer the resident to a hospital. Interview with Acting Director of Nursing #303 on 09/24/25 at 2:00 P.M. confirmed there was no evidence Resident #32's daughter was notified of the resident being outside in the sun and sustaining blisters on her arms and legs on 09/19/25 or the fact that she was transferred to the hospital on [DATE]. This deficiency represents noncompliance investigated under Complaint Numbers 2623671, 2623597.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, review of a facility timeline of events, review of hospital records and a physician after visit summary, facility policy review and interview, the facility failed to prevent an incident of neglect involving Resident #32. This resulted in Immediate Jeopardy and Actual Harm beginning on 09/19/25 at 10:30 A.M. when Resident #32, who was identified to have confusion and poor decision making, was left outside the facility in the sun with the air temperature between 82 and 85 degrees Fahrenheit unattended. On 09/19/25 at approximately 1:45 P.M. Resident #32 was found outside the facility unresponsive with a body temperature of 107 degrees (F) and an oxygen saturation level of 88 percent with resulting second degree burns/blisters on her arms and legs. The physician was not notified for approximately 12 hours, and the resident was not transferred to the hospital for evaluation/treatment until approximately 24 hours after the incident. This affected one resident (#32) of 17 sampled residents. The facility census was 94. On 09/25/25 at 10:00 A.M., the Administrator, Acting Director of Nursing #303, Regional Director of Operations #350, [NAME] President of Operations #203, and [NAME] President of Clinical Services #300 were notified Immediate Jeopardy began on 09/19/25 at approximately 10:30 A.M. when Resident #32 was left outside the facility in the sun with air temperatures of 82-85 degrees F until approximately 1:45 P.M. when she was found unresponsive with a body temperature of 107 degrees (F) and an oxygen saturation level of 88 percent with resulting second degree burns/blisters on her arms and legs. The physician was not notified for approximately 12 hours, and the resident was not transferred to the hospital for approximately 24 hours after the incident. The Immediate Jeopardy was removed on 09/29/25 when the facility implemented the following corrective actions: On 09/20/25- Resident #32 was sent to the ER for evaluation and treatment. Resident #32 returned to facility with an order to follow up with the outpatient burn center for 10/03/25. Resident #32 has wound care orders in place to affected areas. Resident #32 was also reeducated on risks factors of prolonged heat and sun exposure. On 09/20/25- The [NAME] President of Clinical Services reviewed the following policies and procedures to ensure they were comprehensive and accurate: Examination and Assessment, Charting and Documentation, Routine Checks, Change in Condition, Heat Related Illness, and Abuse Policy. These policies and procedures were deemed to be comprehensive and accurate, and no changes were made. On 09/20/25 at 5:00 P.M.- The Regional Director of Clinical Services, Regional Director of Operations and the Administrator initiated education for all licensed staff on the following: Examination and Assessment, Charting and Documentation, Routine Checks, Change in Condition, Heat Related Illness, and Abuse Policy. The education was completed on 9/20/25 for 22 Licensed Practical Nurses (LPNs), three (3) Registered Nurses (RN), 35 Certified Nurse Aides (CNAs), four (4) Activity Personnel, seven (7) Dietary Staff, eight (8) Housekeeping/Laundry Staff, one (1) Maintenance Staff, 12 Administrative Staff. All staff did receive the education by 9/20/25. Education was completed via phone and in person. On 09/20/25 at 5:00 P. M.- , the Administrator posted at the Second Floor Courtyard door, First Floor Courtyard door and Smoking Area door, the 7-day forecast of weather conditions with high and low temperatures. At this time, staff were educated by the Administrator to reference the high temperature to the heat-related illness guidance and to educate all residents on risks of outside temperatures that day if they request to go outside. For temperatures of 80 degrees (Fahrenheit) or higher, staff will increase resident safety checks to every 30 minutes. If residents choose to remain outside, they offer additional safety interventions from the facility Excessive Heat policy, which include additional education, ice water, move to shaded areas, etc. On 09/20/25 at 5:03 P.M.- The MDS Nurse reviewed Resident 32's care plan and the care plan was updated to reflect the current resident's condition and needs. On 09/20/25 at 6:00 P.M.-, the Administrator initiated a post-education test on Heat Illness Education for 22 LPNs, three (3) RNs, 35 CNAs, four (4) Activity Personnel, seven (7) Dietary Staff, eight (8) Housekeeping/Laundry Staff, one (1) Maintenance Staff, 12 Administrative Staff. All staff successfully completed the post test. On 09/20/25 at 6:00 P.M.-, the Regional Director of Clinical Services (RDCS) and the ADON initiated head-to-toe assessments on all residents to ensure there were no negative outcomes from heat-related illnesses. The RDCS and the ADON completed these assessments, and no adverse outcomes were noted. On 09/20/25- , the facility Quality Assessment and Performance Improvement (QAPI) Committee, including the Administrator, Regional Director of Clinical Service, SSD, Minimum Data Set (MDS) Nurse, Human Resources (HR), Director of Nursing (DON), activities, Assistant DON (ADON)/LPN , and Medical Director reviewed the deficiencies, the plan of action, the policies and procedures related to Heat Related Illness, Change in Condition and Notification and a root</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, review of controlled substance inventory count sheets, review of pharmacy proof of delivery reports, review of written staff statements, staff interview, resident interview, and policy review, the facility failed to prevent the misappropriation of resident property when a resident's narcotic pain medications were diverted and unaccounted for. This affected one (#51) of three residents reviewed for narcotic pain medications. The facility census was 94. Findings include: Review of the record for Resident #51 revealed an admission date of 06/23/25 and diagnoses including chronic kidney disease, diabetes, congestive heart failure, and bipolar disorder. Review of a minimum data set assessment completed 07/10/25 revealed a brief interview for mental status score of 13, indicating intact cognition. Review of physician's orders revealed on 07/10/25 Oxycodone (a narcotic pain medication) 15 milligrams every six hours as needed for severe pain (6-10 level) was ordered. Review of a written statement dated 09/03/25 from Licensed Practical Nurse (LPN) #169 revealed on 08/29/25 LPN #195 reported that she believed Resident #51 had a full card of Oxycodone during her last shift. However, she stated the resident is currently out of medication. The resident is allowed to take one tablet every six hours as needed. LPN #195 and I reviewed the documentation to determine why the resident was out of medication. We discovered that the pharmacy had delivered 30 tablets of Oxycodone on 08/23/25. The Oxycodone card was signed into the narcotics log during the day shift on 08/23/25 by Registered Nurse (RN) #227 but was never signed out (when empty). So the card of narcotics should be located within the narcotic box in the B-Hall medication cart. While reviewing the narcotic logs for B-Hall, we identified that on 08/28/25, 45 tablets of Alprazolam (used for the treatment of anxiety and panic disorders) were delivered and signed into the narcotics book. RN #227 signed that she received one card of medication and one sheet (administration record). Each narcotic card can hold a maximum of 30 tablets. Therefore, a delivery of 45 tablets should have been documented as two separate cards. However, RN #227 recorded only one card, which is incorrect. This discrepancy should have been identified during the shift change narcotic count between nurses but was not. The only possible explanation is that a card of narcotic medication would have had to be taken from the narcotics box without being signed out. After uncovering this information, LPN #169 texted LPN/Unit Manager #241 requesting the phone number of the Director of Nursing. When a response was not received, LPN #169 followed up with LPN/Unit Manager #241 informing her that narcotics were missing from the B-Hall cart. In that message, she explained that 30 tablets of Oxycodone were delivered 08/23/25. According to the medication administration record, they have only been administered seven times. There should have been approximately 23 tablets remaining. There was no medication remaining. The written statement noted that, to date, she had not received any response from LPN/Unit Manager #241. Review of a written statement dated 08/29/25 from LPN #195 revealed she worked the 7 P.M. to 7 A.M. shift of 08/29/25. During medication pass for bedtime medications, a resident asked the nurse for her as needed oxycodone for pain to help her pain while she slept. (A room number was identified indicating that it was Resident #51). Upon looking in the narcotic book and drawer, there was none to administer. I then questioned why there was none remaining because while working on 08/23/25 or 08/24/25 the pharmacy had delivered a refill. The resident decided to try a muscle relaxer since there were no pain medications available. LPN #195 was unable to find the controlled substance administration record for the Oxycodone. LPN #195 then found two other instances where narcotic cards were not added or deducted properly (to the controlled substance inventory count sheet). One was when one card and one sheet was added for 45 pills and it would have been two cards and two sheets due to the fact that only 30 pills fit on one card. The second nurse messaged the Assistant Director of Nursing about the situation. This nurse made the unit manager aware of what was found during the shift. Interview with Administrator #188 on 09/16/25 at 2:30 P.M. confirmed an allegation of missing narcotics was reported by LPN #169. She was unsure of the date. The facility documented that the Medical Director was notified on 09/03/25 at 2:20 P.M. of an allegation of potentially a card of narcotics missing. The note further stated the Administrator and Corporate were currently investigating. Interview with Regional Nurse #200 on 09/16/25 at 2:35 P.M. revealed the facility investigated the allegations of missing narcotics by LPN #169 and LPN #195. However, they could not determine what happened. She stated that all of the controlled substance administration records for Oxycodone for Resident #51 were missing from 07/10/25 to 08/31/25. (Sheets documenting when the medications were removed from the double locked cart they were secured in). On 09/17/25 at 10:30 A.M. she stated there were also missing controlled substance inventory</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>(continued on next page)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, staff interview, and policy review, the facility failed to ensure a resident was free from chemical restraints which were not required to treat a resident's medical symptoms. This affected one (#32) of 17 sampled residents. The facility census was 94. Findings include: Review of the medical record for Resident #32 revealed an admission date of 07/10/23 and diagnoses including cerebral infarction, glaucoma, anxiety disorder, and vascular dementia. Review of a Minimum Data Set assessment completed 07/07/25 revealed a brief interview for mental status score of 14, indicating intact cognition. The resident required substantial/maximum assistance from staff with transfers. The resident was able to independently wheel her wheelchair 50 feet. The resident had no routine orders for any type of psychoactive medications. Review of nursing progress notes dated 09/21/25 at 2:01 A.M. by Licensed Practical Nurse (LPN) #169 revealed the resident returned from the hospital after being sent on 09/20/25 for multiple blisters on her arms and legs which were noted after she had sat outside in sun. The resident returned by stretcher accompanied by two ambulance service staff. The resident was yelling at the transport staff stating to get me out of here, this is not my daughter's house. Take me outside, I'll walk there. Resident refusing to let facility staff or transport staff touch her or the transport stretcher. When staff approaches, attempts to hit staff. Transport staff informed nurse that resident did not want to leave the hospital and hospital staff told the resident that transport staff was taking her to her daughters house. Multiple attempts were made to redirect and calm resident. All unsuccessful. On call physician contacted and advised to sent to emergency room. While waiting on emergency services to arrive, resident agreed to sit in a chair provided by nurse. After unsuccessfully attempting to transfer self from stretcher to chair, agreed to let nursing assistant help her into chair. 911 cancelled. On call physician notified and gave order for 0.5 milligrams of Haldol (antipsychotic medication) orally for a one time dose and 1 milligram of Ativan (antianxiety) intramuscularly for a one time dose for agitation and aggression if unable to administer oral medications. However, the medications were not given at that time. On 09/21/25 at 2:38 A.M. the resident was resting in chair with eyes closed. Review of nursing progress notes by LPN #166 dated 09/22/25 at 4:27 A.M. (over 24 hours later) revealed Resident #32 pulled the alarm. No fire detected at this time. Called 911 that there is no fire and we do not need them at this time. There was no further documentation regarding the incident. Review of behavior tracking revealed no behaviors documented for Resident #32 on night shift on 09/21/25 or 09/22/25 by LPN #166. Review of the medication administration record (MAR) revealed LPN #166 administered Haldol 0.5 milligrams to Resident #32 dated 09/22/25 at 4:54 A.M. There were no progress notes to indicate why the medication was given. Interview with LPN #166 on 09/24/25 at 5:10 P.M. revealed the dayshift nurse had told her that there was a one time order for Haldol if the resident was combative. She stated that on 09/22/25 she was attempting to do a dressing change for the resident's arms and legs and the resident tried to hit her so she gave her Haldol. Review of the facility policy revised December 2016 and titled Antipsychotic Medication Use revealed antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record: schizophrenia, schizo-affective disorder, schizophreniform disorder, delusional disorder, mood disorders (bi-polar, depression with psychotic features), psychosis in the absence of dementia, medical illness with psychotic symptoms and/or treatment related psychosis or mania (high dose steroids), Tourette's disorder, Huntingtons disease, Hiccups, nausea and vomiting associated with cancer or chemotherapy. