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	12/15/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 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 reviews, interview, and facility policies review, the facility failed to ensure residents were not physically restrained. This affected one (#10) of three residents reviewed for abuse. The facility census was 84. Findings Include:Review of the medical record for the Resident # 10 revealed an admission date of 11/18/25. Diagnoses included Type II Diabetes, morbid obesity, bipolar disorder and depression. Review of his admission Minimum Data Set (MDS) assessment dated [DATE] and discharged MDS dated [DATE] revealed Resident #10's brief interview of mental status (BIMS) was not recorded. Review of hospital documentation dated 11/22/25 revealed Resident #10 was alert and oriented three times (person, place and time). He used a walker and wheelchair to transport himself throughout the facility and required one person supervision for activities of daily living. Review of nursing facility progress notes dated 11/22/25 from 11:10 A. M. through 11:30 A.M. revealed Resident #10 was in the hall yelling he was going to punch everyone. Staff immediately went to talk to the resident and assist with his needs and calm the resident down. Resident #10 started swinging his fist at all the staff attempting to go to other resident rooms. Staff continued to attempt to talk with Resident #10 unsuccessfully. Resident #10 continued to yell and swing his fist in the hallway. The physician was made aware. At 11:05 A.M. Resident #10 was documented to become more aggressive and staff was not successful in assisting the resident. 911 was called. At 1:30 P.M. the Sheriff arrived to assist with the resident and the resident stated he would listen to the Sheriff when asked if he would calm down. The resident was agreeable to go to the hospital, and the ambulance transported Resident #10 out of the facility. Review of progress note dated 11/22/25 at 7:02 P.M. revealed Resident #10 was returned to the facility from the hospital at 4:30 P.M. and upon return the resident was yelling at the ambulance crew using profanity and the ambulance crew was attempting to calm the resident, who did transfer to his wheelchair so the ambulance crew could leave the facility. Nursing staff offered to get the resident food or something to drink and attempted to see if he had other needs, but the Resident said no he was fine. Resident #10 was then documented to start yelling at staff about where his dog went, started swinging at staff making contact with his fist and multiple staff members. The physician was called immediately, and the facility retained an order to pink slip the resident. Resident #10 continued to get aggressive, and staff stayed with the resident to assist in keeping him safe and other staff and residents safe. At 5:20 P.M. the Sheriff deputy arrived at the facility and the resident started to calm down when he saw them stating he would be good with them at the facility. The sheriff went to the resident room and at approximately 6:00 P.M. the paperwork for the pink slip was obtained. At 7:00 P.M. the county ambulance was at the facility to transport Resident #10 out of the facility. Review of Resident #10's physician orders revealed no orders for a restraint. Interview on 12/08/25 at 2:37 P.M. with Regional Administrator (RA) revealed it was reported to her on Monday, 11/24/25 that Resident #10 was restrained to a chair over the weekend due to behavior. RA stated because of the information, she started an internal investigation which determined Resident #10 was not restrained. RA did confirm Resident #10's behavior was out of control and LPN #118 used a bath sheet held in front of Resident #10 to prevent Resident #10 from hurting other residents and staff until the police and emergency medical services (EMS) arrived at the facility. Review of staff statements for the internal investigation revealed CNA #205, and LPN # 126 had statements related to the incident with Resident #10 on 11/22/25 but neither documented LPN #118 using a bath blanket to prevent Resident #10 from hurting staff or residents. The statements obtained explained the behaviors Resident #10 was displaying.Review of the internal investigation documents compiled by the Regional Administrator confirmed LPN #118 on 11/22/25 had an incident with Resident #10 where Resident #10 was being held in his wheelchair with a bath sheet across his torso. The sheet was being held behind Resident #10 by LPN #118. Further review of the progress notes revealed the there was no documentation of Resident #10 having a sheet put around him and held by LPN #118. Interview on 12/08/25 from 3:20 P.M. to 3:45 P.M. with Certified Nursing Assistant (CNA) #124 confirmed she was working in the unit when Resident #10 was having behaviors, his behaviors were bad, he was trying to go through the unit doors to get to other residents. Several attempts were made to calm him, but they were unsuccessful. CNA #124 stated Resident #10 was a large man and punched her in the stomach causing bruises. She confirmed a bed sheet was used to prevent Resident #10 from hitting other residents or staff. The bed sheet was placed across his torso and one across his chest and held behind him by Licensed Practical Nurse (LPN)#118. CNA #124 stated the sheet was not tied in a knot but was just being

