STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365699	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Ctr IV	55801 Conno-Mara Drive Bellaire, OH 43906

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, facility investigation review, facility policy review, and interviews, the facility failed to timely report a suspicion of misappropriation of narcotics. This affected one (#19) of three residents reviewed for misappropriation. The facility census was 46. Findings include:Review revealed there was not a recent Self-Reported Incident (SRI) filed with the Ohio Department of Health (ODH) related to misappropriation. Review of the medical record for Resident #19 revealed an admission date of 11/05/25 with diagnoses including multiple sclerosis, hypertension, major depressive disorder, diabetes mellitus, conversion disorder with seizures, and chronic kidney disease. The Minimum Data Set (MDS) revealed the resident was cognitively intact. Interview on 11/25/25 at 10:54 A.M. with the Director of Nursing (DON) revealed on 11/20/25 she was answering a question regarding a narcotic with Licensed Practical Nurse (LPN) #100 when she opened the narcotic book she noticed several blank entries with the same handwriting indicating Registered Nurse (RN) #126's signature. The DON compared Resident #19's Controlled Drug Records with the Medication Administration Record (MAR)s, which revealed discrepancies with the administration of both Tramadol and Ativan. The DON stated she interviewed Resident #19 who reported that she didn't know she had pain medications and didn't request pain medication. The DON stated her investigation didn't provide enough evidence to conclude misappropriation; however, she found the frequency of documentation errors odd. The DON stated RN #126 was terminated on 11/25/25 because she had enough of a concern due to the repeated pattern and poor nursing. The DON further stated that she immediately reported the suspicion of potential misappropriation to the Administrator and was advised by the Administrator and the [NAME] President of Operations #200 to suspend RN #126 immediately pending an investigation. Review of the Controlled Drug Record indicated Resident #19 received Tramadol HCL 50 mg two tablets by mouth every six hours as needed for pain on 11/15/25 at 8:00 A.M., 12:00 P.M. and 7:00 P.M., administered by RN #126. Review of the Medication Administration Record (MAR) revealed no documentation of the administration of Tramadol HCL 50 mg two tablets on 11/15/25 at 8:00 AM., 12:00P.M. and 7:00 P.M. Further review revealed Resident #19's Controlled Drug Record indicated Resident #19 received Ativan 0.5 mg one tablet by mouth on 11/08/25, 11/10/25, 11/11/25, 11/12/25, 11/14/25, 11/15/25, 11/17/25, and 11/18/25, administered by RN #126. Review of the MAR revealed no documentation of the administration of Ativan 0.5 mg one tablet by mouth on 11/08/25, 11/10/25, 11/11/25, 11/12/25, 11/14/25, 11/15/25, 11/17/25, and 11/18/25. Interview on 11/25/25 at 8:48 A.M. with the Administrator confirmed he did not timely complete and file an SRI regarding the suspicion of misappropriation of narcotics involving RN #126. He stated he was notified on 11/20/25 by the DON of her suspicion of blanks on narcotic sheets. He confirmed RN #126 was immediately suspended pending the investigation. The Administrator further stated his investigation did not reveal sufficient evidence to prove misappropriation, however, he is going to report the nurse to the Ohio Board of Nursing and she was terminated on 11/25/25. Review of the facility's policy titled, Abuse, dated 01/31/20, revealed the Administrator or designee will notify ODH of all alleged violations involving mistreatment, neglect, abuse, exploitation, misappropriation of resident property and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2649219.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Concern Log, review of the Call Light Audit Report, and interview, the facility failed to ensure staff assistance was provided timely for five dependent residents. This affected five (#7, #10, #23, #37, and #30) of six resident reviewed for activities of daily living (ADL's). The facility census was 46. Findings include:1. Review of the medical record for Resident #7 revealed an admission date of 10/15/25 with diagnoses including acute kidney failure, weakness, acute respiratory failure, depression, diabetes mellitus, and atrial fibrillation. room [ROOM NUMBER] Review of the admission Minimum Data Set (MDS) assessment, dated 10/20/25, revealed Resident #7 had intact cognition and required assistance from staff with ADLs. The MDS indicated the resident required substantial/maximal staff assistance with toileting and was always incontinent of bowel and frequently incontinent of urine. Review of the Care Plan dated 10/21/25 revealed the intervention for assistance from staff with toileting. Review of the Call Light Audit Report dated 11/08/24 revealed Resident #7's call light was initiated at 1:08:38 P.M. and remained on for 52 minutes and six seconds until cleared by staff. Interview on 11/25/25 at 10:05 A.M. with Resident #7 revealed he recalled on 11/08/25 there was only one certified nurse aide (CNA) working and he rang his call light because he needed to go to the bathroom. He stated he waited for a very long time and eventually had to scream for help. Resident #7 stated other residents were also screaming for help. Resident #7 stated he was unable to wait and did have a bowel movement and felt humiliated. 