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: The behavioral symptoms present a danger to the resident and others and the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations, delusions, paranoia, or grandiosity); or behavioral interventions have been attempted and included in the plan of care. Interview with the Acting Director of Nursing #303 on 09/24/25 at 2:00 P.M. confirmed there was no reason documented for the use of the Haldol on 09/22/25 at 4:54 A.M. except that she had pulled the fire alarm earlier. She stated in order to give the Haldol, there would have had to be an imminent danger to self or others and there was no evidence of that. She confirmed the order had originally been obtained when the resident refused to get off</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, review of self-reported incidents (SRI), and staff interviews, the facility failed to report an allegation of missing narcotics. This affected two (#51, #81) of 17 sampled residents. The facility census was 94. Findings include: Review of the record for Resident #51 revealed an admission date of 06/23/25 and diagnoses including chronic kidney disease, diabetes, congestive heart failure, and bipolar disorder. Review of a minimum data set assessment completed 07/10/25 revealed a brief interview for mental status score of 13, indicating intact cognition. Review of physician's orders revealed on 07/10/25 Oxycodone (a narcotic pain medication) 15 milligrams every six hours as needed for severe pain (6-10 level) was ordered. Review of a written statement dated 09/03/25 from Licensed Practical Nurse (LPN) #169 revealed on 08/29/25 LPN #195 reported that she believed Resident #51 had a full card of Oxycodone during her last shift. However, she stated the resident is currently out of medication. The resident is allowed to take one tablet every six hours as needed. LPN #195 and I reviewed the documentation to determine why the resident was out of medication. We discovered that the pharmacy had delivered 30 tablets of Oxycodone on 08/23/25. The Oxycodone card was signed into the narcotics log during the day shift on 08/23/25 by Registered Nurse (RN) #227 but was never signed out (when empty). So the card of narcotics should be located within the narcotic box in the B-Hall medication cart. While reviewing the narcotic logs for B-Hall, we identified that on 08/28/25, 45 tablets of Alprazolam (used for the treatment of anxiety and panic disorders) were delivered and signed into the narcotics book. RN #227 signed that she received one card of medication and one sheet (administration record). Each narcotic card can hold a maximum of 30 tablets. Therefore, a delivery of 45 tablets should have been documented as two separate cards. However, RN #227 recorded only one card, which is incorrect. This discrepancy should have been identified during the shift change narcotic count between nurses but was not. The only possible explanation is that a card of narcotic medication would have had to be taken from the narcotics box without being signed out. After uncovering this information, LPN #169 texted LPN/Unit Manager #241 requesting the phone number of the Director of Nursing. When a response was not received, LPN #169 followed up with LPN/Unit Manager #241 informing her that narcotics were missing from the B-Hall cart. In that message, she explained that 30 tablets of Oxycodone were delivered 08/23/25. According to the medication administration record, they have only been administered seven times. There should have been approximately 23 tablets remained. There was no medication remaining. The written statement noted that, to date, she had not received any response from LPN/Unit Manager #241. Review of a written statement dated 08/29/25 from LPN #195 revealed she worked the 7 P.M. to 7 A.M. shift of 08/29/25. During medication pass for bedtime medications, a resident asked the nurse for her as needed oxycodone for pain to help her pain while she slept. (A room number was identified indicating that it was Resident #51). Upon looking in the narcotic book and drawer, there was none to administer. I then questioned why there was none remaining because while working on 08/23/25 or 08/24/25 the pharmacy had delivered a refill. The resident decided to try a muscle relaxer since there were no pain medications available. LPN #195 was unable to find the controlled substance administration record for the Oxycodone. LPN #195 then found two other instances where narcotic cards were not added or deducted properly (to the controlled substance inventory count sheet). One was when one card and one sheet was added for 45 pills and it would have been two cards and two sheets due to the fact that only 30 pills fit on one card. The second nurse messaged the Assistant Director of Nursing about the situation. This nurse made the unit manager aware of what was found during the shift. Interview with Administrator #188 on 09/16/25 at 2:30 P.M. confirmed an allegation of missing narcotics was reported by LPN #169. She was unsure of the date. The facility documented that the Medical Director was notified on 09/03/25 at 2:20 P.M. of an allegation of potentially a card of narcotics missing. The note further stated the Administrator and Corporate were currently investigating. Interview with Regional Nurse #200 on 09/16/25 at 2:35 P.M. revealed the facility investigated the allegations of missing narcotics by LPN #169 and LPN #195. However, they could not determine what happened. She stated that all of the controlled substance administration records for Oxycodone for Resident #51 were missing from 07/10/25 to 08/31/25. (Sheets documenting when the medications were removed from the double locked cart they were secured in). On 09/17/25 at 10:30 A.M. she stated there were also missing controlled substance inventory count sheets (sheets used to keep track of narcotic count sheets coming in when delivered and going out when empty). She stated that with the missing records, they could not figure out the amount of Oxycodone missing for Resident #51. Interview with</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, staff interviews, policy review, and observation, the facility failed to ensure that residents on the locked unit were protected during the course of an investigation into resident to resident abuse. This affected one (#14) of three residents reviewed for abuse. The facility also failed to thoroughly investigate an allegation of missing narcotics. This affected two (#51, #81) of three residents reviewed for narcotic use. The facility census was 94. Findings include: 1. Review of the record for Resident #51 revealed an admission date of 06/23/25 and diagnoses including chronic kidney disease, diabetes, congestive heart failure, and bipolar disorder. Review of a minimum data set assessment completed 07/10/25 revealed a brief interview for mental status score of 13, indicating intact cognition.</p> <p>Review of physician's orders revealed on 07/10/25 Oxycodone (a narcotic pain medication) 15 milligrams every six hours as needed for severe pain (6-10 level) was ordered.</p> <p>Review of a written statement dated 09/03/25 from Licensed Practical Nurse (LPN) #169 revealed on 08/29/25 LPN #195 reported that she believed Resident #51 had a full card of Oxycodone during her last shift. However, she stated the resident is currently out of medication. The resident is allowed to take one tablet every six hours as needed. LPN #195 and I reviewed the documentation to determine why the resident was out of medication. We discovered that the pharmacy had delivered 30 tablets of Oxycodone on 08/23/25. The Oxycodone card was signed into the narcotics log during the day shift on 08/23/25 by Registered Nurse (RN) #227 but was never signed out (when empty). So the card of narcotics should be located within the narcotic box in the B-Hall medication cart. While reviewing the narcotic logs for B-Hall, we identified that on 08/28/25, 45 tablets of Alprazolam (used for the treatment of anxiety and panic disorders) were delivered and signed into the narcotics book. RN #227 signed that she received one card of medication and one sheet (administration record). Each narcotic card can hold a maximum of 30 tablets. Therefore, a delivery of 45 tablets should have been documented as two separate cards. However, RN #227 recorded only one card, which is incorrect. This discrepancy should have been identified during the shift change narcotic count between nurses but was not. The only possible explanation is that a card of narcotic medication would have had to be taken from the narcotics box without being signed out. After uncovering this information, LPN #169 texted LPN/Unit Manager #241 requesting the phone number of the Director of Nursing. When a response was not received, LPN #169 followed up with LPN/Unit Manager #241 informing her that narcotics were missing from the B-Hall cart. In that message, she explained that 30 tablets of Oxycodone were delivered 08/23/25. According to the medication administration record, they have only been administered seven times. There should have been approximately 23 tablets remained. There was no medication remaining. The written statement noted that, to date, she had not received any response from LPN/Unit Manager #241.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a written statement dated 08/29/25 from LPN #195 revealed she worked the 7 P.M. to 7 A.M. shift of 08/29/25. During medication pass for bedtime medications, a resident asked the nurse for her as needed oxycodone for pain to help her pain while she slept. (A room number was identified indicating that it was Resident #51). Upon looking in the narcotic book and drawer, there was none to administer. I then questioned why there was none remaining because while working on 08/23/25 or 08/24/25 the pharmacy had delivered a refill. The resident decided to try a muscle relaxer since there were no pain medications available. LPN #195 was unable to find the controlled substance administration record for the Oxycodone. LPN #195 then found two other instances where narcotic cards were not added or deducted properly (to the controlled substance inventory count sheet). One was when one card and one sheet was added for 45 pills and it would have been two cards and two sheets due to the fact that only 30 pills fit on one card. The second nurse messaged the Assistant Director of Nursing about the situation. This nurse made the unit manager aware of what was found during the shift.</p> <p>Interview with Administrator #188 on 09/16/25 at 2:30 P.M. confirmed an allegation of missing narcotics was reported by LPN #169. She was unsure of the date.</p> <p>The facility documented that the Medical Director was notified on 09/03/25 at 2:20 P.M. of an allegation of potentially a card of narcotics missing. The note further stated the Administrator and Corporate were currently investigating.</p> <p>Interview with Regional Nurse #200 on 09/16/25 at 2:35 P.M. revealed the facility investigated the allegations of missing narcotics by LPN #169 and LPN #195. However, they could not determine what happened. She stated that all of the controlled substance administration records for Oxycodone for Resident #51 were missing from 07/10/25 to 08/31/25. (sheets documenting when the medications were removed from the double locked cart they were secured in). On 09/17/25 at 10:30 A.M. she stated there were also missing controlled substance inventory count sheets (sheets used to keep track of narcotic count sheets coming in when delivered and going out when empty). She stated that with the missing records, they could not figure out the amount of Oxycodone missing for Resident #51.</p> <p>Interview with LPN/Unit Manager #175 on 09/17/25 at 9:30 A.M. revealed two nurses were supposed to sign in/sign out controlled substance administration records on the controlled substance inventory count sheet and were not.</p> <p>Interview with LPN #169 on 09/16/25 at 2:55 P.M. revealed LPN #195 first noticed a card containing Oxycodone missing for Resident #51. She stated the resident should have had Oxycodone left since only seven of 30 had been given. She stated the whole card, which should have had 23 pills, was missing from the locked cart. She confirmed she texted LPN/Unit Manager #241 regarding the situation with no response. She confirmed that Resident #81 should have had two sheets of Alprazolam signed in and only had one sheet signed in. She stated that RN #227 messes with the numbers of count sheets coming in.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #195 on 09/17/25 at 6:10 A.M. revealed she had noted missing Oxycodone narcotics for Resident #51. She stated LPN #169 reported it and she provided a written statement. She stated no one from management talked with her and only asked for written statement. She confirmed a full card of Oxycodone had been delivered for Resident #51 and then was missing within a week. She stated she was unable to find the card with the medications or the sheet used to sign out the medications. She stated the sheet had not been signed out on the inventory log as empty. She confirmed that Resident #81 had 45 Alprazolam delivered. She stated that two sheets should have been signed in when delivered. However, RN #227 signed in only one sheet. She confirmed the controlled substance administration records for Resident #51 were missing. She stated that Resident #51 had asked for a pain pill last evening (09/16/25) after she came on duty at 7:00 P.M She stated when she went to get one for the resident, RN #227 had documented that she had just given her one at 6:27 P.M She stated the resident said she did not receive one at that time. She was unable to give the resident any pain medication at that time.</p> <p>Interview with LPN #194 on 09/17/25 at 6:25 A.M. revealed she won't work on B-Hall because narcotics are missing all the time. She stated RN #227 works that hall all the time. She stated narcotics were reported missing for another resident back in June 2025.</p> <p>Interview with Resident #51 on 09/17/25 at 8:15 A.M. revealed she did not take any pain medication the day before. She stated she asked the nurse for a pain pill last evening and the nurse told her she had taken one at 6:45 P.M. She stated she did not take any pain medication at that time and that RN #227 stole it. She stated when she asked for the pain medication the evening of 09/16/25, she had a pain level of 8 in her abdomen. She stated that when she takes her pain medication, is usually takes the pain level to 0. She stated not getting the pain medication made her anxious and she couldn't sleep. She just had to suffer until she finally went to sleep.