

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 03/05/2026
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, review of activities calendars, and review of facility policy, the facility failed to ensure activity preferences were available to aides and failed to complete activities according to preference for Resident #37, #59, #89, and #90. This affected four residents (#37, #59, #89, and #90) of four residents reviewed for activities. The facility census was 82. Findings include:</p> <p>1. Review of Resident #90's medical record revealed an admission date of 02/27/26 with diagnoses including chronic obstructive pulmonary disease, bipolar disorder, alcohol dependence, and hypertension.</p> <p>Review of Resident #90's admission assessment dated [DATE] revealed the resident was alert to person only.</p> <p>Review of Resident #90's activity assessment dated [DATE] revealed he did not respond to the questions asked. There was no evidence his family was contacted.</p> <p>Review of Resident #90's activity documentation from 02/27/26 to 03/04/26 revealed no evidence Resident #90 had been invited to group activities. The only activity documented was a one on one activity of chatting performed by a nurses aide.</p> <p>Review of Resident #90's care conference dated 03/02/26 revealed activity staff was to offer group activities and review the monthly calendar.</p> <p>Observation on 03/02/26 at 10:30 A.M., 11:40 A.M., 2:12 P.M., and 4:15 P.M. revealed Resident #90 in bed with no entertainment.</p> <p>Observation on 03/03/26 at 9:37 A.M., 10:30 A.M., 11:05 A.M., 1:20 P.M., 2:12 P.M., and 4:15 P.M. revealed Resident #90 in bed with no entertainment. At 1:20 P.M. and 2:12 P.M. activities staff were observed in the common area with craft materials.</p> <p>Interview on 03/03/26 at 1:20 P.M. with Activities #141 verified no residents were participating in the scheduled activity of laundry sorting.</p> <p>Observation on 03/04/26 at 9:35 A.M. revealed Resident #90 in bed. Observation at 10:35 A.M., 1:55 P.M., and 2:29 P.M. revealed the resident in his wheelchair in the hallway with no entertainment. At 10:35 A.M. craft activities were occurring in the common area.</p> <p>Interview on 03/05/26 at 8:37 A.M. Activities #223 revealed she was unable to document any (continued on next page)</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
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>activities for Resident #90 and had no evidence he had participated in or been invited to activities since his admission.</p> <p>2. Observations on 03/02/26 from 3:15 P.M. to 3:40 P.M., 03/03/26 from 10:00 A.M. to 10:15 A.M., and 03/04/26 from 2:00 P.M. to 2:10 P.M. revealed Resident #59 was lying in bed the entire time. No staff went in her room to ask if she wanted to participate in any activities.</p> <p>Review of Resident #59's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses were chronic respiratory failure, morbid obesity, chronic obstructive pulmonary disease, sleep apnea, lymphedema, anxiety disorder, hyperlipidemia, post traumatic stress disorder, bipolar disorder, hypertension, delusional disorder, paranoid personality disorder, insomnia, and irritable bowel syndrome. Review of her minimum data set (MDS) assessment, dated 12/18/25, revealed she was cognitively intact.</p> <p>Review of Resident #59 activity assessments, dated 11/19/25 and 02/19/26, revealed staff will visit her room three times per week. The assessments stated she does not want to participate in activities outside her room, but there was nothing to indicate the question was asked if she wanted to participate in activities in the community.</p> <p>Review of Resident #59's activity logs, dated December 2025 to February 2026, revealed zero activities outside her room, including zero activities in the community.</p> <p>Interview with Resident #59 on 03/02/2026 at 3:21 P.M. confirmed they do not do any activities into the community. She stated she would love to go out to eat at a restaurant or go shopping at a store occasionally, but that is never offered.</p> <p>Interview with Activities Staff #223 on 03/05/26 at 8:38 A.M. confirmed she does not have access to any of the resident's activities assessments. She is not sure what activities each resident would like to complete, unless she gets to know the residents and they tell her. She confirmed they do not have availability or schedule any activities for residents to go out into the community; they will go to the store or pick up food from restaurants and bring them back to the facility.</p> <p>Review of facility activity calendars, dated January 2026 to March 2026, revealed no activities in the community for the residents.