2. Review of the medical record for Resident #10 revealed an admission date of 02/21/24 with diagnoses including Parkinson's disease, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, depression, and atrial fibrillation Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/25, revealed Resident #10 had intact cognition and required assistance from staff with activities of daily living (ADLs). The MDS indicated the resident required substantial/maximal staff assistance with toileting and was occasionally incontinent of both urine and bowel. Review of the Care Plan dated 03/05/24 revealed the intervention for assistance from staff with bathing, per the resident's preference. Review of Resident #10's Shower Task Log revealed she did not receive a shower/bath on 11/08/25. Interview on 11/20/25 at 1:50 P.M. with Resident #10 revealed she prefers and is scheduled to receive a shower daily. Resident #10 stated on Saturday, 11/08/25, she did not get her shower/bath and was told there was only one CNA working and not enough staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #23 revealed an admission date of 02/21/24 with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, chronic kidney disease, dementia, diabetes mellitus, flaccid hemiplegia affecting left side, and feeling of incomplete bladder emptying. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, revealed Resident #23 had intact cognition and required assistance from staff with activities of daily living (ADLs). The MDS indicated the resident required substantial/maximal staff assistance with toileting and was occasionally incontinent of both urine and bowel. Review of the Care Plan dated 03/01/23 revealed the intervention for assistance from staff with toileting. Review of the Call Light Audit Report dated 11/08/24 revealed Resident #23's call light was initiated at 1:04:09 P.M. and remained on for 36 minutes and 29 seconds until cleared by staff. Interview on 11/24/25 at 3:15 P.M. with Resident #23 revealed sometimes has to wait for a very long time, often over thirty minutes after ringing her call light. She stated it is hard to hold her urine that long when she needs to go to the bathroom. Interview on 11/20/25 at 1:22 P.M. with Certified Nursing Assistant (CNA) #110 revealed she was the only CNA providing care to residents on 11/08/25 between 12:19 P.M. and 2:11 P.M. and several residents require two-person staff assistance. CNA #110 stated she was unable to answer most of the call lights timely, with some residents waiting for up to an hour for assistance. CNA #110 stated she was unable to assist with baths/showers during this time. CNA #110 revealed Resident #10 requested a shower that day, but she was unable to provide her bath due to short staffing. CNA #110 stated this was her last day working at the facility because she had submitted her resignation mainly due to staffing and due to having been the only CNA working in the facility on 11/08/25 for a period of time. Interview on 11/25/25 at 8:45 A.M. with the DON confirmed Resident #7, Resident #10, and Resident #23 did not receive timely ADL assistance due to the CNA staffing shortage on 11/08/25. The DON stated it was her expectation that one of the nurses working should have provided assistance to CNA #110. 4. Review of the medical record for Resident #37 revealed an admission date of 02/19/25/25. Diagnoses include syncope and collapse; insomnia; weakness; essential hypertension; depression; hyperlipidemia; gastro-esophageal reflux; morbid obesity; osteoarthritis; and chronic pain. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, a score which would suggest cognitive intactness. On 11/20/25 at 11:20 A.M., an interview with Resident #37 revealed she had concerns regarding staffing. She reported six months ago there were lots of aides in the facility, and if you rang your call bell someone came quickly. Now she reported she would wait 45 minutes to an hour just to get assistance. She indicated this had become a problem when she was no longer getting showers when she was supposed to. She had a shower preference of every Tuesday and Thursday. She was not getting showers like she was supposed to and she had complained to someone, she could not recall who, regarding this. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a treatment administration record for Resident #37 revealed a treatment order, dated 03/07/25 for a head to toe skin assessment to be completed weekly on Thursdays. These were documented as being completed on 11/06/25, 11/13/25, and 11/20/25. Review of shower logs for Resident #37 for the month of November 2025 revealed the resident had a shower on 11/02/25, 11/05/25, 11/07/25, 11/09/25, 11/12/25, 11/15/25, 11/17/25, and 11/20/25. Only 11/20/25 was noted to have been a Thursday. There were no showers completed on Tuesdays. On 11/25/25 at 10:00 A.M., an interview with Director of Nursing revealed skin assessments were completed on residents during showers. She confirmed shower sheets for Resident #37 and also confirmed only 11/09/25 and 11/12/25 revealed any information regarding skin assessments. The other shower forms did not address the skin assessment area. 5. Review of the medical record for Resident #30 revealed an admission date of 10/09/25. Diagnoses included periprosthetic fracture around internal prosthetic right knee joint; diverticulitis of intestine; muscle weakness, fall on same level from slipping; unspecified asthma; hyperlipidemia; morbid obesity, depression, gastro-esophageal reflux; hyperparathyroidism; essential hypertension; obstructive sleep apnea; sciatica; generalized anxiety disorder; chronic pain syndrome, and low back pain. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 on a 0-15 scale. A score of 15 would indicate the resident was cognitively intact. The MDS further revealed the resident had been assessed to need scheduled and as needed pain medications. The resident was assessed to have lower extremity impairment on one side, required a wheelchair, and substantial or maximal assistance for toileting, showering or bathing, putting on footwear, and for bed mobility, which included transferring from bed to chair. She was dependent with lower body dressing. Review of a care plan for Resident #30, dated 10/14/25, revealed a focus of care for risk of skin breakdown related to decreased mobility and incontinence. Interventions for this focus included assisting resident with incontinence care using soap and water, and assisting the resident with toileting as needed. On 11/24/25 at 3:32 P.M., an interview with Resident #30 revealed concerns regarding staff responding to call lights. She indicated on 10/18/25 at 9:20 A.M., she rang her call light for staff assistance when she had to have a bowel movement. The staff did not respond until some time after 9:45 A.M. By the time the staff arrived, the resident had been incontinent of bowel. She reported this incident left her humiliated. She stated, It is bad enough to have to need help, but to be in that situation was horrible. This deficiency represents non-compliance investigated under Complaint Number 2649219

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility assessment, review of the daily staffing schedule, review of the Time Punch Detail Hours Report, record review, and staff and resident interviews, the facility failed to maintain sufficient levels of direct care staff to meet the total care needs of all residents. This affected five (#7, #10, #23, #30, and #37) of six residents reviewed for activities of daily living (ADLs), and had the potential to affect all 46 residents residing in the facility. Findings include: 1.Review of the facility assessment, updated September 2025, revealed the general staffing plan is to ensure sufficient staff to meet the needs of the residents at any given time and is determined based on resident population and census. The staffing plan indicated the average number of certified nursing assistants (CNA) required is five. Staffing is reviewed daily and adjusted to meet the needs of the residents. Review of the Daily Staffing Schedule revealed on 11/08/25 the facility census was 46, between 12:19 P.M. and 2:11 P.M., there was only one Certified Nursing Assistant (CNA) #110 scheduled to provide direct care to the residents. Review of the Time Punch Detail Hours Report dated 11/08/25 revealed CNA #110 was the only nursing assistant working in the facility between 12:19 P.M. and 2:11 P.M. Interview on 11/20/25 at 1:22 P.M. with Certified Nursing Assistant (CNA) #110 revealed she was the only CNA providing care to residents on 11/08/25 between 12:19 P.M. and 2:11 P.M. and several residents require two-person staff assistance. CNA #110 stated she was unable to answer most of the call lights timely, with some residents waiting for up to an hour for assistance. CNA #110 stated she was unable to assist with baths/showers during this time. CNA #110 revealed Resident #10 requested a shower that day, but she was unable to provide her bath due to short staffing. CNA #110 stated this was her last day working at the facility because she had submitted her resignation mainly due to staffing and due to having been the only CNA working in the facility on 11/08/25 for a period of time. Interview on 11/20/25 at 1:13 P.M. with the Director of Nursing (DON) revealed staffing levels are based on the census and acuity, and she is budgeted for 2.9 hours of direct care daily staff. The DON confirmed there was only one CNA providing care to residents on 11/08/25 between 12:19 P.M. and 2:11 P.M. and several residents require two-person staff assistance with activities of daily living. The DON stated there had been an additional CNA scheduled to work, but she was running late. Interview on 11/20/25 at 8:40 A.M. with the Administrator confirmed on 11/08/25 the facility census was 46 and between 12:19 P.M. and 2:11 P.M., there was only one Certified Nursing Assistant (CNA) scheduled to provide direct care to the residents. 