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	03/05/2026

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview and review of facility policy the facility failed to dispose of expired medications and ensure medications were dated when opened. This had the potential to affect all residents residing at the facility. The facility census was 82.Findings include:Observation and interview on 03/04/26 at 8:03 A.M. with Licensed Practical Nurse (LPN) #238 during the medication administration, revealed one bottle of Sodium Chloride (mineral) 1 gram (gm) with an expiration date of 11/2025 with an open date of 11/23/25, one bottle of vitamin B12 5000 micrograms (mcg) with an expiration date of 03/27 and no open date, and one bottle of Magnesium Oxide (supplement) 400 milligrams (mg) with an expiration date of 06/27 and no open date. LPN #238 verified the expired medication and the medications that were not dated when they were opened. Observation and interview on 03/04/26 at 9:15 A.M. with Registered Nurse (RN) # 215 of the medication room on the first floor revealed one opened bottle of Tuberculin purified protein derivative, diluted Aplisol with an expiration date of 09/27 and no open date; one unopened bottle of extra strength stool softener Docusate Sodium 250 mg with an expiration date of 02/26; one unopened bottle of Dakins solution (wound cleaner) full strength 16 fluid ounce with an expiration date of 10/25. RN #215 verified the expired medications and the opened bottle of Tuberculin that was opened and not dated. Observation and interview on 03/04/26 at 9:30 A.M. with LPN #168 of medication cart E/F revealed one bottle of vitamin B6 100mg with an open date of 3/03/26 and an expiration date of 01/26. LPN #168 verified the expired medication. Observation and interview on 03/04/26 at 9:40 A.M. with LPN #168 of the treatment cart on the second floor revealed an opened bottle of Dakins solution quarter strength 16 fluid ounce with an expiration date of 05/24, and no open date. LPN #168 verified the expired medication. Review of facility policy titled, Storage of Medications, revised April 2007, revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Review of facility policy titled, Administering Medications, revised December 2012, revealed the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to develop and implement comprehensive care plans to address identified resident needs and preferences. This affected four residents (#23, #6, #58, and #59) of 33 residents reviewed. The facility census was 82. Findings include:Review of Resident #23's medical record revealed an admission date of 01/31/2026 with diagnoses including primary progressive multiple sclerosis, severe protein-calorie malnutrition, adult failure to thrive, type II diabetes mellitus with complications, bipolar disorder, anxiety disorder, attention-deficit hyperactivity disorder, nicotine dependence, difficulty walking, lack of coordination, and generalized muscle weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had moderately impaired cognition, required substantial to maximal assistance with bathing, toileting hygiene, dressing, and transfers. Resident #23 had a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident was able to participate in care decisions. Review of Resident #23's Bladder and Bowel assessment dated [DATE] revealed Resident #23 was documented as frequently incontinent of bowel and bladder. Review of the comprehensive care plan for Resident #23 revealed the resident required staff assistance with bathing and personal hygiene; the care plan did not identify resident preferences related to staff providing bathing assistance and did not include interventions addressing resident refusals of bathing care. Review of Resident #23's shower logs, dated 02/09/2026 through 02/19/2026, revealed four total refusals or shower sheets with no supporting documentation if the shower was provided or refused on 02/09/26, 02/12/26, 02/16/2026, and 02/19/2026. Interview with Resident #23 on 03/03/2026 at 9:40 A.M. revealed the resident had concerns regarding bathing and reported he had received only one bath since being admitted in early February. Resident #23 stated he required assistance with bathing and hygiene. Resident #23 further stated he experiences bowel issues and is not always able to make it to the bathroom in time. Resident #23 stated he does not always receive assistance in the mornings when he needs help cleaning up. Interview with Resident #23 on 03/03/2026 at 11:40 AM revealed the resident was asked whether he received a bath on 03/02/2026, as it was his scheduled day for a shower/bath. Resident #23 stated he did not receive a bath on 03/02/2026 and stated no staff member asked if he would like a bath. Resident #23 stated he preferred bathing assistance in the morning. Interview with Certified Nursing Assistant #134 on 03/03/2026 at 11:45 AM revealed nursing assistants follow the facility's shower book to determine when residents are