STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365645	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health Center, The	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, review of a police report, review of facility investigation documents, and policy review, the facility failed to ensure a resident's change in condition was reported to the physician in a timely manner. This affected two (#23 and #20) of four residents reviewed for assessments and monitoring. The census was 69. Findings include:1. Record review for Resident #70 revealed an admission date of 02/04/25 and a discharge date of 05/01/25. Diagnoses included bipolar disorder, cocaine use, and alcohol abuse. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 was cognitively intact. Resident #70 had no impairment to the upper or lower extremities, was independent with eating, used a wheelchair for mobility and was independent for wheelchair mobility. Review of a progress note dated 01/30/25 from Resident #70 ' s emergency room physician, prior to admission to the facility, revealed Resident #70 was a [AGE] year-old male with a past medical history of polysubstance use. The note further indicated Resident #70 had been admitted to the same hospital from a substance use treatment setting. Record review of Resident #70 ' s medical record for 04/28/25 through 05/01/25 revealed no documentation of Resident #70 smoking an illegal substance while inside the facility.Review of a handwritten statement signed and dated 04/28/25, untimed, completed by Certified Nurse Aide (CNA) #229 revealed at 11:15 (no A.M. or P.M. documented) the nurse aide went into Resident #70 ' s room because the nurse aide saw him roll his wheelchair into the hallway. When CNA #229 went into his room he told the nurse aide to come into the bathroom. The resident rolled into his bathroom and he told the nurse aide to look as he was unfolding a ball of toilet paper. CNA #229 noticed white chunks inside and asked Resident #229 if it was an illicit drug. Resident #70 told CNA #229 to be quiet and lifted a paper towel and exposed two pipes that were obviously used to smoke the substance in the toilet paper. CNA #229 told Resident #70 he needed to give the nurse aide everything he had but he refused. The resident then asked CNA #229 to party with him. CNA #229 immediately left the room and got Licensed Practical Nurse (LPN) #202, and LPN #358 was also called to assess Resident #70. Review of the handwritten statement signed and dated 04/28/25, untimed, completed by LPN #202 revealed she was notified by her CNA (#229) that Resident #70 was seen in the bathroom smoking an illicit drug. LPN #202 then called LPN #358 to have a witness and both nurses entered Resident #70 ' s room and witnessed Resident #70 smoking in the bathroom. LPN #358 asked Resident #70 for the substance, he refused to let go of it, he asked if he could throw it out himself.Review of the handwritten statement signed and dated 04/28/25, untimed, completed LPN #358 revealed the nurse was called to Resident #70 ' s room at approximately 11:19 P.M. She ran to his room and found Resident #70 smoking from a crack pipe and thick white smoke was coming out. As she approached him, Resident #70 blew a cloud of smoke into her face. She stepped into the bathroom and told Resident #70 he needed to give her the pipe and lighter. She grabbed onto them and he would not let go. After about 15 minutes, he let the nurse have them. The Director of Nursing (DON), police, and the Administrator were notified. The police confiscated the drug items. Review of the police incident report date 04/28/25 at 11:56:38 P.M. revealed nurses observed Resident #70 actively smoking out of a pipe. After talking to the resident, he did not know what it was and indicated he found it outside. Review of the progress note dated 04/29/25 at 2:30 P.M. completed by the Administrator revealed he and the DON presented Resident #70 with a behavior contract and the resident refused to sign it. Resident #70 informed the staff another facility would no longer accept him and the facility reviewed alternative options as his Medicaid authorization ended on 4/30/25. Interview on 09/02/25 at 4:57 P.M. with the Administrator revealed on 04/28/25 Resident #70 was found by a CNA smoking an illicit substance in the bathroom of his room. The CNA tried to confiscate the paraphernalia. Resident #70 blew smoke in the CNA ' s face. The police were called, and the CNA and the nurses went to the hospital to get checked out. The resident did give the paraphernalia to the staff, and it was found to just be residue left over. The police did not want to test the residue and said it was because it was not a chargeable amount. The Administer revealed he and the police went through the resident's room and nothing else was found. The next day, Resident #70 was presented with a contract to remain drug free. Resident #70 refused to sign the contract and discharged himself to the community on 05/01/25. The Administrator confirmed Resident #70 had a roommate at the time the incident occurred and revealed he was unaware of any restrictions or further monitoring/interventions put into place for Resident #70 to prevent further drug use while in the facility. The

