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	12/09/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 37097 Based on observation, interview, and record review, the facility failed to complete personal laundry and return it to residents in a timely manner. This affected three of three residents (#49, #74, and #80) reviewed and had the potential to affect all 81 residents in the facility who had their laundry done by the facility. The family did the laundry for six residents (#2, #11, #22, #51, #55, #74). The facility census was 87. Findings include: Interview on 12/03/24 at 8:18 AM through 10:41 A.M. with Licensed Practical Nurse (LPN) #101, LPN #104, Certified Nursing Assistant (CNA) #114, and CNA #115 revealed there had been some issues with laundry. The staff members reported they had received complaints from residents and families about missing clothes or clothes that had not yet returned from laundry. Interview on 12/03/24 at 11:49 A.M. with Resident #49 revealed it took two weeks for him to get his clothing back from laundry. Interview on 12/03/24 at 12:03 P.M. with Resident #79 stated residents did not get their laundry back in a timely manner. Resident #79 stated in the last resident council meeting a bunch of residents complained. An unnamed staff member at the meeting took the residents' names and wrote down what was missing. Resident #79 stated she went down to the laundry room and asked them to look for her missing items. Sometimes laundry is able to locate some missing items. Resident #79 reported names were in every item that was lost. Resident #79 stated the laundry department was bad, had gotten better, and now it is bad again. Interview on 12/03/24 at 11:45 A.M. with Resident #80 revealed the laundry was not done promptly and that items were not always returned. Resident #80 estimated that sometimes it was a couple weeks before he got his laundry back. Interview on 12/03/24 at 12:55 A.M. with the Laundry Account Manager (LAM) #111 revealed CNAs pick up all of the laundry and put it in bins in the soiled room. Laundry aides pick up the laundry from the soiled room. Laundry is collected three times a day. Staff tried to work four hours a day on residents' personal laundry. Linens were done separately. Laundry aides sorted items and placed personal clothes in a bin. The facility had two medium washers which only held up to 45 pounds of laundry, and two dryers. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/03/24 at 12:59 P.M. of the soiled-side of the laundry room revealed a large bin of residents' dirty personal clothing. The pile was over five feet tall. Interview on 12/03/23 at 2:46 P.M. with the Administrator revealed she was going to go look at the laundry room. The Administrator stated two weeks was not an acceptable turnaround time for laundry to be returned to the residents. Interview on 12/03/24 at 3:05 P.M. with the Administrator verified that the amount of residents' dirty personal clothing awaiting to be laundered was a problem. Interview on 12/04/24 at 5:56 P.M. with Regional Environmental Services Manager #120 revealed they had hired two people since 12/02/24. The company had people at the facility all night on 12/03/24 and throughout the day on 12/04/24 doing laundry. They laundered all the residents' personal laundry and delivered it back to all of the residents. Review of the facility's Resident Council Minutes dated 11/30/24 revealed residents reported at the meeting reported the facility's laundry service was poor. Review of the facility's Grievance/Complaint Log from 08/18/24 through 11/04/24. revealed 16 separate complaints of residents with missing clothing. This deficiency represents non-compliance investigated under Complaint Number OH00159778.

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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** 37097 Based on observation, interview, and record review, the facility failed to arrange for an escort to an outside appointment for Resident #80, who at previous appointments had always had an escort. This affected one Resident of three residents reviewed for transportation arrangements. The facility census was 87. Findings Include: Review of the medical record for Resident #80 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, legal blindness, glaucoma, and schizophrenia. Review of Resident #80's appointment orders revealed an escort needed for appointments scheduled for 09/24/24, 09/27/24, and 10/01/24. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #80 had intact cognition. Resident #80 had highly-impaired vision and used a wheelchair for mobility. Review of the nurse's note on 10/24/24 at 3:01 P.M. revealed for upcoming appointments, an escort was needed. Review of Resident #80's appointment order for 11/05/24 does not mention the need for an escort. Interviews on 12/03/24 at 8:18 A.M. and 1:12 P.M. with LPN #101 and LPN #104 revealed nurses are responsible for setting up appointments and will arrange for an escort if needed when arrange for transportation. Interview 12/03/24 at 11:45 A.M. with Resident #80 staff usually escorted him to appointments since he was blind. There was only one time they didn't. That was on 11/05/24. Interview on 12/04/24 at 11:21 A.M. with the Director of Nursing (DON) confirmed an escort was not sent to the appointment with Resident #80 on 11/05/24. This deficiency represents non-compliance investigated under Complaint Number OH00159778.