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	02/02/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, medical record review, and staff, and resident interview, the facility failed to maintain a homelike environment for residents by ensuring the facility supplied sufficient hot water for resident bathing and laundry needs. This deficiency had the potential to affect all 81 residents residing in the facility. The census was 81. Findings include:Observation and interview on 01/14/26 from 10:15 A.M. through 10:25 A.M. revealed the water temperature from Resident #60's bathroom faucet was tepid to touch. Interview with Resident #60 at the time of the observation confirmed the water in the resident's room was sometimes too cold. Interview on 01/14/26 at 10:28 A.M with Certified Nurse Aide (CNA) #141 confirmed the facility had issues with the boiler at least once every week, since at least March 2025. CNA #141 stated nursing management had previously advised staff that if the hot water was not working, to reschedule the assigned residents' baths and showers for the residents' comfort. She confirmed several residents have complained about the lack of hot water because their scheduled baths and showers for the impacted day have to be postponed.Observation and interview on 01/14/26 at 10:46 A.M., during a walking tour with Maintenance Director (MD) #750 and Regional Maintenance Director (RMD) #800, it was discovered the water temperature in the resident rooms on the first floor B area was 95.4 degrees Fahrenheit (F). The temperature reading was obtained on RMD #800's temperature gauge. MD #750 and RMD #800 acknowledged the temperature was below acceptable hot water temperatures. Interview with RMD #800 on 01/14/26 at 10:57 A.M. stated the facility had been in the process of purchasing and installing a new boiler. He said the process began in February 2025, but due to issues with their preferred supplier hindering the completion of the purchase, the new boiler had just been delivered to the facility within the past thirty days. The facility was currently obtaining bids for the boiler installation, which he expected to be completed soon. In the interim, MD #750 hired a consultant to immediately fix the existing boiler to produce water at the appropriate temperature.Interview with Housekeeping Director #799 on 01/20/26 at 11:53 A.M. confirmed the hot water in the facility intermittently did not get very hot. She acknowledged sometimes the water temperature delayed the residents from receiving their laundry in a timely manner because she has to wait to complete the laundry until the issue was fixed. She said it was usually less than a day that the issue persists.Review of medical record of Resident #70, who was cognitively impaired, revealed on 12/17/25 she declined to take her scheduled shower that evening because the water in the facility was too cold.Interview on 01/21/26 between 1:03 P.M. and 1:29 P.M. with Resident #20, Resident #08, and Resident #15 all confirmed the hot water temperatures in the facility do not always get hot enough and it had an impact of their bathing schedule. Interview on 01/20/26 at 11:21 A.M. with the Administrator and Regional Director of Operations (RDO) #490 revealed neither were aware of the water temperature concerns by residents and direct care staff within the facility.This deficiency represents non-compliance investigated under Master Complaint Number 2711777.

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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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, interviews with staff and the contracted psychiatric mental health nurse practitioner, review of facility self-reported incidents (SRIs), review of facility investigation documents, and review of facility policies and clinical protocols, the facility failed to ensure residents with a diagnosis of dementia and history of sexually inappropriate behaviors received adequate and effective behavioral health services to address their need for individualized interventions, monitoring, and supervision. This resulted in Immediate Jeopardy and the risk for serious life-threatening harm or negative health outcomes beginning on 12/12/25 when Resident #10, who was assessed with severely impaired cognition and had a history of sexual inappropriate behaviors, was moved to the secured unit where a resident (#05) with moderately impaired cognition and history of sexual acts with other residents resided, without either resident being adequately assessed/reassessed or revisions made to their behavioral health care plans related to monitoring and supervision to prevent potentially unsafe and inappropriate (sexual) behaviors. Due to the lack of