scheduled for showers. CNA #134 stated if a resident is unavailable or declines a shower, staff attempt to offer the shower at least twice and document showers in the record. Interview with CNA #134 and CNA #160 on 03/03/2026 at 3:30 PM confirmed by review of the shower book that Resident #23 did not have a shower sheet completed for 03/02/2026, which was identified as the resident's scheduled shower day CNA #134 and CNA #160 both stated neither worked on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/02/2026. Interview with CNA #132 on 03/05/2026 at 8:55 AM revealed staff ask residents one to two times if they would like to perform personal hygiene or take a shower. CNA #132 stated if the resident refuses, staff attempt again later and notify the nurse if the resident continues to refuse. Interview with Director of Nursing (DON) #175 on 03/05/2026 at 9:01 AM confirmed the resident's care plan did not include interventions addressing refusals of bathing care or resident preference for staff assisting with bathing. 2.Review of Resident #6's medical record revealed an admission date of 09/08/2022 with diagnoses including cerebral palsy, schizophrenia, schizoaffective disorder bipolar type, generalized anxiety disorder, major depressive disorder, post-traumatic stress disorder (PTSD), dysphagia, generalized muscle weakness, and intellectual disability. Review of the psychiatric evaluation completed by Psychiatric Certified Nurse Practitioner (CNP) #248 dated 05/20/2025 revealed Resident #6 had a diagnosis of Post-Traumatic Stress Disorder (PTSD) and reported a history of sexual trauma beginning in childhood. The evaluation documented Resident #6 reported experiencing flashbacks and nightmares every other day and night and identified interactions with male individuals as a trigger that caused increased anxiety, fear, and emotional distress. Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #6 dated 02/03/2026 revealed the resident required staff assistance with activities of daily living including transfers, mobility, toileting, bathing, and personal hygiene. Review of Resident #6's comprehensive care plan dated 02/03/2026 revealed a care planned need of Resident #6 requiring staff assistance with activities of daily living including bathing and personal hygiene. The care plan failed to identify the resident's trauma triggers or include individualized interventions for staff to implement to prevent re-traumatization or address PTSD-related symptoms. Interview on 03/02/2026 at 12:45 P.M. with Resident #6 revealed the resident stated she has post-traumatic stress disorder (PTSD) and was unsure if the facility was aware of her triggers. Interview on 03/04/2026 at 1:20 P.M. with Resident #6 revealed the resident reported a history of trauma related to sexual abuse by her father. Resident #6 stated interactions with male individuals can trigger symptoms related to PTSD, and she would prefer to be cared for by female caregivers. Interview on 03/04/2026 at 1:30 PM with CNA #134 regarding Resident #6 revealed CNA #134 stated they were not aware Resident #6 had PTSD or identified triggers related to care. Interview on 03/05/2026 at 9:40 AM with Director of Nursing (DON) #175 regarding documentation of Resident #6's PTSD triggers revealed DON #175 was unable to locate documentation identifying triggers related to PTSD, including interactions with male staff providing care. DON #175 stated they were not aware that interactions with male staff were a trigger for Resident #6. 3. Resident #58 was admitted to the facility on [DATE]. His diagnoses were arthropathy, venous insufficiency, hypokalemia, epilepsy, hyperlipidemia, chronic pulmonary embolism, hypertension, anxiety disorder, major depressive disorder, vitamin D deficiency, vitamin B12 deficiency, dementia, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscle weakness, and insomnia. Review of his minimum data set (MDS) assessment, dated 12/22/25, revealed he was cognitively intact, was dependent on staff for full physical assistance with bathing/showering. Review of Resident #58 shower logs, dated December 2025 to February 2026, revealed nine total refusals or shower sheets with no supporting documentation if the shower was provided or refused on 12/08/25, 12/17/25, 12/29/25, 01/05/26, 01/07/26, 01/21/26, 01/26/26, 02/09/16, and 02/16/26. There was no documentation on the forms to indicate why the shower/bath was refused or why it was not completed on the nine dates. Review of Resident #58's behavior care plan, dated 08/21/25, revealed Resident #58 was identified as someone who can be non-compliant with care and treatment, which included bathing/showering. One of the interventions was for staff to notify the physician of non-compliance with care after more than three refusals. Interview with CNA #132 on 03/05/2026 at 8:55 A.M. revealed they will ask a resident once or twice when it's time perform personal hygiene and/or showers. If the resident refuses, they will try again a short time