

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review and interview, the facility failed to have the correct advance directives in Resident #22's medical record. This affected one resident (#22) out of three reviewed for advance directives. This had the potential to affect all 60 residents. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses including dementia, hypertension, mood disorder, and anxiety disorder.</p> <p>Review of the scanned documents in the electronic medical record revealed on 06/15/23 Resident #22's advance directives were documented as a full code (all resuscitation procedures to be performed to keep a resident alive if their heart stops beating or their breathing stops).</p> <p>Review of the scanned documents in the electronic medical record revealed on 09/15/23 an order was signed to change Resident #22's code status to Do Not Resuscitate Comfort Care (DNRCC)-Arrest (can receive standard medical care until they experience a cardiac or respiratory arrest).</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had a Brief Interview Mental Status (BIMS) score of 11 out of 15, which indicated cognitive impairment.</p> <p>Review of the medical record at the nurse's station on 05/14/24 revealed no evidence of advance directives.</p> <p>Interview on 05/14/24 at 8:58 A.M. Licensed Practical Nurse (LPN) #57 verified Resident #22 did not have advance directives in the medical record at the nurse's station. LPN #57 verified the electronic record revealed Resident #22 was a DRNCC-Arrest.</p>

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: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review, self-reported incident (SRI) review, facility policy review, and interviews, the facility failed to protect Resident #4 from staff-to-resident physical abuse and Resident #17 from staff-to-resident verbal abuse. This affected two residents (#4 and #17) out of two residents reviewed for abuse. This had the potential to affect all 60 residents. The facility census was 60.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression.</p> <p>Review of the plan of care dated 05/13/22 revealed Resident #4 required assistance from staff for activities of daily living. Interventions included to assist with toileting as needed.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had a Brief Interview Mental Status (BIMS) score of one out of 15 which indicated severe cognitive impairment. Resident #4 was dependent on staff for toileting.</p> <p>Review of SRI #246175 dated 04/09/24 revealed on 04/09/24 at approximately 7:20 P.M. State tested Nursing Assistant (STNA) #5 notified the Director of Nursing (DON) that STNA #102 slapped the back of Resident #4's hand. Resident #4 was unable to recall the incident. STNA #5 was interviewed and stated during incontinence care Resident #4 became agitated and began to scratch and hit STNA #5 and STNA #102. STNA #102 slapped the back of Resident #4's hand and stated not to do that. Resident #4 responded with that hurt. An interview with STNA #102 revealed Resident #4 became agitated and began scratching and hitting STNA #5 and STNA #102. STNA #102 stated when Resident #4 attempted to hit STNA #102, STNA #102 raised her hand to block Resident #4 which resulted in causing contact with Resident #4's hand. STNA #102 confirmed Resident #4 stated that hurt.</p> <p>Review of a typed statement dated 04/09/24 signed by the DON revealed an interview was conducted with STNA #102. STNA #102 reported care was being provided for Resident #4. Resident #4 was sitting on the toilet when Resident #4 became agitated and began hitting and scratching at STNA #5 and STNA #102. Resident #4 reached towards STNA #102 to hit her. STNA #102 stated she instinctively raised her hand to prevent Resident #4 from hitting her which caused contact between STNA #102 and Resident #4. STNA #102 did not recall Resident #4 reporting any discomfort from the incident.</p> <p>Review of a signed statement by STNA #5 dated 04/10/24 revealed they were assisting STNA #102 with providing incontinence care to Resident #4 on 04/09/24. Resident #4 was sitting on the toilet, and STNA #102 was in front of Resident #4 and STNA #5 was standing on Resident #4's left side. Resident #4 reached up to possibly scratch or hit STNA #102. STNA #102 slapped the top of Resident #4's hand and said I said not to do that. Resident #4 stated that hurt. STNA #5 notified the DON of the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the police report dated 04/11/24 at 10:47 A.M. revealed a deputy was dispatched to investigate a complaint. Administrator #500 reported on 04/09/24 STNA #102 was cleaning Resident #4, and STNA #102 smacked Resident #4's hand. Administrator #500 stated STNA #5 witnessed the incident. STNA #5 told the police officer, Resident #4 had dementia and was trying to hit and kick staff during care. Resident #4 was very agitated and continued to hit and scratch STNA #5 and STNA #102. STNA #102 then swatted Resident #4's hand away.</p> <p>Review of the Employee Change of Status Notification dated 04/11/24 revealed STNA #102 was involuntarily terminated. There was not a description of the circumstances surrounding the involuntary termination.</p> <p>Interview on 05/15/24 at 2:45 P.M. STNA #5 verified STNA #102 did slap Resident #4's hand while Resident #4 was being combative with care.</p> <p>Interview on 05/16/24 at 8:33 A.M. Corporate Nurse #100 verified STNA #102 was interviewed but did not sign the statement. Corporate Nurse #100 stated he and the DON wanted to interrogate STNA #102, so a signed statement was not obtained by STNA #102. Corporate Nurse #100 verified the unsigned statement revealed Resident #4 did not report any pain or discomfort, but the SRI revealed STNA #102 reported Resident #4 did complain of pain.</p> <p>Review of the abuse policy revised on 01/31/20 revealed residents have the right to be free from abuse. It is the facility's policy to investigate all alleged violations involving abuse. Abuse is defined as the willful infliction of injury. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Investigation protocol includes interviewing the resident, the accused, and all witnesses. In the case of staff-to-resident abuse, the facility will follow the facility's procedure for disciplining or dismissing an employee, depending upon the circumstances and results of the investigation.</p> <p>48568</p> <p>2. Review of medical record for Resident #17 revealed admitted [DATE] with diagnoses including polyneuropathy, unspecified fracture of lower end of left tibia, and morbid obesity.</p> <p>Review of the most recent quarterly MDS assessment dated [DATE] revealed Resident #17 was cognitively intact and required setup/clean up assistance for eating, oral hygiene, upper body dressing, personal hygiene, and rolling left and right.</p> <p>Interview on 05/14/24 at 1:31 P.M. at the Resident Council meeting revealed Resident #17 stated she was threatened with bodily harm by an aide.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/24 at 12:49 P.M. with Resident #17 revealed she left the facility with a bone crack in her leg. When she returned to the facility, Resident #17 said STNA #40 came into her room with an attitude. Resident #17 told STNA #40 she was being rough with her, and STNA #40 said I will break your other leg. STNA #40 also yelled at her for going into another room. Resident #17 stated she was embarrassed when STNA #40 yelled at her in front of a family member from the room next door. Resident #17 said she reported this situation to a housekeeper, who is now STNA #42. Resident #17 said STNA #42 went to Social Service Director (SSD) #9. Resident #17 said she will not have STNA #40 take care of her anymore, and STNA #40 is not allowed in her room. Resident #17 stated both incidents happened last September. Resident #17 said she talked to the Ombudsman about this situation as well. She can't remember who or when she talked to the Ombudsman.</p> <p>Interview on 05/15/24 at 1:02 P.M. with SSD #9 revealed SSD #9 stated Resident #17 had an issue with an STNA. Resident #17 didn't tell her which one. SSD #9 was told by Resident #17 that an STNA was refusing to help her, and the aide said you can do this yourself. SSD #9 said it was that type of thing. She reported it to the Administrator at that time, but that Administrator does not work here anymore. This occurred close to the time Resident #17 was admitted. The current DON did an investigation, but she doesn't know what the result was. SSD #9 said she has met with Resident #17 since, and Resident #17 has not had complaints or further issues with her care.