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

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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 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. Based on observation and interviews, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect 70 of the 72 residents who received food from the facility kitchen. The facility identified two residents, Residents #14 and #70, who received no food from the kitchen. The facility census was 72.Findings include:Observations during the initial kitchen tour conducted on 02/10/26 between 8:31 A.M. and 8:53 A.M. with Assistant Dietary Manager (ADM) #223 revealed one opened and undated bag tortilla chips and three loaves of outdated bread. The ice machine had pink growth on the rims that came off when wiped with a paper towel. The oven knobs had accumulated grease and dirt. The shelf above the oven had a layer of grease and dust. The sanitizer buckets when tested did not meet the required chemical level for sanitizing surfaces. The wall next to the reach-in freezer had food splatters. Interview at the time of the observation with ADM #223 verified the above findings and stated the kitchen cleaned the ice machine monthly.

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility assessment review, and review of infection-Antibiotic (ATB) Surveillance logs and facility policy, the facility failed to have a designated infection preventionist (IP) who effectively monitored and implemented the facility's Infection Prevention and Control Program (IPCP). This had the potential to affect all 72 residents residing in the facility.Findings include: 1. Review of the medical record for Resident #69 revealed an admission date of 07/15/24 and a diagnosis of COVID-19 (Coronavirus, an infectious respiratory disease) dated 02/09/26. Review of physician orders for February 2026 identified an order for isolation airborne/droplet precautions (infection control measures to prevent the spread of germs using a mask, eye protection and proper hand hygiene) due to a positive test result for COVID-19 dated 02/09/26.Observation on 02/10/26 at 9:43 A.M. of Resident #69 revealed signage on the door for transmission-based precautions for COVID-19. The sign indicated isolation was in effect for Resident #69 from 02/09/26 until 02/19/26. The signage specified the wearing of at minimum eye, nose and mouth protection. The required personal protective equipment including masks, gowns and eye protection was in a bin outside the resident's room.Observation on 02/11/26 at 11:38 A.M. of CNA #289 revealed she delivered Resident #69's lunch into the resident's room. The CNA did not adhere to the required precautions by only wearing a surgical mask and gloves. She did not wear a gown, eye protection or an N95 respirator. Interview at the time of the observation with CNA #289 after exiting Resident #69's room confirmed the required precautions were not followed. 2. Review of Infection Log- ATB Surveillance log dated December 2025 revealed for the month of December 2025 there were 14 occurrences of residents ordered antibiotic use that did not meet McGeer's criteria (infection surveillance definitions for long term facilities for antibiotic use), and one occurrence for the month of December 2025 that was not marked if the ATB use met or did not meet McGeer's criteria. Review of January 2026 ATB surveillance revealed there was no log present only individual sheets labeled, McGeer Criteria for Infection Surveillance Checklists for each resident that was on an ATB for the month. There were 13 individual sheets that did not include the date the ATB was ordered, reason for the ATB, name of the ATB and/or if the ATB met criteria for ATB use. Review of Infection Log-ATB Surveillance log for February 2026 revealed there were five occurrences that were marked on the log that the ATB did not meet McGeer's criteria.3. Review of the medical record for Resident #32 revealed she was admitted on [DATE] with diagnoses of diabetes, cognitive communication deficit, dysphagia, congestive heart failure, chronic kidney disease stage four and obesity. There was no record Resident #32 was offered and/or received the pneumococcal vaccination.Interview on 02/12/2026 at 10:30 A.M. with DON confirmed the facility had no record that Resident #32 had received or had been offered the pneumococcal vaccine.4. Review of Nursing Home Infection Preventionist Training Course certificate dated 10/24/23 revealed the Director of Nursing (DON) had completed it. She was the only one with training at the facility. Review of Facility Assessment Tool dated 12/22/25 revealed under infection prevention and control included the identification and containment of infections, and prevention of