

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Northridge Health Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 35990 Westminster Ave North Ridgeville, OH 44039	
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** 37096 Based on record review and staff and resident interviews the facility failed to ensure narcotic pain medication was available for administration. This affected one (#32) of the three residents reviewed for receiving narcotic pain relief. The facility identified 28 residents receiving narcotic pain medications. The facility census was 80. Finding Include: Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included acute kidney failure, lymphedema, obesity, cerebral infarction, obstructive sleep apnea, chronic ulcer of the left lower leg, chronic pain, and cellulitis. Review of the physician order dated 04/15/24 for Resident #27 revealed an order to administer oxycodone five milligram (mg) every four hours as needed (PRN) and an order to administer cyclobenzaprine 10 mg PRN for spasms. Review of Resident #27's Controlled Drug Record/Disposition Form, dated 05/13/24 for oxycodone five mg, revealed the last pill was administered on 06/14/24 at 7:00 A.M. The record revealed the resident was taking the medication consistently in the evenings. Review of the Care Plan dated 05/16/24 revealed the Resident had the potential for alteration in comfort. Intervention included requesting pain medication before pain becomes severe. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 05/29/24, revealed the resident had intact cognition and required substantial assistance for transfers, bed mobility and was dependent on staff for toileting and showering. Review of the June 2024 Medication Administration Record (MAR) for Resident #27 revealed oxycodone was administered on 06/14/24 at 7:06 A.M. and the next administration was on 06/20/24 at 1:20 P.M. Cyclobenzaprine 10 mg was administered was administered on 06/15/24 at 10:10 P.M. and on 06/20/24 at 1:19 P.M. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's progress note dated 06/19/24 at 8:46 P.M. written by Licensed Practical Nurse (LPN) #117, revealed the resident was complaining of pain and her narcotic script was not in for days. The pharmacy was called and stated the pain medication needed a new script. The on-call physician stated she would not call in the script because it should have been done during office hours. A progress note dated 06/19/24 at 9:20 P.M. stated the physician called back and said to have the pharmacy call her for a new prescription. Review of the Medication Delivery Receipt, dated 06/20/24 at 7:58 A.M., revealed 14 oxycodone five mg were delivered for Resident #27. Review of the Resident #27's Controlled Drug Record/Disposition Form, dated 06/20/24 for oxycodone five mg, revealed the first pill was administered on 06/20/24 at 1:21 P.M. There were no pills administered from 06/14/24 through 06/20/24. The record revealed the resident was taking the medication consistently in the evenings. Interview on 06/25/24 at 11:30 A.M. with Resident #27 revealed she went without her pain medication for five days and just took her cyclobenzaprine. On 06/14/24, 06/15/24 and 06/16/24 she reminded three nurses the script needed to be called in. Interview on 06/27/24 at 9:27 A.M. with the Assistant Director of Nursing (ADON) stated the nurse should have notified the pharmacy to refill Resident #27's oxycodone on 06/11/24 when there were five pills left. Interview on 06/27/24 at 10:19 A.M. with LPN #117 revealed the resident was complaining of pain and not having her medication. The pharmacy told her a new script was needed to send out the oxycodone. Review of a 08/22/22 facility policy titled Medication Administration revealed medications would be administered as ordered by the physician and in accordance with professional standards. This deficiency represents non-compliance investigated under Complaint Number OH00154355.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review, staff interview and review of facility policy, the facility failed to ensure a narcotic pain medication was accurately documented in the resident's Medication Administration Record (MAR). This affected one (#27) of three residents reviewed for pain medications. The facility census was 80. Finding Include: Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included acute kidney failure, lymphedema, obesity, cerebral infarction, obstructive sleep apnea, chronic ulcer of the left lower leg, chronic pain, and cellulitis. Review of the physician order dated 04/15/24 for Resident #27 revealed an order to administer oxycodone 5 milligram (mg) every four hours as needed (PRN). