STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365642	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Ret Center I I I	925 E 26th St Ashtabula, OH 44004

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to maintain accurate and thorough documentation for Resident #2's wound assessments in the medical record. This affected one resident (#2) out of two residents reviewed for medical record accuracy with wounds documentation. The facility census was 72.Findings include: Review of the medical record for Resident #2 revealed an admission date of 09/30/20 and his diagnoses included quadriplegia, muscle weakness, contractures, and abnormal posture. Review of care plan dated 04/11/25 revealed Resident #2 had pressure ulcers to his left ischium (region of hip bone) and right buttock. Interventions included scheduling wound clinic appointments, and treatment as ordered. There was nothing in the care plan regarding assessing or documenting his wounds at least weekly. Review of Weekly Wound Assessments in the medical record for Resident #2 revealed an assessment was completed 12/03/25, 12/10/25, 12/18/25, 12/26/25 and 01/14/26. There was no documentation a weekly wound assessment was completed from 12/26/25 to 01/14/26 (18 days) and from 01/14/26 to 02/03/26 (19 days) while seen at an outside wound clinic. Review of Wound Progress Note dated 12/16/25 completed by Wound Nurse Practitioner (WNP) #902 revealed Resident #2 was seen and his wounds were assessed. He continued to have left and right ischium pressure ulcers that were both classified as Stage 4 (full-thickness skin and tissue loss, exposing underlying tissue, muscle, tendon, ligament, cartilage or bone). Review of Weekly Wound Tracking Log dated from 12/19/25 to 01/28/26 revealed a log that contained multiple residents and for each resident it identified the following in regards to their wound: date of discovery; if the wound was in house acquired or not; stage of the wound; wound location; measurements; if the wound was improving or declining; and treatment orders and/or comments. The logs contained weekly documentation regarding Resident #2's pressure wounds to both his right and left ischium. Review of After Visit Summary dated 02/03/26 completed by WNP #901 revealed Resident #2 was seen in an outside wound clinic and his pressure ulcers to his left and right ischium were assessed and measured. Both wounds continued to be classified as Stage 4. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had intact cognition. He had impairment of both his upper and lower extremities. He was totally dependent on staff assistance with his activities of daily living (ADL) including turning left and right, transfers, toileting, hygiene, and showers. He had two Stage 4 pressure ulcers that were not present on admission. Observation of wound care on 02/11/26 at 11:25 A.M. completed by Program Nurse/Licensed Practical Nurse (LPN) #209, LPN #238, and Certified Nursing Assistant (CNA) #259 revealed Resident #2 had two Stage 4 pressure ulcers to his right and left ischium areas. Interview on 02/11/26 at 11:30 A.M. with Resident #2 revealed he used to go weekly to an outside wound clinic and see WNP #902, but she had retired so he was unable to see her any longer. He recently started going to another outside wound clinic and was seen by WNP #901 on 02/03/26.Interview on 02/12/26 at 6:45 A.M. with Program Nurse/LPN #209 revealed she followed the wounds at (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. She verified Resident #2 was seen at an outside wound clinic weekly by WNP #902, but she was unable to see Resident #2 any longer. The last time Resident #2 saw WNP #902 was on 12/16/25. The facility was able to get Resident #2 into another outside wound clinic and he was seen by WNP #901 for his initial visit on 02/03/26. She verified that from 12/26/25 to 01/14/26 (18 days) and from 01/14/26 to 02/03/26 (19 days) there were no wound assessments in his medical record, and that wound assessments were to be completed at least weekly. She stated since the former Assistant Director of Nursing (ADON) #304 had left (10/29/25), she has had a hard time completing everything that now became her responsibility including wounds. She stated, I am one person cannot get to them, and it is a lot so yes measurements for him did not get done. Interview on 02/12/26 at 7:59 A.M. with Program Nurse/LPN #209 revealed she brought in weekly wound logs that she stated she submitted on a weekly basis to the facility corporate office and that Resident #2's measurements were on the log. She had forgotten she had assessed Resident #2's wounds weekly including measurements of the wounds and placed the information on the log. She verified the wound assessments were not documented into Resident #2's medical record and that the wound log was not part of his medical record as it contained multiple residents on the log. She revealed she did not have time to document his weekly wound assessments into his medical record. Review of facility policy labeled, Documentation of Wound dated 06/25/21 revealed wound assessments were documented upon admission, every seven days, and as needed if a resident or wound condition deteriorates. The following elements were documented as part of a complete wound assessment: type of wound, stage of wound, measurements, and description of wound. This deficiency represents non-compliance investigated under Complaint Number 2673147.