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	04/21/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications, the medication cart, and the treatment cart were secured properly. This had the potential to affect 10 residents (Residents #11, #15, #20, #22, #25, #27, #36, #37, #41, and #34) who were identified as cognitively impaired and independently mobile. The facility census was 46.Findings include:Observation on 04/20/26 at 10:41 A.M. revealed the medication cart and treatment cart located near the main nurses' station were unlocked and unattended.Interview on 04/20/26 at 10:42 A.M. with Licensed Practical Nurse (LPN) #115 confirmed the medication and treatment carts were unlocked and unattended.Observation on 04/21/26 at 6:12 A.M. of the medication cart in the 200 hallway revealed a bottle of Gabapentin (anticonvulsant used to treat partial seizures and neuropathic pain) 300 mg/6 mL solution sitting on top of the cart unattended. At this time, both the medication and treatment carts were locked. However, the Gabapentin remained unsecured on top of the cart through 6:19 A.M.Observation at 6:19 A.M., Registered Nurse (RN) #142 emerged from a resident's room and approached the medication cart. He unlocked the treatment cart, which remained unlocked. RN #142 prepared a resident's medication using the Gabapentin solution and entered the resident's room at 6:20 A.M. During this period, the treatment cart remained unlocked and unattended from 6:20 A.M. through 6:25 A.M.Interview on 04/21/26 at 6:25 A.M. with RN #142 confirmed the gabapentin had been left on top of the medication cart while he was assisting another resident across the hallway with a treatment. He acknowledged the medication remained unattended and that the treatment cart was left unlocked while he was in the resident's room.Interview on 04/21/26 at 9:35 A.M. with the Director of Nursing (DON) confirmed medications must be stored securely in medication carts, and that medication and treatment carts must remain locked when staff are not preparing medications and must not be left unlocked when staff are not present.Review of the facility's Medication Storage Policy dated 07/01/21 revealed that medication rooms, carts, and medication supplies are to remain locked when not attended by authorized personnel.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to report alleged abuse concerns to the state agency timely. This affected one (Resident #8) out of one residents review for abuse. The facility census was 46. Findings include:Review of the medical record for Resident #8 revealed an admission date of 08/25/24 with diagnoses including Type II Diabetes Mellitus, need for assistance with personal care, muscle weakness, chronic pain syndrome, legal blindness and low back pain.Review of care plan dated 01/07/25 revealed Resident #8 required assistance from staff to meet activities of daily living, interventions include assist with hair, oral, transfers, toileting and bed mobility as needed. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 is cognitively intact, exhibits no physical or verbal behaviors, and requires substantial/maximal assistance with toileting.Review of a hospice note dated 04/14/26 revealed the resident reported a facility staff person was mean to me last night. She was helping me to the toilet and she was being rough. I started screaming and telling her my leg hurt, but she didn't listen and kept doing it anyway. I tried to push her away from me, and she brought her hand to my face and made contact. She didn't hit my face, but I think she wanted to. She does not like me and there is nothing I can do about it. Registered Nurse (RN) #126 was made aware of this concern by the hospice nurse and reported, There is a complaint with one of our thirdˆshift aides. She was suspended for an investigation. Staff reported no matter the outcome, this aide will not be permitted to care for the resident. We don't know what will happen next, but we are investigating.Interview on 04/21/26 at 10:32 A.M. with Resident #8 revealed that on either 04/10/26 or 04/11/26 an incident occurred with a night shift aide. Two aides were attempting to change her brief and rolled her over; the resident reported one of the aides were pushing too hard and hurting her left leg. The aide did not stop until the resident began yelling, and at one point the aides hand made its way up to the resident face. The resident stated that a male nurse entered the room and made the aide stop turning her. The aide then left the room immediately, and the resident reported she had not seen that aide or the other staff nurse since. Resident #8 reported the hospice nurse was made aware of her concerns, the resident could not provide any identifying details or names of the alleged abuser. Interview on 04/21/26 at 10:51 A.M. with Licensed Practical Nurse (LPN) #129 revealed she was unaware of Resident #8's report of abuse; however, she stated that if she had been aware, she would have immediately notified the Director of Nursing (DON) or Administrator.An attempted interview was made on 04/21/26 at 11:03 A.M. with Hospice Nurse #200.Interview on 04/21/26 at 11:22 A.M. with RN #126 revealed she had been made aware of the abuse allegation by Hospice Nurse #200. She stated that when she learned of the concern on 04/14/26, she reported it to both the Administrator and Assistant Director of Nursing (ADON) #144.Interview on 04/21/26 at 11:25 A.M. with the Administrator and DON revealed that after reviewing the hospice documentation, they confirmed neither hospice nurse #200 nor RN #126 notified them of the reported abuse concerns. The DON stated she was responsible for reviewing hospice records in a timely manner and acknowledged she had not seen the documented report of abuse.Interview on 04/21/26 at 11:37 A.M, with Resident #8 and the DON revealed an abuse interview was initiated at that time.Interview on 04/21/26 at 12:36 P.M. with LPN #130 revealed she was also unaware of Resident #8's report of abuse, and stated any such report would be relayed immediately to the DON or Administrator.Review of SRI case #273583 created 04/21/26 at 11:35 A.M. involving resident #8 revealed hospice note claiming a resident was mean to her. Review of the facility's abuse policy dated 03/01/26 revealed staff must report all incidents and allegations in a timely manner to the Administrator or designee. The policy further states that if an allegation involves abuse or serious bodily injury, it must be reported to the state no later than two hours after the allegation is made.