STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365811	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwestern Center	570 North Rocky River Drive Berea, OH 44017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #46's incontinence care was provided timely. This affected one resident (Resident #46) out of three residents reviewed for incontinence care. The facility census was 90. Findings include: Review of Resident #46's medical record revealed an admitted [DATE] and diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, muscle weakness, type two diabetes mellitus, and morbid obesity due to excess calories. Review of Resident #46's care plan dated 04/11/24 included Resident #46 had ADL self-care performance due to hemiparesis, history of CVA (cerebrovascular accident), decreased functional mobility, pain, incontinence and other diagnoses. Resident #46 would maintain current level of function. Interventions included Resident #46 required the use of a mechanical lift with two person support. Resident #46 was incontinent of bowel and bladder due to hemiparesis, decreased functional mobility and other diagnoses. Resident #46 would remain free of skin breakdown due to incontinence. Interventions included check Resident #46 for incontinence, wash, rinse and dry perineum, change clothing as needed after incontinence episodes; Resident #46 used disposable briefs, change as needed. Review of Resident #46's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 had moderate cognitive impairment. Resident #46 was dependent for ability to roll from lying on back to left and right side, and return to lying on back on the bed. Sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer were not attempted due to medical condition or safety concerns. Resident #46 was dependent for chair, bed-to-chair transfers, and ADL's (Activity of Daily Living)'s except for eating. Resident #46 was always incontinent of urine and bowel. Review of Resident #46's aide charting in the electronic record for bowel and bladder incontinence from 08/19/24 at 7:00 P.M. until 08/20/24 at 7:00 A.M. revealed Resident #46 was incontinent of urine and bowel at 6:42 A.M. (only one time in twelve hours). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/20/24 at 9:51 A.M. of State tested Nursing Assistant (STNA) #279 revealed she was preparing to provide incontinence care for Resident #46. Resident #46 stated she often did not get changed timely when she was incontinent. Resident #46 stated she was wet all last night, she had her light on all night until STNA #248 answered it around 4:00 A.M. STNA #279 stated even if they were short staffed during the night the call light should have been answered at some point. Observation of Resident #46's incontinence care revealed STNA #279 stated this was the first time Resident #46 was changed since she arrived for work at 7:00 A.M. and Resident #46 was not in her assignment. Resident #46's incontinence brief was soaked with urine and feces. STNA #279 stated the day shift aides transfer Resident #46 to a padded wheelchair, do not transfer her back to her bed for an incontinence check, and Resident #46 had to wait until the second shift aides lay her down to receive incontinence care. Resident #46 stated staff did not change her incontinence brief timely most of the time. Resident #279 stated Resident #46 frequently urinates and if she did not get changed she just lays in urine and bowel movement. Interview on 08/20/24 at 4:02 P.M. of STNA #248 revealed she picked up a shift to work on 08/20/24 from 3:00 A.M. until 7:00 A.M. STNA #248 stated she was sitting at the nurses station and she saw Resident #46's call light was activated and heard Resident #46 calling her aides name, she waited five to ten minutes and Resident #46's aide did not answer her call light or go in the room so STNA #248 went in the room to assist Resident #46. STNA #248 stated Resident #46's bed, gown and incontinence brief were saturated with urine and feces, and she washed her up and changed the linens on Resident #46's bed. STNA #248 stated she did not know how long Resident #46 was calling her aides name before she arrived for work. STNA #248 indicated Resident #46 told her she waited long periods of time before the STNA's go in her room to help her. STNA #248 stated quite a few residents told her the STNA's do not go in their rooms to help them. STNA #248 indicated a lot of the STNA's do not like taking care of Resident #46 because she is a bigger lady, was kind of needy and could not do anything for herself. Review of the facility policy titled Routine Resident Care undated included it was the policy of the facility to promote resident centered care by attending to the physical, emotional, social, and spiritual needs and honor resident lifestyle preferences while in the care of the facility. Provide routine daily care by a certified nursing assistant with specialized training in rehabilitation, restorative care under the supervision of a licensed nurse including but not limited to toileting, providing care for incontinence with dignity and maintaining skin integrity. This deficiency represents non-compliance investigated under Complaint Number OH00156946 and OH00156175.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review, review of hospital records and facility policy the facility failed to ensure Resident #91's left knee contusion with fracture blisters, hematoma and effusion was evaluated, monitored, and treated timely. This affected one resident (Resident #91) out of three residents reviewed for wounds. The facility census was 90. Findings include: Review of Resident #91's emergency department (ED) Provider Note, prior to admission to the facility, dated 07/11/24 included Resident #91 fell on [DATE] at around 3:00 A.M. and around 7:00 A.M. she noted her left knee had become very swollen and noted bruising to the area. The ED Clinical Impression included contusion of left knee, injury of left knee, initial encounter. Review of Resident #91's medical record revealed an admitted to the facility of 07/17/24 and diagnoses included hemiplegia and hemiparesis following nontraumatic intracerbral hemorrhage affecting the left non-dominant side, repeated falls, generalized anxiety disorder, nondisplaced fracture of the third and fourth metatarsal bone, left foot and contusion of left knee. Resident #91 was discharged from the facility on 07/24/24. Review of Resident #91's After Visit Summary for hospital stay 07/11/24 through 07/17/24 included Orthopaedic Discharge Note stated no weight bearing to the left leg, maintain the post-op shoe while ambulating. Left knee immobilizer at all times, may open, remove while resting in bed, icing, hygiene and skin checks. No bending the knee for now, soft tissue rest. Final diagnosis was left knee contusion with evolving fracture blisters, hematoma and effusion. Review of Resident #91's care plan dated 07/17/24 included Resident #91 had an ADL self care performance deficit. Resident #91 would maintain current level of function. Interventions included Resident #91 was totally dependent of two staff members for eating, oral hygiene, toileting hygiene. Further review of the care plan did not reveal a care plan for Resident #91's left knee immobilizer and left knee contusion with evolving fracture blisters, hematoma and effusion. Review of Resident #91's Nursing