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	05/09/2024

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on interview, record review and policy review, the facility failed to implement the abuse policy and procedure after receipt of an allegation of abuse for Resident #52. This affected one resident (Resident #52) of one reviewed for abuse and had the potential to affect all 68 residents residing in the facility. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type 2, need for assistance with personal care and neuromuscular dysfunction of bladder. The quarterly Minimum Data Set (MDS) assessment completed 04/08/24 indicated Resident #52 had moderate cognitive impairment. Review of Resident #52's nursing progress note by Licensed Practical Nurse (LPN) #211 dated 03/01/24 at 5:13 P.M. revealed staff reported Resident #52's spouse smacked her in the face, so the two were separated for the night. Interview on 05/07/24 at 9:38 A.M. with Resident #52 and Resident #52's spouse revealed the spouse lived in the adjoining assisted living facility and visited Resident #52 daily and usually all day long. The two had arguments but the spouse denied ever laying a hand on Resident #52 or details of the incident on 03/01/24. Resident #52 was unable to recall the incident on 03/01/24. Interview on 05/08/24 at 8:13 A.M. with Registered Nurse (RN) #258 stated Resident #52's spouse visited daily from the adjoining facility and were known to fight with each other frequently. There were times when staff had to separate them but denied knowledge of the 03/01/24 incident. Interview on 05/09/24 at 7:26 A.M. with LPN #211 confirmed on 03/01/24, another staff member who LPN #211 could not remember the name, reported an incident had occurred in the adjoining assisted living facility dining room area. Both Resident #52 and the spouse were visiting each other in the adjoining facility dining room when staff reportedly saw the spouse slap Resident #52 across the face, then Resident #52 supposedly tried to throw a bowl back at him. LPN #211 denied reporting the incident to the facility's Administrator or any other staff member because she assumed the adjoining facility's staff took care of it. However, LPN #211 stated she made sure the two stayed separated for the night on 03/01/24. (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/09/24 at 9:22 A.M. with Administrator confirmed no knowledge of the incident on 03/01/24 with Resident #52 and verified an abuse investigation was not completed due to the lack of staff reporting it to Administrator. Interview on 05/09/24 at 3:54 P.M. with Administrator and Assistant Director of Nursing (ADON) #232 revealed ADON #232 was present in the facility on 03/01/24, received a report of the incident from the adjoining assisted living facility's staff member, Hospitality Companion Aide (HCA) #292 so ADON #232 completed a facility incident report. This incident report was provided to the surveyor with a facility copy of Self-Reported Incident (SRI) instructions on abuse. A marking was made on the instruction sheet to highlight Examples from CMS (Centers for Medicare & Medicaid Services) of issues that do not need reported: Resident to resident altercations that do not result in physical injury, mental anguish, and/or pain. Review of the facility incident report dated 03/01/24 at 6:00 P.M. which was provided by ADON #232 indicated an incident occurred in the location of the apartment dining room (of the adjoining assisted living facility) which involved Resident #52 and Resident #52's husband (who lived in the adjoining assisted living facility). The incident report indicated an apartment aide (from the adjoining facility) reported Resident #52's husband smacked Resident #52 in the back of the head after Resident #52 threw a bowel of food at him. A skin assessment of Resident #52 resulted in no injury. Resident #52 stated the husband was following girls and fooling around, so she got mad and he got mad. As part of the incident report a nurse progress note which was obtained from the adjoining assisted living facility's medical record for Resident #52's spouse. It was dated 03/01/24 at 5:06 P.M., authored by LPN #293, a nurse employed by the adjoining facility, and indicated a companion aide reported Resident #52's spouse was physically fighting with Resident #52. The spouse hit Resident #52, who then attempted to hit back with a bowl from dinner. The incident report further recorded the two were separated and the spouse was instructed not to visit Resident #52 until the next day. There was also a history of arguments between the two. Continued interview on 05/09/24 at 3:54 P.M. with Administrator and ADON #232 confirmed ADON #232 did not report the incident to Administrator as required for abuse prevention. ADON #232 indicated a belief the incident was resident to resident despite the fact the spouse did not live in the same facility as Resident #52. The Administrator conferred and stated that although the two individuals lived in separate facilities, the two facilities were adjoined so staff responded to the incident as if it was one facility and being resident to resident. Review of facility policy, Abuse, revised 01/31/20 revealed staff should report all incident/allegations immediately