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	12/02/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record and interview with staff the facility failed to ensure call lights were within reach of Resident #7 and #8. This affected two residents (#7 and #8) of three residents reviewed for physical environment. The facility census was 55. Findings included: 1. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes, vascular dementia, hydrocephalus, chronic kidney disease, chronic respiratory failure, adjustment disorder, generalized anxiety disorder and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #7 had severely impaired cognition. Observation on 11/25/24 at 9:38 A.M. revealed Resident #7 was sitting up in her wheelchair. She had her noninvasive Trilogy ventilator on and her call light was not within reach. The call light was across the room attached to her left grab bar on her bed. An interview at this time with Registered Nurse (RN) #320 confirmed the call light was not within reach of Resident #7. Observation on 11/27/24 at 1:56 P.M. revealed Resident #7 was in bed and her call light was hanging on her Triglogy ventilator machine out of her reach. An interview at this time with Medical Records #329 confirmed the call light was not within reach of Resident #7. Review of the facility policy titled, Call Lights, dated 12/26/23 did not address call lights needing to be within reach of the resident. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included left side hemiparesis, dementia, hypothyroidism, hypertension, benign prostatic hyperplasia, iron deficiency anemia, chronic pain syndrome, depression, and insomnia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #8 had moderately impaired cognition and had upper extremity impairment on one side. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/25/24 at 9:32 A.M. revealed Resident #8 was sitting in the recliner. The call light was hanging on the right grab bar out of his reach and on his left paralysis side. An interview at this time with Resident #8 stated he could not reach his call light while he was sitting in the recliner so he just yelled out if he needed help. On 11/25/24 at 9:42 A.M. an interview with RN #320 confirmed the call light for Resident #8 was too short and could not reach to the recliner he was sitting in. She stated he would usually yell out if he needed anything and the call light was not in his reach. Review of the facility policy titled, Call Lights, dated 12/26/23 did not address call lights needing to be within reach of the resident.

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	365417	A. Building B. Wing	12/02/2024

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on medical record review and interview, the facility failed to ensure there was a signed Do Not Resuscitate (DNR) form in Resident #1's medical record. This affected one resident (#1) out of 17 residents reviewed for advance directives. The facility census was 55. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included intellectual disability, fatty liver, chronic obstructive pulmonary disease and essential hypertension. Review of physician orders in Resident #1's electronic medical record revealed an order dated [DATE] for DNR-CCA (do not resuscitate comfort care arrest). Review of Resident #1's care plan, dated [DATE], revealed the resident wished to be a DNR-CCA (do not resuscitate comfort care arrest) with a goal of the resident's wishes would be followed through next review. Interventions indicated the resident was a DNR-CCA with no CPR (cardiopulmonary resuscitation) and advance directives would be reviewed in care conferences quarterly and as needed. Further review of Resident #1's physical chart and electronic chart revealed there was no signed DNR form in either chart to support the resident's wishes to be a do not resuscitate comfort care arrest Review of Resident #1's physical and electronic medical record and interview on [DATE] at 1:25 P.M. with Registered Nurse (RN) #320 confirmed there was no signed code status form in Resident #1's medical record. She stated the code status for residents should be in both the electronic and physical medical record and could not give an explanation on why there was no copy of Resident #1's code status form in Resident #1's medical record.

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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** 46195 Based on observation, record review, interview and review of facility policy the facility did not ensure Resident #1's preference to wear undersized clothing was added to her care plan. This affected one resident (#1) of 17 residents reviewed for care plans. The facility census was 55. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. Pertinent diagnoses included panic disorder, bipolar disorder, anxiety disorder, intellectual disability and morbid obesity. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/29/24, revealed Resident #1 was cognitively intact, had not shown any signs or symptoms of delirium or behaviors, required supervision or touch assistance from staff for upper body dressing and transfers from bed to chair and substantial/maximum assistance for lower body dressing. Review of the care plan for Resident #1 revealed she did not have a care plan in place to indicate it was her preference to wear an undersized nightgown. Observation on 11/25/24 at 1:28 P.M. with Registered Nurse (RN) #320 revealed Resident #1 was sitting in a reclined chair in her room and she was wearing a short length nightgown that was undersized so it exposed her bare abdomen and her brief was fully exposed. There was a room mate in the room with her, but the privacy curtain was pulled so no one was able to see the resident unless they went behind the privacy curtain. At the time of observation with RN #320 present, RN #320 verified Resident #1's brief and part of her bare abdomen were showing and verified it was due to the undersized nightgown. An interview was conducted on 11/27/24 at 11:52 A.M. with Resident #1 in her room. Resident #1 was alert and oriented, and she was wearing an undersized nightgown which exposed her brief and part of her abdomen while she was sitting behind a privacy curtain. Resident #1 stated it did not bother her to wear the undersized nightgown. Interview on 11/27/24 at 2:30 P.M. with the Director of Nursing (DON) revealed Resident #1 prefered to wear the undersized nightgown, and verified she reviewed Resident #1's care plan and it did not address this preference. Interview on 12/02/24 at 8:18 A.M. with Registered Nurse (RN) #371 revealed Resident #1 was finicky and prefered to provide her own nightgowns which were too small on her. RN #371 stated she had made suggestions to Resident #1, such as covering herself with a blanket due to the exposure of her brief and stomach area while wearing the undersized nightgown, but Resident #1 was not interested and prefered to wear the nightgown. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/24 at 9:19 A.M. with Social Services Designee (SSD) #338 revealed she worked as a Certified Nursing Assistant (CNA) prior to taking the SSD position in June of 2024 and she was familiar with Resident #1. SSD #338 stated Resident #1 always wore nightgowns too small and that it was Resident #1's preference. SSD #338 verified Resident #1's care plan did not address her preference to wear undersized nightgowns. Review of facility policy Care Plan, undated, revealed the facility would develop and implement and maintain care plan for each resident that included instructions needed to provide effective and person-centered care. The care plan would include any services that would be required but are not provided due to the resident's exercise of rights including the right to refuse treatment and would be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on medical record review, facility policy review, and interview, the facility failed to ensure discharge summaries were completed as required for Resident #47 and #51. This affected two Residents (#47 and #51) of three residents reviewed for discharge. The facility census was 55. Findings include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included schizoaffective disorder, anxiety disorder, hyperlipidemia, bipolar disorder, osteoarthritis, and hypothyroidism. Review of the Discharge Assessment and Plan, dated 08/12/24, revealed Resident #51 had fair discharge potential and Resident #51 would require home health upon discharge. Resident #51's discharge plan was to return home with her husband after completion of rehabilitation services and antibiotic course. Review of Minimum Data Set (MDS) 3.0 discharge return not anticipated assessment dated [DATE] revealed Resident #51 discharged home to the community. Review of the electronic medical record and hard chart revealed there was no evidence of a discharge summary, a post discharge plan of care, or discharge instructions were completed for Resident #51. Interview on 11/27/24 at 8:20 A.M. with Social Service Designee (SSD) #338 confirmed there was no discharge summary, plan of care or instructions completed for Resident #51. SSD #338 indicated she had just started in this position and was still learning what assessments needed completed. 46195 2. Review of the medical record for Resident #47 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included metabolic encephalopathy, urinary tract infection, protein-calorie malnutrition, type two diabetes, and dysphagia. Review of comprehensive MDS 3.0 assessment, dated 09/13/24, revealed Resident #47 was cognitively intact, required set-up or clean up assistance for eating, supervision or touch assistance for oral hygiene, partial or moderate assistance for upper body dressing and for mobility, which included walking ten feet, and substantial or maximum assistance for lower body dressing and putting on and taking off footwear. Review of the care plan, dated 10/02/24, revealed the discharge plan for Resident #47 was short term and the plan was for her to return home. Interventions included care conference meeting with resident and/or family to discuss progress and discharge plans, home evaluation as needed, referral to community resources for home going support as needed, resident and/or family education for care, and therapy to evaluate and treat. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes in Resident #47's medical record revealed the discharged plan was short term rehabilitation and for the resident to return home upon completion of therapy. The resident had everything she needed on the main floor and had a wheelchair, transport chair, walker, quad cane, shower bench at home. The family had stated the resident would have assistance at home and would be safe to discharge and was requesting assistance for setting up home health and obtaining a medical grade bed. Medications and discharge instructions were reviewed with the resident and family prior to being discharged and the resident was discharged home on 10/30/24. Further review of Resident #47's medical record revealed there was no discharge summary. Interview on 11/27/24 at 10:57 A.M. with the Director of Nursing (DON) confirmed after looking through Resident #47's medical record there was no discharge summary for Resident #47. Review of the facility policy Transfer and Discharge Policy, undated, revealed when a discharge was anticipated the facility would develop a discharge summary that would include but was not limited to a summary of stay (a summary which included but not limited to diagnoses, course of illness/treatment, and pertinent lab, radiology, and consultation results) , a final summary available for release (a final summary of the resident's status to include the resident's needs, strengths, goals, life history and preferences at the time of discharge that was available for release to authorize persons and agencies, with the consent of the resident or resident's representative), a Medication Reconciliation (a reconciliation of all predischarge medications with the resident's post discharge medications, and a post-discharge plan of care (a post discharge plan of care which would assist the resident to adjust to his or her new living environment, which would indicate where the individual plans to reside, any arrangements that had been made for the resident's follow up care and any post discharge medical and non-medical services). A copy of the post-discharge plan would be provided to the resident, or resident representative if applicable, and a copy would be filed in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** 35765 Based on observation, review of the medical record, interview with staff and review of facility policy the facility failed to ensure fall interventions were implemented as ordered for Resident #31. This affected one resident (Resident #31) of two residents reviewed for falls. The facility census was 55. Findings include: Review of the medical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, fracture of nasal bones, dementia, bipolar disorder, muscle weakness, hyperlipidemia, and hypothyroidism. Review of the plan of care dated 07/19/24 revealed Resident #31 was at risk for falls and/or injury related to weakness, potential side effects of medications, bowel incontinence and impaired cognition. Interventions included Dycem (rubber gripper mat) to the wheelchair, medication review by pharmacist or physician, obtain work as needed, perimeter mattress, staff to anticipate needs, therapy services to evaluate and treat, call light within reach, encourage non skid/gripper socks when shoes were off, maintain room and pathways free of clutter and provide adequate lighting. Review of the November 2024 physician's orders revealed Resident #31 had an order for Dycem to the wheelchair dated 09/30/24. Review of the fall assessment dated [DATE] revealed Resident#31 was moderate risk for falls. Review of the Significant Change Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #31 had moderately impaired cognition and had one fall with no injury, two or more with injury and one with major injury. Observation on 11/25/24 at 8:32 A.M. revealed Certified Nursing Assistant (CNA) #373 and #348 stood Resident #31 up from her wheelchair. Observation revealed there was no Dycem under or on top of the wheelchair cushion. An interview at this time with CNA #373 confirmed there was no Dycem to Resident #31's wheelchair as ordered. Review of the facility policy titled, Falls Policy and Procedure, dated 01/27/20, revealed the policy was to establish a policy and procedure to ensure resident with falls or potentials for falls were monitored and assessed. All residents would be assessed quarterly and as needed. Based on the assessment the Interdisciplinary Team would develop interventions based upon the residents risk factors and individual needs and implement a fall plan of care and applicable interventions would be implemented in accordance with the assessment,

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, interview and review of facility policy the facility failed to ensure reweights were obtained in a timely manner for Residents #15 and #31 and meal intakes were adequately monitored for Resident #31. This affected two residents (#15 and #31) of five residents reviewed for nutrition. The facility census was 55. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included anemia, age related osteoporosis, hyperparathyroidism, hyperlipidemia, recurrent depressive disorders, essential hypertension, and gastro-esophageal reflux disease without esophagitis. Review of Resident #15's physician orders revealed an order dated 10/23/18 for a NAS (No Added Salt) diet, regular texture, thin liquids. An order dated 10/08/24 revealed Resident #15 was to receive a mighty shake (a nutritional supplement shake) two times a day, and an order dated 11/14/24 revealed Resident #15 also received Resource 2.0 (a calorie dense nutritional shake). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/11/24, revealed Resident #15 was moderately impaired cognitively, required set up or clean up assistance from staff for eating, had a significant weight loss and was not on a prescribed weight loss regimen and was on a therapeutic diet. Review of progress notes in Resident #15's medical record revealed a dietary note, dated 11/14/24, indicating the resident had been showing a gradual weight loss over the past one, three and six months and weight fluctuation could be related the diuretic. The resident was consuming 51 to 100 percent (%) of meals and was accepting her mighty shake supplements. It was recommended at the time of the note the resident be put on weekly weights times four weeks and two ounces of a house supplement at night time, which was agreed with by the nurse practitioner on the same day. Review of Resident #15's weights in the medical record revealed a weight of 120.0 pounds (lbs) on 05/01/24, a weight of 119.4 lbs on 06/02/24, a weight of 121.2 lbs on 07/01/24, a weight of 120.0 lbs on 08/08/24, a weight of 122.2 lbs on 09/09/24, a weight of 115.0 lbs on 10/04/24, a weight of 115.9 lbs on 10/31/24, a weight of 111.4 lbs on 11/04/24, and a weight of 139.5 lbs on 11/22/24, which reflected a 28.1 pound or a 25 percent weight increase from 11/04/24 to 11/22/24. Review of Resident #15's reweight of 110.6 lbs obtained on 11/27/24 revealed the 139.5 pound weight was inaccurate. Interview on 11/27/24 at 10:31 A.M. with Registered Dietitian (RD) #524 revealed she came to the facility every couple of weeks and was able to document offsite. RD #524 confirmed the 28.1 pound or 25% weight increase from 11/04/24 to 11/22/24 and stated a reweight should have been obtained after the weight of 139. 5 lbs on 11/22/24 to verify accuracy of that weight change. RD #524 stated she did not have an explanation of why a reweight was not done, and it did not look accurate because Resident #15 had been gradually losing weight. RD #524 verified she did not see this weight increase until 11/27/24 so a reweight would be obtained for Resident #15. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/24 at 8:29 A.M. with Registered Nurse (RN) #371 revealed the nurses gave a list of weights needed to the aides. Once the aides obtain the weights, they would give the list of completed weights back to the nurses who would put them in the computer. If there was a huge gap like five or ten pounds, RN #371 stated she would ask for a reweight. When reviewing Resident #15's weights, RN #371 confirmed the 28.1 pound (25%) weight increase from 11/04/24 to 11/22/24 should have been immediately reweighed. 35765 2. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, fracture of nasal bones, dementia, bipolar disorder, muscle weakness, hyperlipidemia, and hypothyroidism. Review of the Significant Change MDS 3.0 assessment dated [DATE] revealed Resident #31 had moderately impaired cognition, weighed 185 lbs and was not on a therapeutic diet. Review of the plan of care dated 07/14 24 revealed Resident #31 was at risk for altered nutrition related to medical diagnoses, nutrient-relevant medications, elevated body mas index, abnormal lab values, variable meal intakes, history of significant weight gain, and history of impaired skin integrity. Interventions included provide and serve diet as ordered, obtain and monitor lad work as needed, obtain weights as ordered, and administer medications as order Review of the physician's order dated 05/31/24 revealed Resident#31 had an order for regular diet with regular texture. She did not have any orders for supplements or nutritional interventions. Further review of the physician's orders revealed Resident #31 had an order for Mighty Shakes twice daily discontinued on 09/09/24. Review of the weights revealed on 06/27/24 Resident #31 weighed 166.0 lbs, on 07/01/24 weighed 182.4 lbs for a 16.4 pound weight gain without a follow up reweigh done until 07/06/24 for a weight of 181 lbs. Review of the Weight Change Note dated 09/09/24 at 10:20 A.M. revealed Resident #31 weighed 187.8 lbs with a Body Mass Index of 33.3 indicating she was obese for her height. Resident #31 had a significant weight gain of 12.4 percent in 90 days. Her weight gain was due to excellent oral intakes. She was on a regular diet with Mighty Shake twice daily. Her intake for supplements was excellent however the weight gain was not desirable and recommended discontinuing the Mighty Shakes and to continue to monitor nutritional parameters as needed. Further review of the weights revealed on 10/04/24 Resident #31 weighed 185.4 lbs then on 11/04/24 weighed 178.6 for a 6.8 pound weight loss in one month without a follow up reweigh done. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of October 2024 meal intakes revealed there were no meal intakes documented on 10/01/24 for breakfast and lunch, on 10/03/24 for breakfast, lunch and dinner, on 10/04/24 for dinner, on 10/05/24 for lunch, on 10/06/24 for breakfast and lunch, on 10/07/24 for dinner, on 10/10/24 for breakfast and lunch, on 10/12/24 for breakfast and lunch, on 10/14/24 for breakfast and lunch, on 10/15/24 for breakfast and lunch, on 10/17/24 for breakfast and lunch, on 10/18/24 for breakfast, on 10/20/24 for breakfast, lunch and dinner, on 10/22/24 for lunch and dinner, on 10/23/24 for breakfast and dinner, on 10/24/25 for breakfast, lunch, and dinner, on 10/25/24 for breakfast, lunch and dinner, on 10/27/24 for dinner, on 10/29/24 for dinner. Resident #31's meal intakes varied from 26 percent to 75 percent consumed. Review of November 2024 meal intakes revealed there were no meal intakes documented on 11/02/24 from breakfast lunch and dinner, on 11/07/24 for dinner, on 11/12/24 for dinner, on 11/13/24 for dinner, on 11/14/24 for dinner, on 11/16/24 for dinner, on 11/17/24 for dinner, ob 11/22/24 for dinner, on 11/25/24 for lunch, and on 11/26/24 for dinner. Resident #31 meal intakes varied from 26 percent to 75 percent consumed. On 11/27/24 at 10:17 A.M. an interview with RD #524 revealed she only came to the facility every couple weeks however she was able to review and document offsite. She stated the facility would email, text, or call her with any issues they would have with weights or diets. She stated she would email the DON if a resident needed reweigh. She stated the nurses put the weights onto the computer. She stated either her or the DON would monitor any weight loss. She stated the normal processes was for a five-pound or more weight loss they should be reweighed. She stated she had so much to do and so many admissions this week that she feels like she is drowning. She stated she has about 400 residents in seven buildings. She stated she was not even supposed to be at the facility today but they had her come today to be available for questions. She stated Resident#31 should have been reweighed on 11/04/24 for a 6.8 pound weight loss however she would not have implemented interventions or documented a monthly note because she did not trigger for a five percent weight loss in a month. She stated the 16 pound weight gain from July was due to her excellent meal intakes and verified she was not reweighed timely. Observation on 11/27/24 at 3:40 P.M. revealed Certified Nursing Assistant (CNA) #318 placed Resident #31 on the scale in her wheel chair and she weighed 241.0 lbs. CNA #318 stated they subtract the wheelchair weight which was written on a piece of tape on the back of the wheelchair. She stated her wheelchair weighed 69.4 lbs as verified by the piece of tape on the back of the wheelchair. She stated Resident #31 weighed 171.6 lbs. On 11/27/24 at 3:45 P.M. an interview with Assistant Director of Nursing #384 verified Resident #31 had lost more weight based on the weight of 171.6 lbs obtained by CNA #318. On 11/27/24 at 4:20 P.M. interview with RD #524 confirmed Resident #31 had another seven pound weight loss since 11/04/24 for a total of 13.8 lbs since 10/04/24. She verified there were several meal intakes from October and November not documented. She stated it was an ongoing problem at the facility and they were working on it. She verified the meal intakes were important and should be documented. She stated she just reviewed her weights and recommended her be placed on a nutritional supplement twice a day and have speech therapy evaluate her. (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	12/02/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled,Nutrition and Hydration, dated 06/09/17 revealed all residents would be reviewed at least quarterly by the facility dietician and more often as needed based on skin issues, changes in condition, change in intakes, weight concerns or other clinical changes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51074 Based on observation, interview and record review the facility failed to administer oxygen at the prescribed dose, failed to ensure oxygen in use signage was posted and oxygen tubing was dated and not lying on the floor. This affected one resident (#153) of four residents reviewed for respiratory care. The facility census was 55. Findings include: Review of the medical record revealed Resident #153 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, anxiety disorder, and dementia- unspecified severity without behavioral disturbance. Further review of the medical record revealed a physician order dated 11/19/24 for continuous oxygen at two liters per minute (2 LPM) via nasal cannula (NC). Observation on 11/25/24 at 8:58 A.M. of Resident #153 revealed a portable oxygen concentrator was lying on the resident's bed. The oxygen was being delivered at 3.5 LPM however the undated nasal cannula tubing was lying on the floor. There was no sign clearly displayed outside of the resident's room to indicate oxygen was in use. Interview on 11/26/24 at 7:49 A.M. with the Director of Nursing (DON) & Assistant Director of Nursing (ADON) #471 verified the resident's oxygen was being delivered at the incorrect liters per minute and should be delivered at 2 LPM via NC. Further interview verified the nasal cannula tubing was not dated to indicate when it was last changed, and no sign was visible to indicate oxygen was in use for Resident #153.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on medical record review, facility policy review, and interview, the facility failed to ensure residents on dialysis were assessed and monitored routinely. This affected one Resident (#154) of one reviewed for dialysis. The facility census was 55. Findings include: Review of the medical record for Resident #154 revealed an admitted [DATE] and diagnoses including diabetes mellitus, acute kidney failure, stage four chronic kidney disease, dependence on renal dialysis, and diabetic autonomic polyneuropathy. Review of Intermediate Care Plan dated 11/16/24 revealed Resident #154 was on dialysis with interventions including to monitor site for signs and symptoms of complications and complete labs as needed. Review of nurse progress note dated 11/16/24 revealed Resident #154 admitted to the facility with a dialysis port to her right upper chest. Review of dialysis communication forms dated 11/18/24, 11/20/24, 11/22/24, and 11/24/24 revealed pre and post dialysis weights, blood pressure, and pulse were recorded by the dialysis center. Review of physician's order dated 11/21/24 revealed Resident #154 had dialysis on Mondays, Wednesdays, and Fridays. Review of the physician's orders revealed no evidence of monitoring of Resident #154's dialysis site. Review of the electronic medical record and physical paper chart revealed there was no evidence of ongoing assessment or monitoring of Resident #154's dialysis site. Interview on 11/26/24 at 1:05 P.M. with the Assistant Director of Nursing (ADON) confirmed there was no ongoing assessment or monitoring of Resident #154's dialysis site completed by the facility. Review of the facility policy Dialysis Patients dated 05/23/17 revealed the facility would implement and maintain orders for central line care and other dialysis needs. \

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	365417	A. Building B. Wing	12/02/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 22653 Based on medical record review and interview, the facility failed to ensure pharmacy recommendations were fully addressed in an acceptable manner. This affected one (Resident #32) of five residents reviewed for medication use. The facility census was 55. Findings include: Review of Resident #32's medical record revealed diagnoses including bipolar disorder, dementia with behavioral disturbance, manic episodes, and schizophrenia. a. Review of Resident #32's physician orders revealed an order dated 11/30/22 for Restoril 30 milligrams (mg) one time a day for insomnia. Review of a pharmacy review dated 02/16/24 indicated Resident #32 had been receiving hypnotic therapy with Restoril 30 mg every night at bedtime for some time without a gradual dosage reduction (GDR). The pharmacist requested, in order to achieve the minimum effective dose, if an attempt could be made to reduce the Restoril to 22.5 mg every night at bedtime. If no GDR was warranted, the pharmacist requested the physician document in the medical record why a reduction might be detrimental to the residents mental or physical health. The first response documented on the form was Resident #32 was pending an evaluation by new psychiatric services. The second response indicated no change to the medication. The response lacked a rationale as to the reason a dose reduction was contraindicated. b. A pharmacist review dated 05/22/24 indicated Resident #32 had an order for Ativan 0.5 mg every four hours as needed for anxiety. The pharmacist addressed according to Centers for Medicare and Medicaid Services (CMS) regulations, anti-anxiety medications ordered on an as necessary basis were limited to 14 days. The pharmacist indicated, in order to extend the duration of an anti-anxiety medication ordered on an as-necessary basis, the prescriber was required to document a rationale in the medical record and indicate a specific period of time that the order could continue, before it must once again be re-evaluated. The pharmacist noted hospice residents were not exempt from the requirement. The physician response was that there were to be no changes made to the order. There was no rationale, no time limit or discontinuation of the order. Resident #32 had an order for Lorazepam 0.5 mg every four hours as needed for restlessness/anxiety dated 09/06/24. c. Resident #32 had a physician order dated 10/05/22 for Olanzapine (anti-psychotic) 5 mg at bedtime. On 09/13/24 an order was written adding Olanzapine 2.5 mg three times a day. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacist review dated 10/24/24 addressed the use of Olanzapine 2.5 mg three times a day and 5 mg every night at bedtime. If a dose reduction was not warranted, the physician was asked to add documentation to the medical record expressing why reducing the medication might not be clinically beneficial and might be detrimental to their psychological or physical well being. The physician response was not to make changes. No rationale was provided indicating why a dose reduction was not warranted. Interview on 11/26/24 at 4:18 P.M., with Registered Nurse (RN) #308 confirmed the pharmacy recommendations did not include a documented rationale indicating why GDR's were contraindicated for the Restoril and Olanzapine, she also confirmed the pharmacy recommendations did not fully address the recommendation regarding the Ativan which was ordered on an as necessary basis.