</p> <p>Review of the administration record for Resident #51 revealed RN #227 documented she gave Resident #51 Oxycodone on 09/16/25 at 11:59 A.M. and 6:27 P.M.</p> <p>Review of pharmacy proof of delivery reports revealed the pharmacy delivered 30 tablets of Oxycodone 15 milligrams to the facility for Resident #51 on 07/10/25, 07/18/25, 07/27/25, 08/02/25, 08/09/25, and 08/15/25 for a total of 180 tablets. Review of medication administration records for Resident #51 from 07/10/25 to 08/23/25 revealed she was given 78 tablets of Oxycodone 15 milligrams. She should have had 102 tablets left on 08/23/25. On 08/23/25 30 more tablets were delivered from the pharmacy. The total should have been 132. Review of the medication administration record for 08/24/25 to 08/29/25 revealed she was given seven tablets. Therefore, when LPN #195 noted on 08/29/25 that there was no Oxycodone available, she should have had 125 tablets left.</p> <p>In addition, review of the controlled medication shift change log revealed that on 08/28/25, RN #227 signed in one card and one sheet of Alprazolam for Resident #81. She documented that 45 pills were delivered. Review of the controlled substance administration records for Resident #81 revealed on 08/28/25, two sheets and two cards were delivered (one with 30 pills and one with 15 pills). Both sheets and both cards were placed into the narcotic counts. By only signing in one sheet and one card, you would be able to take out a card and sheet belonging to someone else without the count being off.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Regional Nurse #200 on 09/17/25 at 10:30 A.M. and 10:50 A.M. revealed the initial allegation was made on 09/03/25. She confirmed there were Oxycodone sent for Resident #51 that are not accounted for from the documentation. She confirmed the facility did not have a summary or conclusion of their investigation into the allegation of missing narcotics for Resident #51. She stated that since the allegation focused on RN #227, she was drug tested. (Test negative on 09/06/25). She confirmed the facility did not investigate the allegation regarding the Alprazolam being signed in inappropriately for Resident #81. She confirmed that RN #227 only signed in one sheet and one card of Alprazolam for Resident #81 on 08/28/25. She confirmed it should have been two sheets and two cards. She confirmed that it was around that time when Resident #51's card of oxycodone was missing (08/29/25 per staff statements). She confirmed Resident #51 did not receive any Oxycodone from 08/28/25 to 08/31/25, when more were sent on 08/31/25. She stated that education was done with nursing on the day she was aware of the allegation (09/03/25) after it was determined what a mess it was. She stated that the pharmacy was notified 09/03/25 but was not involved in doing any investigation into missing narcotics. She stated she was notified last night that Resident #51 stated she did not receive a pain pill. She stated that the unit manager had called RN #227 to verify that she gave the medication. She stated she was not aware that Resident #51 had stated that RN #227 was stealing her medications.</p> <p>Interview with LPN/Unit Manager #175 on 09/17/25 at 1:30 P.M. confirmed Resident #81 had two count sheets for Alprazolam on 08/28/25 when RN #227 only signed one into the count. She stated this would make the count wrong unless a card and sheet were removed by someone.</p> <p>RN #227 was observed working in the facility on B-Hall on 09/16/25 and 09/17/25 on day shift.</p> <p>Review of the facility policy last revised 10/27/17 and titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property revealed the facility will not tolerate abuse, neglect, exploitation of its residents or the misappropriation of resident property. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy further stated that once the administrator and State survey agency are notified, an investigation of the allegation violation will be conducted. The investigation must be completed within five working days, unless there are special circumstances. Evidence of the investigation should be documented. After completion of the investigation, all of the evidence should be analyzed and the administrator will make a determination regarding whether the allegation or suspicion is substantiated.</p> <p>2. Review of the medical record for Resident #14 revealed an admission date of 02/17/25 with diagnoses that included anoxic brain damage, dementia, bipolar disorder, major depressive disorder, hepatitis C, edema, post-traumatic stress disorder (PTSD), attention deficit disorder, opioid use, anxiety disorder, iron deficiency anemia, vitamin deficiency, female pelvic inflammatory disease, psychoactive substance abuse, insomnia, dementia, and nightmare disorder.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #14 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. No physical behaviors were noted, but verbal behaviors, wandering, and other behaviors such as hitting or scratching occurred 1&ndash;3 days per week. She required setup for eating and oral hygiene, supervision for most daily activities and transfers, maximal help for showering, and could walk up to 150 feet with supervision.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan for Resident #14 revealed the care plan, initiated 02/18/25 and revised through 09/15/25, addressed Resident #14's history of sexually inappropriate behavior. The guardian permitted one partner but not multiple partners. Staff provided safe-sex education on 04/01/25. Incidents included pulling pant legs up for a male resident on 04/07/25 and repeated sexual talk with a roommate on 09/15/25. Goals included preventing inappropriate sexual behaviors through the next review. Interventions were to administer prescribed medications, involve behavioral health as needed, monitor for wandering, provide safe-practice education, and immediately remove Resident #14 and notify the administrator if inappropriate behavior occurred, using 1:1 supervision when necessary.</p> <p>Review of Resident #14's orders revealed safety checks every 15 minutes starting 09/23/25 and ongoing behavior assessments each shift. Current medications included Prazosin 1 mg at bedtime for PTSD (started 09/16/25), Sertraline 25 mg for bipolar disorder (09/17/25), Ativan 0.5 mg at bedtime for anxiety (08/27/25), Zyprexa 5 mg for bipolar disorder (07/11/25), Depakote 500 mg for bipolar disorder (06/28/25), Cimetidine 200 mg every morning and bedtime for sexual behaviors (from 06/08/25, previously 200 mg twice daily from 02/17/25&ndash;06/08/25), and Errin 0.35 mg daily for birth control (02/18/25).</p> <p>Review of the progress notes for Resident #14 revealed no mention of the sexual abuse between Resident #14 and another resident that occurred on 09/19/25, with the only indication being a late note submitted on 09/24/25 from social services at 1:00 P.M. after surveyor intervention. The note stated, SSD and UM completed a psychosocial wellness visit with Resident #14. Resident #14 was resting comfortably in her room watching television. Resident #14 denied any sexual encounter with another male resident. Resident #14 stated she was trying to help a male resident put his shirt on. Resident #14's mood was stable at this time. SSD and UM educated Resident #14 on not going into male resident rooms and to get staff if someone requested help. Resident #14 had no issues or concerns at this time. In addition, there was a general note dated 09/22/25 at 5:49 A.M. that stated Resident #14 remained on 1:1 supervision during that shift.</p> <p>Review of the medical record for Resident #50 revealed an admission date of 12/05/24 with diagnoses that included spastic hemiplegia affecting the left side, dementia, seizures, hypothyroidism, hyperlipidemia, hypertension, ischemic cardiomyopathy, hyperplasia without lower urinary tract symptoms, adult failure to thrive, anxiety, mood disorder, major depressive disorder, contracture, and paraphilia.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #50 revealed a BIMS score of 05, indicating severe cognitive impairment. Physical and verbal behaviors occurred 1&ndash;3 days per week. Resident #50 had one-sided limb impairment, used a wheelchair, required supervision for eating, was dependent for all other daily activities, required maximal help for bed mobility and transfers, and could not walk more than 10 feet.</p> <p>Review of the progress notes for Resident #50 revealed no mention of the sexual abuse that occurred between Resident #14 and himself.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/24/25 at 9:00 A.M. with Certified Nursing Assistant (CNA) #167 revealed that she observed Resident #14 standing next to Resident #50's bed touching him inappropriately. Resident #14 stated she was putting his shirt on while touching his penis. CNA #167 notified the nurses, wrote a report, and the Assistant Director of Nursing (ADON) and management were informed. She estimated the incident occurred Thursday or Friday around 10&ndash;11 A.M. but could not recall the exact date and time. She stated Resident #14 was placed on 1:1 supervision for a few hours, then on 15-minute checks. She was unaware of any other incidents between the residents and noted no preventive measures had been in place prior to the incident occurring. CNA #167 stated she did not know how long Resident #14 was in Resident #50's room and only witnessed the ending of what had occurred in the room.</p> <p>Interview on 09/25/25 at 12:16 P.M. with CNA #204 revealed that the sexual abuse incident between Resident #14 and Resident #50 had already occurred prior to her shifts. She stated that she did not fill out the 1:1 paperwork herself and that Scheduling Coordinator #150 had completed the initial documentation. CNA #204 confirmed she completed her assigned 1:1 supervision on her shifts but did not personally document initials.</p> <p>Interview on 09/25/25 at 12:23 P.M. with CNA #191 revealed that Scheduling Coordinator #150 had completed the 1:1 paperwork on his behalf. He reported that he did not personally complete all assigned 1:1s. He stated that on Friday night no 1:1s occurred and on Saturday night there was a two-hour gap from midnight to 2:00 A.M. during which no 1:1 supervision was provided. He indicated that day shift staff had no paperwork for him to begin documentation.</p> <p>Review of the 1:1 initialed check sheet revealed that all initials were present, including during the reported gaps when no 1:1s occurred. The initials for both CNA #204 and CNA #191 were present, even though each confirmed they did not complete any 1:1 documentation during their shifts, resulting in gaps in protection for other residents on the locked unit.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2623748, Complaint Numbers 2615387, 2608772, 2608729.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on record review, staff interview, and resident interview, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. This affected one (#51) of three residents reviewed for showers/bathing. The facility census was 94. Findings include: Review of the medical record for Resident #51 revealed an admission date of 06/23/25 and diagnoses including Bipolar disorder, diabetes, chronic kidney disease, and congestive heart failure. Review of the Minimum Data Set assessment completed 07/10/25 revealed a brief interview for mental status (BIMS) score of 13, indicating intact cognition. It further indicated the resident was always incontinent of bowel and bladder, was dependent for toileting, and required substantial/maximal assistance with bathing. Interview with Resident #51 on 09/16/25 at 1:05 P.M. revealed she normally only gets one shower per week and that is when she asks for it. She stated she would prefer two per week. Review of shower sheets for the past month revealed Resident #51 received showers on 08/01/25, 08/12/25, 08/19/25, 08/20/25, 09/05/25, and 09/10/25. Interview with Regional Nurse #200 on 09/22/25 at 9:20 A.M. revealed Resident #51 had not been placed on the shower schedule. Therefore, she was not being provided/offered showers twice weekly as she should be. She confirmed the resident had only received six showers since 08/01/25. This deficiency represents noncompliance investigated under Complaint Number 2596564.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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 10/15/2025
NAME OF PROVIDER OR SUPPLIER Country Lane Gardens Rehab & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 7820 Pleasantville Road Pleasantville, OH 43148	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, death certificate review, facility policy and procedure review, facility assessment review, and interview, the facility failed to timely identify and provide comprehensive, resident centered interventions following an acute change in condition for Resident #95. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on 06/27/25 when Resident #95, who had severe cognitive impairment and required staff assistance with activities of daily living (ADL) was noted by staff to have an acute change in medical condition which included dusky colored hands and feet, limited food and fluid intake, lethargy, and the need for supplemental oxygen. There was no additional assessment of the resident's condition at that time or intervention provided. On 06/29/25 at 8:30 P. M. (two days later) Licensed Practical Nurse (LPN) #194 notified Resident #95's physician of this change in condition (lethargy, lying in bed in the fetal position, dusky skin color with poor skin turgor) and the resident was transferred by emergency medical transport to the emergency room where she was admitted to the hospital with a diagnosis of severe dehydration (with thin, frail skin, muscle/fat wasting, and poor skin turgor) and acute kidney injury. Hospital records identified the resident was estimated to have a 3.8-to-4-liter free water deficit. The resident was subsequently admitted to a hospice facility on 06/30/25 and passed away on 07/02/25. This affected one resident (#95) of three residents reviewed for change in condition. The facility census was 94. On 09/26/25 at 10:00 A.M. the Administrator, Regional Director of Operations #350, [NAME] President of Clinical Operations #203 and Acting Director of Nursing (DON) #303 were notified Immediate Jeopardy began on 06/27/25 when Certified Nursing Assistant (CNA) #204 identified a change in condition for Resident #95 and verbally notified Licensed Practical Nurse (LPN) #198, without evidence the LPN or other licensed staff completed a timely assessment of the resident's condition and/or implemented/obtained necessary intervention/medical treatment. Resident #95 remained in the facility until 06/29/25 at approximately 8:30 P.M. when LPN #194 notified the resident's medical provider, called 911, and the resident was transferred to the emergency room and subsequently admitted to the hospital with diagnoses including severe dehydration and acute kidney injury. Resident #95's status did not improve, and the resident was transferred from the hospital to a hospice facility on 06/30/25 and expired on 07/02/25. The Immediate Jeopardy was removed on 09/20/25 when the facility implemented the following actions: On 06/29/25 Resident #95 was transferred to the hospital and did not return to the facility. The resident expired on 07/02/25. On 09/20/25, an audit was completed by DON/ Designee on all 44 residents who went out to the hospital between 06/29/25 and 9/20/25 to determine if any changes in resident conditions went unreported. On 09/20/25 the [NAME] President of Clinical Operations #203 reviewed the following policies and procedures to ensure they were comprehensive and accurate: Examination and Assessment, Charting and Documentation, Routine Checks, Change in Condition, and Abuse. On 09/20/25 at 5:00 P.M. the Regional Director of Clinical Services #201, Regional Director of Operations (RDO) #350 and Administrator initiated education for all licensed staff on Examination and Assessment, Charting and Documentation, Routine Checks, Change in Condition, and Abuse Policy. Education was completed on 09/20/25 for 22 Licensed Practical Nurses (LPNs), three (3) Registered Nurses (RN), 35 Certified Nurse Aides (CNAs), four (4) Activity Personnel, seven (7) Dietary Staff, eight (8) Housekeeping/Laundry Staff, one (1) Maintenance Staff, 12 Administrative Staff. All staff were educated on 9/20/25. On 09/20/25, the DON/Designee provided education for nursing staff on the POC alert function in Point Click Care (PCC) charting to identify potential condition changes and how alerts generate on the alert panel on PCC dashboard. Education was completed on 09/20/25 for 22 Licensed Practical Nurses (LPNs), 3 Registered Nurses (RNs) and 35 Certified Nurse Aides (CNAs). This was provided in person and via phone before staff were allowed to work. Education included how alerts appear on the dashboard and are reviewed daily in morning clinical meetings. If reported changes were not addressed by the nurse, they were to report it to the DON. Education also included ongoing changes in conditions would be reported to the DON. On 09/20/25, the DON/Designee educated in person and via phone 22 Licensed Practical Nurses (LPNs) and 3 Registered Nurses (RNs) on the Change in Condition policy, which included when a change of condition was reported, new orders were obtained, entered in PCC/implemented, which would include appropriate monitoring, including oxygen therapy needs. Ongoing compliance would include new nurses in orientation upon hire. On 09/20/25 the Quality Assessment and Performance Improvement (QAPI) Committee, including the Administrator, Regional Director of Clinical</p>		

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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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)		

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F 0687 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, clinic note review, hospital record review and interview the facility failed to ensure Resident #79 was provided adequate and necessary comprehensive, resident centered care following a vascular procedure for arterial stenosis to prevent complications. Actual Harm occurred on 09/02/25 when Resident #79 was diagnosed with osteomyelitis (infection of the bone) of the left foot after the facility failed to administer physician ordered medication following a vascular procedure (on 05/23/25) to maintain patency of the stent placed and failed to arrange transportation to follow up appointments with the vascular surgeon from 07/02/25 to 09/02/25, resulting in the resident developing infected arterial wounds that required emergent transport to the hospital for evaluation and treatment of osteomyelitis with intravenous antibiotics administered through a peripherally inserted central catheter. This affected one (#79) resident of 17 residents reviewed for care. Findings include: Review of the medical record for Resident #79 revealed an admission date of 06/15/24 with diagnoses including diabetes, peripheral vascular disease, dementia, chronic kidney disease, hypertension, and atrial fibrillation. Review of the plan of care initiated on 05/01/25 revealed the resident had an arterial/ischemic ulcer to the left lateral foot with interventions including monitoring the wound and circulation of the foot. Review of a vascular office clinic note by the vascular surgeon on 05/02/25 revealed he had called the resident's daughter to discuss the results of a bilateral lower extremity arterial duplex and ankle-brachial index (ABI) testing which showed moderate disease. (ABI testing assesses the blood flow in the legs and detects artery disease, a condition where arteries in the legs become narrowed and blocked). The resident had stenosis of the left anterior tibial artery and nonvisualization of the tibials on the right. A right lower extremity angiogram with possible intervention was offered and the power of attorney was in agreement to proceed. The surgeon also contacted the facility and spoke with the wound nurse who reported the resident's right heel wound was not healing but the wounds on the right toes were. The resident would continue taking his Aspirin (81 milligrams (mg) daily). Review of a nursing progress note dated 05/23/25 at 7:40 A.M. revealed the resident was picked up by transport for the angiogram procedure. Further review of the nursing progress note dated 05/23/25 at 6:43 P.M. revealed the resident returned from the hospital, transferred from cot back into bed. There was no mention of the resident's discharge/post-procedure orders. Review of the Patient Discharge Summary and Instructions dated 05/23/25 revealed the resident was to receive medications including Plavix 75 mg every day and Aspirin 81mg. The discharge instructions also directed the resident to keep all follow-up appointments. This is important. Review of the medical record revealed the resident had not received Aspirin since 11/14/24 and the Plavix was never administered after ordered on 05/23/25. Review of additional care plan documentation revealed arterial/ischemic ulcer to the right heel, right lateral foot initiated 06/25/25, an arterial/ischemic ulcer to the right third and fourth toes initiated 09/04/25 with interventions including to inspect the feet daily, keep the feet clean and dry, monitor/document the wound, monitor/document signs/symptoms of infection. There was no care plan related to the resident's angiogram, post operative care, follow-up appointments or transportation needs required for appointments. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 (out of 15), indicating the resident had moderately impaired cognition. The assessment also revealed the resident required assistance of one to two staff with activities of daily living. Review of a consultant wound care note dated 09/02/25 revealed Resident #79 was being followed for multiple arterial wounds to his bilateral feet that appeared to decline quickly. The wound locations were identified as Wound #1 located on the right foot, third digit measuring 0.7 centimeters (cm) by (x) 0.7 cm with the wound bed 50% slough (stringy tissue) and 50% exposed bone with a moderate amount of thick, white, purulent drainage (this wound was slightly larger in size than the week prior). Wound #2 was the right lateral foot measuring 2.0 cm x 2.2 cm with the wound base 10% granulation tissue (new tissue) and 90% necrotic tissue (black, dead tissue) with a moderate amount of serosanguinous (bloody) drainage (this wound was concerning to the wound team and represented an infected wound); Wound #3 right foot 4th digit measuring 0.5 cm x 0.5 cm with 100% slough and a moderate amount of thick, white, purulent drainage; Wound #4 left foot, third toe, dorsal measuring 0.9 x 1.0 cm covered completely by a scab and no drainage. This wound was unchanged; Wound #5 was located at the left lateral foot and measured 2.1 cm x 1.7 cm with the wound bed covered with 80% granulation and 20% slough with a moderate amount of serosanguinous (thin, watery blood) (this wound was identified to be improving) drainage. The assessment</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, hospital record review, interview and policy review the facility failed to provide a comprehensive, resident centered plan of care to prevent, timely identify, and treat weight loss and dehydration. This resulted in actual harm on 06/29/25 when Resident #95, who was identified at nutritional risk, was cognitively impaired and required staff assistance with activities of daily living (ADLs), was assessed by hospital staff to exhibit possible severe malnutrition and severe dehydration with a weight of 77 pounds. The most recent facility weight, documented on 06/25/25 was recorded to be 91 pounds. The facility failed to ensure effective, appropriate and sustainable interventions were in place to prevent the significant weight loss and severe dehydration resulting in hospitalization. This affected one resident (#95) of three residents reviewed for change in condition. An additional example that did not rise to the level of actual harm resulted when the facility failed to ensure dietician follow up after a significant weight loss for a resident. This affected one (#65) of three residents reviewed. The facility census was 94. Findings include: 1. Review of Resident #95's closed medical record revealed an admission date of 05/30/25 with diagnoses including Alzheimer's disease, osteoarthritis, osteoporosis, cannabis use, nicotine dependence, and dementia severe with agitation. Resident #95 was admitted to the facility after a hospital stay for treatment of agitation and combativeness.</p> <p>Review of Resident #95's physician's orders revealed an order dated 05/30/25 for weekly weights for four weeks and then monthly. A physician's order dated 06/02/25 revealed the resident received a regular diet with thin liquids and requested a full code status (the resident wished to receive all possible life-saving measures in the event of a cardiac or respiratory arrest).</p> <p>Review of Resident #95's medical record revealed on 05/30/25 the resident weighed 98 pounds on admission to the facility and on 06/02/25 the resident weighed 92.6 pounds.</p> <p>Review of Certified Nurse Practitioner (CNP) #202 progress note on 06/02/25 at 10:50 A.M. revealed the resident was in no acute distress, the CNP confirmed the resident's advanced directive with the family on 06/02/25. There was no mention of the resident's weight loss since admission.</p> <p>Review of the History and Physician dated 06/03/25 at 12:00 A.M. and written by Medical Director #301 did not indicate the resident had experienced a significant weight loss since admission.</p> <p>Review of Resident #95's medical record revealed a nutrition assessment dated [DATE] at 10:06 A.M. indicating the resident had lost 5.4 pounds in a week, a significant weight loss of 5.8%, related to poor appetite. Registered Dietician #302 recommended the addition of 240 milliliters of the house supplement three times daily. The resident was also assessed to have estimated nutritional need of 1263-1473 calories per day and an estimated fluid need of one milliliter (ml) of fluid per calorie a day (1263-1473 ml of fluid per day). However, please note, the resident's meal intake records only included fluids consumed but did not specify how much actual fluid was consumed during meals.</p> <p>Review of Resident #95's physicians orders revealed an order dated 06/04/25 for house supplement 240 milliliters three times daily. Please note, there was no evidence of the resident receiving the nutritional supplement, consumption or acceptance of the ordered nutritional supplement contained within the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's meal tickets revealed the house supplement (nutritional shake for weight loss) was to be provided by dietary staff on the resident's meal trays.</p> <p>Review of Resident #95's care plan revealed a nutrition care plan initiated on 06/03/25 for a nutritional problem or potential nutritional problem related to a borderline low body mass index (BMI), dementia, osteoporosis, cannabis use, poor appetite, weight loss in the facility and the need for an oral nutritional supplement. The goal was for Resident #95 to maintain adequate nutritional status as evidenced by her maintaining her weight without significant weight changes, having no signs or symptoms of malnutrition and consuming at least 50% of her meals daily through the next review date. Interventions for Resident #95 were to administer medications as ordered and monitor for and document side effects and effectiveness of the medications, provide and serve the resident's diet as ordered, monitor the resident's food and fluid intake and record the intake for every meal and the registered dietician was to evaluate the resident and make diet change recommendations as needed. Record review revealed there were no additional interventions added to the nutrition care plan after the care plan was created.</p> <p>Further review of the resident's care plan revealed the facility had not developed a plan of care related to hydration or a risk for dehydration or related to the resident's physical ability to consume food/liquids. There was no plan of care in place to reflect the resident needed/required staff assistance for eating/fluid consumption as it pertained to her cognitive status, identified poor appetite and weight loss.</p> <p>Review of Resident #95's admission Minimum Data Set (MDS) assessment, dated 06/06/25, revealed a Brief Interview for Mental Status (BIMS) score of 03 (out of a possible score of 15) indicating the resident had impaired cognition. The assessment revealed the resident required setup/cleanup assistance with eating, supervision with bed mobility, transfers and walking and substantial/maximal assistance with toileting hygiene. The MDS indicated Resident #95 was frequently incontinent of bladder and always incontinent of bowel. No weight loss or skin alterations were identified during the assessment.</p> <p>Review of the resident's meal percentages for breakfast, lunch and dinner from 06/06/26 through 06/23/25 revealed the resident's meal (food and fluid) intake varied from day to day and meal to meal. There was no documentation to support the resident was offered different foods or selections when she did not eat what was offered and no documentation the resident received the ordered nutritional supplement or accepted any amount of the supplement.</p> <p>Review of Resident #95's medical record revealed a weight on 06/09/25 of 92 pounds, an additional weight loss of 0.6 pounds since 06/02/25.