2. Medical record review revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, chronic kidney disease, dementia, diabetes mellitus, flaccid hemiplegia affecting left side, and feeling of incomplete bladder emptying. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, revealed Resident #23 had intact cognition and required assistance from staff with activities of daily living (ADLs). The MDS indicated the resident required substantial/maximal staff assistance with toileting and was occasionally incontinent of both urine and bowel. Review of the Care Plan dated 03/01/23 revealed the intervention for assistance from staff with toileting. Review of the Call Light Audit Report dated 11/08/24 revealed Resident #23's call light was initiated at 1:04:09 P.M. and remained on for 36 minutes and 29 seconds until cleared by staff. Interview on 11/24/25 at 3:15 P.M. with Resident #23 revealed sometimes has to wait for a very long time, often over thirty minutes after ringing her call light. She stated it is hard to hold her urine that long when she needs to go to the bathroom. Interview on 11/25/25 at 8:45 A.M. with the DON confirmed Resident #7, Resident #10, and Resident #23 did not receive timely ADL assistance due to the CNA staffing shortage on 11/08/25. The DON stated it was her expectation that one of the nurses working should have provided assistance to CNA #110. 3. Review of the medical record for Resident #7 revealed an admission date of 10/15/25 with diagnoses including acute kidney failure, weakness, acute respiratory failure, depression, diabetes mellitus, and atrial fibrillation. room [ROOM NUMBER] Review of the admission Minimum Data Set (MDS) assessment, dated 10/20/25, revealed Resident #7 had intact cognition and required assistance from staff with ADLs. The MDS indicated the resident required substantial/maximal staff assistance with toileting and was always incontinent of bowel and frequently incontinent of urine. Review of the Care Plan dated 10/21/25 revealed the intervention for assistance from staff with toileting. Review of the Call Light Audit Report dated 11/08/24 revealed Resident #7's call light was initiated at 1:08:38 P.M. and remained on for 52 minutes and six seconds until cleared by staff. Interview on 11/25/25 at 10:05 A.M. with Resident #7 revealed he recalled on 11/08/25 there was only one CNA working and he rang his call light because he needed to go to the bathroom. He stated he waited for a very long time and eventually had to scream for help. Resident #7 stated other residents were also screaming for help. Resident #7 stated he was unable to wait and did have a bowel movement and felt humiliated. 4. Review of the medical record for Resident #10 revealed an admission date of 02/21/24 with diagnoses including Parkinson's disease, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, depression, and atrial fibrillation Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/25, revealed Resident #10 had intact cognition and required assistance from staff with activities of daily living (ADLs). The MDS indicated the resident required substantial/maximal staff assistance with toileting and was occasionally incontinent of both urine and bowel. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan dated 03/05/24 revealed the intervention for assistance from staff with bathing, per the resident's preference. Review of Resident #10's Shower Task Log revealed she did not receive a shower/bath on 11/08/25. Interview on 11/20/25 at 1:50 P.M. with Resident #10 revealed she prefers and is scheduled to receive a shower daily. Resident #10 stated on Saturday, 11/08/25, she did not get her shower/bath and was told there was only one CNA working and not enough staff. 5. Review of the medical record for Resident #30 revealed an admission date of 10/09/25. Diagnoses included periprosthetic fracture around internal prosthetic right knee joint; diverticulitis of intestine; muscle weakness, fall on same level from slipping; unspecified asthma; hyperlipidemia; morbid obesity, depression, gastro-esophageal reflux; hyperparathyroidism; essential hypertension; obstructive sleep apnea; sciatica; generalized anxiety disorder; chronic pain syndrome, and low back pain. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 on a 0-15 scale. A score of 15 would indicate the resident was cognitively intact. The MDS further revealed the resident had been assessed to need scheduled and as needed pain medications. The resident was assessed to have lower extremity impairment on one side, required a wheelchair, and substantial or maximal assistance for toileting, showering or bathing, putting on footwear, and for bed mobility, which included transferring from bed to chair. She was dependent with lower body dressing. Review of a care plan for Resident #30, dated 10/14/25, revealed a focus of care for risk of skin breakdown related to decreased mobility and incontinence. Interventions for this focus included assisting resident with incontinence care using soap and water, and assisting the resident with toileting as needed. Further review of the care plan for Resident #30, dated 10/14/25, revealed a focus of care for potential alteration in comfort related to right knee periprosthetic fracture. The goal was the resident would have no signs or symptoms of pain. The interventions for the focus of care included pain medication as ordered and per request, attempting alternate pain relief measures including relaxation, reposition, and as needed medications prior to activities, as well as to invite residents to activities. On 11/24/25 at 3:32 P.M., an interview with Resident #30 revealed concerns regarding staff responding to call lights. She indicated on 10/18/25 at 9:20 A.M., she rang her call light for staff assistance when she had to have a bowel movement. The staff did not respond until some time after 9:45 A.M. By the time the staff arrived, the resident had been incontinent of bowels. She reported this incident had left her feeling humiliated. She stated, It is bad enough to have to need help, but to be in that situation was horrible. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The interview further revealed Resident #30 had been frustrated with the staff response time on Veteran's Day (11/11/25), when the staff did not respond to her call light for an extended period of time. She reported it took almost two hours for the staff to respond to her call light for assistance to get out of bed and ready for the Veteran's Day program at the facility. She reported she rang her call bell at 9:00 A.M., and no one came until after the program at 11:00 A.M. to get her up. By that time, she missed the program. The resident reported she met with the Director of Nursing that day, and told her this was unacceptable. The DON told her she would check into the matter and had never addressed it. Two hours later, the Administrator spoke with her and Resident #30 reported the Administrator's response was Are you a veteran?, then changed the subject and there had been no further discussion regarding the incident, until just a couple days ago, when the Social Services Director met with her. On 11/24/25 at 3:32 P.M., an interview with Resident #30 revealed she was not getting her showers as she had requested. She was supposed to get showered on Monday, Wednesday, and Friday. She had plans to go out of the facility on 11/22/25 with family, and had requested a shower on Friday, however this did not happen. She was upset and crying when she had to go to therapy, after Certified Nurse Assistant (CNA) #128 and #140 refused to shower her. They told the resident they would get to her if they had time. Following therapy, Licensed Practical Nurse #122 assisted the resident with a shower. This was confirmed by Licensed Practical Nurse (LPN) #122 on 11/25/25 at 10:40 A.M. Review of a facility document titled Concern Log, and dated for November 2025, revealed a concern logged on 11/19/25 by Resident #30. The concern was noted to be regarding Call lights. The incident was documented as resolved by the social worker. Review of a facility document titled concern form with a submission date of 11/19/25. The document revealed Resident #30 had a concern regarding staffing and call light response times. The Social Services Director response, documented 11/20/25, was for the Director of Nursing to run staffing call light audit for two weeks. The summary of findings/conclusion was the complaint was not confirmed. This was confirmed by the Director of Social Services on 11/24/25 at 4:15 P.M. On 11/24/25 at 4:15 P.M., an interview with the Social Services Director revealed she had not received any concerns from Resident #30 until a corporate nurse mentioned this to her on 11/19/25. She reviewed the details of the concerns and met with the resident, and no further follow up was needed. 6. Review of the medical record for Resident #37 revealed an admission date of 02/19/25/25. Diagnoses include: syncope and collapse; insomnia; weakness; essential hypertension; depression; hyperlipidemia; gastro-esophageal reflux; morbid obesity; osteoarthritis; and chronic pain. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, a score which would suggest cognitive intactness. On 11/20/25 at 11:20 A.M., an interview with Resident #37 revealed she had concerns regarding staffing. She reported six months ago there were lots of aides in the facility, and if you rang your call bell someone came quickly. Now she reported she would wait 45 minutes to an hour just to get assistance. She indicated this had become a problem when she was no longer getting showers when she was supposed to. She had a shower preference of every Tuesday and Thursday. She was not getting showers like she was supposed to and she had complained to someone, she could not recall who, regarding this. (continued on next page)