Admission Evaluation dated 07/17/24 included Resident #91 had a left lower leg immobilizer in place. PT (Physical Therapy) to evaluate, wound consult, NP consult for orders for immobilizer. Immobilizer not to be removed until assessment done by NP and PT, wound to follow. Review of Resident #91's physician orders dated 07/17/24 revealed Weekly Skin assessment to be completed. Documentation to be completed on Weekly Skin assessment every evening shift, every Saturday for Skin Assessment. Further review of Resident #91's physician orders revealed wound care consult. Review of Resident #91's Treatment Administration Record (TAR) dated 07/20/24 revealed Weekly Skin assessment to be completed. Documentation to be completed on Weekly Skin Assessment every evening shift, every Saturday for skin assessment. Resident #91's Skin Assessment was not documented it was completed and the medical record including progress notes and assessments did not reveal evidence the Skin Assessment was completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's medical record including progress notes and physician orders dated 07/17/24 through 07/23/25 did not reveal evidence Resident #91 had skin assessments or documentation regarding size, appearance of her left knee contusion and fracture blisters. There were no physician orders for the care of the left knee contusion and fracture blisters. Review of Resident #91's Physical Therapy Evaluation and Plan of Treatment included care was started on 07/18/24 and clinical impressions were Resident #91 presented with left knee lower extremity pain and weakness, impaired bed mobility, transfers, gait and balance. Resident #91 was issued a wheelchair and she was presently non ambulatory. Left elevating leg rest due to left knee immobilizer. Review of Resident #91's Wound Assessment Report dated 07/24/24 included Resident #91's left anterior wound Bullae (large fluid filled blisters on the skin that are more than 0.5 cm in diameter) measured length 9. 0 cm, width 8.5 cm and depth 0.0 cm. The Bullae was present on admission and was 100 percent epithelial. The periwound had edema, was fragile and had ecchymosis (bruising). Treatment was cleanse with normal saline daily and as needed and cover with ABD (abdominal pad). Review of Resident #91's progress notes revealed a late entry Clinical Meeting Note dated 07/25/24 at 8:03 P.M. included on 07/18/24 at 10:57 P.M. Resident #91 was S/P (status post) hospitalization for a left knee contusion with fracture blisters, hematoma and effusion with sever tricompartmental OA (osteoarthritis) with complex lateral meniscus tear. Resident #91 noted with immobilizer to RLE (right lower extremity) to remain in place until PT consult with follow up with sports medicine and ortho. Review of Resident #91's Admission and Discharge documents for hospital stay from 07/24/24 through 07/26/24 included Resident #91 refused to return to the facility and planned to return home, have assistance from family, and receive home health services. Resident #91 transferred to the hospital from the local Emergency Department for left knee evolving hemorrhagic bursitis. Resident #91 was originally admitted on [DATE] for a fall with left knee injury followed by orthopaedics. Resident #91 was placed in a knee immobilizer and to follow-up in outpatient setting with sports medicine. Resident #91 presented for severe hemorrhagic prepatellar bursitis. Resident #91 stated over the past several days she had worsening left knee pain and had the aide at the facility take her knee immobilizer off which had blood on it. Resident #91 had concern with current care she was receiving, ongoing left knee pain and concern for wound check. Resident #91 had ecchymosis, healing blister, and hematoma to left anterior knee. Review of Resident #91's Final Report for a CT (computerized tomography) of the left knee dated 07/24/24 revealed the reason for the scan was new knee swelling and skin wound since most recent admission. Result included slightly increased size of the evolving prepatellar blood products, now measuring approximately 11.7 cm by 2.8 cm by 10.8 cm and was previously 11.1 cm by 2.1 cm by 10.5 cm. Resident #91 was known to the physician from multiple medical issues and recent fall with severe prepatellar hematoma and bursitis came to the hospital after not being cared for at the nursing home. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/19/24 at 3:07 P.M. of Physical Therapist (PT) #231 revealed Resident #91 was very cooperative and was making progress. Resident #91's left knee contusion was treated conservatively with a knee immobilizer. PT #231 stated Resident #91 was not very happy with her nursing care. PT #231 stated he took Resident #91's immobilizer off her leg the first day he evaluated her and it looked bruised and swollen, and he did not remember seeing blisters or drainage. PT #231 indicated when he took the immobilizer off Resident #91 had an ABD (abdominal) pad on and it had a small amount of dried dark red drainage on it, he told the nurse there was drainage and the area should be looked at. PT #231 stated he did not remember which nurse he told or if the nurse looked at Resident #91's left leg. Interview on 08/19/24 at 3:18 P.M. of the Director of Nursing (DON), Regional Director of Clinical Operations (RDCO) #310 and Wound Nurse/Unit Manager (WN/UM) #271 revealed Resident #91 could be verbally aggressive when she became agitated. The DON stated Resident #91 was transported to the hospital per her request. The DON and WN/UM #271 confirmed Resident #91 did not have a skin assessment until 07/24/24, and there were no treatment orders until 07/24/24. The DON stated Resident #91's dressing was to remain in place until she was seen by the wound physician, the wound team saw her on 07/24/24, and a full skin assessment was done on 07/24/24 (a week after Resident #91 was admitted to the facility). The DON stated Resident #91 would not let us touch the dressing (there was no evidence of this in the documentation). The DON confirmed there was no order stating the dressing was to remain in place until Resident #91 was seen by the wound physician, but a lot of times the nurses got verbal reports that did not match the orders from hospitals. Interview on 08/19/24 at 5:04 P.M. of hospital Social Worker (SW) #313 revealed Resident #91 was discharged from the hospital without a wound and she returned with a wound and the hospital staff was concerned because the wound was now open and it was not open before. Interview on 08/20/24 at 8:47 A.M. of the DON revealed she could not find additional information about the dressing remaining in place until Resident #91 was seen by the wound physician, and it was an oversight. The DON stated going forward she would have a better plan so it did not happen again. The DON stated Resident #91 would not let her look at her left knee, and she should have written a note that she would not let me look at it. Review of the facility policy titled Skin Care and Wound Management Overview undated included each resident was evaluated upon admission and weekly thereafter for changes in skin condition. Resident skin condition was also reevaluated with a change in clinical condition, prior to transfer to the hospital and upon return from the hospital. This deficiency represents non-compliance investigated under Complaint Number OH00156175.