</p> <p>Review of Resident #95's progress note dated 06/10/25 at 11:22 A.M. revealed a nutrition note written by Registered Dietician (RD) #302 revealed the resident had not had any significant changes in weight since the dietician's previous assessment and her weight had been stable for one week. Further review of the progress note revealed RD #302 stated Resident #95 was on appropriate nutrition and the RD had no new recommendations at the time of the note and would monitor the resident as needed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #95's progress note written by CNP #202 dated 06/11/25 at 12:00 A.M. revealed a follow up on the resident's mood disorder, dementia and insomnia. CNP #202 noted the staff had no new concerns with Resident #95. The progress note did not include mention of the resident's weight loss identified since admission to the facility. (A significant weight loss since admission to the facility from 98 pounds to 92 pounds).</p> <p>Review of Resident #95's medical record revealed no documentation of a weight for Resident #95 the week of 06/14/25 and no documentation of a weight the week of 06/21/25.</p> <p>Review of Resident #95's medical record revealed a weight on 06/25/25 of 91 pounds (an additional weight loss of one pound from 06/09/25). Record review revealed no evidence the cause of the weight loss was identified, the resident's nutritional intake was reviewed and/or evidence new interventions were implemented at this time to address the resident's nutrition/hydration status. There was no documentation the RD was notified the resident had experienced additional weight loss.</p> <p>Review of the resident's meal intake records (which included fluid intakes during the meal but was not isolated from food consumed and calculated in with the meal percentage) from 06/24/25 through 06/29/25 revealed the following:</p> <p>On 06/24/25 the resident had no intake (food or fluid) for breakfast, lunch or dinner with one staff member assisting with each meal.</p> <p>On 06/25/25 the resident had no intake for breakfast with one staff member assisting, up to 25% of the lunch meal with one staff member assisting and 75-100% of the dinner meal with only set up help from one staff.</p> <p>On 06/26/25 the resident had no intake for breakfast or lunch with set up help from staff and there was no documentation for the dinner meal.</p> <p>On 06/27/25 the resident refused breakfast and lunch and had no intake for dinner with set up help for the meal.</p> <p>On 06/28/25 the resident had no intake for breakfast and lunch with the assistance of one staff member and up to 25% of the dinner meal was consumed with staff assistance.</p> <p>On 06/29/25 the resident had no intake for breakfast, lunch or dinner with assistance of one staff.</p> <p>Review of the medical record revealed no notification of the resident's decreased food or fluid intake from 06/24/25 through 06/29/25 to the medical provider or RD. There was also no documentation as to why the resident was not eating or drinking or alternate options attempted or provided.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #95's medical record revealed the next progress note was dated 06/29/25 at 8:25 P.M., written by LPN #194 which revealed Resident #95 was lying in bed in the fetal position with oxygen on via mask. Resident #95 did not want to open her eyes, was restless and less verbal than her normal. Resident #95's color was pale, her skin was cool to touch, her skin turgor was poor (refers to the elasticity of the skin and represents a person's hydration status) and her lips and mouth were very dry. The resident's vital signs included blood pressure 102/53 millimeters of Mercury (mmHg) (normal 120/60 mmHg), temperature 97.3 (degrees Fahrenheit) (average body temperature 98.6 degrees F), pulse 54 (normal range 60-90 beats per minute) and respirations 14 (normal 12-20 breaths per minute). LPN #194 was unable to obtain Resident #95's peripheral oxygenation saturation (a pulse oximeter is placed on a person's finger and will provide a reading of the resident's oxygen level in the bloodstream but the oximeter will have difficulty identifying oxygen levels with cool hands and movement) reading due to the resident moving her hands. LPN #194 notified the on-call physician and received an order to send the resident to the emergency room for evaluation and treatment and activated 911 to transport the resident. LPN #194 notified the resident's spouse of the resident being sent to the hospital.</p> <p>Review of Resident #95's hospital records revealed an admission history and physical dated 06/30/25 at 2:03 A.M. that indicated the resident was admitted to the service of the hospitalist for severe dehydration. Resident #95's weight when admitted to the hospital was documented to be 77 pounds (the facility's most recent weight on 06/25/25 was documented to be 91 pounds). The resident was described as extremely debilitated, malnourished, as well as very dehydrated with parched lips and parched oral mucosa. The hospitalist estimated the resident had an approximate 3.8-to-4-liter free water deficit. A hospice consultation was initiated after discussion with the resident's family.</p> <p>Further review of the resident's hospital records revealed a consultation note dated 06/30/25 at 11:33 A.M. that revealed the resident was brought to the emergency room on [DATE] from the facility with decreased food/fluid intake for several days according to staff. Labs were notable including a hemoglobin of 17, hematocrit of 42.6 and a (critical) sodium level of 173 (all indicative lab studies for dehydration). The resident's admission weight was documented to be 77.66 pounds with a body mass index of 13. The consultation note included the patient was examined at bedside. She was lethargic, unable to answer questions and unable to follow simple commands. The resident appeared thin, frail and cachectic with muscle/fat wasting noted to temples, orbits, cheeks, clavicles, arms and legs. Mucus membranes appeared dry and skin turgor was poor. The resident's skin was warm, dry and dusky. Spouse agreeable to hospice consult with patient hopefully being transported to (named) house (hospice house). Primary hospice diagnosis could either be advanced dementia (no specified type but based on clinical picture and review of medical records, likely Alzheimer's dementia with possibility of vascular component) or severe malnutrition as patient was eligible with either diagnosis.</p> <p>Interview on 09/17/25 at 6:25 A.M. with LPN #194 revealed she came into work on Sunday, 06/29/25 (after being off for a few days), and when she went into Resident #95's room to administer her evening medication, she found the resident in bed with oxygen on and not really responding. The LPN stated she could not find anything about a change in the resident's condition in the nurse's progress notes (prior to her observation) or an order for oxygen use in the medical record so she contacted the on-call medical provider and then transferred the resident to the emergency room due to this significant change in the resident's condition since the last time she had worked with the resident (the night of 06/24/25).</p> <p>(continued on next page)</p>		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	<p>Interview on 09/18/25 at 4:00 P.M. with Certified Nursing Assistant (CNA) #226 revealed Resident #95 normally spent a lot of time during the day either lying or sitting on her bed. CNA #226 stated she cared for Resident #95 during the day on 06/29/25, the day the resident was sent to the hospital. CNA #226 stated the resident had slept all day, was hard to wake up, and did not eat or drink on day shift. CNA #226 stated she verbally reported this to her nurse, Registered Nurse (RN) #237, who responded that she would look into getting hospice for the resident.</p> <p>Interview on 09/22/25 at 11:10 A.M. with CNA #204, stated Resident #95 seemed to sleep more, and her food and fluid intake became more limited (the documentation in the resident's medical record reflects poor intake of food and/or fluid during meals leading up to the resident's hospital transfer). Prior to this, the resident had been up and wandering around and rummaging in other residents' rooms.</p> <p>Interview on 09/22/25 at 11:55 A.M. with CNP #202 revealed she was not notified of Resident #95's changes in condition (not eating or drinking, wearing oxygen, previous weight loss or changes in her usual activity). CNP #202 further stated that when she saw Resident #95 on 06/25/25 she felt the resident was at her neurological baseline and she was unaware of issues or concerns with the resident's status. The CNP verified the on-call service had not added a system note for Resident #95 between her visit on 06/25/25 until 06/29/25, when the order was given to transfer the resident to the emergency room.</p> <p>Interview on 09/22/25 at 10:30 A.M. with Regional Registered Nurse #200 verified no weight was obtained for Resident #95 the week of 06/14/25. Regional Registered Nurse #200 also verified that there was no specific documentation of the percentage or amount of the house supplement that the resident consumed and stated this should be documented.</p> <p>Interview on 09//22/25 at 11:55 A.M. with CNP #202 revealed she was not notified of Resident #95's weight loss or changes in the resident's condition (not eating or drinking, wearing oxygen, not her usual behaviors). CNP #202 further stated that when she saw Resident #95 on 06/25/25 she felt the resident was at her neurological baseline. The CNP verified the on-call service had not added a system note for Resident #95 between her visit on 06/25/25 until 06/29/25 when the order was given to transfer the resident to the emergency room. CNP #202 stated she or the on-call provider should have been notified when Resident #95's condition changed enough that oxygen was placed on her. CNP #202 also expected to be made aware of weight changes and any other changes with residents that she was caring for.</p> <p>Interview on 09/22/25 at 1:37 P.M. with Registered Nurse (RN) #237 revealed she did not normally work the hall Resident #95 resided on and did not know the resident well. RN #237 stated she did recall the resident being very sleepy that weekend (June 27-28), the CNAs assisted the resident with eating, and she did not eat much.</p> <p>Interview on 09/22/25 at 3:18 P.M. with CNA #163 revealed she had just recently started working at the facility in June 2025 and did not know much about Resident #95 other than she was difficult to redirect and she did not eat or drink well. The CNA stated she attempted to assist the resident with her lunch meal on 06/27/25 but Resident #95 would not open her mouth. She stated she did report this to a nurse working on this date but could not recall the nurse she reported this to.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Country Lane Gardens Rehab & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 7820 Pleasantville Road Pleasantville, OH 43148	
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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/23/25 at 8:48 A.M. with CNA #249 revealed she worked day shift on Saturday and Sunday (06/28/25 and 06/29/25) before Resident #95 was sent to the hospital on [DATE]. CNA #249 stated Resident #95 slept a lot and did not eat or drink well those two days.</p> <p>Interview on 09/23/25 at 1:40 P.M. with RD #302 revealed she believed the house supplement was given by nursing and the amount the resident received was recorded on the medication administration record, but she stated that she could be wrong about that. RD #302 stated that new admissions were to be weighed weekly for four weeks and any resident that weighed less than 100 pounds should also be on weekly weights. RD #302 indicated that she was at the facility on Tuesdays and reviewed any weights taken since the previous Tuesday while at the facility and made any recommendations at that time. RD #302 stated Resident #95 was stable at 92 pounds on 06/10/25 when she reviewed her weight but Resident #95 did not get weighed the week of 06/14/25 and was not weighed the following week until after the weekly dietician visit (06/24/25) so she was not aware Resident #95's weight was continuing to decline and was not notified of the continued weight loss.</p> <p>Review of the policy titled Weight Assessment and Intervention updated 01/10/23 revealed that the assessment information would be analyzed by the multidisciplinary team and the physician to identify conditions and medications that may be causing anorexia, weight loss or increasing the risk for weight loss.</p> <p>2. Review of the medical record for Resident #65 revealed an admission date of 10/10/12 with diagnoses that included encephalopathy, ataxia, cerebral aneurysm non-ruptured, nontraumatic subdural hemorrhage, chronic obstructive pulmonary disease, psychotic disorder, bipolar disorder, convulsions, vitamin B deficiency, sexual disorders, anxiety disorders, hypokalemia, combined forms of age-related cataract, fracture of shaft of left fibula, panic disorder, vitamin B12 deficiency, mood disorder, hypo-osmolality and hyponatremia, dementia, constipation, personal history of COVID-19, presence of cerebrospinal fluid drainage device, alcohol use, and hypertension.</p> <p>Review of the annual minimum data set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09, indicating impaired cognition.</p> <p>Review of the weights for Resident #65 revealed a decrease from 181.7 pounds on 08/05/24 to 168.9 pounds on 09/10/24, reflecting a weight loss of 12.8 pounds (7.6%), followed by an increase to 188.8 pounds on 10/14/24. More recently, weights decreased from 188 pounds on 08/19/25 to 178.4 pounds on 09/13/25, reflecting a loss of 9.6 pounds (5.1%), with a reweight on 09/19/25 confirming no change at 178.4 pounds.</p> <p>Review of the progress notes for Resident #65 revealed a dietician note dated 09/10/24 at 11:18 A.M. documenting a significant weight loss of 12.8 pounds (7.6%) over 30 days with a current weight of 168.9 pounds. The resident was on a regular diet with regular texture and thin liquids, with oral intakes ranging from 50&ndash;100%. Medications were reviewed, and skin was noted to be intact per the 09/04/24 weekly skin assessment. The registered dietitian (RD) requested a reweight to verify the weight loss. No follow-up weight or note occurred after this dietician note.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress notes for Resident #65 revealed a dietician note dated 09/16/25 at 10:27 A.M. documenting a triggering weight loss of 9.6 pounds (5.4%) over 30 days with a current weight of 178.4 pounds and body mass index of 29.7, indicating overweight. The resident was on a regular diet with regular texture and thin liquids, with oral intakes ranging from 75&ndash;100%. Medications were reviewed, and skin assessment revealed no pressure areas or edema. Estimated nutritional needs were calculated based on an adjusted body weight of 147 pounds at 1,670&ndash;2,005 kcal/day, 67 grams protein/day. The RD requested a reweight to verify weight loss and noted that the resident remained on appropriate nutrition orders with monitoring as needed.