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No. 0938-0391

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	04/17/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and policy review, the facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior which was neat and well kept. This affected six residents (#4, #7, #44, #54, #55, and #57) of 52 residents reviewed for a safe, clean, comfortable homelike environment. The facility census was 52.Findings include: On 03/30/26 at 10:57 A.M., an observation of Resident #54 and #55's room, revealed blue carpeting which had multiple white stains, a brownish-red stain, and tears/snags at the entryway to the room and scattered throughout the room. The stained and snagged areas could be viewed from the hallway. On 03/30/26 at 10:59 A.M., an interview with certified nurse aide (CNA) #115 revealed the facility had several rooms with stained, torn/snagged and dirty carpets which were not well kept (including the room of Resident #54, #55). She reported someone had tried to bleach them to clean them, and that was what had caused the stains. She reported it was mostly the rooms which still had blue carpet, because most of the other rooms had wooden floors.On 03/30/26 at 12:50 P.M., observations of the rooms for Resident #44, #57, #54, #55, #4, #7 revealed blue carpeting which was stained, torn/snagged and not well kept. All of these could be viewed from the hallway. At the time of the observation, the condition of the carpeting was confirmed by Regional Maintenance Director (RMD) #1500. During the observation, RMD #1500 confirmed the carpeting of these rooms all needed replaced, and he believed it was in the facility capital plan for 2026. He thought one of the stains on the floor appeared to be feces and not an actual stain, and the carpet of the room needed cleaned as soon as possible.Review of a facility policy titled 5 Step Resident Room Cleaning Procedure, dated 10/2019, revealed a policy to ensure resident rooms were cleaned and disinfected. The policy failed to reveal a process to clean and maintain the carpeting of resident rooms.This deficiency represents noncompliance investigated under Complaint Number 2961570.

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 04/17/2026
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, interview, and policy review the facility failed to ensure residents were free from physical abuse.Actual harm occurred on 03/20/26 when the facility failed to implement appropriate interventions to prevent a resident-to-resident physical altercation despite staff knowledge of Resident #52's known history of aggression and verbal threats to kill his roommate, Resident #15. Resident #15 sustained bruising and psychosocial harm of fear and self-isolation because of the altercation. This affected two residents (Resident #15 and #52) of two residents reviewed for abuse. The facility census was 52. Findings include: 1.Review of Resident #15's medical record revealed an admission date of 10/22/21 with diagnoses including hypertension, hemiplegia (left side) and hemiparesis following cerebral infarction, major depressive disorder, muscle weakness, chronic pain syndrome, and insomnia. Review of Resident #15's care plan dated 11/01/21 revealed the resident needs assistance from staff to meet activity of daily living (ADL) needs related to decreased mobility, hip fracture, and hemiparesis due to an old cerebrovascular accident. Interventions include assisting the resident with transfers and mobility as needed. Review of Resident #15's quarterly minimum data set (MDS) completed on 01/30/26 revealed Resident #15 was moderately cognitively impaired. The resident did not exhibit behaviors or indicators of psychosis during the assessment period. The resident had upper and lower extremity impairment on one side and required a wheelchair for mobility (left sided hemiparesis, required maximum assistance (from staff) for showering, toileting hygiene, lower body dressing including footwear, and personal hygiene and required moderate assistance from staff for mobility and transfers. Resident #15 received antiplatelet medication. Review of Resident #15's care plan dated 02/02/26 revealed the resident had potential for bleeding related to anemia and aspirin therapy. Goals included the resident would be free from bruising, or injury. Interventions included observe for bruising. Review of Resident #15's progress notes revealed a late entry, dated 03/24/26 at 9:05 A.M., for 03/21/26 at 1:00 A.M. The progress note was authored by the Director of Nursing (DON), who was not in the facility at the time of the incident, that documented Resident #15's roommate was upset about the TV volume. Resident #15 wanted the TV volume to stay increased. Resident #52 was upset, and no harm came to Resident #15. Review of the grievance form dated 03/23/26 for Resident #15, completed through interview by Social Services Designee (SSD) #275, revealed Resident #15 said he was lying in bed, dozing on and off, when his roommate, Resident #52, came through the closed curtain and punched him in the left shoulder. Resident #15 stated he did not know why Resident #52 hit him. During an interview on 04/08/26 at 9:01 A.M., SSD #275 stated she was called by Certified Nursing Assistant (CNA) #22 on 03/10/26 related to a verbal altercation between Resident #15 and his roommate, Resident #52. CNA #22 reported there was a verbal altercation and Resident #52 had threatened to shoot Resident #15. SSD #275 stated she was not in the facility at the time of the incident and she was unsure if Resident #52 and/or Resident #15 needed to be sent out for evaluation so she called the Director of Nursing (DON) and the DON said to move Resident #52 out of the room. Resident #52 was moved to a private room at that time. The DON informed SSD #275 to instruct staff (CNA #22 and an agency nurse) not to document the incident in the progress notes. SSD #275 stated (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	she did not instruct the CNA/nurse not to document the incident and the agency nurse did make an entry in the medical record regarding the incident in Resident #52's record. The following day on 03/11/26, SSD #275 spoke with Resident #52 and he stated he didn't remember threatening Resident #15 but he remembered the TV was loud. Resident #52 stated he would apologize to his roommate, Resident #15. SSD #275 stated she checked with the DON and shared what Resident #52 said and the DON advised the CNAs Resident #52 could return to the room he shared with Resident #15. SSD #275 verified there was no room change documentation but when Resident #15 was informed Resident #52 would be returning as his roommate, Resident #15 stated whatever. SSD #275 stated there were no interventions or increased monitoring after the verbal altercation and no updates to either resident's care plan. SSD #275 stated the was not discussed afterwards, it was never mentioned in the morning stand-up meetings and the DON acted like it didn't happen. SSD #275 shared there was a physical altercation between Resident #52 and Resident #15 which occurred on 03/20/26, when SSD #275 was not in the building. SSD #275 found out about the physical altercation on Monday 03/23/26 when she returned to work after the weekend. She was informed that late in the evening on Friday, 03/20/26 Resident #52 hit Resident #15. SSD #275 confirmed there was a nurse progress note entered by the DON regarding the incident but the DON was not working when the incident occurred. SSD #275 stated she was not made aware of the incident until 03/23/26 and she observed Resident #52 in a different room and the DON told her it was a long story but she was provided with no additional information. SSD #275 stated the CNAs (cannot recall who) informed her the residents had a physical altercation with Resident #52 striking Resident #15. SSD #275 stated she interviewed each resident. Resident #15 stated he was lying in bed, dozing on and off with the TV on and his roommate, Resident #52, came through the privacy curtain and hit him in the shoulder. Resident #15 then demonstrated what happened and lifted his right arm with his hand in a fist and swung towards his left shoulder. Resident #15 was unable to move his left arm due to a previous stroke and when he lay in bed, his left side would be toward Resident #52's bed. SSD #275 stated she asked Resident #15 if he was hurt and the resident stated he had a knot on his shoulder but she did not confirm this. SSD #275 she reported the information to the Administrator, but the administrator denied knowledge of a physical altercation, as she (the Administrator) was originally told by the DON the altercation was verbal and nothing physical happened. SSD #275 stated she followed up with Resident #52 on 03/24/26, the next day. Resident #52 reported Resident #15 said the F' word and Resident #52 was tired of hearing it so he slapped him. Resident #52 stated he hit Resident #15 in the head or the shoulder. SSD #275 stated she shared this information with Corporate Staff #21 and then called the [NAME] President of Operations (VPO) #957 who advised her to write up the concerns for each resident (Resident #15 and #52) and send them to VPO #957. SSD #275 completed grievance forms and emailed both forms to VPO #957 on 03/24/26. Following the email, Corporate Registered Nurse (RN) #751 called the SSD and they did a rundown of the situation. Corporate RN #751 wanted to know who worked the night of 03/20/26 and SSD #275 provided the information which included the name of Agency Nurse #23. SSD #275 said she was unsure where it went from there so she asked VPO #957 and was informed to provide the grievance forms to the Administrator because the Administrator was to investigate the incident. SSD #275 stated she emailed the grievance forms to the Administrator around 03/27/26. SSD #275 believed the grievance was given to the DON to investigate but she was unsure if the DON investigated the incident as she never got an update. During an interview on 03/31/26 at 9:26 A.M., Resident #15 stated his previous roommate, Resident #52, moved rooms about a week ago. Resident #15 stated he was attacked by Resident #52 when the resident ran up to him and hit him in the shoulder. At the time, the hit was painful. Resident #15 stated he reported what happened to him to the nurse but he couldn't remember which nurse he told. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #15 shared, as of this time, no one followed up with him regarding the incident or asked him for a statement. Resident #15 stated there was no investigation done that he was aware of. During an interview on 04/08/26 at 11:20 A.M., the Administrator stated she was told Resident #52 and Resident #15 had a disagreement about the TV sometime in March 2026 but she could not recall the exact dates. The Administrator stated the DON informed her that Resident #52 had requested to return to the room with Resident #15 however there was no documentation of Resident #52's request or that Resident #15 was notified. There was no evidence Resident #15 said he felt safe and that he agreed with Resident #52 returning. On 03/20/26, the DON called her twice and ADON #390 called her once but was sleeping and didn't see the calls until about an hour and a half later. The Administrator stated she called the ADON back but the DON answered since they were together. The DON informed the Administrator Resident #15 and Resident #52 had a verbal altercation but there was no physical contact made. The DON stated she was going to separate the residents because it was an ongoing issue between the two residents bickering about the TV. The Administrator stated she didn't feel the incident needed reported to the State Agency as she thought it was a verbal altercation and not physical. The following Friday, 03/27/26, the Administrator received the concern/grievance form from SSD #275, and Resident #15 was saying he was hit by Resident #52. The Administrator stated she spoke with Resident #52 about the altercation and he didn't want to talk about it, he said he was happy in his private room. The Administrator stated SSD #275 did interviews with the residents following the altercation. The Administrator confirmed, until notification on 03/27/26 from SSD #275, she was told by the DON that the altercation was verbal, not physical. During an interview on 04/08/26 at 12:31 P.M. ADON #390 stated she was unaware of Resident #52 threatening to shoot Resident #15 until after the altercation on 03/20/26 as no one reported this to her. ADON #390 stated it was not appropriate to move Resident #15 and Resident #52 back into the same room and she was unsure who made the decision to do so but this placed Resident #15 at risk of being hurt. On 03/20/26 ADON #390 was called by Agency Nurse #23 around 9:00 P.M. to 10:00 P.M. ADON #390 confirmed she was not in the building at the time and there was no documentation of either party's family being notified, or a physician being notified of Resident #15 being hit by Resident #52. ADON #390 confirmed Resident #52 was the aggressor. ADON #390 stated when asking Resident #15 about the incident he did not want to talk about it but didn't state why. During an interview on 04/08/26 at 1:39 P.M., CNA #22 stated that around 03/10/26, she came into work, and Resident #52 was in front of the building, which was unusual. CNA #22 approached Resident #52 and asked him what wrong as Resident #52's face was beet red. Resident #52 responded I need you to move me to another room because I'm going to (explicit word) kill my roommate (Resident #15). CNA #22 reported this to SSD #275, and they (CNAs on shift) moved Resident #52 to a separate room. The next day the DON told the CNAs to move Resident #52 and Resident #15 back into the same room. Several staff members voiced concerns it wasn't safe because Resident #52 has a temper, he has physically assaulted staff and even had one CNA pinned against the wall with his cane. It was pretty evident where Resident #15 would not be able to fend for himself as Resident #15 is very dependent on staff. He is either in his bed or wheelchair. Despite staff concerns of the residents moving back into the same room, the DON told them they had to do what she said. On 03/20/26 CNA #22 heard Agency Nurse #23 yell for help. The nurse stated Resident #52 was punching Resident #15. CNA #22 asked Resident #15 if he was okay, he stated he could not talk about it, when asked why Resident #15 said I don't want him [Resident #52] to get me again. CNA #22 stated Resident #15 looked scared and terrified. CNA #22 stated they were not asked to make a statement on 03/20/26 or the days following. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/08/26 at 2:50 P.M., Resident #15 recalled what happened the night of 03/20//26 and stated he was scared for while after the incident because he was afraid Resident #52 would find him again. Resident #15 stated he was unable to use his left arm after a stroke and depended on the staff for mobility and transfers as well as dressing and other activities. During an observation on 04/09/26 at 12:12 P.M., Resident #15 had a yellow green bruise on the left bicep approximately 1.5 inch in length, and a quarter sized bruise, in various stages of healing, to the left shoulder. Resident #15 stated at the time of the observation those bruises were from the altercation with his roommate. This observation was verified by CNA #115. 2.Review of Resident #52's medical record revealed an admission date of 01/02/25 with diagnoses including anxiety, hypertension, heart failure, and pulmonary embolism. Review of Residents #52's care plan dated 03/14/25 revealed the resident had inappropriate behaviors at times related to being verbally/ physically aggressive towards staff, had delusions of seeing communists, and seeing stars. Goals included no injury to self or others. Interventions included documenting behaviors and speak to the resident about inappropriate behavior and redirect as possible. Review of Resident #52's annual MDS completed on 01/09/26 revealed he was moderately cognitively impaired. Resident #52 was independent/ required supervision from staff for mobility and transfers and received anti-anxiety and anti-depressant medications. Review of Resident #52 progress notes on 03/11/26 at 1:41 A.M. at approximately 6:30 P.M. this nurse was notified by staff that Resident #52 stated he was going to shoot Resident #15 due to his TV being too loud. The on-call person for nursing was notified and Resident #52 was removed from the room and placed in private room until morning. Notified on call physician who gave orders for trazadone 25 milligram, hourly checks for six hours, urinalysis, culture and sensitivity, complete blood count, and basic metabolic panel. Review of a late entry progress note dated 03/21/26 at 12:50 P.M., entered on 03/24/26 at 8:53 A.M., and authored by the DON documented Resident #52 was yelling and being verbally aggressive towards staff, mad about TV volume while trying to sleep, told roommate (Resident #15) to turn the volume down. Review of a grievance form completed on 03/24/26 via interview by SSD #275 revealed Resident #52 stated Resident #15 said expletive and he (Resident #52) had heard that word enough so he went over and slapped him with an open hand on the head. (The grievance form was used by the SSD to document the interview/incident as reported by Resident #52). During an interview on 03/31/26 at 9:33 A.M., Resident #52 stated he had problems with his previous roommate, Resident #15. Resident #52 stated Resident #15 was a grouchy old man, and about a week ago before they moved his room, Resident #15 dropped the F bomb so he hit him. Resident #52 stated he hit Resident #15 in either the head or the shoulder. During an interview on 04/02/26 at 10:08 A.M., CNA #685 stated prior to the evening of the physical altercation between Residents #15 and #52, Resident #52 was threatening to kill Resident #15, and Resident #15 was moved out of the room to a different room. At some point they moved the two residents back into the same room. On the evening of 03/20/26, less than a week after Resident #52 threatened to shoot Resident #15, Resident #15 was physically assaulted by Resident #52. CNA #685 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	stated Resident #15 would not be able to defend himself as he was dependent on staff for most activities of daily living (ADL) and was weak, and Resident #52 was pretty independent. CNA #685 stated several staff members were concerned why the two residents were moved back into the same room as the two residents had ongoing issues between the two of them, CNA #685 was working at the time of the incident but did not witness the incident but came to help staff. During an interview on 04/02/26 at 2:30 P.M., CNA #480, who came in at 5:00 A.M. the morning after the incident and received report of the occurrence, stated Resident #52 threatened to shoot and kill Resident #15 about two to three days prior to their physical altercation. Resident #52 was moved to a separate room away from Resident #15 after threatening him. Then at some point Residents #15 and #52 were moved back into the same room, leading up to Resident #52 physically assaulting Resident #15. CNA #480 stated Resident #15 was upset for a few days after the altercation, he would not talk to anyone, he was withdrawn, he seemed terrified. CNA #480 stated Resident #15 has started talking to people again. The day after the physical altercation Resident #15 was complaining of his body being sore and hurting. CNA #480 stated they were unsure who physically moved the residents back together before the incident occurred. During an interview on 04/02/26 at 3:18 P.M., CNA #485, who came in to work the night of the incident at 10:00 P.M., heard of the incident through report. She stated the DON had the residents moved back in together. On the evening of 03/19/26, or 3/20/26, (could not recall exact date) Resident #15 and Resident #52 got into it. Resident #52 attacked Resident #15. Prior to this incident Resident #52 would threaten Resident #15 that he would choke, shoot or kill him. The facility moved Resident #52 to a different room, then they placed him back into the same room with Resident #15, but Resident #52 became hostile again leading to the attack. During an interview of 04/06/26 at 10:55 A.M., CNA #195 stated Resident #52 had an episode and beat up Resident #15. The two have been split up before due to arguing and threats. Staff advocated the residents needed split up. Management moved Resident #52 to a different room once, and then he and Resident #15 ended up in the same room again. After being moved back into the same room Residents #15 was physically assaulted by Resident #52. Review of facility policy titled Abuse, revised on 01/30/20 revealed it is the facility policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property including injuries of unknown origin in accordance with the policy. Residents have the right to be free from abuse, neglect, exploitation and misappropriation. Individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Staff should report allegations to the administrator and to the Ohio department of health (ODH). If a staff member is disciplined for failing to report an incident/ allegation timely in accordance with this policy, any disciplinary action taken as a result of that failure shall not constitute retaliation or reprisal. abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. it includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Mistreatment is inappropriate treatment or exploitation of a resident. Neglect is the failure of the facility, its employees, or facility service providers to provide good and services to a resident necessary to avoid physical ham, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately. Initial response is to protect the resident. If a resident is accused or suspected of abuse, mistreatment, exploitation, or misappropriate, the facility will ensure other residents are protected as determined by the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	circumstances, which may include but are not limited to, increased supervision, of the victim, perpetrator, and/or other residents, room or staffing changes, and immediate transfer or discharge if indicated. The resident's representative and the attending physician should be notified. Notification to social services so that it may take appropriate interventions to care for the psychosocial needs of any involved resident. Documentation in the nurses notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. For the initial report, incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property an all injuries of unknown source must be reported in a timely manner to the administrator or designee per regulations. ODH will be notified of all alleged violations involving mistreatment, neglect, abuse, exploitation, misappropriation, and injuries of unknown source must be reported as soon as possible, but in no event later than 24 hours from the time of the incident/allegation was made to the staff member. If the allegation involves an allegation of abuse or serious bodily injury it should be reported to ODH no later than 2 hours after the allegation is made. the investigation must be completed within five working days. Interview the resident, the accused, and all witnesses including anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents, family members) and employees who worked closely with the accused employees and/ or alleged victim the day of the incident. if there are no direct witnesses then the interviews may be expanded. Obtain a statement from the resident, if possible, the accused, and each witness, obtain all medical reports and statements, review the resident record. evidence of the investigation should be documented. Ensure involved residents plan of care is reviewed and revised and complete staff training. in the case of resident to resident abuse, mistreatment, the facility will refer the matter to the facility interdisciplinary team to determine appropriate interventions. This deficiency represent noncompliance investigated under Master Complaint Number 2964189.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, self-reported incident dash board review, and policy review the facility failed to ensure an allegation of resident to resident physical abuse were reported to the Administrator and State Survey Agency (SSA) as required. This affected two residents (Resident #15 and #52) of two residents reviewed for abuse. The facility census was 52. Findings include: 1.Review of Resident #15's medical record revealed an admission date of 10/22/21 with diagnoses including hypertension, hemiplegia (left side) and hemiparesis following cerebral infarction, major depressive disorder, muscle weakness, chronic pain syndrome, and insomnia. Review of Resident #15's care plan dated 11/01/21 revealed the resident needs assistance from staff to meet activity of daily living (ADL) needs related to decreased mobility, hip fracture, and hemiparesis due to an old cerebrovascular accident. Interventions include assisting the resident with transfers and mobility as needed. Review of Resident #15's quarterly minimum data set (MDS) completed on 01/30/26 revealed Resident #15 was moderately cognitively impaired. The resident did not exhibit behaviors or indicators of psychosis during the assessment period. The resident had upper and lower extremity impairment on one side and required a wheelchair for mobility (left sided hemiparesis, required maximum assistance (from staff) for showering, toileting hygiene, lower body dressing including footwear, and personal hygiene and required moderate assistance from staff for mobility and transfers. Resident #15 received antiplatelet medication. Review of Resident #15's care plan dated 02/02/26 revealed the resident had potential for bleeding related to anemia and aspirin therapy. Goals included the resident would be free from bruising, or injury. Interventions included observe for bruising. Review of Resident #15's progress notes revealed a late entry, dated 03/24/26 at 9:05 A.M., for 03/21/26 at 1:00 A.M. The progress note was authored by the Director of Nursing (DON), who was not in the facility at the time of the incident, that documented Resident #15's roommate was upset about the TV volume. Resident #15 wanted the TV volume to stay increased. Resident #52 was upset, and no harm came to Resident #15. Review of the grievance form dated 03/23/26 for Resident #15, completed through interview by Social Services Designee (SSD) #275, revealed Resident #15 said he was lying in bed, dozing on and off, when his roommate, Resident #52, came through the closed curtain and punched him in the left shoulder. Resident #15 stated he did not know why Resident #52 hit him.During an interview on 03/31/26 at 9:26 A.M., Resident #15 stated his previous roommate, Resident #52, moved rooms about a week ago. Resident #15 stated he was attacked by Resident #52 when the resident ran up to him and hit him in the shoulder. At the time, the hit was painful. Resident #15 stated he reported what happened to him to the nurse but he couldn't remember which nurse he told. Resident #15 shared, as of this time, no one followed up with him regarding the incident or asked him for a statement. Resident #15 stated there was no investigation done that he was aware of. Interview on 04/06/26 at 9:07 A.M. with facility Administrator revealed as of Friday (04/03/26) they put the incident in as a reportable between Resident #52 and #15 because they felt with more information they uncovered, that more had happened between the two residents than they initially thought. During an interview on 04/08/26 at 9:01 A.M., SSD #275 shared there was a physical altercation between Resident #52 and Resident #15 which occurred on 03/20/26, when SSD #275 was not in the building. SSD #275 found out about the physical altercation on Monday 03/23/26 when she returned to work after the weekend. She was informed that late in the evening on Friday, 03/20/26 Resident #52 hit Resident #15. SSD #275 confirmed there was a nurse progress note entered by the DON regarding the incident but the DON was not working when the incident occurred. SSD #275 stated she was not made aware of the incident until 03/23/26 and she observed Resident #52 in a different room and the DON told her it was a long story but she was provided with no additional information. SSD #275 stated the CNAs (cannot recall who) informed her the residents had a physical altercation with Resident #52 striking Resident #15. SSD #275 stated she interviewed each resident. Resident (continued on next page)

