STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365071	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Pointe Care Center	23900 Chagrin Blvd Beachwood, OH 44122

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on record review and interview, the facility failed to timely reorder medications to avoid missed doses. This affected one resident (Resident #32) of three residents reviewed for pharmacy services. The total census was 105. Findings include: Record review of Resident #32 revealed an admitted [DATE] with diagnoses including schizophrenia, diabetes, and breast cancer. Resident #32 had an order dated 12/13/24 and a previous order lasting from 09/05/23 to 12/13/24 for Verzenio (a medication for breast cancer) 150 milligram tablets to be given twice per day. Review of the December medication administration record revealed she did not receive doses of Verzenio on the mornings of 12/12/23 through 12/14/23. Progress notes on 12/12/24 and 12/13/24 revealed the medication was not at the facility. No physical effect on the resident was noted. Interview with Resident #32 on 01/15/25 at 9:44 A.M. revealed she had no knowledge of missed medications. Interview with Registered Nurse (RN) #202 on 01/15/25 at 9:54 A.M. revealed Resident #32's Verzenio was delivered from an outside pharmacy in opaque boxes. There was an event in December where an agency nurse stored empty boxes in the medication cart, and when RN #202 counted remaining doses she believed those boxes were full. Due to the resulting delay in reordering, this resulted in the resident missing roughly two days of doses. Interview with the Director of Nursing (DON) on 01/15/25 at 2:46 P.M. confirmed the above findings. She confirmed Resident #32 missed doses of Verzenio due to the facility running out of the medication. In response, the facility provided education and changed the order to clarify reordering procedures. This deficiency represents noncompliance investigated under OH00160400.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365071	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Pointe Care Center	23900 Chagrin Blvd Beachwood, OH 44122

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on observation, interview, and record review, the facility failed to provide privacy curtains in shared rooms. This affected two (Resident #5 and #82) of six residents reviewed for privacy. The total census was 105. Findings include: Record review of Resident #82 revealed he was admitted on [DATE] and resided in the same room since his admission. Record review of Resident #5 revealed he was admitted [DATE] and resided in the same room since his admission, with a room mate (Resident #82) Observation on 01/15/25 at 3:48 P.M. of Resident #82 and #5's room revealed it had no wall or other barrier between the residents' beds, and no privacy curtain or hooks on which one could be hung. Interview with the Administrator on 01/16/25 at 4:13 P.M. confirmed the above observations. Interviews with Resident #5 and Resident #82 on 01/16/25 from 9:23 A.M. to 9:32 A.M. revealed their room never had a privacy curtain throughout their stay. Both roommates entered the bathroom when changing clothes to preserve their own and each other's privacy. This deficiency represents noncompliance investigated under OH00160860.