later. If they continue to refuse, they will let the nurse know. In regard to the care plan intervention, notify physician with three refusals, she understands that as three refusals in the same instance/day for care/shower that they should be notifying the physician. She confirmed there should be documentation of how many times the resident refused and what was done after the last refusal on the forms. Interview with Regional Nurse #217 on 03/05/2026 at 9:01 A.M. revealed the care plan intervention for report for three refusals to physician would be three different instances, like refusing on Monday, Wednesday, and Friday. When told that floor staff stated they took that intervention as three instances on the same day, she confirmed they would have to do some education. She confirmed there was no reasoning why Resident #58 refused his showers. 4. Resident #59 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. Review of Resident #59 MDS assessment, section GG, dated 12/22/25, revealed she was dependent on staff for full physical assistance with bathing/showering. Review of Resident #59's's shower logs, dated December 2025 to February 2026, revealed nine total refusals or shower sheets with no supporting documentation if the shower was provided or refused on 12/03/25, 12/17/25, 12/20/25, 12/27/25, 01/14/26, 01/24/26, 01/31/26, 02/07/26, and 02/21/26. There was no documentation on the forms to indicate why the shower/bath was refused or why it was not completed on those dates. Review of Resident #59 's behavior care plan, dated 08/19/25, revealed Resident #59 was identified as someone who can be non-compliant with care. One of the interventions was for staff to notify the physician of non-compliance with care after more than three refusals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA #132 on 03/05/2026 at 8:55 A.M. stated they will ask a resident once or twice when it's time perform personal hygiene and/or showers. If they refuse, they will try again a short time later. If they continue to refuse, they will let the nurse know. In regard to the care plan intervention, notify physician with three refusals, she understands that as three refusals in the same instance/day for care/shower that they should be notifying the physician. She confirmed there should be documentation of how many times the resident refused and what was done after the last refusal on the forms. Interview with Regional Nurse #217 on 03/05/2026 at 9:01 A.M. stated the care plan intervention for report for three refusals to physician would be three different instances, like refusing on Monday, Wednesday, and Friday. When told that floor staff stated they took that intervention as three instances on the same day, she confirmed they would have to do some education. She confirmed there was no reasoning why Resident #59 refused her showers. Review of the facility policy titled Care Plans, Comprehensive Person-Centered revealed the facility policy stated a comprehensive person-centered care plan must be developed and implemented for each resident and include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The policy stated the interdisciplinary team develops the care plan using information gathered during the comprehensive assessment and the care plan must identify resident needs, preferences, and problem areas and include interventions designed to address those identified needs. The policy also stated the interdisciplinary team must review and update the care plan when resident needs or conditions change or when desired outcomes are not met.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **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: 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. Review of Resident #90's admission assessment dated [DATE] revealed the resident was alert to person only. 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. 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. Review of Resident #90's care conference dated 03/02/26 revealed activity staff was to offer group activities and review the monthly calendar. 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. 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. 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. 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. Interview on 03/05/26 at 8:37 A.M. Activities #223 revealed she was unable to document any activities for Resident #90 and had no evidence he had participated in or been invited to activities since his admission. 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. Review of Resident #59's medical record revealed the resident was admitted to the facility on (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[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. 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. 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. 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. 