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 04/17/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#15 stated he was lying in bed, dozing on and off with the TV on and his roommate, Resident #52, came through the privacy curtain and hit him in the shoulder. Resident #15 then demonstrated what happened and lifted his right arm with his hand in a fist and swung towards his left shoulder. Resident #15 was unable to move his left arm due to a previous stroke and when he lay in bed, his left side would be toward Resident #52's bed. SSD #275 stated she asked Resident #15 if he was hurt and the resident stated he had a knot on his shoulder but she did not confirm this. SSD #275 she reported the information to the Administrator, but the administrator denied knowledge of a physical altercation, as she (the Administrator) was originally told by the DON the altercation was verbal and nothing physical happened. SSD #275 stated she followed up with Resident #52 on 03/24/26, the next day. Resident #52 reported Resident #15 said the F' word and Resident #52 was tired of hearing it so he slapped him. Resident #52 stated he hit Resident #15 in the head or the shoulder. SSD #275 stated she shared this information with Corporate Staff #21 and then called the [NAME] President of Operations (VPO) #957 who advised her to write up the concerns for each resident (Resident #15 and #52) and send them to VPO #957. SSD #275 completed grievance forms and emailed both forms to VPO #957 on 03/24/26. Following the email, Corporate Registered Nurse (RN) #751 called the SSD and they did a rundown of the situation. Corporate RN #751 wanted to know who worked the night of 03/20/26 and SSD #275 provided the information which included the name of Agency Nurse #23. SSD #275 said she was unsure where it went from there so she asked VPO #957 and was informed to provide the grievance forms to the Administrator because the Administrator was to investigate the incident. SSD #275 stated she emailed the grievance forms to the Administrator around 03/27/26. SSD #275 believed the grievance was given to the DON to investigate but she was unsure if the DON investigated the incident as she never got an update. During an interview on 04/08/26 at 11:20 A.M., the Administrator stated on 03/20/26, the DON called her twice and ADON #390 called her once but was sleeping and didn't see the calls until about an hour and a half later. The Administrator stated she called the ADON back but the DON answered since they were together. The DON informed the Administrator Resident #15 and Resident #52 had a verbal altercation but there was no physical contact made. The DON stated she was going to separate the residents because it was an ongoing issue between the two residents bickering about the TV. The Administrator stated she didn't feel the incident needed reported to the State Agency as she thought it was a verbal altercation and not physical. The following Friday, 03/27/26, the Administrator received the concern/grievance form from SSD #275, and Resident #15 was saying he was hit by Resident #52. The Administrator stated she spoke with Resident #52 about the altercation and he didn't want to talk about it, he said he was happy in his private room. The Administrator stated SSD #275 did interviews with the residents following the altercation. The Administrator confirmed, until notification on 03/27/26 from SSD #275, she was told by the DON that the altercation was verbal, not physical.During an interview on 04/08/26 at 12:31 P.M. ADON #390 stated on 03/20/26 ADON #390 was called by Agency Nurse #23 around 9:00 P.M. to 10:00 P.M. ADON #390 confirmed she was not in the building at the time and there was no documentation of either party's family being notified, or a physician being notified of Resident #15 being hit by Resident #52. ADON #390 confirmed Resident #52 was the aggressor. ADON #390 stated when asking Resident #15 about the incident he did not want to talk about it but didn't state why.During an interview on 04/08/26 at 1:39 P.M., CNA #22 stated on 03/20/26 CNA #22 heard Agency Nurse #23 yell for help. The nurse stated Resident #52 was punching Resident #15. CNA #22 asked Resident #15 if he was okay, he stated he could not talk about it, when asked why Resident #15 said I don't want him [Resident #52] to get me again. CNA #22 stated Resident #15 looked scared and terrified. CNA #22 stated they were not asked to make a statement on 03/20/26 or the days following. During an interview on 04/08/26 at 2:50 P.M., Resident #15 recalled what happened the night of 03/20//26 and stated he was scared for while after the incident because he was afraid Resident #52 would find him again. Resident #15 stated he was unable to use his left arm after a stroke and depended on the staff for mobility and transfers as well as dressing and other activities. (continued on next page)

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 04/17/2026
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/08/26 at 3:12 P.M. with [NAME] President of Operations (VPO) revealed on 03/20/26 at 8:51 P.M. DON texted her and stated she thought she had a mess, possibly a Self Reported Incident (SRI). On 03/20/26 DON texted VPO again and stated never mind (NVM) I got it figured out. VPO stated she was under the impression DON investigated the incident. VPO confirmed there is no documentation of DON investigation the incident between Resident #15 and Resident #52. VPO confirmed she did not reach out to DON regarding the text messages sent on 03/20/26.During an observation on 04/09/26 at 12:12 P.M., Resident #15 had a yellow green bruise on the left bicep approximately 1.5 inch in length, and a quarter sized bruise, in various stages of healing, to the left shoulder. Resident #15 stated at the time of the observation those bruises were from the altercation with his roommate. This observation was verified by CNA #115.2.Review of Resident #52's medical record revealed an admission date of 01/02/25 with diagnoses including anxiety, hypertension, heart failure, and pulmonary embolism. Review of Residents #52's care plan dated 03/14/25 revealed the resident had inappropriate behaviors at times related to being verbally/ physically aggressive towards staff, had delusions of seeing communists, and seeing stars. Goals included no injury to self or others. Interventions included documenting behaviors and speak to the resident about inappropriate behavior and redirect as possible. Review of Resident #52's annual MDS completed on 01/09/26 revealed he was moderately cognitively impaired. Resident #52 was independent/ required supervision from staff for mobility and transfers and received anti-anxiety and anti-depressant medications. Review of a late entry progress note dated 03/21/26 at 12:50 P.M., entered on 03/24/26 at 8:53 A.M., and authored by the DON documented Resident #52 was yelling and being verbally aggressive towards staff, mad about TV volume while trying to sleep, told roommate (Resident #15) to turn the volume down.Review of a grievance form completed on 03/24/26 via interview by SSD #275 revealed Resident #52 stated Resident #15 said expletive and he (Resident #52) had heard that word enough so he went over and slapped him with an open hand on the head. (The grievance form was used by the SSD to document the interview/incident as reported by Resident #52).During an interview on 03/31/26 at 9:33 A.M., Resident #52 stated he had problems with his previous roommate, Resident #15. Resident #52 stated Resident #15 was a grouchy old man, and about a week ago before they moved his room, Resident #15 dropped the F bomb so he hit him. Resident #52 stated he hit Resident #15 in either the head or the shoulder.During an interview on 04/02/26 at 3:18 P.M., CNA #485, who came in to work the night of the incident at 10:00 P.M., heard of the incident through report. On the evening of 03/19/26, or 3/20/26, (could not recall exact date) Resident #15 and Resident #52 got into it. Resident #52 attacked Resident #15. Review of facility policy titled Abuse, revised on 01/30/20 revealed it is the facility policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property including injuries of unknown origin in accordance with the policy. Residents have the right to be free from abuse, neglect, exploitation and misappropriation. Individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Staff should report allegations to the administrator and to the Ohio department of health (ODH). Initial response is to protect the resident. If a resident is accused or suspected of abuse, mistreatment, exploitation, or misappropriate, the facility will ensure other residents are protected as determined by the circumstances, which may include but are not limited to, increased supervision, of the victim, perpetrator, and/or other residents, room or staffing changes, and immediate transfer or discharge if indicated. The resident's representative and the attending physician should be notified. Notification to social services so that it may take appropriate interventions to care for the psychosocial needs of any involved resident. Documentation in the nurses notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. For the initial report, incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property an all injuries of unknown source must be reported in a timely manner to the administrator or designee per regulations. ODH will be notified of all alleged violations (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Center I	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involving mistreatment, neglect, abuse, exploitation, misappropriation, and injuries of unknown source must be reported as soon as possible, but in no event later than 24 hours from the time of the incident/allegation was made to the staff member. If the allegation involves an allegation of abuse or serious bodily injury it should be reported to ODH no later than 2 hours after the allegation is made. the investigation must be completed within five working days. This deficiency represent noncompliance investigated under Master Complaint Number 2964189 and Complaint Number 2963759.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, interview, investigation review and policy review the facility failed to ensure allegations of abuse were thoroughly investigated. This affected two residents (Resident #15 and #52) of two residents reviewed for abuse.Findings include: 1.Review of Resident #15's medical record revealed an admission date of 10/22/21 with diagnoses including hypertension, hemiplegia (left side) and hemiparesis following cerebral infarction, major depressive disorder, muscle weakness, chronic pain syndrome, and insomnia. Review of Resident #15's care plan dated 11/01/21 revealed the resident needs assistance from staff to meet activity of daily living (ADL) needs related to decreased mobility, hip fracture, and hemiparesis due to an old cerebrovascular accident. Interventions include assisting the resident with transfers and mobility as needed. Review of Resident #15's quarterly minimum data set (MDS) completed on 01/30/26 revealed Resident #15 was moderately cognitively impaired. The resident did not exhibit behaviors or indicators of psychosis during the assessment period. The resident had upper and lower extremity impairment on one side and required a wheelchair for mobility (left sided hemiparesis, required maximum assistance (from staff) for showering, toileting hygiene, lower body dressing including footwear, and personal hygiene and required moderate assistance from staff for mobility and transfers. Resident #15 received antiplatelet medication. Review of Resident #15's care plan dated 02/02/26 revealed the resident had potential for bleeding related to anemia and aspirin therapy. Goals included the resident would be free from bruising, or injury. Interventions included observe for bruising. Review of Resident #15's progress notes revealed a late entry, dated 03/24/26 at 9:05 A.M., for 03/21/26 at 1:00 A.M. The progress note was authored by the Director of Nursing (DON), who was not in the facility at the time of the incident, that documented Resident #15's roommate was upset about the TV volume. Resident #15 wanted the TV volume to stay increased. Resident #52 was upset, and no harm came to Resident #15. Review of the grievance form dated 03/23/26 for Resident #15, completed through interview by Social Services Designee (SSD) #275, revealed Resident #15 said he was lying in bed, dozing on and off, when his roommate, Resident #52, came through the closed curtain and punched him in the left shoulder. Resident #15 stated he did not know why Resident #52 hit him.During an interview on 03/31/26 at 9:26 A.M., Resident #15 stated his previous roommate, Resident #52, moved rooms about a week ago. Resident #15 stated he was attacked by Resident #52 when the resident ran up to him and hit him in the shoulder. At the time, the hit was painful. Resident #15 stated he reported what happened to him to the nurse but he couldn't remember which nurse he told. Resident #15 shared, as of this time, no one followed up with him regarding the incident or asked him for a statement. Resident #15 stated there was no investigation done that he was aware of. Interview on 04/06/26 at 9:07 A.M. with facility Administrator revealed as of Friday (04/03/26) they put the incident in as a reportable between Resident #52 and #15 because they felt with more information they uncovered that more had happened between the two residents than they initially thought. The Administrator confirmed there were no witness statements regarding the altercation between the two residents and confirmed the investigation was not thorough. During an interview on 04/08/26 at 9:01 A.M., SSD #275 shared there was a physical altercation between Resident #52 and Resident #15 which occurred on 03/20/26, when SSD #275 was not in the building. SSD #275 found out about the physical altercation on Monday 03/23/26 when she returned to work after the weekend. She was informed that late in the evening on Friday, 03/20/26 Resident #52 hit Resident #15. SSD #275 confirmed there was a nurse progress note entered by the DON regarding the incident but the DON was not working when the incident occurred. SSD #275 stated she was not made aware of the incident until 03/23/26 and she observed Resident #52 in a different room and the DON told her it was a long story but she was provided with no additional information. SSD #275 stated the CNAs (cannot recall who) informed her the residents had a physical altercation with Resident #52 striking Resident #15. SSD #275 stated she interviewed each resident. Resident #15 stated he was lying in bed, dozing on and off with the TV on and his roommate, (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52, came through the privacy curtain and hit him in the shoulder. Resident #15 then demonstrated what happened and lifted his right arm with his hand in a fist and swung towards his left shoulder. Resident #15 was unable to move his left arm due to a previous stroke and when he lay in bed, his left side would be toward Resident #52's bed. SSD #275 stated she asked Resident #15 if he was hurt and the resident stated he had a knot on his shoulder but she did not confirm this. SSD #275 she reported the information to the Administrator, but the administrator denied knowledge of a physical altercation, as she (the Administrator) was originally told by the DON the altercation was verbal and nothing physical happened. SSD #275 stated she followed up with Resident #52 on 03/24/26, the next day. Resident #52 reported Resident #15 said the F' word and Resident #52 was tired of hearing it so he slapped him. Resident #52 stated he hit Resident #15 in the head or the shoulder. SSD #275 stated she shared this information with Corporate Staff #21 and then called the [NAME] President of Operations (VPO) #957 who advised her to write up the concerns for each resident (Resident #15 and #52) and send them to VPO #957. SSD #275 completed grievance forms and emailed both forms to VPO #957 on 03/24/26. Following the email, Corporate Registered Nurse (RN) #751 called the SSD and they did a rundown of the situation. Corporate RN #751 wanted to know who worked the night of 03/20/26 and SSD #275 provided the information which included the name of Agency Nurse #23. SSD #275 said she was unsure where it went from there so she asked VPO #957 and was informed to provide the grievance forms to the Administrator because the Administrator was to investigate the incident. SSD #275 stated she emailed the grievance forms to the Administrator around 03/27/26. SSD #275 believed the grievance was given to the DON to investigate but she was unsure if the DON investigated the incident as she never got an update. During an interview on 04/08/26 at 11:20 A.M., the Administrator stated on 03/20/26, the DON called her twice and ADON #390 called her once but was sleeping and didn't see the calls until about an hour and a half later. The Administrator stated she called the ADON back but the DON answered since they were together. The DON informed the Administrator Resident #15 and Resident #52 had a verbal altercation but there was no physical contact made. The DON stated she was going to separate the residents because it was an ongoing issue between the two residents bickering about the TV. The following Friday, 03/27/26, the Administrator received the concern/grievance form from SSD #275, and Resident #15 was saying he was hit by Resident #52. The Administrator stated she spoke with Resident #52 about the altercation and he didn't want to talk about it, he said he was happy in his private room. The Administrator stated SSD #275 did interviews with the residents following the altercation. The Administrator confirmed, until notification on 03/27/26 from SSD #275, she was told by the DON that the altercation was verbal, not physical.During an interview on 04/08/26 at 1:39 P.M., CNA #22 stated on 03/20/26 CNA #22 heard Agency Nurse #23 yell for help. The nurse stated Resident #52 was punching Resident #15. CNA #22 asked Resident #15 if he was okay, he stated he could not talk about it, when asked why Resident #15 said I don't want him [Resident #52] to get me again. CNA #22 stated Resident #15 looked scared and terrified. CNA #22 stated they were not asked to make a statement on 03/20/26 or the days following. During an interview on 04/08/26 at 2:50 P.M., Resident #15 recalled what happened the night of 03/20//26 and stated he was scared for while after the incident because he was afraid Resident #52 would find him again. Resident #15 stated he was unable to use his left arm after a stroke and depended on the staff for mobility and transfers as well as dressing and other activities. During an observation on 04/09/26 at 12:12 P.M., Resident #15 had a yellow green bruise on the left bicep approximately 1.5 inch in length, and a quarter sized bruise, in various stages of healing, to the left shoulder. Resident #15 stated at the time of the observation those bruises were from the altercation with his roommate. This observation was verified by CNA #115.Interview on 04/08/26 at 3:12 P.M. with [NAME] President of Operations (VPO) revealed on 03/20/26 at 8:51 P.M. DON texted her and stated she thought she had a mess, possibly a Self Reported Incident (SRI). On 03/20/26 DON texted VPO again and stated never mind (NVM) I got it figured out. VPO stated she was under the impression DON investigated the incident. VPO confirmed there is no documentation of DON (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation the incident between Resident #15 and Resident #52. VPO confirmed she did not reach out to DON regarding the text messages sent on 03/20/26.2.Review of Resident #52's medical record revealed an admission date of 01/02/25 with diagnoses including anxiety, hypertension, heart failure, and pulmonary embolism. Review of Residents #52's care plan dated 03/14/25 revealed the resident had inappropriate behaviors at times related to being verbally/ physically aggressive towards staff, had delusions of seeing communists, and seeing stars. Goals included no injury to self or others. Interventions included documenting behaviors and speak to the resident about inappropriate behavior and redirect as possible. Review of Resident #52's annual MDS completed on 01/09/26 revealed he was moderately cognitively impaired. Resident #52 was independent/ required supervision from staff for mobility and transfers and received anti-anxiety and anti-depressant medications. Review of Resident #52 progress notes on 03/11/26 at 1:41 A.M. at approximately 6:30 P.M. this nurse was notified by staff that Resident #52 stated he was going to shoot Resident #15 due to his TV being too loud. The on-call person for nursing was notified and Resident #52 was removed from the room and placed in private room until morning. Notified on call physician who gave orders for trazadone 25 milligram, hourly checks for six hours, urinalysis, culture and sensitivity, complete blood count, and basic metabolic panel. Review of a late entry progress note dated 03/21/26 at 12:50 P.M., entered on 03/24/26 at 8:53 A.M., and authored by the DON documented Resident #52 was yelling and being verbally aggressive towards staff, mad about TV volume while trying to sleep, told roommate (Resident #15) to turn the volume down.Review of a grievance form completed on 03/24/26 via interview by SSD #275 revealed Resident #52 stated Resident #15 said expletive and he (Resident #52) had heard that word enough so he went over and slapped him with an open hand on the head. (The grievance form was used by the SSD to document the interview/incident as reported by Resident #52).During an interview on 03/31/26 at 9:33 A.M., Resident #52 stated he had problems with his previous roommate, Resident #15. Resident #52 stated Resident #15 was a grouchy old man, and about a week ago before they moved his room, Resident #15 dropped the F bomb so he hit him. Resident #52 stated he hit Resident #15 in either the head or the shoulder.During an interview on 04/02/26 at 10:08 A.M., CNA #685 stated prior to the evening of the physical altercation between Residents #15 and #52, Resident #52 was threatening to kill Resident #15, and Resident #15 was moved out of the room to a different room. At some point they moved the two residents back into the same room. On the evening of 03/20/26, less than a week after Resident #52 threatened to shoot Resident #15, Resident #15 was physically assaulted by Resident #52. CNA #685 stated Resident #15 would not be able to defend himself as he was dependent on staff for most activities of daily living (ADL) and was weak, and Resident #52 was pretty independent. CNA #685 stated several staff members were concerned why the two residents were moved back into the same room as the two residents had ongoing issues between the two of them, CNA #685 was working at the time of the incident but did not witness the incident but came to help staff.During an interview on 04/02/26 at 3:18 P.M., CNA #485, who came in to work the night of the incident at 10:00 P.M., heard of the incident through report. On the evening of 03/19/26, or 3/20/26, (could not recall exact date) Resident #15 and Resident #52 got into it. Resident #52 attacked Resident #15. Review of facility policy titled Abuse, revised on 01/30/20 revealed it is the facility policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property including injuries of unknown origin in accordance with the policy. Residents have the right to be free from abuse, neglect, exploitation and misappropriation. Individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Documentation in the nurses notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. the investigation must be completed within five working days. Interview the resident, the accused, and all witnesses including anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents, family (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members) and employees who worked closely with the accused employees and/ or alleged victim the day of the incident. if there are no direct witnesses then the interviews may be expanded. Obtain a statement from the resident, if possible, the accused, and each witness, obtain all medical reports and statements, review the resident record. evidence of the investigation should be documented. Ensure involved residents plan of care is reviewed and revised and complete staff training. in the case of resident to resident abuse, mistreatment, the facility will refer the matter to the facility interdisciplinary team to determine appropriate interventions. This deficiency represent noncompliance investigated under Master Complaint Number 2964189.