individualized and effective behavioral health care, on 12/18/25 at 11:00 A.M., facility staff discovered Resident #10 in Resident #05's bedroom, with Resident #05 wearing no pants straddling Resident #10 who was also wearing no pants. The residents were observed engaged in sexual intercourse. This affected two residents (#05 and #10) of four sampled residents reviewed with a diagnosis of dementia who were vulnerable to targeted behaviors of other residents. The facility identified five residents (#60, #61, #63, #64, and #65) residents with impaired cognition and who exhibited sexually inappropriate behaviors. The facility census was 81.On 01/21/26 at 5:14 P.M., the Administrator, Regional Director of Operations (RDO) #490, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 12/12/25 when Resident #10, with a diagnosis of dementia, a history of sexually inappropriate behaviors, and after having recently been identified to have exhibited an increase in sexual behaviors, was moved to the secured unit on the second floor where Resident #05 resided. Resident #05 also had a diagnosis of dementia and a history of sexually inappropriate behaviors. Once Resident #10 and Resident #05 resided on the same unit, the facility failed to perform re-assessments of the residents or implement any increased supervision or monitoring related to their sexually inappropriate behaviors to prevent further sexual incidents. This continued until 12/18/25 at 11:00 A.M. when Resident #10 was discovered in Resident #05's bedroom both wearing no pants and engaged in sexual intercourse and required intervention by multiple staff members to separate the two residents. The Immediate Jeopardy was removed on 01/21/26 when the facility implemented the following corrective actions:- On 12/18/25 at 11:00 A.M., the DON, Certified Nurse Practitioner (CNP) #900, and Resident #05's guardian were all notified of the sexual incident with Resident #10. Full body skin assessments were completed for Resident #05 and Resident #10. - On 12/18/25 at 1:07 P.M., Resident #10's guardian was notified by the facility of the sexual incident with Resident #05. The facility requested permission to transfer Resident #10 out of the facility later that day.- On 12/18/25 at 1:24 P.M., the facility submitted an initial SRI with an allegation of sexual abuse to the State Survey Agency regarding the incident between Resident #05 and Resident #10.- On 12/18/25 at 1:30 P.M., Resident #05 and Resident #10 were visited and evaluated by Psychiatric Mental Health Nurse Practitioner (PMHNP) #905. - On 12/18/25 at 4:41 P.M., Resident #05 was sent to the hospital for further medical evaluation and sexually transmitted disease and hepatitis screenings.- On 12/18/25 at 5:55 P.M., Resident #10 was discharged to another facility.- On 12/23/25, Resident #05 was discharged to another facility.- On 01/21/26, Minimum Data Set (MDS) Nurse #273, Assistant Director of Nursing (ADON) #339, and Wound Nurse #354 interviewed all residents with a (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Brief Interview for Mental Status score of 13 and above (indicating intact cognition) and asked if they had ever experienced an inappropriate sexual encounter while in the facility, if they knew who to report those types of encounters to, and if they felt safe in the facility. All other residents with a BIMS score of 12 and below (indicating cognitive impairment) had a skin assessment completed to identify any possible changes. - On 01/21/26, MDS Nurse #273, ADON #339, and Wound Nurse #354 completed behavior assessments for all residents in the facility.- On 01/21/26, RDO #490 and Corporate Quality Assurance Nurse (CQAN) #467 completed education to all staff on the facility dementia clinical protocol, resident routine checks, behavioral assessment, intervention, and monitoring, and the facility system change for sexually inappropriate residents. The new process included, before residents were admitted to the facility, the interdisciplinary team (IDT) would review the referrals to see if the residents had sexual inappropriate behaviors. All residents with diagnosis of dementia with sexual inappropriate behaviors, as well as cognitive intact residents with sexual inappropriate behaviors, would be care planned for sexual inappropriate behaviors. All of the identified residents would be followed by the psychiatric team. If a resident was sexually inappropriate with staff and/or another resident, the nursing management team and psychiatric team would be notified immediately. The resident would immediately be placed on every 15-minute checks and/or up to being placed on one-to-one observation until the resident was deemed safe by the psychiatric team or physician.