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, incident file review, and staff interview, the facility failed to ensure comprehensive resident centered care plans were developed to address resident medical and psychosocial needs. This affected one (#70) of four residents reviewed for care plans. The facility census was 69.Findings include:Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses that included alcohol abuse, cocaine use, type II diabetes, and morbid obesity.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #70 was cognitively intact and required extensive assistance to complete activities of daily living. Resident #70 discharged to the community on 05/01/25.Review of a progress note dated 01/30/25 from Resident #70's emergency room physician, prior to admission to the facility, revealed Resident #70 was a [AGE] year-old male with a past medical history of polysubstance use. The note further indicated Resident #70 had been admitted to the same hospital from a substance use treatment setting.Review of the incident file for Resident #70 revealed that on 04/28/25, Resident #70 was found smoking an illicit substance in his room at the facility. When confronted, Resident #70 did not deny his drug use.Review of the care plan for Resident #70 revealed no care plans with goals or interventions related to Resident #70's history of or continued drug use.Social Worker #700 verified Resident #70's medical record lacked a care plan with goals and interventions for drug use during an interview conducted on 08/29/25 at 2:11 P.M.This deficiency represents non-compliance investigated under Complaint Number OH00165746 (1393119).

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure dependent residents received timely care and services from staff to provide activities of daily living (ADLs). This affected one (#38) of three residents reviewed for ADLs care. The facility census was 69. Findings include:Record review for Resident #38 revealed an admission date of 12/09/21. Diagnoses included cerebral infarction due to embolism of the right middle cerebral artery, muscle weakness, congestive heart failure, cardiac pacemaker, contracture of the right and left knee, unspecified moderate dementia with agitation, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. Resident #38 had impairment on one side of the upper extremity and both sides of the lower extremities. Resident #38 required set up or clean up assist with eating, was dependent for toileting hygiene, personal hygiene, chair/bed to chair transfers, required substantial/maximal assistance for bed mobility, and was independent for wheelchair mobility. Resident #38 was always incontinent of bowel and bladder, and was assessed at risk for pressure ulcers but had no unhealed pressure ulcers or other wounds or skin problems during the assessment look-back period. Review of the care plan dated 07/18/24 revealed Resident #38 required assistance for all ADLs related to weakness, cardiovascular accident with hemiparesis, decreased range of motion (ROM) to the left hand, and bilateral knee contractures. Interventions included set up or clean up assistance for eating, and two staff assistance for toileting tasks, dressing, bathing, and hygiene.Record review of the care plan for Resident #38 dated 12/09/23 revealed Resident #38 experienced bowel and bladder incontinence. Interventions included to check and change Resident #38 every two hours and as needed. Staff were to provide peri-care with incontinent episodes.Observation on 09/03/25 at 8:49 A.M. revealed Resident #38 was sitting in her chair in the dining room. Resident #38 had dried liquid and crumbs on her shirt. Observation on 09/03/25 at 10:55 A.M. revealed Resident #38 was sleeping in her chair in the dining room. Resident #38 had her same clothes on with the dried liquid spilled on her shirt. Observation and interview on 09/03/25 at 1:33 P.M. revealed Resident #38 was sitting in her chair in the dining room. Resident #38's shirt and pants were soiled with dried food and her pants were visibly wet in the peri-area. Resident #38 had the same clothes on from the previous two observations. Resident #38 revealed the staff got her up at 7:00 A.M., placed her in the dining room, and have not checked her for incontinence or changed her all day. Resident #38 revealed she had not been moved from the dining room since staff took her there that morning and Resident #38 confirmed she was wet and stated she would prefer to lay down after breakfast and changed. Observation and interview on 09/03/25 