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 22653 Based on medical record review and interview, the facility failed to ensure a resident receiving medications to treat diabetes mellitus had blood glucose levels monitored in accordance with orders to monitor effectiveness of medications. This affected one (Resident #1) of five residents reviewed for medications. The facility census was 55. Findings include: Review of Resident #1's medical record revealed diagnoses including diabetes mellitus, morbid obesity and intellectual disabilities. Resident #1 had an order for Metformin (a medication used to treat high blood glucose levels) 500 milligrams (mg) twice a day (start date 09/04/24), Trulicity (a medication used to treat high blood glucose levels) subcutaneous solution pen-injector 4.5 units subcutaneously every Friday (start date 09/06/24), and on 11/13/24 there were new orders to discontinue sliding scale insulin, Tresiba insulin 50 units every night at bedtime, Humalog insulin 26 units before meals, and glucometer check (blood glucose monitoring) every morning. Review of the care plan revealed Resident #1 had the potential for hypoglycemia/hyperglycemia related to the diagnosis of diabetes with interventions to obtain Accu check (blood glucose monitoring) as ordered and per nursing judgement. Review of the November 2024 Medication Administration Record (MAR) and blood glucose recordings revealed between 11/14/24 and 11/23/24 only one blood glucose level was recorded on 11/20/24. Interview on 11/27/24 at 4:42 P.M., with Licensed Practical Nurse (LPN) #384 verified Resident #1 had an order to check her blood glucose level every day, however the only blood glucose level recorded between 11/14/24 and 11/23/24 was one obtained on 11/20/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 22653 Based on medical record review and interview, the facility failed to ensure anti-anxiety medications ordered on an as necessary basis had time limits for use and failed to address why gradual dose reductions (GDR) of psychotropic medications were contraindicated. This affected one (Resident #32) of five residents reviewed for medication use. The facility census was 55. Findings include: Review of Resident #32's medical record revealed diagnoses including bipolar disorder, dementia with behavioral disturbance, manic episodes, and schizophrenia. a. Review of Resident #32's physician orders revealed an order dated 11/30/22 for Restoril 30 milligrams (mg) one time a day for insomnia. Review of a pharmacy review dated 02/16/24 indicated Resident #32 had been receiving hypnotic therapy with Restoril 30 mg every night at bedtime for some time without a gradual dosage reduction (GDR). The pharmacist requested, in order to achieve the minimum effective dose, if an attempt could be made to reduce the Restoril to 22.5 mg every night at bedtime. If no GDR was warranted, the pharmacist requested the physician document in the medical record why a reduction might be detrimental to the residents mental or physical health. The first response documented on the form was Resident #32 was pending an evaluation by new psychiatric services. The second response indicated no change to the medication. The response lacked a rationale as to the reason a dose reduction was contraindicated. b. A pharmacist review dated 05/22/24 indicated Resident #32 had an order for Ativan 0.5 mg every four hours as needed for anxiety. The pharmacist addressed according to Centers for Medicare and Medicaid Services (CMS) regulations, anti-anxiety medications ordered on an as necessary basis were limited to 14 days. The pharmacist indicated, in order to extend the duration of an anti-anxiety medication ordered on an as-necessary basis, the prescriber was required to document a rationale in the medical record and indicate a specific period of time that the order could continue, before it must once again be re-evaluated. The pharmacist noted hospice residents were not exempt from the requirement. The physician response was that there were to be no changes made to the order. There was no rationale, no time limit or discontinuation of the order. c. Resident #32 had a physician order dated 10/05/22 for Olanzapine (anti-psychotic) 5 mg at bedtime. On 09/13/24 an order was written adding Olanzapine 2.5 mg three times a day. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacist review dated 10/24/24 addressed the use of Olanzapine 2.5 mg three times a day and 5 mg every night at bedtime. If a dose reduction was not warranted, the physician was asked to add documentation to the medical record expressing why reducing the medication might not be clinically beneficial and might be detrimental to their psychological or physical well being. The physician response was not to make changes. No rationale was provided indicating why a dose reduction was not warranted. Interview on 11/26/24 at 4:18 P.M., with Registered Nurse (RN) #308 confirmed the pharmacy recommendations did not include a documented rationale indicating why GDR's were contraindicated for the Restoril and Olanzapine, she also confirmed the pharmacy recommendations did not fully address the recommendation regarding the Ativan which was ordered on an as necessary basis.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observations, interview, record review, and review of manufacturer information, the facility failed to ensure medications were administered in accordance with physician orders. Three errors were identified out of 30 opportunities for error resulting in a 10% medication error rate. This affected three (Residents #10, #20, and #152) of four residents observed for medication administration. The facility census was 55. Findings include: 1. Review of Resident #10's record revealed physician orders for Mucinex 600 mg to be administered twice a day. On 11/26/24 at 7:18 A.M., Licensed Practical Nurse (LPN) #328 was observed administering multiple medications, including Mucinex 400 milligrams (mg), to Resident #10. Interview on 11/26/24 at 7:43 A.M., with LPN #328 verified she had administered the incorrect dosage of Mucinex. 2. Review of Resident #152's record revealed physician orders for Humalog Insulin to be administered prior to meals and at bed time, per sliding scale (a dosage range based on the residents blood sugar level). On 11/26/24 at 10:28 A.M. between 10:28 A.M. and 10:33 A.M., Registered Nurse (RN) #381 was observed administering Humalog Insulin to Resident #152. RN #381 dialed the insulin pen to four units and administered it. The pen was not primed prior to administration. Interview on 11/26/24 at 11:35 A.M., with RN #381 verified she had not primed the pen/needle prior to administering the insulin. Review of manufacturer's information for Humalog Kwik pens revealed instructions to prime the pen before each injection. The information stated priming the pen meant removing the air from the needle and cartridge that might collect during normal use and also ensured the pen was working correctly. It further revealed if the pen was not primed prior to each injection, the resident might get too much or too little insulin. 35765 3. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, anxiety disorder, bilateral hip osteoarthritis, hypertension, and depression. Review of the November 2024 physician's orders revealed Resident #20 had on order for one tablet of Mucus Relief 600 milligrams (mg). (continued on next page)

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	365417	A. Building B. Wing	12/02/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of medication administration on 11/26/24 at 6:17 A.M. revealed Registered Nurse (RN) #351 gave one tablet of Mucus Relief 400 milligrams (mg) to Resident #20 from the facility's stock medications. On 11/26/24 at 7:50 A.M. an interview with Registered Nurse #351 verified she gave 400 mg of Mucus Relief and not the ordered 600 mg. She stated they did not have 600 mg in stock, only 400 mg, but she would let someone know so they could order the 600 mg dosage.

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	365417	A. Building B. Wing	12/02/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observation, review of medication manufacturer information, review of physician orders, policy review and interview, the facility failed to ensure multi-dose medication vials and pens were dated when opened, disposed of when expired, and stored at the appropriate temperature. This involved one of two medication carts observed for medication storage and affected Residents #33 and #252. Findings include: On [DATE] between 1:57 P.M. and 2:05 P.M., the following concerns were noted with medication storage. 1. Resident #33 had a plastic sleeve of insulin glargine insulin pens with one open and one sealed. The envelope had directions to refrigerate. At the time of the observation, Registered Nurse (RN) #320 verified the sealed insulin pen was stored at room temperature. Review of manufacturer information for insulin glargine revealed unopened insulin vials were to be stored in the refrigerator at a temperature of 36 to 46 degrees Fahrenheit. Resident #33 also had a pen of admelog insulin. The open date label read ,d+[DATE]. A full date was not recorded. At the time of the observation, RN #320 verified she was unable to verify the actual date the admelog was opened and stated Resident #33 did not have an order for admelog. The admelog was disposed of at that time. Review of manufacturer information for admelog revealed the pen was to be disposed of after the 28 th day. 2. Resident #252 had a vial of flonase in the medication cart. There was a label to indicate the open date which was blank. The delivery date was [DATE]. RN #320 verified there was no open date indicated on the label. Review of Resident #252's physician orders revealed no current order for flonase. Review of the facility's Storage of Medications policy (effective [DATE]) revealed all expired medication would be removed from the active supply and destroyed. The policy indicated when the original seal of a manufacturer's container or vial was initially broken, the container or vial would be dated.