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. Review of facility activity calendars, dated January 2026 to March 2026, revealed no activities in the community for the residents. 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. 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. Review of most recent Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #37 with moderate cognitive impairment. 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. 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. 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 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff #223 stated she has not provided any activities for Resident #37 this week. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' have an axe throwing game and a balloon game as well that happens a couple times a week. 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. 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. 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. This deficiency represents non-compliance investigated under Complaint Number 2738898.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 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 iwere 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 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.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and review of facility policy, the facility failed to timely review baseline care plans for one (Resident #8) of 33 reviewed. The census was 82.Findings include:Medical record review revealed Resident #8 was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, morbid (severe) obesity, neuromuscular dysfunction of bladder, stage IV pressure ulcer of right buttock, congestive heart failure, atrial fibrillation, paraplegia, and tracheostomy status. Review of the admission Nursing assessment dated [DATE] revealed an unsigned Baseline Care Plan. There was no evidence the resident was provided with the baseline care plan or that it had been reviewed with Resident #8.Interview on 03/03/26 at 2:47 P.M. with Regional Nurse #237 verified Resident #8 had not been provided with a copy or explained the baseline care plan during the required time frame.Review of facility policy title Care Plans, Comprehensive Person-Centered, revised December 2016 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure resident glasses were obtained in a timely manner. This affected one (Resident #58) of one resident reviewed for vision services. The census was 82.Findings Include:Resident #58 was admitted to the facility on [DATE]. His diagnoses were arthropathy, venous insufficiency, hypokalemia, epilepsy, hyperlipidemia, chronic pulmonary embolism, hypertension, anxiety disorder, major depressive disorder, vitamin D deficiency, vitamin B12 deficiency, dementia, muscle weakness, and insomnia. Review of his minimum data set (MDS) assessment, dated 12/22/25, revealed he was cognitively intact.Review of Resident #58 vision appointment documentation, dated 12/15/25, revealed he had a complete vision exam. Review of the recommendations/plan after this visit included Resident #58 needing new bifocals. Review of resident vision documents, dated 12/15/25 to 03/04/26, revealed no evidence to support the bifocals had been ordered and/or received. Interview with Resident #58 on 03/02/26 at 3:40 P.M. confirmed he has not received his new glasses that they were supposed to order quite a while ago. He confirmed they would help him to see a little better. Interview with Social Service Designee (SSD) #136 on 03/04/2026 at 1:20 P.M. revealed they have not ordered Resident #58 bifocals yet. She stated she contacted the vision doctor's office, and they are waiting for payment. She said the bill for the glasses went to Resident #58, and they didn't get a copy of it; she didn't know they were waiting on that document and/or payment to receive them. She confirmed they did not follow up with Resident #58 or the vision doctor's office to see the progress of the bifocals.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review the facility failed to document urine output and description each shift for one (Resident #5) of two reviewed for a urinary catheter. The facility census was 82.Findings include:Review of the medical record for Resident #5, revealed an admission date of 12/31/24. Diagnoses included but were not limited to obstructive and reflux uropathy, chronic kidney disease stage III, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12. The resident was assessed to require no assistance with bed mobility, setup or clean-up assistance with shower/bathe self, and supervision or touching assistance with toilet hygiene, and transfers. The resident was coded to have an indwelling catheter. Review of the active plan of care for Resident #5 revealed an at risk for urinary tract infections related to foley in place with interventions including but not limited to empty foley catheter bag every shift and as needed, monitor drainage bag contents for changes in the character of urine and