- On 01/21/26, ADON #339 and Regional Nurse #255 reviewed the last 72 hours of resident charting to identify any documentation of sexual behaviors. During the review, five (#60, #61, #63, #64, and #65) residents were placed on every 15-minute checks for inappropriate comments to staff. All orders were in place for monitoring and notifications were made on 01/21/26. All direct care staff, including nurses and nurse aides, would be completing the resident observations and if a change was needed, a member of the management team would conduct the resident checks. The IDT team, collaborating with the psychiatric team and physician, would determine when the resident checks would be discontinued. All residents at risk would be reviewed weekly, and any change would warrant a conversation and meeting with the team to determine a plan of action.- On 01/21/26, MDS Nurse #273 reviewed and confirmed all residents with sexual behaviors had care plans in place with appropriate interventions.- On 01/21/26 at 7:30 P.M., an ad hoc (as needed) Quality Assurance and Performance Improvement (QAPI) meeting was held to review the system change for sexually inappropriate residents and education provided to staff. Staff who were at the meeting included Medical Director #1 (via telephone), Activities Director #440, Human Resources Director (HRD) #201, Social Services Assistant #430, Regional Nurse #255, MDS Nurse #273, Receptionist #221, Wound Nurse #354, and CQAN #467.- On 01/21/26, the facility created an audit tool to be reviewed weekly at the standard of care meetings with the IDT to ensure residents were identified and interventions were in place. The residents would be audited with a diagnosis of sexual behavior or any sexual behavior identified. The IDT would be completing the audits weekly. The system change was on-going and would continue to ensure all residents at risk would be identified and interventions would be put into place.- The DON or designee would audit behavior documentation five times a week for four weeks to ensure interventions were in place.- On 01/22/26, the medical records for Resident #60, Resident #61, Resident #63, Resident #64, and Resident #65 were reviewed and verified care plans were in place with acceptable interventions for inappropriate sexual behaviors and confirmed each resident was under the care of PMHNP #905.- On 01/22/26 between 3:20 P.M. and 3:55 P.M., direct staff members were noted to be providing adequate surveillance for Resident #60, Resident #61, Resident #63, Resident #64, and Resident #65 with no issues noted.- Interviews on 01/22/26 between 3:20 P.M. and 3:52 P.M. with Registered Nurse (RN) #191, Licensed Practical Nurse (LPN) #504, (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and Certified Nurse Aide (CNA) #141 verified all staff members were educated on 01/21/26 regarding dementia clinical protocol, resident routine checks, and behavioral assessment, intervention, and monitoring, and were knowledgeable of the education content and were able to identify residents requiring increased surveillance and procedure for the resident checks.Although the Immediate Jeopardy was removed on 01/21/26, the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance.Findings include:Review of Resident #05's medical record revealed an admission date of 02/17/25 with diagnoses including anoxic brain damage, dementia, bipolar disorder, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD). Resident #05 had an appointed legal guardian.Review of Resident #5's admission progress note dated 02/17/25 revealed the resident arrived at the facility and was alert and oriented to self. Resident #05 exhibited repetitive speech, inappropriate laughter, was pacing the hallways, and had flight of ideas with unrelated conversation. Further review revealed Resident #05 made unusual statements regarding miscarriages, birth control, and her prior facility. Resident #05 frequently asked questions, did not like to be alone, and required encouragement to remain appropriately dressed.Review of a care plan dated 02/18/25 revealed Resident #05 could be sexually inappropriate with others per her guardian. The care plan indicated the resident's guardian was agreeable to Resident #05 having one partner. Interventions on 02/18/25 included but were not limited to providing behavioral health services as indicated, monitoring the resident for wandering into other residents' rooms, if sexually inappropriate behaviors occurred, remove the resident from the situation and place on a one-on-one observation immediately until the Administrator is notified for further instruction, and administer medication as ordered.Review of Resident #05's comprehensive care plan revealed a focus area initiated on 04/01/25 