STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365417	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Center I	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, and review of the facility policy, the facility failed to knock prior to entering the room of Resident #16. This affected one resident (Resident #16) of three reviewed for privacy.Findings Include: Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes, chronic kidney disease, bipolar disorder, generalized anxiety disorder, lymphedema, and gout.Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #16 had intact cognition.Observation and interview on 01/17/26 at 10:12 A.M. revealed Maintenance #106 opened the door of Resident #16's room without knocking prior to entering. An interview at this time with Maintenance #106 stated he was doing fire watch rounds and verified she had not knocked on the door prior to opening it.Review of the undated facility policy titled, Ohio Resident Rights and Facility Responsibilities, revealed the resident had the right upon reasonable request to have room doors closed and to have them not opened without knocking, except in the case of an emergency or unless not medically advisable as documented in the resident's medical record by the attending physician.

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 02/02/2026

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, interview, review of facility Self-Reported Incidents (SRI) and associated investigations, and review of the facility's Abuse policy, the facility failed to prevent the verbal abuse of Resident #10 by a facility staff member. This affected one resident (Resident #10) of three reviewed for abuse however this had the potential to affect all 56 residents in the facility.Findings Include: Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included traumatic subdural hemorrhage, chronic obstructive pulmonary disease, asthma, respiratory failure, diabetes, blindness, heart failure, end stage renal disease with renal dialysis, major depressive disorder, generalized anxiety disorder, cannabis use, hypertension, hypothyroidism and traumatic brain injury.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #10 had intact cognition with no behaviors.Review of the Self-Reported Incident dated 12/09/25 revealed on 12/01/25 at 6:15 P.M. Resident #10 was in the dining room and asked for assistance getting back to her room. CNA #111 said to the resident that she would when she was finished with another resident. Resident #10 then turned to CNA #200 and she said, [Expletive]. This was said in front of others and Resident #10 felt embarrassed and humiliated. She was tearful throughout the night. The allegation of Emotional/Verbal Abuse was substantiated, and CNA #200 was terminated.Review of the facility investigation completed by the Interim Administrator dated 12/09/25 at 6:05 P.M. revealed she had received a call from the Interim Director of Nursing (DON) indicating after dinner a resident came to the Interim DON and said that a resident told her one of the nursing assistants yelled [Expletive] you at the dinner table. Resident #10 had asked CNA #200 to help her get back to her room and CNA #200 told her she would as soon as she could. Resident #10 stated she was sitting there waiting and CNA #200 was huffy and yelled, [Expletive] you. The Interim Administrator had the DON take CNA #200 into her office and place her on speaker phone; She asked CNA #200 what had happened at supper. CNA #200 stated she told Resident #10 she would help her to get back to her room then the resident shrugged and rolled her eyes. CNA #200 stated she just got angry and said, Well [expletive] you. The Interim Administrator told CNA #200 to clock out, and she would get with her the next day. The Interim DON went with her to leave the building. On 12/10/25 the Interim Administrator met briefly with Resident #10 as she was on her way out to dialysis. Resident #10 told the Interim Administrator she did not like CNA #200 because she was not nice to her and it seemed like she hated her. The Interim Administrator questioned if she thought the statement from CNA #200 was aimed at her and she stated she was the only one at the table. CNA #200 was called and terminated.Review of the concern form written by the Social Service Designee #233 dated 12/09/25 revealed Resident #10, during a day the week prior, had asked CNA #111 and CNA #200 to take her back to her room. CNA #111 stated she was busy passing trays but would when she was done. CNA #200 was just standing there and said [expletive] and threw her arms down. The resident asked one of the other girls to take her back and the resident went back to her room and cried herself to sleep in her wheelchair. No one ever woke her up to put her in her chair. The resident stated she did tell CNA #200 to not touch her. CNA #200 was suspended until the investigation was completed and she was terminated on 12/10/25.Review of the signed witness statement from CNA #200 dated 12/09/25 revealed the week before, Resident #10 requested for her to put her to bed and she said the word [explicit] in front of her, but was not directing it at the resident. She stated she was talking to CNA #111 and did not realize at the time the Resident #10 had heard her. She stated she offered to take Resident #10 to her room and she refused. So, she finished serving dinner. After dinner she did go back to Resident #10 ' s room to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apologize and Resident #10 told her to forget about it, so she walked out of her room. She stated she felt really bad she had said that and she had heard her.Review of the signed witness statements from CNA #111 dated 12/09/25 