</p> <p>Interview on 05/15/24 at 01:13 P.M. with the DON revealed she didn't know off the top of her head if Resident #17 brought her any concerns about care provided by aides. When asked if a certain aide does not work with Resident #17, the DON stated not that I can think of. The DON was also questioned if SSD #9 brought anything like that to her attention, the DON said potentially if there would have been something.</p> <p>Interview on 05/15/24 at 3:20 P.M. with STNA #40 revealed she had issues with Resident #17 sometime last year. STNA #40 said she usually answers call lights as they go off to make it fair unless the resident is a fall risk. STNA #40 said she was in the room next to Resident #17 and talking to a resident and their family. STNA #40 said Resident #17 came into that room mad and upset that I answered his call light before hers. STNA #40 told Resident #17 that it would be a minute. STNA #40 said I guess that is what made Resident #17 mad. STNA #40 said Resident #17 wanted a gown before she got into bed. STNA #40 said Resident #17 was calling her all kinds of names. STNA #40 said to diffuse the situation she stepped out of the room and closed the door. STNA #40 said she heard loud banging coming from the room. STNA #40 said she got another aide to see what Resident #17 needed, and Resident #17 was nasty to them too. STNA #40 said she could not remember what aide she got to help her. STNA #40 said she reported it to her nurse at that time. She said she also messaged Assistant Director of Nursing (ADON) #47. STNA #40 said she was told not to go into Resident #17 's room to care for her anymore. STNA #40 said she remembered it happened towards the end of September. STNA #40 said she was not suspended and thinks the next-door family member wrote down statements. STNA #40 said Resident #17 did not say she was hurting her when providing care. STNA #40 said the DON and ADON #47 did the investigation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/24 at 04:32 P.M. with the DON who was accompanied by Corporate Nurse #100 revealed when the DON found out about the situation, she went to get a statement from the resident. The DON said Resident #17 told her STNA #40 ignored her call light. The DON said Resident #17 did not describe mistreatment. Resident #17 told the DON that STNA #40 wasn't receptive to her needs and ignored the call light. The DON stated it was more of a customer service thing. The DON said STNA #40 was talking to a family in the hallway. The DON said Resident #17 did allow STNA #40 to provide care. The DON said Resident #17 stated she was calling STNA #40 names, and STNA #40 went to get another STNA. The DON said when she was talking to Resident #17 there was no allegation of any type of mistreatment. The DON said if Resident #17 is alleging mistreatment now, they would do an SRI. When asked who made the decision that this incident was not reportable, the DON replied that it was the previous Administrator. When asked if an investigation was done, the DON replied that she does not know where they are.</p> <p>Interview on 05/16/24 at 01:04 P.M. with STNA #42 revealed Resident #17 told her about a situation last September with STNA #40. STNA #42 said STNA #40 got real smart with Resident #17 and didn't get her out of bed and took a tone with her. STNA #42 said she was visiting her dad next door when this occurred. STNA #42 explained that Resident #17 asked STNA #40 to change her bed, and STNA #40 took an inappropriate tone with her. STNA #42 said STNA #40 said she didn't have time for it, and she would get to it when she gets to it. STNA #42 said it wasn't physical, but STNA #42 talked to Resident #17 like a child. She belittled her and said it was a lack of respect. STNA #42 said she would consider the interaction verbal abuse. STNA #42 said she went to the DON and the previous Administrator. STNA #42 thinks she remembers filling something out.</p> <p>Interview on 05/16/24 at 1:19 P.M. revealed the Ombudsman was left a voicemail and a call was not returned.</p> <p>Interview on 05/16/24 1:34 P.M. with ADON #47 revealed she remembered an issue with STNA#40 and Resident #17 in September of last year. ADON #47 said it was reported that statements were made, and we went down and talked to Resident #17 and staff. ADON #47 said Resident #17 said STNA #40 was saying stuff to her. ADON #47 said when we talked to Resident #17, she said STNA #40 didn't make the statements Resident #17 said STNA #40 had made. When asked if ADON #47 has the statements, she said she would have to check. When asked if ADON #47 or the DON filled out a report, ADON #47 said we investigated it and talked to staff. When asked if any of this information was documented, ADON #47 said she does not remember. ADON #47 said a couple of call lights were going off in the area and the staff member chose the one that was a priority. ADON #47 said Resident #17 felt like STNA #40 chose that resident over her. When asked if she had proof that the resident said that ADON #47 said she would have to see if they had that statement. When asked if ADON #47 received complaints about STNA #40, she said I think sometimes STNA #40 gets overwhelmed. But at the end of the day, she does what she needs to do. She's a good aide.</p> <p>Interview on 05/16/24 at 03:43 P.M. with the DON revealed they do not have documentation from the September incident between Resident #17 and STNA #40.</p> <p>Review of the facility self-reported incidents to the State agency revealed no evidence this incident of abuse was reported to the agency as required.</p> <p>Review of the personnel record for STNA #40 revealed one written consultation from 08/02/23 revealed an unexpected absence and 12 call offs during her 90-day probationary period.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the abuse policy dated 01/31/20 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review, interview, review of the self-report incidents (SRI), and facility policy review, the facility failed to report an allegation of staff-to-resident verbal abuse against Resident #47 to the state agency as required. This affected one resident (#47) of two residents reviewed for abuse. The facility census was 60.</p> <p>Findings include:</p> <p>Review of medical record for Resident #17 revealed admitted [DATE] with diagnoses including polyneuropathy, unspecified fracture of lower end of left tibia, and morbid obesity.</p> <p>Review of the most recent quarterly MDS assessment dated [DATE] revealed Resident #17 was cognitively intact and required setup/clean up assistance for eating, oral hygiene, upper body dressing, personal hygiene, and rolling left and right.</p> <p>Interview on 05/14/24 at 1:31 P.M. at the Resident Council meeting revealed Resident #17 stated she was threatened with bodily harm by an aide.</p> <p>Interview on 05/15/24 at 12:49 P.M. with Resident #17 revealed she left the facility with a bone crack in her leg. When she returned to the facility, Resident #17 said STNA #40 came into her room with an attitude. Resident #17 told STNA #40 she was being rough with her, and STNA #40 said I will break your other leg. STNA #40 also yelled at her for going into another room. Resident #17 stated she was embarrassed when STNA #40 yelled at her in front of a family member from the room next door. Resident #17 said she reported this situation to a housekeeper, who is now STNA #42. Resident #17 said STNA #42 went to Social Service Director (SSD) #9. Resident #17 said she will not have STNA #40 take care of her anymore, and STNA #40 is not allowed in her room. Resident #17 stated both incidents happened last September. Resident #17 said she talked to the Ombudsman about this situation as well. She can't remember who or when she talked to the Ombudsman.</p> <p>Interview on 05/15/24 at 1:02 P.M. with SSD #9 revealed SSD #9 stated Resident #17 had an issue with an STNA. Resident #17 didn't tell her which one. SSD #9 was told by Resident #17 that an STNA was refusing to help her, and the aide said you can do this yourself. SSD #9 said it was that type of thing. She reported it to the Administrator at that time, but that Administrator does not work here anymore. This occurred close to the time Resident #17 was admitted. The current DON did an investigation, but she doesn't know what the result was. SSD #9 said she has met with Resident #17 since, and Resident #17 has not had complaints or further issues with her care.