to place Resident #05 on every 15-minute checks for sexually inappropriate behaviors as the resident stated she gave another resident oral sex and her mouth hurt. The care plan focus area was marked as resolved on 04/04/25. On 09/19/25 a plan of care was initiated for Resident #05 to have one-to-one observation with a staff member to be with the resident at all times (this care plan was resolved on 09/23/25) and the resident was placed on every 15-minute checks. This care plan was resolved on 09/25/25. Resident #05's care plan was updated again on 09/25/25 to include a focus area for the resident to be on one-to-one observation with a staff member at all times (care plan resolved on 10/17/25). On 11/20/25, Resident #05 was care-planned for every 15-minute checks with a resolution date of 12/02/25.Review of Resident #05's nursing progress note dated 04/01/25 revealed the resident had oral sex with another resident. Resident's guardian was informed of the resident's sexual behaviors the same date and the guardian requested male residents be kept out of Resident #05's room.Review of the provider visit notes by PMHNP #905 dated 04/01/25 revealed Resident #05 was restless and stated she wanted to slit her wrists but promised she would not harm herself. Resident #05 again reported she had engaged in oral sex with a male resident. PMHNP #905 educated Resident #05 on safe sexual practices and condoms were provided. Resident #05 agreed to not have males in her room while she was unclothed.Review of a nursing progress note dated 04/06/25 revealed Resident #05 was observed rolling up her pant legs and encouraging a male resident to rub her legs. Per nursing staff, Resident #05 remained non-compliant with redirection despite repeated attempts. Her guardian was notified and stated she was agreeable to the resident having a boyfriend but requested Resident #05 and the boyfriend not be left alone together.Review of a nursing progress note dated 04/10/25 revealed Resident #05 was observed by facility staff kissing a male resident in her room. Review of a nursing progress note dated 04/18/25 revealed (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #05 was observed by other residents with a male resident's hands in her pants while the two residents were sitting together. Facility staff separated the residents and placed Resident #05 temporarily on every 15-minute checks.Review of a nursing progress note dated 05/05/25 revealed Resident #05 was observed entering multiple male residents' rooms. The note indicated staff redirected the resident with short-term success.Review of a nursing progress note dated 05/11/25 revealed Resident #05 was repeatedly observed in a male resident's room. The note indicated staff redirected the resident with short-term success.Review of nursing progress note dated 07/18/25 at 12:43 P.M. revealed the facility suggested, and Resident #05 and her guardian agreed to a room change from the second-floor secured unit to the first floor. The move was in effort to curb ongoing sexual behaviors by Resident #05. The guardian stated if the inappropriate sexual behaviors persisted, she would request placement of Resident #05 in an all-female facility in the interest of her safety.Review of the nursing progress note dated 08/25/25 revealed Resident #05 repeatedly entered the lobby without wearing pants or an incontinence brief. Further review revealed when staff redirected Resident #05, she mocked staff. The note also indicated Resident #05 was found sitting on a male resident's bed the same day.Review of the nursing progress note dated 09/14/25 revealed Resident #05 was speaking in explicit sexual detail to her roommate. Facility staff encouraged her to stop; however, the resident refused and stated she liked discussing the topic.Review of an incident note dated 09/19/25 at 1:00 P.M. revealed Resident #05 was found in Resident #61's room and appeared to touch Resident #61's penis. Resident #05 was removed from the room and placed on one-to-one observation for safety. A head-to-toe assessment was completed on both residents with no injuries identified, and Resident #05's physician and guardian were notified. Review of the provider visit notes by PMHNP #905 dated 09/19/25 at 1:00 P.M. revealed Resident #05 denied sexual encounters and reported she was assisting the male resident (#61) with dressing. Resident #05 was educated to avoid male residents' rooms.Review of the nursing progress note for Resident #05 revealed she was placed on one-to-one observation from 09/19/25 to 09/23/25. On 09/23/25, during an interdisciplinary team (IDT) meeting, PMHNP #905 decreased Resident #05's surveillance activity to every 15-minute checks. The intervention of every 15-minute checks was subsequently discontinued after 10/11/25, but there was no documentation in the medical record of the reason for it being discontinued. Review of social services documentation dated 09/30/25 revealed Resident #05's guardian officially requested the resident be transferred to an all-female facility due to ongoing inappropriate sexual behavioral concerns.