notify nurse of no urine output. Review of the active physician orders dated 02/07/26 through 03/04/26 for Resident #5 revealed no order to empty and document urine description and output every shift. Review of the Medication Administration Record and the Treatment Administration Record dated 02/07/26 through 03/04/26 for Resident #5 revealed no documentation and description of urine output every shift.Review of the progress notes dated 02/07/26 through 03/04/26 for Resident #5 revealed no documentation and description of urine output every shift.Review of the plan of care documentation dated 02/07/26 through 03/04/26 for Resident #5 revealed no documentation and description of urine output every shift.Interview with the Regional Nurse #217 on 03/04/26 at 1:21 P.M. revealed it is not facility policy to document output amounts obtained from foley catheters every shift, the staff are expected to empty the catheter each shift and if there is no output to alert a provider. Regional Nurse #217 verified there was no documentation for Resident #5's urine including a description or place to document no output by either a Nurse or Certified Nurse Assistant for providers and other staff members to be aware. Review of the facility policy titled Catheter Care, Urinary revised September 2014 revealed observe the resident's urine level for noticeable increases and decreased. If the levels stay the same, or increase rapidly, report it to the physician or supervisor.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review the facility failed to ensure a speech therapy evaluation was completed for one, (Resident #03) and the facility failed to the facility failed to monitor fluid intake for one (Resident #09) who was on fluid restriction. This affected two residents (#03 and #09) of four reviewed for nutrition. The facility census was 82. Findings include:1. Review of Resident #03's medical record revealed an admission date of 10/18/19 with diagnoses that included but were not limited to other bipolar disorder, schizophrenia, dementia, and chronic pain syndrome. Review of the quarterly Minimum Data Set (MDS) 3.0 dated 01/02/26 revealed a Brief Interview of Mental Status score of zero, indicating the resident was not cognitively intact. Review of Resident #03's physician orders revealed an order for a mechanical soft diet dated 11/06/25. Review of Resident #03's Nutritional Assessment Review dated 07/01/25 revealed the resident had been on a regular diet, regular texture, and had no swallowing difficulties. Review of Resident #03's quarterly Dietary Review, dated 10/02/25, revealed no swallowing concerns. Review of the resident's assessments revealed no speech therapy evaluation around the time of the altered diet order. Review of Resident #03's progress notes revealed a note dated 10/31/25 at 12:23 P.M. revealed Resident #03 was no longer able to hold handheld foods and that a phone call to the resident's daughter attempted to discuss downgrading the resident's diet to mechanical soft. Review of progress note dated 11/03/25 at 12:30 P.M. revealed a speech evaluation was ordered by the nurse practitioner due to Resident #03's change in ability to hold foods. There were no further progress notes related to the speech therapy evaluation. Interview on 03/04/26 at 1:55 P.M. with Dietitian #180 revealed if there are concerns with the diet a resident is on a referral is made to speech therapy to identify the appropriate diet. Dietitian #180 reported they were not aware of concerns related to Resident #03's ability to swallow or chew their food. Interview on 03/05/26 at 9:38 A.M. with Registered Nurse (RN) #217 confirmed Resident #03's diet was downgraded from regular to mechanical soft without a speech evaluation. RN #217 further confirmed a speech evaluation was ordered but was not completed or followed up with and should have been. 2.Review of Resident #09'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, long term use of antibiotics. Review of Resident #09's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #09's physician order dated 12/03/25 revealed an order for a fluid restriction of 1800 milliliters (ml) per day; 720 ml was to be provided by dietary and 1080 ml from nursing. Review of Resident #09's Medication Administration Record (MAR) from 02/01/26 to 03/01/26 revealed no evidence the amount of liquid that the resident was provided from the nursing during medication pass was tracked. Review of Resident #9's fluid documentation in the tasks portion of the electronic record revealed from 02/03/26 to 03/03/26 Resident #09 exceeded his daily allowance of 1800 ml on 02/10/26, 02/14/26, 02/15/26, 02/18/26, 02/21/26, 02/22/26, 02/23/26, 02/24/26, 02/26/26, 02/28/26, 03/01/26, 03/02/26, and 03/03/26. He exceeded the dietary allowance of 720 ml of fluid on 02/03/25, 02/04/26, 02/05/26, 02/07/27, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/17/26, 02/19/26, 02/20/26, and 02/25/26. Review of Resident #09's plan of care revealed it did not