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	365417	A. Building B. Wing	12/02/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, record review, and interview the facility failed to ensure meals were served at a palatable temperature. This had the potential to affect all 55 residents who received meals from the kitchen, as the facility identified zero residents who did not eat by mouth (NPO). The facility census was 55. Findings include: 1. Review of medical record for Resident #156 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, osteoarthritis, essential hypertension, bipolar, morbid obesity, chronic pain syndrome, anxiety disorder, heart failure, tremor, gout, and gastro-esophageal reflux disease without esophagitis. Review of Resident #156's physician orders revealed an order dated 11/07/24 for a regular diet regular texture thin liquid consistency diet. Review of Resident #156's admission Minimum Data Set (MDS) 3.0 assessment, dated 11/17/24, revealed the resident was cognitively intact, was independent for eating, had no significant weight changes, and was not on either a mechanically altered or therapeutic diet. Interview on 11/25/24 at 11:56 A.M. with Resident #156 revealed the food was cold for all meals. 2. Review of medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included type two diabetes, dementia, essential hypertension, and hyperlipidemia. Review of physician orders for Resident #42 revealed an order dated 06/07/24 for a Reduced Concentrated Sweets (RCS)/No Added Salt (NAS) mechanical soft texture thin liquids diet. Review of quarterly MDS 3.0 assessment, dated 11/08/24, revealed Resident #42 was moderately impaired cognitively and required setup and clean up assistance from staff for eating. The resident hadn't had any significant weight changes and was on a mechanically altered and therapeutic diet. Interview with Resident #42 on 11/25/24 at 12:24 P.M. revealed the food was not very good and the food was very, very cold. 3. Review of medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included lymphedema, sepsis, asthma, non pressure ulcer of left lower leg, osteoarthritis, chronic pain syndrome, and depression. Review of Resident #24's physician orders revealed an order dated 10/28/24 for a No Added Salt (NAS) Regular texture thin liquids consistency. Review of Resident #24's admission MDS 3.0 assessment, dated 11/04/24, revealed the resident was cognitively intact, independent for eating, had no significant weight changes, and received a therapeutic diet. (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	12/02/2024

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/25/24 at 2:27 P.M. with Resident #24 revealed food was terribly cold. 4. Review of medical record for Resident #154 revealed an admitted [DATE]. Diagnoses included chronic kidney disease stage four, essential hypertension, hyperlipidemia, diabetes mellitus, gastro-espophageal reflux disease without esophagitis, and congestive heart failure (CHF). Review of Resident #24's physician orders revealed an order dated 11/21/24 for No Added Salt (NAS) diet, regular texture, thin liquids consistency. No citrus, bananas, tomatoes, or tomato products. Review of Resident #154's five-day Medicare MDS 3.0 assessment, dated 11/22/24, revealed it was still in progress of being completed. Review of Resident #154 BIMS (Brief Interview for Mental Status) assessment, dated 11/17/24, revealed the resident was cognitively intact. Interview on 11/25/24 at 3:16 P.M. with Resident #154 revealed the food was cold no matter where one ate. 5. Review of the facility menu for lunch on 11/26/24 revealed ham, au gratin potatoes, brussel sprouts, and berry trifle was to be served. During tray line observations on 11/26/24 between 11:45 A.M. and 12:45 P.M. revealed all items were at a safe serving temperature prior to the tray line starting. At 12:45 P.M. a test tray was plated and placed on the bottom of the two tier service cart. The service cart was then wheeled out to the dining area where beverages were added to the meal trays on the service cart. The service cart, which had two room trays plus the test tray, was then taken at 12:48 P.M. to the D wing hall by Dietary Supervisor (DS) #378. The service cart arrived on the D wing at 12:50 P.M. and the first tray was delivered at 12:50 P.M. and the second and final meal tray was delivered at 12:51 P.M. The test tray was taken off the bottom of the service cart at 12:52 P.M. by DS #378 and placed on top of the two tier service cart. Using a calibrated facility thermometer, DS #378 temped the au gratin potatoes at 140 degrees Fahrenheit (F), the brussel sprouts at 115 degrees F, the ham at 120 degrees F, the berry trifle at 40 degrees F, and the coffee at 140 degrees F. A taste of the food items on the test tray revealed the au gratin potatoes were dry to texture, the [NAME] sprouts were tender but not hot, and the ham had good flavor but was not hot. There were no concerns with the roll, berry triffle or coffee palatability. DS #378 also tasted the test tray and stated the au gratin potatoes were dry and could be warmer, he refused to taste the [NAME] sprouts but stated with a temperature of 115 degrees F it would not be warm and tasted the ham and stated the ham had good flavor but was not warm. 6. Interview on 12/02/24 at 8:23 A.M. with Registered Nurse #371 revealed most of the complaints she heard from residents regarding the meals was the food was cold. 7. Review of the facility concern log from August 2024 through November 2024 revealed on 08/27/24 there was a concern regarding cold room trays. Review of facility policy Menu and Preferences, revised 05/05/22, did not address palatability of meals.

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	365417	A. Building B. Wing	12/02/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interviews, record reviews, and review of facility policy, the facility failed to ensure residents requiring a mechanically altered diet were served the appropriate diet consistency. This affected four residents (#12, #42, #153, and #202) of four residents reviewed for mechanically altered diets. The facility identified eight residents (#12, #16, #22, #25, #42, #152, #153, #202) as receiving mechanically altered diets. The facility census was 55. Findings include: 1. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE]. Diagnoses included dementia, hypertension, major depressive disorder, hyperlipidemia, anxiety disorder, osteoporosis, mood disorder, anxiety disorder, insomnia, and weakness. Review of the November 2024 physician's orders revealed Resident #12 had an order for NAS (No Added Salt), pureed texture diet with thin liquids dated 10/03/24. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/23/24, revealed Resident #12 had severely impaired cognition and was on a mechanically altered diet. Review of the menu for lunch on 11/26/24 revealed the meal would consisted of ham, au gratin potatoes, Brussel sprouts, roll, and berry trifle. Observation of tray line on 11/26/24 from 11:45 A.M. to 12:45 P.M. revealed at 11:59 A.M. Resident #12's plate had both puree ham and non-pureed au gratin potatoes. Review of Resident #12's meal ticket, which was sitting next to the plate on the shelf above the tray line, indicated she had chosen the main menu items and was on a NAS (No Added Salt) puree diet. The surveyor intervened as State tested Nursing Assistant (STNA) #317 took the plated items to the dining room to be served to the resident. STNA #317 confirmed at the time of observation the au gratin potatoes had not been pureed and returned to the kitchen to have the non-pureed au gratin potatoes replaced with puree au gratin potatoes. Interviews with Dietary [NAME] #353 or Assistant Dietary Manager #360 at the time of observation revealed they didn't have a spread sheet to indicate what each diet was allowed. Interview on 11/26/24 at 12:44 P.M. with Dietary Supervisor (DS) #378 confirmed there was no spreadsheet to identify what each diet was allowed and when asked why there wasn't a spread sheet he replied, I don't have an answer for that. Interview on 11/26/24 at 12:59 P.M. with Speech Language Pathologist (SLP) #525 revealed a puree consistency had a baby food consistency which was smooth with no residue. Review of facility policy Therapeutic Diets, undated, revealed therapeutic diets, which included an altered consistency diet, would match resident orders (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medial record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included diabetes, absence of toes, insomnia, dementia, hypertension, hypothyroidism, osteoarthritis, and weakness. Review of the November 2024 physician's orders revealed Resident #42 had an order for Reduced Concentrated Sugars (RCS) and No Added Salt (NAS), mechanical soft texture, and thin liquids. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #42 had moderately impaired cognition and received a mechanical altered diet. Observation of trayline on 11/26/24 from 11:45 A.M. to 12:45 A.M. revealed at 12:21 P.M. an intact hotdog in a hot dog bun had been placed on Resident #42's meal tray which contained a dietary slip indicating the resident had chosen a hot dog and was on a NAS diet mechanical soft diet consistency. Prior to the plate being taken to the dining room, the state surveyor intervened. Interview at time of observation with Dietary [NAME] #353 confirmed for a mechanical soft diet the hot dog should have been ground and proceeded to ground the hot dog for Resident #42 in the robo coupe (a commercial food processor) prior to the meal items being served to the resident. Interview on 11/26/24 at 12:59 P.M. with Speech Language Pathologist (SLP) #525 revealed for a mechanical soft diet almost all meat was ground except meat loaf and fish which could be cut up. She confirmed the hot dog should have been ground for mechanical soft diet and intact hot dogs being served to residents on a mechanical soft diet had been an issue with the facility in the past. Review of facility policy Therapeutic Diets, undated, revealed therapeutic diets, which included an altered consistency diet, would match resident orders 3. Review of the medical record revealed Resident #153 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, depression, anxiety disorder, fibromyalgia, osteoporosis, dementia, weakness, and gastro-esophageal reflux disease. Review of the November 2024 physician's orders revealed Resident #153 had an order for regular mechanical soft texture diet. Observation of tray line on 11/26/24 from 11:45 A.M. to 12:45 P.M. revealed at 12:25 P.M. two tacos, which consisted of taco meat on soft tortilla with diced tomatoes shredded cheddar cheese and cut up lettuce, which had been cut into small square pieces, was placed on Resident #153's meal tray, which had a dietary ticket which indicated the resident had chosen tacos for lunch and was on a mechanical soft diet. Prior to the tacos being served to the resident on a mechanical soft diet, the surveyor intervened with Dietary [NAME] #353 and Assistant Dietary Manager #360 confirming the lettuce was cut into small square pieces. Interviews with Dietary [NAME] #353 or Assistant Dietary Manager #360 at the time of observation revealed they didn't have a spread sheet to indicate what each diet was allowed, and they didn't know what a mechanical soft diet could have. Assistant Dietary Manager #360 proceeded to take the tacos and cut everything up in the tacos into very small bite size pieces with a knife, which was then served to the resident. Interview with Dietary Supervisor #378 on 11/26/24 at 12:44 P.M. confirmed there was no spreadsheet to identify what each diet was allowed and when asked why there wasn't a spread sheet he replied, I don't have an answer for that. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/26/24 at 12:59 P.M. with Speech Language Pathologist (SLP) #525 revealed for a resident receiving a soft taco, the soft shell, taco meat, diced tomatoes and shredded cheese were all appropriate for a resident on a mechanical soft diet, but the lettuce had to be shredded instead of cutting the lettuce into small square pieces. Review of facility policy Therapeutic Diets, undated, revealed therapeutic diets, which included an altered consistency diet, would match resident orders 4. Review of the medical record revealed Resident #202 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, kidney disease, Lewy Bodies disease, hypothyroidism, atrial fibrillation, pacemaker, cirrhosis, history of falls, subdural hemorrhage, anxiety disorder, depression, Alzheimer's disease, asthma, complex regional pain syndrome, congestive heart failure, diabetes, fibromyalgia, hypertension, and epilepsy. Review of the November 2024 physician's orders revealed Resident #202 had an order for no added salt (NAS), mechanical soft texture diet with nectar thick liquids dated 11/20/24. Review of the menu for lunch on 11/26/24 revealed the meal would consist of ham, au gratin potatoes, Brussel sprouts, roll, and berry trifle. Observation of tray line on 11/26/24 from 11:45 A.M. to 12:45 A.M. revealed on the steam table there was no ground ham. At 12:30 P.M. a plate containing a ham slice cut up with a knife by Dietary [NAME] #364, au gratin potatoes, brussel sprouts and a dinner roll had been placed on Resident #202's meal tray which contained a dietary slip indicating the resident had chosen the main menu items and was on a NAS diet mechanical soft diet consistency. Interview at time of observation with Dietary [NAME] #364 confirmed residents on a mechanical soft diet received ham cut up with a knife. Prior to the resident receiving the incorrect diet consistency, the state surveyor brought the intact ham to the attention of Dietary [NAME] #353, and Dietary [NAME] #353 took the ham and placed it into the robo coupe (commercial food processor) and ground the meat. Interviews conducted with Dietary Assistant Manager #360 and Dietary [NAME] #353 stated there were no spread sheets stating what each diet could have, and they were unsure what a mechanical soft consistency was allowed. Interview with Dietary Supervisor on 11/26/24 at 12:44 P.M. confirmed there was no spreadsheet to identify what each diet was allowed and when asked why there wasn't a spread sheet he replied, I don't have an answer for that. Interview on 11/26/24 at 12:59 P.M. with Speech Language Pathologist (SLP) #525 revealed for a mechanical soft diet almost all meat was to be ground except meatloaf and fish which could be cut up. Review of facility policy Therapeutic Diets, undated, revealed therapeutic diets, which included an altered consistency diet, would match resident orders. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation of the puree process and interviews on 11/26/24 between 10:45 A.M. and 10:56 A.M. with Dietary [NAME] #364 and Dietary Supervisor #378 revealed the cook was pureeing three portions of ham and was trying to achieve a smooth pudding consistency. When the cook stated she was done pureeing the ham, the state surveyor tasted the finished product. The product appeared dried and didn't have smooth consistency. Dietary [NAME] #364 stated she usually didn't test the puree, but when she tasted the ham she had just pureed, she had no concerns. She then took the product and placed it into a small square metal container for mealtime service. On 11/26/24 at 10:55 A.M. Dietary Supervisor #378 tasted the finished pureed ham product and confirmed the final product was not at a puree consistency and stated bits of ham stuck to his tongue. The puree ham product was then returned to the robo coupe (commercial food processor) and chicken broth was added and at 10:56 A.M. the final product was smooth and not dry and was at an appropriate puree consistency when tasted by the state surveyor. Interview on 11/26/24 at 12:59 P.M. with Speech Language Pathologist (SLP) #525 revealed a puree consistency had a baby food consistency, which was smooth with no residue. Review of facility policy Therapeutic Diets, undated, revealed therapeutic diets, which included an altered consistency diet, would match resident orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46195 Based on observation, interview, record review and review of facility policy the facility did not ensure food was stored, prepared and served under sanitary conditions. This had the potential to affect all 55 residents who received a meal from the kitchen, as the facility identified zero residents who did not eat by mouth (NPO). The facility census was 55. Findings include: 1. Observation of the kitchen on 11/25/24 between 8:15 A.M. and 8:47 A.M. with Dietary Supervisor (DS) #378 revealed the following concerns: Observation of the walk-in cooler revealed sitting on a top of a service cart in the cooler was a pan half-full of hamburger patties not labeled or dated, one pan that was three-fourth full of mash potatoes that had red and brown discoloration and were not labeled or dated, one pan of spaghetti sauce not labeled or dated, one pan of taco meat not labeled or dated, and one pan of carrots not dated or labeled. Observation of the walk-in freezer revealed there was one opened factory bag with 12 rectangular hashbrown patties which was open to air and undated, and one open and half-full factory bag of pizza crusts which was open to air and undated. The floor of the freezer had a buildup of debris which included one crescent shaped area of dried chocolate ice cream and multiple individual ice cream containers on the floor. Observation of the dry stock area revealed one opened bag of country style gravy mix which had been resealed with plastic wrap but was not dated when opened. Observation of the sandwich cooler revealed the base of the unit had a buildup of shredded orange cheese. Observation of the refrigerator/freezer combination unit revealed one plastic clear container that was half-full of pickles with a date of 11/15/24 and one clear, plastic, square storage container that was three-fourths full of parmesan cheese dated 11/02/24. There was One factory bag with two breaded fish patties open to air and undated, one-half full bag of potato wedges open to air and undated, one factory bag of tator tots open to air and undated, and one factory bag of breakfast sausage patties open to air and not dated. At the time of observation, DS #378 confirmed items should be dated when opened, should not be open to air, should be thrown out after seven days, and areas should be cleaned. Review of the facility policy Food Storage Cold, dated 08/01/17, revealed refrigerated food items would be stored properly, labeled, dated and arranged in a manner that will prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy Cleaning Schedules, revised 06/20/17, revealed the purpose of the policy was to ensure equipment, floor, etc. were cleaned on a regular basis in the dietary department. Review of facility policy Food Preparation, revised 06/20/17, revealed all foods that are to be held more than 24 hours will be labeled and dated with a prepared date (Day 1) and an use by date (day 7). 2. Review of the facility document Nutrition Services Quality Validation-Kitchen Sanitation completed by Registered Dietitian (RD) #524 revealed there have been multiple kitchen sanitation concerns and concerns with items being either outdated, undated, or not resealed after being opened with the kitchen consistently scoring below the desired goal of 90 percent (%) as evidenced by: The sanitation audit, dated May 2024, revealed a review of the sanitation of the cook's work area revealed out of 18 pieces of equipment only eight were considered acceptable in regards to cleanliness and when all the points were added up the facility had scored 89 points out of a 119 possible points for a sanitation score of 75% with the form indicating any score less than 90% would require an action plan and follow up review. The sanitation audit, dated June 2024, revealed a review of the sanitation of the cook's work area revealed out of 18 pieces of equipment only 10 were considered acceptable in regards to cleanliness and when all the points were added up the facility had scored 105 points out of a 128 possible points for a sanitation score of 82% with the form indicating any score less than 90% would require an action plan and follow up review. The sanitation audit, dated 07/24/24, revealed a review of the sanitation review of the sanitation of the cook's work area revealed out of 19 pieces of equipment only five were considered acceptable in regards to cleanliness and when all the points were added up the facility had scored 77 points out of a 132 possible points for a sanitation score of 58% with the form indicating any score less than 90% would require an action plan and follow up review. The sanitation audit, dated August 2024, revealed a review of the sanitation review of the sanitation of the cook's work area revealed out of 18 pieces of equipment only eight were considered acceptable in regard to cleanliness. Sausage patties, meatballs, diced ham, and sliced salami were either not dated, not covered, or not labeled. It was also noted that moldy outdated hotdogs and pasta were in the reach-in cooler. When all the points were added up the facility had scored 89 points out of 129 possible points for a sanitation score of 69% with the form indicating any score less than 90% would require an action plan and follow-up review. The sanitation audit, dated 09/27/24, revealed a review of the sanitation review of the sanitation of the cook's work area revealed out of 19 pieces of equipment only eight were considered acceptable in regard to cleanliness. In the walk-in cooler, it was noted there were open pizza crusts and, in the reach-in cooler multiple open and undated food items. It was also noted that the entire kitchen needed a good cleaning. When all the points were added up, the facility had scored 82 points out of 130 possible points for a sanitation score of 63% with the form indicating any score less than 90% would require an action plan and follow-up review. (continued on next page)