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #05 was assessed with moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 12 and required (staff) assistance with activities of daily living (ADLs).Review of a nursing progress note dated 12/18/25 at 11:00 A.M. revealed Resident #05 was found in a room with another resident (#10). The note indicated the residents were separated immediately. The guardian and the DON were notified. The note included Resident #05 was assessed with no pain or injuries reported.Review of Resident #05's psychosocial visit note dated 12/18/25 at 4:16 P.M. revealed the resident admitted she initiated the sexual encounter with Resident #10 and believed she did nothing wrong.Review of Resident #05's Discharge summary dated [DATE] revealed the resident was discharged to another long-term care facility with an all-female unit per the guardian's request.Review of Resident #10's medical record revealed an admission date of 09/11/25 with diagnoses including ischemic cardiomyopathy, diabetes mellitus, gastroesophageal reflux disease, dementia, and major depressive disorder.Review of an admission note dated 09/11/25 at 4:25 P.M. revealed at the time of admission, Resident #10 was alert and oriented, pleasant, and cooperative. Review of a progress note dated 09/16/25 revealed Resident #10 and his sister requested and agreed to a room (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	transfer with no concerns reported.Review of the comprehensive MDS assessment dated [DATE] revealed Resident #10 had severely impaired cognition evidenced by a BIMS score of four (04) and required self-care assistance from staff.Review of Resident #10's care plan dated 10/07/25 revealed the resident exhibited sexually inappropriate behaviors related to an encounter with another resident. Interventions included but were not limited to administering medications as ordered, behavioral health services as indicated, and if sexually inappropriate behavior occurred, remove the resident from the situation and place on one-on-one observation until the Administrator was notified for further instruction, monitor for wandering in other residents' rooms. One of the goals for the care plan was Resident #10 would be monitored every 15 minutes for 72 hours for adjustments with being moved to the locked unit and no sexual behaviors which was initiated on 12/12/25.Review of the provider visit notes by PMHNP #905 dated 10/07/25 revealed Resident #10 was prescribed cimetidine (Tagamet), a medication used to reduce the amount of acid in the stomach, but an off-label use to reduce sexual desires, to target sexually inappropriate behaviors related to his dementia.Review of the nursing progress notes dated 11/28/25 revealed Resident #10 was observed in the dining hall touching himself inappropriately. The note indicated Resident #10 was redirected to his room and educated on boundaries and privacy. The note included the resident verbalized understanding.Review of the nursing progress note dated 11/30/25 revealed Resident #10 was observed fondling his genitals in the dining room. The note indicated the resident was redirected to his room, educated on privacy, and complied.Review of nursing progress notes dated 12/01/25 revealed Resident #10 was observed touching himself inappropriately on multiple occasions in common areas. The documentation indicated staff redirected the resident to his room each time.Review of the social services progress notes dated 12/10/25 at 2:54 P.M. revealed Resident #10's sister reported sexually inappropriate behaviors occurring at the resident's day program.Review of the nursing progress notes dated 12/11/25 revealed Resident #10's sister expressed concerns regarding medication (Tagamet) effectiveness for sexually inappropriate behaviors and discussed possible medication adjustments with nursing staff. Review of the provider notes by PMHNP #905 dated 12/12/25 revealed she adjusted Resident #10's medication (Tagamet) at the request of Resident #10's guardian and due to his recently observed inappropriate sexual behaviors.Review of the nursing progress notes dated 12/12/25 revealed Resident #10's room was changed from the first floor to the second-floor secured unit after staff witnessed the resident engaging in inappropriate touching of a female resident (#70).Review of nursing progress notes dated between 12/12/25 and 