</p> <p>3. Review of Resident #37's medical record revealed an admission date of 11/20/24 with diagnosis including vascular dementia, anxiety disorder, and muscle weakness.</p> <p>Review of an Activities assessment dated [DATE] revealed activities staff will offer independent activities items as needed, staff will offer room visits, she wishes to not participate in group activities, and activity related focuses as per current care plan.</p> <p>Review of most recent Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #37 with moderate cognitive impairment.</p> <p>Review of an Activity plan of care created 07/13/23 and revised 01/23/26 revealed Resident #37 preferred listening to music, doing word searches, going to church services, and staff will provide music and word search books, and crafting supplies for independent activities. (continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations made on 03/02/26 at 9:00 A.M., 11:30 A.M. and 3:15 P.M., 03/03/26 at 8:30 A.M., 10:47 A.M., 1:30 P.M. and 3:33 P.M revealed Resident #37 sitting in room and no independent preferred activities provided.</p> <p>Interview on 03/05/26 at 8:38 A.M. with Activities staff #223 revealed 1:1 documentation is completed on paper and kept in a book and the activity coordinator has the book. 1:1 resident individual preferences come from the Activity Director, asking the staff and just by learning what the resident likes. Resident #37 enjoys sitting, talking and going down to the vending machine. Activities staff #223 stated she has not provided any activities for Resident #37 this week.</p> <p>Interview on 03/05/26 at 9:30 A.M. with Activities staff #155 revealed he has not provided any activities this week for Resident #37.</p> <p>4. Review of Resident #89's record revealed an admission date of 11/12/25 and diagnoses that included but were not limited to major depressive disorder, generalized anxiety disorder, schizoaffective disorder, schizoaffective disorder bipolar type, dementia in other diseases classified elsewhere, and restlessness and agitation.</p> <p>Review of Minimum Data Set (MDS) 3.0 dated 11/12/25 revealed Resident #89 has a Brief Interview of Mental Status score of nine indicating the resident was not cognitively intact.</p> <p>Interview with Resident #89's legal guardian on 03/02/26 at 12:53 P.M. revealed concerns that the resident was not given enough opportunities to engage in activities and believed this was leading to an increase in the residents' behaviors. Resident #89's legal guardian reported the resident would benefit from being able to go outside and did not believe the facility was doing this either.</p> <p>Observations made on 03/03/26 at 10:30 A.M., 11:07 A.M., and 1:30 P.M., and 3:30 P.M. revealed Resident #89 in their room with the door shut and not participating in activities. Residents in the common room were observed to be coloring and/or drawing.</p> <p>Observations made on 03/04/26 from 9:00 A.M to 9:10 A.M., and at 10:40 A.M. revealed Resident #89 in their room with the door shut and not participating in activities. Residents in the common room were observed to be coloring and/or drawing.</p> <p>Review of Resident #89's care plan, initiated 11/12/25, revealed an intervention to encourage resident to attend activities of interest on the unit and to provide activities of interest. Further review revealed an intervention of Resident #89's preferred activities including bingo, dancing, singing, writing and solving math problems, and going outside. The care plan also revealed Resident #89 does not like to color or draw.</p> <p>Review of Resident #89's plan of care (POC) response history for the task of activities on 03/03/26, for the last 30 days, revealed predominately coloring, crafts, 'chit chat', or art being offered to the resident. Further review of the activity task revealed Resident #89's participation was often passive or the resident refused.</p> <p>Review of Resident #89 Documentation Survey Report for one-on-one activities for the last 90 days, on 03/05/26, revealed activities were not consistently offered to Resident #89, and entries entered often labeled the resident as being out of their room or morning news as the activity. Review of the report did not have entries of bingo, music, dancing, or outdoor activities listed for Resident #89. (continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/03/26 at 11:16 A.M. with Activities #223 revealed if a resident does not want to participate in a group activity they will offer a one-on-one activity with the resident. Activities #223 provided examples of sitting in their room and talking and hand massages as activities that would be provided during one-on-ones.