STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. Building B. Wing	11/26/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, review of self-reported incidents (SRI), interviews, and policy review the facility failed to implement their abuse policy to report an allegation of abuse accurately and in a timely manner for Resident #60. The facility also failed to thoroughly investigate an allegation of physical abuse between Resident #3 and #49. This affected three (Resident #3, #49, and #60) out of four residents reviewed for abuse. The facility census was 85.Findings include: 1. Review of the medical record revealed Resident #60 was admitted on [DATE] with diagnoses that included schizoaffective disorder, generalized anxiety disorder, obsessive-compulsive disorder, delusional disorders, and dementia.Review of the self-reported incident (SRI) #267325 dated 11/09/25 revealed an allegation of emotional/verbal abuse by staff towards Resident #60. It was reported Licensed Practical Nurse (LPN) #302 was speaking and behaving in a manner that could be deemed inappropriate. Resident #60 stated a LPN #302 took Resident #60 down the hallway, away from other residents, and spoke with Resident #60 in a manner that made her feel uncomfortable. LPN #302 told Resident #60 it was none of her business to speak about LPN #302 to other staff members. When Resident #60 stated they did not do that, LPN #302 continued to talk to the resident and made the resident uncomfortable. After completing the investigation, facility determined that abuse did not occur based on the Resident #60 stated it was not abusive in nature, interviews with other residents found no negative outcomes, and assessment of residents found no negative outcomes. Although the facility found the incident unsubstantiated, the employee was no longer with the facility as the employee did not follow the facility policy and procedures on customer service. A typed statement (no date) by Regional Director of Operations revealed SRI #267325 was opened and closed with the allegation being unsubstantiated. An interview with Resident #60 revealed there was no negative outcome, and interviews or assessments of like residents showed there were no negative outcomes. The SRI was opened up (initial was opened on 11/09/25). The description of the allegation was put in correctly. LPN #119 allegedly spoke in an aggressive manner regarding getting juice for Resident #60. LPN #119 was suspended pending investigation. SW #190 interviewed the resident, and the resident had no concerns with LPN #119 and no issue with juice. When SRI was being updated and closed, the wrong information was put in including the following. LPN #302 was entered as the perpetrator instead of LPN #119. The summary in the SRI was from another SRI that was copied and pasted in the wrong one. Although the wrong employee was put into SRI #267325, the facility completed and investigated allegations in appropriate manner. An interview on 11/26/25 at 11:35 A.M. Regional Director of Operations (RDO) verified he put the incorrect perpetrator into SRI #267325, the SRI narrative did not accurately describe the allegation, and the actual alleged perpetrator was still employed at the facility. Interviews with SW #190 and Regional DON on 11/26/25 at 12:43 P.M. verified on 11/07/25 CNA #114 asked for the DON's phone number. SW #190 stated she talked to CNA #114 on 11/07/25 and 7:26 P. M. but was not aware of an allegation of abuse. The allegation of abuse was reported to the Regional Director of operations on 11/09/25 at 2:37 P.M. The Regional DON verified the allegation of abuse was not immediately reported. The Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy and procedure dated 11/01/19 revealed facility staff should immediately report all such allegations to the Administrator/designee and to the Ohio Department of Health in accordance with the procedures in this policy. If a staff member is accused or suspected of abuse, neglect, exploitation, or mistreatment of a resident, the facility should immediately remove that staff member from the facility. All incidents and allegations of abuse, neglect, exploitation, mistreatment of a resident must be reported immediately to the administrator or designee. 2. Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included schizoaffective disorder, type 2 diabetes, psychosis, anxiety, and dementia.A general progress note dated 10/29/25 at 5:44 A.M. revealed Resident #3 was sitting in a chair by the elevator, and another resident (Resident #49) was standing in front of him. Resident #3 started yelling and telling the other resident to move away. Resident #3 then stood up and pushed the other resident. The nurse separated the residents and asked Resident #3 to go to his room. A general progress note dated 10/29/25 at 5:38 P.M. revealed Resident #3 was sitting in a chair by the elevator when he stood up and yelled and pushed another resident (unknown resident). The nurse separated the residents. Resident #3 went to his room. A new order was received for a pink slip and 911 was called and Resident #3 was transported to the hospital. Review of SRI #266942 dated 10/29/25 revealed an allegation of physical abuse between Resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of self-reported incident (SRI), interviews, and policy review the facility failed to report an allegation of abuse immediately and accurately. This affected one (Resident #60) out of four residents reviewed for abuse. The facility census was 85.Findings include:Review of the medical record revealed Resident #60 was admitted on [DATE] with diagnoses that included schizoaffective disorder, generalized anxiety disorder, obsessive-compulsive disorder, delusional disorders, and dementia. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #60 was cognitively intact. Review of self-reported incident (SRI) #267325 dated 11/09/25 revealed an allegation was made of emotional/verbal abuse by staff towards Resident #60. It was reported Licensed Practical Nurse (LPN) #302 was speaking and behaving in a manner that could be deemed inappropriate. Resident #60 stated a LPN #302 took Resident #60 down the hallway, away from other residents, and spoke with Resident #60 in a manner that made her feel uncomfortable. LPN #302 told Resident #60 it was none of her business to speak about LPN #302 to other staff members. When Resident #60 stated they did not do that, LPN #302 continued to talk to the resident and made the resident uncomfortable. After completing the investigation, facility determined that abuse did not occur based on Resident #60 stated it was not abusive in nature, interviews with other residents found no negative outcomes, and assessment of residents found no negative outcomes. Although the facility found the incident unsubstantiated, the employee was no longer with the facility as the employee did not follow the facility policy and procedures on customer service. The facility investigation revealed a handwritten statement dated 11/07/25 by Certified Nursing Assistant (CNA) #121 revealed CNA #114 asked for the cigarette box out of the medication room. During that time a resident came up to get some juice. CNA #114 got juice off the snack cart and went to hand it to the resident. LPN #119 hurried up and grabbed the cup from the resident and stood in front of CNA #114. LPN #119 told the resident to only ask LPN #119 for the juice. LPN #119 went to get ice to put in Resident #60's cup. LPN #119 grabbed the cigarette box and then put it back down in the medication room and laughed. LPN #119 caused a very uncomfortable and hostile work environment. A handwritten statement dated 11/07/25 by CNA #114 revealed LPN #119 was asked for the cigarette box so residents could go out to smoke. LPN #119 stated she was giving report. Resident #60 came out of her room and asked for juice. LPN #119 stopped giving report to the oncoming nurse and stood between CNA #114 and Resident #60. LPN #119 grabbed Resident #60's cup and told the resident she knew who she could get juice from. CNA #114 had the juice pitcher in her hand and told LPN #119 she could get Resident #60 the juice. LPN #119 then stopped giving report to the oncoming nurse and went to the medication room and grabbed the cigarette box, slammed it down, and walked out of the medication room laughing without the cigarette box. Resident #20 witnessed this and was immediately upset. CNA #114 calmed Resident #20 and asked LPN #117 to get the cigarette box. LPN #119 told LPN #117 not to get the cigarette box and stated she would get it. LPN #119 then slammed the cigarette box on the nurse's cart for CNA #114. CNA #114 stated LPN #119's actions intimidated Resident #60 by snatching things (juice cup) and scolding Resident #60 for coming out of her room to get juice. CNA #114 felt it was embarrassing and abusive.A handwritten statement dated 11/08/25 by LPN #119 revealed during report on 11/07/25 Resident #60 came out with a purple robe on, a white see threw shirt, and no pants and stated she wanted some juice. LPN #119 approached Resident #60 near the bathroom and closed the resident's robe and whispered that Resident #60 did not have pants on. Resident #60 went back to her room. During this time CNA #114 told Resident #20 she's doing it on purpose. A short time later CNA #114 asked LPN #117 to get the cigarette box since LPN #119 was ignoring her. LPN #119 went to get the cigarette box and heard CNA #114 tell Resident #20 that LPN #119 was ignoring her. Resident #20 stated, that (expletive) was definitely ignoring you. LPN #119 walked away to get Resident #60 a cup of juice. A typed statement dated 11/09/25 of an interview with Resident #20 by Social Worker (SW) #190 revealed a nurse ignored the CNA when they asked for the cigarette box. The LPN had a smirk on her face. A resident wanted juice and the nurse said they would get the juice. The nurse got the juice instead of the cigarette box. Resident #20 stated it was a bunch of drama. Resident #20 also stated there was no yelling or cursing but the nurse (LPN #119) was a smartass. A typed statement dated 11/09/25 of an interview with Resident #60 by SW #190 revealed a staff member did not want to give her juice. Resident #60 did not know the staff members' name and stated someone did give her juice. A typed statement (no date) by Regional Director of Operations (RDO) revealed