12/18/25 revealed no documented evidence Resident #10 was monitored at any increased intervals or new interventions were initiated.Review of the nursing progress notes dated 12/15/25 revealed Resident #10 made inappropriate sexual comments and attempted to touch a nurse during a blood sugar check. Resident #10 was educated on boundaries and redirected. Review of the nursing progress notes dated 12/16/25 revealed Resident #10 touched a nurse inappropriately following a shower. The resident was educated and redirected.Review of a nursing progress note dated 12/18/25 at 11:00 A.M. revealed Resident #10 was found in another resident's (#05) bed. The note indicated both residents were separated immediately and a head-to-toe assessment was completed with no injuries identified. The DON and the resident's family member were notified.Review of Resident #10's Discharge summary dated [DATE] revealed Resident #10 was discharged to another long-term care facility with all belongings and medications. The note indicated the resident's mood was stable at discharge and the receiving facility was aware of the resident's attendance at a day program.Review of a facility self-reported incident (SRI) dated 12/18/25 revealed the facility submitted the SRI related to an incident of sexual abuse. The facility initiated an investigation into Resident #05 and Resident #10's sexual encounter. CNA #141 reported to a nurse (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #05 was in bed with Resident #10 in an alleged sexual encounter. The residents were separated and both were assessed with no negative findings. The Administrator, both residents' responsible parties, and the physician were notified. Resident #05 was sent to the emergency room for evaluation with no new orders given at the hospital. Resident #10 was placed on one-to-one observation with no events noted until discharged to another facility on 12/18/25 at 8:00 P.M. Resident #05 was placed on every 15-minute checks until 12/19/25 with no negative outcomes. Review of CNA #141's written statement regarding the incident on 12/18/25 revealed she got Resident #05's roommate up for a shower and Resident #05 was noted to be half-asleep. After finishing Resident #05's roommate's shower, CNA #141 walked the resident down the hallway back to her room and noticed the bedroom door was closed. When CNA #141 opened the door, she witnessed Resident #05 on top of Resident #10 with no pants on and only wearing a shirt. Resident #10 was underneath Resident #05 with his pants down to his ankles and was penetrating Resident #05.Review of CNA #300's written statement regarding the incident on 12/18/25 revealed she noticed the door to Resident #05's room was closed, and when she opened the door, she saw Resident #05 on top of Resident #10. Resident #05 was wearing a big t-shirt and was wearing no pants, and Resident #10 was underneath Resident #05 with his pants down to his ankles and was penetrating Resident #05. The nurses were notified and after getting Resident #05 off of Resident #10, Resident #10 continued to masturbate. Interview on 01/15/26 at 10:45 A.M with CNA #141 confirmed she found Resident #05 and Resident #10 in bed together on 12/18/25 and verified the two residents were engaged in sexual intercourse. CNA #141 stated when she opened Resident #05's closed bedroom door, she observed Resident #05, without a covering on her perineal and sacral area, straddling Resident #10. CNA #141 stated underneath Resident #05, she saw Resident #10's exposed bare testicles exposed. CNA #141 stated she alerted other staff members to help separate the two residents. CNA #141 stated Resident #10 had been recently moved to the secured unit due to his sexually inappropriate behaviors and had concerns about him being moved there. CNA #141 stated residents on the secured unit were, generally, less cognitively aware and more vulnerable to another resident's behaviors. CNA #141 stated she reported her concerns to management on 12/12/25 on the date Resident #10 was moved to the second-floor secured unit. CNA #141 stated neither Resident #05 or Resident #10 were on any increased monitoring and she was not aware of any changes to their behavioral interventions after Resident #10 was moved to the secured unit on 12/12/25. Interview on 01/15/26 at 11:20 A.M. with CNA #161 stated she was working on the first floor of the facility on 12/18/25 but had concerns about Resident #10 being moved to the secured unit on the second floor due to his sexual inappropriateness. CNA #161 stated she did not relay her concerns to any of the management team.Interview with Resident #05's guardian on 01/15/26 at 11:50 A.M. confirmed Resident #05 had a history of inappropriate sexual behaviors at