</p> <p>Review of the progress notes for Resident #65 revealed a dietician follow-up note dated 09/23/25 at 9:24 A. M. indicating that the resident's weight had remained stable for one week. The RD noted the goal to promote weight stability and slow the rate of further weight loss. A plan was made to add an oral nutrition supplement (ONS) and monitor weight trends, with a recommendation to add a 120 ml house supplement once daily. The RD stated the resident would be monitored as needed.</p> <p>Interview on 09/25/25 at 1:16 P.M. with the Registered Dietitian (RD) confirmed that for the period of August 2024 through September 2024, she suspected the documented weight was inaccurate and requested a reweight; however, the reweight was never completed. She explained that this oversight slipped through the cracks. The RD further stated that when a resident refuses a meal or supplement, staff should attempt multiple times to encourage intake, but in this case, no such attempts were documented. The RD also reported that a reweight was missed following the weight obtained on 09/13/25. She stated that when nutrition orders were recommended, she expected the orders to be implemented within 24 hours so that supplements could be started and monitoring initiated promptly. The RD explained that staff were expected to record in the Medication Administration Record (MAR) the percentage of the supplement consumed, and if intake was low, staff should offer an alternative supplement to determine if the resident preferred it. The RD confirmed that the recommended 120 ml house supplement for Resident #65 had not yet been initiated as of the interview date, despite being recommended in the progress notes. She emphasized that timely implementation and monitoring of nutrition interventions were critical to addressing weight loss and preventing further nutritional decline.</p> <p>Review of the facility policy titled, Weight Assessment and Intervention dated 01/13/23 revealed that a 5% or greater weight change since the last assessment triggered a re-measurement the next day, with the nurse notifying the Dietitian in writing for confirmation within 24 hours, who then responded within 24 hours to recommend trends over time. Significant weight loss was defined as 5% in one month (severe if >5%), 7.5% in three months (severe if >7.5%), or 10% in six months (severe if >10%), with desirable changes documented without care plan adjustments. The multidisciplinary team analyzed assessment data, considering target weight ranges, medical conditions, and potential causes such as anorexia or cognitive decline, and developed individualized care plans with goals, benchmarks, and monitoring timelines, ensuring resident preferences and rights were respected, including documentation if a resident declined intervention.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2615387.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, staff interview, and contract review, the facility failed to ensure ongoing communication and collaboration with a dialysis facility regarding dialysis care and services for a resident. This affected one (#40) of 17 sampled residents. The facility census was 94. Findings include: Review of the record for Resident #40 revealed an admission date of 07/10/25 and diagnoses including diabetes, end stage renal disease, and left leg below the knee amputation. Review of a Minimum Data Set assessment completed 08/08/25 revealed a brief interview for mental status of 15, indicating intact cognition. Record review revealed Resident #40 went to an outside dialysis facility three times weekly for hemodialysis. Review of nursing progress notes revealed on 07/25/25 at 5:26 P.M. it was documented that the resident had a critically low hemoglobin of 6.9 grams per deciliter (g/dL) (normal 14-18). (Hemoglobin is a protein in red blood cells that carries oxygen throughout the body). It was documented that the nurse practitioner was notified and a new order was given. A blood test completed on 07/25/25 verified the hemoglobin level of 6.9 g/dL. Review of the medication administration record revealed Ferrous Sulfate 325 milligrams was increased from every other day to daily on 07/25/25. On 07/28/25 there was a written physician's order from Physician #301 for Epoetin alfa 10,000 units weekly for four weeks. (Epoetin alfa is used to treat anemia by stimulating the production of red blood cells). Review of medication administration records revealed the Epoetin alfa 10,000 units was not given as scheduled on 07/29/25, 08/05/25, or 08/19/25 due to not being available from the pharmacy. He did receive a dose on 08/12/25. There was no evidence the physician was notified of the medication not being available from the pharmacy. However, review of a dialysis anemia patient history graph revealed Resident #40 had received Mircera (a drug from the same drug class as Epoetin alfa) to treat low hemoglobin on 07/28/25, 08/11/25, 08/25/25, and 09/08/25. Interview with Registered Nurse (RN) #701 from the dialysis center on 09/23/25 at 8:37 A.M. confirmed Mircera and Epoetin alfa were from the same drug class (one long acting and one short acting). She confirmed Resident #40 had received Mircera every two weeks since 07/28/25 at the dialysis center. She stated the dialysis center was not aware that he had an order to receive Epoetin alfa weekly at the facility. She stated if they would have known that, he would not have received the Mircera at the dialysis center. She confirmed there should be collaboration between the dialysis center and the facility regarding care provided and medications given. Interview with Physician #301 on 09/22/25 at 1:45 P.M. revealed he did not remember if he was notified of Resident #40 not receiving the weekly Epoetin alfa as ordered. He stated he knew the resident was receiving dialysis but was not aware of medications being provided by the dialysis center. He stated that information was not available. Review of dialysis communication reports revealed on 07/28/25 the dialysis center did not complete their portion of the communication report. The report on 08/11/25 did not include that the dialysis center had given Mircera. The report from the dialysis center for 09/08/25 was not received by the facility until 09/23/25. Interview with Regional Nurse #201 on 09/18/25 at 3:00 P.M. confirmed there was no evidence the physician was notified that the Epoetin alfa was not given as ordered. Interview with [NAME] President of Clinical Operations #300 on 09/23/25 at 11:45 A.M. confirmed there should have been collaboration on the provision of medications between the dialysis center and the facility physician. She confirmed on 09/23/25 at 1:45 P.M. that the dialysis communication sheets either were not filled out by the dialysis center or did not include that medications were provided while there. She confirmed the facility received the communication sheet for the 09/08/25 dialysis visit on 09/23/25. Review of the contract between the dialysis center and the facility dated 04/25/17 revealed the facility shall provide for the interchange of information useful or necessary for the care of the resident, including a contact person at the facility whose responsibilities include assisting with the coordination of renal dialysis services for end stage renal disease residents. It further stated obligations of the dialysis center included to provide to the facility information on all aspects of the management of the resident's care related to the provision of renal dialysis services. This deficiency represents incidental finding of noncompliance investigated under Complaint Number 2623671.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on review of facility staffing reports, review of facility staff time punches and staff interviews, the facility failed to provide eight hours of consecutive Registered Nurse (RN) direct care and had the Regional Director of Nursing as providing resident care for three days reviewed in a seven-day (one week) period. This had the potential to affect all 94 residents living in the facility. Findings include: A review of the facility staffing reports dated 09/04/25, 09/05/25, and 09/10/25 revealed that the facility did not have a Registered Nurse scheduled for eight hours of consecutive direct care on those three dates. Regional Director of Nursing #200 was scheduled to be the Director of Nursing in the building for 09/04/25, 09/05/25, and 09/10/25. A review of the punch report dated 09/04/25 through 09/10/25 revealed that no RN coverage was in place for 09/04/25, 09/05/25, and 09/10/25. An interview with Regional Director of Nursing #200 on 09/16/25 at 2:03 P.M. revealed that she was in the facility on 09/04/25, 09/05/25, and 09/10/25 providing resident care. An interview with Staffing Coordinator #150 on 09/16/25 at 3:31 P.M. confirmed that Regional Director of Nursing #200 was the only RN in the building on 09/04/25, 09/05/25, and 09/10/25, and that no other RNs had worked on 09/04/25, 09/05/25, and 09/10/25. An interview with the Administrator on 09/16/25 at 4:01 P.M. revealed that the facility did not have a policy on RN coverage requirements in the building; however, the Administrator confirmed that she knew that it was a regulation to have 8 hours of consecutive RN coverage, seven days a week and that the Director of Nursing could not serve as the RN coverage for the facility. This deficiency represents non-compliance investigated under Master Complaint Number 2623748, Complaint Number 2615387, 2596564.</p>		

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<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** Based on review of the medical record and staff interviews, the facility failed to implement appropriate behavioral healthcare and interventions for a resident's behaviors. This affected one (#14) resident of three residents reviewed for behavioral services. The facility census was 94. Findings include: Review of the medical record for Resident #14 revealed an admission date of 02/17/25 with diagnoses that included Anoxic brain damage, dementia, bipolar disorder, major depressive disorder, hepatitis C, edema, post-traumatic stress disorder (PTSD), attention deficit disorder, opioid use, anxiety disorder, iron deficiency anemia, vitamin deficiency, female pelvic inflammatory disease, psychoactive substance abuse, insomnia, dementia, and nightmare disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #14 required setup for eating and oral hygiene, supervision for most daily activities and transfers, maximal help for showering, and could walk up to 150 feet with supervision. Review of the care plan, initiated 02/18/25 and revised through 09/15/25, documented a history of sexually inappropriate behaviors. Interventions included administering medications, involving behavioral health as needed, monitoring for wandering, providing safe-practice education, and immediate removal from situations where inappropriate behavior occurred using one-to-one (1:1) supervision when necessary. Interview on 09/24/25 at 8:32 A.M. with Licensed Practical Nurse (LPN) #248 revealed that she was informed Resident #14 engaged in sexual behaviors with a male resident (#50). LPN #248 stated that she believed Resident #14 required a female-only facility due to her age and history of anoxic brain injury, and expressed concern that placement on the dementia floor increased risk to other residents. She confirmed that she was unsure who had observed the incident and that Resident #14's behavior was ongoing. Interview on 09/24/25 at 8:41 A.M. with Certified Nursing Assistant (CNA) #163 revealed that she was not present during the incident between Resident #14 and Resident #50 but confirmed that the situation was reported to nursing staff and witness statements were completed. She confirmed that following the incident, Resident #14 was placed on 1:1 supervision. Interview on 09/24/25 at 9:00 A.M. with CNA #167 confirmed that Resident #14 was observed inappropriately touching Resident #50 and stated that she was not aware of any preventive measures in place prior to the incident. She reported that Resident #14 was on 1:1 supervision for a few hours and then placed on 15-minute checks. Interview on 09/24/25 at 9:36 A.M. with Resident #14's guardian, confirmed that the facility moved Resident #14 to a new unit following the incident. She stated that she believed Resident #14 would engage in sexual activity if she wanted and recommended placement in an all-female facility. Interview on 09/24/25 at 9:59 A.M. with LPN #189 confirmed that the incident between Resident #14 and Resident #50 occurred on 09/19/25 between 10:00 and 11:00 A.M. She reported that Resident #14 was removed from the room and placed on 1:1 supervision, but no additional interventions were completed prior to her move to another unit. Interview on 09/24/25 at 10:36 A.M. with Regional Director (RD) #350 confirmed that staff moved Resident #14 to the locked unit due to her sexual behaviors. He reported that no alternative interventions or individualized behavioral strategies were documented prior to placement on the locked unit. Interview on 09/24/25 at 11:38 A.M. with Social Services Director (SSD) and HR Director #152 confirmed that psychosocial assessments for both residents were completed verbally but not documented, and that a late progress note would be submitted using witness statements as reference. Interview on 09/25/25 at 9:46 A.M. with RD #350 and Administrator confirmed plans to place Resident #14 in a more appropriate facility and maintain 1:1 supervision until an appropriate placement was located. This deficiency represents incidental finding of non-compliance investigated under Master Complaint Number 2623748.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, staff interview, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected two (#3, #40) of 17 sampled residents. The facility census was 94. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 08/16/23 and diagnoses including multiple sclerosis, anxiety disorder, and legal blindness. Review of physician's orders revealed Ativan (antianxiety medication) 0.5 milligrams was decreased from two tablets to one tablet at bedtime on 07/21/25. Review of medication administration records for August and September 2025 revealed nurses were documenting Ativan 0.5 milligrams one tablet at bedtime was given. However, review of controlled substance administration records revealed that on 08/21/25, 08/29/25, 08/30/25, 09/02/25, 09/04/25, and 09/06/25 Ativan 0.5 milligrams two tablets were signed out for Resident #3, indicating he received a double dose of Ativan on those days. The medication label on the controlled substance administration record still indicated to give two tablets, even though the physician's order was changed on 07/21/25. Someone had written: Watch dose! on the label. Interview with LPN/Unit Manager #241 on 09/17/25 at 2:05 P.M. confirmed controlled substance administration records indicated Resident #3 received a double dose of Ativan on 08/21/25, 08/29/25, 08/30/25, 09/02/25, 09/04/25, and 09/06/25. She stated this would be considered a medication error. She confirmed the double dose given on 09/03/25 (documented as 09/02/25) was given by her. 2. Review of the record for Resident #40 revealed an admission date of 07/10/25 and diagnoses including diabetes, end stage renal disease, and left leg below the knee amputation. Review of a Minimum Data Set assessment completed 08/08/25 revealed a brief interview for mental status of 15, indicating intact cognition. Record review revealed Resident #40 went to an outside dialysis facility three times weekly for hemodialysis. Review of nursing progress notes revealed on 07/25/25 at 5:26 P.M. it was documented that the resident had a critically low hemoglobin of 6.9 grams per deciliter (g/dL) (normal 14-18). (Hemoglobin is a protein in red blood cells that carries oxygen throughout the body). It was documented that the nurse practitioner was notified and a new order was given. A blood test completed on 07/25/25 verified the hemoglobin level of 6.9. Review of the medication administration record revealed Ferrous Sulfate 325 milligrams was increased from every other day to daily on 07/25/25. On 07/28/25 there was a written physician's order from Physician #301 for Epoetin alfa 10,000 units weekly for four weeks. (Epoetin alfa is used to treat anemia by stimulating the production of red blood cells). Review of medication administration records revealed the Epoetin alfa 10,000 units was not given as scheduled on 07/29/25, 08/05/25, or 08/19/25 due to not being available from the pharmacy. He did receive a dose on 08/12/25. There was no evidence the physician was notified of the medication not being available from the pharmacy. However, review of a dialysis anemia patient history graph revealed Resident #40 had received Mircera (a drug from the same drug class as Epoetin alfa) to treat low hemoglobin on 07/28/25, 08/11/25, 08/25/25, and 09/08/25. Interview with RN #701 from the dialysis center on 09/23/25 at 8:37 A.M. confirmed Mircera and Epoetin alfa were from the same drug class (one long acting and one short acting). She confirmed Resident #40 had received Mircera every two weeks since 07/28/25 at the dialysis center. She stated the dialysis center was not aware that he had an order to receive Epoetin alfa weekly at the facility. She stated if they would have known that, he would not have received the Mircera at the dialysis center. Interview with Physician #301 on 09/22/25 at 1:45 P.M. revealed he did not remember if he was notified of Resident #40 not receiving the weekly Epoetin alfa as ordered. He stated he knew the resident was receiving dialysis but was not aware of medications being provided by the dialysis center. He stated that information was not available. Interview with Regional Nurse #201 on 09/18/25 at 3:00 P.M. confirmed there was no evidence the physician was notified that the Epoetin alfa was not given as ordered. Interview with [NAME] President of Clinical Operations #300 on 09/23/25 at 11:45 A.M. confirmed Resident #40 was prescribed medications from the same drug class at the dialysis center and at the facility, with neither knowing that the other one was giving them. In addition, Resident #40 had a physician's order for Tramadol (an opioid pain medication) 50 milligrams every six hours as needed for pain on 07/19/25. Review of the controlled substance administration record revealed the resident received Tramadol 50 milligrams at 6:07 P.M. on 07/24/25. Review of the medication administration record revealed the dose on 07/24/25 at 6:07 P.M. was not documented as given. Review of the medication administration record and the controlled substance administration record revealed he received another dose on 07/24/25 at 9:19 P.M. (three hours and 12 minutes after the previous dose). The medication should not have been given until six hours had passed. Interview with [NAME] President of</p>		

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 10/15/2025
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on record review, review of the facility assessment, review of the Administrator Job Description, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This affected four (#32, #51, #79, #81) of 17 sampled residents with the potential to affect all 94 residents residing in the facility. Findings include: During the survey, the following care concerns were identified by the survey team. The facility's inaction caused serious harm and had the likelihood of causing serious harm or injury to all residents: 1. Based on observation, record review, review of a facility timeline of events, review of hospital records and a physician after visit summary, facility policy review and interview, the facility failed to prevent an incident of neglect involving Resident #32. This resulted in Immediate Jeopardy and Actual Harm beginning on 09/19/25 at 10:30 A.M. when Resident #32, who was identified to have confusion and poor decision making, was left outside the facility in the sun with the air temperature between 82 and 85 degrees Fahrenheit unattended. On 09/19/25 at approximately 1:45 P.M. Resident #32 was found outside the facility unresponsive with a body temperature of 107 degrees (F) and an oxygen saturation level of 88 percent with resulting second degree burns/blisters on her arms and legs. The physician was not notified for approximately 12 hours, and the resident was not transferred to the hospital for evaluation/treatment until approximately 24 hours after the incident. Interview with the Administrator on 09/29/25 at 8:45 A.M. revealed she was aware Resident #32 was outside on 09/18/25. She stated staff were having trouble getting her back inside, so she went and talked to the resident and brought her back in. She stated the resident was only outside for a short time. She stated she told staff it was the resident's right to go outside. She stated she also told staff if she refused to come in, to get someone with good rapport with the resident. She stated there were days the resident was more irritable. The Administrator stated she was not at the facility on 09/19/25 when the incident happened. 2. Actual harm occurred on 09/02/25 when Resident #79 was diagnosed with osteomyelitis (infection of the bone) of the foot after the facility failed to provide physician ordered medication to be used after a stent procedure to prevent the stent from closing up and failed to arrange transportation to follow up appointments with the vascular surgeon from 07/02/25 to 09/22/25. Interview with Administrator #188 on 09/18/25 at 1:55 P.M. revealed that around the beginning of July 2025 the facility no longer had a contract with a non-emergent ambulance transportation service. She stated the facility still did not have a contract with a non-emergent ambulance transportation service. She stated a contract had been arranged but she had not yet signed the contract to put it into effect. She stated she did not know who or how many residents were not transported to appointments during that time. 3. The facility administration failed to prevent the misappropriation of resident property when Resident #51's narcotic pain medications were diverted and unaccounted for. Review of the record for Resident #51 revealed an admission date of 06/23/25 and diagnoses including chronic kidney disease, diabetes, congestive heart failure, and bipolar disorder. Review of a minimum data set assessment completed 07/10/25 revealed a brief interview for mental status score of 13, indicating intact cognition. Review of physician's orders revealed on 07/10/25 Oxycodone (a narcotic pain medication) 15 milligrams every six hours as needed for severe pain (6-10 level) was ordered. Review of a written statement dated 09/03/25 from Licensed Practical Nurse (LPN) #169 revealed on 08/29/25 LPN #195 reported that she believed Resident #51 had a full card of Oxycodone during her last shift. However, she stated the resident is currently out of medication. The resident is allowed to take one tablet every six hours as needed. LPN #195 and I reviewed the documentation to determine why the resident was out of medication. We discovered that the pharmacy had delivered 30 tablets of Oxycodone on 08/23/25. The Oxycodone card was signed into the narcotics log during the day shift on 08/23/25 by Registered Nurse (RN) #227 but was never signed out (when empty). So the card of narcotics should be located within the narcotic box in the B-Hall medication cart. While reviewing the narcotic logs for B-Hall, we identified that on 08/28/25, 45 tablets of Alprazolam (used for the treatment of anxiety and panic disorders) were delivered and signed into the narcotics book. RN #227 signed that she received one card of medication and one sheet (administration record). Each narcotic card can hold a maximum of 30 tablets. Therefore, a delivery of 45 tablets should have been documented as two separate cards. However, RN #227 recorded only one card, which is incorrect. This discrepancy should have been identified during the shift change narcotic count between nurses but was not. The only possible explanation is that a card of narcotic medication would have had to be taken from the</p>		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. (continued on next page)		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on review of quality assurance/performance improvement (QAPI) minutes, review of the governing body, interviews, and policy review the facility failed to have an effective governing body to oversee the functions of the facility. This affected four (#32, #51, #79, #81) of 17 sampled residents with the potential to affect all 94 residents residing in the facility. Findings include: Review of the facility Governing Body composition revealed it stated the intent of the facility was to establish a governing body that oversees the establishing and implementing of policies and procedures regarding the management and operation of the facility. The governing body for the facility is as follows:Administrator #188; Director of Nursing #303; Medical Director #301; Regional Director of Clinical Services #201; Regional Director of Operations #350; Director of Corporate Compliance; [NAME] President of Operations #203; and [NAME] President of Clinical Services #300.During the survey, the following care concerns were identified by the survey team related to the facility's failure to have an effective governing body.Review of QAPI minutes dated 07/30/25 revealed transportation is experiencing issues with residents getting to appointments who need to go by cot. The transportation contract was suddenly dropped and no backup plan was in place. An action step stated the transportation coordinator and the administrator will reach out to cot transport companies to secure a contract for the facility to ensure residents who need cot transport receive those services. It stated the administrator and transportation aide would meet weekly to discuss progress with a cot transportation contract until the issue is resolved. There was no evidence of weekly meetings by the administrator and transportation aide. There was no list of who attended the meeting. Review of QAPI minutes dated 09/03/25 revealed policy and procedures were not being followed by nursing regarding medication management. The root cause was identified as failure to follow med pass policies. Action steps included medication delivery records were audited for any deficient practices and no issues were identified; all controlled substances and as needed med use were audited for any deficient practices and no issues were identified; Narcotic sheets and medication administration records were audited for any deficient practices; education was provided to nursing to ensure policy and procedures regarding medication management were being followed. There was no list of who attended the meeting. During the survey it was determined that actual harm occurred on 09/02/25 when Resident #79 was diagnosed with osteomyelitis (infection of the bone) of the foot after the facility failed to provide physician ordered medication to be used after a stent procedure to prevent the stent from closing up and failed to arrange transportation to follow up appointments with the vascular surgeon from 07/02/25 to 09/22/25. (He required cot transport).Interview with Administrator #188 on 09/18/25 at 1:55 P.M. revealed that around the beginning of July 2025 the facility no longer had a contract with a non-emergent ambulance transportation service. She stated the facility still did not have a contract with a non-emergent ambulance transportation service. She stated a contract had been arranged but she had not yet signed the contract to put it into effect. She stated she did not know who or how many residents were not transported to appointments during that time. Interview with Transportation Manager #221 on 09/22/25 at 7:38 A.M. confirmed the facility had not had a contract for non-emergent transportation since 07/01/25. She confirmed Resident #79 had missed appointments with the vascular surgeon on 07/02/25, 09/08/25, and 09/10/25. During the survey, it was determined the facility failed to thoroughly investigate an allegation of missing narcotics and that misappropriation of narcotics occurred for Resident #51. The facility provided education for nurses without determining the extent of the issue and did not determine that misappropriation occurred as follows:Interview with Administrator #188 on 09/16/25 at 2:30 P.M. confirmed an allegation of missing narcotics was reported by LPN #169. She was unsure of the date. The facility documented that the Medical Director was notified on 09/03/25 at 2:20 P.M. of an allegation of potentially a card of narcotics missing. The note further stated the Administrator and Corporate were currently investigating. (Same date as QAPI meeting regarding medication policies not being followed).Interview with Regional Nurse #200 on 09/16/25 at 2:35 P.M. revealed the facility investigated the allegations of missing narcotics by LPN #169 and LPN #195. However, they could not determine what happened. She stated that all of the controlled substance administration records for Oxycodone for Resident #51 were missing from 07/10/25 to 08/31/25. (sheets documenting when the medications were removed from the double locked cart they were secured in). On 09/17/25 at 10:30 A.M. she stated there were also missing controlled substance inventory count sheets (sheets used to keep track of narcotic count sheets coming in when delivered and going out when empty). She stated that with the missing records, they could not figure out the amount of Oxycodone missing for</p>		