infections. There was no other documentation identified in the facility assessment regarding the amount of time the IP was designated to work on infection control and/or any other specific responsibilities for the IP. Interview on 02/11/26 at 2:25 P.M. with the Director of Nursing (DON) revealed both she and the former Assistant Director of Nursing (ADON) #304 had shared the infection control preventionist responsibilities but the former ADON #304's last date of employment was 10/29/25. She tried to spend two to three hours per day on infection control but stated, yes I do wear many hats as she also verified, she had the responsibilities of the DON, as well as restorative nurse and infection control. She verified the December 2025 infection log had 14 occurrences of residents requiring antibiotic use that did not meet McGeer's criteria. She was asked what happened (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	if an ATB did not meet the criteria and she stated she just put it on the log. She was asked if she contacted the physician to let them know that the ATB did not meet the criteria, and she stated she may mention it in general to a physician but that she did not contact the physician on each individual resident. She verified there was no documentation the physician was notified that the ATBs did not meet criteria for ATB use. She did not know she needed to, as she thought she just needed to put it on the log. She verified there was no log for January 2026 and that all the individual McGeer Criteria for Infection Surveillance Checklists did not include if the ATB met criteria or not. Then, she stated she might have it on the computer. She also verified several of the checklists were blank and included no signs and symptoms. She stated all the residents ordered ATBs in January 2026 most likely did not meet criteria which was why the individual sheets were blank. Interview on 02/12/26 at 1:26 P.M. with DON as she brought in an Infection Log-ATB Surveillance log dated January 2026 revealed on the log it stated all the ATBs met criteria. She also brought in new individual McGeer Criteria for Infection Surveillance Checklists for the individuals on ATBs in January 2026 that were no longer blank and/or had different items checked on the forms including that the ATB met criteria at the bottom. She revealed after talking to Corporate Nurse #800, she found out she had been doing the forms wrong as she thought for an ATB to meet criteria all the symptoms had to be in one sentence in a nursing note. She did not know she could look at different entries in the notes and/or records to determine if an ATB met the criteria. She verified she had redone the log and the forms on 02/11/26 after she was informed by Corporate Nurse #800 on how the process should go. She verified on February 2026 Infection Log-ATB Surveillance log there were five occurrences marked that the ATB did not meet criteria and that she had no documentation the physician was notified.Interview on 02/13/2026 11:12 AM with the Administrator verified there was nothing in the facility assessment regarding the amount of time the IP was designated to work on infection control. He verified after reviewing the infection control concerns identified during the survey of immunizations, wearing of appropriate personnel protective equipment into a COVID-19 room, and effective antibiotic stewardship program that since former ADON #304 left, it had been rough for the DON to keep up on infection control. Review of facility policy labeled, Antibiotic Stewardship dated 11/30/17 revealed the purpose of the policy was to meet the regulatory guidelines of ATB stewardship program and promote responsible utilization of ATBs. All residents with newly diagnosed infections utilizing ATBs were reviewed for appropriate utilization. The policy revealed residents without proof of infection symptoms prior to the initiation of an ATB were reviewed for ATB holiday, and/or a culture and sensitivity. The results of the testing and the recommendations for treatment were discussed with the physician to ensure ATBs were utilized in a responsible manner. Review of facility policy labeled, Infection Control Preventionist dated 8/25/23 revealed the purpose of the policy was to establish a process that investigates, monitors, identifies, controls, and surveys infections. The policy revealed when a resident was admitted or when a resident acquired an infection, the infection report was completed by the infection preventionist. The infection control preventionist encouraged the oversight of the environment, followed up on areas of concern, and educated staff. There was nothing in the policy regarding the infection control preventionist working at least part-time on infection control.