</p> <p>Interview with CNA #232 on 03/04/26 at 10:42 A.M. confirmed the residents in the common room were participating in a coloring activity and that craft activities occur often. CNA #232 reported the residents' have an axe throwing game and a balloon game as well that happens a couple times a week.</p> <p>Interview on 03/04/26 at 11:32 A.M. with the Administrator confirmed the facility did not have consistent activity logs to confirm when activities were occurring and which residents were participating in the activity.</p> <p>Additional interview on 03/05/26 at 8:25 A.M. with Activities #223 revealed they keep track of one-on-one activities for some residents on paper due to not having access to it on everyone's chart in their documentation system. Activities #223 revealed activities staff does not have access to residents' activity evaluations to identify what their activity preferences are and will often get the residents' preferences by learning from the residents directly. Activities #223 reported Resident #89 often struggles with group activities due to not being able to sit still for long periods of time, so they will do one-on-ones. Activities #223 identified listening to music and talking as being interests for Resident #89. Activities #223 confirmed the facility was not doing community activities at this time.</p> <p>Review of the facility policy titled Activity Programs, revised August 2006, revealed the activity programs are to be geared to the individual resident's needs. The Activity Programs policy also revealed the individual and group activities are to reflect the schedules, choices, and rights of the residents as well as be reflective of the residents' interests, hobbies and personal preferences.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2738898.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to provide non pressure skin treatments as ordered for Resident #27 and #67. The facility also failed to accurately document the correct location for a skin alteration for Resident #67. This affected two (Resident #27 and #67) of two residents reviewed for non-pressure skin alterations. The facility census was 82. Findings include: 1. Review of the medical record for Resident # 67, revealed an admission date of 12/24/24. Diagnoses included but were not limited to type II diabetes mellitus, morbid (severe) obesity due to excess calories, dementia, and rheumatoid arthritis with rheumatoid factor. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident has a severe cognitive impairment. The resident was assessed to require total dependence on toilet hygiene, shower/bathe self, bed mobility and transfers. This resident was assessed to have no skin conditions. Review of the active plan of care for Resident #67 revealed an at risk for red and/or open areas related to present condition, needs assist with bed mobility, toileting, with fluctuating ability with interventions including but not limited to follow facility protocols for treatment of injury and monitor/document location, size and treatment of skin injury. Review of the progress note for Resident #67 dated 02/13/26 revealed two open areas on the right gluteal fold, one the size of an eraser head and the other just smaller than a dime. Physician on call service called. Review of the physician orders and the Treatment Administration Record (TAR) for Resident #67 dated 02/13/26 through 02/16/26 revealed no treatment ordered or treatment being completed for the two open areas on the right gluteal fold. Review of the weekly wound observation tool for Resident #67 dated 02/16/26 revealed an abrasion to the back of the right thigh with measurements, assessment, and a treatment order. Review of the physician order for Resident #67 dated 02/16/26 revealed for the abrasion of the back right thigh to cleanse with normal saline and apply Zinc barrier cream every shift and as needed until healed. Review of the medical record for Resident #67 dated 02/16/26 through 02/24/26 revealed no documentation and treatment order for the two open areas of the right gluteal fold. Review of the weekly wound observation tool for Resident #67 dated 02/24/26 revealed the gluteal fold, (no exact location), other skin alteration (no type provided) acquired on 02/13/26 was healed out. Interview on 03/05/26 at 8:16 A.M. with the Assistant Director of Nursing (ADON) #215 verified Resident #67, had an area discovered on 02/13/26 that was located on the right gluteal fold and no treatment was ordered until 2/16/26. On 2/16/26, the area was incorrectly documented as being located on the resident's back right thigh for the assessment and the treatment order, but was correctly documented for the site but not type of alteration or location of the alteration and was healed out on 02/24/26. That documentation was completed on paper as she was not aware she had to complete a healed out note for skin alteration areas. 