</p> <p>Interview on 05/15/24 at 01:13 P.M. with the DON revealed she didn't know off the top of her head if Resident #17 brought her any concerns about care provided by aides. When asked if a certain aide does not work with Resident #17, the DON stated not that I can think of. The DON was also questioned if SSD #9 brought anything like that to her attention, the DON said potentially if there would have been something.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/24 at 3:20 P.M. with STNA #40 revealed she had issues with Resident #17 sometime last year. STNA #40 said she usually answers call lights as they go off to make it fair unless the resident is a fall risk. STNA #40 said she was in the room next to Resident #17 and talking to a resident and their family. STNA #40 said Resident #17 came into that room mad and upset that I answered his call light before hers. STNA #40 told Resident #17 that it would be a minute. STNA #40 said I guess that is what made Resident #17 mad. STNA #40 said Resident #17 wanted a gown before she got into bed. STNA #40 said Resident #17 was calling her all kinds of names. STNA #40 said to diffuse the situation she stepped out of the room and closed the door. STNA #40 said she heard loud banging coming from the room. STNA #40 said she got another aide to see what Resident #17 needed, and Resident #17 was nasty to them too. STNA #40 said she could not remember what aide she got to help her. STNA #40 said she reported it to her nurse at that time. She said she also messaged Assistant Director of Nursing (ADON) #47. STNA #40 said she was told not to go into Resident #17 's room to care for her anymore. STNA #40 said she remembered it happened towards the end of September. STNA #40 said she was not suspended and thinks the next-door family member wrote down statements. STNA #40 said Resident #17 did not say she was hurting her when providing care. STNA #40 said the DON and ADON #47 did the investigation.</p> <p>Interview on 05/15/24 at 04:32 P.M. with the DON who was accompanied by Corporate Nurse #100 revealed when the DON found out about the situation, she went to get a statement from the resident. The DON said Resident #17 told her STNA #40 ignored her call light. The DON said Resident #17 did not describe mistreatment. Resident #17 told the DON that STNA #40 wasn't receptive to her needs and ignored the call light. The DON stated it was more of a customer service thing. The DON said STNA #40 was talking to a family in the hallway. The DON said Resident #17 did allow STNA #40 to provide care. The DON said Resident #17 stated she was calling STNA #40 names, and STNA #40 went to get another STNA. The DON said when she was talking to Resident #17 there was no allegation of any type of mistreatment. The DON said if Resident #17 is alleging mistreatment now, they would do an SRI. When asked who made the decision that this incident was not reportable, the DON replied that it was the previous Administrator. When asked if an investigation was done, the DON replied that she does not know where they are.</p> <p>Interview on 05/16/24 at 01:04 P.M. with STNA #42 revealed Resident #17 told her about a situation last September with STNA #40. STNA #42 said STNA #40 got real smart with Resident #17 and didn't get her out of bed and took a tone with her. STNA #42 said she was visiting her dad next door when this occurred. STNA #42 explained that Resident #17 asked STNA #40 to change her bed, and STNA #40 took an inappropriate tone with her. STNA #42 said STNA #40 said she didn't have time for it, and she would get to it when she gets to it. STNA #42 said it wasn't physical, but STNA #42 talked to Resident #17 like a child. She belittled her and said it was a lack of respect. STNA #42 said she would consider the interaction verbal abuse. STNA #42 said she went to the DON and the previous Administrator. STNA #42 thinks she remembers filling something out.</p> <p>Interview on 05/16/24 at 1:19 P.M. revealed the Ombudsman was left a voicemail and a call was not returned.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/16/24 1:34 P.M. with ADON #47 revealed she remembered an issue with STNA#40 and Resident #17 in September of last year. ADON #47 said it was reported that statements were made, and we went down and talked to Resident #17 and staff. ADON #47 said Resident #17 said STNA #40 was saying stuff to her. ADON #47 said when we talked to Resident #17, she said STNA #40 didn't make the statements Resident #17 said STNA #40 had made. When asked if ADON #47 has the statements, she said she would have to check. When asked if ADON #47 or the DON filled out a report, ADON #47 said we investigated it and talked to staff. When asked if any of this information was documented, ADON #47 said she does not remember. ADON #47 said a couple of call lights were going off in the area and the staff member chose the one that was a priority. ADON #47 said Resident #17 felt like STNA #40 chose that resident over her. When asked if she had proof that the resident said that ADON #47 said she would have to see if they had that statement. When asked if ADON #47 received complaints about STNA #40, she said I think sometimes STNA #40 gets overwhelmed. But at the end of the day, she does what she needs to do. She's a good aide.</p> <p>Interview on 05/16/24 at 03:43 P.M. with the DON revealed they do not have documentation from the September incident between Resident #17 and STNA #40.</p> <p>Review of the facility self-reported incidents to the State agency revealed no evidence this incident of abuse was reported to the agency as required.</p> <p>Review of the personnel record for STNA #40 revealed one written consultation from 08/02/23 revealed an unexpected absence and 12 call offs during her 90-day probationary period.</p> <p>Review of the abuse policy dated 01/31/20 revealed the administrator or his/her designee will notify The Ohio Department of Health of all alleged violations involving mistreatment, neglect, abuse, exploitation, misappropriation of property, and injuries of unknown origin as soon as possible, but in no event later than 24 hours from the time the allegation was made known to the staff member.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review, self-reported incident (SRI) review, facility policy review, and interviews, the facility failed to thoroughly investigate allegations of abuse for Residents #4 and #17. This affected two residents (#4 and #17) out of two residents reviewed for abuse. This had the potential to affect all 60 residents. The facility census was 60.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had a Brief Interview Mental Status (BIMS) score of one out of 15 which indicated severe cognitive impairment. Resident #4 was dependent on staff for toileting.</p> <p>Review of SRI #246175 dated 04/09/24 revealed on 04/09/24 at approximately 7:20 P.M. State tested Nursing Assistant (STNA) #5 notified the Director of Nursing (DON) that STNA #102 slapped the back of Resident #4's hand. Resident #4 was unable to recall the incident. STNA #5 was interviewed and stated during incontinence care Resident #4 became agitated and began to scratch and hit STNA #5 and STNA #102. STNA #102 slapped the back of Resident #4's hand and stated not to do that. Resident #4 responded with that hurt. An interview with STNA #102 revealed Resident #4 became agitated and began scratching and hitting STNA #5 and STNA #102. STNA #102 stated when Resident #4 attempted to hit STNA #102, STNA #102 raised her hand to block Resident #4 which resulted in causing contact with Resident #4's hand. STNA #102 confirmed Resident #4 stated that hurt.</p> <p>Review of the medical record for Resident #4 revealed no documentation of the event that occurred on 04/09/24.</p> <p>Review of a typed statement dated 04/09/24 signed by the DON revealed an interview was conducted with STNA #102. STNA #102 reported care was being provided for Resident #4. Resident #4 was sitting on the toilet when Resident #4 became agitated and began hitting and scratching at STNA #5 and STNA #102. Resident #4 reached towards STNA #102 to hit her. STNA #102 stated she instinctively raised her hand to prevent Resident #4 from hitting her which caused contact between STNA #102 and Resident #4. STNA #102 did not recall Resident #4 reporting any discomfort from the incident.