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 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Center I	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review and interview, the facility failed to ensure a comprehensive discharge process and receipt of a bed hold notice upon transfer. This affected two residents (#24 and #63) of six residents reviewed for discharges. The census was 52. Findings include:1. Closed medical record review revealed Resident #63 was admitted on [DATE] with diagnoses including hypertension, anxiety, cerebral infarction, peripheral vascular disease, gangrene and cardiomyopathy. The resident was discharged from the facility on 03/11/26. Review of the care plan: Discharge Planning dated 03/16/25 revealed Resident #63 was long term placement due to his needs exceeded community resources. There was no evidence the care plan was updated to reflect the facility had been assisting the resident with discharge back to the community reflected on the care plan. The care plan was 'cancelled' on 03/16/26 after the resident was discharged from the facility. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #63 was cognitively intact for daily decision-making and had an active discharge plan to return to the community. Review of the electronic Physician Orders dated March 2026 revealed the following medications included but were not limited to the following: apixaban (anticoagulant) 5 milligrams (mg) twice a day, carvedilol (beta-blocker) 25 (mg) twice a day, entresto (heart failure) 49-51 (mg) twice a day, gabapentin 400 (mg) three times a day for nerve pain, hydralazine (hypertension) 50 (mg) three times a day, Glargine (long-acting insulin) 7 units daily, isosorbide (angina) 40 (mg) three times a day, jardiance 10 (mg) daily for diabetes, sodium bicarbonate 650 (mg) daily, and tamsulosin (BPH) 0.4 (mg) daily. Review of the Nurse Progress Note dated 03/11/26 revealed Resident #63 was discharged from the facility on this date. Discharge instructions reviewed included medications, medications and prescriptions provided as ordered. Review of the closed medical record including the Discharge summary dated [DATE] revealed no evidence of the medications or prescriptions reviewed at the time of Resident #63's discharge and no evidence of reconciliation for accuracy. There were no prescription/copies in the record that were provided to the resident at the time of discharge as indicated in the Nursing Progress Note dated 03/11/26 for review. Review of the Discharge summary dated [DATE] revealed Resident #63 was discharged home after the resident's health had improved sufficiently to discharge to a less skilled level of care. Review of the section labeled Post-Discharge (Rx/OTC) revealed a hand written note across the section stating See List. There was no medication list attached to the discharge summary. Review of the Social Service Note/Narrative dated 03/11/26 revealed Resident #63 discharged home and medications were faxed to pharmacy per POA's request. Resident provided discharge notice, discharge summary, list of follow-ups and medication list. Review of the Nursing Progress Note dated 03/16/26 revealed the resident's POA called and stated (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications were not called into the pharmacy. Called pharmacy to confirm and medications were called into a different pharmacy after orders confirmed and POA was updated. Review of the closed medical record revealed no evidence the discharge instructions included the ordered medications or prescriptions to ensure an accurate reflection of the reconciled medications list provided at the time of discharge. There was no evidence of the order's faxed to the pharmacy or provided to the resident on 03/11/26 or on 03/16/26. On 04/13/26 at 12:11 P.M., electronic interview with the Administrator verified the Nursing Progress Note date 03/16/26 indicated the resident's power of attorney notified the facility as the resident's prescriptions had not been received at the pharmacy. The nurse verified with the pharmacy the resident's prescriptions had not been received; therefore, Registered Nurse #390 refaxed the resident's prescriptions to a different pharmacy. On 04/14/26 at 7:51 A.M., electronic interview with the Administrator verified the Discharge Planning care plan did not have revisions reflecting planned discharge back to the community. On 04/14/26 at 9:13 A.M., electronic interview with Administrator revealed the fax confirmation showed that it was sent there (on 03/12/26 at a different number) but when facility staff called they said that they had not received them. Registered Nurse #390 re-faxed the prescriptions and they were received on 3/16/26 after the facility was notified by the responsible party that they did not have them. Review of the undated policy: Transfer and Discharge Notifications revealed the facility was to follow all regulations and requirements related to transfers and discharges. 2. Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD), hyperlipidemia, hypothyroidism, chronic gout, fatty liver, intellectual disabilities, obstructive sleep apnea (OSA), chronic obstructive pulmonary disease (COPD), fibromyalgia, insomnia, anxiety, diabetes mellitus, and panic disorder. Review of Resident #24's quarterly minimum data set (MDS) assessment completed on 01/29/26 revealed a brief interview for mental status (BIMS) score of 15. Review of Resident #24's progress note dated 09/09/25 at 6:30 P.M. authored by Licensed Practical Nurse (LPN) #40 revealed 911 was called. Resident #24 was transported to the hospital where he was admitted to the hospital in the Intensive Care Unit (ICU). Review of Resident #24's record revealed the resident was re-admitted to the facility on [DATE] after their hospital stay beginning on 09/09/25, for a seven day hospital stay. Electronic interview on 04/15/26 at 4:55 P.M. with the facility administrator confirmed there was no documentation of Resident #24 or their representative being given a bed hold notice, or the option to hold the bed or not. Review of facility policy titled Nursing Home Bed Hold policy revised 10/16/18 revealed at the time of transfer the facility will complete a copy of the bed hold notice. This will include the number of Medicaid covered bed hold days remaining for the resident if applicable. The facility will document a bed hold was provided. At the time of transfer, a bed hold notice will be hand delivered to the resident (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/ or representative and a certified copy, return receipt requested will be mailed to resident/ resident representative. This deficiency represents non-compliance investigated under Complaint Number 2809223.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure care plans were reviewed after each assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. Further the facility failed to appropriately revise discharge plans of care. The affected two residents (#51 and #63) reviewed for care plan accuracy. The facility census was 52.Findings include: 1.Review of the medical record for Resident #51 revealed an admission date of 11/01/25. Diagnoses included acute systolic congestive heart failure, chronic obstructive pulmonary disease, type two diabetes mellitus with diabetic polyneuropathy, muscle weakness, fall on same level, and benign prostatic hyperplasia. Review of a Minimum Data Set (MDS) assessment version 3.0 dated 03/04/26 for Resident #51 revealed the resident required a wheelchair for mobility, and partial to moderate assistance for bathing/showering. Review of a Minimum Data Set (MDS) assessment version 3.0 dated 12/02/25 for Resident #51 revealed a Brief Interview for Mental Status (BIMS) score was 13 on a 0-15 scale. A score of 13 would indicate the resident had intact cognitive function, or normal thinking and memory. Review of a care plan for Resident #51 revised 03/04/26 revealed a focus of care for risk of infection related to an indwelling medical device. The goal was to remain free from infection, with an intervention to wear gown and gloves when providing high-contact resident care activities. Review of discontinued orders for Resident #51 revealed an order for a urinary catheter, which was discontinued on 07/09/25. There were no further orders for an indwelling catheter noted. On 03/30/26 at 10:00 A.M., interview with Certified Nurse Aide (CNA) #115 confirmed Resident #51 did not have a catheter. The care plan for Resident #51 revised on 03/04/26 further revealed an intervention for assistance to meet activities of daily living (ADL) needs, with a goal to remain clean, dry and odor free and participate in self care to his maximum capacity. Interventions included assisting with meal time, ambulation, hair care, oral care, toileting, transfers, bed mobility, clothing, shaving, bathing and care of glasses as needed. The resident was to be transferred at all times with a mechanical lift. The intervention for mechanical lift was initiated 01/18/26. Review of orders for Resident #51 revealed an active order for the resident to have all transfer completed with a mechanical lift. On 03/30/26 at 10:00 A.M., Resident #51 was observed to transfer self independently to motorized scooter and go into restroom. This was confirmed by Certified Nurse Assistant (CNA) #115 at the time of the observation. On 03/30/26 at 10:10 A.M., an interview with CNA #115 revealed the resident was a hoyer transfer for quite a while, however the facility CNAs had been advised by therapy the resident was now able to transfer himself and had been doing so for about two weeks. She did not know the order had not been (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed. 2. Closed medical record review revealed Resident #63 was admitted on [DATE] with diagnoses including hypertension, anxiety, cerebral infarction, peripheral vascular disease, gangrene and cardiomyopathy. The resident was discharged from the facility on 03/11/26. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #63 was cognitively intact for daily decision-making and had an active plan to discharge back to community. Review of the care plan: Discharge Planning dated 03/16/25 revealed Resident #63 was long term placement due to his needs exceeded community resources. There was no evidence the care plan was updated to reflect the facility had been assisting the resident with discharge back to the community reflected on the care plan. The care plan was 'cancelled' on 03/16/26 after the resident was discharged from the facility. Review of the Nurse Progress Note dated 03/11/26 revealed Resident #63 was discharged from the facility on this date. Discharge instructions reviewed included medications, medications and prescriptions provided as ordered. On 04/09/26 at 12:40 P.M., interview with Registered Nurse #390 verified Resident #63's discharge planning care plan was not revised when the facility assisted and ultimately discharged the resident back to the community on 03/11/26.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview, record review, call light audits, and policy review the facility failed to ensure residents were provided care and services to support their activities of daily living. This affected two residents (#24, #63) of twelve residents reviewed for activities of daily living. The census was 52.Findings include: 1. Review of Resident #24's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview review for mental status (BIMS) score of 15 indicating the resident had no cognitive impairments. The resident had no exhibited behaviors. The resident required mobility assistance with a walker and a wheelchair. The resident required maximal assistance for toileting, showering, lower body dressing including footwear, and personal hygiene. The resident required supervision/ touching assistance for toileting and tub / shower transfer. The resident was at risk for developing pressure ulcer/ injuries. Review of Resident #24 care plan dated 09/13/24 revealed the resident needs assistance from staff to meet Activity of Daily Living (ADL) needs related to diagnosed panic disorder, weakness, unspecified intellectual disabilities, chronic obstructive pulmonary disease, gout, lumbar radiculopathy, alcohol abuse, depression, type two diabetes mellitus with neuropathy, morbid obesity, has clothing (tops) that she prefers to wear and, she will inadvertently expose herself at times, resident states she is able to adjust her clothing herself as needed; observed to roll head in bed frequently tangling hair, will not leave hair pulled back or braided to prevent tangling. Goals included the resident will be clean, dry and odor free. Interventions included to assist resident with hair care as needed, assist resident with toileting as needed, assist resident with bathing as needed per resident preference. Review of Resident #24's shower/bed bath sheets revealed in February 2026 the resident received a shower/bed bath three times on 02/14/26, 02/18/26, and 02/23/26. Documentation revealed the resident could not be showered on 02/11/26 due to the facility having no hot water. Review of the resident's record revealed no documentation of the resident refusing shower/bed baths in the month of February 2026. Interview on 03/31/26 at 9:12 A.M. with Resident #24 revealed she preferred to get a bath in the mornings. On 03/30/26 she asked staff several times throughout the day when she would get bathed, no one knew when it was going to happen. Finally, around 7:00 P.M. to 7:30 P.M. she still had not received a bath, staff ended up giving her a sponge bath while she was on the toilet before she went to bed. Resident #24 stated she prefers to have a bath or shower in the morning. Resident #24 stated she feels left out of the loop, and that her opinions and wants do not matter. Interview on 04/13/26 at 9:38 A.M. with Corporate Clinical Director #960 confirmed Resident #24 was not getting bathed/ showered per preference or preferred and needed frequency. 2. Closed medical record review revealed Resident #63 was admitted on [DATE] with diagnoses including hypertension, anxiety, cerebral infarction, peripheral vascular disease, gangrene and cardiomyopathy. The resident was discharged from the facility on 03/11/26. Review of the care plan: Needs Assistance from Staff to Meet ADL Needs dated 02/27/25 revealed (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident required staff assistance with bathing per preference. The ADL care plan was not revised to reflect the resident's bathing preference or frequency. Review of the care plan: Inappropriate Behavior care plan dated 04/08/25 indicated Resident #63 just wanted bed baths and refused showers. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #63 was cognitively intact for daily decision-making, had no rejection of care, and required moderate assistance with bathing. Review of the electronic ADL record dated February 2026 and March 2026 revealed bath/showers were provided to Resident #63 on 02/01/26, 02/04/26, 02/09/26, 02/14/26, 02/23/26, 02/25/26, 02/26/26, 03/04/26 and 03/09/26. Further review of the bath/shower sheet documentation revealed Resident #63 refused a bath on 02/18/26 and was provided a shower on 02/01/26. On 04/09/26 at 12:40 P.M., interview with Registered Nurse #390 verified Resident #63's ADL care plan was not revised to reflect the resident's preferences regarding bathing including frequency and it was often five days between documented bathing. This deficiency represents non-compliance investigated under Complaint Number 2809223, 2809745 and 2961570.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, policy review and interview, the facility failed to provide activities of daily living (ADLs) for residents who needed assistance. This affected seven residents (#65, #55, #30, #7, #18, #51 and #1) of seven residents reviewed for ADLs. The facility census was 52.Findings include: 1. Review of medical record for Resident #65 revealed he was admitted to the facility on [DATE] with diagnoses that included acute osteomyelitis of the left ankle and foot, type two diabetes mellitus with foot ulcer, repeated falls, pain in left and right hip and major depressive disorder. Review of the Minimum Data Set (MDS) assessment version 3.0 dated 02/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 12 on a 0-15 scale. A score of 12 would indicate the resident had moderate problems with thinking and memory. The MDS further revealed the resident needed partial/moderate assistance with bathing, lower body dressing, and toileting. Review of the care plan indicated the resident needed assistance from staff to meet ADL needs and was initiated 01/14/26. The goal was for the resident to participate in self care to his/her maximum capacity. Interventions included assisting the resident with bathing as needed, per resident's preferences. It also indicated the resident had inappropriate behaviors such as being non-compliant, and staff was to provide support and encouragement while allowing resident to make choices with daily care when possible. The resident had impaired cognition with occasional forgetfulness, and staff was to assist with ADLs, and explain all treatments and procedures to the resident. Review of paper shower sheets for the month of March 2026 revealed Resident #65 refused showers on 03/03/26, 03/07/26, 03/17/26, 03/24/26, 03/27/26,and 03/28/26. There was no documentation that indicated interventions to encourage or explain need for ADL assistance to the resident. Review of the electronic bath task documentation from 01/14/26 through 03/30/26 revealed Resident #65 had shower assistance on only two occasions, 01/27/26 and 02/02/26. On 04/07/26 at 2:30 P.M., an interview with Resident #65 revealed he wanted to get showered, however he had to have the wounds covered on both of his legs. He had a device he had been given by the wound clinic for his right leg, but needed the staff to cover his left lower leg as well. He reported every time he asked for the staff to cover both, he would be told they did not have time, so he just told them never mind. He would just wipe off if he needed to. On 04/07/26 at 2:37 P.M., an interview with Assistant Director of Nursing (ADON) #140 revealed Resident #65 always refused shower assistance. She reported she had tried numerous times. She was not sure why no one would apply the shower devices for him because they knew he needed them. 2. Review of the medical record for Resident #55 revealed an admission date of 04/30/25. Diagnoses included Parkinson's disease without dyskinesia, fall on same level, muscle weakness, chronic pain, major depressive disorder, and dementia. Review of a MDS dated [DATE] for Resident #55 revealed he used a wheelchair for ambulation and was dependent for all ADLs. Review of a care plan for Resident #55, last reviewed 02/04/26, revealed the resident needed assistance from staff to meet ADL needs and would participate in self-care to his/her maximum (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	capability. Staff would assist the resident with bathing as needed, per resident's preference. Review of the undated Shower Preference book revealed the resident had a preference for showers during the day time three times per week on Monday, Wednesday and Friday. Review of paper shower sheets and electronic bathing task for the month of March 2026 for Resident #55 revealed he was bathed on his preferred day on 03/04/26, 03/20/26, and 03/23/26. He was showered on 03/04/26, and 03/24/26. On 03/30/26 at 10:57 A.M., an observation revealed Resident #55 was up in wheelchair, hair was disheveled and dirty appearing. His clothing was soiled. The condition of the resident was confirmed by Certified Nurse Aide (CNA) #715 at the time of observation. 3. Review of the medical record for Resident #30 revealed an admission date of 03/31/21. Diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, psycho-physiologic insomnia, unspecified mood disorder, weakness, history of falling, dysphagia oropharyngeal phase, hyperlipidemia; age-related osteoporosis, unspecified osteoarthritis, essential hypertension, major depressive disorder, vitamin D deficiency, muscle weakness and difficulty walking. Review of the Minimum Data Set (MDS) version 3.0, dated 03/13/26, for Resident #30 revealed a Brief Interview for Mental Status (BIMS) score of 7 on a 0-15 scale. A score of 7 would indicate severe problems with thinking and memory. Per the MDS, the resident required a wheelchair for ambulation, and was dependent for all activities of daily living (ADLs). Review of a care plan dated 03/23/26 revealed Resident #30 required assistance from staff to meet activities of daily living (ADL) needs related to decreased mobility, depression, arthritis, history of left tibia and femur fracture, and osteoporosis. The goal was for the resident to participate in her maximum capacity. Interventions included mealtime assistance, hair care, incontinent care, oral care, assisting with toileting as needed, assist with transfers using a mechanical lift for all transfers, assist with clothing, and bathing as needed per resident preference. Review of Resident #30's preferences listed on the demographics page of the electronic medical record indicated the resident preferred an early morning shower versus a bed bath, three times weekly. Review of the undated Shower Preference book documented Resident #30 preferred showers Sunday, Tuesday and Thursday. Review paper shower sheets for the month of March 2026 for Resident #30 revealed the resident was given a bed bath on 03/01/26, 03/03/26, 03/15/26, and 03/29/26. Documentation did not specify if the resident received a bed bath or a shower on 03/05/26, 03/08/26, 03/10/26, 03/12/26, 03/17/26, 03/22/26, and 03/26/26. 