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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 record reviews, interview, and facility policy reviews, the facility failed to notify the State Agency of an allegation of abuse. This had the potential to affect one resident (#10) of three residents reviewed for abuse. The census was 84. Findings Include: Review of the medical record for the Resident # 10 revealed an admission date of 11/18/25. Diagnoses included Type II Diabetes, morbid obesity, bipolar disorder and depression . Review of his admission Minimum Data Set (MDS) assessment dated [DATE] and discharged MDS dated [DATE] revealed Resident #10's brief interview of mental status (BIMS) was not recorded. Review of hospital documentation dated 11/22/25 revealed Resident #10 was alert and oriented three times (person, place and time). He used a walker and wheelchair to transport himself throughout the facility and required one person supervision for activities of daily living. Review of Resident #10's medical record revealed no physician order for a restraint and no documented incident where the resident was restrained by the staff. Interview on 12/08/25 at 2:37 P.M. with Regional Administrator (RA) revealed it was reported to her on Monday, 11/24/25 that Resident #10 was restrained to a chair over the weekend due to behaviors. RA stated because of the information , she started an internal investigation, but denied notifying the Ohio Department of Health of the potential abuse incident. The RA confirmed she did not file a Self-Reported Incident (SRI) stating she believed the incident was not abuse, as the internal investigation determined Resident #10 was not restrained. RA did confirm Resident #10's behavior was out of control and LPN #116 used a bath sheet held in front of Resident #10 to prevent Resident #10 from hurting other residents and staff until the police and emergency medical services (EMS) arrived at the facility. Interview on 12/08/25 from 3:20 PM to 3:45 PM with Certified Nursing Assistant (CNA) #124 confirmed she was working in the unit when Resident #10 was having behaviors, his behaviors were bad, he was trying to go through the unit doors to get to other residents . Several attempts were made to calm him, but they were unsuccessful. CNA #124 stated Resident #10 was a large man and punched her in the stomach causing bruises. She confirmed she witnessed a a bed sheet used to prevent Resident #10 from hitting other residents or staff . CNA #124 said the bed sheet was placed across his torso and one across his chest and held behind him by Licensed Practical Nurse (LPN) #118. CNA #124 stated the sheet was not tied in a knot but was just being held by LPN #118 hands. Interview on 12/09/25 at 12:00 P.M. with LPN # 126 confirmed he was working as the nurse on 11/22/25 when Resident #10 was sent to the hospital two times for his behaviors. He confirmed staff tried every possible intervention to calm Residents #10 with no success. He confirmed he witnessed a sheet used across Resident #10's torso and chest, which was held behind the resident's back by LPN #118 to keep Resident #10 from striking or hurting other residents and staff . Telephone interview on 12/12/10/25 at 10:01 A.M. with LPN #118 confirmed she was the nurse who on 11/22/25 at approximately 5:15 P.M. did place the sheets across Resident #10's body to prevent him from hurting himself, staff and residents. LPN #118 stated she was instructed by corporate to do whatever was needed to keep everyone safe. She held the sheets for approximately five minutes until Police and EMS arrived at the facility and Resident #10 was taken to a local hospital. Review of the internal investigation documents compiled by the Regional Administrator confirmed LPN #118 on 11/22/25 had an incident with Resident #10 where Resident #10 was being held in his wheelchair with a bath sheet across his torso . The sheet was being held behind Resident #10 by LPN #118. Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property 10/27/2017 , revealed Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain , or mental anguish.It is the facility's policy to investigate alleged violations involving abuse, neglect, and exploitation of a resident. Facility staff should immediately report all such allegations to the Administrator and to the Ohio Department of Health (ODH) in accordance with the procedures in the policy.Review of facility policy titled, Use of Restraints the definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same way the staff applied it given that resident's physical condition and restricts his typical ability to change position or place, that device is considered a restraint.This deficiency substantiates Complaint Number 2683512.This deficiency is a recite to the complaint survey completed 11/26/25.