</p> <p>Review of a signed statement by STNA #5 dated 04/10/24 revealed they were assisting STNA #102 with providing incontinence care to Resident #4 on 04/09/24. Resident #4 was sitting on the toilet, and STNA #102 was in front of Resident #4 and STNA #5 was standing on Resident #4's left side. Resident #4 reached up to possibly scratch or hit STNA #102. STNA #102 slapped the top of Resident #4's hand and said I said not to do that. Resident #4 stated that hurt. STNA #5 notified the DON of the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Employee Change of Status Notification dated 04/11/24 revealed STNA #102 was involuntarily terminated. There were no details of the circumstances surrounding the involuntary termination.</p> <p>Interview on 05/16/24 at 8:33 A.M. Corporate Nurse #100 verified STNA #102 was interviewed but did not sign the statement. Corporate Nurse #100 stated he and the DON wanted to interrogate STNA #102, so a signed statement was not obtained by STNA #102. Corporate Nurse #100 verified the unsigned statement revealed Resident #4 did not report any pain or discomfort, but the SRI revealed STNA #102 reported Resident #4 did complain of pain. Corporate Nurse #100 also verified there were no details listed of why STNA #102 was terminated. Corporate Nurse #100 verified the incident was not documented in Resident #4's medical record.</p> <p>Review of the abuse policy revised on 01/31/20 revealed residents have the right to be free from abuse. It is the facility's policy to investigate all alleged violations involving abuse. Abuse is defined as the willful infliction of injury. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Investigation protocol includes interviewing the resident, the accused, and all witnesses. In the case of staff-to-resident abuse, the facility will follow the facility's procedure for disciplining or dismissing an employee, depending upon the circumstances and results of the investigation.</p> <p>48568</p> <p>2. Review of medical record for Resident #17 revealed admitted [DATE] with diagnoses including polyneuropathy, unspecified fracture of lower end of left tibia, and morbid obesity.</p> <p>Review of the most recent quarterly MDS assessment dated [DATE] revealed Resident #17 was cognitively intact and required setup/clean up assistance for eating, oral hygiene, upper body dressing, personal hygiene, and rolling left and right.</p> <p>Interview on 05/14/24 at 1:31 P.M. at the Resident Council meeting revealed Resident #17 stated she was threatened with bodily harm by an aide.</p> <p>Interview on 05/15/24 at 12:49 P.M. with Resident #17 revealed she left the facility with a bone crack in her leg. When she returned to the facility, Resident #17 said STNA #40 came into her room with an attitude. Resident #17 told STNA #40 she was being rough with her, and STNA #40 said I will break your other leg. STNA #40 also yelled at her for going into another room. Resident #17 stated she was embarrassed when STNA #40 yelled at her in front of a family member from the room next door. Resident #17 said she reported this situation to a housekeeper, who is now STNA #42. Resident #17 said STNA #42 went to Social Service Director (SSD) #9. Resident #17 said she will not have STNA #40 take care of her anymore, and STNA #40 is not allowed in her room. Resident #17 stated both incidents happened last September. Resident #17 said she talked to the Ombudsman about this situation as well. She can't remember who or when she talked to the Ombudsman.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/24 at 1:02 P.M. with SSD #9 revealed SSD #9 stated Resident #17 had an issue with an STNA. Resident #17 didn't tell her which one. SSD #9 was told by Resident #17 that an STNA was refusing to help her, and the aide said you can do this yourself. SSD #9 said it was that type of thing. She reported it to the Administrator at that time, but that Administrator does not work here anymore. This occurred close to the time Resident #17 was admitted. The current DON did an investigation, but she doesn't know what the result was. SSD #9 said she has met with Resident #17 since, and Resident #17 has not had complaints or further issues with her care.</p> <p>Interview on 05/15/24 at 01:13 P.M. with the DON revealed she didn't know off the top of her head if Resident #17 brought her any concerns about care provided by aides. When asked if a certain aide does not work with Resident #17, the DON stated not that I can think of. The DON was also questioned if SSD #9 brought anything like that to her attention, the DON said potentially if there would have been something.</p> <p>Interview on 05/15/24 at 3:20 P.M. with STNA #40 revealed she had issues with Resident #17 sometime last year. STNA #40 said she usually answers call lights as they go off to make it fair unless the resident is a fall risk. STNA #40 said she was in the room next to Resident #17 and talking to a resident and their family. STNA #40 said Resident #17 came into that room mad and upset that I answered his call light before hers. STNA #40 told Resident #17 that it would be a minute. STNA #40 said I guess that is what made Resident #17 mad. STNA #40 said Resident #17 wanted a gown before she got into bed. STNA #40 said Resident #17 was calling her all kinds of names. STNA #40 said to diffuse the situation she stepped out of the room and closed the door. STNA #40 said she heard loud banging coming from the room. STNA #40 said she got another aide to see what Resident #17 needed, and Resident #17 was nasty to them too. STNA #40 said she could not remember what aide she got to help her. STNA #40 said she reported it to her nurse at that time. She said she also messaged Assistant Director of Nursing (ADON) #47. STNA #40 said she was told not to go into Resident #17 's room to care for her anymore. STNA #40 said she remembered it happened towards the end of September. STNA #40 said she was not suspended and thinks the next-door family member wrote down statements. STNA #40 said Resident #17 did not say she was hurting her when providing care. STNA #40 said the DON and ADON #47 did the investigation.</p> <p>Interview on 05/15/24 at 04:32 P.M. with the DON who was accompanied by Corporate Nurse #100 revealed when the DON found out about the situation, she went to get a statement from the resident. The DON said Resident #17 told her STNA #40 ignored her call light. The DON said Resident #17 did not describe mistreatment. Resident #17 told the DON that STNA #40 wasn't receptive to her needs and ignored the call light. The DON stated it was more of a customer service thing. The DON said STNA #40 was talking to a family in the hallway. The DON said Resident #17 did allow STNA #40 to provide care. The DON said Resident #17 stated she was calling STNA #40 names, and STNA #40 went to get another STNA. The DON said when she was talking to Resident #17 there was no allegation of any type of mistreatment. The DON said if Resident #17 is alleging mistreatment now, they would do an SRI. When asked who made the decision that this incident was not reportable, the DON replied that it was the previous Administrator. When asked if an investigation was done, the DON replied that she does not know where they are.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/16/24 at 01:04 P.M. with STNA #42 revealed Resident #17 told her about a situation last September with STNA #40. STNA #42 said STNA #40 got real smart with Resident #17 and didn't get her out of bed and took a tone with her. STNA #42 said she was visiting her dad next door when this occurred. STNA #42 explained that Resident #17 asked STNA #40 to change her bed, and STNA #40 took an inappropriate tone with her. STNA #42 said STNA #40 said she didn't have time for it, and she would get to it when she gets to it. STNA #42 said it wasn't physical, but STNA #42 talked to Resident #17 like a child. She belittled her and said it was a lack of respect. STNA #42 said she would consider the interaction verbal abuse. STNA #42 said she went to the DON and the previous Administrator. STNA #42 thinks she remembers filling something out.</p> <p>Interview on 05/16/24 at 1:19 P.M. revealed the Ombudsman was left a voicemail and a call was not returned.