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review and review of facility policy, the facility failed to ensure Resident #89 was free from significant medication errors when Resident #89's admission orders were not timely transcribed, resulting in a delay in the resident receiving his ordered medications. This affected one Resident (#89) out of three residents reviewed for medication administration. The facility census was 87. Findings included: Review of the closed medical record for Resident #89 revealed an admitted [DATE]. Medical diagnoses included paraplegia, fractures to vertebra, seizures, diabetes, gout, depression, and hypertension. Resident #89 was discharged to the hospital on 10/30/24. Review of hospital discharge orders dated 10/09/24 revealed Resident #89 was to receive the following orders: acetaminophen 975 milligram (mg) tablet by mouth three times a day for pain, allopurinol 300 mg tablet by mouth every day for gout, amlodipine 10 mg tablet by mouth every day for hypertension, aspirin enteric coated (EC) 81 mg tablet by mouth every day for cardiac prevention, atorvastatin 40 mg tablet by mouth every day for high cholesterol, baclofen (muscle relaxant) 5 mg tablet by mouth every night, bisacodyl suppository 10 mg per rectum every night for constipation, cholecalciferol (vitamin D supplement) 25 mg tablet by mouth every day, cyanocobalamin (vitamin B12 supplement) 1000 microgram (mcg) tablet by mouth every day, dextrose 15 gram (gm) per 37.5 gm orally if blood sugar was less than 70 or symptomatic and give 30 gm if blood sugar less than 54 as needed for diabetic management, give dextrose 50 percent in water injection 25 gm per 50 milliliter (ml) as needed if unconscious or unable to swallow as needed, diclofenac one percent gel 4 gm topically to left shoulder four times a day, diclofenac one percent gel 4 gm topically to knuckles, elbows, and shoulders four times a day as needed for pain, docusate sodium 100 mg capsule by mouth every day for constipation, furosemide (hypertension/ diuretic) 20 mg tablet by mouth every day, gabapentin (seizures) 600 mg capsule by mouth three times a day, glucagon injection (diabetic management) 1 mg per ml subcutaneous (SQ) as needed if patient was unconscious and unable to swallow, hydroxyzine hydrochloride (HCL) (hypertension) 20 mg tablet by mouth every night, lactobacillus acidophilus (probiotic) chewable tablet every day, lamotrigine (seizures) 250 mg tablet by mouth twice a day, levetiracetam (seizures) 1250 mg tablet by mouth twice a day, lidocaine five percent topical patch one patch every day applied to chest and remove after 12 hours for pain, lidocaine patch five percent topically apply two patches every day to back for pain, losartan (hypertension) 50 mg tablet by mouth every day, meloxicam (anti-inflammatory pain medication) 15 mg tablet by mouth every day, metformin (diabetes) 750 mg tablet by mouth twice a day with meals, methocarbamol (muscle relaxant)1000 mg tablet by mouth three times a day, and oxycodone 2.5 mg tablet by mouth every six hours as needed for pain. Review of nursing note dated 10/10/24 at 3:51 P.M. and authored by the former Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #117 revealed Resident #89 was admitted to the facility. There was no documentation regarding medication administration orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing note dated 10/10/24 at 5:33 P.M. and authored by Licensed Practical Nurse (LPN) #116 revealed Resident #89 had arrived at the facility at 2:00 P.M. and the note revealed the nurse practitioner and physician were notified regarding his admission. The note revealed the ADON RN #117 had verified the physician orders and pain medications. There was nothing in the nursing note regarding discontinuing or not following any of the orders listed on the discharge hospital orders. Review of physician orders dated 10/10/24 for Resident #89 revealed the only medication order that was transcribed on the date of admission was Oxycodone 5 mg give one half tablet by mouth every six hours as needed for mild to moderate pain for two weeks and Oxycodone 5 mg give one tablet by mouth every six hours as needed for moderate to severe pain for two weeks. There were no orders discontinuing, holding, or providing clarification to of any of the orders per the hospital discharge orders. Review of Nurse Practitioner (NP) #105's progress note dated 10/11/24 at 9:18 P.M. revealed she had evaluated Resident #89 and revealed per the note there were no hospital records available. The progress note that Resident #89's medication list included the following: Tricor 48 mg tablet by mouth at bedtime for elevated triglycerides, lidocaine patch four percent apply to right lumbar area topically one time a day for back pain and remove the patch every 12 hours, cyclobenzaprine HCL 10 mg tablet by mouth three times a day for muscle spasm relief, amlodipine 10 mg tablet by mouth one time a day for hypertension, diclofenac sodium topical gel one percent apply to anterior thorax topically every six hours as needed for pain, tramadol 50 mg tablet by mouth every six hours as needed for moderate to severe pain, diclofenac sodium gel one percent apply to top of left hand, right hand and left shoulder topically every 12 hours as needed for pain. The note revealed to restart his home medications: metformin, Norvasc, and losartan. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of October 2024 Physician Orders and October 2024 Medication Administration Record (MAR) revealed Resident #89 had not received and/or his order was not transcribed timely per hospital discharge orders including: allopurinol 300 mg tablet by mouth every day was (not transcribed or administered) until 10/18/24 A.M. dose (eight days after admission), Aspirin 81 mg chewable tablet by mouth every day was (not transcribed or administered) until 10/18/24 A.M. dose (eight days after admission), atorvastatin 40 mg tablet by mouth every day was (not transcribed or administered) until 10/17/24 bedtime dose (seven days after admission), bisacodyl suppository 10 mg per rectum one suppository at bedtime every Tuesday, Thursday, and Saturday was (not transcribed or administered) until 10/15/24 bedtime dose (five days after admission), cholecalciferol 1000 unit tablet by mouth every day was (not transcribed or administered) until 10/19/24 A.M. dose (nine days after admission), furosemide 20 mg by mouth every day was (not transcribed or administered) until 10/18/24 (eight days after admission), lactobacillus acidophilus chewable tablet every day was (not transcribed or administered) until 10/18/24 A.M. dose (eight days after admission), gabapentin 600 mg capsule by mouth three times a day was (not transcribed or administered) until 10/12/24 at A.M. dose (two days after admission), lidocaine four percent topical patch one patch every day applied to left chest and remove at night was (not transcribed or administered) until 10/15/24 at 9:00 A.M. (five days after admission), lidocaine patch four percent topically apply to right chest one every day and remove at night was (not transcribed or administered) until 10/16/24 at 9:00 A.M. (six days after admission), lidocaine patch four percent apply to right lumbar area topically every day and remove 12 hours later was (not transcribed or administered) until 10/12/24 at 9:00 A.M. (two days after admission), methocarbamol 1000 mg tablet by mouth at bedtime was (not transcribed or administered) until 10/19/24 U.S. dose (nine days after admission), methocarbamol 1000 mg tablet by mouth in the afternoon was (not transcribed or administered) until 10/19/24 afternoon dose (nine days after admission), methocarbamol 1000 mg tablet by mouth in the morning was (not transcribed or administered) until 10/19/24 A.M. dose (nine days after admission), losartan 50 mg tablet by mouth at bedtime was (not transcribed or administered) until 10/18/24 bedtime dose (eight days after admission), amlodipine 10 mg tablet by mouth every day was (not transcribed or administered) until 10/12/24 A.M. dose (two days after admission), levetiracetam 1250 mg tablet by mouth twice a day was (not transcribed or administered) until 10/17/24 BEDTIME dose (seven days after admission), lamotrigine 250 mg tablet by mouth twice a day was (not transcribed or administered) until 10/17/24 BEDTIME dose (seven days after admission), metformin 750 mg tablet by mouth twice a day before breakfast and dinner was (not transcribed or administered) until 10/12/24 at 9:00 A.M. (two days after admission), cyanocobalamin 10 mg tablet by mouth three times a day was (not transcribed or administered) until 10/12/24 A.M. dose (two days after admission), colace 100 mg capsule by mouth as needed was (not transcribed or administered) until 10/15/24 (five days after admission). Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #89 had intact cognition. He received one injection in the last seven days during the assessment period. He was on hypoglycemic medications. There was no documentation he was on diuretics. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of care plan dated 10/22/24 revealed Resident #89 was at risk for dehydration or potential fluid deficit related to diuretic use. Interventions included administering medications as ordered, and nutritional consultation on admission, quarterly and as needed. An additional care plan focus revealed Resident #89 had diabetes and was on hypoglycemic medication. Interventions included observe for signs of hypoglycemia and hyperglycemia. Resident #89 also had a neurological disorder related to thoracic fractures sustained after a fall down the stairs at home resulting in paralysis. Resident #89 also had a seizure disorder. Interventions included administer medications per orders, observe for side effects and effectiveness of the medications, observe for changes in mental status, and altered neurological status. Attempted interviews on 12/04/24 at 1:39 P.M., 12/04/24 at 1:40 P.M. and 12/05/24 at 11:13 P.M. with the former ADON RN #117 were unsuccessful. There was no answer and ADON RN #117's voicemail box was full. Interview on 12/04/24 at 2:14 P.M. with LPN #116 (nurse assigned when Resident #89 was admitted) revealed that she did not recall Resident #89's name or any details regarding his admission. LPN #116 revealed she was unsure why the orders were not transcribed but stated the former ADON RN #117 usually handled transcribing the admission orders into the electronic medical record. Interview on 12/04/24 at 1:01 P.M. with Regional Director of Nursing (RDN) #99 verified Resident #89's discharge orders from the hospital were not transcribed the day he was admitted , and he was not administered his medications as ordered. Interview on 12/04/24 at 3:26 P.M. and 12/05/24 at 11:18 A.M. with the Director of Nursing (DON) revealed she was new to the facility and was not working at the facility when Resident #89 was admitted . She verified Resident #89's discharge orders from the hospital were not transcribed as well as Resident #89 did not receive his medication in a timely manner as some of the orders were not transcribed for up to nine days after Resident #89 was admitted . The DON revealed, upon review, she was not able to explain why the orders were not transcribed the day he was admitted as there was no documentation to explain the reason in the medical record. She revealed former ADON RN #117 no longer worked at the facility and she had attempted to contact her to see if there was a reason but was unable to reach her. The DON revealed if the facility was not to transcribe an order from the discharge instructions on admission there should have been an order from a physician discontinuing the order and/or documentation in the medical record as to why the medication was not transcribed and administered. Review of the undated facility policy Medication Administration revealed the purpose of the policy was to provide guidance for general medication administration. The policy included administer medications only as prescribed by the provider. There was nothing in the policy in regard to transcribing physician orders including on admission. Review of facility policy Physician Orders dated 4/17/24 revealed the provider may write the order in the medical record or in the electronic medical record. The policy revealed the nurse may receive an order over the phone; the nurse would provide a read-back to the provider for accuracy and transcribe the order into the electronic medical record. The policy revealed the nurse would discontinue any previous contradicting orders. There was nothing in the policy regarding transcribing admission orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00159560.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, record review, and interviews, the facility failed to maintain acceptable infection control practices during medication administration to prevent the spread of infection. This affected one Resident (#39) and had the potential to affect eight residents (Residents #16, # 28, #47, #55, 60, #65, #77, and #87) residing on the Back North Hall. The facility census was 87. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnosis included but not limited to schizoaffective disorder, bipolar type, type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), vascular dementia, and repeated falls. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed the resident had impaired cognition. Review of the physician's orders for December 2024 revealed Resident #39 was ordered daily accuchecks, (accu-check is a brand of products for people with diabetes to help them monitor and manage their blood sugar levels) without coverage and to notify physician or NP if blood glucose is less than 70 or greater than 400, one time a day for DM. On 12/03/24 at 8:31 A.M. Licensed Practical Nurse (LPN) 100 was observed administering medications to Resident #39. During the medication administration observation, LPN #100 went into the resident room to take a blood sugar test and placed the glucometer on the resident's bed with no barrier. Interview on 12/03/24 at 8:39 A.M. with LPN #100 verified she placed the glucometer on the resident's bed without placing a barrier first. LPN #100 reported she forgot. Interview on 12.03/24 at 10:34 A.M. with the Director of Nursing (DON) confirmed a barrier is to be placed under the glucometer. The DON reported she would provide education to LPN #100. Review of facility policy, Blood Glucose Point of Care Testing, undated, revealed to place a clean barrier under glucometer until disinfected. This deficiency represents an incidental finding of non-compliance identified while investigating OH00157560.