4. Review of medical record for Resident #7 revealed an admission date of 09/29/25. Diagnoses included osteomyelitis of vertebra, lumbar, epistaxis, venous insufficiency, morbid obesity due to excess calories, moderate protein-calorie malnutrition, chronic respiratory failure with hypoxia, generalized anxiety disorder, delirium due to known physiological condition, depression, Alzheimer's disease with early onset, essential hypertension, paroxysmal atrial fibrillation, dermatophytosis, (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	superficial mycosis, insomnia, muscle weakness, retention of urine, nausea, constipation, and pain. Review of a Minimum Data Sheet (MDS) version 3.0 for Resident #7, dated 12/31/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 on a 0-15 scale. A BIMS score of 12 indicated moderate problems with thinking and memory. The MDS also indicated the resident required a walker or wheelchair for mobility. He required partial to moderate assistance with showering, and supervision for dressing. Review of a care plan for Resident #7 revealed a focus of care for activities of daily living (ADLs). The goal was for the resident to remain clean, dry and odor free. Interventions were to include assistance with hair care, oral care, toileting, clothing, shaving and bathing as needed. On 03/30/26 at 9:00 A.M., an interview, and observation, with Resident #7 revealed he could not shower in his room because the floor gets too slippery. The resident stated he does not always get to shower when he would like to. The resident was hoping someone was coming shortly to get him to the shower room. The resident appeared disheveled and his shirt was dirty. 5. Review of the medical record for Resident #18 revealed an admission date of 04/28/25. Diagnoses included sepsis, dysphagia, pneumonitis due to inhalation of food and vomit, unspecified asthma with exacerbation, acute respiratory failure, dyspnea, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified right bundle-branch block, obesity, unspecified protein-calorie malnutrition, major depressive disorder, insomnia, generalized anxiety disorder, repeated falls, and personal history of transient ischemic attack and cerebral infarction without residual deficits. Review of a Minimum Data Set (MDS) version 3.0 for Resident #18 dated 03/12/26, revealed the resident had a Brief interview Mental Status (BIMS) score of 15 on a 0-15 scale. A score of 15 indicated the resident was cognitively intact. The MDS further indicated the resident required partial assistance from another person to complete any activities. She used both a manual wheelchair and walker for ambulation, and required partial to moderate assistance with bathing/showering and dressing. Review of a care plan for Resident #18 dated 03/23/26 revealed a focus of care for need of assistance from staff to meet ADL (activities of daily living) needs. The goal was for resident to remain clean, dry and odor free. Interventions included assisting with hair care, oral care, dressing, and bathing using resident choice, as needed. Review of electronic bathing and showering tasks in medical record for Resident #18 revealed from 03/07/26 through 04/07/26, the resident was assisted with a shower on 03/15/26, 03/31/26, and 04/01/26. Shower sheets for the resident were only available for 03/04/26 and indicated the resident was assisted with shower set up. On 03/30/26 at 10:26 A.M., an interview with Resident #18's spouse revealed he was there all of the time and assisted the resident with all of her care. He did not feel the staff did enough to assist his wife with her ADLs. On 04/07/26 at 7:57 A.M., an interview with the Administrator confirmed shower sheets and tasks for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18. The Administrator indicated she thought the Assistant Director of Nursing (ADON) #140 was working on the issue to document reasons for refusals. 6. Review of the medical record for Resident #51 revealed an admission date of 11/01/25. Diagnoses included acute systolic congestive heart failure, chronic obstructive pulmonary disease, type two diabetes mellitus with diabetic polyneuropathy, low back pain, muscle weakness, fall on same level, fatigue, hypertension, obesity, peripheral vascular disease, and longstanding persistent atrial fibrillation. Review of a Minimum Data Set (MDS) version 3.0 dated 03/04/26 for Resident #51 revealed the resident required a wheelchair for mobility, and partial to moderate assistance for bathing/showering. Review of a care plan for Resident #51 revealed a focus of care of need for assistance to meet activities of daily living (ADL) needs, with a goal to remain clean, dry and odor free and participate in self care to his maximum capacity. Interventions included assisting with meal time, ambulation, hair care, oral care, toileting, transfers, bed mobility, clothing, shaving, bathing and care of glasses as needed. Review of the undated Shower Preference book documented Resident #30 preferred day shift showers on Sunday, Monday and Thursday. Review of paper shower sheets revealed the resident refused a shower on 03/05/26 and opted for a bed bath because the shower was offered too close to Bingo. A shower was documented on 03/12/26, and a bed bath on 03/19/26. There were no other documented baths/showers for this resident on the paper shower sheets. Review of the electronic bath/shower tasks for the month of March 2026 for Resident #51 revealed the resident received a bed bath on 03/05/26 and 03/19/26. He last received a shower on 03/12/26. The last documented bath or shower for Resident #51 for the month of March was 03/19/26. On 03/30/26 at 10:26 A.M., during observations and interview, Resident #51 reported it had been four weeks since he had been in the actual shower. He would love nothing more than to get in the shower. He reported all staff did was wash up his groin area and thought that was ok. He felt like he was not getting clean and that made him uncomfortable. The resident appeared disheveled and his shirt was soiled with what appeared to be dried food stains. An interview with CNA #685 on 04/02/26 at 9:41 A.M. revealed it was the expectation an aid do eight showers per shift. They would do as many as they could, however it was almost impossible to get all of those done with all of the other responsibilities and resident needs they had to meet throughout a shift. There were usually only three aides on day shift, and it was the only place she had ever worked where you were told not to shower someone who required a mechanical lift, even though they had a lift chair which was new in the shower room. She had heard Resident #30 tell CNA #115 she wanted a shower, but the other aide told the resident she did not have time, and she just washed her hair. She could not recall when this occurred. An interview with CNA #700 on 04/02/26 at 12:40 P.M. revealed she never felt they had enough staff to meet resident needs. CNA #700 stated, in fact two extra people were added to the schedule at 2:00 P.M. today because surveyors are here. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with CNA #340 on 04/06/26 at 2:20 P.M. revealed she did not believe the facility had enough staff. She was concerned because she felt the residents were not getting the care they needed. Residents who were asking were not even able to get showers, and she felt the residents deserved better than that. On 04/13/26 at 9:32 A.M., an interview with Registered Nurse (RN) #956 confirmed residents of the facility were not getting showered or bathed per their preference, and it appeared from what she could see that activities of daily living (ADLs) were not being completed as ordered or needed to keep residents clean, dry and odor free as noted in their care plans. 7. Medical record review revealed Resident #1 was admitted on [DATE] with diagnoses including diabetes mellitus, malignant neoplasm of right lower bronchus or lung, generalized anxiety disorder, obstructive sleep apnea, asthma, chronic obstructive pulmonary disease, weakness and a urinary tract infection. Review of the modified admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact for daily decision-making, required maximum assistance with bathing/showering and required moderate assistance with personal hygiene. Review of the care plan: Needs Assistance from Staff to meet ADL needs related to decreased mobility, diagnoses and impaired cognition dated 02/18/26 revealed interventions including to assist Resident #1 with bathing as needed per resident's preference. Review of the undated Shower Schedule Book revealed Resident #1 was scheduled a dayshift shower on Monday, Wednesday and Friday. Review of the paper Shower/Bath Sheets and electronic Bath Task documentation dated 02/13/26 through 04/06/26 revealed Resident #1 was not provided a shower/bed bath as scheduled on 03/02/26, 03/11/26, 03/16/26, 03/18/26 or 03/20/26. On 03/30/26 at 1:25 P.M., interview with Resident #1 stated she does not always receive showers as scheduled and had only received one shower last week. Resident #1 stated she was to receive her showers on Monday, Wednesday and Fridays and needed staff to complete as she could not do it by herself. At the time of the interview, observation revealed Resident #1 was sitting up in her room and was covered with a light blanket. The resident's hair appeared greasy, uncombed and a body odor was noted. On 04/07/26 at 11:18 A.M., interview with Registered Nurse #751 verified Resident #1 bathing/showers were not provided as scheduled during March 2026. Review of the policy: ADL's revised 03/04/26 revealed support was to be provided to meet care deficits related to ADL needs including the ability to bathe. A resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal hygiene and oral hygiene. The facility was to maintain individual objectives of the care plan and periodic review and evaluation. This deficiency represents non-compliance investigated under Complaint Number 2809223, 2809745 and 2961570.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to ensure residents were provided an on-going, comprehensive activity program to meet their preferences. This affected two residents (#2 and #28) of two residents sampled for activities. The census was 52.1.Closed medical record review revealed Resident #28 was admitted on [DATE] with diagnoses including encephalopathy, heart failure, anemia, diabetes and a fractured hip. The resident expired on [DATE].Review of the Activities assessment dated [DATE] revealed activities were to be offered one to three times a week. The resident's activity pursuit and preferences included current the following interests: One-on-One included animals/pets (very important), beauty/barber (very important), exercises (somewhat important), family/friend visit (very important), gardening (important), movies/television (important), cooking (very important), and current events (somewhat important). Small group activity interests included: bingo (very important), cards (somewhat important), resident council (important), volunteering current (somewhat important), walking current (somewhat important), Arts/crafts current (important), Community Outings (important) and social parties (important). Individual activities included: Music: past interest (somewhat important), reading current interest (somewhat important) and shopping (important).Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making.Review of the care plan: Involved with Activities Little of the Time dated [DATE] revealed Resident #28 was encouraged to participate in activities, loves pool, bingo and happy hour music. Interventions included to assist Resident #28 to activities, encourage family involvement, invite resident to resident council, break activity into manageable tasks, face resident when speaking encourage resident to participate activities, assist with set up of self-activities as needed, encourage resident to attend activities and provide activity calendar.Review of the Activity Calendars dated [DATE] through [DATE] revealed the following:a.Review of the [DATE] calendar revealed One-on-One visits were scheduled at 3:00 P.M. on [DATE], [DATE], [DATE] and [DATE]. Further review of the [DATE] calendar revealed bingo was offered once a week, cards/games were offered three times a week, pet therapy once a week, outings weekly and spa day once a month.b.Review of the February 2026 through [DATE] revealed no one-on-one activities were scheduled.Review of Resident #28's medical record revealed no evidence Resident #28 was offered/participated in One-on-One or the above group activities during [DATE].Review of the Record of One-on-One Activities for Resident #28 revealed the following:a. On [DATE], staff went in to visit and husband was in the room. Resident #28 was non-responsive and sleepy.b. On [DATE], staff took popsicles to Resident a#28 and husband/visitor.c. On [DATE], staff visited resident and offered word search. Resident #28 was sleeping and her husband declined word search.d. On [DATE], staff took applesauce and snack to Resident #28 and her husband. Resident #28 opened her eyes with no response.e. On [DATE], staff took popsicles to resident, husband and two granddaughters.f. On [DATE], certified nurse aides asked for popsicles for the resident. On [DATE] at 1:24 P.M., interview with Activity Supervisor (AS) #110 verified the activities provided were documented on paper and there were only a few to provide. AS #110 stated she just took over this role recently and has been trying to involve more activities. AS #110 verified the above activities documented were all there was for Resident #28 since her admission. 2. Medical record review revealed Resident #2 was admitted on [DATE] with diagnoses including cerebral vascular accident with hemiplegia affecting left non-dominant side, encephalopathy, chronic systolic congestive heart failure, respiratory failure, altered cognitive function, insomnia, sleep apnea, hypertension, atrial fibrillation, abdominal aortic aneurysm without rupture, and presence of a prosthetic heart valve.Review of the modified admission Minimum Data Set assessment dated [DATE] revealed Resident #2 was severely impaired for daily decision-making, functional limitations on one-side upper and lower extremities, Listening to music (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she liked was somewhat important to the resident and practicing in religious services or practices was somewhat important to her.Review of Resident #2's Activity assessment dated [DATE] revealed the resident was to participate in activities at random times throughout the month in her room, day/activity room or inside facility/in unit. The resident's activity pursuit and preferences included the following current interests: individual animals/pets, current events, exercises, movies, music, family/friend visit (somewhat important). The resident had current interests in religious studies, shopping, sing alongs, social parties, volunteering, walking, and arts/crafts but there was no importance documented. The resident's past interests included bingo and cards, cooking, creative writing, dominoes, educational programs, reading and she had no interest in community outings, computer, gardening or resident council.Review of the care plan: Resident is involved with activities some of the time. Review of the care plan: Resident is involved with activities some of time. Decreased activity, recent hospitalization/illness, Memory impairment dated [DATE] revealed goals including to participate in activities of her choice and remain active with individual activities of interest. Interventions included to assist the resident to activities, encourage family involvement with activities; invite resident to resident council (this was identified in the assessment that this was not an interest she had); provide intervention during activities to address any physical, emotional or cognitive deficits; break activity into manageable tasks, one instruction at a time; face resident when speaking; encourage resident to participate in activities; assist with set-up of self-activities as needed; encourage resident to attend activities; provide activity calendar.Review of the Record of One-on-One Activities dated [DATE] and [DATE] revealed to encourage resident to participate in activities, comfort and listen. Resident #2 preferred not to participate in scheduled group activities and frequency of the one-on-one activities was not specified. A one-on-one visit was completed on [DATE] and [DATE] when staff sat and talked with the resident for 10 to 15 minutes. Review of the Record of One-on-One Activities dated [DATE] revealed staff provided an in room manicure for the Resident #2.There was no evidence of any activities provided between [DATE] and [DATE], and no evidence of activities provided between [DATE] and [DATE].On [DATE] at 7:40 A.M., observation revealed Resident #2 lying in bed on an air mattress. The resident's breakfast tray had been delivered and was observed on the overbed table untouched. The resident's eyes were closed; however, she verbalized acceptance to enter her room. The resident was unable to answer screening questions appropriately and was not able to provide information related to activities.On [DATE] at 7:15 A.M., Resident #2 was observed in the dining room, breakfast was served, and resident provided hand-over-hand assistance to hold fork and resident began to eat.On [DATE] at 1:26 P.M., Resident #2 was observed lying in bed, eyes closed and radio was on.On [DATE] at 8:00 A.M., Resident #2 was observed lying in bed. No activities were observed in the resident room. Resident #2 asked for a blanket and stated she did not know what she was going to do today. Resident #2 stated she does not go out of her room much.On [DATE] at 1:24 P.M., interview with AS #110 verified the activities provided for Resident #2 were documented on paper and there were only a few activities for One-on-One activities to provide. AS #110 verified the two activities completed on [DATE], [DATE] and [DATE] were the only documented activities completed since Resident #2's admission that she could find. AS #110 stated the resident had cognitive impairment, did not want to join other activities and only came out of room for meals. On [DATE] at 8:15 A.M., interview with the Administrator verified there were no documented activities in the electronic medical record stating she was not aware of this until today. The Administrator verified the above activities were the only documented activities for Resident #2 and #28, the Activity calendars dated February through [DATE] did not have any scheduled One-on-One activities and there was little variety of daily activities week to week. The Administrator stated she was going to educate AS #110 as of today. The Administrator did state the facility had recently added an evening activity to address no evening activities. On [DATE] at 10:34 A.M., interview with Social Service Designee (SSD) #275 brought the surveyor notes from Medicaid program staff Quality Moments that visit the facility and see certain residents that qualify (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for emotional/behavioral support. SSD #275 verified this program was not provided by facility staff, was not available to all residents and they had a schedule of residents they would see for emotional/behavioral support needs. SSD #275 verified this was not part of the residents' activity care plan.On [DATE] at 10:22 A.M., observation revealed Resident #2 was lying in bed. No activities were observed. The activity calendar was posted on the resident's wall not within view.Review of the policy: Resident Activities revised [DATE] revealed the purpose was to ensure all residents of the skilled nursing facility including residents with cognitive impairment or dementia, are provided with an ongoing, individualized activity (life enrichment) program that supports their physical, mental and psychosocial well-being, consistent with state and federal regulations. Each resident will have an admission Activity Assessment completed, resident preferences will be updated annually/prn and resident activity plan of care will be updated accordingly. Residents with cognitive impairment or dementia shall have activity needs addressed within the comprehensive care plan and approaches adapted to cognitive ability, attention span and functional level. One-on-One activities was to be completed by staff per activity calendar.This deficiency represents non-compliance investigated under Complaint Number 2961570.