revealed Resident #10 had asked CNA #200 to take her back to her room and CNA #200 stated [expletive] I do not wanna do this, and Resident #10 heard her say it. Resident #10 stated she was going to report CNA #200 to the DON. She stated CNA #200 was facing CNA #111 when she said it. 01/29/26 at 845 A.M. an interview Social Service Designee #233 revealed she was a medical assistant. She stated she interviewed Resident #10 and she told her that she asked the girls to take her back to her room after dinner and she heard the one girl say, Expletive you, She stated the aide working stated she told her she had to finish passing the trays and then she would get her. She stated CNA #200 was standing by the resident and she was the one who said, expletive you and the resident heard her say it. The resident told her another aide pushed her back to her room and she cried herself to sleep. She stated during the investigation that no staff mentioned the resident had been upset after the incident and she stated she had no signs of distress the next day at dialysis. She stated she did follow up with her the next day but verified there was no documentation in the residents ' chart she followed up with her for emotional support. She stated the resident could not pinpoint the day the incident occurred.Review of the Nurse Progress notes from 12/06/25 to 12/20/25 revealed no documentation of an incident with Certified Nursing Assistant (CNA) #200 or emotional support or counseling for Resident #10.On 01/27/26 at 1:00 P.M. an interview with the Interim Administrator verified CNA #200 admitted to cussing at Resident #10 so she was fired over the telephone.On 01/29/26 at 8:45 A.M. an interview Social Service Designee #233 revealed she interviewed Resident #10 and was told that she asked the girls to take her back to her room after dinner and she heard the one girl say [Explicit] you, She stated the aide working (CNA #111) stated she told her she had to finish passing the trays and then she would get her and CNA #200 was standing by the resident and she was the one who said the explicit word, and the resident heard her say it. The resident stated to her that another aide pushed her back to her room and she cried herself to sleep. She stated during the investigation no staff mentioned the resident had been upset after the incident and she stated there was no signs of distress the next day at dialysis. She stated she did follow up with her the next day, but verified there was no documentation in the residents' chart that she followed up with her for emotional support. She stated the resident could not pinpoint the day the incident occurred.Review of the facility policy titled, Abuse, dated 01/31/20 revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint that was not required to treat the resident's medical symptoms. The policy stated it was the facility's policy to investigate all alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations were free from retaliation or reprisal for reporting the incident.

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NAME OF PROVIDER OR SUPPLIER Country Club Center I		STREET ADDRESS, CITY, STATE, ZIP CODE 860 Iron Avenue Dover, OH 44622	

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and policy review, the facility failed to ensure a pressure ulcer was comprehensively assessed and treatment orders were obtained timely for Resident #28 to prevent the further decline of an identified in-house obtained pressure ulcer.Actual Harm occurred on 12/12/25 when Resident #28, who had moderately impaired cognition, and was at risk for pressure ulcer development, developed a new, in-house acquired left buttock pressure ulcer. The ulcer was first assessed as an open area without proper prevention, treatment, and interventions implemented. This affected one resident (Resident #28) of three residents reviewed for pressure ulcers. The facility census was 56.Findings Include: Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included diabetes left buttock stage III (full thickness that extends into the fatty tissue but does not expose the bone or muscle) pressure ulcer, diabetic neuropathy, hyperlipidemia, adjustment disorder, hypertension, repeated falls, altered mental status, and atherosclerotic heart disease.Review of the care plan, dated 09/03/25, revealed Resident #28 needed assistance from staff for activities of daily living related to decreased mobility. Interventions included to assist the resident in ambulation as needed, assist the resident with incontinence care as needed, assist the resident with toileting as needed, assist the resident with transfers as needed, and assist the resident with bed mobility as needed.Review of the care plan, dated 09/03/25, revealed Resident #28 was at risk for skin breakdown related to decreased mobility, diabetes and incontinence. Interventions included encouraging turning and repositioning, staff to perform skin checks, assist resident with toileting as needed, and provide diet as ordered. New interventions included an air mattress to the bed dated 01/08/26 and a Roho cushion (a cushion used for pressure relief) for pressure relief dated 01/09/26.Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/13/25, revealed Resident #28 had moderately impaired cognition, required touching assistance for rolling side to side, required moderate assistance for transfers and ambulation, and did not have any pressure injuries.Review of the Braden Scale dated 11/28/25 revealed Resident #28 was at risk for pressure injuries.Review of the Weekly Skin Observation note dated 12/12/25 revealed Resident #28 had a new skin area to the right buttock. The area was reddened and hard to touch. It measured 0.5 centimeters (cm) in width.Review of the progress note dated 12/12/25 revealed Resident #28 had 0.5 (measurements were not noted) small open area to the right buttock. The area was hard and painful to touch. The area was cleaned and covered with a two-by-two border foam dressing. The area was reported to the Nurse Practitioner (NP) and the wound team; however, no treatment order was ever written.There was no further documentation of a right buttock pressure ulcer or treatments ordered or completed until 12/15/25.Review of the physician's orders dated 12/15/25 revealed Resident #28 received an order to cleanse the left (previously noted as the right) gluteal fold with normal saline (NS), apply triple antibiotic ointment, cover with a dressing, change twice a day and as needed and order doxycycline hyclate (an antibiotic) 100 milligrams (mg) twice daily for five days for wound care.Review of the Wound Care NP #300 note dated 12/18/25 revealed Resident #28 had an unstageable ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) that occurred due to prolonged pressure on a specific area of the skin, resulting in the lack of blood flow and oxygen to the tissue. It is a full thickness tissue loss where the depth of the wound or bed sore was completely obscured by eschar in the wound bed) pressure ulcer to the left buttock which measured 5.1 cm by 2.9 cm by an undetermined depth. The wound had 60 percent granulation (healthy tissue) and 40 percent slough (dead tissue), and scant drainage. Debridement was postponed due to the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	residents' high discomfort and pain concerns. A new order was received for Anasept gel (wound healing gel) and moist gauze daily.Review of the Progress Note dated 12/18/25 at 10:27 A.M., recorded as a late entry on 12/23/25 at 10:29 A.M. by Licensed Practical Nurse #110, revealed Resident #28 was seen by an unnamed Wound NP and received new orders to cleanse with normal saline, apply Anasept gel and a moist gauze, and apply a dry sterile dressing daily and as needed.Review of the physician's orders dated 12/22/25 revealed Resident #28 had an order for amoxicillin-potassium Clavulanate (an antibiotic) 875-125 mg twice daily for a bacterial infection to the left gluteal for seven days and a gel cushion to the resident's chair for preventative care.Review of the plan of care dated 12/23/25 revealed Resident #28 had an open area related to decreased mobility, diabetes, incontinence of bladder and bowel, and left buttock abscess. Interventions included administering medication as ordered, applying treatment to the area as ordered, encouraging the resident to turn and reposition, give supplements as ordered, and monitor for signs and symptoms of infection.Review of the physician orders dated 12/23/25 revealed the orders written on 12/18/25 were initiated, to cleanse with normal saline, apply Anasept gel and moist gauze, and apply a dry sterile dressing daily and as needed. Additionally, there was a new order for a wound culture to the left gluteal fold, and 30-gram protein shakes twice daily.Review of Resident #28's lab results revealed a wound culture was completed on 12/23/25 but there was no documentation obtained by the facility of what the wound culture results were.Review of the Wound Care NP #301 note dated 12/24/25 revealed Resident #28 had a Stage III pressure ulcer to the left buttock which measured 2.8 cm by 2.9 cm by 0.2 cm with 90 percent granulation and 10 percent slough, moderate drainage, and the wound was improving. Debridement was postponed due to the resident's high discomfort and pain concerns. A new order was given to apply Anasept gel and calcium alginate, and cover with a silicone bordered foam dressing daily was ordered with instructions that they may use Medi-honey gel until Anasept was available.Review of the physician's order dated 12/24/25 revealed Resident #28 received an order to cleanse the left buttock with normal saline, apply Anasept gel and calcium alginate with instructions to cover with a dry sterile dressing daily and as needed, though the Wound Care NP noted stated to cover with a bordered foam dressing.Review of the Wound Care NP #301 note dated 12/31/25 revealed Resident #28 had a Stage III left buttock pressure ulcer which measured 2.5 cm by 1.5 cm by 0.2 cm with undermining between 10 o'clock and 12 o'clock for a maximum depth of 0.3 cm. The wound had 90 percent granulation and 10 percent fibrin with moderate drainage. The wound was improved even though undermining was noted. It noted the wound would benefit from debridement though the resident declined. A new order was given to cleanse with normal saline, apply Mesalt and a silicone bordered foam dressing daily.Review of the physician's order dated 12/31/25 revealed Resident #28 received an order to cleanse the left buttock with normal saline, apply Mesalt dressing, and cover with bordered foam dressing daily and as needed.Review of the Wound Care NP #301 note dated 01/07/26 revealed Resident #28 had a Stage III left buttock pressure ulcer which measured 2.5 cm by 1.5 cm by 0.2 cm with undermining between 10 o'clock and 12 o'clock for a maximum depth of 0.3 cm. The wound had 100 percent granulation tissue with moderate drainage. There was no change in the treatment order.Review of the Wound Care NP #301 note dated 01/14/26 revealed Resident #28 had a Stage III left buttock pressure ulcer which measured 1.7 cm by 1.5 cm by 0.1 cm with undermining between 6 o'clock and 8 o'clock for a maximum depth of 0.2 cm. The wound had 100 percent granulation tissue with moderate drainage. Silver Nitrate was used to cauterize excess granulation tissue. There was no change in the treatment order.During an interview on 01/27/26 