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to monitor weights for a resident that experienced a significant weight loss. This affected one (Resident #3) of one resident reviewed for nutrition. The census was 46.Findings Include:Resident #3 was admitted to the facility on [DATE]. His diagnoses were chronic respiratory failure with hypoxia, acute respiratory failure, dependence on respirator, neuromuscular dysfunction of bladder, hypertension, Type II Diabetes, hyperlipidemia, chronic kidney disease, colostomy status, cerebral infarction, tracheostomy status, morbid obesity, anoxic brain damage, obstructive and reflux uropathy, and muscle weakness. Review of his minimum data set (MDS) assessment, dated 03/13/26, revealed he had a severe cognitive impairment.Review of Resident #3's weights, dated 03/10/26 to 03/29/26, revealed the following weights documented as being completed:03/10/26 (289.1 pounds), 03/27/26 (262 pounds), and 03/29/26 (262.7 pounds). The weights taken represented a 9.4 percent decline from 03/10/26 to 03/27/26. Review of Resident #3's physician orders, dated 03/15/26 to 04/19/26, revealed the facility was to complete weekly weights for four weeks. The order was dated as being originally created on 03/09/26, but not started until 03/15/26. Review of Resident #3's care plan, dated 03/09/26, revealed he was at risk for malnutrition. The goals for this care plan were to have no significant weight changes noted, which included five percent or more in 30 days. Interview with Director of Nursing (DON) on 04/21/26 at 11:28 A.M. confirmed she can't explain why Resident #3 did not have any weights from 03/10/26 to 03/27/26. She confirmed there should have been at least one other weight between 03/10/26 and 03/27/26, and there was a significant weight loss when the second weight was obtained. Interview with Dietitian #201 on 04/21/2026 at 12:27 P.M. confirmed when they (her and another contracted dietary staff) visited the facility on 03/18/26, they did not have any recommendations because there were no weight changes. When asked if it was her preference to have weights taken once a week for the first four weeks after a resident admission, she stated she would have the facility follow their policy and/or dietary orders when it comes to obtaining weights. Review of facility Height and Weight policy, dated 09/26/16, revealed a height and weight will be obtained from each resident upon admission to the facility and entered into EMR under the weights and vitals tab. Hospital weights will not be used. Baseline height and weight will be updated in EMR yearly prior to annual MDS. All newly admitted residents will be weighed weekly and longer if requested per dietitian, physician or per nursing recommendation. Weights will be recorded in EMR and will be made available for dietitian visits.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to properly address and plan for resident's diagnosis of post traumatic stress disorder (PTSD) by identifying specific triggers and addressing underlying causes. This affected one (Resident #17) of one resident reviewed for PTSD. The census was 46.Findings Include:Resident #17 was admitted to the facility on [DATE]. Her diagnoses were acute and chronic respiratory failure, congestive heart failure, muscle weakness, dependence on respirator, mild cognitive impairment, venous insufficiency, chronic obstructive pulmonary disease, peritoneal abscess, borderline personality disorder, mood disorder, hypokalemia, mild protein calorie malnutrition, morbid obesity, tracheostomy status, anxiety disorder, depression, insomnia, Type II Diabetes, and hypertension. Review of her minimum data set (MDS) assessment, dated 01/29/26, revealed she was cognitively intact. Review of Resident #17's Life Event Checklist (LEC)-5 document, dated 10/10/24, revealed the following difficult or stressful events that have occurred in her life: life threatening illness or injury and sudden accidental death. There was nothing else listed on this form to identify specifically what the events were that caused difficulty and stress in Resident #17 life. Review of Resident #17 care plan, dated 09/17/24, revealed resident had PTSD and/or experienced a traumatic event(s)in the past related to life-threatening illness or injury, or sudden accidental death. Review of her interventions revealed the following: observe for indications that resident is experiencing a triggered event, which included increased anxiety, crying, withdrawn, not eating, and anger and offer psychological services as needed. There was nothing listed within the care plan to identify what the events were that caused the traumatic experience so others were aware of what incidents/actions could cause harm to her mental health. Review of Resident #17's behaviors logs, dated 02/01/26 to 04/21/26, revealed there was only one behavior identified during that period, which was verbal behaviors directed to others. The behavior logs were not personalized to Resident #17 behaviors. Interview with Director of Nursing (DON) on 04/21/26 at 9:12 A.M. confirmed the behavior log is general and not specific to Resident #17. She confirmed they could not find any documentation to identify what the specific incidents were that caused the trauma in her life, nor a plan to help address potential triggers from the incident(s) that occurred in her past.