2. Review of the medical record for Resident # 27, revealed an admission date of 06/23/21. Diagnoses included but were not limited to type II diabetes mellitus without complications, dementia, and age-related osteoporosis without current pathological fracture. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with transfers and was dependent for toilet hygiene and shower hygiene. Review of the resolved plan of care for Resident #27 revealed the resident had three skin tears to right anterior leg with an intervention including but not limited to treat per facility protocol. Review of the progress notes dated 11/01/25 for Resident #27 revealed three skin tears measured and assessed with a treatment order obtained. Review of the physician order dated 11/01/25 for Resident #27 revealed saline solution (Soft Lens Products) apply to right anterior leg topically every night shift for skin tear cleanse areas to right lower anterior leg with saline, pat dry. Apply then maintain steri strips every day. May apply abdominal pad and secure with kerlix as needed for drainage. Review of the TAR for Resident #27 for the dates of 11/01/25 and 11/02/25 revealed (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>treatment was completed as ordered for the right leg skin tears. Review of the physician order for Resident #27 dated 11/03/25 revealed a treatment for the right lower extremity skin tears to cleanse with normal saline, leave open to air unless drainage noted. Review of the medical record for Resident #27 revealed no clarification and discontinuation of the treatment order dated 11/01/25 for the right leg skin tears. Review of the TAR for Resident #27 dated 11/03/25 revealed two treatment orders completed for the right leg skin tears. Review of the Wound Care Consultation visit dated 11/04/25 by Advanced Practitioner Registered Nurse (APRN) #239 for Resident #27 revealed a new treatment order for the right anterior lower extremity skin tears of daily (and as needed) with no other details of the treatment. Review of the medical record revealed no addendum or clarification with the APRN #239 of a treatment order for the skin tears of the right anterior lower extremities. Review of the TAR for Resident #27 dated 11/04/25 through 11/11/25 revealed the two treatments ordered on 11/01/25 and 11/03/25 for the right leg skin tears were completed. Review of the medical record for Resident #27 dated 11/11/25 through 12/31/25 revealed two treatments on 11/01/25 and 11/03/25 occurred for the right leg skin tear as well as once the area was healed out, ongoing treatment continued to be documented by the staff as completed. Interview on 03/04/26 at 1:31 P.M. with Regional Nurse #217 verified Resident #27 had an order not appropriate for skin tears initiated on 11/01/25 as well as two orders throughout the month of November with ongoing treatment to the skin tear area being continued once the area was healed. Further review of the record revealed and confirmed no clarification of the 11/01/25 order, as well as the incomplete treatment order from APRN #239 on the 11/04/25 visit. Review of the facility policy titled Skin Tears-Abrasions and Minor Breaks, Care of revised September 2013 revealed obtain a physician order as needed. This deficiency represents non-compliance investigated under Complaint Number 2738898.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and policy review, the facility failed to provide medications as ordered for Resident #9. This affected one resident (#9) of five residents reviewed for unnecessary medications. The facility census was 82. Findings include: Review of Resident #9's medical record revealed an admission date of 07/10/25 with diagnoses including end stage renal disease with dependence on renal dialysis, type two diabetes mellitus, major depressive disorder, opioid dependence, anxiety disorder, and long term use of antibiotics. Review of Resident #9's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #9's physician order dated 07/10/25 revealed an order for Amitriptyline (antidepressant) oral tablet 50 milligrams (mg) two tablets by mouth at bedtime for depression. Review of Resident #9's physician order dated 02/21/26 revealed an order for Sevelamer Carbonate (phosphate binder) 800 mg two tablets before meals for hyperphosphatemia. Review of Resident #9's physician order revised 03/02/26 revealed an order for Reglan (antiemetic) five mg by mouth three times a day for nausea. Review of Resident #9's Medication Administration Record (MAR) from 02/04/26 to 