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	365417	A. Building B. Wing	12/02/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The sanitation audit, dated 10/18/24, revealed a review of the sanitation review of the sanitation of the cook's work area revealed out of 19 pieces of equipment only six were considered acceptable in regard to cleanliness. In the walk-in cooler, it was noted there were open pie crusts. When all the points were added up, the facility had scored 78 points out of 129 possible points for a sanitation score of 60% with the form indicating any score less than 90% would require an action plan and follow up review. The sanitation audit, dated 11/21/24, revealed the sanitation review of the cook's work area revealed out of 17 pieces of equipment 12 were considered acceptable in regard to cleanliness. In the walk-in cooler, it was noted there were frozen beef patties not resealed or dated. When all the points were added up, the facility had scored 99 points out of 123 possible points for a sanitation score of 80% with the form indicating any score less than 90% would require an action plan and follow up review. Interview on 11/27/24 at 10:17 A.M. with RD #524 confirmed she completed sanitation audits once a month and she had concerns with cleanliness, items being resealed and being dated after being opened. Review of facility policy Food Storage Cold, dated 08/01/17, revealed refrigerated food items would be stored properly, labeled, dated and arranged in a manner that will prevent cross contamination. Review of facility policy Cleaning Schedules, revised 06/20/17, revealed the purpose of the policy was to ensure equipment, floor, etc. are cleaned on a regular basis in the dietary department. 3. Observation of the dish machine during the initial facility tour on 11/25/24 from 8:15 A.M. to 8:47 A.M. with DS #378 revealed the facility had a high temperature dish machine with two temperature gauges: one for the wash and one for the rinse. Factory Posting on the dish machine revealed the minimum temperature for washing should be 150 degrees Fahrenheit (F) and the minimum temperature for rinsing to meet sanitizing levels was 180 degrees F. Dishes were observed being run through the dish machine and were being put away once dried. Observation of the dish machine on 11/25/24 at 9:40 A.M. to 9:44 A.M. with DS #378 revealed the dish machine had met the minimum temperature requirement for washing with the wash gauge reading 154 degrees F but had not met the minimum temperature requirement of 180 degrees F for the rinse with the rinse gauge reading 150 degrees F. At the time of observation, DS #378 confirmed the dish machine had not met the recommended minimum temperature of 180 degrees F for sanitation and wanted to run the dishwasher again. DS #378 ran the dish machine through the wash cycle and rinse cycle two more times and the temperature did not exceed 150 degrees F for the rinse. DS #378 stated he would have the dish machine serviced and check with his boss on how to proceed. No resident food was being served off the facility dishes at the time of the observation. Review of the temperature log for the dish machine for November 2024 revealed there were three columns (one for wash temperature, one for rinse temperature, and one for sanitizing rinse) for the staff to fill out three times a day. At the top of the wash column, it was indicated 150 degrees F was the minimum, for the rinse column 160 degrees F was the minimum, and for the final rinse the minimum was 180 degrees F. According to the dish machine log, the final rinse had been meeting the minimum requirement of 180 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility document Nutrition Services Quality Validation-Kitchen Sanitation, dated 11/21/24 and authored by RD #524, revealed when the sanitation audit had been completed the dish machine had a wash temperature of 160 degrees F and rinse temperature of 180 degrees F which met the recommended levels of 150 degrees F for washing and 180 degrees F for rinsing. Review of email from Innoserv (a repair company), dated 11/26/24, confirmed the dish machine was down because the heating element part #13417.92 was faulty. A new heating element had been ordered urgently, was shipped on 11/25/24, and they were waiting for the part to arrive. Review of service report from Innoserv, dated 11/26/24, revealed the dish machine had been fixed. Interview on 11/25/24 at 9:10 A.M. with DS #378 and the Administrator revealed the facility would implement the use of disposable dishware until the dish machine issue was resolved. Observation of disposable products being used for breakfast and interview on 11/26/24 8:02 A.M. with DS #378 confirmed the repair company was out yesterday and the heating element for the dish machine was bad, and a new one would be installed today and confirmed the facility was still using disposable ware until it could be replaced. Observation of residents still eating breakfast confirmed plastic ware was still being used along with disposable beverage cups. Interview on 11/26/24 at 8:46 A.M. with Dietary Aide #314 who had filled out the temperatures for the dish machine that morning revealed she recorded the temperature of the wash gauge for the wash temperature and the temperature of the rinse gauge for the rinse column and for the sanitizing rinse column she always just marked 180. Review of the facility policy Dishwasher Temperature, revised 06/20/17, revealed the purpose of the policy was to establish a procedure to ensure the dishwasher was maintaining the proper temperatures. On a daily basis at least three times a day the temperature of the water shall be recorded and if the temperature fell below the proper temperature of 180 degrees or above Fahrenheit for the rinse and 150-160 degrees for the wash cycle it shall not be used and dishes would need to be washed and rinsed manually and/or proper disposable products would be used until the dishwasher met the proper temperatures. 4. Observation of the puree process on 11/26/24 from 10:45 A.M. to 10:59 A.M. with Dietary [NAME] #364 revealed after she was done pureeing up the ham, she took the parts of the robo coupe (commercial processor) and took them to an empty three compartment sink where she poured blue dish soap on stainless steel scrubber and proceeded to wash the parts. She then turned the faucet spigot on and rinsed the items in the second compartment and then placed the items in the bottom of the third compartment of the sink. She then tuned on the hose connected to the sanitizer in the third compartment of the sink and briefly rinsed the items off and put the items on a drying rack. At the time of observation, Dietary [NAME] #364 confirmed she had briefly rinsed the items off with sanitizing solution from the hose prior to placing the items in the drying rack and had not submerged the items in a sanitizer solution. Review of the undated facility procedure Three Sink Washing and Sanitizing posted above the three-compartment sink revealed to ensure sanitization the third compartment should be filled with water and the sanitizer. After items were washed and then rinsed, the items were to be submerged into the sanitizer sink for at least one minute.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46195 Based on observation, interviews, review of the facility kitchen sanitation audits and facility policy review, the facility failed to ensure the dumpster area was maintained in a clean and sanitary manner. This had the potential to affect all residents residing in the facility. The facility census was 55. Findings include: Observation of the dumpster area on 11/26/24 at 11:09 A.M. with Dietary Supervisor #378 revealed there was a buildup of debris around the base of the two dumpsters which included one Styrofoam plate, one empty box of oatmeal cream pies, multiple blue surgical gloves, two large clear fast food plastic cups, one white carafe lid, a plastic shopping bag, several plastic drinking straws, numerous plastic utensils, two small plastic drinking cups and a medicine cup. At the time of observation Dietary Supervisor #378 confirmed the debris around the dumpsters. Review of the facility document Nutrition Services Quality Validation-Kitchen Sanitation, dated 09/27/24 and authored by Dietitian #524, revealed the area was unacceptable with trash around and behind the dumpster. Interview on 11/27/24 at 10:17 A.M. with Dietitian #524 confirmed she conducted a sanitation audit in the facility kitchen monthly, and there were a lot of cleanliness concerns. Review of the untitled facility policy, dated 08/17/19, revealed trash would not be deposited on the ground for any reason.

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	12/02/2024

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 46195 Based on interview and review of the facility arbitration agreement, the facility failed to ensure the arbitration agreement allowed for a mutually agreeable arbitrator and venue. This affected all residents residing in the facility. The facility was census was 55. Findings include: Review of the facility arbitration agreement, undated, revealed the matter shall be resolved by binding arbitration administered by the National Arbitration Forum (NAF), under their rules and procedures. If the NAF process was no longer in existence at the time of the dispute, or NAF was unwilling or unable to conduct the arbitration, then the parties shall mutually agree on an alternative organization to conduct the arbitration. The agreement did not identify in what venue the arbitration would occur. Interview on 11/26/24 at 9:53 A.M. with [NAME] President (VP) of Operations #521 and Corporate Marketing #522 revealed during the admission process residents were presented the arbitration agreement by either the marketing director, administrator, social services, or the wellness director, who have been trained to go over the entire admissions agreement, which included the arbitration agreement. Subsequent interview on 11/27/24 at 8:34 A.M. with VP of Operations #521 and Corporate Marketing #522 confirmed the arbitration agreement had clearly stated who the facility had chosen as the arbitrator and had not indicated the selection of the venue would be convenient for both parties. They were unaware that the venue and arbitrators must be mutually agreed upon by the resident or resident representative and the facility. They confirmed the agreement had not given the resident or resident representative a choice in who would conduct the arbitration and where the arbitration would take place. Subsequent interview on 11/27/24 at 10:53 A.M. with VP of Operations #521 and Corporate Marking #522 revealed the facility did not have a policy on arbitration agreements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observations, review of the medical record, interviews with staff, and review of facility policy, the facility failed to ensure proper hand hygiene was maintained while distributing meal tray on the unit, failed to ensure proper handling of linens in the laundry room, failed to ensure the nasal cannula was stored in a protective barrier when not in use for Resident #7, failed to utilize Enhanced Barrier Precautions (EBP) for Resident #253 while receiving an intravenous medication through a peripherally inserted central catheter, and failed to maintain proper infection control measures during wound care for resident Resident #21. This affected six residents (Resident #30, #32 #44, #156, #157, and #202) of 23 residents who received their meals in their rooms, had the potential to affect all 55 residents in the facility who used the facility's laundry, affected one resident (Resident #7) of four residents reviewed for respiratory services, and affected one resident (Resident #21) of two reviewed for wounds. The facility census was 55. Findings included: 1. Dining observation