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, observations, and staff interview, the facility failed to ensure residents were free from significant medication errors when their full course of antibiotics would not be given. This affected two of three sampled residents (Residents #51 and #52). The census was 84.Findings Include:1.Review of the medical record for Resident #51 revealed an admission date of 07/21/25 and diagnoses including chronic obstructive pulmonary disease, morbid obesity, asthma, and chronic respiratory failure with hypoxia.Review of nursing progress notes revealed on 12/05/25 at 4:18 P.M. the resident was noted with cough/congestion this shift. Minimal relief from nebulizer treatments. Lungs with diminished bases bilaterally. Scattered rhonchi (sounds caused by constricted airways) noted throughout, some cleared with cough. Sputum light yellow to brown. Call to Certified Nurse Practitioner with new orders for stat chest X-ray. On 12/06/25 at 3:24 P.M. the notes stated chest X-ray received. Physician contacted and new order for antibiotics. Review of physician's orders revealed an order on 12/06/25 for Doxycycline (an antibiotic) 100 milligrams (mg) twice daily for 7 days (14 doses). Review of the medication administration record (MAR) revealed the first dose of antibiotic was given on 12/06/25 at 10:00 P.M. Review of pharmacy records revealed the first dose of antibiotic was taken from the facility emergency stock on 12/06/25 at 3:22 P.M. The medication administration record indicated the final dose was to be given on 12/13/25 at 10:00 A.M.Observations on 12/11/25 at 9:32 A.M. revealed Resident #51 was given a dose of the antibiotic. Observations revealed that, after the dose was given, there were still eight pills left on the medication card. The medication card indicated that the pharmacy had sent 14 pills on 12/06/25. The medication administration record documented that 10 doses had already been given and four were left to be given (total of 14 doses). Because the initial dose of antibiotic came from the facility emergency stock, there should have only been five pills left on the medication card, not eight. Therefore, this indicated that the resident had missed receiving three doses of the antibiotic up to 12/11/25. Interview with Acting Director of Nursing #126 on 12/11/25 at 11:20 A.M. confirmed Resident #51 only had one dose of antibiotic pulled from the emergency stock. She confirmed that by having eight pills left on 12/11/25, the resident had missed receiving three doses of the antibiotic up to 12/11/25. She confirmed the resident should only have five pills left (four doses left in the course and one extra for the one pulled from the emergency stock). She confirmed there was no other place the nurses could have gotten the antibiotics from to give other than the medication card. She confirmed it was important for residents to receive their whole course of antibiotics to prevent the infection from returning. 2.Review of the medical record for Resident #52 revealed an admission date of 12/31/24 and diagnoses including schizoaffective disorder, chronic kidney disease, hypertension, and benign prostatic hyperplasia.Review of nursing progress notes revealed on 12/05/25 at 4:13 P.M. the resident was noted with increasing pain to his penis. Penis shaft bright red, swollen, and tender to touch. Scrotum also tender and slightly swollen. Call to physician. New order for antibiotics for seven days. Review of physician's orders revealed an order on 12/05/25 for Doxycycline (an antibiotic) 100 milligrams twice daily for 7 days (14 doses). Review of the medication administration record revealed the first dose of antibiotic was given on 12/05/25 at 10:00 P.M. Review of pharmacy records revealed the first dose of antibiotic was taken from the facility emergency stock on 12/05/25 at 6:47 P.M. The medication administration record indicated the final dose was to be given on 12/12/25 at 10:00 A.M. Observations on 12/11/25 at 9:30 A.M. revealed Resident #52 was given a dose of the antibiotic. Observations revealed that, after the dose was given, there were still five pills left on the medication card. The medication card indicated that the pharmacy had sent 14 pills on 12/05/25. The medication administration record documented that 12 doses had already been given and two were left to be given (total of 14 doses). Because the initial dose of antibiotic came from the facility emergency stock, there should have only been three pills left on the medication card, not five. Therefore, this indicated that the resident had missed receiving two doses of the antibiotic up to 12/11/25. Interview with Acting Director of Nursing #126 on 12/11/25 at 11:20 A.M. confirmed Resident #52 only had one dose of antibiotic pulled from the emergency stock. She confirmed that by having five pills left on 12/11/25, the resident had missed receiving two doses of the antibiotic up to 12/11/25. She confirmed the resident should only have three pills left (two doses left in the course and one extra for the one pulled from the emergency stock). She confirmed there was no other place the nurses could have gotten the antibiotics from to give other than the medication card. She confirmed it was important for residents to receive their whole course of antibiotics to prevent the infection from returning. Review of the facility policy titled Administering Medications dated 2001 (Revised December 20212) revealed