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 05/29/24, revealed the resident had intact cognition and required substantial assistance for transfers, bed mobility and was dependent on staff for toileting and showering. Review of Resident #27's Controlled Drug Record/Disposition Form, dated 5/13/24 revealed the resident's oxycodone five mg was signed out for administration on 5/21/24 at 8:00 P.M., 05/22/24 at 8:00 P.M., 05/23/24 at 8:00 P.M., 05/25/24 at 9:00 P.M., 05/26/24 at 8:30 P.M., 05/28/24 at 9:00 P.M., 05/29/24 at 9:00 P.M., 05/30/24 unable to read time, and 05/31/24 unable to read time. Review of Resident #27's Care Plan dated 05/16/24 revealed the Resident had the potential for alteration in comfort. Intervention included requesting pain medication before pain becomes severe. Review of the May 2024 MAR for Resident #27 revealed there was no documentation for oxycodone five mg being administered on 5/21/24 at 8:00 P.M., 05/22/24 at 8:00 P.M., 05/23/24 at 8:00 P.M., 05/25/24 at 9:00 P.M., 05/26/24 at 8:30 P.M., 05/28/24 at 9:00 P.M., 05/29/24 at 9:00 P.M., 05/30/24 and unknown time, and 05/31/24 at an unknown time. Review of June 2024 MAR for Resident #27 revealed there was no documentation for oxycodone being administered on 06/20/24 at unknown time, 06/21/24 at 9:00 P.M., 06/22/24 9:30 P.M., and 06/23/24 at 8:00 P.M. Review of Resident #27's Controlled Drug Record/Disposition Form, dated 06/20/24, for oxycodone five mg was signed out on 06/20/24 unable to read time, 06/21/24 at 9:00 P.M., 06/22/24 9:30 P.M., 06/23/24 at 8:00 P.M., and on 06/23/24 at 8:00 P.M. Interview on 06/27/25 at 9:27 A.M. with the Assistant Director of Nursing (ADON) verified the findings and stated the narcotic medications were to be documented on the Controlled Drug Record/Disposition Form and in the resident's MAR. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 08/22/22 facility policy titled Medication Administration revealed medications were signed on the MAR after administered. If a medication is a controlled substance, the medication is signed off in the narcotic book. This deficiency represents non-compliance investigated under Complaint Number OH00154355.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, staff interviews and review of facility policy, the facility failed to ensure resident call lights were in reach of residents. This affected two (#32 and #69) of the three residents reviewed for call lights. The facility census was 80. Finding Include: 1)Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included acute respiratory failure, paraplegia, traumatic brain injury (TBI), epilepsy, and type II diabetes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/25/24, revealed Resident #32 had intact cognition and was dependent on staff for bed mobility, transfers and hygiene. Review of Resident #32's Care Plan dated 05/09/24 revealed the resident required assistance for activities of daily living (ADLs) related to immobility. Intervention included to keep the call light in reach. 2)Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included hemiplegia, cerebral infarction, respiratory failure, seizures, anxiety, depression and bipolar. Review of the quarterly MDS assessment dated [DATE], revealed Resident #69 had intact cognition and impairment to one side. The resident required set up with eating and needed substantial assistance for transfers and bed mobility. The resident was dependent on toileting and shower. Review of Resident #69's Care Plan dated 05/16/24 revealed the resident has a self-care deficit related to cognitive impairment and confusion. Interventions included encouraging the resident to participate while performing ADLs and to monitor and report a decline to the physician. Observation of Resident #69 on 06/25/24 at 11:49 A.M. revealed the resident was lying in bed and his call light was lying under the foot of his bed. The roommate, Resident #32, was lying in his bed resting and his call light was wrapped around the grab bar and out of his reach. Resident #32 asked the surveyor to locate his call light. Interview at this time with Resident #69 stated he did not have a call light for a week. Resident #32 stated he used his call light and does not mind using his call light for Resident #69. Interview on 06/25/24 at 12:06 A.M. with State tested Nursing Assistant (STNA) #172 verified Resident #32 and Resident #67's call lights were not in reach. STNA #172 stated Resident #32 and Resident #67 were not on her assignment. Interview on 06/25/24 at 12:10 P.M. with STNA #128 stated Resident #32 and Resident #67 were on her assignment and Resident #67 utilized his call light earlier that morning. STNA #128 stated Resident #32's call light probably fell to ground during the wound treatment earlier in the morning and Resident #67 may have knocked his call light out of reach. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 04/01/22 facility policy titled, Call lights: Accessibility and Timely Response, revealed with each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of the resident and secured, as needed.		