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of the facility policy the facility failed to ensure individualized care planned interventions were developed and followed to prevent Resident #46 from developing pressure ulcers, and failed to ensure the pressure ulcers were timely identified, properly treated, and interventions were initiated to promote healing. Actual Harm occurred on 08/20/24 when Resident #46, who was at risk for developing pressure ulcers, and was dependent on staff for bed mobility and incontinence care was identified to have new areas of in-house acquired skin impairment with no additional assessment or new treatment at that time. On 08/21/24 the facility assessed the resident to have two new, in-house acquired Stage III pressure ulcers (full-thickness loss of skin that extended to the subcutaneous tissue, but did not cross the fascia beneath it) on her proximal and distal right posterior thigh, without proper prevention, treatment, and interventions implemented. The resident reported increased pain to the areas and also voiced concerns staff did not provide timely incontinence care or assistance with turning and repositioning. This affected one resident (#91) of three residents reviewed for pressure ulcers. The facility census was 90. Findings include: Review of Resident #46's medical record revealed an admitted [DATE] and diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, muscle weakness, type two diabetes mellitus, and morbid obesity due to excess calories. Review of Resident #46's care plan dated 04/11/24 included Resident #46 had activity of daily living (ADL) self-care performance due to hemiparesis, history of cerebrovascular accident (CVA), decreased functional mobility, pain, incontinence and other diagnoses. The goal included Resident #46 would maintain current level of function. Interventions included Resident #46 required the use of a mechanical lift with two person support. The resident also had a plan of care reflecting impaired skin integrity or being at risk for altered skin integrity due to hemiparesis, history of cerebrovascular accident and other diagnoses, pain and incontinence, and decreased functional mobility. The goal included Resident #46 would have improved or maintain current skin status through next review date of 10/27/24. Interventions included to complete weekly skin checks; encourage Resident #46 to turn and reposition or assist as needed as resident allows. Review of Resident #46's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 had moderate cognitive impairment. Resident #46 was dependent for ability to roll from lying on back to left and right side, and return to lying on back on the bed. Sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer were not attempted due to medical condition or safety concerns. Resident #46 was dependent for chair, bed-to-chair transfers, and ADL care except for eating. Resident #46 was always incontinent of urine and bowel. Resident #46 was at risk for developing pressure ulcers, injuries and did not have a pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #46's Nursing Admission Evaluation dated 08/01/24 revealed Resident #46's was evaluated to be at low risk for developing a pressure ulcer or injury, there were no skin areas noted, and to turn and reposition the resident as needed. Review of Resident #46's physician orders dated 08/01/24 revealed an order for a wound care consult. Review of Resident #46's physician orders dated 08/02/24 revealed Triad cream to groin, thighs, buttocks every day and evening shift. Review of Resident #46's physician orders dated 08/01/24 through 08/22/24 did not reveal orders to turn and reposition. Review of Resident #46's medical record including progress notes, Medication and Treatment Administration Records, and aide charting from 08/01/24 through 08/22/24 did not reveal evidence Resident #46 was turned and repositioned. There was no evidence Resident #46 refused to be turned and repositioned. Further review revealed there were no Weekly Skin Checks completed during this time period. During an observation on 08/20/24 at 9:51 A.M. with State tested Nursing Assistant/Power of Attorney (STNA/POA) #279 of Resident #46's incontinence care the resident stated the aides did not complete her incontinence care timely and did not offer to turn and reposition her when she was in bed, and if they did offer to turn and reposition her she would not refuse. Observation of Resident #46's right upper posterior thigh revealed two open areas, one area that was approximately an inch and a half long and a half inch wide, and the second area that was approximately an inch long and a half inch wide. The wound bed of both open areas was a medium red to dark red color, and there was a small amount of serosanguineous drainage. The open areas did not have a dressing on then. STNA #279 stated she was Resident #46's POA and was also an STNA at the facility. STNA/POA #279 stated Resident #46 needed a mechanical lift for transfers and after Resident #46 was transferred to her chair on day shift a lot of the STNAs would not bring her back to her room and transfer her back to her bed so her incontinence brief could be changed, and her skin checked, and would wait for second shift to do it. STNA/POA #279 indicated Resident #46 had the two open areas about two weeks and she told the nurses including Licensed Practical Nurse (LPN) #258 and Wound Nurse/Unit Manager (WN/UM) #271 about the two open areas and they did not do anything except to tell her to put Triad on the open areas, and sometimes they did not even look at the open areas and told her to put Triad on the area. After surveyor intervention, LPN #258 entered Resident #46's room and before she looked at the open areas stated Resident #46 had Triad ordered. After looking at the two open areas LPN #258 stated she was going to have Wound Nurse/Unit Manager (WN/UM) #271 evaluate the open areas because Resident #46 only had Triad ordered. Resident #46 indicated the aides did not change her incontinence brief timely. WN/UM #271 entered Resident #46's room, looked at her two open areas, and said she needed to get supplies, left the room and returned with dressing items. WN/UM #271 cleansed the wounds and Resident #46 cried out and said that hurt, WN/UM #271 finished cleaning the open areas, applied Triad and a border dressing. Resident #46 stated the nurses and WN/UM #271 did not thoroughly evaluate the open areas before today. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/20/24 at 11:12 A.M. with WN/UM #271 revealed Resident #46 was admitted to the facility with a wound to her right posterior thigh, it was resolved (date not provided), and today she had a wound on her left side (the two open areas were on Resident #46's right thigh). WN/UM #271 indicated Resident #46's skin was fragile and Triad was ordered on 08/02/24 by facility Nurse Practitioner (NP) #312. WN/UM #271 then stated Resident #46 did not have any wounds from 05/2024 until now. WN/UM #271 stated she looked at Resident #46's skin a lot due to discomfort, the felt the nurses had also seen her skin. Observation on 08/20/24 at 12:00 P.M. of Resident #46 revealed she was lying in her bed, was on her back with the head of bed elevated. No observation of an STNA turning and repositioning Resident #46 or offering to reposition her occurred at that time. Observation on 08/20/24 at 2:00 P.M. of Resident #46 revealed she was lying in her bed, was on her back with the head of bed elevated. No observation of an STNA turning and repositioning Resident #46 or offering to reposition her occurred at that time. Interview on 08/20/24 at 4:02 P.M. with STNA #248 revealed Resident #46 told her she waited long periods of time before the STNAs came into her room to help her. STNA #248 stated quite a few residents told her the STNAs do not go in their rooms to help them. STNA #248 indicated a lot of the STNAs do not like taking care of Resident #46 because she is a bigger lady, was kind of needy and could not do anything for herself. Interview on 08/21/24 at 6:54 A.M. with Wound Nurse Practitioner (WNP) #311 revealed Resident #46's two open areas looked like the open areas were some pressure with pressure injuries. WNP #311 stated she ordered silver alginate with border gauze dressing and Triad to the surrounding tissue. WNP #311 stated she had not seen Resident #46 in quite a while. Review of Resident #46's Wound Assessment Report dated 08/21/24 completed by Wound Nurse Practitioner (WNP) #311 included Resident #46 had a new Stage III pressure ulcer to her right distal posterior thigh. The pressure ulcer was acquired in house on 08/20/24. Measurements were length 1.40 cm (centimeters), width 2.40 cm, and depth was 0.10 cm. The wound had 10 percent epithelial tissue, 90 percent granulation tissue and 0 percent slough. The periwound was fragile with scarring. There was a moderate amount of serosanguineous drainage. Treatment was cleanse the wound with wound cleanser, apply silver alginate, bordered foam dressing, and Triad (wound healing, barrier cream) to periwound daily and as needed. Further Review of Resident #46's Wound Assessment Report dated 08/21/24 completed by WNP #311 included Resident #46 had a new Stage III pressure ulcer to her right proximal posterior thigh. The pressure ulcer was acquired in house on 08/20/24. Measurements were length 0.4 cm, width 4.0 cm, and depth was 0. 10 cm. The wound had 90 percent granulation tissue and 10 percent slough. The periwound was fragile with scarring and there was a moderate amount of serosanguineous drainage. Treatment was cleanse with wound cleanser, apply silver alginate, bordered foam dressing, and Triad to periwound daily and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/22/24 at 4:46 P.M. with WN/UM #271 and Regional Director of Clinical Operations (RDCO) #310 revealed Resident #46 returned from the hospital on 08/01/24 and the order for a wound consult was a standing order when a resident was admitted or readmitted to the facility, and to be used as needed. WN/UM #271 stated the Wound Nurse Practitioners did a skin check on all new residents and readmissions to the facility, and did a quarterly skin sweep as well. RDCO #310 stated if there were no wounds the nurse practitioners did not document in the resident records, but would send an email stating the residents they evaluated and whether or not each had a wound. RDCO #310 stated nurses on the floor should do weekly skin checks, and both RDCO #310 and WN/UM #271 confirmed Resident #46 did not have weekly skin checks from 08/01/24 through 08/22/24. WN/UM #271 stated Resident #46 had a previous ulcer that healed back in May, and she was not seen by the Nurse Practitioner until 08/21/24. Review of the facility undated policy titled Skin Care and Wound Management Overview included each resident was evaluated upon admission and weekly thereafter for changes in skin condition. Resident skin condition was also reevaluated with a change in clinical condition, prior to transfer to the hospital and upon return from the hospital. Skin care and wound management program included identification of residents at risk for the development of pressure ulcers, implementation of prevention strategies to decrease the potential for developing pressure ulcers, develop a care plan with individualized interventions to address risk factors, communicate risk factors and interventions to the care giving team. This deficiency represents non-compliance investigated under Complaint Number OH00156946.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwestern Center	570 North Rocky River Drive Berea, OH 44017

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of facility policy the facility failed to ensure care and services were provided to ensure Resident #46 was safely transferred and transported to an appointment, and failed to ensure fall interventions were implement to prevent Resident #76's from falling. This affected two residents (#46 and #76) of three residents reviewed for accident hazards. The facility census was 90. Findings include: 1. Review of Resident #46's medical record revealed an admitted [DATE] with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, muscle weakness, type two diabetes mellitus, and morbid obesity due to excess calories. Review of Resident #46's care plan dated 04/11/24 included Resident #46 had activity of daily living (ADL) self-care performance due to hemiparesis, history cerebrovascular accident (CVA), decreased functional mobility, pain, incontinence and other diagnoses. The goal included Resident #46 would maintain current level of function. Interventions included Resident #46 required the use of a mechanical lift with two person support. Review of Resident #46's physician orders dated 07/16/24 revealed Resident #46 had an appointment with Rheumatology on 08/14/24 at 2:00 P.M., and pick-up was at 1:15 P.M. Review of Resident #46's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 had moderate cognitive impairment. The assessment revealed Resident #46 was dependent for ability to roll from lying on back to left and right side, and return to lying on back on the bed. Sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer were not attempted due to medical condition or safety concerns. Resident #46 was dependent for chair, bed-to-chair transfers, and ADL care except for eating. Resident #46 was always incontinent of urine and bowel. Review of Resident #46's weight dated 08/01/24 revealed she weighed 317 pounds. Review of the facility incident log revealed Resident #46 experienced a fall on 08/14/24 at 4:30 P.M. Review of Resident #46's progress note dated 08/14/24 at 6:21 P.M. revealed Resident #46 returned from her appointment at 4:30 P.M. The driver was unable to get Resident #46 out of the van. Resident #46's hoyer pad (mechanical lift pad) was not placed under her correctly, staff were unsuccessful trying to help Resident #46 out of the van, and she had to be lowered to the ground. Resident #46 was then able to be positioned into a bariatric chair without difficulty. Resident #46 had no complaints of pain or discomfort, her vital signs were stable and range of motion was within normal limits. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's Falls Details Report dated 08/14/24 at 4:30 P.M. included Resident #46 had a fall outside the facility which required a transfer. The incident was reported on 08/14/24 at 6:15 P.M. and the resident's power of attorney, POA #279 and the physician were notified. Witnesses were State tested Nursing Assistants (STNA) #214, STNA #280, Licensed Practical Nurse (LPN) #204 and LPN #208. Resident #46's vital signs included blood sugar 134, temperature 97.8 Fahrenheit, blood pressure 119/74, respirations 18, pulse 72, and oxygen saturation 95 percent. Resident #46 was oriented times two (to person and place). Resident #46 was lowered to the ground outside after she was transported out of van to the wheelchair. The conclusion did not have a root cause identified and not applicable (N/A) was written next to root cause. Review of facility witness statements revealed a statement dated 08/14/24 by STNA #214 who wrote Resident #46 pulled up from appointment and was sliding out of the wheelchair, and staff had to lower her to the ground just to get the hoyer pad (mechanical lift pad) up under her to put her in the proper chair. There was no injury. Review of a witness statements dated 08/14/24 by LPN #208 revealed she wrote she was called out to the transportation van, and Resident #46 was halfway out of her wheelchair, and her mechanical lift pad was up near her umbilicus. Five staff members were present and were unable to get Resident #46 back into the wheelchair. Resident #46 was placed gently on van floor with assistance of five. Resident #46 was laid down and the hoyer pad was adjusted under her. Resident #46 was brought out of the van and hoyered into her Broda chair (padded wheelchair). Resident #46 did not hit her head at any time. Review of a witness statement dated 08/14/20 (08/14/24) revealed STNA #261 wrote she went with Resident #46 to her appointment and during her appointment she needed repositioned frequently using the hoyer pad. When Resident #46 was in the transport van she continued to slide in the wheelchair. Resident #46 was buckled in the back of the van. During the ride from the appointment to the facility I noticed it was not going to be safe the entire ways with the way she was sliding. STNA #261 had the driver pull over and assist with repositioning, the driver ensured the buckles were in place. STNA #261 called the facility to tell them to meet the van outside with a hoyer (mechanical lift), and stayed on the phone with the facility. The driver drove at the lowest speed until they reached the facility. Three nurses and three STNAs assisted with lowering Resident #46 to the van floor removing the wheelchair with the hoyer (mechanical lift) pad in place. Resident #46 was hoyered to her wheelchair. Resident #46 was on the phone with her granddaughter the whole time. Resident #46 was yelling out and upset, but not complaining of pain. Nobody saw any injuries. Observation on 08/20/24 at 9:51 A.M. revealed Resident #46 was lying in bed with the head of the bed elevated. At the time of the observation, Resident #46 stated last week she went to an appointment, the van driver did not put the seat belt on and she slid off the chair to the end. The van driver stopped the van a lot to get me in and her escort told the van driver she can't get the resident up in the chair. Resident #46 stated the escort called the facility and said she needed four people to help when they reached the facility. Resident #46 stated they had to drag me out from behind the seat, and dragged me like I was a piece of tissue. Resident #46 stated she had to be dragged off the van, onto the ground, and dragged to the hoyer and was put in a chair. Resident #46 stated she was in pain when they were dragging me. Resident #46 indicated she did not know why the driver forgot the seat belt, he drove slow and had to keep stopping. Resident #46 stated she was upset, very frightened and scared she was going to fall over and get injured, and felt very bad when this happened and repeated very bad and I was embarrassed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/20/24 at 11:25 A.M. with STNA #214 revealed she received a call from Resident #46's escort and was told to bring the hoyer (mechanical lift) to the front because Resident #46 was sliding out of her chair and she was in a chair not for her. STNA #214 stated Resident #46 had to be put in a regular bariatric wheelchair to be transported to her appointment, but she couldn't bend her legs and started sliding, and Resident #46 told her when the van hit a bump she slid. STNA #214 stated we were trying to figure out what to do and tried to pull the hoyer pad (mechanical lift pad) out and that made her fall to the floor. Resident #46 had to be lowered to the floor of the van, and she was already halfway there. Once Resident #46 was on the floor, the wheelchair was removed, and there was no way out of the van without pulling her, and it took all six of us to pull her while she was on the ground. STNA #214 stated Resident #46 was on the hoyer pad and they had to pull her and pull her off the van ramp to the ground, got the mechanical lift and used it to place Resident #46 in her padded wheelchair. STNA #46 stated Resident #46's custom padded wheelchair was broken and the bariatric broda chair (padded wheelchair) Resident #46 was using since her chair was broken did not fit in the van, and she did not know who put her in the regular bariatric wheelchair for transportation to her appointment. STNA #214 indicated it was very upsetting to see Resident #46 in this situation and Resident #46 was very upset this happened. Interview on 08/20/24 at 11:39 A.M. with Physical Therapist (PT) #231 revealed Resident #46 used a tilt-in-space wheelchair, and about a month ago the back fastener snapped off which secured the back of the wheelchair to the rest of the wheelchair. PT #231 stated the wheelchair company who made the tilt-in-space chair was contacted, a tech evaluated the chair, the broken part was ordered, but the part was not received yet and they were waiting for it so Resident #46's chair could be fixed. PT #231 stated the wheelchair company was called multiple times regarding the ordered part and the facility was told the part had not arrived. A tan bariatric padded wheelchair which was located in the common area was being used when Resident #46 was out of bed until her wheelchair was repaired, but the tan bariatric wheelchair was too big to fit on the transportation van. PT #231 stated no one asked him to okay the use of the bariatric wheelchair the facility used to transport Resident #46 to her appointment. PT #231 stated he did not know if the bariatric wheelchair used was weighted for her, did not know if they had dycem on the seat of the wheelchair. PT #231 stated he did not place Resident #46 in the bariatric wheelchair, did not know if the chair was appropriate for her, and would be [NAME] of her sitting on something in a van. Observation on 08/20/24 at 11:58 A.M. with PT #231 of Resident #46's wheelchair revealed a plastic fastener was broken, the plastic fastener secured the back of the wheelchair to a metal bar which would securely connect the back of the chair to the body of the chair. PT #231 stated since the fastener was broken the back of the chair could not be connected to the body of the chair and Resident #46 could not use the chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/20/24 at 12:28 P.M. with LPN #208 revealed on 08/14/24 Resident #46 was transported to an appointment in a standard bariatric wheelchair and there were some problems with Resident #46 sliding out of the wheelchair at the physician's office. When Resident #46 returned to the facility LPN #208 stated she was called to help because staff could not get the resident into her into the wheelchair, and she went to help