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	09/24/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation of medication pass, staff interview, medical record review, review of manufacturer's instructions, review of medication card instructions and review of facility policy, the facility failed to maintain a medication error rate of less than five percent. The facility medication error rate was calculated to be 10.34 percent (%) and included three medication errors of 29 observed medication opportunities. This affected two residents (#58 and #75) of four residents observed for medication pass. The facility census was 96. Findings include: 1. Review of the medical record for the Resident #58 revealed an admitted [DATE]. Diagnoses included cerebral infarction (stroke), dementia, syncope (fainting), type II diabetes, chronic kidney disease and depression. Review of the September 2024 physician orders revealed an order for potassium chloride extended release (ER) 20 milliequivalent (meq) by mouth, vitamin C 50 milligram (mg), ferrous sulfate 325 mg, losartan 25 mg and a multivitamin. Observation on 09/18/24 at 8:40 A.M. of medication pass with Licensed Practical Nurse (LPN) #250 revealed LPN #250 prepared Resident #58's morning medications, including the potassium chloride ER. Resident #58 requested LPN #250 cut the pill in half due to difficulty swallowing. Resident #58 was unable to swallow the potassium chloride ER. LPN #250 then crushed the potassium chloride ER, mixed the crushed medication in pudding and administered the crushed potassium chloride ER to Resident #58. Interview on 12/08/20 at 8:51 A.M. with LPN #250 verified she crushed the potassium chloride ER and administered the crushed medication to Resident #58. LPN #250 stated the pill was scored and able to be crushed. LPN #250 stated she called the pharmacy about crushing potassium for another resident and was told potassium could be crushed. Review of the manufacture's prescribing instructions for potassium chloride ER revealed the formulation was intended to slow the release of potassium so the likelihood of a high localized concentration of potassium chloride within the gastrointestinal tract is reduced. Potassium chloride ER tablets are to be swallowed whole without crushing, chewing or sucking the tablets. (continued on next page)

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, heart failure, anxiety disorder, peripheral vascular disease, hypothyroidism and constipation. Review of the September 2024 physician orders revealed morning medications included levothyroxine (used to treat hypothyroidism) 50 microgram (mcg) by mouth in the morning, simethicone (used to treat flatulence) 80 mg, Eliquis (anticoagulant) 2.5 mg, aspirin 81 mg, carvedilol (used to treat high blood pressure) 6.25 mg, clopidogrel (used to treat heart problems) 75 mg, gabapentin (used to treat pain) 100 mg losartan 50 mg and omeprazole (used to treat gastroesophageal reflux) 40 mg. Instructions included resident requests not to receive medication before 8:00 A.M. Observation of medication pass on 09/19/24 at 8:30 A.M. with Medication Technician (MT) #240 revealed the MT prepared levothyroxine and simethicone, along with seven additional medications, and administered the medications to Resident #75. Review of the levothyroxine medication card revealed instructions to give the medication on an empty stomach and four hours after receiving an antacid, iron and/or simethicone. Concurrent interview with Resident #75 revealed he had breakfast, including a muffin and cereal, proportionately 20 minutes prior to his medications being administered. Interview on 09/19/24 at 8:45 A.M. with MT #240 revealed she administered Resident #75's medications based on his preference. MT #240 stated she was unaware levothyroxine was to be given on an empty stomach and should not be administered with simethicone. Review of the manufactures prescribing instructions for levothyroxine revealed the medication should be administered on an empty stomach, one-half hour to one hour before breakfast, and administer at least four hours before or after drugs that are known to interfere with absorption, including simethicone. Review of the facility policy titled Medication Administration, undated, revealed follow manufacture's recommendations for medications that note do not crush. This deficiency represents noncompliance investigated under Complaint Number OH00157286 and Complaint Number OH00157231.