to the Administrator or designee per regulations. The Administrator should be notified by informing him/her in person, calling via telephone, or sending an email or text message. The Administrator or designee will notify the survey agency of all alleged violations involving mistreatment, neglect, abuse, exploitation, misappropriation of resident property and injuries of unknown source as soon as possible but no later than 24 hours from the time the incident/allegation was made known to the staff member. If a third party (including family members) have abused, exploited, mistreated, neglected, or misappropriated property from a resident, the Administrator will determine an appropriate response up and including notifying the appropriate legal authorities and permanently banning the individual from the premises.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review, the facility failed to provide individualized and sufficient care to manage edema for Resident #24. This affected one resident (#24) of one resident reviewed for edema. The facility census was 68. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type 2, congestive heart failure, chronic severe kidney disease and essential primary hypertension. Review of the progress note for admitted d 01/03/24 revealed Resident #24 had edema at a grade of plus two pitting in both ankles and feet. Review of the Admission and Medicare 5-day MDS (Minimum Data Set) assessment completed 01/10/24 indicated no cognitive impairment. The plan of care initiated on 01/18/24 revealed cardiac impairment and potential for fluid volume excess. Interventions included observing edema and reporting to physician as needed. Review of the physician orders, medication administration record (MAR), treatment administration record (TAR) and nursing progress notes for January 2024 to February 2024 revealed there was an order for Bumex (a diuretic) 1 milligram (mg) daily for edema which started 11/15/23 (during a previous facility admission) which was discontinued on 01/03/24 at the time of the current facility admission. There was no additional evidence for the care, monitoring and management of Resident #24's edema after admission. Review of the physician progress note dated 03/09/24 revealed the physician examined Resident #24 who complained of chronic pitting leg edema. The physician documented will use loop diuretics with monitoring renal profile. The leg (specific location(s) not described) had edema at a grade of plus three pitting. Review of the physician orders, MAR, TAR, and nursing progress notes from March 2024 to April 2024 revealed on 03/09/24 spironolactone (a diuretic) was ordered and administered for two days. There was no additional evidence for the care, monitoring and management of Resident #24's edema. Review of the physician progress note dated 05/02/24 revealed the physician examined Resident #24 and documented massive chronic edema with need to try to reduce amlodipine (medication for hypertension), add chlorthalidone (a diuretic), and monitor blood pressure and kidney profile. Review of the physician orders, MAR, TAR, and nursing progress notes for May 2024 revealed there were no medication changes made, and no additional evidence for the care, monitoring and management of Resident #24's edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/24 at 9:51 A.M. with Resident #24 who complained of being frustrated with the swelling in both legs because it was hard to get any shoes on the feet, and although she was able to still walk it was getting more difficult. Resident #24 stated prior to admission she took 40 mg of a diuretic (could not remember the name) daily and at times took 80 mg when it was bad, but since being at the facility nothing is being done. Resident #24 talked to the physician each time when examined and it is said something will be done but nothing yet. The physician said once a stronger diuretic was needed but Resident #24 indicated not being aware of receiving any medication to address the edema. Observation at the time of the interview revealed Resident #24 was reclined in a chair. Both lower legs, particularly the ankles, had gross edema. Some of the skin appeared shiny and tight. Velcro foot coverings covered the feet and were snug. Interview on 05/08/24 at 7:24 A.M. with Registered Nurse (RN) #258 confirmed Resident #24 had edema in both legs since admission and was not on a diuretic. RN #258 indicated Resident #24's legs were not routinely monitored and was not aware of Resident #24 making any complaints related to the edema. Interview on 05/08/24 at 2:09 P.M. with Assistant Director of Nursing (ADON) #232 verified the above findings and confirmed the facts were accurate. ADON #232 indicated for the physician visit on 05/02/24, the physician did not communicate a plan of care or orders to nursing, so it just did not get done. ADON #232 also reported seeing Resident #24 prior to the interview and confirmed the gross edema was present. Review of the facility policy, Resident Condition Changes, revised 04/01/23 revealed the nurse will implement all new physician's orders immediately and if unable to implement order will contact the physician immediately for direction as to how to proceed. This conversation will be documented in nurses' notes.