along with another nurse. LPN #208 stated Resident #46 was a large woman and was half out of the wheelchair, the wheelchair was locked in, and she crawled in the van by Resident #46's feet to help move her back into the wheelchair. LPN #208 stated five staff members were trying to move Resident #46 back into her wheelchair, they were huffing and puffing, but they were unable to do it. There were two blankets in the van and the staff decided to sit Resident #46 on the ground, lay her down and position the mechanical lift pad under her correctly. LPN #208 stated the mechanical lift pad was up by her belly button and the whole situation was a mess. LPN #208 indicated the staff placed Resident #46's head on the blanket and pulled Resident #46 out of the van and down the ramp of the van as safely as they could. LPN #208 stated Resident #46 did not hit her head and she was not injured. The mechanical lift was used to transfer Resident #46 from the ground to the tan padded broda chair, and she was taken into the facility. LPN #208 stated she did not know how Resident #46 slid out of the wheelchair, the wheelchair had foot rests and one of Resident #46's feet were on the foot rest and one was off the foot rest. LPN #208 indicated the foot rests had to be removed when Resident #46 was assisted off the van. Interview on 08/20/24 at 12:43 P.M. with the Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO) #310 revealed on 08/14/24 Resident #46 was transported to an appointment, Resident #46 kept sliding out of the wheelchair, and the DON called the transport company during her investigation to talk to the driver, but the transport company did not call her back. The DON stated she would try again today to contact the driver of the van. The DON stated she did not understand why the driver would transport her if there were issues with Resident #46 sliding out of the wheelchair, or why Emergency Medical Services (EMS) were not contacted. The DON stated the transportation company told her in the past EMS was called to assist with issues like this and they would not come. The DON indicated Resident #46 was a bigger woman, she slides, and the mechanical lift was typically used to reposition her. The escort stated she was improperly placed in the wheelchair at the physician's office. The DON stated Resident #46 told her she did not have a seat belt securing her in the van. The DON stated Resident #46 had her own wheelchair, it was broken, and staff must have made a decision on their own to use the standard bariatric wheelchair the day of the appointment and did not notify anyone. The DON stated an STNA could have made the decision to use the standard bariatric wheelchair. Review of an email sent to Director of Rehab (DOR) #308 on 08/20/24 at 1:09 P.M. from the Medical Supply company revealed the company received a service request via phone for Resident #46 on 07/18/24 stating Resident #46 needed her chair repaired. A service tech evaluated Resident #46's chair on 07/25/24. A quote for parts was received on 08/01/24, a prior authorization was submitted on 08/01/24 and received authorization approval back on 08/08/24. Parts for Resident #46's wheelchair were ordered on 08/08/24, came in on 08/15/24 and installation was scheduled for 08/28/24. Interview on 08/20/24 at 1:30 P.M. with DOR #308 revealed Resident #46's wheelchair parts were on order and it was taking so long due to insurance authorization. DOR #308 stated the parts came in and were getting installed on 08/28/24. DOR #308 stated we would never have recommended that Resident #46 was transported in the standard bariatric wheelchair used for her appointment on 08/14/24. DOR #308 stated the standard bariatric wheelchair belonged to Resident #12 and was not an appropriate chair for Resident #46. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/20/24 at 2:34 P.M. with Certified Occupational Therapy Assistant (COTA) #229 revealed on 08/14/24 Resident #46's custom tilit-in-space wheelchair was broken, she was transferred in Resident #12's standard bariatric wheelchair and it was not an appropriate wheelchair to transfer Resident #46. COTA #229 stated Resident #46 needed a tilt-in-space wheelchair because she did not have the strength to hold herself up in the proper position. COTA #229 stated Resident #46 leaned back and her hips go forward and she did not have the lower body strength to hold herself properly, and that was why she needed the custom tilt-in-space chair. Interview on 08/21/24 at 10:06 A.M. with STNA #261 revealed on 08/14/24 she escorted Resident #46 to her appointment, but she did not transfer Resident #46 to the bariatric wheelchair used for transportation. STNA #261 stated the wheelchair was not suitable for Resident #46 and by the time she got to her Resident #46 was loaded in the van. STNA #261 stated while they were at the physician's office she had to keep picking her legs up and putting them back on the foot rests. STNA #261 stated the doorways and halls were not wheelchair friendly and when she made a turn through a doorway she had to pick up the back of the wheelchair and reposition it so she could continue down the hall. Resident #46's leg popped off the foot rest every time she had to do that, and she would have to reposition her legs back on the foot rests. On the way back to the facility STNA #261 called Resident #46's granddaughter. STNA #261 stated during the drive Resident #46's foot popped off the leg rest and was down, the van driver stopped in a parking lot and the two of them tried to readjust her, but were unable to. STNA #261 stated she called the facility to let them know what was going on, the van driver had to drive slow, Resident #46 was properly secured and there was a seat belt across her lap. STNA #261 stated she stood behind Resident #46 the whole time. STNA #261 stated when they got to the facility staff came out and helped lower Resident #46 to the ground and she was pulled out of the van and transferred to a padded wheelchair using a mechanical lift. STNA #261 stated Resident #46 was very upset because her hat came off when staff were pulling her out of the van and her hair was not fixed. Interview on 08/26/24 at 9:33 A.M. of the DON revealed the staff should have checked with therapy to make sure Resident #46 was transported to her appointment in an appropriate wheelchair for her. The DON stated resident safety was very important and the facility was working to put new processes in place so this situation did not happen again. Review of the facility undated policy titled Resident Transportation included it was the policy of the facility to provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents. The facility would assist the resident in making transportation arrangements to and from the source of any needed service, such as dental visits, or physician visits in the event the resident required such assistance. Social Services would collaborate with nursing for a needs assessment for transportation. Provide an escort with a cell phone, as needed to contact the facility in the event of an emergency. 