address his fluid restriction or noncompliance with his fluid restriction. Review of Resident #09's progress notes from 02/01/26 to 03/03/26 revealed no mention of Resident #09's noncompliance with his fluid restriction. Additionally, there was no evidence the physician was notified of Resident #9's noncompliance. Interview on 03/04/26 at 1:46 P.M. with Dietitian #180 revealed she did not monitor compliance/noncompliance with Resident #9's fluid restriction, she believed nursing did. Interview on 03/04/26 at 2:25 P.M. with Certified Nursing Assistant (CNA) #115 revealed the aides documented fluid intake under tasks in the electronic record. This included what was provided by the dietary department and what they saw the resident drinking throughout the day. CNA #115 stated the nurses would be documenting fluids they provided separately. CNA #115 reported the resident was noncompliant with his fluid restriction and frequently got beverages from the vending machine. Interview on 03/04/26 at 8:18 A.M. and 9:02 A.M. with the Director of Nursing (DON) and Regional Nurse #237 revealed nurses should be documenting when a resident was noncompliant with their fluid restrictions. It was verified nursing was not documenting the amount of fluids they were providing at medication pass, and the resident was noncompliant with the fluid restriction. It was verified that the medical record did not address Resident #09's noncompliance with the fluid restriction.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview, record review, and review of facility policy, the facility failed to ensure trauma-informed care was implemented for a resident with a documented diagnosis of post-traumatic stress disorder (PTSD). This affected one resident (Resident #6) of eight residents reviewed for behavioral-emotional care. The facility census was 82.Findings include:Review of Resident #6's medical record revealed an admission date of 09/08/2022 with diagnoses including cerebral palsy, schizophrenia, schizoaffective disorder bipolar type, generalized anxiety disorder, major depressive disorder, intellectual disability, and post-traumatic stress disorder (PTSD).Review of the psychiatric evaluation completed by Psychiatric Certified Nurse Practitioner (CNP) #248 dated 05/20/2025 revealed Resident #6 had a diagnosis of Post-Traumatic Stress Disorder (PTSD) and reported a history of sexual trauma beginning in childhood. The evaluation documented Resident #6 reported experiencing flashbacks and nightmares every other day and night and identified interactions with male individuals as a trigger that caused increased anxiety, fear, and emotional distress.Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #6 dated 02/03/2026 revealed the resident required staff assistance with activities of daily living including transfers, mobility, toileting, bathing, and personal hygiene. Review of Resident #6's comprehensive care plan dated 02/03/2026 revealed the resident had care planned needs requiring staff assistance with activities of daily living including bathing and personal hygiene. The comprehensive care plan also revealed interventions addressing psychiatric diagnoses including anxiety, depression, psychosis, and schizoaffective disorder. The care plan did not include interventions addressing PTSD triggers or the resident's preference for female caregivers.Interview on 03/02/2026 at 12:45 P.M. with Resident #6 revealed the resident stated she has post-traumatic stress disorder (PTSD) and was unsure if the facility was aware of her triggers.Interview on 03/04/2026 at 1:20 PM with Resident #6 revealed the resident reported a history of trauma related to sexual abuse by her father. Resident #6 stated interactions with male individuals can trigger symptoms related to PTSD. Resident #6 stated she would prefer to be cared for by female caregivers.Interview on 03/04/2026 at 1:30 PM with CNA #134 regarding Resident #6 revealed CNA #134 stated they were not aware the resident had a diagnosis of PTSD or any identified triggers related to care.Interview on 03/05/2026 at 9:40 AM with Director of Nursing (DON) #175 regarding documentation of Resident #6's PTSD triggers revealed DON #175 was unable to locate documentation identifying triggers related to PTSD, including interactions with male staff providing care. DON #175 stated they were not aware that interactions with male staff were a trigger for Resident #6.Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring revealed behavioral symptoms are to be identified through assessment and evaluated using information obtained from the resident, family, caregivers, and medical record review. The policy stated the interdisciplinary team will identify precipitating factors or triggers related to behavioral symptoms and incorporate findings from the comprehensive assessment into the care plan with targeted and individualized interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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.