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 medical record review, review of hospital records, review of medical education provided by The University of Pittsburgh Medical Center, facility policy review, and interview, the facility failed to timely and accurately assess Resident #24 and failed to respond to an acute change in condition. This resulted in Immediate Jeopardy and Actual Harm beginning on [DATE] at 7:30 A.M. when Resident #24 was noted to have an oxygen saturation (SpO2) of 83% (normal SpO2 95-100%), a heart rate of 138 ((tachycardic) normal heart rate 60-100), was febrile (elevated body temperature) with a temperature of 102.1 degrees Fahrenheit (normal temperature 97.5 to 98.9 degree Fahrenheit) and rhonchus lung sounds bilaterally (abnormal lung sounds in both lungs occurring when air moves through partially obstructed or narrowed airways due to fluid, mucus, or thick secretions). There was no evidence of further evaluation or monitoring of the resident until [DATE] at approximately 6:30 P.M. when Resident #24 was transferred to the hospital. At the time of transfer, Resident #24 was hypotensive (low blood pressure) with a BP of 55/31 millimeters of mercury (mm/Hg) (normal blood pressure 120/80 mm Hg), and she was febrile (elevated body temperature) at 102 degrees Fahrenheit. At this time the resident had irregular respirations and was lethargic with difficulty breathing. The resident was admitted to the hospital where she required continuous bi level positive airway pressure (BiPAP) ventilation, intravenous (IV) antibiotics, continuous intravenous life sustaining blood pressure medication requiring internal jugular central venous catheter placement, and admission to the intensive care unit due to acute hypoxic respiratory failure and severe septic shock secondary to pneumonia and urinary tract infection. The resident remained hospitalized until [DATE] at which time she was re-admitted to the facility with additional days of IV antibiotic therapy required. On [DATE] at 2:23 P.M. [NAME] President of Operations #957, Corporate Clinical Director #751, Administrator #750 were notified Immediate Jeopardy began on [DATE] at 7:30 A.M. when Resident #24 was noted to have abnormal vital signs and a significant decline in condition with subsequent transfer to the hospital and admission to the intensive care unit for necessary medical intervention. Prior to the hospitalization, the facility failed to ensure Resident #24 was comprehensively assessed and provided timely, necessary and effective intervention to prevent the decline in her condition. This affected one resident (#24) of one resident reviewed for change in condition. The facility census was 52.The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: - On [DATE] at 6:30 P.M. Resident #24 was transferred to the hospital. The resident returned to the facility on [DATE]. - On [DATE] Resident #24 was seen by the Psychiatric Nurse Practitioner (NP) and Primary NP with orders in place for on-going care/medical treatment. -Between [DATE] and [DATE] facility staff were educated on monitoring and reporting resident changes of condition.-On [DATE] a facility Quality Assessment and Performance Improvement meeting was held which included the Administrator and facility management team. During the meeting the education that was provided between [DATE] and [DATE] was discussed. - On [DATE] the facility Resident Condition Changes policy was reviewed by Corporate Clinical Director #956 and [NAME] President of Operations (VPO) #957. - On [DATE] an interdisciplinary team (IDT) meeting was held to complete a root cause analysis (RCA) of what had happened with Resident #24. The meeting included Corporate Clinical Directors #956 and #751, VPO #957, Corporate Minimum Data Set (MDS) Director #3 , Director of Dietary Services #4, Interim Director of Nursing (DON) #390, Assistant Director of Nursing (ADON) #140, and Administrator #725. The analysis included record review of nurse's notes, vital signs (VS), provider notes, medication administration record (MAR), and treatment administration record (TAR). The facility concluded nursing staff failed to follow the order obtained on [DATE] at 730 A.M. for every four (4) hour vital sign monitoring, therefore the resident's decreasing blood pressure (BP) and declining condition wasn't noted until [DATE] at 6:18 P.M. resulting in resident (#24) being sent to the hospital [DATE] at 6:30 P.M.- On [DATE] all residents (52 total) were assessed by ADON #140 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which included obtaining vital signs, respiratory status, signs/symptoms of infection (fever, respiratory distress, hypotension). All results were sent to Medical Director #1122 for review on [DATE].- On [DATE] 24 the DON/designee initiated hour audits. This included resident observations, staff interviews (at least one certified nurse aide (CNA), licensed practical nurse (LPN) or registered nurse (RN) assigned to resident care during assessment period to question if they observed a change in resident's condition.- On [DATE] all licensed nurses (three RNs and seven LPNs), one respiratory therapist (RT), 27 Certified Nursing Assistants (CNAs), seven medication technicians, one MDS LPN, and one wellness director were re-educated either in-person or via phone by ADON #140 and Interim DON #390. Agency nurses were educated via clipboard (email confirmation included). Education topics included Change in Condition policy and procedure, recognition of change in condition, sepsis indicators (fever, tachycardia, hypotension, decreased O2 saturation), physician notification requirements, frequency of monitoring per orders (e.g., every four (q4) hour vitals). Education also included documentation expectations of information to be documented in the resident medical record (objective observations, medications administered, treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident, and progress toward or changes in the care plan goals and objectives).-On [DATE] all other staff were educated by Administrator #725 either in-person or via phone on reporting of change in condition and included five activity staff, two general administrative staff, two ADONs, 13 dietary staff, one driver, seven housekeeping staff, two laundry staff, two maintenance staff, one marketing director, one social service designee (SSD). -On [DATE] Director of Rehab (DOR) #753 was educated by Administrator #725. In turn, DOR #753 educated therapy staff to include two occupational therapists (OT), five physical therapy assistants (PTA), and four occupational therapy assistants (OTA). One speech language pathologist (SLP) who is PRN would be educated before returning to work. New hires would be educated upon hire. -On [DATE] the Change in Condition Protocol was reinforced by Corporate Clinical Director #956 to include nurses reporting to provider immediate any significant change triggers, immediate nurse assessment, Physician/NP notification, and documentation in progress notes. The expectation was no delay in escalation. A change in condition was identified as a new, worsening, or unexpected change in resident status including but not limited to: new onset or uncontrolled pain, falls or injuries, skin issues - new or worsening, change in mobility or ADL's, weight loss/gain, poor intake, abnormal VS, new or worsening confusion, delirium, or altered level of consciousness, new or worsening behaviors, sudden mood changes, new diagnosis or infection, change in respirator status, medication reactions or ineffectiveness, and hospitalization or ER visit.- On [DATE] an Infection/Sepsis Early Recognition Process was implemented facility-wide to include sepsis screening triggers with a Point Click Care assessment to trigger. Sepsis screen triggers occur as follows: Upon admission: every shift for three days; Suspected sepsis: every shift until resolution of symptoms and/or resolution of known infection: 1. Temperature above 100.4 2. Heart Rate above 90 3. Pulse Ox < 90 or increasing oxygen demands 4. SBP below 100 5. WBC > 12,000 or WBC < 4,000 (new onset) 6. Respiratory rate above 20 BPM; Upon diagnosis of infection: every shift until completion of antibiotic therapy and resolution of infection. Escalation protocol for abnormal findings includes Does the resident have an infection and meet two or more of the SIRS criteria: -1. Temperature above 100.4 2. Heart Rate above 90 3. Pulse Ox < 90 or increasing oxygen demands 4. SBP below 100 5. WBC > 12,000 or WBC < 4,000 (new onset) 6. Respiratory rate above 20 BPM or have an infection and meet 1 or more of the SIRS criteria with elevated blood glucose for a non-diabetic (if yes suspect sepsis) and contact provider. The Infection Preventionist (DON #390) is to oversee sepsis screening triggers to ensure ongoing compliance.- On [DATE] an Ad Hoc Quality Assessment and Performance Improvement (QAPI) meeting was completed with the interdisciplinary team (IDT) team in person (included Maintenance Director #170, Office Manager #240, Marketing Director #635, MDS LPN #632, ADON #230, DON #390, DOR #1122 , Activity Director #110, Transportation #535, SSD #275, Dietary Manager #315, and Clinical Director of Operations #751 to (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	include the Medical Director #1122 (participated via phone). Trends tracked include delayed physician notification, missed monitoring, and documentation gaps. Corrective actions would be implemented as needed. An audit tool would be utilized to ensure the completion of all of the above.-On [DATE] Clinical leaders including DON #390, ADON #140, MDS LPN #632, and LPN #230 were educated by Corporate Director of Clinical Services #956.-On [DATE] at 1:26 PM, VPO #957 and Corporate Clinical Director #956 spoke with Medical Director #750 regarding the concern with Resident #24. - On [DATE] Corporate Clinical Director #956 and DON #390 implemented shift-to-shift clinical review of high-risk residents. Nurse shift to shift report sheets utilized with added areas to include the following mandatory review: new orders, abnormal vital signs, residents on antibiotics. Daily clinical standup meeting was reinforced. Daily clinical stand-down meeting was reinforced to include follow-up items that were identified in the stand-up meeting to include abnormal vitals / change in condition. Clinical Leaders to attend standup and stand-down include DON #390, ADON #140, MDS LPN #632 and nonclinical leaders to attend clinical standup and stand-down include Administrator #750 and SSD #275.-Beginning on [DATE] a company clinical morning meeting and follow up tool was provided to be utilized daily starting [DATE] for 14 days then on [DATE] change to every business day (Monday to review weekend data, day returning from holiday to review holiday data). This would be completed by DON #390 and/or ADON #230. To ensure compliance this would be overseen by Corporate Clinical #751 or #956.-Beginning on [DATE] a change in condition compliance audited by utilizing Company clinical morning meeting and follow up tool provided daily starting [DATE] for 14 days then on [DATE] change to every business day (Monday to review weekend data, day returning from holiday to review holiday data). This would be completed by the DON #390 and/or ADON #230. To ensure compliance this would be overseen by Corporate Clinical Director #751 or #956.-Beginning on [DATE] vital sign monitoring compliance would be audited by DON #390 by utilizing Company clinical morning meeting and follow up tool provided to be utilized daily starting [DATE] for 14 days then on [DATE] change to every business day (Monday to review weekend data, day returning from holiday to review holiday data). All orders for increased monitoring (e.g., q4 vitals) must be completed as ordered and audited daily by DON/designee. Any missed documentation would result in immediate corrective action including contacting nurses that missed the documentation immediately with disciplinary action as necessary. Immediate assessment of the resident to include missing VS and immediately contacting overseeing medical provider. -Beginning on [DATE] compliance would be audited by DON#390 by utilizing company clinical morning meeting and follow up tool provided to be utilized daily starting [DATE] for 14 days then on [DATE] change to every business day (Monday to review weekend data, day returning from holiday to review holiday data). Nurses must document assessment findings, physician communication, and resident responses to interventions.-Beginning on [DATE] the facility implemented a monitoring system to ensure ongoing compliance including daily monitoring (for the first 14 Days to start [DATE]). Company clinical morning meeting and follow up tool provided to be utilized daily starting [DATE] for 14 days then on [DATE] change to every business day (Monday to review weekend data, day returning from holiday to review holiday data). The DON/designee audits would include 100% of residents with change in condition, antibiotic use, and abnormal vitals. The audits include timeliness of assessment, physician notification, and documentation completeness. -Beginning on [DATE] weekly monitoring will include company clinical morning meeting and follow-up tool provided to be utilized. The random audit of would include 10-20 residents per week to be completed by DON/designee. The focus areas would include change in condition response, monitoring compliance, and documentation. Although the Immediate Jeopardy was removed on [DATE] the facility remains out of compliance at severity Level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure ongoing compliance.Findings Include: Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD), hyperlipidemia, (continued on next page)

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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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hypothyroidism, chronic gout, fatty liver, intellectual disabilities, obstructive sleep apnea (OSA), chronic obstructive pulmonary disease (COPD), fibromyalgia, insomnia, anxiety, diabetes mellitus, and panic disorder. Review of Resident #24's care plan initiated [DATE] revealed the resident had a potential for alteration in respiratory function related to diagnoses of COPD, OSA, preferring to have head of bed (HOB) elevated or to be in a recliner. Goals included the resident will have no signs or symptoms of respiratory distress, the resident will have adequate oxygen exchange as evidenced by no increase in confusion, and the resident would be free from infection. Interventions included auscultation of lung sounds, elevate head of bed as needed, encourage fluids, encourage the resident to cough and deep breathe, obtain pulse oximetry as needed, obtain vital signs as ordered and as needed.Review of Resident #24's record revealed a paper order signed and dated by Nurse Practitioner (NP) #20 on [DATE] for Mucinex 600 mg twice a day (BID) for seven days then as needed (PRN). Also, percussive ventilation per respiratory therapy. There was no evidence of a corresponding nursing progress note or NP note to indicate why the orders were given and/or evidence of a comprehensive resident assessment being completed at this time. Review of Resident #24's record revealed a paper order signed and dated by NP #20 on [DATE] for Diflucan 150 mg orally for one dose, and nystatin powder to groin, cleanse and apply daily. Signed and dated by RN #30 on [DATE]. There was no evidence of a corresponding nursing progress note or NP note to indicate why the orders were given and/or evidence of a comprehensive resident assessment being completed at this time. Review of paper order signed and dated by NP #20 on [DATE] revealed two view chest x-ray, Doxycycline 100 mg BID for seven days, COVID-19 test, and monitor vital signs BID for three days and update the provider if temperature is above 100 degrees Fahrenheit, systolic blood pressure below 100, diastolic blood pressure below 50, pulse is above 120, respiratory rate is above 24, or SpO2 below 91%. Complete blood count (CBC) and basic metabolic panel (BMP), and DuoNeb inhalation 3 milliliter (ml) BID for three days. Signed and dated by RN #30 on [DATE]. There was no evidence of a corresponding nursing progress note or NP note to indicate why the orders were given and/or evidence of a comprehensive resident assessment being completed at this time. Review of Resident #24's chest x-ray (CXR) completed on [DATE] resulting at 4:13 P.M. revealed the resident had diffuse opacity seen in the bilateral lower lungs. This could be due to pulmonary edema, atelectasis and/or pneumonia. Record review revealed there was no evidence Resident #24's medical provider was notified of the abnormal chest x-ray results.Review of Resident #24's COVID-19 test results resulted [DATE] revealed the resident tested negative for COVID. Review of an untimed progress note dated [DATE] authored by NP #20 revealed Resident #24 was seen in assisted living or long-term care for respiratory congestion, increased temperature, and decreased oxygen saturation. Resident #24 had been experiencing respiratory congestion, increased temperature, and decreased oxygen saturation. Staff reports fever of 101-102 degrees Fahrenheit and a pulse of 113 beats per minute (bpm). Vital signs taken on [DATE] at 11:36 A.M. were heart rate of 113, respiratory rate of 20, and SpO2 of 91%, lung sounds revealed rhonchi throughout. Ordered a chest x-ray, complete blood count (CBC), and basic metabolic panel (BMP) for the next available lab services on [DATE]. Prescribed Doxycycline 100 Milligram (mg) twice daily due to increased temperature in the setting of respiratory congestion. Ordered a COVID nasal swab. Changed DuoNeb inhalations from as needed (PRN) to scheduled twice daily for three days. Encourage oral hydration, deep breathing, and sitting up in chairs and in bed. Ordered a green Acapella device (a handheld, drug-free airway clearance system that uses a combination of Positive Expiratory Pressure (PEP) and vibrations to mobilize mucus, making it easier to cough up) to be used three times a day for 10 repetitions each. Please encourage hydration, deep breathing, and upright positioning, monitor vital signs and alert the provider if any changes are noted, contact the provider for any changes in pain, appetite, constipation, sleep, recent falls, or memory disturbances in the resident. Review of Resident #24's nursing progress note dated [DATE] at 7:30 A.M authored by Respiratory Therapist (RT) #958 revealed Resident #24 was febrile with a temperature of 102.1 degrees Fahrenheit, heart rate (HR) of 138 (tachycardic), respiratory rate (RR) of (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	24, oxygen saturation (SpO2) of 83% on room air (RA), with rhonchi auscultated bilaterally. Resident #24 was placed on oxygen (O2) via nasal cannula (NC) at 3 liters per minute (LPM). The note included nursing is aware.Review of Resident #24's progress note dated [DATE] at 7:30 A.M. authored by RN #30 revealed Resident #24 was febrile with a temperature of 102.1 degrees Fahrenheit, BP 96/73, HR 138, RR 24, SpO2 83% on RA. Respiratory Therapist placed resident on oxygen at 3 LPM via NC. Order received from Clinical Nurse Practitioner (CNP) for (antibiotic) Augmentin 875 mg twice a day (BID) for seven days along with the Doxycycline prescribed [DATE]. Also received order for Tylenol 325 mg, two tabs every six hours for 24 hours. Order for complete blood count (CBC), Basic Metabolic panel (BMP), and C-type natriuretic peptide (CNP) and to continue to monitor vitals every four hours for 24 hours. There was no rationale for the addition of the Augmentin antibiotic or evidence of a medical diagnosis to warrant the recommended treatment orders at this time. In addition, there was no evidence the resident's abnormal vital signs were addressed other than the order for Tylenol (which is frequently ordered for fever). Review of Resident #24's medical record revealed no corresponding documentation on [DATE] as to why NP #20 placed new orders (from the original orders placed by NP's first note on [DATE]) and changed treatments for the resident. In addition, there was no documentation regarding the reason NP #20 was notified the second time on [DATE] regarding Resident #24 status or what specifically was communicated with NP #20 that resulted in the second set of orders on this date.Review of Resident #24 progress note dated [DATE] at 8:12 A.M authored by RT #958 revealed Resident #24 was given a nebulizer treatment (Tx), post treatment vital signs SpO2 91%, HR 121 (tachycardic), RR 24, and lung sound rhonchi bilaterally. The note included resident remains on oxygen via NC at 3 LPM.Review of Resident #24's medical record revealed no documentation of vital signs including blood pressure, heart rate, SpO2, or temperature being monitored every four as directed by NP #20. In addition, review of Resident #24's record revealed no documentation of increased monitoring, encouragement of fluids, deep breathing, or sitting up-right.Review of Resident #24's progress note dated [DATE] at 6:30 P.M. (over 10 hours later) authored by LPN #40 revealed Resident #24's condition gradually declined throughout the day according to report given by the off going nurse. At this time, assessment of Resident #24's blood pressure revealed a BP of 55/31 mm Hg (hypotensive), mean arterial pressure (MAP) of 39. The resident's temperature was 102.3 degrees Fahrenheit, heart rate 94 (tachycardic), SpO2 90% on 3 LPM NC, RR 15 with respirations that peaked then dropped irregularly. Resident #24 was visibly lethargic with increased difficulty breathing. 