

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Country Club Center I		STREET ADDRESS, CITY, STATE, ZIP CODE 860 Iron Avenue Dover, OH 44622	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on review of the medical record, review of the Self-Reported Incident (SRI), review of facility investigation, review of the facility policy, and interview with staff the facility failed to prevent misappropriation of medication for Resident #40 by a staff member. This affected one resident (#40) of three residents reviewed for medication.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure dependence on a ventilator, morbid obesity, dependent of oxygen, tracheostomy, congestive heart failure, diabetes, restless leg syndrome, obstructive and reflux uropathy, and disorders of the penis.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #40 had intact cognition.</p> <p>Review of the physician's order revealed Resident #40 had an order for hydrocodone-acetaminophen (Norco) (narcotic pain medication) 5/325 milligrams (mg) every four hours for pain dated 07/20/23.</p> <p>Review of the April 2024 Medication Administration Records (MAR) revealed the last dose of Norco 5/325 mg was administered to Resident #40 on 04/12/24 at 6:35 P.M.</p> <p>Review of the narcotic sign out sheet for hydrocodone/acetaminophen 5/325 mg revealed Registered Nurse (RN) #300 had been the only nurse to sign out the medication from 04/22/24 to 06/17/24. The administration dates were as follows: 04/22/24 at 6:00 A.M. and 1:00 P.M., 04/23/24 at 7:00 A.M., 07/24/24 at 7:00 A.M., 04/27/24 at 7:00 A.M and at 7:00 P.M., 05/02/24 at 7:00 A.M., 05/03/24 at 7:00 A.M., 05/06/24 at 7:00 A.M. and at 2:00 P.M., 05/11/24 at 7:00 A.M., 05/12/24 at 7:00 A.M., 05/16/24 at 7:00 A.M., 05/17/24 at 7:00 A.M., 05/20/24 at 7:00 A.M., 05/22/24 at 7:00 A.M., 05/23/24 at 7:00 A.M., 06/03/24 at 7:00 A.M., 06/05/24 at 7:00 A.M., 06/08/24 at 7:00 A.M, 06/09/24 at 7:00 A.M., 06/13/24 at 7:00 A.M., 06/14/24 at 7:00 A.M., and 06/17/24 at 7:00 A.M.</p> <p>Review of the May 2024 MARs revealed Resident #40 was not administered any hydrocodone/acetaminophen 5/325 mg.</p> <p>(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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Country Club Center I		STREET ADDRESS, CITY, STATE, ZIP CODE 860 Iron Avenue Dover, OH 44622	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the June 2024 MAR revealed Resident #40 was not administered any hydrocodone/acetaminophen 5/325 mg.</p> <p>Review of the SRI tracking number 248910 dated 06/22/24 revealed on 06/20/24 facility staff identified a supply of six tablets was missing from the medication supply indicated for Resident #40. The tablets in question were the remaining amount of an initial 30 tablet supply. A suspected perpetrator was identified and suspended pending investigation. Resident #40's physician was notified. The investigation consisted of interview of Resident #40, interview of the suspected perpetrator, interviews of residents with potential to be affected, audits of medication quantities, audits of medication availability and interviews of staff with potential knowledge. During interview of Resident #40 denied experiencing any recent change in health or symptom management as well as any knowledge of the missing medication. Interviews of residents with potential to be affected did not identify any reports of failed symptom management. The audit conducted of medication quantities and availability according to receipt did not identify any abnormalities. During interview the suspected perpetrator denied any knowledge of the missing medication but failed to cooperate further with the investigation. Interviews of facility staff did not identify any knowledge of the missing medication. During the investigation the expense of the medication was ensured to have been provided for by the facility. Local law enforcement was notified as well as the Board of Pharmacy through the facility's pharmacy provider and the Board of Nursing. Through investigation the facility concluded misappropriation had occurred. The suspected perpetrator's employment was terminated as well as initial contact to report made with the Ohio Board of Nursing (OBN). Education regarding controlled substance receipt, securement, documentation of administration, exhaustion, and misappropriation to be initiated for all licensed nursing staff. As well as further auditing of current controlled substance records. Once completed on-going audits of controlled substance receipt, shift to shift count, securement, documentation and exhaustion to be initiated with results reviewed by the Quality Assurance and Performance Improvement (QAPI) committee weekly.</p> <p>Review of the signed typed statement from Licensed Practical Nurse (LPN) #415 dated 06/20/24 revealed he was looking for another medication for a resident and was searching the narcotic book for the sheet when he found a narcotic sheet in the back of the narcotic book. He stated he tried to find the card of medication that went with the sheet and could not find it, so he went to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #410 to inform them. He stated the sheet indicated there were six tablets left in the card. He stated he thought maybe it had been discontinued and they gave the card of narcotic to the DON but not the sheet.