</p> <p>Interview on 05/16/24 1:34 P.M. with ADON #47 revealed she remembered an issue with STNA#40 and Resident #17 in September of last year. ADON #47 said it was reported that statements were made, and we went down and talked to Resident #17 and staff. ADON #47 said Resident #17 said STNA #40 was saying stuff to her. ADON #47 said when we talked to Resident #17, she said STNA #40 didn't make the statements Resident #17 said STNA #40 had made. When asked if ADON #47 has the statements, she said she would have to check. When asked if ADON #47 or the DON filled out a report, ADON #47 said we investigated it and talked to staff. When asked if any of this information was documented, ADON #47 said she does not remember. ADON #47 said a couple of call lights were going off in the area and the staff member chose the one that was a priority. ADON #47 said Resident #17 felt like STNA #40 chose that resident over her. When asked if she had proof that the resident said that ADON #47 said she would have to see if they had that statement. When asked if ADON #47 received complaints about STNA #40, she said I think sometimes STNA #40 gets overwhelmed. But at the end of the day, she does what she needs to do. She's a good aide.</p> <p>Interview on 05/16/24 at 03:43 P.M. with the DON revealed they do not have documentation from the September incident between Resident #17 and STNA #40.</p> <p>Review of the facility self-reported incidents to the State agency revealed no evidence this incident of abuse was reported to the agency as required.</p> <p>Review of the personnel record for STNA #40 revealed one written consultation from 08/02/23 revealed an unexpected absence and 12 call offs during her 90-day probationary period.</p> <p>Review of the abuse policy dated 01/31/20 revealed It is the facility's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review and interview the facility failed to provide Resident #12, #22, #28, #30, and #43, who were dependednt on staff for care, with scheduled bathing. This affected five residents (#12, #22, #28 #30, and #43) out of six residents reviewed for activities of daily living (ADL). The facility census was 60.</p> <p>Findings include:</p> <p>1. Resident #12 was admitted on [DATE] and readmitted on [DATE] with diagnoses including type II diabetes, heart failure, polyneuropathy, and chronic kidney disease.</p> <p>Review of the plan of care dated 10/13/23 revealed Resident #12 required assistance from staff to meet ADL needs. Interventions included assisting Resident #12 with bathing as needed and per Resident#12's requests.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12's Brief Interview Mental Status (BIMS) score was 12 of 15, which indicated cognitive impairment. Resident #12 required substantial/maximal assistance for bathing.</p> <p>Review of electronic documentation by State tested Nursing Assistants (STNAs) revealed Resident #12 was dependent on staff for bathing.</p> <p>Review of the electronic record and paper bathing sheets for the last 30-days revealed Resident #12 did not receive a shower or bed bath on 04/20/24, 04/24/24, 05/01/24, and 05/08/24.</p> <p>Interview on 05/13/24 at 1:27 P.M. Resident #12 revealed they received a shower once a week. Resident #12 stated they preferred showers and wanted a shower at least twice a week.</p> <p>Interview on 05/14/24 at 2:51 P.M. Corporate Nurse #100 verified Resident #12 was not bathed twice a week as scheduled/preferred.</p> <p>2. Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses including dementia, mood disorder, and anxiety disorder.</p> <p>Review of the plan of care dated 09/17/23 revealed Resident #22 required assistance from staff to meet ADL needs. Interventions included assisting Resident #22 with bathing as needed and per Resident #22's preference.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #22's BIMS score was 11 of 15, which indicated cognitive impairment.</p> <p>Review of electronic documentation by STNAs revealed Resident #22 required physical assistance with showers and was totally dependent for bed baths.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the electronic record and paper bathing sheets for the last 30-days revealed Resident #12 did not receive a shower or bed bath on 04/22/24, 05/02/24, 05/06/24, and 05/09/24.</p> <p>Interview on 05/13/24 at 10:11 A.M. Resident #22 revealed there was a sign in Resident #22's room that revealed showers were scheduled for Mondays and Thursdays. Resident #22 stated she did not always receive a shower twice a week.</p> <p>Interview on 05/14/24 at 2:51 P.M. Corporate Nurse #100 verified Resident #22 was not bathed twice a week as scheduled/preferred.</p> <p>3. Review of the medical record revealed Resident #28 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included diverticulitis, type II diabetes, pleural effusion, and chronic kidney disease stage III.</p> <p>Review of the plan of care dated 11/22/23 revealed Resident #28 required assistance from staff to meet ADL needs. Interventions included assisting Resident #28 with bathing as needed and per Resident #28's preference.</p> <p>Review of the end of stay MDS assessment dated [DATE] revealed Resident #28 was cognitively intact. Resident #28 required supervision or touching assistance for bathing.</p> <p>Review of electronic documentation by STNAs on 04/18/24 revealed Resident #28 required physical assistance with a shower on 04/18/24.</p> <p>Review of the electronic record and paper bathing sheets for the last 30-days revealed Resident #28 received a shower on 04/18/24.</p> <p>Interview on 05/14/24 at 2:51 P.M. Corporate Nurse #100 verified Resident #28 was not bathed twice a week as scheduled/preferred.</p> <p>4. Review of the medical record revealed Resident #30 was admitted on [DATE] with diagnoses including chronic atrial fibrillation, type II diabetes, and pain.</p> <p>Review of the plan of care dated 01/07/24 revealed Resident #30 required assistance from staff to meet ADL needs. Interventions included assisting Resident #30 with bathing as needed and per Resident #30's request.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 was cognitively intact. Resident #30 required partial to moderate assistance for bathing.</p> <p>Review of electronic documentation by STNAs revealed Resident #30 required physical assistance with bathing.</p> <p>Review of the electronic record and paper bathing sheets for the last 30-days revealed Resident #30 was not bathed on 04/17/24, 04/19/24, 04/22/24, 04/24/24, 04/26/24, 05/01/24, 05/03/24, 05/08/24, and 05/10/24.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/13/24 at 1:08 P.M. Resident #30 revealed they were scheduled to receive showers on Mondays, Wednesdays, and Fridays but did not received showers as scheduled.</p> <p>Interview on 05/14/24 at 2:51 P.M. Corporate Nurse #100 verified Resident #30 was not always bathed at least once a week.</p> <p>41271</p> <p>5. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including dementia, abnormalities of gait and mobility, and adult to failure to thrive.</p> <p>Review of Resident #43's quarterly assessment dated [DATE] revealed a BIMS score of two of 15, indicating severely impaired cognition for daily decision-making ability. Resident #43 was noted to experience impairment to bilateral upper and lower extremities and required substantial to maximal staff assistance for toileting hygiene, bath and/or shower care, and dressing.</p> <p>Review of the plan of care dated 08/20/21 revealed Resident #43 required assistance from staff to meet ADL needs related to decreased mobility, history of a hip fracture, and impaired cognition.</p> <p>Review of the completed ADL for Resident #43 from 04/16/24 through 05/14/24 revealed the resident received a shower on 04/21/24 and 04/30/24 and refused a bath or shower on 05/14/24.</p> <p>Interview on 05/16/24 at 9:16 A.M. with the Director of Nursing (DON) revealed Resident #43 was supposed to receive a bath/shower on Sundays, Tuesdays, and Fridays, which was Resident #43's preference.</p> <p>Review of the completed shower sheets provided for Resident #45 revealed the resident received a bath/shower eight out of the 13 scheduled days for April 2024. A bath or shower was documented as being completed on 04/02/24 bed bath (Tuesday), 04/07/24 bath or shower was not indicated (Sunday), 04/12/24 Shower (Friday), 04/14/24 shower (Sunday), 04/16/24 Shower (Tuesday), 04/19/24 bed bath (Friday), 04/26/24 Shower Sunday), and 04/30/24 shower (Thursday).</p> <p>Interview on 05/16/24 at 9:16 A.M. with the DON revealed Resident #45 was supposed to receive a bath or shower every Sunday, Tuesday, and Friday. The DON verified that per documentation, Resident #45 was not receiving a bath or shower as per schedule/preference.