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Country Lane Gardens Rehab & Nursing Ctr	7820 Pleasantville Road Pleasantville, OH 43148

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **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. 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. Review of the active plan of care for Resident #75 revealed no interventions for monitoring of multiple medications of the same class. 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. 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. 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. 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. 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. 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)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. This surveyor was unable to interview CNP #181 as the provider was no longer with the facility. 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. 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. 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. 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. 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. 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). 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 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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 12/03/25,12/06/25,12/08/25,12/09/25,12/1225, 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. 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 on01/08/26, 01/15/26, 01/16/26, 01/19/26, 01/22/26, 01/23/2601/28/26, 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. 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. 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. 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. 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. 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 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. 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). 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. Review of Resident #9's vitals from 02/01/26 to 03/02/26 revealed no evidence his blood pressure (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was checked for the evening dose and no evidence his heart rate was obtained during the reviewed period. 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. Review of the policy 'Administering Medications' dated December 2012, revealed medications were to be administered in accordance with orders. This deficiency represents non-compliance investigated under Complaint Number 2738898.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review, review of pharmacy recommendations, interview, and policy review, the facility failed to ensure laboratory tests were completed as ordered and the physician was notified of incomplete laboratory tests. This affected one resident (Resident #89) of five reviewed for unnecessary medications. The facility census was 82. Findings include: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, restlessness and agitation. Review of Minimum Data Set (MDS) 3.0 dated 11/12/25 revealed Resident #89 had a Brief Interview of Mental Status score of nine indicating the resident was not cognitively intact. Review of pharmacy recommendations for Resident #89 revealed a Medication Regimen Review (MRR) dated on 01/19/26 for Atorvastatin (used to lower cholesterol) 80 milligrams (mg) one tab by mouth daily with a request to order a lipid panel laboratory test with the next scheduled laboratory draw. This recommendation was agreed to by the physician and signed with a date of 01/20/26. Review of the laboratory report for Resident #89 dated 01/22/26 revealed the resident refused, two more attempts would be made and then the order would be discontinued. The report also requested for the physician to be informed of the resident's refusal. Review of Resident #89's physician orders on 03/03/26 revealed no further orders for laboratory test. Review of Resident #89's progress notes revealed no notification to the physician after the 01/22/26 refusal and no further attempts to schedule the laboratory test. Interview on 03/04/26 at 1:40 P.M. with Regional Registered Nurse (RN) #237 confirmed there was no documentation of the notification to the physician of Resident #89 refusing to have laboratory test completed. Additional interview on 03/05/26 at 10:00 A.M. with Regional RN #237 confirmed the facility did follow up with the laboratory company for another attempt to obtain the laboratory test. Review of the facility's protocol titled Lab and Diagnostic Test Results, revised September 2012, revealed staff will process test requisitions and arrange for tests. Further review of the protocol revealed facility staff, for physician notification, should document information about when, how, and to whom information was provided and the response, and that this should be done in the progress notes of the medical record.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure routine dental appointments occurred for all residents. This affected one (Resident #59) of one resident reviewed for dental services. The census was 82.Findings Include:Resident #59 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.Review of Resident #59's dental appointment records revealed she had an initial appointment completed on 12/04/24. She was scheduled for another appointment on 12/10/25, but the appointment was cancelled due to Resident #59's refusal on that day. There were no other appointments documented as being completed and/or scheduled for Resident #59. Interview with Resident #59 on 03/02/26 at 3:21 P.M. confirmed she has not had a dental appointment scheduled for a while. She stated she does want to have one. Interview with Social Service Designee (SSD) #136 on 03/04/2026 at 10:07 A.M. confirmed Resident #59 refused her dental appointment. She confirmed Resident #59 was sick on 12/10/25, so she refused her dental appointment. She confirmed they have not rescheduled the appointment yet, but will do so this day. She confirmed each resident will be scheduled and see (barring refusals) at least once a year.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to implement antibiotic stewardship regarding antibiotic use. This affected one (Resident #8) of one resident reviewed for antibiotics. The facility census was 82.Findings include:Review of the medical record for Resident #8 revealed an admission date of 12/16/25 with diagnoses including acute respiratory failure with hypoxia, morbid (severe) obesity, neuromuscular dysfunction of bladder, stage IV pressure ulcer of right buttock, congestive heart failure, atrial fibrillation, paraplegia, and tracheostomy status. Review of the most recent minimum data set (MDS) completed 12/23/25 revealed the resident had intact cognition and had an indwelling foley catheter.Review of the physician's orders revealed Resident #8 had an order for Ciprofoxacin (antibiotic) 500 milligrams (mg) twice daily for 14 days dated 02/17/26 through 03/03/26.Review of the medical record revealed hospital paperwork dated 02/17/26 with urinalysis results with no urine culture. Interview on 03/04/2026 at 2:12 P.M. with regional nurse #237 revealed the facility used McGeer's Criteria for the antibiotic stewardship program and verified Resident #8 did not meet criteria for antibiotic usage for a urinary tract infection. Review of facility policy titled Antibiotic Stewardship revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program.