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of self-reported incident (SRI), interviews, and policy review, the facility failed to thoroughly investigate an allegation of physical abuse between Resident #3 and #49. This affected two (Resident #3 and #49) out of four residents reviewed for abuse. Facility census was 85. Findings include: Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included schizoaffective disorder, type 2 diabetes, psychosis, anxiety, and dementia.A general progress note dated 10/27/25 at 1:53 P.M. revealed Resident #3 appeared agitated over smoking schedule. A new order was received for two milligrams of Ativan (antianxiety) now. A general progress note dated 10/27/25 at 3:23 P.M. revealed Resident #3 appeared calm. There were no outbursts of yelling or any inappropriate behaviors at this time. A general progress note dated 10/28/25 at 4:45 P.M. revealed a new order was received for scheduled Ativan two milligrams every evening for anxiety and aggression.A general progress note dated 10/29/25 at 5:44 A.M. revealed Resident #3 was sitting in a chair by the elevator, and another resident was standing in front of him. Resident #3 started yelling and telling the other resident to move away. Resident #3 then stood up and pushed the other resident. The nurse separated the residents and asked Resident #3 to go to his room. A behavior charting note dated 10/29/25 at 8:00 A.M. revealed Resident #3 was upset about not being able to smoke. Resident #3 went out the E hall exit door by kicking it open. Staff were able to get the resident to return to the building. A general progress note dated 10/29/25 at 8:37 A.M. revealed Resident #3's guardian was notified of Resident #3's increased behaviors. The medical and psychiatric doctor were notified Resident #3 had increased behaviors. A general progress note dated 10/29/25 at 5:38 P.M. revealed Resident #3 was sitting in a chair by the elevator when he stood up and yelled and pushed another resident. The nurse separated the residents. Resident #3 went to his room. A new order was received for a pink slip and 911 was called and Resident #3 was transported to the hospital.The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had cognitive impairment. Review of additional medical record revealed Resident #49 was admitted on [DATE] with diagnoses that included dementia, atrial fibrillation, and cachexia. The admission MDS dated [DATE] revealed Resident #49 had severe cognitive impairment. A narrative note dated 10/29/25 at 11:44 P.M. revealed Resident #49 denied any pain or discomfort from previous incident.Review of SRI #266942 dated 10/29/25 revealed an allegation of physical abuse between Resident #3 and #49. The SRI was marked that Resident #3 and #49 were able to provide meaningful information. An investigation determined Resident #3 did not push Resident #49 but did touch Resident #49's arm in a nonaggressive manner.The facility investigation revealed a handwritten statement (no date) by CNA #115. The statement revealed on 10/29/25 during supper and out of nowhere Resident #3 stood up and got in Resident #49's face and started yelling. Resident #3 yelled at the nurse and a laundry aide. A handwritten statement (no date) by CNA #151 revealed on 10/29/25 revealed they did not witness the incident but did witness Resident #3 yelling at the nurse and laundry aide. A handwritten statement dated 10/29/25 by CNA #130 revealed she heard yelling but did not see any altercations between the two residents. The nurse broke them up and Resident #3 started to walk away and then cursed at CNA #130.An interview on 11/26/25 at 12:40 P.M. Regional Director of Operations (RDO) verified the complete investigation for SRI #266942 had been provided to surveyor. RDO stated he started a SRI because it was reported that Resident #3 pushed Resident #49. RDO verified the investigation did not include any statements about Resident #3 pushing Resident #49. RDO also verified the SRI revealed Resident #3 and Resident #49 were marked as able to provide meaningful statements and no statements were included in the facility investigation provided to the surveyor. RDO was unable to say who reported the incident, to whom it was reported, and when RDO was made aware of the allegation of abuse. RDO was unable to