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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** 41526 Based on observation, interview, and record review, the facility failed to provide tracheostomy care for Resident #170. This affected one resident (#170) of one resident reviewed for tracheostomy care. The facility census was 68. Findings include: Review of the medical record for Resident #170 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of supraglottis, emphysema, diabetes mellitus type 2, and tracheostomy status. The baseline care plan undated for admission on 05/02/24 indicated tracheostomy and oxygen saturation checks as needed. Review of Resident #170's physician orders for May 2024 revealed an order dated 05/05/24 for trach care daily and every 24 hours PRN (as needed) for tracheostomy. There were no orders for any tracheostomy related care including oxygenation monitoring, suctioning, dressing changes, or cannula changes at the time of admission or thereafter until the order for trach care daily was started on 05/05/24. No other tracheostomy related orders were in place. Review of the medication administration record for May 2024 revealed no tracheostomy related care was completed. Review of the treatment administration record for May 2024 revealed tracheostomy care daily and PRN was not provided until 05/06/24. Other than the trach care provided on 05/06/24, there was no evidence of any tracheostomy related care provided after admission. Review of the nursing progress note for admission assessment dated [DATE] indicated Resident #170 had no cognitive impairment and trach care was provided. A nursing progress note dated 05/05/24 indicated the tracheostomy dressing and ties were changed. There was no additional evidence in the progress notes of any tracheostomy related care being provided. Interview on 05/08/24 at 7:50 A.M. with Resident #170 using a writing method to communicate complained of tracheostomy care not being completed daily since admission. Resident #170 indicated having to remind the staff to give care for the tracheostomy including changing the dressing. Resident #170 stated some nurses do it and some do not. Observation at the time of the interview revealed tracheostomy supplies and a suctioning machine was present in the room. Interview on 05/08/24 at 7:53 A.M. with Registered Nurse (RN) #258 reported after Resident #170 was admitted there was an issue with availability of supplies such as a shipment was received with the wrong sized disposable cannulas but it was now resolved. Interview on 05/08/24 at 9:46 A.M. with Director of Nursing (DON) and Corporate Nurse #289 verified the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review and staff interview, and the facility failed to ensure as needed (PRN) orders for psychotropic drugs were limited to 14 days or had a determined stop date. This affected three residents (#51, #28 and #48) of five reviewed for unnecessary medications. The facility census was 68. Findings include: 1. Resident #28 was admitted on [DATE]. Medical diagnoses included major depression, type two diabetes, anxiety, dysphasia, muscle weakness, assistance with personal care, difficulty walking, and dementia. Review of the facility electric medical record Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) revealed a score of 04 out of 15 indicating severe cognitive impairment. Review of the facility electric medical record Plan of Care dated 04/22/24 revealed Resident # 28 would have no episodes of inappropriate behaviors. Interventions included administer medications as ordered, approach resident in a slow manner, bring Resident #28 to a quiet environment as needed, document behaviors, observations of environment and situation for possible cause of behaviors, observe Resident #28 for pain, provide diversional activities such as ambulation, food , drink, toileting and small group activities. Provide verbal support as needed, psychological consult, and redirect as possible. Review of electric medical record physician orders dated 05/08/24 revealed an order for Lorazepam oral tablet one milligram (mg) , given by mouth two times a day for anxiety and agitation. Start date was 05/08/24 and end date was indefinite. Review of electric medical record physician order start date 02/27/24 and end date was indefinite for Lorazepam oral tablet one milligram give by mouth every twelve hours as needed for anxiety was discontinued 05/08/24. Review of electric medical record physician order dated 05/08/24 revealed a new order for Lorazepam oral tablet one milligram given by mouth every twelve hours for anxiety was started 05/08/24 and end date was indefinite. Review of the electronic medical record Pharmacist Medication Regimen Review dated 04/20/24 revealed a report of irregularities was provided to the Director of Nursing and prescriber. The facility could not locate the note to Attending Physician document dated 04/20/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of electronic medical record Medication Administration Record dated May 2024 revealed Lorazepam oral tablet one milligram by mouth was provide as needed every twelve hours : once on 05/01/24 at 4:06 P.M. , twice on 05/02/24 at 9:59 A.M. and 9:40 P.M., once on 05/03/24 at 7:30 P.M., 05/04/24 at 4:15 P.M. , 05/05/24 