03/02/26 revealed Sevelamer Carbonate mid day (lunch) dose was not administered on 02/04/26, 02/07/26, 02/09/26, 02/20/26, and 03/02/26. Reglan was not administered twice on 02/07/26 and Amitriptyline was not administered on 02/28/26 and 03/01/26. Review of Resident #9's progress notes revealed there was no indication why Sevelamer Carbonate was not administered on 02/04/26, 02/07/26, and 03/02/26, on 02/09/26 and 02/20/26 it was indicated he was at dialysis. Reglan was documented as not administered due to being on order. It was indicated Amitriptyline was not available and was reordered. There was no evidence the physician was notified of the missing doses of Sevelamer Carbonate or Amitriptyline, and the physician was not notified of the missing Reglan until 02/09/26. Interview on 03/04/26 at 12:24 P.M. with Regional Nurse #237 verified Reglan and Amitriptyline were not administered due to the facility running out of the medication. The Sevelamer was not administered because it had not been given prior to the resident going to dialysis. However, he was eating lunch at dialysis and they were not providing it, so he did need the medication. She verified there was no evidence the physician was timely notified of missing medications. Review of the policy 'Administering Medications' dated December 2012, revealed medications were to be administered in accordance with orders. This deficiency represents noncompliance investigated under Complaint Number 2738898.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure physician oversight for medications prescribed from an outside prescriber for Resident #75 and to failed to ensure parameters were followed for blood pressure medications for Resident # 9 and Resident #29. This affected three Residents (#9, #29 and #75) of 7 reviewed for unnecessary medications. The facility census was 82. Findings include: 1. Review of the medical record for Resident #75, revealed an admission date of 08/12/25. Diagnoses included but were not limited to dementia, muscle weakness generalized, adult failure to thrive and poly osteoarthritis.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a the resident had moderate cognitive impairment, required supervision or touching assistance with toilet hygiene, bed mobility, and transfers with total dependence with shower/bathe self.</p> <p>Review of the active plan of care for Resident #75 revealed no interventions for monitoring of multiple medications of the same class.</p> <p>Review of the emergency department patient discharge summary and instructions dated 09/14/25 for Resident #75 revealed two new medications. A Lidocaine (five percent (%)) topical patch (pain) every day for thirty days, to remove the patch after 12 hours and Tizanidine (muscle relaxer) 2 milligrams (mg) give one tablet orally every eight hours as needed for muscle spasms for ten days.</p> <p>Review of the active physician orders dated 11/04/25 for Resident #75 revealed Xanax 2 mg (antianxiety) give one tablet by mouth every eight hours, Baclofen 5 mg (muscle relaxer) give one tablet by mouth every eight hours as needed, Hydroxyzine 25 mg (antianxiety) give one tablet by mouth every eight hours as needed, Tramadol 50 mg (pain) give one tablet by mouth every six hours as needed for pain and Tylenol 325 mg (pain) give two tablets every six hours as needed for pain.</p> <p>Further review of the physician orders dated 09/14/25 for this Resident revealed a verbal order from Certified Nurse Practitioner (CNP) #181 for: Lidocaine (four percent) topical patch (pain) every day for thirty days, to remove the patch after 12 hours and Tizanidine (muscle relaxer) 2 mg give one tablet orally every eight hours as needed or muscle spasms for ten days. These orders were never signed as ordered by CNP #181.</p> <p>Review of the Medication Administration Record (MAR) for Resident #75 dated 09/14/25 through 09/16/25 revealed: Xanax 2 mg given as ordered, and as needed medications administered of: Baclofen 5 mg (muscle relaxer) one tablet, Hydroxyzine 25 mg (antianxiety) one tablet, Lidocaine (4 percent) topical patch (pain) every day for thirty days, to remove the patch after 12 hours and Tizanidine (muscle relaxer) 2 mg give one tablet, Tramadol 50 mg (pain) one tablet and Tylenol 325 mg (pain) give two tablets.</p> <p>Review of the progress note dated 09/17/25 at 1:45 A.M. revealed Resident #75 had fallen in her room and was assessed to be slower to respond.</p> <p>Further review of the progress notes dated 09/17/25 at 2:40 A.M. for this resident revealed the on-call physician was notified of the fall and assessment of slower to respond and slurred speech and was sent out to the emergency department per physician order. (continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the emergency room documentation dated 09/17/25 for Resident #75 revealed a diagnosis of polypharmacy with muscle relaxers held and mental status improvement.