STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365815	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Center	1350 Yauger Road Mount Vernon, OH 43050

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, review of a facility Self-Reported Incident (SRI), facility investigation review, personnel file review, facility policy review and interview, the facility failed to ensure Resident #51 was free from an incident of staff to resident physical abuse when State tested Nursing Assistant (STNA) #267 slapped the resident during the provision of care. This affected one resident (#51) of three residents reviewed for abuse. The facility census was 69. Findings Include: Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including unspecified dementia, high blood pressure, asthma, and muscle weakness. Review of Resident #51's bladder and bowel incontinence care task documentation dated 08/30/24 to 09/30/24 revealed Resident #51 was always incontinent of bowel and bladder, there were no refusal marked for care attempted by staff. Review of the facility's Self-Reported Incident (SRI) Tracking Number 251637 dated 09/07/24 revealed on 09/07/24 at approximately 10:00 P.M. it was reported that a facility State tested Nursing Assistant (STNA) (identified as STNA #267) slapped the hand of Resident #51 during the provision of care. The alleged perpetrator was suspended pending investigation. Resident #51's emergency contact and physician were notified. An investigation was initiated consisting of interview and skin assessment of Resident #51, interview of the reporting witness, interview of the alleged perpetrator, interviews of staff and interviews of residents within the same care section as Resident #51. During interview Resident #51 he was unable to recall the occurrence. The skin assessment performed revealed no signs of injury directly or indirectly related to the alleged incident. Interview of the reporting witness (staff) revealed that during the performance of care, Resident #51 was observed grabbing. According to the witness's recollection and perspective Resident #51 had been grabbing at his incontinence brief at the time of the occurrence. During interview the alleged perpetrator reported that Resident #51 grabbed her ' , very hard and that in response she smacked his hand. As a result of the investigation the facility concluded the alleged perpetrator's actions were not reflective of facility standards of conduct and the decision was made to terminate her employment. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation dated 09/07/24 revealed a statement dated 09/07/24, authored by STNA #267 (alleged perpetrator), stating STNA #267 was assisting Resident #51 when Resident #51 forcefully grabbed STNA #267. STNA #267 moved Resident #51's hand away and tapped/smacked Resident #51's hand as if to scold Resident #51 and said No, don't grab me. Further review revealed a statement dated 09/07/24 authored by STNA #177 stating STNA #267 was helping with changing Resident #51 when Resident #51 grabbed STNA #267, STNA #267 was witnessed smacking Resident #51's hand. STNA #177 asked STNA #267 to leave the room. STNA #177 reported the incident to Registered Nurse (RN) #213. Review of STNA #267's personnel file revealed a hire date of 12/2023 and she had received abuse and dementia education during orientation to the facility. Further review revealed the STNA was no longer an employee of the facility. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had severely impaired cognition and had impaired vision and hearing. The assessment revealed Resident #51 was always incontinent of bladder and bowel requiring total care by staff to complete incontinence care. Resident #51 required assistance from staff to complete activities of daily living (ADL) tasks. Review of Resident #51's resistive behavior care plan dated 09/17/24 revealed Resident #51 would be resistive to care related to dementia with interventions including if resident resists with ADLs, reassure resident, leave and return five to ten minutes later and try again. Further review of Resident #51's behavior management care plan dated 09/17/24 revealed interventions including attempt an alternate time to provide care refused, per resident's preference and ensure the safety of the resident and others. Interview on 10/01/24 at 3:08 P.M. with RN #213 revealed STNA #177 reported an incident to RN #213 related to Resident #51. In turn, RN #213 removed STNA #267 from the schedule and requested a statement to be written by STNA #267. Upon completion of the statement, STNA #267 was placed on suspension pending investigation and directed to leave the facility. RN #213 stated on the following Monday, 09/09/24, STNA #267 had sent a text message to the Director of Nursing (DON) which stated she was self-terming employment with the facility. Interview on 10/01/24 at 3:20 P.M. with the Administrator confirmed STNA #267 had smacked Resident #51's hand during care on the night of 09/07/24. Review of the facility's policy titled, Abuse dated 01/31/20 revealed, Residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint that is not required to treat the resident's medical symptoms. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology, such as through the use of photographs and recording devices to demean or humiliate a resident. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 THIS IS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of a facility Self-Reported Incident (SRI), facility investigation review, medical record review, staff interviews, and facility policy review the facility failed to prevent misappropriation of resident narcotic medication. This affected one resident (Resident #12) of three residents reviewed for abuse The facility census was 69. Findings Include: Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including rheumatoid arthritis (RA), osteoporosis, gastric ulcer, and restless leg syndrome. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #12 required assistance from staff for activities of daily living (ADL) tasks including medication administration. The resident was cognitively intact. Review of the physician orders for Resident #12 revealed an order dated 06/27/24 for narcotic as needed pain medication, Percocet Oral Tablet 10-325 milligrams (mg), give one tablet by mouth every six hours as needed for pain. Review of Resident #12's Medication Administration Record (MAR) dated 08/01/24 to 08/31/24 revealed the as needed pain medication, Percocet Oral Tablet 10-325 mg, had been administered daily, at bedtime, for the month of August including the night of 08/16/24 at 8:04 P.M. Review of the facility Self-Reported Incident (SRI) Tracking Number 250912 dated 08/26/24 revealed on 08/17/24 facility staff identified that eight narcotic tablets were missing from the medication supply for Resident #12. The tablets in question were the remaining amount of an initial 30 tablet supply for Resident #12. A suspected perpetrator was identified and suspended pending investigation. Resident #12's physician and responsible party were notified. Interview with Resident #12 denied experiencing any recent change in health or symptom management as well as any knowledge of the missing tablets. During interview with the suspected perpetrator, she denied any knowledge of the missing medication but did not cooperate further with the investigation. The suspected perpetrator's employment was terminated. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation dated 08/18/24 revealed on the night of 08/17/24, during shift change and narcotic counting for A hallway, Resident #12's narcotic medication count sheet was discovered lying underneath the narcotic medication binder which was located on top of the medication cart. Registered Nurse (RN) #213 was notified by Licensed Practical Nurse (LPN) #197 of Resident #12's count sheet being found with a comment of completed written across the sheet and LPN #265's signature below the comment. The sheet indicated there were eight tablets remaining that had not been administered or signed out as being administered by the nursing staff. The Director of Nursing (DON) was notified by RN #213 and the DON immediately came to the facility to begin the investigation. LPN #265 had last worked the night shift of 08/16/24 on A hallway and during shift change for the morning of 08/17/24 and the shift change for the night shift on 08/17/24 the narcotic count of medication cards and count sheet was correct at 23 cards and 23 sheets. The DON contacted LPN #265 for an interview and LPN #265 denied knowledge of the removal of Resident #12's narcotic medication card or the count sheet and was placed on suspension pending investigation. LPN #265 agreed to meet with the DON on 08/18/24 for further investigation and statement. On the morning of 08/18/24, the DON returned to the facility and attempted to notify LPN #265 with no success. The DON then filed a police report with the local police department for the missing narcotic medication. Resident #12's empty narcotic card for Percocet Oral Tablet 10-325 mg was located in the paper shred box on A hallway, the card was noted to be empty of all tablets, which did not reflect the count sheet total of tablets left at being eight. The empty narcotic medication card matched the pharmacy prescription number located on the narcotic count sheet for Resident #12. Interview on 10/01/24 at 10:07 A.M. with the DON revealed Resident #12's missing eight tablets of narcotic pain medication, Percocet, had not been located during the facility investigation dated 08/18/24. The DON stated the facility immediately began education with the nurses on 08/18/24 to review the proper procedures for counting narcotic medications during shift change and to implement a new procedure to prevent missing narcotic medications in the future. This new procedure detailed two nurses were to verify and sign when a narcotic medication was completed and the count sheet was removed from the narcotic count binder, the count sheet would be signed by the two nurses, upon verification of the empty card, and the two nurses would sign the removal of the empty narcotic medication card and the completed count sheet removal from the narcotic count binder. The DON stated LPN #265 was eventually interviewed on 08/20/24 and denied removing Resident #12's narcotic medication tablets but could not defend the actions taken on the night of 08/17/24. LPN #265 was terminated employment at the facility. LPN #265 had been reported to the state Board of Nursing and the state Board of Pharmacy. Review of the Pharmcy Fill History report for Resident #12 revealed the prescription for 60 tablets of Percocet Oral Tablet 10-325 mg give one tablet by mouth every six hours as needed for pain had been initially filled and delivered to the facility on [DATE] and billed to Resident #12's insurance company. Upon notification of the missing remaining eight tablets on 08/17/23, the facility requested to be charged for a 30-day supply of Resident #12's Percocet Oral Tablets to cover the missing eight tablets and the insurance company for Resident #12 would be billed for the other 30-day supply of Percocet Oral Tablets. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/01/24 at 11:35 A.M. with RN #163 revealed during shift change narcotic count the two nurses will count the narcotic cards and verify the amount of medication in the card matches the narcotic count sheet. If there is an empty card that required removal for the medication cart, the two nurses will verify the empty narcotic card with the completed count sheet, and both will sign to verify the completion of the narcotic medication. RN #163 confirmed the DON had provided education to the nurse on 08/18/24 for the new procedure. Interview on 10/01/24 at 11:45 A.M. with the DON confirmed Resident #12's narcotic medication Percocet had been missing on 08/17/24. The DON stated the facility had completed a through investigation of the incident and had educated the nurses on 08/18/24 for a new procedure to aid in the prevention of missing narcotic medications in the future. The DON stated the facility's regional nurse (RN #263) had notified the pharmacy following the incident and the facility had been charged for a 30-day supply of Resident #12's narcotic medication, Percocet, to cover the missing eight Percocet tablets. Review of the facility policy titled, Abuse revised on 01/30/20 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint that is not required to treat the resident's medical symptoms. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The deficiency was corrected on 08/18/24 when the facility implemented the following corrective actions: On 08/18/24 the DON educated 16 nurses on controlled substances procedures for receipt from pharmacy, administration of, shift to shift verification, and exhausting/removal of medications. On 08/18/24 the Regional Nurse Consultant notified pharmacy and requested for the 30-day supply dated 08/07/24 for Resident #12 be charged to the facility and the missing narcotic medication be replaced for Resident #12. On 08/18/24 the DON completed an audit for all residents receiving narcotic medications for verification of the medications remaining in the medication card is accurate with the corresponding signature count sheet. There were no discrepancies found. Beginning 08/22/24 the DON will audit narcotic count binder, narcotic medication cards and the corresponding narcotic signature count sheets for accuracy two times weekly times four weeks and then weekly times four weeks with the findings being reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) committee meeting. Between 08/18/24 and 10/01/24, there had been no additional allegations of narcotic misappropriation reported.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, medical record review, review of emergency room records, review of the facility incident and accident logs, interview and facility policy review, the facility failed to develop and implement a comprehensive and individualized fall prevention program to prevent falls including a fall with major injury for Resident #60. Actual Harm occurred on 09/04/24 at 7:45 P.M. when Resident #60, who was identified as a high fall risk and experienced recent falls without individualized fall prevention interventions implemented to prevent further falls, climbed out of bed, unassisted and had to be lowered to the floor by State tested Nursing Assistant (STNA) #222 when she became unsteady and began to fall. The resident denied pain on 09/04/24 and was assisted back to bed; however, on 09/05/24 at 8:29 A.M. an order was received for an immediate (STAT) x-ray of the right hip, pelvis, femur and knee due to complaints of increased pain. On 09/05/24 at 1:00 P.M. the facility was notified the resident had acute fractures of the distal femur and proximal tibia (as a result of the incident on 09/04/24) and was transferred to the emergency room (ER) for further evaluation and treatment. This affected one resident (#60) of three residents reviewed for falls. Findings Include: Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses including heart failure, muscle weakness, depression, dementia, osteoporosis, osteopenia, and syncope. Resident #60 was receiving hospice services for end stage heart failure. Review of Resident #60's at risk for falls/injury related to cognitive impairment, dizziness, history of falls, impaired balance, pain, osteoporosis, syncope related to aortic stenosis, poor safety awareness with impulsiveness noted at times care plan dated 01/06/20 revealed interventions including to encourage the resident to change positions slowly due to dizziness dated 01/06/20, room moved to a higher traffic area on 02/14/24, staff to anticipate needs dated 01/06/20, visual reminders to utilize call light for assistance dated 02/17/24, proper footwear to be worn at all times while out of bed dated 06/15/24, encourage non-skid/gripper socks when shoes are off dated 01/06/20, a personal alarm bed/chair to alert staff of unassisted transfer check for placement and function every shift was implemented on 07/07/24 and a fall intervention for a medication review completed by hospice was implemented on 07/29/24. Review of the physician orders dated 07/07/24 revealed an order for a personal alarm bed/chair to alert staff of unassisted transfers. Check for placement and function every shift (alarms to sound to walkies and computer only as to be non-disruptive.) Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] Resident #60 had severely impaired cognition and required minimal assistance with transfers, ambulated with the assist of a walker and stand-by assist from staff, and moderate assist with activities of daily living (ADL) tasks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility incident logs dated 07/01/24 to 09/30/24 revealed Resident #60 had witnessed falls on 08/26/24 and 09/04/24, and unwitnessed falls on 07/07/24, 07/21/24, 07/28/24, and 07/29/24. Review of Resident #60's fall investigations revealed the following: A fall on 07/07/24 at 9:46 A.M. revealed Resident #60 was observed by a visitor to be sitting on the floor inside the room with her back against the side stand with the walker noted in the doorway to the bathroom. Resident #60 stated she struck her head on the side stand when she fell . There was no redness or swelling observed to the left side of the head. A fall intervention for the use of a bed/chair alert alarm pad was implemented. Review of the Post-Fall Risk assessment dated [DATE] revealed the resident was determined to be a high fall risk. A fall on 07/21/24 at 10:25 P.M. revealed Resident #60 was observed on her knees at her bedside. Resident #60 sated she had been ambulating and fell on to buttocks and bilateral knees. Resident #60 complained of pain to her bilateral knees and buttocks. Resident #60 was able to move all extremities. Resident #60 was placed into the recliner with the alert bed/chair alarm in place. There was no fall interventions implemented following the fall. A fall on 07/28/24 at 11:50 A.M. revealed Resident #60 was observed sitting on the floor beside the recliner with her back against a suitcase and the bookshelf. Resident #60 complained of pain to her back and a bruise was noted to be forming on the lower back from falling on the suitcase. There was no mention of the alert bed/chair alarm to be sounding at the time of the fall. A fall intervention for a medication review to be completed by hospice was requested. A fall on 07/29/24 at 3:44 P.M. revealed Resident #60 was observed sitting on the floor with her legs drawn up between the bookshelf and the recliner with her walker tipped over. Resident #60 was observed with a hematoma forming to the right side of her forehead. Resident #60 did not have appropriate footwear in place. The fall intervention implemented was for a medication review to be completed by hospice. The medication review was completed on 07/30/24 with no new orders or changes to the resident's medications. A fall on 08/26/24 at 11:20 P.M. revealed Resident #60 was ambulating unassisted with her walker, in the hallway. Resident #60 stopped ambulating and fell backwards onto the floor forcefully striking the back of her head on floor. Upon assessment a large lump was palpated to the left back of her head and her blood pressure and pulse were elevated. Resident #60 complained of pain to her head. Resident #60 had appropriate footwear in place. There was no mention of the alert bed/chair alarm sounding. Resident #60 was sent to the hospital for further evaluation and possible treatment. There was no fall interventions implemented following the fall. Review of Resident #60's emergency room paperwork dated 08/26/24 revealed Resident #60 was diagnosed with an acute right posterior head contusion and returned to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall on 09/04/24 at 7:45 P.M. revealed Resident #60 was observed by State tested Nursing Assistant (STNA) #222 standing at her bedside, unassisted, with the alert alarm sounding. Resident #60 became unsteady and started to slide downwards. STNA #222 assisted Resident #60 down to the floor, in a seated position with her legs extended outwards. Resident #60 was assessed for injury by Registered Nurse (RN) #259. There were no indication of injury and Resident #60 denied pain. Resident #60 was assisted off the floor and into a wheelchair, taken to the restroom and then assisted back into bed. There was no fall intervention implemented following the fall. The facility was unable to provide evidence the falls were reviewed to determine a root cause, identify a trend or to ensure appropriate, individualized fall prevention interventions were added to the resident's plan of care for the falls dated 07/29/24 (a duplicate intervention to the fall that occurred on 07/28/24), 08/25/24 and 09/04/24. Review of the nurse progress note dated 09/05/24 at 8:29 A.M. (the first progress note entry after the resident's fall on 09/04/24) revealed an order was received for STAT x-rays to the right hip, pelvis, femur and knee due to complaints of increased pain. On 09/05/24 at 1:00 P.M. the facility was notified (by the x-ray company) the resident sustained acute fractures of the distal femur and proximal tibia and was transferred to