at 8:42 P.M., 05/06/24 10:15 A.M. , and twice on 05/07/24 at 5:42 A.M. and 9:07 P.M. Review of electric medical record Medication Administration Record dated April 2024 revealed Lorazepam oral tablet one milligram provide every twelve hours as needed for anxiety was provided by mouth once on 04/03/24 at 4:25 P.M., 04/06/24 at 4:49 P.M., 04/07/24 at 4:35 P.M., 04/08/24 at 5:32 P.M. , 04/10/24 at 9:08 A.M., 04/14/24 at 10:47 A.M., 04/21/24 at 10:29 A.M. , 04/22/24 at 4:31 P.M. , 04/23/24 at 4:31 P.M., 04/24/24 at 9:07 A.M., 04/28/24 at 9:16 A.M., 04/29/24 at 5:54 P.M. and 04/30/24 6:24 P.M. Review of electronic medical record Medication Administration Record dated March 2024 revealed Lorazepam oral tablet one milligram give every twelve hours as needed for anxiety was provided once on 03/01/24 at 9:29 A.M., 03/03/24 at 7:38 A.M., 03/06/24 at 8:16 A.M., twice on 03/07/24 at 7:23 A.M. and 7:53 P.M., once on 03/10/24 at 7:30 A.M., twice on 03/11/24, once on 03/13/24 at 12:00 P.M. , 03/14/24 at 5:00 P. M., 03/15/24 at 6:38 P.M. , 03/16/24 at 4:43 P.M., 03/17/24 at 10:15 A.M., 03/27/24 at 7:26 A.M., 03/28/24 at 10:00 A.M., 03/29/24 at 9:36 A.M., 03/30/24 at 8:59 A.M. and 03/31/24 at 9:32 A.M 2. Resident #51 was admitted to the facility on [DATE]. Medical diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, anxiety, depression, muscle weakness, hypertension, congestive heart failure, cerebral palsy, insomnia, constipation. Review of electric medical record Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #51 had a Brief Interview Mental Status (BIMS) revealed a score of 14 out of 15 indicating cognition was intact. No verbal or physical behaviors were exhibited. Review of facility electric medical record Plan of Care dated 04/11/24 revealed Resident #51 had potential for feelings of sadness, emptiness, anxiety, and depression. Interventions included Resident #51 to accept care and medication as prescribed, discuss feeling about placement, encourage loved ones to keep contact, encourage resident to attend group activities, , praise and reward for demonstration of desired mood and behavior, provided one on one as needed. Review of electronic medical record physician order start date of 02/07/24 and end date was indefinite of hydroxyzine HCL 25 milligrams by mouth four times a day for anxiety related to depression. Review of electronic medical record physician order start date of 03/25/24 and end date was indefinite for hydroxyzine Pamoate (antianxiety) oral capsule by mouth every twelve hours as needed for anxiety. Review of the facility Note to Attending Physician document dated 03/25/24 from the pharmacist #290 revealed Resident #51 had an order for both Hydroxyzine HCL 25 milligrams and Hydroxyzine Pamoaye 25 milligrams every twelve hours as needed for anxiety. The pharmacist stated in order to avoid duplication of therapy please consider discontinuing one. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Note to Attending Physician document dated 03/25/24 revealed Advanced Practitioner Registered Nurse #291 responded on 04/08/24 and disagreed with the recommendation. The Advanced Practitioner Registered Nurse declined to change treatment because it was a necessary treatment. Review of the facility medical record Medication Administration Record dated April 2024 revealed as needed hydroxyzine Pamoate oral capsule was provided by mouth the night of 04/23/24, twice a day on 04/24/23, 04/25/23, 04/26/23, 04/27/24, 04/28/24, 04/29/24 and 04/30/24 the time medication was given was not documented. Interview with the Assistant Director of Nursing on 05/09/24 at 10:55 A.M. revealed the Advanced Practice Registered Nurse #291 declined to change Resident #51 as needed Hydroxyzine Pamoave 25 milligram every twelve hours as needed for anxiety with any stop date as indicated. 37097 3. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included diabetes, muscle weakness, need for assistance with personal care, difficulty in walking, other abnormalities of gait and walking, cognitive communication deficit, other specified disorders of bone density and structure, chronic kidney disease, osteoarthritis, encephalopathy, and a history of falling. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #48, dated 04/05/24, revealed impaired cognition. The assessment identified the resident had received insulin and antianxiety medication. Review of physician orders for Resident #48 revealed medication orders including Lorazepam Tablet 1 mg by mouth every 12 hours as needed for anxiety and agitation started 04/08/24 with no stop date. Review of the Pharmacy Recommendation dated 03/25/24 revealed the pharmacist had informed the physician Resident #48 had an as needed (PRN) order for Lorazepam and that PRN orders for Anxiolytics, Antidepressants, and Sedative/Hypnotics medications were to be limited to 14 days. If PRN use was extended, the medical record must contain documented rationale for use and a determined duration. Review of the Medication Administration Records (MAR) for Resident #48 for April 2024 revealed Lorazepam Tablet 1 mg had been given eight times. Review of the MAR for May 2024 revealed Lorazepam Tablet 1 mg had been given twice. Interview on 05/08/24 at 2:30 P.M. with ADON #232 verified the order for Lorazepam did not have a stop date.