of room trays on 11/25/24 at 11:55 A.M. to 12:05 P.M. revealed State tested Nursing Assistant (STNA) #347 started to distribute meal trays out on the unit. She took a meal tray into the room of Resident #156 and set the meal tray down on the bedside table. STNA #347 exited out of the room into the hallway and retrieved another tray off the meal cart without washing her hands. She proceeded to take the meal tray into the room of Resident #157 where she touched her over-the-bed table, removed two remote controls from the table, assisted the resident to sitting on the side of the bed, touched the bed control, and raised the bed up. STNA #347 exited the room into the hallway and picked up a meal tray from the meal cart without washing her hands. STNA #347 proceeded to take the meal tray into the room of Resident #32 and moved the remote control from the over-the-bed table and touched the over-the-bed table before placing the meal tray on the table. STNA #347 exited the room into the hallway without washing her hands. STNA #347 picked up another meal tray from the meal cart and took it into the room of Resident #44, she placed the tray on the over-the-bed and moved it in front of the resident in bed. She then touched the bed control to raise the head of his bed. STNA #347 exited the room without washing her hands and retrieved another meal tray from the meal cart and took it into the room of Resident #202. She moved personal items from the over-the-bed table before place the tray on the table. She placed two pillow behind Resident #202's back and then touched the bed control to roll her up in bed. She picked her dinner roll up off the plate with her bare hands, buttered it, and placed it back down on her plate. STNA #347 exited the room without washing her hands and retrieved the last meal tray on the meal cart and took it into the room of Resident #30 and placed it on her over-the-bed table. On 11/15/24 at 12:05 P.M. an interview with STNA #347 confirmed she had not washed her hands while passing out meals trays on the unit. Review of the facility policy titled, Handwashing, dated 12/07/22 revealed handwashing was the simplest, easiest, most economical way to prevent the spread of infections employees would at minimum wash their hands before, during and after handling food and beverages,after handling potential contaminated objects, after touching clothing or equipment, and after each resident contact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation of laundry on 12/02/24 at 10:00 A.M. with Housekeeping Supervisor #361 revealed there was a pile of soiled bed pads and linens on the floor in front of the last washing machine lying directly on the floor. Housekeeping Supervisor #361 verified the linens were lying directly on the floor without a protective barrier down first. She stated the plastic bag they were in broke and she was just waiting for the the washing machine to finish with the load it was on to put them into the washing machine. On 12/02/24 at 10:36 A.M. an interview with the Administrator revealed the facility did not have a laundry service or handling of linens in the laundry policy. 3. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes, vascular dementia, hydrocephalus, chronic kidney disease, chronic respiratory failure, adjustment disorder, generalized anxiety disorder and atrial fibrillation. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #7 had severely impaired cognition. Observation on 11/25/24 at 9:38 A.M. revealed Resident #7 was sitting up in the tilt-in-space wheelchair. She had her noninvasive ventilator on. She had a portable oxygen tank on the back of her tilt-in-space wheelchair. The nasal cannula for the portable oxygen was lying across the back of the wheelchair not in a protective barrier bag. On 11/25/24 at 9:45 A.M., an interview with Registered Nurse #320 confirmed the nasal cannula for Resident #7 was not stored properly while not in use. Review of the facility policy titled, Oxygen Therapy, dated 08/07/14 revealed the purpose was to administer oxygen in condition in which insufficient oxygen was present to provide adequate tissue perfusion. 22653 4. On 11/26/24 at 1:18 P.M., Licensed Practical Nurse (LPN) #328 was observed administering an antibiotic (ampicillin/sulbactam sodium 3 grams) intravenously (IV) through Resident #253's peripherally inserted central catheter line (PICC) (a long, thin tube that's inserted through a vein into a person's arm and passed through to the larger veins near his/her heart. Very rarely, the PICC line may be placed in the leg). LPN #328 wore gloves but no other personal protective equipment. Review of Resident #253's physician orders revealed on 11/25/24 Enhanced Barrier Precautions (EBP) were ordered. At 1:20 P.M., LPN #328 verified she had not worn a gown per EBP protocol, stating she was associating the EBP with the foot wound but did not associate the need for use of a gown with administration of the IV via a PICC line. LPN #328 stated after thinking about it, use of the gown made sense. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Enhanced Barrier Precautions policy (not dated) revealed EBP was an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes. EBP involved gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organism (MDRO) as well as those at increased risk of MDRO acquisition. High-contact resident activities included device care or use of indwelling medical devices such as central lines. Care and use of indwelling medical devices would mean any dressing changes, injecting or infusing medication or tube feedings on the indwelling medical devices. 51074 5. Review of medical record for Resident #21 revealed an admitted [DATE]. Diagnoses include pressure ulcer, pressure ulcer of sacrum region, spinal stenosis, thoracic region, colostomy, anemia, nicotine dependence, paraplegia, other psychoactive substance use unspecified in remission, unspecified intracranial injury with loss of consciousness, depression, psychoactive substance abuse, transient ischemic attack, cerebral infarction, neuromuscular dysfunction of the bladder, thrombocytopenia, hypotension, depression and gastroesophageal reflux disease. Review of Plan of Care intervention dated 10/08/24 revealed to apply treatment to area as ordered. Review of Minimum data set (MDS) dated [DATE] revealed Resident #21 had intact cognition, had unhealed pressure ulcers/injury and was at risk for pressure ulcers/injuries. Observation on 11/27/24 at 10:55 A.M. of wound care for pressure ulcer treatment provided by Staff #320 for Resident #21 revealed Staff #320 did not clean over the bed table with disinfectant prior to placing supplies on the table. Bath towel used as barrier, dressing supplies opened and placed on the barrier. Foam (2x 2) dressing on left hip is dated 11/22/24. The dressing was removed from sacrum and left hip then placed in a trash bag. Hand hygiene performed. Wound cleansed with wound wash solution and gauze then gloves removed. No hand hygiene performed. Applied gloves. Silver alginate 4x 5 dressing cut with scissors into spiral shape and used to pack the wound, then area covered with foam dressing (6x 6). Abdominal (ABD) placed over foam dressing and secured with tape. Interview on 11/27/24 at 11:15 A.M. with Staff #320 verified over the bed table was not disinfected prior to use and hand hygiene was not performed after cleansing wound. Review on 11/27/24 at 11:25 A.M. of Policy Hand Washing, infection control written/revised 12/07/22 revealed (c) during dressing changes or performing of treatments when moving from clean to dirty tasks. This deficiency is a recite to the complaint survey completed 10/24/24.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35765 Based on review of the medical record, interview with staff, information from the Pneumonia (Pneumo) Recommendations (Rec) Vaccinations (Vax) Advisor application, and policy review, the facility failed to ensure pneumonia vaccine were up-to-date for Resident #7 and #30. This affected two residents (Resident #7 and #30) of five reviewed for vaccination status. The facility census was 55. Findings included: 1. Review of the Consent to Administer Pneumonia Vaccine form dated 12/17/21 revealed Resident#7 had received the pneumococcal vaccine according to the recommended schedule Review of the Immunization record in the resident's chart revealed Resident #7 received the PPSV23 vaccine on 12/17/21. There was no documentation she received the PCV15, PCV20 or PCV21. Review of the Pneumonia Recs Vax Advisor application revealed it was recommended to give Resident #7 one dose of PCV15, PCV20 or PCV21 at least one year after the last dose of PPSV23. This was never given. On 11/27/24 at 3:10 P.M., an interview with Infection Preventionist #356 verified Resident #7 was not up to date on her vaccine however, she was not aware she needed another one. 2. Review of the Consent to Administer Pneumonia Vaccine form dated 08/17/24 revealed Resident #30 had received the PPSV23 pneumococcal vaccine. Review of the Immunization record in the resident's chart revealed Resident #30 received the PPSV23 vaccine on 06/03/19. There was no documentation she received the PCV15, PCV20 or PCV21. Review of the Pneumonia Rec Vax Advisor application revealed it was recommended to give Resident #30 one dose of PCV15, PCV20 or PCV21at least one year after the last dose of PPSV23. This was never given. On 11/27/24 at 4:01 P.M., an interview with Infection Preventionist #356 verified Resident #30 was not up to date on her vaccine. Review of the facility policy titled, Influenza and Pneumococcal Vaccine Policy, date 01/20/20 revealed the purpose was to provide guidelines and indication for influenza and pneumonia vaccinations. It was noted that the Center for Disease Control (CDC) recommends adults 65 and older receive the pneumococcal vaccine. All newly admitted residents would be assessed for their pneumococcal vaccine status on admission. Residents without proof of previous pneumococcal vaccination should receive one dose of pneumonia vaccine per CDC guidelines if consent and physician orders are obtained.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 22653 Based on observations and interviews, the facility failed to maintain a safe environment in good repair. This affected three residents (#7, #48 and #160) of 55 residents observed for physical environment. The facility census was 55. Findings include: 1. On 11/25/24 at 2:23 P.M., Resident #160 stated he had taken a shower in the bathroom adjoining his room when water soaked the bathroom floor and went out into his room and under his bed. Resident #160 stated he was told he needed a longer shower curtain, but he had not received one. The bottom of the shower curtain was approximately six inches from the floor. There was no lip on the shower floor to hold the water. During environmental observations with the Director of Nursing (DON) on 11/26/24 beginning at 1:46 P.M., the DON acknowledged Resident #160's shower curtain did not reach the floor. 2. During the environmental observations with the DON on 11/26/24 beginning at 1:46 P.M., the DON verified there were gouges and/or missing pieces to the walls in Residents #7 and #48's rooms. The DON was unaware if maintenance had been informed of the areas but could find out. No additional information was provided.