at 2:15 P.M., Resident #28 stated the nurses did not change her wound dressing daily. When asked why there was not a dressing on her wound at that time, Resident #28 stated it came off all the time and they did not (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	replace it, even when she asked them to replace it. She stated she does not know how she got the wound but did say she sat in her high back chair in her room most of the time. She also stated the facility did get her a cushion for her chair.During an observation on 01/27/26 at 2:20 P.M., there was no dressing to Resident #28's pressure ulcer on the left buttock. Registered Nurse (RN) #107 verified at the time of the observation the dressing was not on the wound. RN #107 asked the resident where the dressing was, and the resident stated it fell off during the night. The nurse asked if the resident told anyone and the resident stated she told the previous nurse it was off, but she never replaced it. The wound was clean, the edges were well approximated but slightly reddened, and the wound bed was beef red with no observed slough. Additionally, for the completion of the dressing change, RN #107 placed the packaged dressing supplies and scissors on the resident's over-the-bed table without cleaning the over-the-bed table prior to placing the clean dressing supplies directly on the table with the residents personal items. The table was visibly soiled with a white substance. RN #107 then moved the resident's personal items off the over-the-bed table onto another table and moved the over-the-bed table in front of the bathroom door. RN #107 removed her gloves, washed her hands, redonned gloves and placed three paper towels from the bathroom dispenser on the over-the-bed table. She opened the dressings onto the paper towels on the over-the-bed table and placed the scissors directly on the table, not on the paper towels. She proceeded to clean the wound, remove her gloves, wash her hands, redonn gloves, open the Mesalt dressing, pick up the scissors from the dirty table, cut the Mesalt with the contaminated scissors and she applied it to the wound and covered it with the foam dressing.During an interview on 01/27/26 at 2:35 P.M. with RN #107 verified she had not cleaned the table prior to placing the paper towels on the table and she stated she had cleaned the scissor prior to the taking them to the room. However, she did verify she placed them directly on the soiled over-the-bed table.During an interview on 01/27/26 at 5:00 P.M., the Director of Nursing (DON) stated she had just taken over wound rounds at the facility. She stated Licensed Practical Nurse (LPN) #110 had been doing them prior to her. She stated she did not feel LPN #110 was assessing the wounds properly and comprehensively so that was why she took over. She verified at this time she believed the assessment on 12/12/25 indicating the right buttock was not corrected, and it should have been the left buttock because Resident #28 never had a wound or treatment orders to the right buttock. She also verified there were no treatment orders or interventions put into place until 12/15/25, three days after the wound was identified. She believed it was an abscess that opened but verified all the documentation stated it was a pressure ulcer.During an On 01/28/26 at 1:00 P.M., Resident #28 stated she had been suffering from some pain from her wound in the beginning, but it was not very bad. She stated she was able to tolerate it.During an interview on 01/28/26 at 1:30 P.M., LPN #110 stated he was previously the wound nurse for the facility up until about two weeks ago. He stated he usually completed his wound rounds on Wednesdays and Thursdays. He stated he also worked as the Assisted Living Wellness Director for the rest of the week. He stated he was notified of new skin concerns either by looking at the shower sheets or the wound tracking sheets at the nurse's station on the clip boards. He stated he would go to each nurse's station and look at those boards when he worked. He stated the right buttock documentation on 12/12/25 for Resident #28 was incorrect and it was always her left buttock.During an interview on 01/29/26 at 8:25 A.M., the Director of Nursing verified the wrong type of dressing was transcribed on 12/24/25. She verified it was supposed to be a silicone border foam dressing however the order was transcribed for a dry sterile dressing. She verified the Wound NP's order for 12/18/25 was not initiated until 12/23/25 for Anasept gel and moist gauze daily. She verified the facility never received the wound culture results. She stated she investigated the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	lab's result portal and it stated the lab received the results, however it never resulted. She stated she did not know if it was contaminated or what had happened, but they never received the results, and nobody followed up.Review of the policy titled Wound and Skin Care Program, undated, revealed any newly identified skin impairment will be reported to the nurse for assessment. Assessment findings will then be reported to the physician for treatment guidance and evaluation of further interventions. The policy stated the wound treatments/dressings will be supported by a physician order and wound dressing orders will be accompanied by a separate order for dressing monitoring to be conducted each shift. Review of the facility policy titled, Wound and Skin Care, dated 09/26/24 revealed the purpose was to ensure documentation, monitoring, and treatment of a dressing change. Step number three of the procedure stated to prepare a clean, dry work area at bedside and apply a barrier. Step six indicated to use clean or sterile scissors.