911 was called with Resident #24 subsequently being transferred to the hospital and admitted to the hospital in the Intensive Care Unit (ICU). Review of Resident #24's hospital records revealed Resident #24 was admitted to the hospital on [DATE] with diagnoses of severe septic shock, acute cystitis, pneumonia, urinary tract infection, and acute kidney injury with a white blood cell (WBC) count of 17.46 k/uL (normal range 3.7-11 k/uL), blood urea nitrogen (BUN) of 46 (normal range 7-21) and creatinine of 2.42 (normal 0.58-0.96 mg/dl), PH of 7.30 (7.35-7.45). Hospital record review revealed Resident #24 had a central venous catheter inserted via internal jugular vein (a long catheter placed into the superior vena cava of the heart through a large vein of the neck) on [DATE] at 1:02 A.M. due Resident #24's BP being unresponsive to fluid boluses. The resident was started on a continuous norepinephrine drip (a life sustaining vasoconstrictive medication used to raise blood pressure in those with severe hypotension and shock, including septic shock). Resident #24 was admitted to the intensive care unit, started on bi level positive airway pressure (BIPAP) and an indwelling urinary catheter was inserted due to urinary retention. The resident was identified with cardiovascular impairment, severe metabolic abnormality and shock (hypercapnic respiratory failure and septic shock), which the resident had and/or has high probability of suddenly developing. Resident #24 was started on several intravenous (IV) antibiotics including Vancomycin, Zosyn, and Meropenem The resident remained in the hospital for intensive care and required hospital treatment until [DATE]. Hospital record review revealed a discharge summary by Physician #22 revealing Resident #24 was admitted to the hospital due to septic shock and acute (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hypoxic respiratory failure. The resident was treated for pneumonia and transferred to the ICU due to the requirement of vasopressor and Levophed (norepinephrine) support. Resident #24 also required BiPAP ventilatory support. Resident #24 was found to have positive blood cultures for E. coli and urine culture and sensitivity revealed E. coli, which was multidrug resistant and sensitive to carbapenems, therefore the resident was treated with IV Ertapenem (antibiotic). Resident #24 completed a 5-day course of IV Ertapenem and discharged back to the facility with two additional days of IV Ertapenem. Review of Resident #24's record revealed a progress note dated [DATE] at 10:44 P.M. stating the resident had an IV site to the right had for Ertapenem sodium injection solution reconstituted one gram. Use one gram IV one time a day for sepsis until [DATE] at 11:59 P.M. Review of Resident #24's quarterly Minimum Data Set (MDS) assessment completed on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had no cognitive impairments. The resident had no exhibited behaviors. The assessment revealed the resident required mobility assistance with a walker and a wheelchair. The resident required maximal assistance for toileting, showering, lower body dressing including footwear, and personal hygiene. The resident required supervision/ touching assistance for toileting and tub / shower transfer. The resident was at risk for developing pressure ulcer/ injuries. The resident did not require oxygen therapy. On [DATE] at 9:18 P.M. interview with Resident #24 revealed in [DATE] she had a urinary tract infection (UTI) for approximately two weeks. Resident #24 stated she went septic and they almost called her (death). Resident #24 stated the day she went to the hospital she was incoherent, she recalls the emergency room Physician telling her it was almost too late, she would have expired. Resident #24 stated it was very traumatic; she was scared now. Resident #24 became tearful while telling the story of her hospitalization - near death experience in September of 2025. Resident #24 stated for several days prior to going to the hospital she did not feel well, she was complaining of issues such as being unable to void (urinate) and other symptoms, but no one would listen. Resident #24 stated she expressed concerns to staff members for four to five days that something was wrong, eventually she was sent to the hospital, but she remembered nothing from that day, just little pieces and things others had told her. Resident #24 stated she was out of it and incoherent for that time period. Interview on [DATE] at 11:52 A.M. with ADON #390 revealed any e-triage notes would be in the electronic health record. For Resident #24 any notification to the provider whether e-triage or not should be in the resident's record either progress notes or miscellaneous. ADON #390 confirmed it was the expectation that any communication was documented including reason for communication and outcome (orders/ recommendations provided by the provider).Interview on [DATE] at 7:31 A.M. with Certified Nurse Assistant (CNA) #60 revealed for a few days leading up to Resident#24 discharge to the hospital (in [DATE]) the resident was complaining of itching, burning, and having the urge to urinate frequently. Resident #24 had mentioned she was not cleaned well or changed enough. CNA #60 stated Resident #24 was very routine, she gets up every morning around the same time, 8:00 A.M. the day she went out (to the hospital) she wouldn't get out of bed, she laid there the entire day until emergency medical services (EMS) came to take her to the hospital. To CNA #60's knowledge no one did anything for Resident #24 or looked into her having a UTI prior to the resident going to the hospital even though the resident had voiced concerns.Interview on [DATE] at 7:51 A.M. with RT #958 revealed he could recall Resident #24 going out to the hospital in September of 2025. RT #958 reported having a good rapport with Resident #24 revealing she would joke around with hm, and he knew something was off because she wasn't doing that, she wasn't herself, her heart rate was outside of her normal - cannot recall specifics but remembers it was high, she was always below 100. RT #958 stated Resident #24 was not a person who complained of sickness but the morning of the day she was sent to the hospital she mentioned she didn't feel good, she did not feel right.Interview on [DATE] at 10:44 A.M. with RN #30 revealed concerns with the facility staffing stating staffing was bad, there was nothing but agency. Staff nurses were expected to do so much, it could affect residents and their care. When nurses asked management for help, they would tell staff they were not (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	there to hold their, they would gloat about firing people, and there was no communication. Things would change [orders, procedures, etc.] for residents and staff would have no idea. Management kept adding more tasks to floor staff. RN #30 revealed Resident #24 in September of 2025 was sent to the hospital. Resident #24's vital signs were not great, the resident was on antibiotics, so they were told by NP #20 that day [[DATE]] to let the antibiotics work, keep an eye on the resident, and breathing treatments were ordered. Through the day Resident #24 became out of sorts. Resident #24 had antibiotics ordered so the NP wanted to give them [the antibiotics] time to work. RN #30 stated she recalls the situation being scary but stated it was difficult to remember specifics from that long ago.Interview on [DATE] at 11:08 A.M. with CNA #50 revealed the CNA recalled taking care of Resident #24 the day she was sent out (to the hospital), and the days leading up to it in [DATE]. CNA #50 stated Resident #24 was not doing well. Resident #24 wouldn't eat, which was out of her norm. Resident #24 was sick for a few days before she was sent out. CNA #50 stated she and other people reported to the nurses [cannot recall which ones] something was wrong with Resident #24; she was acting strange- she wasn't herself. The nurse told staff they would give her [Resident #24] some medications and keep an eye on her. Resident #24 wouldn't get out of bed, she was someone who got up every single day, and would walk to the bathroom in the mornings, but those days she was very under the weather. Resident #24 was complaining of generally not feeling good during the days leading to her hospitalization.Interview on [DATE] at 12:22 P.M. with Transportation/Medical Record #535 confirmed all information regarding Resident #24's paper chart including physician notifications, orders, and documentation were provided to the surveyor for review. Interview on [DATE] at 1:32 P.M. with Corporate Clinical Director #751 revealed it was the expectation that any resident with a change in condition (vital signs, behavior, activity of daily living (ADL) assistance, or refusals) have documentation in the medical record. Corporate Clinical Director #751 stated if a resident had these changes, a provider should be notified, and a representative if applicable, and the resident should have continued frequent monitoring. Corporate Clinical Director #751 stated for changes in vital signs, cognition, or behavior they would expect to see orders for the residents from the providers and the orders and interventions to be implemented with continued monitoring, and/or the resident being sent out (to the hospital) if necessary. Interview on [DATE] at 2:40 P.M. with LPN #40 revealed she worked on the evening of [DATE] and could recall the incident with Resident #24. LPN #40 revealed upon starting her shift she began walking rounds, during report with the off going nurse, the off going nurse reported Resident #24 was sick but fine. When walking by Resident #24's room she [LPN #40] immediately stopped shift report and began assessing the resident and contacted EMS because her [Resident #24] eyes were rolled back, she was unresponsive, and she did not look good. This was not Resident #24's norm or even close to it. Resident #24 was someone who could talk with you - she was ornery. The LPN revealed Resident #24 would occasionally walk to the bathroom on her own, she would utilize her call light when needed- it was on often, and the resident did not require oxygen. Resident #24 was oriented and could voice her needs. LPN #40 stated she believed Resident #24 would have been dead soon if she was not sent out immediately upon finding her. Interview on [DATE] at 12:55 P.M. Medical Director (Physician) #50 revealed with the clinical presentation of Resident #24, on [DATE] the low blood pressure, high heart rate, other symptoms she was having sounded septic, and the resident was obviously going into respiratory failure. Medical Director #50 reveale[TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, review of manufacturer's guideline, policy review, and interview, the facility failed to safely transfer residents while using a mechanical lift, failed to provide staff training on the use of all mechanical lifts, and failed to ensure resident call lights were within reach for a resident at risk for falls. This affected three residents (#30, #55, #11) of three residents reviewed for accidents. The facility census was 52. Findings include: 1.Review of the medical record for Resident #30 revealed an admission date of 03/31/21with diagnoses that included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, psychophysiologic insomnia, unspecified mood disorder, weakness, history of falling, dysphagia oropharyngeal phase, hyperlipidemia, age-related osteoporosis, unspecified osteoarthritis, essential hypertension, major depressive disorder, vitamin D deficiency, muscle weakness and difficulty walking. Review of the Minimum Data Set (MDS) version 3.0, dated 03/13/26, for Resident #30 revealed a Brief Interview for Mental Status (BIMS) score of 7 on a 0-15 scale. A score of 7 would indicate severe problems with thinking and memory. Per the MDS, the resident required a wheelchair for ambulation and was dependent for all activities of daily living (ADLs). The resident's height was 67 inches. The resident weighed 144 pounds. Review of a progress note for Resident #30 marked as a late entry, revealed on 03/18/26 at 6:30 P.M., Licensed Practical Nurse (LPN) #150 entered a note which identified the nurse was alerted the resident was lowered to the floor on the mechanical lift due to lift pad needing adjustment. Nurse asked the resident if she had fallen, which resident replied no. Nurse asked resident if she was having any pain, resident replied no. There were no signs of injury, the resident was able to do passive range of motion (PROM) with no complaints of pain. The resident is unable to move lower extremities on her own, patient also did active rom for her BLE (bilateral lower extremities) by herself with no reports of pain. Once assessment was completed and no injuries were found and no complaints of pain the Hoyer pad was readjusted, and the resident was put into bed by the certified nurse aides (CNA's) and was left comfortable with call light in reach. On 04/02/26 at 2:30 P.M., an interview with Resident #30 revealed she was unable to accurately recall the incident which occurred on 03/18/26. She reported she had fallen recently and when she was asked what happened she indicated she had fallen from a high ladder. On 04/06/26 at 10:56 A.M. an interview with CNA #377 revealed she was present during the mechanical lift incident with Resident #30, along with CNA #265. She reported the resident began sliding out of the mechanical lift pad when they were lifting her. They tried to reposition her, however she came out the side of the sling and was hanging out. They had to unclip the lift pad and Resident #30 came out of the sling and onto the floor. On 04/15/26 at 8:12 A.M., electronic communication with the Administrator revealed the mechanical lift pad size for residents was determined based on weight only. She confirmed on 04/15/26 at 11:38 A.M. there was no documentation in the medical record for Resident #30 indicating the size mechanical lift sling she would require. On 04/15/26 at 11:38 A.M., an interview with CNA #340 revealed she selected mechanical lift pads for a resident by looking at their size. She reported the size required was not noted on the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record. She would usually just go to the laundry where the slings were kept and pick out one that looked to be about the right size. CNA #349 stated, you want some room in them, but not so much they are getting swallowed up, or not so small their body is flowing out of the lift pad. She reported the size of the lift pad being used for Resident #30 was a Medium. On 04/16/26 at 7:22 A.M., electronic communication with the Administrator revealed all the mechanical lift pads used at the facility were from a company called Invacare and the facility did not use a Proactive lift pad while transferring Resident #30 on 03/18/26. The Administrator reported the sling size used for Resident #30 was Small. Review of the manufacturer's guidelines from Proactive medical products revealed an owner's manual for a Protekt 600 Lift Power Patient Lift Model 33600, (which was the mechanical lift used to transfer Resident #30 on 03/19/26). The manual indicated special care must be taken with users/patients who require assistance while being lifted. While being lifted in a sling, the user/patient should always be kept centered over the base and facing the caregiver when operating the lift. There was a warning to select a Proactive Medical Product sling which was both practical and comfortable. The sling should be one that meets the needs of the patient while providing maximum safety. There was another warning that Proactive Medical slings were specially designed to be used in conjunction with Proactive lifts. The manual stated Do not use slings manufactured by other companies with any Proactive Medical's equipment. USING OTHER MANUFACTURER'S SLINGS ON THIS EQUIPMENT IS UNSAFE AND MAY RESULT IN SERIOUS INJURY TO USERS AND CAREGIVERS. Lifter base should be widened and brakes locked during lifting. The owner's manual included a recommended sizing guide. Small slings should be used for a person from 75 to 150 pounds and 59 to 64 inches in height. Medium slings should be used for a person from 125 to 200 pounds and 63 to 68 inches in height. Large slings should be used for a person from 175 to 300 pounds and 67 to 72 inches in height. Extra Large slings should be used for a person from 275 to 500 pounds and 71 to 76 inches in height. Extra extra-large slings should be used for a person from 350 to 600 pounds, and the height could be determined as needed. The Hoyer was not to be used for a person over 600 pounds. 2. Review of medical record for Resident #55 revealed an admission date of 04/30/25. He was admitted to hospice care on 11/25/25. Diagnoses included Parkinson's disease without dyskinesia, fall on same level, muscle weakness, essential hypertension, lumbago with sciatica, chronic pain, spinal stenosis, and dementia in other diseases classified elsewhere, moderate with other behavioral disturbance. Review of a Minimum Data Set (MDS) version 3.0, dated 01/20/26, Section GG indicated Resident #55 used a wheelchair for ambulation. He was dependent for activities of daily living. Review of a care plan for Resident #55, last reviewed 02/04/26, revealed the resident needed assistance from staff to meet ADL needs. On 03/30/26 at 12:15 P.M., an observation of Resident #55 being transferred via mechanical lift revealed CNA #340 operated the lift with CNA #115 assisting with the transfer. During the transfer, CNA #340 failed to lock the brakes of the lift prior to lifting the resident from his recliner and prior to lowering him into his wheelchair. The failure to lock the brakes during the transfer with Resident #55 was confirmed with CNA #340 at the time of the observation. CNA #340 indicated at that time she had never had Hoyer training at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 03/30/26 at 1:25 P.M., an interview with the director of nursing (DON) revealed all CNAs were trained on hire to use the mechanical lift. She indicated all new employees were checked off using the mechanical lift by the therapy department during orientation. She stated she had personally checked off all the CNAs on the use of the new bariatric mechanical lift the week prior, which was to be used for any resident over 300 pounds. Review of the facility education information revealed there was no sign in sheet for education on the bariatric mechanical lift. On 03/30/26 at 1:30 P.M., an interview with assistant director of nursing (ADON) #140 revealed she had personally trained all staff on the facility mechanical lifts including the new bariatric lift, the week before and had completed a return demonstration with each one. The DON was present during this interview and stated, I popped in and out when she would do the training. On 04/01/26 at 12:15 P.M., an interview with CNA #115 revealed she had never had mechanical lift training at the facility. There was a new bariatric mechanical lift which staff had only watched the DON use. They had never done a return demonstration on any of the mechanical lifts to be sure how to use it. On 04/01/26 at 12:45 P.M., an interview with Physical Therapist #753 revealed she was the individual from the therapy department who participated in orientation of all staff. There was no training on mechanical lifts done by her during orientation or at any time. Her only part in orientation was to describe how best to communicate with the therapy department and to provide each new employee with a gait belt to assist with safe transfers. On 04/02/26 at 12:40 P.M. an interview with CNA #700 revealed she knew mechanical lift training, including Hoyer lift, was on the orientation check list, but they just checked it off when they showed them where the mechanical lifts were when staff first started. She had watched but had never used or been trained on the bariatric mechanical lift. An electronic communication with the Administrator on 04/15/26 at 1:16 P.M. revealed Hoyer lift training was part of the orientation checklist, and the CNAs were trained by another CNA by walking through the technique. On 04/15/26 at 1:42 P.M., the Administrator confirmed there was no annual Hoyer lift training available in any CNA education or employee file. Review of a facility policy titled Lifting Machine, Using a Mechanical, revised 02/2017, revealed the policy was to establish safe lifting using a mechanical lifting device. The policy made note it was not a substitute for manufacturer's training or instructions. At least two nursing assistants were needed to safely move a resident with a mechanical lift. Lifts could be used to lift a resident from the floor, transfer a resident from bed to chair, lateral transfers, lifting limbs, toileting or bathing, or repositioning. The policy indicated lift design and operation varied across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices used in the facility. Residents should be measured for proper sling size and purpose, according to manufacturer's instructions. The sling should be selected which was appropriate for the resident's size and task. The lift should be stable and locked prior to lifting the resident. Prior to use, staff should double-check the sling and machine's weight limits against the resident's weight. Following use of a mechanical lift, the staff should document in the medical record the reason for the transfer, the type of lift used, the equipment size and condition, the names and titles of staff assisting, the resident's physical and mental condition before and after the procedure, and how the resident tolerated the procedure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Safe Resident Handling/Transfers, dated 2025, revealed it was the policy of the facility to ensure residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping employees safe in accordance with current standards and guidelines. The use of mechanical lifts was a safer alternative to manual lifting and should be used. Mechanical lifting equipment would be used based on the resident's needs to prevent manual lifting except in medical emergencies. The facility would ensure there were appropriate amounts of varying sized slings to accommodate residents and residents would be measured correctly per the manufacturer's instructions on proper sling sizing. A sling designed to fit the specific lift should be utilized. Staff were to be educated on the use of safe handling/transfer practices to include the use of mechanical lift devices upon hire, annually and as the need arose or changes in equipment occurred. Staff were to demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency placed in their education file. Staff were expected to maintain compliance with safe handling /transfer practices. They would perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device. Review of a facility policy titled Falls Policy and Procedure dated 05/21/26 revealed a policy to ensure residents with falls or potential for falls were monitored and assessed. The policy indicated when a fall occurred, the licensed nurse should assess the resident's condition, complete the incident report, complete the falls investigation, implement immediate safety approaches if identifiable until the interdisciplinary team (falls committee) could meet to review the fall and implement interventions to the plan of care, document the incident in the medical record and post fall assessment and notify the physician and responsible party. 