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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** 37097 Based on record review and interview the facility failed to accurately document the resident's diagnoses to justify use of ordered medications. This affected one resident (#48) of five residents reviewed for medications. Facility census was 68. Findings Include: Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included diabetes, muscle weakness, need for assistance with personal care, difficulty in walking, other abnormalities of gait and walking, cognitive communication deficit, other specified disorders of bone density and structure, chronic kidney disease, osteoarthritis, encephalopathy, and a history of falling. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #48, dated 04/05/24, revealed impaired cognition. Review of physician orders for Resident #48 revealed medication orders including the following which did not have corresponding diagnosis: Atorvastatin Calcium Oral Tablet 40 MG. for cholesterol dated 12/14/23. Amitiza Oral. 24 MCG. for irritable bowel syndrome dated 12/14/23. Levothyroxine Sodium Oral Tablet 25 MCG. for hypothyroidism dated 12/14/23. Tizanidine HCl Oral Tablet 2 MG. for spasms dated 01/18/24. Buspirone HCl Oral Tablet 10 MG. for anxiety dated 03/15/24. Lorazepam Tablet 1 MG. for anxiety and agitation dated 04/08/24. Interview on 05/08/24 at 2:30 P.M. with Assistant Director of Nursing (ADON) #232 verified there were not diagnosis listed that justified all medications orders.

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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** 41526 Based on observation, interview, record review, facility policy review, review of the memorandum from the Department of Health & Human Services, and review of guidelines from the Centers for Disease Control and Prevention, the facility failed to implement and utilize required enhanced barrier precautions (EBP) for Residents #35, #36, #163, #170 and #172, and use appropriate standards of practice with use of gloves during catheter care and tracheostomy care for Residents #36 and #170. This affected five residents (#35, #36, #163, #170 and #172) and had the potential to affect all 68 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included dysphagia (difficulty swallowing), dementia and gastrostomy status. Physician orders effective May 2024 included enteral feeding 16 hours daily via gastrostomy tube. Observation and interview on 05/06/24 at 9:40 A.M. with Resident #35 indicated an enteral tube feeding was used. There was no EBP posted and no PPE (personal protective equipment) available at the room entrance. 2. Review of the medical record for Resident #170 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of supraglottis, emphysema, and tracheostomy status. Physician orders effective May 2024 included tracheostomy care daily and as needed. Observation on 05/06/24 at 10:54 A.M. of Resident #170 revealed a tracheostomy was in place. There was no EBP posted and no PPE available at the room entrance. Observation on 05/08/24 at 7:53 A.M. with RN #258 of tracheostomy care for Resident #170 revealed Registered Nurse (RN) #258 entered the room wearing gloves without donning a gown and then completed tracheostomy care without wearing the required gown for EBP. Interview at the time of the observation with RN #258 verified a gown was not worn as required. Further observation Observation on 05/08/24 at 7:53 A.M. with RN #258 of tracheostomy care for Resident #170 revealed RN #258 removed the soiled tracheostomy dressing and inner cannula using gloved hands then removed the gloves and used hand sanitizer. RN #258 then donned sterile gloves and using the right hand and a sterile cotton tipped applicator moistened with normal saline, cleansed around the tracheostomy opening and discarded the applicator. RN #258 then picked up sterile gauze saturated with normal saline and cleansed around the base of the tracheostomy tube. Using both gloved hands, RN #258 pulled the gauze underneath the flange and around the base of the tube for cleansing then disposed of the soiled gauze. Using the gloved hands now soiled, RN #258 picked up the sterile disposable cannula with the right hand making contact with the tip of the cannula and the upper portion of the sterile tube and inserted it into Resident #170's tracheostomy tube. Then using the same soiled gloved hands picked up a clean tracheostomy collar and applied it around Resident #170's neck. Interview at the time of the observation with RN #258 verified the above observation and confirmed the soiled gloves were not changed prior to touching and inserting the sterile cannula. (continued on next page)

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	05/09/2024

