STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366026	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Center V, Inc	478 S Sandusky St Delaware, OH 43015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of self-reported incident, interviews, review of facility policies, and employee handbook, the facility failed to ensure Resident #50 was free from verbal abuse on social media. This affected one (Resident #50) out of three residents reviewed for abuse. Facility census was 49. Findings include: Review of the medical record revealed Resident #50 was admitted on [DATE] and discharged on [DATE] with diagnoses of paraplegia, chronic respiratory failure, dysphagia, tracheostomy, anxiety, and depression. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #50 was cognitively intact. The MDS revealed no behaviors. Resident #50 felt down/depressed/hopeless, had trouble falling/staying asleep or sleeping too much, feeling tired or having little energy, and feeling bad about herself/a failure/let family down. Resident #50 had no impairment to upper extremities. Review of Self-Reported Incident (SRI) revealed on [DATE] at 4:00 P.M. the Director of Nursing (DON) notified the Licensed Nursing Home Administrator (LNHA) of inappropriate messages posted by an employee on Facebook. The messages reflected what was believed to be terrible things to say about any individual and their family and were aggressive and racist by nature. The facility assumed that the employee was speaking about a resident. The employee was suspended immediately. No names were named in any of the posts. LNHA spoke with the resident to assure psychosocial support was available if needed. Resident verbalized she did see the post but was unbothered. Review of the typed statement by the Assistant Director of Nursing (ADON) dated [DATE] revealed the ADON spoke with Resident #50 about the Facebook posts made by Certified Nursing Assistant (CNA) #75. The ADON assured Resident #50 the matter would be properly handled by management staff. The ADON offered emotional support to Resident #50. Resident #50 was accepting and appreciative of ADON offering emotional support and assuring Resident #50's safety. The incident was immediately reported to the Director of Nursing (DON). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Country Club Center V, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 478 S Sandusky St Delaware, OH 43015	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facebook posts revealed, CPS (child protective services) will be getting them kids soon as you go to jail for killing your other kids, That's why I hate (expletive) like you maybe you should've died with all your kids the world would be a better place, Don't be mad the CC wont fire me, and You and your kids deserved everything that happened to ya'll. Review of the typed statement by the LNHA dated [DATE] revealed Resident #50 had seen the posts on Facebook and was aware CNA #75 had been suspended. Resident #50 verbalized that she felt comfortable with the action being taken. The LNHA asked Resident #50 if she felt safe and Resident #50 stated she did. Resident #50 refused any psychosocial support. Review of employee file for CNA #75 revealed a hire date of [DATE]. CNA signed an acknowledgement of employee handbook, abuse policy, and cell phone and social media policy on [DATE]. Interview on [DATE] at 10:38 A.M. with Resident #50 verified she was friends with CNA #75 on Facebook and saw the negative posts made about her. Resident #50 and her friends were upset about what was posted. Resident #50 stated the previous day she had exchanged words with CNA #75 and CNA #75 was cursing at Resident #50. Activity Director #65 was working on the floor as a CNA and could not help with the crafts. Resident #50 told CNA #75 to go to work so Activity Director #65 could help with crafts. Resident #50 stated she was surprised that CNA #75 posted negative comments on Facebook because they had been friends. Resident #50 stated she felt CNA #75 verbally abused her and disrespected Resident #50 by the comments that were made and referring to the death of Resident #50's child. Interview on [DATE] at 11:39 A.M. CNA #75 stated she did not post on Facebook and her Facebook profile was cloned. CNA #75 stated Resident #50 told CNA #75 to go relieve Activities Director #65. CNA #75 stated Resident #50 got really smart about it and told CNA #75 what to do. Another CNA told CNA #75 she did not have to do what Resident #50 said. Resident #50 continued to tell CNA #75 what to do. CNA #75 verified she told Resident #50 to take her butt down the hallway. CNA #75 verified she was irritated with Resident #50 telling her what to do and Resident #50 was texting the DON and Activity Director #65 about the situation. CNA #75 stated Resident #50 was under the influence of drugs and alcohol and did not have children buckled in when the wreck occurred that killed Resident #50's daughter and Resident #50's sister. The van rolled seven times and Resident #50 was injured and on a ventilator and now paralyzed because of the accident. CNA #75 stated she became friends with Resident #50 on Facebook to help raise money for Resident #50. CNA #75 stated she was not asked to write a statement about the Facebook posts before being suspended or terminated. Resident #50 posted on Facebook that she would sue the facility if they did not terminate CNA #75. CNA #75 stated the facility terminated her so Resident #50 would not sue. During the interview CNA #75 was unable to provide any evidence her Facebook was cloned or that the posting on her Facebook page was about someone else other than Resident #50. Interview on [DATE] at 12:31 P.M. with Activities Director #65 revealed she was working on the floor and CNA #75 was supposed to replace her so Activities Director #65 could return to the activity room to help residents with a craft. CNA #75 pointed her finger at Resident #50 and said the DON told CNA #75 what to do. CNA #75 then stated she was tired of Resident #50 telling her how to do her job. Activities Director #65 stated CNA #75 needed to discuss her concerns in private and not in front of other residents. CNA #75 walked away at that time. (continued on next page)

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER: Country Club Center V, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 478 S Sandusky St Delaware, OH 43015	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 1:26 P.M. LNHA revealed she did not feel abuse had occurred due to a resident and facility was not originally named. LNHA verified that since the original posts were made, the posts had been shared on many forums and the facility has received multiple phone calls from people in the community. Review of the Abuse policy revised [DATE] revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It includes verbal abuse and mental abuse including abuse facilitated or enabled through the use of technology to demean or humiliate a resident. Review of the Cell Phones and Social Media policy revised [DATE] revealed the policy was intended to assist employees who partake in social media activities to do so effectively and responsibly and to ensure that a resident's right to privacy is maintained and residents remain free from abuse. The policy revealed while engaging in any form of social networking, employees were prohibited from sharing confidential resident information. Employees could not share any information about residents regardless of whether the employee thought the subject of such information was unidentifiable. No employee may friend or accept a friend request on social media from a resident. Review of the employee handbook revealed prohibited conduct included making false, malicious, vicious, or misleading statements about any employee, the company, or its services. This included any disparaging comments posted on social media sites. Prohibited conduct also included knowingly and negligently providing incorrect or misleading information. Threatening, intimidating or coercing any person was also prohibited. Review of the facility's corrective action revealed the following actions were implemented and the deficiency corrected as of [DATE]: [DATE] at 4:00 P.M. LNHA became aware of an inappropriate racially insensitive post on social media by CNA #75. [DATE] at 4:30 P.M. LNHA and DON suspended CNA #75 pending investigation regarding prohibited conduct. [DATE] LNHA was sent additional social media posts further incriminating CNA #75. [DATE] CNA #75 was terminated for several offenses of prohibited conduct outlined in the handbook. [DATE] LNHA initiated SRI. [DATE] Random audit of residents completed, no knowledge of any social media posts or abuse. [DATE]-[DATE]: Education with was completed. Facility continues to monitor weekly for reports of inappropriate social media postings or any knowledge of abuse or harm. This deficiency represents non-compliance investigated under Complaint Number OH00162004.