</p> <p>Review of the medical record dated 09/14/25 through 09/17/25 for Resident #75 revealed the physician orders entered from the emergency room visit on 09/14/25 were never signed by CNP #181 there additionally was no documented communication to any facility provider this resident was now on new medications. No in-house visits from any provider was also documented.</p> <p>This surveyor was unable to interview CNP #181 as the provider was no longer with the facility.</p> <p>Interview on 03/04/25 at 1:53 P.M. with Regional Nurse # 217 verified for Resident #75, upon return to the facility from the emergency room on [DATE], no documentation could be provided for communication with any provider regarding the new medications and the new medication orders were never signed off by the entered ordering CNP at the facility and should have been as that indicates the provider was aware of the new orders. Therefore, there was no oversight for these medications for this resident as no provider for the facility was aware of the new medications.</p> <p>Interview on 03/05/26 at 9:38 A.M. with Unit Manager Licensed Practical Nurse #225 revealed she had been working at this facility for a while. It is expected when a resident returns from the emergency room for the on-call physician service to be called with new medications to be verified before ordering them especially if a provider is not on site at that time. A progress note needs to be added for return to the facility and notification of the provider of return and verification of new orders. The Unit Managers then do review of the new and or changed orders upon return.</p> <p>2. Review of the medical record for Resident # 29, revealed an admission date of 08/03/18. Diagnoses included but were not limited to dementia, hypotension, other specified anxiety disorder, unspecified mood disorder, major depressive disorder and paraphilia.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident has a severe cognitive impairment. The resident was assessed to require supervision or touching assistance with bed mobility, substantial/maximal assistance with transfers and total dependence with toilet hygiene, and shower/bathe self.</p> <p>Review of the active plan of care for Resident # 29 revealed altered cardiovascular status related to hypotension with an intervention including but not limited to medication as ordered by the physician.</p> <p>Review of the physician order for Resident #29 dated 11/18/25 revealed Midodrine Hydrochloride (for low blood pressure) 15 mg give orally three times a day, hold if systolic (blood pressure) is greater than 110 millimeters of mercury (mm/hg).</p> <p>Review of the MAR dated 11/19/25 through 02/28/26 for Resident #29 revealed Midodrine Hydrochloride 15 mg being administered when systolic was greater than 110 mm/hg</p> <p>Review of the November 2025 MAR revealed Midodrine Hydrochloride 15 mg being administered w [NAME] systolic was greater than 110 at the 9:00A.M. dose on 11/19/25, 11/20/25, 11/24/25, 11/25/25, 11/26/25, 11/27/25 and 11/18/25. At the 2:00 P.M. dose on 11/19/25, 11/20/25, 11/21/25, 11/24/25, 11/25/25, 11/26/25, 11/27/25, 11/28/26, 11/29/25, and 11/30/25. And at the 9:00 P.M. dose on 11/24/25, and 11/27/25.</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 03/05/2026
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the December 2025 MAR revealed Midodrine Hydrochloride 15 mg being administered when systolic was greater than 110 at the 9:00A.M. dose on 12/03/25, 12/06/25, 12/08/25, 12/09/25, 12/12/25, 12/13/25, 12/17/25, 12/19/25, 12/20/25, 12/24/25, 12/25/, and 12/27/25. At the 2:00P.M. dose on 12/02/25/, 12/08/25, 12/09/25, 12/12/25, 12/13/25, 12/14/25, 12/20/25, 12/25/25, 12/27/25, and 12/28/25. And on the 9:00P.M. dose on 12/06/25, 12/07/25, 12/09/25, 12/11/25, 12/17/25, 12/18/25, 12/20/25, 12/24/25, and 12/25/25.</p> <p>Review of the January 2026 MAR revealed Midodrine Hydrochloride 15 mg being administered when systolic was greater than 110 at the 9:00A.M. dose on 01/08/26, 01/15/26, 01/16/26, 01/19/26, 01/22/26, 01/23/26, 01/28/26, 01/29/26, and 01/31/26, On the 2:00P.M. dose on 01/01/26, 01/08/26, 01/09/26, 01/15/26, 01/16/26, 01/19/26, 01/21/26, 01/22/26, 01/23/26, 01/27/26, 01/28/26, 01/29,26 and 01/31/26. And on the 9:00P.M. dose on 01/02/26, 01/22/26, and 01/23/26.