2. Review of Resident #76's medical record revealed an admitted [DATE] and a re-entry of 07/05/24. Resident #76's diagnoses included dementia with behavioral disturbance, mood disturbance, and anxiety, repeated falls, contusion of left hip, fracture of left pubis, fracture of left acetabulum, displaced comminuted fracture of shaft of humerus, left arm. Review of Resident #76's progress notes dated 07/05/24 revealed Resident #76 arrived to the facility at around 5:00 P.M., vital signs were stable, Resident #76 was alert and oriented times four (person, place, time, event), had no wounds. Resident #76 had a patent left forearm fistula. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #76's care plan dated 07/06/24 included Resident #76 was at risk for falls and had a history of falls. Resident #76 would not sustain a major injury related to falls through the review date. Interventions included to ensure Resident #76's room was free of potential visible hazards; place call light in reach and remind resident to call for assistance; ensure Resident #76 was wearing appropriate non-skid footwear (initiated 07/17/24); provide assistive devices as needed (07/17/24). Review of Resident #76's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #76 was cognitively intact. Resident #76 required partial to moderate assistance for toileting, bathing, lower body dressing, personal hygiene and putting on and taking off foowear. Resident #76 required supervision or touching assistance when walking 10 feet and 50 feet. Review of Resident #76's physician progress notes dated 07/23/24 at 1:00 A.M. included Resident #76 had a fall and hit his head. Found Resident #76 in his room on his knees leaning over his bed and had a pool of blood next to his bedside. Assisted back to bed by Registered Nurse (RN) #286 and State tested Nursing Assistant (STNA) #224. Resident #76's vital signs were stable, his neurological status was unchanged and pupils equal and reactive to light. Resident #76 had a large laceration left parietal area about two inches by two inches where the epidermis was scraped off. Resident #76 did not remember how he fell . Resident #76 was transferred via 911 to the local Emergency Department. Review of Resident #76's progress notes dated 07/23/24 at 12:18 P.M. included RN #286 heard help yelling out in the hall, and with Nurse Practitioner (NP) #312 entered Resident #76's room to find him on his knees bending forward and holding his head. A puddle of blood was next to Resident #76 on the floor, resident was alert and oriented times three (person, place, time), and had a laceration to the top of his left skull. Bleeding was controlled by nursing, NP #312 evaluated Resident #76 and his blood pressure was 149/76, heart rate 79, temperature 97.3 Fahrenheit and oxygen saturation was 96 percent, neuro checks within normal limits. Resident #76 was sent via 911 to the local Emergency Department. Next of kin notified. Review of Resident #76's Fall Details Report dated 07/23/24 at 12:18 P.M. included Resident #76 was visually observed on 07/23/24 at 12:00 P.M. but there was no documentation regarding events leading up to the fall. N/A (not applicable) was marked for toileted, given fluids, repositioned, medicated for pain, and medicated for anxiety. Further review revealed Resident #76 was visually observed on the floor on his knees, and his hands were on his forehead. The report stated Resident #76 was independent for toileting (Resident #76 required partial to moderate assistance with toileting). Resident stated the floor was slippery causing him to fall. Resident #76 was observed without any footwear on, the floor was dry and free of clutter. The report had not applicable written in the area for Resident #76's statement of what happened and not applicable in the area for witness statement of what happened. Recommendations were ED transfer, non-slip footwear (although already care planned on 07/17/24), proper footwear for ambulation and transfers. Review of Resident #76's skin and wound progress notes dated 07/24/24 at 4:50 A.M. included Resident #76 had a scalp skin tear, laceration which measured length 5.0 centimeters (cm), width 4.5 cm, depth 0.1 cm. wound base 25 to 49 percent epithelial, 50 to 74 percent granulation, 0 percent slough. The scalp laceration had a scant amount of serosanguineous drainage. Treatment cleanse with normal saline, apply xeroform to base of the wound and secure with ABD (abdominal pad) daily and as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #76's progress notes dated 07/24/24 at 9:00 A.M. included on 07/23/24 at 12:18 P.M. Resident #76 was observed calling out and upon entering Resident #76's room he was observed on the floor of his room on his knees with both hands on his head in the center of the room. Large amount of blood noted to floor, on Resident #76's head, hands and clothing. Resident #76 stated the floor was slippery causing him to fall. Resident #76 was observed without any footwear on, the floor was dry and free of clutter. NP #312 evaluated Resident #76. No other injuries noted. Physician and family were notified. Resident #76 to have non-skid socks on when out of bed as tolerated with proper footwear for ambulation and transfers to prevent falls. Observation on 08/19/24 at 8:40 A.M. of Resident #76 revealed he was sitting in a wheelchair and a large dark red dried scab could be seen on the left side of his head. The scab was about one and a half inches in diameter. When asked what happened Resident #76 stated he fell about three weeks ago when he was at the hospital. Interview on 08/22/24 at 9:31 A.M. with the Director of Nursing (DON) revealed Resident #76 liked to be independent and did not realize his physical limitations. When Resident #76 fell on [DATE] he did not have shoes on and that was why he fell . Interview on 08/22/24 at 12:41 P.M. with Certified Occupational Therapy Assistant (COTA) #229 revealed therapy was providing Resident #76 with strengthening for balance because he was unsteady due to weakness. COTA #229 stated Resident #76 lived at home and had a fall before coming to the facility. COTA #229 indicated she worked with Resident #76 for the first time on 07/09/24, he used a walker and she evaluated his functional mobility using a walker. COTA #229 stated Resident #76 needed supervision when he was walking and anytime he was out of bed he required supervision because he was weak and unsteady. COTA #229 stated she spoke with staff and they were aware Resident #76 needed supervision, and she verbally told staff he was unsafe, and was not safe to stand in shower. Review of the facility policy titled Fall Prevention and Management undated included the resident should not be moved until assessed by a licensed nurse. If the resident can be safely moved they could be transferred to a bed or a chair with the assistance of other staff and, or mechanical lift. Once the resident was safely transferred a fall investigation should begin. Ask the resident what they were doing when they fell (this should be asked even if the resident had dementia). Identify if there were any witnesses to the fall and ask what they saw and have them write a statement immediately if possible. The IDT team should review all information for all falls at the next Daily Clinical Meeting and a deep root cause investigation should be discussed. This deficiency represents non-compliance investigated under Complaint Number OH00156991 and Complaint Number OH00156946.