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<p>F 0841</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0841</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on review of Quality Assurance and Performance Improvement (QAPI) minutes, review of policies, and interviews, the facility failed to ensure the medical director implemented resident care policies, coordinated medical care in the facility, and participated in QAPI meetings. This affected three (#40, #79, #95) of 17 residents reviewed during the course of the survey and affected all 94 residents residing in the facility due to the failure of the medical director fulfillment of his responsibilities. Findings include:1.Review of QAPI minutes dated 07/30/25 revealed transportation is experiencing issues with residents getting to appointments who need to go by cot. The transportation contract was suddenly dropped and no backup plan was in place. An action step stated the transportation coordinator and the administrator will reach out to cot transport companies to secure a contract for the facility to ensure residents who need cot transport receive those services. It stated the administrator and transportation aide would meet weekly to discuss progress with a cot transportation contract until the issue is resolved. There was no evidence of weekly meetings by the administrator and transportation aide. There was no list of who attended the meeting or that the medical director was involved.During the survey it was determined that actual harm occurred on 09/02/25 when Resident #79 was diagnosed with osteomyelitis (infection of the bone) of the foot after the facility failed to provide physician ordered medication to be used after a stent procedure to prevent the stent from closing up and failed to arrange transportation to follow up appointments with the vascular surgeon from 07/02/25 to 09/22/25. (He required cot transport).Interview with Administrator #188 on 09/18/25 at 1:55 P.M. revealed that around the beginning of July 2025 the facility no longer had a contract with a non-emergent ambulance transportation service. She stated the facility still did not have a contract with a non-emergent ambulance transportation service. She stated a contract had been arranged but she had not yet signed the contract to put it into effect. She stated she did not know who or how many residents were not transported to appointments during that time.Interview with Transportation Manager #221 on 09/22/25 at 7:38 A.M. confirmed the facility had not had a contract for non-emergent transportation since 07/01/25. She confirmed Resident #79 had missed appointments with the vascular surgeon on 07/02/25, 09/08/25, and 09/10/25. Interview with Administrator #188 and Regional Director of Operations #350 on 09/29/25 at 3:00 P.M. confirmed there were no attendance records for QAPI meetings. 2. In addition, Immediate Jeopardy began on 06/27/25 when Certified Nursing Assistant (CNA) #204 identified a change in condition for Resident #95 and verbally notified Licensed Practical Nurse (LPN) #198 without evidence of a timely assessment and interventions/medical treatment provided. Resident #95 remained with discoloration of her hands and feet; oxygen delivered at an unknown amount via face mask and limited food and fluid intake. On 06/29/25 at approximately 8:30 P.M. Licensed Practical Nurse (LPN) #194 identified the resident ' s significant condition change and notified the resident ' s medical provider, called 911, and the resident was transferred to the emergency room and admitted to the hospital with diagnoses including severe dehydration and acute kidney injury. Resident #95 ' s status did not improve and the resident was subsequently transferred from the hospital to a hospice facility on 06/30/25 and expired on 07/02/25.There was no evidence the facility identified the staff's lack of intervention or that any corrective action was taken prior to the survey.In an interview on 09/23/25 at 4:25 P.M. Medical Director #301 stated his expectation is that if a resident is having a decline, he expects nursing to evaluate the resident and then notify him, the CNP or the on-call medical provider to obtain orders.3. The facility failed to ensure ongoing communication and collaboration with a dialysis facility regarding care for Resident #40.Record review revealed Resident #40 went to an outside dialysis facility three times weekly for hemodialysis. Review of nursing progress notes revealed on 07/25/25 at 5:26 P.M. it was documented that the resident had a critically low hemoglobin of 6.9. (normal 14-18). (Hemoglobin is a protein in red blood cells that carries oxygen throughout the body). It was documented that the nurse practitioner was notified and a new order was given. A blood test completed on 07/25/25 verified the hemoglobin level of 6.9. Review of the medication administration record revealed Ferrous Sulfate 325 milligrams was increased from every other day to daily on 07/25/25.On 07/28/25 there was a written physicians order from Physician #301 for Epoetin alfa 10,000 units weekly for four weeks. (Epoetin alfa is used to treat anemia by stimulating the production of red blood cells. Review of medication administration records revealed the Epoetin alfa 10,000 units was not given as scheduled on 07/29/25, 08/05/25, or 08/19/25 due to not being available from the pharmacy. He did receive a dose on 08/12/25. There was no evidence the physician was notified of the medication not being available from the pharmacy. However</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review, observations, and staff interview, the facility failed to ensure resident records were complete and accurately documented. This affected four (#6, #40, #79, and #81) of 17 sampled residents. The facility census was 94. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 01/18/18 and diagnoses including anxiety disorder, hypertension, and chronic obstructive pulmonary disease. The resident had a physician's order for Ativan (an anti-anxiety medication) one milligram three times daily at 9:00 A.M., 3:00 P.M., and 9:00 P.M. Review of the medication administration record for September 2025 revealed the Ativan was documented as given on 09/07/25 at 9:00 A.M. However, review of the controlled substance administration record revealed Ativan was not signed out as given on 09/07/25 at 9:00 A.M. Interview with LPN/Unit Manager #241 on 09/17/25 at 2:15 P.M. confirmed the medication was documented as given on the medication administration record but had not been signed out on the controlled substance administration record on 09/07/25. She confirmed this was not accurate. 2. Review of the medical record for Resident #40 revealed an admission date of 07/10/25 with diagnoses including diabetes, end stage renal disease, and left leg below the knee amputation. The resident had a physician's order for Tramadol (an opioid pain medication) 50 milligrams every four hours as needed for pain. Review of Controlled substance administration records revealed the Tramadol was signed out as given on 07/24/25 at 6:07 P.M., 08/06/25 at 10:35 P.M., 08/16/25 at 4:00 A.M., 08/17/25 at 10:20 P.M., 08/26/25 at 12:30 A.M., and 09/14/25 at 6:24 P.M. (three of the doses by LPN #223). Review of the medication administration records for July, August, and September 2025 revealed that those doses were not signed as given on the medication administration records. Interview with [NAME] President of Clinical Operations #300 on 09/23/25 at 9:00 A.M. confirmed the documentation for the doses of Tramadol given to Resident #40 did not match on the medication administration records and the controlled substance administration records and should have. 3. Review of the medical record for Resident #79 revealed an admission date of 06/15/24 and diagnoses including peripheral vascular disease, dementia, and diabetes. Review of wound consult notes on 09/16/25 revealed he currently had multiple arterial wounds to both feet. Observations on 09/18/25 at 2:30 P.M. revealed Resident #79 to be in bed with Prevalon boots on both feet (used to float heels and reduce the risk of pressure wounds). Review of the medical record revealed the resident did not have a physician's order for the Prevalon boots and the boots were not listed as an intervention on the plan of care. Interview with Acting Director of Nursing #303 on 09/24/25 at 10:35 A.M. confirmed there was no physician's order for the Prevalon boots and they were not included on the plan of care. She stated the boots had been in place since 11/10/24. 4. Review of the medical record for Resident #81 revealed an admission date of 08/12/25 and diagnoses including anxiety disorder, fibromyalgia, and chronic pain syndrome. The resident had a physician's order for Tramadol 50 milligrams every six hours as needed for pain. Review of controlled substance administration records revealed the Tramadol was signed out as given on 08/17/25 at 5:46 A.M., 08/25/25 at 5:00 A.M., 08/26/25 at 6:19 A.M., 08/29/25 at 3:00 P.M., 08/30/25 at 9:40 P.M., and 09/06/25 at 1:29 P.M. Review of the medication administration records for August, and September 2025 revealed that those doses were not signed as given on the medication administration records. Interview with [NAME] President of Clinical Operations #300 on 09/23/25 at 9:00 A.M. confirmed the documentation for the doses of Tramadol given to Resident #81 did not match on the medication administration records and the controlled substance administration records and should have.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>(continued on next page)</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on review of quality assurance/performance improvement (QAPI) minutes, interviews, and policy review the facility failed to have an effective QAPI program. This affected six (#3, #40, #51, #79, #81, #95) and of 17 residents reviewed during the course of the survey and all 94 residents residing in the facility. Findings include: Review of QAPI minutes dated 07/30/25 revealed transportation is experiencing issues with residents getting to appointments who need to go by cot. The transportation contract was suddenly dropped and no backup plan was in place. An action step stated the transportation coordinator and the administrator will reach out to cot transport companies to secure a contract for the facility to ensure residents who need cot transport receive those services. It stated the administrator and transportation aide would meet weekly to discuss progress with a cot transportation contract until the issue is resolved. There was no evidence of weekly meetings by the administrator and transportation aide. There was no list of who attended the meeting. Review of QAPI minutes dated 09/03/25 revealed policy and procedures were not being followed by nursing regarding medication management. The root cause was identified as failure to follow med pass policies. Action steps included medication delivery records were audited for any deficient practices and no issues were identified; all controlled substances and as needed med use were audited for any deficient practices and no issues were identified; Narcotic sheets and medication administration records were audited for any deficient practices; education was provided to nursing to ensure policy and procedures regarding medication management were being followed. There was no list of who attended the meeting. During the survey it was determined that actual harm occurred on 09/02/25 when Resident #79 was diagnosed with osteomyelitis (infection of the bone) of the foot after the facility failed to provide physician ordered medication to be used after a stent procedure to prevent the stent from closing up and failed to arrange transportation to follow up appointments with the vascular surgeon from 07/02/25 to 09/22/25. (He required cot transport). Interview with Administrator #188 on 09/18/25 at 1:55 P.M. revealed that around the beginning of July 2025 the facility no longer had a contract with a non-emergent ambulance transportation service. She stated the facility still did not have a contract with a non-emergent ambulance transportation service. She stated a contract had been arranged but she had not yet signed the contract to put it into effect. She stated she did not know who or how many residents were not transported to appointments during that time. Interview with Transportation Manager #221 on 09/22/25 at 7:38 A.M. confirmed the facility had not had a contract for non-emergent transportation since 07/01/25. She confirmed Resident #79 had missed appointments with the vascular surgeon on 07/02/25, 09/08/25, and 09/10/25. During the survey, it was determined the facility failed to thoroughly investigate an allegation of missing narcotics and that misappropriation of narcotics occurred for Resident #51. The facility provided education for nurses without determining the extent of the issue and did not determine that misappropriation occurred as follows: Interview with Administrator #188 on 09/16/25 at 2:30 P.M. confirmed an allegation of missing narcotics was reported by LPN #169. She was unsure of the date. The facility documented that the Medical Director was notified on 09/03/25 at 2:20 P.M. of an allegation of potentially a card of narcotics missing. The note further stated the Administrator and Corporate were currently investigating. (same date as QAPI meeting regarding medication policies not being followed). Interview with Regional Nurse #200 on 09/16/25 at 2:35 P.M. revealed the facility investigated the allegations of missing narcotics by LPN #169 and LPN #195. However, they could not determine what happened. She stated that all of the controlled substance administration records for Oxycodone for Resident #51 were missing from 07/10/25 to 08/31/25. (sheets documenting when the medications were removed from the double locked cart they were secured in). On 09/17/25 at 10:30 A.M. she stated there were also missing controlled substance inventory count sheets (sheets used to keep track of narcotic count sheets coming in when delivered and going out when empty). She stated that with the missing records, they could not figure out the amount of Oxycodone missing for Resident #51. Interview with LPN/Unit Manager #175 on 09/17/25 at 9:30 A.M. revealed two nurses were supposed to sign in/sign out controlled substance administration records on the controlled substance inventory count sheet and were not. Interview with LPN #169 on 09/16/25 at 2:55 P.M. revealed LPN #195 first noticed a card containing Oxycodone missing for Resident #51. She stated the resident should have had Oxycodone left since only seven of 30 had been given. She stated the whole card, which should have had 23 pills, was missing from the locked cart. She confirmed she texted LPN/Unit Manager #241 regarding the situation with no response. She confirmed that Resident #81 should have had two sheets of Alprazolam signed in and only had one sheet signed in. She stated that RN</p>		