at 1:37 P.M. with Certified Nurse Aide (CNA) #324 confirmed she was Resident #38's primary CNA that day. CNA #324 revealed she got Resident #38 up in her chair around 7:00 A.M. CNA #324 confirmed this would be the first time since 7:00 A.M. Resident #38 would be laid down and checked for incontinence or changed. CNA #324 stated, She (Resident #38) has to be up for breakfast and lunch. It's part of her daily plan so we don't lay her down until after lunch. CNA #324 again confirmed Resident #38 was not checked or changed since 7:00 A.M. and CNA #341 was also present at that time. Observation revealed CNA #324 pushed Resident #38's chair to her room, and both CNA #324 and CNA #341 transferred Resident #38 from her geriatric chair to her bed via mechanical lift. CNA #324 confirmed Resident #38's shirt and pants were soiled with dried food and drink items and confirmed Resident #38's pants were wet inside and out. The brief was heavily saturated with urine and Resident #38 had a foul odor of urine. Resident #38's buttocks had deep creases in her skin from where the brief had wrinkled and created temporary indentations in the skin where the brief was located. Resident #38's buttocks was also red. CNA #324 stated, It's just routine to not change her until after lunch. Interview on 09/03/25 at 2:37 P.M. with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #356 revealed staff should check and change residents every two hours and as needed for incontinence. Review of the facility policy titled, Incontinence care policy, dated December 2023, revealed the policy was to provide individualized incontinence care based on a comprehensive assessment and care plan. Residents will be offered timely assistance, appropriate continence aids, and preventative skin care to promote health, comfort, and dignity. The procedures included to provide timely and respectful assistants for toileting, changing, and hygiene needs. Staff are to change incontinent products promptly when soiled to prevent odor, discomfort, and skin irritation This deficiency

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, review of a police report, and review of facility investigation documents, the facility failed to ensure a resident (#70) was properly monitored for behaviors regarding drug use following know usage in the facility and failed to timely assess a resident (#23) following exposure to illicit substances. This affected two (#23 and #70) of four residents reviewed for assessments and monitoring. The census was 69.Findings include:1. Record review for Resident #70 revealed an admission date of 02/04/25 and a discharge date of 05/01/25. Diagnoses included bipolar disorder, cocaine use, and alcohol abuse. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 was cognitively intact. Resident #70 had no impairment to the upper or lower extremities, was independent with eating, used a wheelchair for mobility and was independent for wheelchair mobility. Review of a progress note dated 01/30/25 from Resident #70's emergency room physician, prior to admission to the facility, revealed Resident #70 was a [AGE] year-old male with a past medical history of polysubstance use. The note further indicated Resident #70 had been admitted to the same hospital from a substance use treatment setting. Record review of Resident #70's medical record for 04/28/25 through 05/01/25 revealed no documentation of Resident #70 smoking an illegal substance while inside the facility. Review of a handwritten statement signed and dated 04/28/25, untimed, completed by Certified Nurse Aide (CNA) #229 revealed at 11:15 (no A.M. or P.M. documented) the nurse aide went into Resident #70's room because the nurse aide saw him roll his wheelchair into the hallway. When CNA #229 went into his room he told the nurse aide to come into the bathroom. The resident rolled into his bathroom and he told the nurse aide to look as he was unfolding a ball of toilet paper. CNA #229 noticed white chunks inside and asked Resident #229 if it was an illicit drug. Resident #70 told CNA #229 to be quiet and lifted a paper towel and exposed two pipes that were obviously used to smoke the substance in the toilet paper. CNA #229 told Resident #70 he needed to give the nurse aide everything he had but he refused. The resident then asked CNA #229 to party with him. CNA #229 immediately left the room and got Licensed Practical Nurse (LPN) #202, and LPN #358 was also called to assess Resident #70. Review of the handwritten statement signed and dated 04/28/25, untimed, completed by LPN #202 revealed she was notified by her CNA (#229) that Resident #70 was seen in the bathroom smoking an illicit drug. LPN #202 then called LPN #358 to have a witness and both nurses entered Resident #70's room and witnessed Resident #70 smoking in the bathroom. LPN #358 asked Resident #70 for the substance, he refused to let go of it, he asked if he could