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure infection control practices were implement during incontinence care and high risk care activities. This affected two residents (Resident's #12 and #31) and had the potential to affect 18 residents (#1, #4, #9, #10, #12, #13, #16, #24, #31, #38, #43, #45, #49, #52, #57, #59, #67, #68) requiring enhanced barrier precautions. findings include: 1. Review of Resident #31 medical record revealed an admitted [DATE] and diagnoses included unspecified dementia with mood disturbance, type two diabetes mellitus with hyperglycemia and hypoglycemia, and difficulty in walking. Review of Resident #31's care plan dated 11/27/23 included Resident #31 had an ADL self care performance deficit related to dementia with mood disturbance, behavioral disturbance and other diagnoses. Resident #31 would be without decline in ROM (range of motion). Interventions included Resident #31 was totally dependent of one for personal hygiene and toileting hygiene. Review of Resident #31's Quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #31 had severe cognitive impairment. Resident #31 was dependent for toileting hygiene, upper body dressing and personal hygiene. Resident #31 required substantial to maximal assistance with lower body dressing. Resident #31 was frequently incontinent of urine and bowel. Review of the facility Wound Report dated 08/14/24 revealed Resident #31 had a diabetic foot ulcer of the left heel, it was full thickness, and improving without complications. Observation on 08/19/24 at 11:30 A.M. of Resident #31's room revealed a sign taped to his door which stated Enhanced Barrier Precautions and everyone must wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, wound care including wounds that required more than a band-aid or similar covering. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365811	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwestern Center	570 North Rocky River Drive Berea, OH 44017

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/19/24 at 11:30 A.M. of State tested Nursing Assistant (STNA) #224 revealed he was preparing to provide incontinence care for Resident #31. Resident #31 was lying in bed with his shirt off and his pants were soaking wet in the back. STNA #224 stated he just changed Resident #31's clothes and incontinence brief and he just let loose with a huge pee and now he had to change him again. STNA #223 donned gloves but did not don a gown and proceeded to remove Resident #31's soiled clothes including his padded heel protectors, and urine saturated incontinence brief without a gown on. STNA #223 finished changing Resident #31, did not remove his soiled gloves and touched Resident #31's drawer, his clean sheets and pillow. STNA #223 picked up Resident #31's padded heel protectors, felt them, stated they were damp with urine, but not too wet and found two wash cloths and placed them in the heel protectors to soak up the urine, then placed the heel protectors on Resident #31's bilateral heels. STNA #224 confirmed he there was an Enhanced Barrier Precaution sign on Resident #31's door and he did not wear a gown when providing his incontinence care. STNA #224 confirmed Resident #31 had dressings on his bilateral heels, but he was not sure what the wounds looked like or if Resident #31 had a wound. Interview on 08/19/24 at 3:18 P.M. of the Director of Nursing (DON), Regional Director of Clinical Operations (RDCO) #310 and Wound Nurse/Unit Manager (WN/UM) #271 revealed the facility stocked padded heel protectors and the heel protectors were able to be washed. When told about STNA #224 placing wash cloths in Resident #31's heel protectors to soak up excess urine the DON stated the heel protectors should have been replaced and wash cloths should not have been placed in the heel protectors to soak up excess urine. The DON stated anyone with wounds and have treatments, open wounds (nothing superficial), indwelling catheters, MDRO's, TPN, drains, any ostomies and residents with dialysis ports would be placed on Enhanced Barrier Precautions. The DON and WN/UM #271 stated staff needed more education regarding Enhanced Barrier Precautions, and STNA #224 should have donned a gown before providing incontinence care. 2. Review of Resident #12's medical record revealed an admitted [DATE] and a re-entry date of 04/30/18. Resident #12's diagnoses included morbid obesity, chronic kidney disease, and retention of urine. Review of Resident #12's care plan dated 05/16/24 included Resident #12 required Enhanced Barrier Precautions for an indwelling medical device. Resident #12 would not verbalize or demonstrate symptoms of isolation related to Enhanced Barrier Precautions placement while reducing risk of infection transmission while caring for indwelling catheter. Interventions included appropriate PPE (personal protective equipment) would be utilized during high contact care by care givers; to provide education to resident and resident representative as appropriate. Review of Resident #12's physician orders revealed Enhanced Barrier Precautions related to Foley (indwelling) catheter when dressing, bathing, showering, transferring in room or therapy gym, personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting every shift. Observation on 08/20/24 at 9:38 A.M. of Resident #12's door revealed a sign taped to her door which stated Enhanced Barrier Precautions and everyone must wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, wound care including wounds that required more than a band-aid or similar covering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/20/24 at 9:38 A.M. of Resident #12 revealed she had an indwelling catheter and STNA's #218, #279 and Licensed Practical Nurse (LPN) #258 were transferring Resident #12 with a mechanical lift to her padded wheelchair. Neither STNA #218, #279 or LPN #258 had gowns on. Observation revealed during the transfer STNA's #218, #279 and LPN #258's clothing brushed against Resident #12 while they were assisting her. When asked about the Enhanced Barrier Precaution sign taped to Resident #12's door LPN #258 stated she did not know what the sign meant and would make sure and wear a gown going forward when appropriate. STNA's #218 and #279 confirmed they did not have gowns on and they would make sure they wore gowns in the future. Interview on 08/20/24 at 11:12 A.M. of WN/UM #271 revealed the facility was working on education related to Enhanced Barrier Precautions. Review of the facility list of residents on enhanced barrier precautions revealed Resident #1, #4, #9, #10, #12, #13, #16, #24, #31, #38, #43, #45, #49, #52, #57, #59, #67, #68 were on precautions. Review of the facility policy titled Standard Precautions revised 03/20/20 included it was the policy of the facility to provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents. Proper cleaning of hands could prevent the spread of germs, including those that were resistant to antibiotics and were becoming resistant to antibiotics. When to perform hand hygiene included when hand moved from a contaminated body site to a clean body site during resident care. Review of the facility policy titled Enhanced Barrier Precautions revised 02/02/23 included Enhanced Barrier Precautions included PPE was used during high-contact resident care activities including bathing, showering, transferring, dressing, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use including urinary catheter, and wound care, any skin opening requiring a dressing. Change PPE before caring for another resident.