4.Record review revealed Resident #11 admitted to the facility on [DATE] with diagnoses including multiple myeloma, malignant, anemia, pancytopenia, overactive bladder, and hypertension. Review of Resident #11's care plan dated 01/06/26 revealed the resident was at risk for falls and/or injury related to impaired mobility and medications. Interventions included putting the call light within the resident's reach. Interview on 03/30/26 at 8:15 A.M. with Resident #11 revealed about a month ago she fell and broke her left hip and was sent to the hospital. Resident #11 stated they were coming back to bed from the bathroom when they fell. Observation on 03/30/26 at 8:15 A.M. of Resident #11 revealed their call light was not in reach. A call light for assistance sign was hanging on the wall. Resident #11 confirmed they could not reach their call light with it laying in the bag on the bedside table. Interview and observation on 03/30/26 at 8:21 A.M. with Certified Nurse Assistant (CNA) #115 confirmed Resident #11's call light was out of reach, sitting on the night stand in a bag. This deficiency represents non-compliance investigated under Complaint Numbers 2963735, 2809745, 2961570.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, resident council minute review, grievance review, review of call light audits, record review, facility assessment review and facility policy review the facility failed to maintain sufficient levels of staff to meet the total care needs of all residents. This had the potential to affect all residents residing in the facility. The census was 52.Findings include: 1.On 03/30/26 at 5:55 A.M. the survey team entered the facility to conduct the annual recertification survey and complaint investigation. There were four licensed nurses and five certified nurse aides (CNA) on duty to provide care for 52 residents currently residing in the facility.Review of the Facility assessment dated [DATE] revealed the total number needed or average or range Daily Staffing Numbers included the following Nursing Positions: 4 licensed nurses providing direct care, 13 nurse aides, 3 other nursing personnel.The General Staffing Plan to ensure sufficient staff to meet the needs of residents at any given time included: 1 DON RN full time days, ADON to equal one FTE, MDS RN full time Days, RN/LPN Charge Nurse : 2 for each shift, Direct Care Staff: 1:12 ratio days (total licensed or certified), 1:12 ratio evenings, 1:20 ratio nights.Individual Staff Assignment stated: The IDT will meet to discuss staffing levels or particular staff needed to care for current census meet in QOC, QAPI and daily Nurse Manager Meeting.Review of facility policy titled Resident Dignity and Respect dated 04/17/17 revealed it is the policy of the facility that all residents be treated with kindness, dignity and respect in recognition that they are provided with a homelike environment. Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as a human being. Schedules of daily activities will allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Resident individual preferences regarding such things as menus, clothing, religious activities, are elicited and respected by the facility.2. The following resident concerns were lodged during the survey related to facility staffing: a. On 03/30/26 at 8:29 A.M until approximately 8:43 A.M., interview with Resident #3 (also the resident council president) revealed the call light responses are an issue and residents have waited a long time for assistance because staffing is short. Resident #3 stated he requires mechanical lift assistance for transfers; he has a nice new electric wheelchair, but he cannot get into it due to there isn't enough staff to help him. Resident #3 stated he is in his chair maybe once a week, he would really enjoy being in it at least two to three days if possible. Resident #3 stated he is the resident council president, and he has missed resident council meetings due to inadequate staff to get him into his chair. b. On 03/30/26 at 10:36 A.M. interview with Resident #50 revealed the facility is seriously understaffed and call lights are not responded to for 45 minutes to two hours. c. On 03/30/26 at 1:25 P.M. interview with Resident #1 revealed there were not enough staff. It has taken up to two hours for staff to answer the call light because there are not enough nurses or aides. Call lights are not answered timely. Resident #1 stated he is in the facility for therapy due to weakness and needs assistance with daily activities.d. On 03/31/26 at 8:33 A.M., interview with Resident #10 revealed the residents do not have enough staff especially certified nurse aides (CNA)'s on nightshift. Resident #10 has had to wait up to 30 minutes for someone to answer their call light, especially nightshift. Resident #10 stated she has had to pull the bedpan out from under herself due to sitting on it for so long waiting on staff to come and assist her. Resident #10 stated the bedpan is painful to be on for too long.e. On 03/31/26 at 9:23 A.M. interview with Resident #24 revealed staffing is short. Resident #24 stated she has to wait a long time for assistance. Sometimes staff run in and give an excuse and a list of what they need to do, it makes her feel less important. Some of the things that get put off include going to the bathroom, if she doesn't get help soon enough [the resident requires assistance with transferring and walking to the bathroom] she becomes incontinent, it makes her feel less than. The incontinence is causing her legs and vaginal area to become raw and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	painful. The staffing issue is with nurses and aides, basically all the time but, at night is the worst, Resident #24 stated she does not get the care she is supposed to receive.3. The following staff concerns were lodged during the survey related to facility staffing: a.On 04/02/26 at 9:41 P.M. interview with CNA #685 revealed it was the expectation of an aide to do eight resident showers per shift. CNA #685 stated the aides would do as many as they could, however it was almost impossible to get all of the resident showers done with all of the other responsibilities and resident needs they had to meet throughout a shift. Per CNA #685 there were usually only three aides on day shift, and it was the only place she had ever worked where you were told not to shower someone who required a mechanical lift, even though they had a lift chair which was new in the shower room. She had heard Resident #30 tell CNA #115 she wanted a shower, but the other aide told the resident she did not have time, and she just washed her hair. b. On 04/02/26 at 12:40 P.M., interview with CNA #700 revealed she never felt they had enough staff to meet resident needs. CNA #700 stated, in fact two extra people were added to the schedule at 2:00 P.M. today because surveyors are here. c. On 04/06/26 at 1:22 P.M., interview with Registered Nurse (RN) #390 stated it was her expectation call light response should be five minutes or less. If it was greater than 10 minutes she should follow up to see why (examples would be staff on their phones, assisting other residents, if nurses were helping, etc.). RN #390 verified there were 16 residents that required the use of a mechanical lift and that takes two staff at a minimum. d. On 04/06/26 at 2:20 P.M., interview with CNA #340 revealed she did not believe the facility had enough staff. She was concerned because the residents were not getting the care they needed. Residents were not even able to get showers, and she felt the residents deserved better than that.e. On 04/06/26 at 2:03 P.M. an interview by phone with Anonymous Staff Member #2222 revealed resident care is not timely or quality, when it gets done. One night the DON came in due to short staffing of nurses, and slept in her office, she told staff State requires a certain number of Registered Nurses to be in the building.f. On 04/09/26 at 10:44 A.M. with RN #30 revealed staffing was bad. You [the staff nurse] were expected to do so much, it could affect the residents and their care. Management kept adding more and more tasks to the floor staff. RN #30 stated the facility would have residents on ventilators with no respiratory therapy, there were so many residents with wounds, it was dangerous. The residents needed more staff, a better system, and better management.4. During the onsite survey, concerns were identified residents were not provided with routine showers/baths and ADL care. This concern was correlated to a lack of staff as noted per the interviews above. a. Review of medical record for Resident #65 revealed he was admitted to the facility on [DATE] with diagnoses that included acute osteomyelitis of the left ankle and foot, type two diabetes mellitus with foot ulcer, repeated falls, pain in left and right hip and major depressive disorder.Review of the Minimum Data Set (MDS) assessment version 3.0 dated 02/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 12 on a 0-15 scale. A score of 12 would indicate the resident had moderate problems with thinking and memory. The MDS further revealed the resident needed partial/moderate assistance with bathing, lower body dressing, and toileting. Review of the care plan indicated the resident needed assistance from staff to meet ADL needs and was initiated 01/14/26. The goal was for the resident to participate in self-care to his/her maximum capacity. Interventions included assisting the resident with bathing as needed, per resident's preferences. It also indicated the resident had inappropriate behaviors such as being non-compliant, and staff was to provide support and encouragement while allowing resident to make choices with daily care when possible. The resident had impaired cognition with occasional forgetfulness, and staff were to assist with ADLs, and explain all treatments and procedures to the resident.Review of paper shower sheets for the month of March 2026 revealed Resident #65 refused showers on 03/03/26, 03/07/26, 03/17/26, 03/24/26, 03/27/26,and 03/28/26. There was no documentation that indicated interventions to encourage or explain need for ADL assistance to the resident.Review of the electronic bath task documentation from 01/14/26 through 03/30/26 revealed Resident #65 had shower assistance on only two occasions, 01/27/26 and 02/02/26. On 04/07/26 at 2:30 P.M., an (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview with Resident #65 revealed he wanted to get showered, however he had to have the wounds covered on both of his legs. He had a device he had been given by the wound clinic for his right leg but needed the staff to cover his left lower leg as well. He reported every time he asked for the staff to cover both, he would be told they did not have time, so he just told them, Never mind. He would just wipe off if he needed to.On 04/07/26 at 2:37 P.M., an interview with Assistant Director of Nursing (ADON) #140 revealed Resident #65 always refused shower assistance. She reported she had tried numerous times. She was not sure why no one would apply the shower devices for him because they knew he needed them. b. Medical record review revealed Resident #1 was admitted on [DATE] with diagnoses including diabetes mellitus, malignant neoplasm of right lower bronchus or lung, generalized anxiety disorder, obstructive sleep apnea, asthma, chronic obstructive pulmonary disease, weakness and a urinary tract infection. Review of the modified admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact for daily decision-making, required maximum assistance with bathing/showering and required moderate assistance with personal hygiene. Review of the care plan: Needs Assistance from Staff to meet ADL needs related to decreased mobility, diagnoses and impaired cognition dated 02/18/26 revealed interventions including to assist Resident #1 with bathing as needed per resident's preference. Review of the medical record for Resident #1 revealed a Nurse Practitioner (NP) progress note dated 02/27/26 that identified Resident #1 had acute urinary incontinence due to being too weak to get up to bathroom at this time. The resident has been experiencing incontinence of urine due to waiting for staff to assist her to the bathroom. The NP encouraged the resident to avoid late night drinking, keep Depends clean, dry. The resident was encouraged to notify staff when (incontinence) brief is wet and do not wait for staff to check. Clotrimazole 1% ointment (antifungal medication) was ordered to be applied twice a day.Review of the undated Shower Schedule Book revealed Resident #1 was scheduled for a dayshift shower on Monday, Wednesday and Friday. Review of the paper Shower/Bath Sheets and electronic Bath Task documentation dated 02/13/26 through 04/06/26 revealed Resident #1 was not provided a shower/bed bath as scheduled on 03/02/26, 03/11/26, 03/16/26, 03/18/26 or 03/20/26. On 03/30/26 at 1:25 P.M., interview with Resident #1 stated she does not always receive showers as scheduled and had only received one shower last week. Resident #1 stated she was to receive her showers on Monday, Wednesday and Fridays and needed staff to complete as she could not do it by herself. At the time of the interview, observation revealed Resident #1 was sitting up in her room and was covered with a light blanket. The resident's hair appeared greasy, uncombed and a body odor was noted. On 04/07/26 at 11:18 A.M., interview with Registered Nurse #751 verified Resident #1 bathing/showers were not provided as scheduled during March 2026. c. Review of the medical record for Resident #18 revealed an admission date of 04/28/25. Diagnoses included sepsis, dysphagia, pneumonitis due to inhalation of food and vomit, unspecified asthma with exacerbation, acute respiratory failure, dyspnea, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified right bundle-branch block, obesity, unspecified protein-calorie malnutrition, major depressive disorder, insomnia, generalized anxiety disorder, repeated falls, and personal history of transient ischemic attack and cerebral infarction without residual deficits.Review of a Minimum Data Set (MDS) version 3.0 for Resident #18 dated 03/12/26, revealed the resident had a Brief interview Mental Status (BIMS) score of 15 on a 0-15 scale. A score of 15 indicated the resident was cognitively intact. The MDS further indicated that the resident required partial assistance from another person to complete any activities. She used both a manual wheelchair and walker for ambulation and required partial to moderate assistance with bathing/showering and dressing. Review of a care plan for Resident #18 dated 03/23/26 revealed a focus of care for assistance from staff to meet ADL (activities of daily living) needs. The goal was for resident to remain clean, dry and odor free. Interventions included assisting with hair care, oral care, dressing, and bathing using resident choice, as needed.Review of electronic bathing and showering tasks in medical record for Resident #18 revealed from 03/07/26 through 04/07/26, the resident was assisted with a shower on 03/15/26, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review and interview, the facility failed to ensure medications were administered without significant error. This affected one resident (#1) of five residents sampled for unnecessary medications. The census was 52. Findings include: Medical record review revealed Resident #1 was admitted on [DATE] with diagnoses including malignant right lower lung cancer, obstructive sleep apnea treatment with BIPAP, paroxysmal atrial fibrillation, asthma, chronic pain, GERD, chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy and urinary tract infection. Review of the hospital Discharge summary dated [DATE] revealed the following changes in Resident #1's medication orders were to be implemented upon admission to the skilled nursing facility: Start Betapace (used to treat life-threatening ventricular arrhythmias and maintain normal sinus rhythm in patients with atrial fibrillation or flutter) 40 (mg) twice a day; Start Carafate (peptic/duodenal ulcer treatment) 1 gram (gm) four times a day; Start Lotrisone cream (antifungal) to vaginal area twice a day for eight doses for candidiasis; administer Macrobid (antibiotic) twice a day for five days for urinary tract infection (extended spectrum beta-lactamases); Discontinue Metformin 500 (mg) and start Lantus (insulin) subcutaneous 4 units at bedtime; Complete the course of oral Nystatin (antifungal) liquid 5 milliliters four times a day for 12 doses swish/swallow; Administer Gabapentin (treats diabetic nerve pain) 600 (mg) three times a day; Administer albuterol-budesonide aerosol 90-80 micrograms (mcg)/act two puffs every four hours PRN (as needed) for shortness of breath or wheezing. Review of the eCare Triage Progress Note dated 02/13/26 revealed Resident #1's face sheet and hospital Discharge Summary were reviewed by Nurse Practitioner (NP) #600 and the medications were reviewed and approved.Review of the electronic Order Summary Report dated February 2026 revealed the above medication changes listed on the hospital Discharge Summary orders were not transcribed or started as ordered. Review of the modified admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact for daily decision-making and did not receive insulin or an antibiotic during the assessment period.Review of NP #650's Pain Management and Diabetic Plan Update note dated 03/27/26 revealed Resident #1 was not on any diabetes treatment upon arrival to the facility. On 03/24/26, laboratory blood work included a HgbA1C (measuring average blood sugar levels over the past two to three months) was 8.4%. (This level reflects an average blood sugar level of approximately 194 mg/dL over the past three months, signaling a high risk for complications and a need for immediate intervention via medication, diet, or lifestyle adjustments). The resident reported her diabetes was managed with diet and was agreeable to initiating Metformin XL 500 (mg) daily.On 04/06/26 at 12:40 P.M. through 1:20 P.M., interview with Registered Nurse (RN) #390 verified Resident #1's Hospital Discharge Summary was approved by the Nurse Practitioner but the above medications were not transcribed or administered between 02/14/26 and 04/06/26. RN #390 was unable to determine why the medications were not transcribed except to say they were missed. RN #390 stated the Director of Nursing was the second check at the time of this resident's admission to ensure all new admission orders were transcribed correctly. RN #390 verified Resident #1's medications were not transcribed or administered as ordered upon admission and this had not been identified until this survey. RN #390 was notifying Resident #1's physician/nurse practitioner to inform them of the above. RN #390 further stated that the DON was not available for interview for the remainder of the survey. Review of the electronic Medication Administration Record April 2026 revealed on 04/06/26 new orders were received to start the following medications for Resident #1: administer Buspirone 5 (mg) twice a day instead of once a day; Start Lantus insulin 4 units daily at bedtime; Start Neurontin 100 mg three times a day for pain; and Start Albuterol-Budesonide aerosol 90-80 (mcg/act) two puffs PRN.Review of the policy: admission of the Resident revised 06/13/17 revealed the purpose was to acquire all required information when a resident was admitted , review all available transfer information and orders for the resident to be admitted .