the emergency room (ER) for further evaluation and treatment. Review of Resident #60's emergency room documents, dated 09/05/24, revealed Resident #60 was diagnosed with a displaced fracture the distal (lower) right femur, a fracture of the neck of the right fibula, and a possible fracture line of the right tibial plateau per x-ray of right leg and pelvis. Resident #60's Power of Attorney (POA) requested to not pursue any surgical intervention for the fractures given Resident #60's severe medical problems. Review of Resident #60's Treatment Administration Record dated 09/01/24 to 09/05/24 revealed documentation of completion for monitoring the personal alarm to the bed/chair to alert staff of unassisted transfers, check for placement and function every shift. Observation on 09/30/24 at 10:00 A.M. revealed Resident #60 resting in bed with an alert alarm pad in place, a visual reminder to use the call light, and her call light was within reach. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/01/24 at 10:07 A.M. with the Director of Nursing (DON) revealed Resident #60 was at high risk for falls due to a history of falls, unsteady gait, dementia, and being restless at times. The DON stated Resident #60 was ambulatory with the use of a walker and would ambulate in the hallways of the facility with staff assistance. At times, Resident #60 would not be content to sit in the recliner or lay in bed and would be known to pack her suitcase with her belongings, verbally stating she wanted to leave the facility. She also shared the resident was known to have increased restlessness in the evening/nighttime and she had observed this when she sometimes worked the evening shift on the floor. The facility had moved Resident #60 from her original room on the back hallway to a room closer to the nurses' desk and on a higher trafficked hallway for better monitoring of Resident #60. The DON shared nurses were to assess the resident, check for injuries, complete paperwork and notifications. If the nurse could not determine an intervention to implement, they would contact the nurse on-call for ideas. The DON then stated the fall would be reviewed in the risk meeting to make sure the paperwork is completed, and an intervention had been implemented. Further interview revealed the resident had fallen on night shift, 09/04/24 and when she (the DON) worked the floor as an aide on 09/05/24, we (she did not indicate who the other staff was) went in to reposition Resident #60 for breakfast and she was complaining of her right leg hurting. The DON stated she had the nurse call (the physician) for X-ray orders. The X-rays were completed and that is how the facility learned the resident had fractures and she was sent to the ER for evaluation. Interview on 10/01/24 at 11:35 A.M. with RN #163 revealed the process for completing a post fall assessment, implementation of fall interventions and updating the fall care plans for residents had been the responsibility of RN #163 to help with the administrative nurse's workload but her administrative job responsibilities had been removed. Interview on 10/01/24 at 11:45 A.M. with the DON confirmed Resident #60 did not have fall interventions implemented for falls which occurred on 07/21/24, 07/28/24, 08/26/24 and 09/04/24. The DON stated there should be interventions implemented for each fall that occurs with a resident. Further interview with the DON revealed several nurses were assisting with the follow-up regarding falls and sometimes they did not have time to review the falls to ensure interventions are added to prevent future falls. During the onsite survey, attempts were made to reach STNA #222 via phone; however, no return call was provided. Review of the facility's policy titled, Accident/Incident Reporting last revised 08/13/14 revealed, Accidents and incidents are to be promptly and thoroughly reviewed and investigated. An incident is defined as an event, occurrence or happening that may result in actual or potential harm of a resident. The purpose of the incident reports are to facilitate the early detection problems or compensable events; to establish a foundation for early investigation of all potentially serious events; to develop a database for long-range problem detection, analysis and correction; to enable cross-reference with other risk detection systems; to investigate and respond to serious adverse events, in accordance with accrediting bodies standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365815	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Center	1350 Yauger Road Mount Vernon, OH 43050

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 0689 Level of Harm - Actual harm Residents Affected - Few	When an incident occurs, the individual discovering the incident will notify the supervisor immediately with observations or identification of the incident; follow-up with the resident and family/caregiver and resident's physician as indicated; Complete the Incident Report Form within 24 hours of the incident; the Administrator/Designee will review the incident report and request the necessary follow-up from the appropriate personnel. Corrective actions will be implemented and evaluated for effectiveness as indicated; A witness statement will be obtained, if applicable; Investigation will be completed, and findings will be documented.