the facility and at her previous facility. She thought the behaviors would continue because the facility did not have the resources to provide the supervision Resident #05 needed to prevent these sexual encounters with other residents. Resident #05's guardian stated that was the reason she previously requested the resident be transferred to a facility with an all-female unit.Interview on 01/15/25 at 2:25 P.M. with HRD #201 revealed Resident #10 was moved from the first floor to the second floor because he had become romantically involved with Resident #70, who was cognitively impaired, and the staff thought they were being proactive to deter Resident #10 from engaging in inappropriate sexual activity. HRD #201 denied knowledge of any direct care staff member advising against Resident #10 being moved to the secured unit.Interview with the DON on 01/20/26 at 3:47 P.M. revealed she was alerted of the incident with Resident #05 and Resident #10 on 12/18/25 by Registered Nurse (RN) #199 soon after it occurred. The DON stated the staff did not expect anything of that nature to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. Building B. Wing	02/02/2026

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	occur when Resident #10's room was moved to the second-floor secured unit. The DON stated she believed she was preventing further sexual incidents between Resident #10 and Resident #70. The DON did not provide a response when asked if additional supervision of Resident #10 and Resident #05 was ever explored due to their history of inappropriate sexual behaviors.Interview with Resident #10's guardian on 01/21/25 at 3:10 P.M. confirmed she reported to the facility that Resident #10 was displaying inappropriate sexual behaviors at his offsite day program, and she expressed dissatisfaction with his current treatment plan for these behaviors, including the prescribed Tagamet. She stated she felt the facility was not providing enough surveillance for Resident #10 for the incident on 12/18/25 to occur during the day with facility staff present. Resident #10's guardian stated no staff member ever discussed concerns with her about Resident #10 being moved to the second floor.Interview with PMHNP #905 on 01/21/26 at 9:29 A.M. stated both Resident #05 and Resident #10 suffered traumatic brain injuries earlier in their lives and believed their inappropriate sexual behaviors were partially attributed to those injuries which made the behaviors more difficult to manage and treat. PMHNP #905 revealed her expectation was the facility staff would report to her anytime a resident was having sexually inappropriate behavior so she could recommend an intervention. She verified she was not advised by facility staff that Resident #10 was continuing to have inappropriate sexual behaviors following his room change on 12/12/25. She confirmed she would have adjusted his medication and/or implemented more frequent supervision for him if she had known. She also stated she did not authorize the facility staff to stop the 15-minute checks of Resident #05 in October 2025. Review of a facility policy titled, Dementia-Clinical Protocol, revised 03/15, revealed for the resident with confirmed dementia, the IDT would identify a resident-centered care plan to maximize remaining function and quality of life. The IDT would identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. Progressive or persistent worsening of symptoms and increased need for staff support will be reported to the physician. The IDT would adjust interventions and the overall plan depending on the individual's response to the interventions, progression of dementia, development of new acute medical conditions or complications, and changes in the resident or family's wishes.Review of a facility policy titled, Behavior Assessment, Intervention, and Monitoring, revised 12/16, revealed during the initial and comprehensive assessments, nursing staff and the attending physician were required to identify residents with a history of cognitive impairment or behavioral health conditions and evaluate baseline cognition and behavioral patterns. The IDT would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Interventions would be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. If the resident was being treated for altered behavior or mood, the IDT would seek and document any improvements or worsening in the individual's behavior, mood, and function. The IDT would monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms would be documented and reported. Interventions would be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment.This deficiency represents an incidental finding discovered during the investigation for Complaint Number 2705791.