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, review of the facility diet list, interview, and review of facility policy the facility failed to ensure food was prepared in accordance with the physician ordered diet consistency. This had the potential to affect six residents (Resident #11, #14, #30, #43, #53 and #55) who had physician ordered pureed diets. The census was 52.Findings include:Observation of pureed rice for lunch on 04/07/26 at 11:06 A.M. revealed the rice was in the warming table. Dietary Supervisor #315 verified the pureed rice was ready for the lunch meal, and the surveyor and Dietary Supervisor #315 taste tested a sample of the pureed rice. The rice was gritty in texture and had large clumps. The rice was not smooth like puree consistency was expected.On 04/07/26 at 11:07 A.M. interview with Dietary Supervisor #315 verified the rice was not the correct consistency for puree which should be smooth and without lumps.Review of the facility diet list revealed six residents (Resident #11, #14, #30, #43, #53 and #55) had physician orders for pureed diet consistency.Review of facility policy titled therapeutic diets revised 01/22/25 revealed a therapeutic diet is considered a diet ordered by a physician, practitioner, or dietician as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet.This deficiency demonstrates noncompliance investigated under Complaint Number 2961570.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, text message communication review, incident log review, time punch review, interview, and facility policy review the facility failed to maintain comprehensive and accurate medical records. This affected two residents (Resident #15 and #52) of two residents reviewed for abuse and one resident (Resident #30) of four residents reviewed for accidents. The census was 52. Findings include:1.Review of Resident #15's medical record revealed an admission date of 10/22/21 with diagnoses including hypertension, hemiplegia (left side) and hemiparesis following cerebral infarction, major depressive disorder, muscle weakness, chronic pain syndrome, and insomnia. Review of Resident #15's quarterly minimum data set (MDS) completed on 01/30/26 revealed Resident #15 was moderately cognitively impaired. The resident did not exhibit behaviors or indicators of psychosis during the assessment period. The resident had upper and lower extremity impairment on one side and required a wheelchair for mobility (left sided hemiparesis, required maximum assistance (from staff) for showering, toileting hygiene, lower body dressing including footwear, and personal hygiene and required moderate assistance from staff for mobility and transfers. Resident #15 received antiplatelet medication. Review of Resident #15's progress notes revealed a late entry, dated 03/24/26 at 9:05 A.M., for 03/21/26 at 1:00 A.M. The progress note was authored by the Director of Nursing (DON), who was not in the facility at the time of the incident, that documented Resident #15's roommate was upset about the TV volume. Resident #15 wanted the TV volume to stay increased. Resident #52 was upset, and no harm came to Resident #15. Review of punch-in times for facility director of nursing revealed the director of nursing was not in the facility on 03/21/26 at the time of the documentation. Review of the grievance form dated 03/23/26 for Resident #15, completed through interview by Social Services Designee (SSD) #275, revealed Resident #15 said he was lying in bed, dozing on and off, when his roommate, Resident #52, came through the closed curtain and punched him in the left shoulder. Resident #15 stated he did not know why Resident #52 hit him. During an interview on 03/31/26 at 9:26 A.M., Resident #15 stated his previous roommate, Resident #52, moved rooms about a week ago. Resident #15 stated he was attacked by Resident #52 when the resident ran up to him and hit him in the shoulder. At the time, the hit was painful. Resident #15 stated he reported what happened to him to the nurse but he couldn't remember which nurse he told. Resident #15 shared, as of this time, no one followed up with him regarding the incident or asked him for a statement. Resident #15 stated there was no investigation done that he was aware of. During an interview on 04/08/26 at 9:01 A.M., SSD #275 stated she was called by Certified Nursing Assistant (CNA) #22 on 03/10/26 related to a verbal altercation between Resident #15 and his roommate, Resident #52. CNA #22 reported there was a verbal altercation and Resident #52 had threatened to shoot Resident #15. SSD #275 stated she was not in the facility at the time of the incident and she was unsure if Resident #52 and/or Resident #15 needed to be sent out for evaluation so she called the Director of Nursing (DON) and the DON said to move Resident #52 out of the room. Resident #52 was moved to a private room at that time. The DON informed SSD #275 to instruct staff (CNA #22 and an agency nurse) not to document the incident in the progress notes. SSD #275 stated she did not instruct the CNA/nurse not to document the incident and the agency nurse did make an entry in the medical record regarding the incident in Resident #52's record. The following day on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/11/26, SSD #275 spoke with Resident #52 and he stated he didn't remember threatening Resident #15 but he remembered the TV was loud. Resident #52 stated he would apologize to his roommate, Resident #15. SSD #275 stated she checked with the DON and shared what Resident #52 said and the DON advised the CNAs Resident #52 could return to the room he shared with Resident #15. SSD #275 verified there was no room change documentation but when Resident #15 was informed Resident #52 would be returning as his roommate, Resident #15 stated whatever. SSD #275 stated there were no interventions or increased monitoring after the verbal altercation and no updates to either resident's care plan. SSD #275 stated the was not discussed afterwards, it was never mentioned in the morning stand-up meetings and the DON acted like it didn't happen. SSD #275 shared there was a physical altercation between Resident #52 and Resident #15 which occurred on 03/20/26, when SSD #275 was not in the building. SSD #275 found out about the physical altercation on Monday 03/23/26 when she returned to work after the weekend. She was informed that late in the evening on Friday, 03/20/26 Resident #52 hit Resident #15. SSD #275 confirmed there was a nurse progress note entered by the DON regarding the incident but the DON was not working when the incident occurred. SSD #275 stated she was not made aware of the incident until 03/23/26 and she observed Resident #52 in a different room and the DON told her it was a long story but she was provided with no additional information. SSD #275 stated the CNAs (cannot recall who) informed her the residents had a physical altercation with Resident #52 striking Resident #15. SSD #275 stated she interviewed each resident. Resident #15 stated he was lying in bed, dozing on and off with the TV on and his roommate, Resident #52, came through the privacy curtain and hit him in the shoulder. Resident #15 then demonstrated what happened and lifted his right arm with his hand in a fist and swung towards his left shoulder. Resident #15 was unable to move his left arm due to a previous stroke and when he lay in bed, his left side would be toward Resident #52's bed. SSD #275 stated she asked Resident #15 if he was hurt and the resident stated he had a knot on his shoulder but she did not confirm this. SSD #275 she reported the information to the Administrator, but the administrator denied knowledge of a physical altercation, as she (the Administrator) was originally told by the DON the altercation was verbal and nothing physical happened. SSD #275 stated she followed up with Resident #52 on 03/24/26, the next day. Resident #52 reported Resident #15 said the F' word and Resident #52 was tired of hearing it so he slapped him. Resident #52 stated he hit Resident #15 in the head or the shoulder. SSD #275 stated she shared this information with Corporate Staff #21 and then called the [NAME] President of Operations (VPO) #957 who advised her to write up the concerns for each resident (Resident #15 and #52) and send them to VPO #957. SSD #275 completed grievance forms and emailed both forms to VPO #957 on 03/24/26. Following the email, Corporate Registered Nurse (RN) #751 called the SSD and they did a rundown of the situation. Corporate RN #751 wanted to know who worked the night of 03/20/26 and SSD #275 provided the information which included the name of Agency Nurse #23. SSD #275 said she was unsure where it went from there so she asked VPO #957 and was informed to provide the grievance forms to the Administrator because the Administrator was to investigate the incident. SSD #275 stated she emailed the grievance forms to the Administrator around 03/27/26. SSD #275 believed the grievance was given to the DON to investigate but she was unsure if the DON investigated the incident as she never got an update. During an interview on 04/08/26 at 11:20 A.M., the Administrator stated she was told Resident #52 and Resident #15 had a disagreement about the TV sometime in March 2026 but she could not recall the exact dates. The Administrator stated the DON informed her that Resident #52 had requested to return to the room with Resident #15 however there was no documentation of Resident #52's request or that Resident #15 was notified. There was no evidence Resident #15 said he felt safe and that he agreed with Resident #52 returning. On 03/20/26, the DON called her twice and ADON #390 called her (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	once but was sleeping and didn't see the calls until about an hour and a half later. The Administrator stated she called the ADON back but the DON answered since they were together. The DON informed the Administrator Resident #15 and Resident #52 had a verbal altercation but there was no physical contact made. The DON stated she was going to separate the residents because it was an ongoing issue between the two residents bickering about the TV. The Administrator stated she didn't feel the incident needed reported to the State Agency as she thought it was a verbal altercation and not physical. The following Friday, 03/27/26, the Administrator received the concern/grievance form from SSD #275, and Resident #15 was saying he was hit by Resident #52. The Administrator stated she spoke with Resident #52 about the altercation and he didn't want to talk about it, he said he was happy in his private room. The Administrator stated SSD #275 did interviews with the residents following the altercation. The Administrator confirmed, until notification on 03/27/26 from SSD #275, she was told by the DON that the altercation was verbal, not physical. During an interview on 04/08/26 at 12:31 P.M. ADON #390 stated on 03/20/26 ADON #390 was called by Agency Nurse #23 around 9:00 P.M. to 10:00 P.M. ADON #390 confirmed she was not in the building at the time and there was no documentation of either party's family being notified, or a physician being notified of Resident #15 being hit by Resident #52. ADON #390 confirmed Resident #52 was the aggressor. ADON #390 stated when asking Resident #15 about the incident he did not want to talk about it but didn't state why. During an interview on 04/08/26 at 1:39 P.M., CNA #22 stated that around 03/10/26, she came into work, and Resident #52 was in front of the building, which was unusual. CNA #22 approached Resident #52 and asked him what wrong as Resident #52's face was beet red. Resident #52 responded I need you to move me to another room because I'm going to (explicit word) kill my roommate (Resident #15). CNA #22 reported this to SSD #275, and they (CNAs on shift) moved Resident #52 to a separate room. The next day the DON told the CNAs to move Resident #52 and Resident #15 back into the same room. It was pretty evident where Resident #15 would not be able to fend for himself as Resident #15 is very dependent on staff. He is either in his bed or wheelchair. Despite staff concerns of the residents moving back into the same room, the DON told them they had to do what she said. On 03/20/26 CNA #22 heard Agency Nurse #23 yell for help. The nurse stated Resident #52 was punching Resident #15. CNA #22 asked Resident #15 if he was okay, he stated he could not talk about it, when asked why Resident #15 said I don't want him [Resident #52] to get me again. CNA #22 stated Resident #15 looked scared and terrified. During an interview on 04/08/26 at 2:50 P.M., Resident #15 recalled what happened the night of 03/20//26 and stated he was scared for while after the incident because he was afraid Resident #52 would find him again. Resident #15 stated he was unable to use his left arm after a stroke and depended on the staff for mobility and transfers as well as dressing and other activities. During an observation on 04/09/26 at 12:12 P.M., Resident #15 had a yellow green bruise on the left bicep approximately 1.5 inch in length, and a quarter sized bruise, in various stages of healing, to the left shoulder. Resident #15 stated at the time of the observation those bruises were from the altercation with his roommate. This observation was verified by CNA #115. 2.Review of Resident #52's medical record revealed an admission date of 01/02/25 with diagnoses including anxiety, hypertension, heart failure, and pulmonary embolism. Review of Residents #52's care plan dated 03/14/25 revealed the resident had inappropriate behaviors at times related to being verbally/ physically aggressive towards staff, had delusions of seeing communists, and seeing stars. Goals included no injury to self or others. Interventions included (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documenting behaviors and speak to the resident about inappropriate behavior and redirect as possible. Review of Resident #52's annual MDS completed on 01/09/26 revealed he was moderately cognitively impaired. Resident #52 was independent/ required supervision from staff for mobility and transfers and received anti-anxiety and anti-depressant medications. Review of Resident #52 progress notes on 03/11/26 at 1:41 A.M. at approximately 6:30 P.M. this nurse was notified by staff that Resident #52 stated he was going to shoot Resident #15 due to his TV being too loud. The on-call person for nursing was notified and Resident #52 was removed from the room and placed in private room until morning. Notified on call physician who gave orders for trazadone 25 milligram, hourly checks for six hours, urinalysis, culture and sensitivity, complete blood count, and basic metabolic panel. Review of a late entry progress note dated 03/21/26 at 12:50 P.M., entered on 03/24/26 at 8:53 A.M., and authored by the DON documented Resident #52 was yelling and being verbally aggressive towards staff, mad about TV volume while trying to sleep, told roommate (Resident #15) to turn the volume down. Review of a grievance form completed on 03/24/26 via interview by SSD #275 revealed Resident #52 stated Resident #15 said expletive and he (Resident #52) had heard that word enough so he went over and slapped him with an open hand on the head. (The grievance form was used by the SSD to document the interview/incident as reported by Resident #52). During an interview on 03/31/26 at 9:33 A.M., Resident #52 stated he had problems with his previous roommate, Resident #15. Resident #52 stated Resident #15 was a grouchy old man, and about a week ago before they moved his room, Resident #15 dropped the F bomb so he hit him. Resident #52 stated he hit Resident #15 in either the head or the shoulder. During an interview on 04/02/26 at 10:08 A.M., CNA #685 stated prior to the evening of the physical altercation between Residents #15 and #52, Resident #52 was threatening to kill Resident #15, and Resident #15 was moved out of the room to a different room. At some point they moved the two residents back into the same room. On the evening of 03/20/26, less than a week after Resident #52 threatened to shoot Resident #15, Resident #15 was physically assaulted by Resident #52. CNA #685 stated Resident #15 would not be able to defend himself as he was dependent on staff for most activities of daily living (ADL) and was weak, and Resident #52 was pretty independent. CNA #685 stated several staff members were concerned why the two residents were moved back into the same room as the two residents had ongoing issues between the two of them, CNA #685 was working at the time of the incident but did not witness the incident but came to help staff. During an interview on 04/02/26 at 2:30 P.M., CNA #480, who came in at 5:00 A.M. the morning after the incident and received report of the occurrence, stated Resident #52 threatened to shoot and kill Resident #15 about two to three days prior to their physical altercation. Resident #52 was moved to a separate room away from Resident #15 after threatening him. Then at some point Residents #15 and #52 were moved back into the same room, leading up to Resident #52 physically assaulting Resident #15. CNA #480 stated Resident #15 was upset for a few days after the altercation, he would not talk to anyone, he was withdrawn, he seemed terrified. CNA #480 stated Resident #15 has started talking to people again. The day after the physical altercation Resident #15 was complaining of his body being sore and hurting. CNA #480 stated they were unsure who physically moved the residents back (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

together before the incident occurred.

During an interview on 04/02/26 at 3:18 P.M., CNA #485, who came in to work the night of the incident at 10:00 P.M., heard of the incident through report. She stated the DON had the residents moved back in together. On the evening of 03/19/26, or 3/20/26, (could not recall exact date) Resident #15 and Resident #52 got into it. Resident #52 attacked Resident #15. Prior to this incident Resident #52 would threaten Resident #15 that he would choke, shoot or kill him. The facility moved Resident #52 to a different room, then they placed him back into the same room with Resident #15, but Resident #52 became hostile again leading to the attack.

During an interview of 04/06/26 at 10:55 A.M., CNA #195 stated Resident #52 had an episode and beat up Resident #15. The two have been split up before due to arguing and threats. Staff advocated the residents needed split up. Management moved Resident #52 to a different room once, and then he and Resident #15 ended up in the same room again. After being moved back into the same room Residents #15 was physically assaulted by Resident #52.

Review of facility policy titled Abuse, revised on 01/30/20 revealed it is the facility policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property including injuries of unknown origin in accordance with the policy. Residents have the right to be free from abuse, neglect, exploitation and misappropriation. Individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Staff should report allegations to the administrator and to the Ohio department of health (ODH). If a staff member is disciplined for failing to report an incident/ allegation timely in accordance with this policy, any disciplinary action taken as a result of that failure shall not constitute retaliation or reprisal. abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. it includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Mistreatment is inappropriate treatment or exploitation of a resident. Neglect is the failure of the facility, its employees, or facility service providers to provide good and services to a resident necessary to avoid physical ham, pain, mental anguish, or emotional distress. Documentation in the nurses notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well.

3.Review of the medical record for Resident #30 revealed an admission date of 08/22/22. Diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, psychophysiologic insomnia, unspecified mood disorder, weakness, history of falling, dysphagia oropharyngeal phase, hyperlipidemia; age-related osteoporosis, unspecified osteoarthritis, essential hypertension, major depressive disorder, vitamin D deficiency, muscle weakness and difficulty walking. Review of the Minimum Data Set (MDS) version 3.0, dated 03/13/26, for Resident #30 revealed a Brief Interview for Mental Status (BIMS) score of 7 on a 0-15 scale. A score of 7 would indicate severe problems with thinking and memory. Per the MDS, the resident required a wheelchair for ambulation, and was dependent for all activities of daily living (ADLs). Review of a progress note for Resident #30 revealed she was lowered to the floor with the Hoyer lift when staff was attempting to transfer her from the wheelchair to the bed. No post fall documentation was completed at the time of the incident. This was confirmed by Registered Nurse (RN) #751 on 04/09/26 at 3:45 P.M. Review of an eCare Triage note for Resident #30 dated 03/19/26 at 6:03 A.M. revealed an unnamed individual from the facility contacted the on-call provider at that time stating We were told that this R (resident)
(continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was lowered to the floor during transfer at 1800 (6:00 P.M.) when I was coming on shift. At the time, both the resident and her roommate both agreed that the R was lowered to the floor. It is now the end of the shift, as aides were getting R up-she cried out in pain to R (right) inner thigh, requests not to be moved, and is now saying that she actually fell and was not lowered to the floor. Requesting that the R have an X-RAY completed to confirm any possible injuries. The reason for the call was entered as New Fall. The call continued to ask where the pain was located, and the caller stated, from what I can understand from R it is her inner thigh.but I can't really understand her speech. It was further noted there was no bruising noted. Nurse Practitioner (NP) #616 gave orders for Tylenol Extra Strength two tablets by mouth now. Cold compresses to the area, and a STAT (immediate) X-ray to the right hip. Review NP notes for 03/20/26 revealed no evidence of the fall or complaints of pain. Interview on 04/01/26 at 2:30 P.M. with Anonymous staff member (ASM) #3333 revealed Resident #30 fell out of the mechanical lift and was not lowered to the ground. The ASM shared the director of nursing (DON) said the resident was lowered to the ground but she was not in the building at that time. The ASM stated the DON and ADON #390 told staff to report the resident was lowered to the ground, not that she fell to the ground. An interview with Medical Director (MD) #750 on 04/14/26 at 12:14 P.M. revealed he had never personally seen Resident #30; he just provided oversight to the facility. He confirmed the complaint of pain the resident had on 03/19/26 would be in-line with an injury from falling out of a Hoyer or from being transferred incorrectly using a Hoyer. When the DON had explained the situation to him, he felt this should have been a fall because of the drastic change in planes. Review of the facility document titled Incident by Incident type revealed all witnessed and unwitnessed falls and other incidents for the facility from 09/01/25 through 03/31/26. The log did not indicate any type of fall or incident for Resident #30. This was confirmed by Registered Nurse (RN) #751 on 04/09/26 at 3:45 P.M. This deficiency represents noncompliance investigated under Master Complaint Number 2964189.