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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** Based on observation, interview and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to follow transmission-based precautions for infection control. This affected one resident (#69) and had the potential to affect 12 residents on Certified Nursing Assistant (CNA) #289's assignment (#4, #13, #18, #22, #33, #37, #40, #41, #47, #53, #69 and #73). The facility census was 72.Findings include:Review of the medical record for Resident #69 revealed an admission date of 07/15/24 and a diagnosis of COVID-19 (Coronavirus, an infectious respiratory disease) dated 02/09/26. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had intact cognition. Review of physician orders for February 2026 identified an order for isolation airborne/droplet precautions (infection control measures to prevent the spread of germs using a mask, eye protection and proper hand hygiene) due to a positive test result for COVID-19 dated 02/09/26.Observation on 02/10/26 at 9:43 A.M. of Resident #69 revealed signage on the door for transmission-based precautions for COVID-19. The sign indicated isolation was in effect for Resident #69 from 02/09/26 until 02/19/26. The signage specified the wearing of at minimum eye, nose and mouth protection. The required personal protective equipment including masks, gowns and eye protection was in a bin outside the resident's room.Review of the nurses note dated 02/10/26 at 12:22 P.M. revealed Resident #69 was to continue isolation precautions due to COVID-19 diagnosis.Review of the Infection Note dated 02/11/26 at 5:29 P.M. revealed Resident #69 was to continue isolation precautions due to COVID-19 diagnosis.Observation on 02/11/26 at 11:38 A.M. of CNA #289 revealed she delivered Resident #69's lunch into the resident's room. The CNA did not adhere to the required precautions by only wearing a surgical mask and gloves. She did not wear a gown, eye protection or an N95 respirator. Interview at the time of the observation with CNA #289 after exiting Resident #69's room confirmed the required precautions were not followed. Interview on 02/11/26 at 1:46 P.M. with the DON verified the findings and stated CNA #289 was suspended for three days for not following the required COVID-19 precautions for Resident #69.Review of the CDC guidelines for viral respiratory pathogens in nursing homes dated 01/23/36 and located at https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html revealed to prevent the spread of COVID-19, apply appropriate transmission-based precautions. Healthcare personnel who enter the room of a resident with signs or symptoms of COVID-19 infection should adhere to standard precautions and use an N-95 or higher respirator, gown, gloves and eye protection.Review of the CDC guidelines for droplet precautions dated 01/16/20 and located at https://stacks.cdc.gov/view/cdc/134214 revealed droplet precautions included making sure eyes, nose and mouth were fully covered before room entry, removing face protection before room exit, and cleaning hands including before entering and when leaving the room.Review of the CDC guidelines for airborne precautions dated 07/24/19 and located at https://stacks.cdc.gov/view/cdc/134215 revealed airborne precautions included making sure to wear a fit-tested N-95 or higher-level respirator before room entry, removing the respirator after exiting the room and cleaning hands before entering and when leaving the room.Review of facility policy labeled, Novel Coronavirus Prevention, Response and Source Control, last revised 01/16/25 revealed to implement standard, contact and droplet precautions. Wear gloves, gowns, eye protection and a N-95 or equivalent or higher-level respirator upon entering the room and when caring for the resident.Review of facility policy labeled, Isolation Practices, last revised 03/06/20 revealed airborne precautions required use of respiratory protection and droplet precautions required a mask when working closely with the resident. Centers for Disease Control guidelines will be followed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review, interview, and review of facility policy and the antibiotic surveillance infection logs, the facility failed to maintain an effective antibiotic stewardship program that monitored antibiotic use including reducing the risk of adverse effects of the development of antibiotic-resistant organisms from unnecessary or inappropriate antibiotic use. This affected 25 residents (#1, #2, #3, #5, #10, #14, #15, #19, #28, #29, #32, #33, #34, #36, #37, #45, #46, #47, #48, #49, #50, #55, #56, #65 and #72) who were ordered antibiotics but did not meet McGeer's criteria (infection surveillance definitions for long term facilities for antibiotic use) during the months of December 2025, January 2026 and February 2026. The facility census was 72.Findings include: 1. Review of Infection Log-ATB (antibiotic) Surveillance log dated December 2025 revealed the form tracked residents that received ATBs and the form included unit, date, resident name, room number, sign and symptoms, site, if urinary tract infection (UTI) with or without catheter, culture/organism, ATB, isolation precautions if needed, symptoms present on admission, whether acquired in facility, and if it met McGeer's criteria. For the month of December 2025, there were 14 occurrences of residents with antibiotic use that did not meet McGeer's criteria, and one occurrence that was not marked if the ATB use met or did not meet McGeer's criteria. The log revealed the following: Resident #32 had an admission date of 01/03/24 and was ordered doxycycline on 12/03/25 for bilateral lower extremity cellulitis. The ATB did not meet the criteria for ATB use. Resident #28 had an admission date of 07/21/25 and was ordered doxycycline on 12/03/25 for cellulitis. The ATB did not meet the criteria for ATB use. Resident #2 had an admission date of 09/30/20 and was ordered Augmentin on 12/05/25 for a UTI, then on 12/08/25 ampicillin was ordered for a UTI. Both ATBs did not meet the criteria for ATB use. Resident #49 had an admission date of 04/12/03 and was ordered amoxicillin on 12/08/25 for a UTI. The ATB did not meet the criteria for ATB use. Resident #19 had an admission date of 03/12/25 and was ordered Augmentin on 12/08/25 for bacterial infection. The ATB did not meet the criteria for ATB use. Resident #33 had an admission date of 01/24/25 and was ordered Bactrim on 12/17/25 for a UTI. The ATB did not meet the criteria for ATB use. Resident #15 had an admission date of 09/30/23 and was ordered Augmentin on 12/19/25 for a UTI. The ATB did not meet the criteria for ATB use.Resident #72 had an admission date of 11/14/25 and was ordered Keflex on 12/19/25 for a his foot. The log did not state if it met criteria for ATB use or not. Resident #3 had an admission date of 05/09/25 and was ordered Macrobid on 12/20/25 for a UTI, then on 12/22/25 Levaquin was ordered for a UTI. Both ATBs did not meet the criteria for ATB use. Resident #10 had an admission date of 01/24/23 and was ordered doxycycline on 12/22/25 for an upper respiratory infection. The ATB did not meet the criteria for ATB use. Resident #34 had an admission date of 04/14/24 and was ordered Bactrim on 12/22/25 for a UTI. The ATB did not meet the criteria for ATB use. Resident #48 had an admission date of 07/16/25 and was ordered Keflex on 12/24/25 for her skin. The ATB did not meet the criteria for ATB use. Resident #55 had an admission date of 02/03/23 and was ordered Levaquin on 12/30/25 for a UTI. The ATB did not meet the criteria for ATB use. 2. Review of January 2026 ATB surveillance revealed there was no log present only individual sheets labeled, McGeer Criteria for Infection Surveillance Checklists, one for each resident that was on an ATB for the month. There were 13 individual sheets that did not include a date the ATB was ordered, reason for the ATB, name of the ATB and/or if the ATB met criteria for ATB use. The checklists revealed the following: Resident #5 had an admission date of 01/06/26 and was admitted on an ATB. The only thing marked on the checklist under influenza-like illness was that she had a new or increased cough. The checklist had no other information including whether it did or did not meet criteria for ATB use. Resident #14 had an admission date of 08/17/20. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use.Resident #50 had an admission date of 10/11/23. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use.Resident #49 had an admission (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date of 04/12/23. The checklist specified under influenza-like illness that he had a new or increased cough. At the bottom of the checklist, it noted congestion and it was not checked whether the ATB did or did not meet criteria for ATB use. Resident #36 had an admission date of 05/02/23. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use.Resident #19 had an admission date of 03/12/25. The checklist specified there was confusion and congestion. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use. Resident #29 had an admission date of 12/22/22. The checklist specified under influenza-like illness that he had a cough. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use.Resident #46 had an admission date of 01/01/26. The checklist specified under the pneumonia section that he had a chest x-ray, new or increased cough, and increased sputum production. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use. Resident #15 had an admission date of 09/30/23. The checklist specified under the pneumonia section that he had a chest x-ray, oxygen saturation level was below 94 percent, and had a change in lung abnormalities. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use. Resident #56 had an admission date of 01/17/26 and was admitted with an ear infection. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use. Resident #1 had an admission date of 12/16/25. The checklist specified under the influenza-like illness that he had a new or increased cough, and under the pneumonia section that he had a chest x-ray, new or increased sputum production, new or change in lung abnormalities, and acute functional decline. The checklist did include whether it did or did not meet criteria for ATB use. Resident #37 had an admission date of 10/03/24, and she had drainage from her ear. There was no other information regarding the ATB use including whether it did or did not meet criteria for ATB use. Resident #45 had an admission date of 01/19/26. The checklist specified under the section of UTI that she had acute pain, swelling or tenderness, and had a urine sample. The checklist did include whether it did or did not meet criteria for ATB use. 3. Review of Infection Log-ATB Surveillance log for February 2026 revealed there were five occurrences that were marked on the log that the ATB did not meet McGeer's criteria. The log revealed the following: Resident #10 had an admission date of 01/24/23 and was ordered Augmentin on 02/04/26 as preventative. The ATB did not meet the criteria for ATB use. Resident #47 had an admission date of 01/14/22 and was ordered Macrobid