provide information to coincide with Resident #3 touching Resident #49 in a nonaggressive manner.On 11/26/25 at 1:46 P.M. Regional Director of Nursing (DON) provided two handwritten statements completed by herself dated 10/30/25 that Resident #3 and Resident #49 could not recall the events. Regional DON also provided a handwritten statement dated 10/29/25 by LPN #303 (no longer employed at the facility). The statement revealed Resident #49 was standing by the elevator and Resident #3 was sitting in a chair near the elevator. Resident #3 began yelling at Resident #49 and told Resident #49 to move away from him. The nurse stood up, and Resident #3 also stood up yelling and pushed Resident #49. The nurse separated the residents and told Resident #3 to go to his room and calm down. Resident #3 argued for a few minutes and then went to

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure a requested discharge process was completed timely and thoroughly. This affected two residents (Residents #44 and #82) of three residents reviewed for discharge process. The census was 85.Findings Include:1. Resident #44 was admitted to the facility on [DATE]. Her diagnoses were anoxic brain injury, dementia, bipolar disorder, major depressive disorder, edema, post traumatic stress disorder, opioid use, anxiety disorder, anemia, insomnia, and nightmare disorder. Review of her minimum data set (MDS) assessment, dated 09/30/25, revealed she was cognitively intact.Review of Resident #44 progress notes, dated 09/30/25 to 10/16/25, revealed 13 different referrals were sent to other nursing facilities for the possible transfer/discharge of Resident #44. Documentation supported that she was denied admittance to all of those facilities. After 10/16/25, there was no documentation to support more referrals were sent and/or there was communication with Resident #44 guardian about continuing/discontinuing the process in finding another facility.Review of Resident #44 current care plan revealed a discharge care plan with the intervention of, All discharge planning to be documented.Interview with Resident #44 guardian on 11/26/25 at 11:07 A.M. revealed she has not heard anything more about Resident #44 discharge; she confirmed it was about a month or so since last time she heard about the process.Interview with Social Services Director #190 on 11/26/25 at 2:02 P.M. confirmed there was no documentation to support she had communicated with either Resident #44 guardian about the discharge requests/process. She confirmed it's been at least a few weeks since she has spoke the guardian about the progress of the discharges. She confirmed there was no documentation other than what was listed above, regarding the resident's discharge.2. Resident #82 was admitted to the facility on [DATE]. Her diagnoses were type II diabetes, chronic obstructive pulmonary disease, emphysema, obstructive sleep apnea, bipolar disorder, schizophrenia, hyperlipidemia, hypothyroidism, borderline personality disorder, mood disorder, suicidal ideations, and personal history of transient ischemic attack. Review of her MDS assessment, dated 09/16/25, revealed she was cognitively intact.Review of Resident #82 progress notes, dated 09/24/25, revealed the facility spoke with Resident #82 guardian, and they would work on getting on the assisted living waiver program and discharging to an assisted living.Review of Resident #82 progress notes, dated 09/29/25, revealed the discharge plan was to remain long term in this facility until the assisted living waiver is completed and an assisted living facility accepts her.Review of Resident #82 progress notes, dated 10/09/25, revealed social services left a voicemail with guardian to discuss possible discharge.Review of Resident #82 medical records, including progress notes, physician notes, physician orders, and care plans, revealed no further documentation after 10/09/25, to discuss the progress the facility had made with Resident #82 assisted living waiver and if they were attempting to find an assisted living to accept her and her guardian's request for a transfer/discharge.Interview with Social Services Director #190 on 11/26/25 at 2:02 P.M. confirmed there was no documentation to support she had communicated with Resident #82 guardian about the discharge requests/process. She confirmed it's been at least a few weeks since she has spoke with the guardian about the progress of the discharges. She confirmed there was no documentation other than what was listed above, regarding the resident's discharge.Review of facility Resident Rights policy, dated 2016, revealed federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to communication with and access to people and services, both inside and outside the facility, and be supported by the facility in exercising his or her rights.This deficiency represents non-compliance investigated under Complaint Number 2631251.