</p> <p>Review of the signed typed statement from Registered Nurse (RN) #416 dated 06/21/24 revealed she spoke to Resident #40, who had intact cognition, regarding the last time he received his Norco. He reported that the last time he received any Norco was serval months ago maybe March or early April and he did not know he even still had it available.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Country Club Center I		STREET ADDRESS, CITY, STATE, ZIP CODE 860 Iron Avenue Dover, OH 44622	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review pf the undated unsigned typed statement from the DON revealed the Administrator, DON and ADON #410 conducted a phone interview with RN #300 on 06/20/24 in regard to the missing narcotic. When the DON questioned RN #300 if he knew where the medication could be he just sighed with no proper response. He was then educated on the importance of the situation, RN #300 only stated yeah. RN #300 was unable to give proper response to the question regarding the missing narcotic or count sheet found in the back of the narcotic binder. He was instructed to get a drug screen and would be ineligible to return to work until completed. RN #300 stated he was watching his father and was not able to go get tested . He was reminded of the importance to the investigation and his employment. He stated his understanding and that he would text his siter to come help with his father. Upon ending the phone call RN #300 texted the ADON #410 and stated he was not planning on getting a drug screen.</p> <p>Review of the police report dated 06/21/24 revealed they were called to the facility because a nurse was falsely signing out medication to residents and reported missing pills from March until present.</p> <p>On 08/08/24 at 1:40 P.M. an interview with Director of Clinical Services #400 revealed LPN #415 found a narcotic count sheet for Norco for Resident #40 folded up and stuck in between several blank shift to shift narcotic count sheets. He stated they never found the card of Norco. He stated the identified RN #300 as the perpetrator because he was the only nurse that had signed out any Norco. He stated Resident #40 was interviewed and he stated he was never given the Norco. He stated RN #300 was interviewed but never confessed to taking the Norco, but he would not cooperate, and he refused to be drug tested . He stated the facility paid for the medication, so they do not believe it was misappropriation; however, they do believe it was diversion. He stated they reported it to the Ohio Board of Nursing and the local police department. He stated the Attorney General's office has also been out to investigate.</p> <p>Review of the facility policy titled, Abuse, dated 01/31/20, revealed the residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident's property. This included but not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraints that was not required to treat the resident's medical symptoms. Misappropriation of resident's property was the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.</p> <p>The deficient practice was corrected on 06/27/24 when the facility implemented the following corrective actions:</p> <p>On 06/22/24 the local authorities were notified by the Administrator, report number 24-04962.</p> <p>On 06/24/24 at 9:00 A.M. a QAPI meeting was held with the DON, ADON #410, RN #416, Director of Clinical Services #400, and Administrator.</p> <p>On 06/24/24 an audit of all current residents with controlled substance quantities was completed by the DON, ADON #410, and RN #416 with no discrepancies identified.</p> <p>On 06/24/24 an audit of all controlled substance administration records (cards, count sheets, MAR) were completed by the DON, ADON #410 and RN #416 for evidence of diversion with no discrepancies identified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Country Club Center I		STREET ADDRESS, CITY, STATE, ZIP CODE 860 Iron Avenue Dover, OH 44622	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/26/24 education for all licensed nurses regarding management, securement and administration of controlled substances was done by the DON, ADON #410, and RN #416 and completed on 07/01/24.</p> <p>On 06/26/24 the Director of Clinical Services #400 was notified of suspicion and investigation findings.</p> <p>On 06/27/24 an audit was completed by the DON and ADON #410 of receipt of controlled substances for prior 30 days with no discrepancies identified.</p> <p>On 06/27/24 all residents with narcotic pain medications were interviewed by the DON, ADON #410, and RN #416 for effectiveness of pain management with no concerns identified.</p> <p>Ongoing Actions included the DON, ADON #410 and RN #416 would perform randomized audits of the shift-to-shift controlled substance count process, receipt and removal of controlled substances from active supply, reconciliation of count sheet to MAR process, and interviews of residents to verify administration/effective pain management three times a week for four weeks. Findings would be presented to the QAPI committee weekly for evaluation and recommendations. Audits were completed on 07/25/24 with no further concerns identified.</p>		