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	365699	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Ctr IV	55801 Conno-Mara Drive Bellaire, OH 43906

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a treatment administration record for Resident #37 revealed a treatment order, dated 03/07/25 for a head to toe skin assessment to be completed weekly on Thursdays. These were documented as being completed on 11/06/25, 11/13/25, and 11/20/25. Review of shower logs for Resident #37 for the month of November 2025 revealed the resident had a shower on 11/02/25, 11/05/25, 11/07/25, 11/09/25, 11/12/25, 11/15/25, 11/17/25, and 11/20/25. Only 11/20/25 was noted to have been a Thursday. There were no showers completed on Tuesdays. On 11/25/25 at 10:00 A.M., an interview with Director of Nursing revealed skin assessments were completed on residents during showers. She confirmed shower sheets for Resident #37 and also confirmed only 11/09/25 and 11/12/25 revealed any information regarding skin assessments. The other shower forms were blank. Review of a facility provided document titled shower schedule revealed shower schedules for both nursing shifts, 6:00 A.M. to 6:00 P.M (day shift), and 6:00 P.M. to 6:00 A.M.(evening shift). Resident #37 was scheduled for a shower every day, alternating between evening and day shift. Resident #30 was scheduled for shower on Sunday, Monday, Wednesday, and Friday on day shift, and Saturday on evening shift. Resident #37 was scheduled Sunday and Thursday day shift. This was confirmed by Director of Nursing on 11/25/25 at 10:25 A.M. This deficiency represents non-compliance investigated under Complaint Number 2649219.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, the facility failed to safely administer and appropriately document controlled substances. This had the potential to affect 26 residents (Resident #4, #29, #23, #9, #44, #13, #50, #32, #1, #10, #14, #18, #29, #15, #52, #16, #43, #2, #5, #41, #32, #53, #40, #34, #30, and #8) identified as taking controlled substances by the facility. The facility census was 46. Findings include: On 11/25/25 at 8:30 A.M., during medication pass, an observation revealed narcotics sheets were not accurately completed on the medication cart identified as Back. This was confirmed by Licensed Practical Nurse (LPN) #140 at the time of the observation.Review of a facility form titled Facility Shift to Shift Narcotic Count Record, labeled Back unit, and dated from 11/18/25 through 11/25/25, revealed on 11/24/25 at 7:00 A.M., the medication sheet count was 15. Through the shift, the document indicated there were three sheets removed; however the final count at 7:00 P.M. remained 15. The next count for 11/24/25 at 7:00 P.M. was 14 medication sheets. There were eight medication sheets added, and two medication sheets removed. The final count was listed as 24, no error was noted, and then the number 20 was written over the 24 at 7:00 P. M. The next count, on 11/25/25 noted 21 sheets, then 20 was written over top of the 21. The form further revealed on11/25/25, the incoming nurse failed to sign the medication sheet to confirm narcotic counts. This was confirmed by LPN #140 on 11/25/25 at 8:30 A.M.Interview with LPN #140 on 11/25/25 at 8:30 A.M. revealed she had counted narcotics and narcotic sheets with the outgoing nurse at the beginning of her shift. She revealed nurses should mark one line through an error and initial so that documentation was clear. Further, she revealed she had just forgot to sign the narcotic sheet when counting with the outgoing nurse. She did not know why the numbers did not add up for the day before, however all sheets were in the binder, and the counts were correct at 7:00 A.M.Review of the facility form titled Facility Shift to Shift Narcotic Count Record, which was unlabeled, and dated for 11/23/25 through 11/25/25 revealed incorrect dates for the date of the review. The last date noted on the form should have been 11/25/25, however LPN #122 incorrectly documented the date. This was confirmed by LPN #122 on 11/25/25 at 10:30 A.M.An interview with LPN #122 on 11/25/25 at 10:30 A.M., reported each shift the incoming and outgoing nurse should count narcotic sheets and actual medications in each card to be sure the controlled substance count remained accurate. She confirmed the nurses were not all doing counts the same way and this made the facility shift to shift narcotic count record difficult to follow.On 11/25/25 at 10:57 A.M., an interview with Director of Nursing (DON) revealed she had discovered an issue recently with blank spots on the narcotic sheets and this prompted a further review. She reviewed Resident #19's Medication Administration Record (MAR) and printed the sheet for her Tramadol and Ativan. Neither were signed off on the MAR or the narcotic sheet. The DON double checked the narcotics card