</p> <p>Review of the MAR for February 2026 revealed Midodrine Hydrochloride 15 mg being administered when systolic was greater than 110 at 9:00 A.M. 02/01/25, 02/02/26, 02/05/26, 02/08/26, 02/11/26, 02/12/26, 02/14/26, 02/15/26, 02/16/25, 02/17/26, and 02/18/26. And on 2:00 P.M. on 02/02/26, 02/03/26, 02/04/26, 02/06/26, 02/08/26, 02/09/26, 02/10/26, 02/11/26, 02/12/26, 02/14/26, 02/15/26, 02/16/26, 02/17/26, 02/18/26, 02/19/26, 02/22/26. And at 9:00 P.M. on 02/02/26, 02/04/26, 02/08/26, 02/14/26, 02/15/26, and 02/18/26.</p> <p>Interview on 03/05/26 at 1:10 P.M. with Regional Nurse #217 verified Resident #29 had systolic blood pressure numbers greater than 110mm/hg throughout 11/19/25 to 02/28/26 and the Midodrine Hydrochloride was not held per physician orders.</p> <p>Review of the facility policy titled Administering Medications revised December 2012 revealed medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>3. Review of Resident #9's medical record revealed an admission date of 07/10/25 with diagnoses including end stage renal disease with dependence on renal dialysis, type two diabetes mellitus, major depressive disorder, opioid dependence, anxiety disorder, and long term use of antibiotics.</p> <p>Review of Resident #9's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of Resident #9's plan of care dated 07/22/25 revealed he had hypertension. Interventions included providing antihypertensive medication as ordered and monitor for side effects, monitor blood pressure as clinically indicated, and monitoring and reporting signs of malignant hypertension.</p> <p>Review of Resident #9's physician order dated 11/20/25 revealed an order for Clonidine (a medication that lowers blood pressure) 0.1 milligrams (mg) three tablet by mouth twice a day. The medication was to be held for a systolic blood pressure (SBP) above 110 mmHg and a pulse above 60 beats per minute (bpm).</p> <p>Review of Resident #9's Medication Administration Record (MAR) from 02/01/26 to 03/02/26 revealed Clonidine was to be administered at 10:00 A.M. and at 10:00 P.M. There was no evidence his blood pressure was checked for the evening dose and no evidence his heart rate was obtained during the reviewed period.</p> <p>Review of Resident #9's vitals from 02/01/26 to 03/02/26 revealed no evidence his blood pressure (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	
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was checked for the evening dose and no evidence his heart rate was obtained during the reviewed period.</p> <p>Interview on 03/04/26 at 3:23 P.M. and 4:23 P.M. with Regional Nurse #237 verified the parameters for Clonidine were incorrect in the order, the medication should be held for SBP below 110 mmHg and a pulse below 60 bpm.</p> <p>Review of the policy 'Administering Medications' dated December 2012, revealed medications were to be administered in accordance with orders.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2738898.</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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interviews, and facility policy review, the facility failed to maintain a clean, sanitary environment free from pests. This had the potential to affect all 12 residents residing on the C hall. The facility census was 82. Findings include: Observation on 03/02/26 at 2:48 P.M. and 03/03/26 at 8:00 A.M. revealed live cockroaches were observed in Resident #42's room. Interview on 03/03/26 at 8:00 A.M. with Resident #42 revealed he sees them all the time, sometimes he can't sleep because they are crawling in his bed. He also stated he will see them on the walls. Medical record review revealed a progress note dated 10/03/25 authored by Licensed Practical Nurse (LPN) #182 of Resident #42's room being treated by the exterminator as insects and bugs were observed throughout the room. Interview on 03/03/26 at 8:30 A.M. with LPN #129 verified Resident #42's had live cockroaches currently in his room. Interview on 03/03/26 at 8:35 A.M. with CNA #210 and CNA #132 revealed they had taken Resident #42 his meal tray into his room before and seen cockroaches crawling on his bedside table and in his bed. Interview on 03/03/26 from 9:00 A.M. to 9:30 A.M. revealed two other Residents (#26 and #34) verified they have observed live cockroaches in the C hallway. Review of pest control invoices dated 09/18/25, 10/06/25, 11/14/25, 12/30/25, 01/09/26, 01/30/26, and 02/20/26 revealed no evidence of cockroaches and target pests which included cockroaches. Review of facility policy titled Pest Control last revised May 2008. Revealed our facility shall maintain an effective pest control program. This facility maintains an ongoing pest control program to continuously eliminate any insects and rodents. This deficiency represents non-compliance investigated under Master Complaint Number 2738898 and Complaint Number 2730179.</p>		