throw it out himself. Review of the handwritten statement signed and dated 04/28/25, untimed, completed LPN #358 revealed the nurse was called to Resident #70's room at approximately 11:19 P.M. She ran to his room and found Resident #70 smoking from a crack pipe and thick white smoke was coming out. As she approached him, Resident #70 blew a cloud of smoke into her face. She stepped into the bathroom and told Resident #70 he needed to give her the pipe and lighter. She grabbed onto them and he would not let go. After about 15 minutes, he let the nurse have them. The Director of Nursing (DON), police, and the Administrator were notified. The police confiscated the drug items. Review of the police incident report date 04/28/25 at 11:56:38 P.M. revealed nurses observed Resident #70 actively smoking out of a pipe. After talking to the resident, he did not know what it was and indicated he found it outside. Review of the progress note dated 04/29/25 at 2:30 P.M. completed by the Administrator revealed he and the DON presented Resident #70 with a behavior contract and the resident refused to sign it. Resident #70 informed the staff another facility would no longer accept him and the facility reviewed alternative options as his Medicaid authorization ended on 4/30/25. Interview on 09/02/25 at 4:57 P.M. with the Administrator revealed on 04/28/25 Resident #70 was found by a CNA smoking an illicit substance in the bathroom of his room. The CNA tried to confiscate the paraphernalia. Resident #70 blew smoke in the CNA's face. The police were called, and the CNA and the nurses went to the hospital to get checked out. The resident did give the paraphernalia to the staff, and it was found to just be residue left over. The police did not want to test the residue and said it was because it was not a chargeable amount. The Administer revealed he and the police went through the resident's room and nothing else was found. The next day, Resident #70 was presented with a contract to remain drug free. Resident #70 refused to sign the contract and discharged himself to the community on 05/01/25. The Administrator confirmed Resident #70 had a roommate at the time the incident occurred and revealed he was unaware of any restrictions or further monitoring/interventions put into place

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of a facility policy, the facility failed to assure residents received supplemental oxygen per physicians orders. This affected one (#72) of three residents reviewed for oxygen therapy. The facility census was 69.Findings include:Record review for Resident #72 revealed an admission date of 08/30/25. Diagnoses included anoxic brain damage, pneumonia due to methicillin resistant staphylococcus aureus (MRSA), chronic obstructive pulmonary disease (COPD), asthma, emphysema, and acute and chronic respiratory failure. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was rarely or never understood and cognitive skills were severely impaired. Resident #72 was dependent for eating, toileting hygiene, and bed mobility. Resident #72 received oxygen therapy continuous. Review of the care plan for Resident #72 dated 09/01/25 revealed the resident had potential for complications related to diagnoses of COPD, asthma, and emphysema. Interventions included to administer medications, inhalers as ordered, and to give oxygen as ordered. Review of the physician orders for Resident #72 dated 08/30/25 revealed an order for oxygen delivery via nasal cannula with a liter flow of two liters and the duration was continuous every shift for breathing. Observation on 09/03/25 at 9:56 A.M. revealed Resident #72 was lying in bed. Resident #72's eyes were closed. Observation revealed Resident #72's oxygen concentrator was running. The nasal cannula was lying on the floor under the tube feeding pole next to Resident #72's bed. Resident #72 was not receiving oxygen from the concentrator. Observation on 09/03/25 at 9:57 A.M., as surveyor was exiting the room, revealed Licensed Practical Nurse (LPN) #202 was walking towards the surveyor and entered Resident #72's room. LPN #202 confirmed she was Resident #72's primary care nurse that day. LPN #202 walked over to Resident #72's bed, proceeded to shut off the tube feeding, then exited the room without addressing Resident #72 nasal cannula on the floor at the bottom of the tube feeding pole. LPN #202 returned to the medication cart and proceeded to walk up the hall, away from Resident #72's room pushing the cart. The Surveyor immediately approached LPN #202 and requested information about Resident #72's oxygen therapy. LPN #202 revealed she was not sure if Resident #72 was supposed to receive oxygen. LPN #202 opened Resident #72's physician orders on her computer located on the medication cart and revealed Resident #72 had an order to be on oxygen continuously. After requesting LPN #202 to assess Resident #72's oxygen