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review, facility policy review, Hospice agreement review, and interview the facility failed to follow the bowel policy for Residents #22 and #39. This affected two residents (#22 and #39) out of five residents reviewed for unnecessary medications. The facility also failed to ensure Hospice communication was onsite for Resident #9. This affected one resident (#9) out of one resident reviewed for Hospice. The facility census was 60.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses including dementia, mood disorder, and anxiety disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22's Brief Interview Mental Status (BIMS) score was 11 of 15, which indicated cognitive impairment. Resident #22 was always continent of bowel.</p> <p>Review of the bowel documentation in the electronic medical record revealed Resident #22 did not have a bowel movement on 05/06/24, 05/07/24, 05/08/24, 05/09/24, 05/10/24, 05/11/24, and 05/12/24.</p> <p>Interview on 05/16/24 at 3:21 P.M. Corporate Nurse #100 verified Resident #22 did not have a bowel movement for seven days. Corporate Nurse #100 also verified there was no documented evidence of the physician was notified or Resident #22 received any stool softeners or laxatives.</p> <p>Review of the bowel policy revised 06/09/17 revealed bowel movements will be documented each shift. If after three consecutive days the resident does not have a bowel movement, the nurse will follow as needed medication orders for stool softeners or laxatives. If no orders were in place, the physician will be notified, and orders would be obtained/implemented.</p> <p>2. Review of the medical record revealed Resident #39 was admitted [DATE], readmitted on [DATE] and 04/26/24 with diagnoses including non-displaced intertrochanteric fracture of right femur, acute embolism and thrombosis of right femoral vein, hypovolemic shock, acute kidney failure, and bipolar disorder,</p> <p>Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #39 had a BIMS score of nine of 15, which indicated cognitive impairment.</p> <p>Review of the bowel documentation in the electronic medical record revealed Resident #39 did not have a bowel movement on 05/06/24, 05/07/24, 05/08/24, and 05/09/24.</p> <p>Interview on 05/16/24 at 3:21 P.M. Corporate Nurse #100 verified Resident #39 did not have a bowel movement for four days. Corporate Nurse #100 also verified there was no documented evidence of the physician was notified or Resident #39 received any stool softeners or laxatives.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the bowel policy revised 06/09/17 revealed bowel movements will be documented each shift. If after three consecutive days the resident does not have a bowel movement, the nurse will follow as needed medication orders for stool softeners or laxatives. If no orders were in place, the physician will be notified, and orders would be obtained/implemented.</p> <p>41271</p> <p>3. Review of the medical record for Resident #9 revealed an initial admitted [DATE] and a re-entry date of 05/02/2022. Diagnosis included heart failure, chronic kidney disease, and peripheral vascular disease (PVD).</p> <p>Review of the physician orders for Resident #9 revealed the resident was admitted to Hospice services with the diagnosis of congestive heart failure on 03/05/24.</p> <p>Review of Resident #9's quarterly MDS assessment dated [DATE] revealed a BIMS score of seven of 15, indicating severely impaired cognition for daily decision-making abilities.</p> <p>When requested for review, Hospice notes for Resident #9 were not available on-site.</p> <p>Interview on 05/15/24 at 3:18 P.M. with Registered Nurse (RN) #45 revealed she could not locate the Hospice communications for Resident #9 but knew Hospice normally came to the facility on Tuesdays and Fridays. RN #45 looked in Resident #45's medical record and could not find Hospice notes. RN #45 then looked in the Hospice binder located at the nurse's station and claimed this specific Hospice company does not put their communication forms in the binder and was not sure where it was.</p> <p>Review of provided Hospice communication forms for Resident #9 were noted to have a print date of 05/15/24 at 3:38 P.M.</p> <p>Interview with the Director of Nursing (DON) on 05/15/24 at 4:00 P.M. confirmed the facility did not have the Hospice communication form on-site for Resident #9 and she had contacted the company to send over notes for the last 30 days for her to print for review.</p> <p>Review of the facility and Hospice agreement with the effective date of 12/19/2018 revealed, Article VIII: Records. 8.1 Compilation of Records. (a) Preparation. Nursing Facility and Hospice shall each prepare and maintain complete, accurate, and detailed clinical records concerning each resident receiving Nursing Facility Room and Board Services and Hospice Services under this Agreement as required by applicable Medicare and Medicaid program requirement and state law. All entries made for services provided hereunder are to be legible, clean, complete, and appropriately authenticated and dated in accordance with applicable policy and currently accepted standards of practice. Each such record shall be readily available on request by an authorized federal, state, or local government or regulatory agency.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on observation, record review, facility policy review, and interview the facility failed to comprehensively assess and provide adequate interventions and treatment for Resident #31. Resident #31 developed a stage III (full-thickness loss of skin, in which adipose (fat) is visible in the ulcer. Slough and/or eschar may be visible) pressure ulcer and stage II (partial-thickness skin loss involving the epidermis and dermis) pressure ulcer to buttocks. This affected one resident (#31) out of one resident reviewed for pressure ulcers. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #31 was admitted on [DATE] and expired on [DATE] with diagnoses including type II diabetes, convulsions, history of traumatic brain injury, Parkinson's disease, and chronic kidney disease.</p> <p>Review of the plan of care dated [DATE] revealed Resident #31 had open areas to the right toe, an abrasion to the left lower leg, and areas to the right and left buttock. Interventions dated [DATE] and [DATE] were in place to administer medications as ordered, apply treatments as ordered, diagnostic testing as ordered, encourage Resident #31 to turn and reposition, supplement as ordered, notify physician/wound nurse practitioner as needed.</p> <p>Review of the plan of care dated [DATE] revealed Resident #31 was at risk for skin breakdown. Interventions dated [DATE] revealed staff were to perform skin checks, assist Resident #31 with skin care, and consult with wound nurse practitioner as needed.</p> <p>Review of a physician's order dated [DATE] for Resident #31 revealed barrier cream to be applied to buttocks every shift and as needed. State tested Nursing Assistants (STNAs) may apply to buttocks every shift as a preventative.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was cognitively intact. Resident #31 did not have any pressure ulcers. Resident #31 had a prognosis of less than six months.</p> <p>The medical record revealed Resident #31 was admitted to hospice on [DATE].</p> <p>Review of the weekly skin assessments revealed the only skin assessments for 2024 occurred on [DATE] and [DATE]. The skin assessments for [DATE] and [DATE] revealed there were no new skin areas noted.</p> <p>Review of progress notes dated [DATE] revealed no documented evidence of a pressure ulcer to Resident #31's bilateral buttocks.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the wound nurse note dated [DATE] authored by Nurse Practitioner (NP) #400 revealed Resident #31 had new wounds to the buttocks. Resident #31 had been declining, had increased weakness, and extreme difficulty getting up. Incontinence treatment included applying barrier cream and to be checked frequently. Resident #31 had a stage III pressure ulcer to right buttock that measured 1.5 centimeters (cm) long and 1.5 cm wide. The depth of the wound was not documented. The wound bed had pink tissue and slough (yellow/white necrotic tissue). Serosanguinous (blood and serous fluid) exudate was noted. Treatment was barrier cream every day. Resident #31 had a stage II pressure ulcer to left buttock that measured 1.0 cm long and 1.0 cm wide. The wound bed had pink tissue. Serosanguinous exudate was noted. Treatment was barrier cream every day.