in the cart, and the counts were incorrect, and at that time she felt it was a documentation error. Further errors were discovered and LPN #119 who had made the errors was immediately suspended pending investigation, and subsequently terminated when the investigation was completed.Review of a policy titled Controlled Substance Storage, dated 07/01/21, revealed medications classified as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. The policy further indicated a controlled substance accountability record should be prepared for all controlled substances. Each shift, a physical inventory of all controlled substances was to be completed and documented by two licensed nurses. Any discrepancy was to be reported to the Director of Nursing immediately. This policy was confirmed by the Director of Nursing on 11/25/25 at 10:05 A.M.This deficiency represents non-compliance investigated under Complaint Number 2649219

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, review of facility's medication administration policy, and interview, the facility failed to ensure medical records were accurate and complete regarding the administration of controlled substances. This affected five (#9, #19, #23, #4, and #44) of six residents reviewed for medication administration. The facility census was 46. Findings include: 1. Review of the medical record for Resident #9 revealed an admission date of 06/13/19 with diagnoses including hemiplegia and hemiparesis following cerebral infarction, dementia, heart failure, respiratory failure, and chronic obstructive pulmonary disease. Review of a physician order dated 08/23/25 revealed the order for Hydrocodone-Acetaminophen 5-325 milligrams (mg) one tablet by mouth three times for pain. Review of Resident #9's Controlled Drug Record revealed Hydrocodone-Acetaminophen 5-325 mg one tablet was administered on 11/18/25 at 8:00 A.M.,12:00 P.M. and 7:00 P.M. Review of the Medication Administration Record (MAR) revealed no documentation of the administration of Hydrocodone-Acetaminophen 10-325 mg on 11/18/25 at 8:00 A.M. and 12:00 P.M. There was a discrepancy between the Controlled Drug Record and the MAR. 2. Review of the medical record for Resident #19 revealed an admission date of 11/05/25 with diagnoses including multiple sclerosis, hypertension, major depressive disorder, diabetes mellitus, conversion disorder with seizures, and chronic kidney disease. Review of a physician order dated 11/06/25 revealed the order for Tramadol HCL 50 milligrams (mg) two tablets by mouth every six hours as needed for pain. Review of Resident #19's Controlled Drug Record revealed Tramadol HCL 50 mg two tablets by mouth every six hours as needed for pain was administered on 11/15/25 at 8:00 A.M., 12:00 P.M. and 7:00 P.M. Review of the Medication Administration Record (MAR) revealed no documentation of the administration of Tramadol HCL 50 mg two tablets on 11/15/25 at 8:00 AM., 12:00P.M. and 7:00 P.M. There was a discrepancy between the Controlled Drug Record and the MAR. Further review revealed Resident #19's Controlled Drug Record indicated Resident #19 received Ativan 0.5 mg one tablet by mouth on 11/08, 11/10, 11/11, 11/12, 11/14, 11/15, 11/17, and 11/18, administered by RN #126. Review of the MAR revealed no documentation of the administration of Ativan 0.5 mg one tablet by mouth on 11/08, 11/10, 11/11, 11/12, 11/14, 11/15, 11/17, and 11/18. 3. Review of the medical record for Resident #23 revealed an admission date of 02/21/24 with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, chronic kidney disease, dementia, diabetes mellitus, flaccid hemiplegia affecting left side, and feeling of incomplete bladder emptying. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 08/23/25 revealed the order for Hydrocodone-Acetaminophen 10-325 milligrams (mg) one tablet by mouth four times for pain. Review of Resident #23's Controlled Drug Record revealed Hydrocodone-Acetaminophen 10-325 mg one tablet was administered on 11/18/25 at 12:00 P.M. and 4:00 P.M. Review of the Medication Administration Record (MAR) revealed no documentation of the administration of Hydrocodone-Acetaminophen 10-325 mg on 11/18/25 at 12:00 P.M. and 4:00 P.M. There was a discrepancy between the Controlled Drug Record and the MAR. 4. Review of the medical record for Resident #44 revealed an admission date of 10/17/24. Diagnoses included chronic combined systolic and diastolic heart failure; morbid obesity; chronic obstructive pulmonary disease; hyperlipidemia; hypothyroidism; presence of cardiac pacemaker; dependence on supplemental oxygen; anemia; nonrheumatic aortic stenosis; chronic kidney disease, essential hypertension and other cirrhosis of the liver. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had cognition issues and could not complete the Brief Interview for Mental Status (BIMS). Further review of the MDS revealed the resident was identified to have a scheduled pain medication regimen. Review of a care plan for Resident #44, most recently updated 09/25/25, revealed a focus area which indicated the resident had inappropriate behaviors at times and would refuse medications. An intervention to administer medications as ordered was initiated on 06/18/25. The care plan further indicated the resident received Hospice services through Southern Care Hospice, which began on 06/29/25, who would coordinate care with the facility. Review of a physician order for Resident #44, dated 06/24/25, revealed an order for Hydrocodone-Acetaminophen 5-325 milligrams (mg) one tablet by mouth three times a day for pain. Review of Resident #44's Controlled Drug Record revealed Hydrocodone-Acetaminophen 5-325 mg one tablet was administered on 11/18/25 at 8:00 A.M.,12:00 P.M. and 7:00 P.M. Review of the Medication Administration Record (MAR) for Resident #44 revealed no documentation of the administration of Hydrocodone-Acetaminophen 5-325 mg on 11/18/25 12:00 P.M. There was a discrepancy between the Controlled Drug Record and the MAR. 5. Review of the medical record for Resident #4 revealed an admission date of 01/25/24. Diagnoses included acquired absence of left leg above the knee; essential hypertension; diabetes mellitus due to underlying condition with other circulatory complications; peripheral vascular disease; hyperlipidemia; muscle weakness; anxiety disorder; major depressive disorder; and polyneuropathy. Review of medication orders for Resident #4 revealed an order for oxycodone-acetaminophen 5-325mg dated 05/09/24. Instructions were to give one tablet by mouth every 12 hours as needed for pain. Review of Resident #4's Controlled Drug Record revealed oxycodone-acetaminophen 11/18/25 at 8:00 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record for Resident #4 failed to reveal administration of oxycodone-acetaminophen 5-325mg on 11/18/25 for the entire day. There was a discrepancy between the Controlled Drug Record and the MAR. During interview on 11/25/25 at 9:07 A.M, the Director of Nursing (DON) confirmed there was a discrepancy between the Controlled Drug Receipt and the MAR for Residents #9, #19, #23, #4, #13, and #44. The DON further confirmed all medications administered should be correctly documented in the medical records at the time of administration. Review of the facility's policy titled, Specific Medication Administration Procedures, dated 07/01/21, revealed after administration, document administration in MAR and Treatment Administration Record (TAR), and controlled substance sign out record, if indicated. This deficiency represents non-compliance investigated under Complaint Number 2649219

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to follow proper hand hygiene and management of soiled linens during incontinence care. The affected one (#5) of one resident reviewed for incontinence care. The facility census was 46. Findings include:Review of the medical record for Resident #5 revealed an admission date of 10/21/25. Diagnoses included chest pain, unspecified; atherosclerotic heart disease; essential hypertension; cerebrovascular disease; old myocardial infarction; paranoid schizophrenia; and displaced intertrochanteric fracture of unspecified femur.Review of a care plan for Resident #5 , dated 10/21/25, revealed the resident needed assistance from staff to meet activities of daily living (ADL) needs due to decreased mobility. Staff was to assist resident with incontinent care, toileting, bed mobility, dressing, and laundry.On 11/24/25 at 10:10 A.M., an observation of incontinence care for Resident #5 revealed the Certified Nurse Aide (CNA) #115 failed to maintain infection control while performing incontinence care. After cleansing the resident's perineal area following a bowel movement, CNA #115 did not wash her hands or change her gloves before she applied barrier cream and applied a new incontinence brief. Further, when changing linens, CNA #115 placed the soiled linens on the floor of Resident #5's room and did not place the linens in a bag or a soiled linen container. Following care, CNA #115 confirmed she did not wash hands, change gloves, or use a linen bag for soiled linens during the care process.On 11/24/25 at 10:43 A.M., an interview with Director of Nursing confirmed hands should be washed between performing peritoneal care and putting on new gloves. She also confirmed the soiled linens should be placed into a bag or linen barrel immediately and not placed on the floor.Review of a facility policy titled Perineal Care, dated 06/04/21, revealed the purpose of the of the procedure was to prevent infection and odors and promote comfort. The policy further indicated the staff was to wear gloves during perineal care. During the cleansing process the staff was to place soiled washcloths, towels and linens on an impermeable barrier. The policy further indicated following care, the staff was to remove gloves and wash hands. There was no guidance of hand hygiene or glove changing when applying incontinent brief or barrier cream following perineal care. This deficiency represents non-compliance investigated under Complaint Number 2649219.