status, LPN #202 returned to Resident #72's room and verified the oxygen tubing was on the floor. LPN #202 then monitored Resident #72's oxygen saturation level (percentage of oxygen in the blood) via a pulse oximeter and confirmed Resident #72's oxygen saturation was between 86 percent (%) and 88%. LPN #202 revealed Resident #72's oxygen saturation level was 95% that morning when she assessed it. LPN #202 obtained new oxygen tubing and connected the tubing to the concentrator then placed the cannula in Resident #72's nostrils. LPN #202 then exited the room. Observation revealed the concentrator was set at 1.5 liters per minute. The surveyor immediately returned to LPN #202 who returned to the medication cart. When asked how many liters per minute of oxygen Resident #72 should be receiving, LPN #202 again stated she was not sure and again pulled the order up on the computer on the medication cart. LPN #202 revealed Resident #72 should be on two liters of oxygen per minute per the physician orders. LPN #202 returned to Resident #72's room and confirmed the oxygen was set at 1.5 liters per minute. Review of the facility policy titled, Oxygen Administration, revised 10/2022, revealed the purpose of the procedure was to provide guidelines for safe oxygen administration. Staff are to verify the physicians order for the procedure and turn the oxygen on as directed by the Medical Practitioner. The deficiency represents an incidental finding discovered during the investigation for Complaint Number OH00165746 (1393119).

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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** Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to ensure medications were administered per the physicians orders. This affected two (#17 and #30) of 14 residents identified by the facility with orders for insulin injections via insulin pen. The facility census was 69. Findings include:1. Record review for Resident #17 revealed an admission date of 11/06/23. Diagnoses included type two diabetes mellitus with hyperglycemia and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment completed 08/16/25 revealed Resident #17 was cognitively intact. Resident #17 had impairment on one side to the upper extremity, received insulin injections, and had a diagnosis of diabetes mellitus. Review of the care plan for Resident #17 dated 11/07/23 revealed Resident #17 had potential risk for hyper/hypoglycemia due to a diagnosis of diabetes. Interventions included to administer medications as ordered. Review of the physician orders for Resident #17 dated 08/06/24 revealed an order for Novolog flex pen 100 unit/milliliter (ml) solution pen-injector to give 10 units subcutaneously three times daily before meals. Observation on 09/02/25 at 11:47 A.M. of medication administration revealed Licensed Practical Nurse (LPN) #230 administered insulin to Resident #17 via Novolog flex pen and revealed LPN #230 primed the insulin pen prior to placing the needle on the pen. When asked, LPN #230 confirmed she primed the insulin injector pen prior to placing the needle on the pen. LPN #230 then continued (without repriming the pen) her procedure, dialed in 10 units of Novolog insulin and administered the insulin to Resident #17 via injection.2. Record review for Resident #30 revealed an admission date of 07/07/25. Diagnoses included type one diabetes mellitus with other circulatory complications, diabetic polyneuropathy, hyperglycemia, and muscle weakness. Review of the admission MDS assessment dated [DATE] revealed Resident #30 was cognitively intact. Resident #30 had impairment on one side of the lower extremity, had a diagnosis of diabetes mellitus, and received insulin injections. Review of the care plan for Resident #30 dated 07/25/25 revealed Resident #30 had potential risk for hyper/hypoglycemia due to diagnosis of diabetes. Interventions included to administer medications as ordered. Review of the physician orders for Resident #30 revealed an order dated 07/11/25 for Novolog flex pen subcutaneous solution pen-injector 100 units per milliliter with instructions to inject 13 units subcutaneous in the evening for diabetes management. THe medication was scheduled to be given at dinner. Further review revealed an additional order for Resident #30 to receive Novolog insulin before meals, timed at 7:00 A.M., 11:00 A.M., and 4:00 P.M., via sliding scale including for the resident to receive seven units of insulin for blood sugars between 376 milligrams per deciliter (mg/dL) and 399 mg/dL. Observation on 09/02/25 at 4:00 P.M. of medication administration revealed LPN #222 assessed Resident #30's blood sugar for a result of 383 mg/dL. LPN #222 then dialed in 20 units of Novolog insulin via flex pen. LPN #222 did not prime the pen prior to dialing the amount to administer.Interview on 09/02/25 at 4:11 P.M. with LPN #222 confirmed she did not prime Resident #30's Novolog insulin pen prior to administering the insulin via the pen. LPN #222 revealed she forgot to and stated, To prime the insulin pen, take it to zero and push so you don't lose any insulin.Interview on 09/02/25 at 4:37 P.M. with the Director of Nursing (DON) revealed all insulin pens need to be primed with the needle on, and dialing the pen to two units prior to administration.Review of the facility policy titled, Insulin Pen Priming and Administration Policy, dated July 2024, revealed all injections must be administered by licensed nursing staff trained in insulin pen use. Priming is required before each injection to ensure correct dosing. A new sterile needle is required for each use. Preparation and priming included attach a new sterile needle to the insulin pen. Prime the pen, dial two units, hold the pen upright, press injection button until a drop of insulin appears at the tip. Repeat priming if no insulin appears.The deficiency represents non-compliance investigated under Master Complaint 2601734, Complaint Number 2572439, and Complaint Number OH00165746 (1393119).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365645	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health Center, The	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to maintain infection control practices after providing resident care. This had the potential to affect all 69 residents residing at the facility. The facility census was 69.Findings include:Record review for Resident #38 revealed an admission date of 12/09/21. Diagnoses included muscle weakness, unspecified dementia, and hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was dependent for toileting hygiene and was always incontinent of bowel and bladder. Record review of the care plan for Resident #38 dated 12/09/23 revealed Resident #38 experienced bowel and bladder incontinence. Interventions included to check and change Resident #38 every two hours and as needed. Staff were to provide peri-care with incontinent episodes. Observation on 09/03/25 at 1:37 P.M. with Certified Nurse Aide (CNA) #324 and CNA #341 revealed the staff members transferred Resident #38 to bed using a mechanical lift. Further observation revealed CNA #324 and CNA #341 needed to provide Resident #38 with incontinence care as well as changing the resident's brief, pants, and linen due to the items being saturated with urine. After incontinence care was completed, both CNA #324 and CNA #341 removed their gloves, each grabbed the bags of soiled linen and trash, and both left the room with the soiled items without washing their hands or using hand sanitizer. After disposing of the soiled linen and trash bags, CNA #324 went directly to the clean linen cart and obtained clean sheets, returned to Resident #38's room and placed the linen on the bed, covering Resident #38 up with the linen. CNA #341 returned the mechanical lift to the hall and disposed of the soiled bags, returned to Resident #38's room then used hand sanitizer to clean her hands. CNA #324 then went to the lounge to retrieve Resident #67 who was sitting in her wheelchair and which time CNA #324 was interviewed to review the previous observation of incontinence care. Interview with CNA #324 at approximately 1:45 P.M. confirmed she was preparing to provide care for Resident #67 and confirmed she did not use hand sanitizer or washed her hands after proving incontinence care for Resident #38. CNA #324 confirmed she obtained clean linen from a linen cart used and available for all residents after providing peri-care to Resident #38 without washing her hands or using hand sanitizer. Interview with CNA #341 at this time also confirmed she never washed her hands or used hand sanitizer after providing peri-care for Resident #38 and before exiting the room. Interview on 09/03/25 at 2:37 P.M. with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #356 confirmed staff were expected to wash their hands or use hand sanitizer before going in a resident room, after care, and before leaving the room. Interview on 09/09/25 at 2:48 P.M. with the DON confirmed all nursing staff are able to work or have worked throughout the facility with all residents. Review of the facility policy titled, Hand Hygiene, dated October 2024, revealed the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene included use of an alcohol-based hand rub or soap and water for situations which included before and after direct contact with a resident; after contact with a resident's intact skin; after contact with bodily fluids; after contact with medical equipment; after removing gloves; and after conducting personal hygiene. The policy included the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.This deficiency represents an incidental finding discovered during investigation for Complaint Number 2572439, Complaint Number OH00165746 (1393119), and Complaint Number OH00165124 (1393117).