</p> <p>Review of the physician's order dated [DATE] for Resident #31 revealed house barrier cream was to be applied by nurses to Resident #31's buttocks every shift.</p> <p>Review of the wound care note dated [DATE] authored by NP #400 revealed Resident #31 had a stage III pressure ulcer to the right buttock that measured 1.5 cm long and 1.5 cm wide. The depth of the wound was not documented. The wound bed had pink tissue and no slough now. Serosanguinous exudate was noted. The wound was to be gently cleaned, patted dry, and ongoing autolytic debridement addressed with topical treatment. The topical treatment was barrier cream. The treatment was to be completed daily and as needed. Resident #31 had a stage II pressure ulcer to left buttock that measured 1.0 cm long and 1.0 cm wide. The wound bed had pink tissue. Serosanguinous exudate was noted. The wound was to be cleaned, patted dry and ongoing autolytic debridement addressed with topical treatment. The topical treatment was barrier cream.</p> <p>Interview on [DATE] at 11:28 A.M. Assistant Director of Nursing (ADON) #47 verified the stage III and stage II pressure ulcers to Resident #31's buttocks were discovered on [DATE] but there was no documented evidence of the pressure ulcers. ADON #47 stated NP #400 was scheduled to visit on [DATE] and assessed the wounds at that time. ADON #47 also verified there were no weekly skin assessments and no documentation of skin impairment until the wounds were stage II and stage III. ADON #47 verified no new interventions were put in place after the development of the stage II and stage III pressure ulcers. ADON #47 stated Resident #31 had been declining and often refused care. ADON #47 verified there were no interventions put in place for Resident #31 declining or refusing care. ADON #47 verified the treatment ordered was barrier cream that was already in place other than the nurses were to apply the barrier cream instead of the STNAs. ADON #47 verified the order by NP #400, dated [DATE], was not put into place.</p> <p>Observation of barrier cream on [DATE] at 11:40 A.M. revealed the facility used PeriGuard Skin Protectant with vitamin A, vitamin D, vitamin E, aloe vera and zinc. The barrier cream was to help relieve and prevent rashes and irritation due to wetness from incontinence. The barrier cream protected chafed skin due to irritation and helped seal out wetness. Directions for use were to cleanse the skin and remove any urine or fecal matter. The area was to be patted dry and a generous amount was to be applied to the affected areas as needed, especially after incontinence episodes.</p> <p>Interview on [DATE] at 2:39 P.M. Hospice Registered Nurse (RN) #103 revealed Wound NP #400 also worked for hospice. The hospice nursing staff did not assess or provide treatment to Resident #31's pressure ulcers. NP #400 assessed the area, and the facility nurses did the treatment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 2:01 P.M. interview with NP #400 revealed barrier cream was ordered as treatment for stage II and stage III pressure ulcers to Resident #31's buttocks. NP #400 stated a dressing was not ordered because it would not stay in place where the wounds were. NP #400 verified she did not do full body skin assessment when she saw residents. NP #400 only assessed the wounds the facility had identified. NP #400 stated the depth of wounds were not documented if less than 0.1 cm. NP #400 stated the stage III pressure ulcer did not have a depth due to slough being present and was not classified as unstageable due to part of the wound bed was visible.</p> <p>Review of the wound and skin care policy revised on [DATE] revealed documentation of pressure ulcers included to pressure in cm the width, length, depth, wound margins, and any undermining or tunneling. The site was to be described. The policy defined a stage II as a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. A break in the skin thru the epidermis and into the dermis, usually pink, moist, and painful. A stage III was a full thickness of skin lost, exposing subcutaneous tissues may include or be covered by necrotic tissue. The wound presents as a deep crater with or without undermining adjacent tissue, usually not painful. An unstageable wound had full thickness loss where the base of the ulcer is covered by slough and/or eschar in the wound bed. The category/stage cannot be determined, and depth cannot be obtained.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>Based on medical record review and staff interview, the facility failed to offer an alternative meal choice or nutritional shake for Resident #42 when less than 50% of the meal was consumed. This affected one resident (#42) of the two residents reviewed for nutritional support. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included dementia, muscle weakness, and venous insufficiency.</p> <p>Review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven of 15, indicating severely impaired cognition for daily decision-making abilities. Resident #42 was noted to require supervision or touching assistance by staff for eating and was noted to be 66 inches tall and weighed 146 pounds with a noted weight loss.</p> <p>Review of Resident #42's orders revealed a diet order for a regular diet with regular textured food and thin consistency liquids.</p> <p>Review of the plan of care dated 11/10/22 revealed Resident #42 was at risk for altered nutrition related to the diagnoses of dementia, lymphedema, hypertension, leaves greater than 25% of meals at times, significant weight loss related to decrease in bilateral lower extremity edema. Interventions included honoring food preferences and offering substitution as needed.</p> <p>Review of the meal intakes for Resident #42 from 01/01/24 through 01/29/24 and 04/16/24 through 05/14/24 revealed intakes varied from 25% to 100%, with most days being less than 50% consumed. Continued review of the resident's intakes revealed there was a task for the resident to be offered additional food or a nutritional shake when less than 51% of meals were consumed. There was no documented evidence to indicate additional food or nutritional shakes were offered during this time frame.</p> <p>Interview 05/15/24 at 2:30 P.M. with Cooperate Nurse #100 and the Director of Nursing (DON) confirmed Resident #42 did consume less than 50% of meals, and a supplement was not noted to have been offered.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>Based on medical record review, staff interview, and facility policy review, the facility failed to ensure dialysis communication forms were completed post dialysis treatment and returned to the facility for Resident #267. This affected one resident (#267) of one resident reviewed for dialysis treatment. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record for Resident # 267 revealed an admitted [DATE]. Diagnoses included acute kidney failure, dependence on renal dialysis, and hypertension.</p> <p>Review of Resident #267's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating intact cognition for daily decision-making abilities.</p> <p>Review of the plan of care dated 05/06/24 revealed Resident #267 required dialysis related to renal failure. Interventions included encouraging the resident to attend scheduled dialysis appointments, monitoring labs, monitoring for peripheral edema, depression, infection, renal insufficiency, and monitoring vital signs.</p> <p>Review of the physician's orders for Resident #267 revealed an order for dialysis treatments every Tuesday, Thursday, and Saturday, with chair time being at 11:15 A.M. and arrival time at 11:00 A.M.</p> <p>Review of the dialysis communication forms for Resident #267 revealed forms dated 05/04/24, 05/07/24, and 05/14/24 were not completed by the dialysis center post dialysis treatment.</p> <p>Interview 05/16/24 at 11:00 A.M. with Cooperation Nurse #100 revealed he was only able to locate a hand full of dialysis communication forms and claimed that they have been having issues with the dialysis company completing the communication form or even returning the form at all. Cooperate Nurse #100 confirmed Resident #267 did not have all communication forms on-site, and some that were on-site were not completed as required.