on 02/04/26 for a UTI. The ATB did not meet the criteria for ATB use. Resident #34 had an admission date of 04/14/24 and was ordered doxycycline on 02/09/26 for a cough. The ATB did not meet the criteria for ATB use. Resident #65 had an admission date of 11/26/25 and was ordered cipro and Macrobid on 02/09/26 for a UTI. The ATBs did not meet the criteria for ATB use. Interview on 02/11/26 at 2:25 P.M. with the Director of Nursing (DON) revealed both she and the former Assistant Director of Nursing (ADON) #304 had shared the infection control preventionist responsibilities but the former ADON #304's last date of employment was 10/29/25. She tried to spend two to three hours per day on infection control but stated, yes I do wear many hats as she also verified, she had the responsibilities of the DON, as well as restorative nurse and infection control. She verified the December 2025 infection log had 14 occurrences of residents requiring antibiotic use that did not meet McGeer's criteria. She was asked what happened if an ATB did not meet the criteria and she stated she just put it on the log. She was asked if she contacted the physician to let them know that the ATB did not meet the criteria, and she stated she may mention it in general to a physician but that she did not contact the physician on each individual resident. She verified there was no documentation the physician was notified that the ATBs did not meet criteria for ATB use. She did not know she needed to, as she thought she just needed to put it on the log. She verified there was no log for January 2026 and that all the individual McGeer Criteria for Infection Surveillance Checklists did not include if the ATB met criteria or not. Then, she stated she might have it on the computer. She also verified several of the checklists were blank and included no signs and symptoms. She stated all the residents (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered ATBs in January 2026 most likely did not meet criteria which was why the individual sheets were blank. Interview on 02/12/26 at 1:26 P.M. with DON as she brought in an Infection Log-ATB Surveillance log dated January 2026 revealed on the log it stated all the ATBs met criteria. She also brought in new individual McGeer Criteria for Infection Surveillance Checklists for the individuals on ATBs in January 2026 that were no longer blank and/or had different items checked on the forms including that the ATB met criteria at the bottom. She revealed after talking to Corporate Nurse #800, she found out she had been doing the forms wrong as she thought for an ATB to meet criteria all the symptoms had to be in one sentence in a nursing note. She did not know she could look at different entries in the notes and/or records to determine if an ATB met the criteria. She verified she had redone the log and the forms on 02/11/26 after she was informed by Corporate Nurse #800 on how the process should go. She verified on February 2026 Infection Log-ATB Surveillance log there were five occurrences marked that the ATB did not meet criteria and that she had no documentation the physician was notified.Review of facility policy labeled, Antibiotic Stewardship dated 11/30/17 revealed the purpose of the policy was to meet the regulatory guidelines of ATB stewardship program and promote responsible utilization of ATBs. All residents with newly diagnosed infections utilizing ATBs were reviewed for appropriate utilization. Residents without proof of infection symptoms prior to the initiation of an ATB would be reviewed for ATB holiday, and/or a culture and sensitivity. The results of the testing and the recommendations for treatment were discussed with the physician to ensure ATBs were utilized in a responsible manner.

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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** 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 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 (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	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	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.

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy, the facility failed to ensure Resident #32 was current with her pneumococcal vaccination and had no documentation she was offered the vaccine. This affected one resident (#32) out of six residents reviewed for immunizations. The facility census was 72.Findings include:Review of the medical record for Resident #32 revealed she was admitted on [DATE] with diagnoses of diabetes, cognitive communication deficit, dysphagia, congestive heart failure, chronic kidney disease stage four and obesity. Review of Annual MDS dated [DATE] revealed resident was cognitively intact. Resident #32 was not up to date regarding her pneumococcal vaccination and indicated she was not offered the vaccine. Interview on 02/12/2026 at 10:30 A.M. with DON confirmed the facility had no record that Resident #32 had received or had been offered the pneumococcal vaccine.Review of facility policy labeled, Influenza and Pneumococcal Vaccine last revised 01/20/20 revealed residents were assessed for pneumococcal vaccine status upon admission. Residents without proof of a previous pneumococcal vaccine received one dose per Centers for Disease Control and Prevention (CDC) guidelines if consent and physician's orders were obtained. Review of facility policy labeled, Influenza and Pneumococcal Disease Prevention dated 07/01/21 revealed residents were offered a pneumococcal vaccine in accordance with the CDC recommended immunization schedule.