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included obstructive and reflux uropathy, chronic kidney disease stage 2 mild, and benign prostatic hyperplasia. Physician orders effective May 2024 included urinary catheter care every shift. Observation and interview on 05/06/24 at 11:36 A.M. with Resident #36 indicated a urinary catheter was used. There was no EBP posted and no PPE available at the room entrance. Observation on 05/07/24 at 2:20 P.M. with State tested Nursing Assistant (STNA) #264 and ADON #232 of urinary catheter care for Resident #36 revealed STNA #264 while wearing gloves and a gown performed urinary catheter care which included handling of Resident #36's genitals and washing and drying the urinary catheter site. STNA #264 then emptied the urinary catheter drainage bag. While wearing the soiled gloves worn during the care, STNA #264 assisted Resident #36 to stand, pulled up Resident #264's brief and pants, pulled down the shirt, and completed a transfer from the commode to the wheelchair. The soiled gloves contacted multiple body areas while providing assistance. Upon completion, STNA #264 removed the soiled gloves. Interview at the time of the observation with STNA #264 verified the above observation and indicated the soiled gloves should have been removed after the procedure and prior to assisting Resident #36 with dressing and a transfer. 4. Review of the medical record for Resident #172 revealed an admitted [DATE]. Diagnoses included peritoneal abscess and diverticulosis. Physician orders effective May 2024 included flush the wound drain every shift, antibiotic therapy intravenously four times daily, and change the PICC line dressing weekly. Observation and interview on 05/06/24 at 12:06 P.M. with Resident #172 indicated a left upper arm PICC (peripherally inserted central catheter) used for antibiotic therapy and a wound drain was in place. There was no EBP posted and no PPE available at the room entrance. Observation on 05/08/24 at 11:21 A.M. with RN #201 of intravenous medication administration through a PICC line for Resident #172. RN #201 entered the room wearing gloves without donning a gown and then completed the intravenous medication administration via the PICC line without wearing the required gown for EBP. Interview at the time of the observation with RN #201 verified a gown was not worn as required. 5. Review of the medical record for Resident #163 revealed an admitted [DATE]. Diagnoses included osteomyelitis left ankle and foot and diabetes mellitus type 2. Physician orders effective May 2024 and progress notes from April 2024 to May 2024 indicated antibiotic therapy intravenously twice daily via right upper arm PICC line. Observation and interview on 05/06/24 at 1:46 P.M. with Resident #163 indicated a right upper arm PICC was used for antibiotic therapy. There was no EBP posted and no PPE available at the room entrance. Observations on 05/06/24 at 5:10 P.M. revealed EBPs remained not posted with no PPE available at the room entrances for Residents #35, #36, #163, #170 and #172. (continued on next page)

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	365642	A. Building B. Wing	05/09/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews on 05/06/24 at 5:11 P.M. with Licensed Practical Nurse (LPN) #286 and Registered Nurse (RN) #281 verified there were no EBPs in place for Residents #35, #36, #163, #170 and #172. RN #281 indicated EBP training was completed in the previous month and was planned to be started on the next day, 05/07/24. Interviews on 05/06/24 at 5:18 P.M. with Director of Nursing (DON) and Assistant Director of Nursing (ADON) #232 confirmed the facility had no EBPs in place yet and the plan was to begin on the next day, 05/07/24. EBP orders were in the process of being put in place on this date, 05/06/24, and then the supplies were to be put out on the next morning of 05/07/24. The facility had some issues with supplies being on back order so it took a while to enough into the facility. Interview on 05/06/24 at 5:20 P.M. with Corporate Nurse (CN) #289 confirmed EBPs were planned to begin on the next day, 05/07/24. There was an issue with supplies being available, and staff training was completed in April 2024. Originally there was a planned start date of 05/01/24 but they were unable to start it then. CN #289 indicated being aware of the memorandum from the Department of Health and Human Services for initiating EBPs but was uncertain about the required effective date. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. Review of facility policy for EBP which was untitled and undated revealed EBP involved gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multidrug-resistant organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of Hand Hygiene in Healthcare Settings, Healthcare Providers, Glove Use, last reviewed 01/08/21, from the Centers for Disease Control and Prevention, located at https://www.cdc.gov/handhygiene/providers/index.html revealed gloves are not a substitute for hand hygiene. Change gloves and perform hand hygiene during patient care if gloves become visibly soiled with blood or body fluids following a task and moving from work on a soiled body site to a clean body site on the same patient.