</p> <p>Review of the facility policy titled dialysis patients dated 05/23/17 revealed the facility will provide whatever information is requested by the dialysis unit and review any documentation sent with the resident upon return to the facility. Nurses will review communication documents provided by the dialysis unit, implement new orders, and communicate changes to responsible party upon return from dialysis.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>Based on medical record review, pharmacy recommendation review, and staff interview, the facility to address pharmacy recommendations in a timely manner for Residents #22 and #32. This affected two residents (#22 and #32) of five residents reviewed for pharmacy recommendations. The facility census was 60.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included anxiety, heart disease, and fracture of the left arm.</p> <p>Review of Resident #32's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 of 15, indicating intact cognition for daily decision-making abilities. Resident #32 was noted to receive antianxiety medication daily.</p> <p>Review of the plan of care dated 11/09/23 revealed Resident #32 had the potential for feelings of sadness, emptiness, anxiety, depression. Interventions included discussing feelings, encouraging loved ones to visit, providing one-on-one care, emotional support, and administering medications as ordered.</p> <p>Review of the pharmacy recommendations for Resident #32 dated 03/13/24 revealed, the resident has a as needed (PRN) order for a psychoactive medication, which has been ordered without a stop date: Hydroxyzine 25 milligrams (mg) every eight hours PRN for anxiety/agitation. Please add a duration for use if this order is continued beyond 14 days. Continued review revealed no evidence the physician reviewed or addressed this recommendation.</p> <p>Review of pharmacy recommendations for Resident #32 dated 04/21/24 revealed, the resident has a as PRN order for a psychoactive medication, which has been ordered without a stop date: Hydroxyzine 25 mg every eight hours PRN for anxiety/agitation. Please add a duration for use if this order is continued beyond 14 days. Continued review revealed no evidence the physician reviewed or addressed this recommendation.</p> <p>Interview 05/16/24 at 1:00 P.M. with Cooperate Nurse #100 confirmed Resident #32 had two pharmacy recommendations for the same medication which were not addressed in a timely manner by the physician.</p> <p>34298</p> <p>2. Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses including dementia, mood disorder, and anxiety disorder.</p> <p>Review of a note to the attending physician/prescriber from the pharmacy dated 12/17/23 revealed Resident #22 received Seroquel (antipsychotic) medication that required evaluation for possible dose reduction.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The physician agreed on 01/17/24 to a dose reduction of Seroquel from 200 mg daily to 150 mg daily.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #22 had a BIMS score of 11 of 15, indicating cognitive impairment.</p> <p>Interview on 05/16/24 at 2:24 P.M. Assistant Director of Nursing (ADON) #47 verified the pharmacy recommendation for dose reduction of Seroquel was not addressed by the physician for 30 days.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48568</p> <p>Based on observation, interview and facility policy review, the facility failed to ensure food was served at a palliative and warm food temperature. The deficient practice had the potential to affect all residents who received meals from the kitchen. The census was 60.</p> <p>Findings include:</p> <p>Interview on 05/13/24 at 10:32 A.M. with Resident #35 revealed sometimes the food was not very warm.</p> <p>Observation on 05/13/24 at 12:16 P.M. of the first lunch dining service revealed trays were being passed out of an open-air cart.</p> <p>Observation of the tray line was made on 05/14/24 at 10:46 A.M. with Dietary Supervisor #24 and Dietary Assistant Manager #16. The lunch menu consisted of corn, Spanish rice, and tacos. A test tray was requested on 05/14/24 at 11:52 A.M. with Dietary Supervisor #24 and Dietary Assistant Manager #16. Dietary Assistant Manager #16 started taking temperatures of the food being placed on the test tray. Dietary Assistant Manager #16 confirmed the corn measured 139 degrees Fahrenheit, Spanish rice 142 degrees Fahrenheit, and the tacos were 160 degrees Fahrenheit on the test tray.</p> <p>Observation on 05/14/24 at 11:54 A.M. revealed the test tray left the kitchen on the delivery cart. The cart was open to air and not insulated.</p> <p>Observation on 05/14/24 at 11:55 A.M. with Dietary Supervisor #24 revealed the delivery cart arrived on the hallway.</p> <p>Observation on 05/14/24 at 11:58 A.M. revealed all food trays have been served from the delivery cart. Dietary Supervisor #24 took temperatures of the test tray food items. Dietary Supervisor #24 verified the corn was 109 degrees Fahrenheit, Spanish rice was 118 degrees Fahrenheit, and the taco measured 115 degrees Fahrenheit.</p> <p>Interview and observation on 05/14/24 at 12:06 P.M. with Dietary Supervisor #24 revealed the Spanish rice, corn, and tacos were palatable but lukewarm and/or cold. Interview with Dietary Supervisor #24 revealed the tortilla used for the taco was cold.</p> <p>Interview on 05/16/24 12:50 P.M. with Corporate Nurse #100 revealed the facility does not have a tray delivery policy.</p> <p>Review of the Food Preparation policy dated 06/20/17 stated dietary staff will ensure that all foods are held at appropriate temperatures: greater than 135 degrees Fahrenheit for holding hot foods, under 41 degrees Fahrenheit for holding cold foods.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Country Club Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Yaeger 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41271</p> <p>Based on observations, staff interviews, and facility policy review, this facility failed to ensure enhanced barrier precautions were implemented in a timely manner for Residents #50 #34, #58, #265, #35, and #119, who were noted to have indwelling medical devices. This affected six residents (#50 #34, #58, #265, #35, and #119) of the six residents reviewed for infection control. The facility census was 60.</p> <p>Findings include:</p> <p>Observation completed 05/13/24 from 8:00 A.M. through 4:30 P.M. of multiple residents revealed five residents (#50, #58, #265, #35, and #119) who were noted to have indwelling Foley catheters for bladder function and one (#34) was noted to have peritoneal dialysis site that required treatment care. All six residents did not have enhanced barrier precautions in place during this time.</p> <p>Interview on 05/15/24 12:48 P.M. with Cooperate Nurse #100 revealed education for enhanced barrier precautions was completed in April 2024. The official roll-out date was postponed until supplies became available. Cooperate Nurse #100 claimed the facility's commonly used supply company noted most isolation supplies, including isolation gowns and mask, were in low supply and could take longer to receive. The facility did have sister facilities they could borrow isolation supplies for COVID-19, but these sister facilities did not have enough isolation supplies now. The supplies the facility did have were from the Ohio Department of Health and were received around the third to fourth week of April. Cooperate Nurse #100 confirmed as of 05/15/24, enhanced barrier precautions had not been implemented for required residents.</p> <p>Interview on 05/16/24 at 12:45 P.M. with Supply Company Associate #600 claimed that the supply company had to switch manufactures due to items not being available and on back order. The supply company had received multiple complaints about this leading up to the switch including from this facility. Since April 2024 the facility ordered two cases of gowns and three cases of mask which were ordered on 04/03/24 and should have been delivered 04/07/24 but were not delivered until 04/15/24. Gloves were ordered weekly.</p> <p>Review of the untitled and undated facility policy revealed, it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP involve gowns and gloves used during high-contact resident care activities for residents known to be colonized or infected with MDROs as well as those at increased risk for MDRO acquisition including resident with wounds or indwelling medical devices</p>		