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	08/27/2025

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure the residents received quarterly statements for their resident funds account. This affected one (#54) of six residents reviewed for resident trust funds account. The facility identified 38 residents had resident funds account. The facility census was 81.Findings included: Review of the medical record for Resident #54 revealed an admission date of 09/10/24 and was listed as the primary responsible party for billing. Review of the Resident Fund Management Service Authorization Agreement to Handle Resident Funds, revealed Resident #54 signed the document to set up a resident fund account. The document indicated with a signature, the person was authorizing the facility to establish an insured interest-bearing account and the person signing the document would receive a statement at least quarterly.Review of the facility document Resident Fund Statement dated 08/18/25, revealed Resident #54 had a resident fund account with a balance of $300.55. Resident #54's quarterly statements for the period of 04/01/25 through 06/30/25 revealed the resident had a balance of $300.55. Interview with Resident #54 on 08/11/25 at 10:27 A.M. revealed he had not received any quarterly statements and did not know what was in his personal fund account. Resident #54 stated he had asked multiple times to see his balance but was never given a statement as promised. Interview with Business Office Manager (BOM) # 612 stated she was new to the facility and has not provided any of the quarterly statements to the residents or guardians. BOM #612 verified Resident #54 has not received any quarterly statements. Review of the facility's policy titled Resident Trust Fund dated 10/19/17 revealed the purpose was to hold, safeguard, manage, control and reconcile the personal needs funds deposited with the facility by the residents, as authorized, in a manner and in compliance with all laws and regulations to provide the residents with accurate and timely information regarding their personal funds. Employee #1 will mail quarterly Resident Trust Fund Statements once approved by Employee #3.

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interviews, interviews with family, family friend, and home health aide, review of Emergency Medical Services (EMS) run report and call transcripts, review of the facility's Self-Reported Incident (SRI) and investigation, and review of facility policies, the facility failed to prevent an incident of neglect involving Resident #87. This resulted in Immediate Jeopardy, actual harm and death beginning on [DATE] at 11:30 P.M. when Resident #87 complained of chest pain to Certified Nursing Assistant (CNA) #609 who reported the change to Registered Nurse (RN) #422. RN #422 then failed to timely identify and obtain treatment for Resident #87 following an acute change in condition. In addition, the facility failed to ensure cardiopulmonary resuscitation (CPR) was initiated timely at the time Resident #87 was found unresponsive (without vital signs). On [DATE] at 2:50 A.M., Resident #87 expired with cause of death as cardiopulmonary and pulseless electrical activity with onset of 15 minutes prior to death. This affected one (#87) of three residents reviewed for hospitalization. The facility census was 81. On [DATE] at 10:13 A.M., Regional Director of Clinical Operations (RDCO) #417, the Administrator, the Director of Nursing (DON), and Assistant Director of Nursing (ADON) #813 were notified Immediate Jeopardy began on [DATE] at 11:30 P.M. when Resident # 87, who had advance directives for a full code complained of chest pain. CNA #609 reported the residents' complaint to RN #422. However, RN #422 failed to complete a comprehensive assessment or timely transfer the resident to the hospital for evaluation/medical intervention. The resident was subsequently found unresponsive (no time documented), with bluish-purple lips and fingertips. There was no evidence to support staff immediately initiated cardiopulmonary resuscitation (CPR). The facility failed to conduct a thorough investigation to determine the circumstances of the incident. However, interviews conducted by the State Survey Agency revealed staff did not initiate CPR for approximately seven to twenty minutes per seven staff (two nurses and five CNAs). As a result of Resident #87 not being assessed timely, a code not being called, and CPR not being initiated timely, Resident #87 passed away on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 2:50 P.M., Resident #87 passed away in the facility. On [DATE] at 9:30 A.M., clinical staff reviewing documentation during morning clinical meeting found no documentation of an occurrence with Resident #87. RN #422 was contacted and was instructed to come in and complete documentation immediately. On [DATE] at 11:12 A.M., RN #422 completed a late-entry progress note. From [DATE] to [DATE] staff interviews and statements were obtained by the Administrator, ADON #813 and Acting DON #424 regarding occurrence with Resident #87. On [DATE], Acting DON #424 educated all licensed nurses on clinical documentation standards, notification of change of condition, CPR/Ohio Do Not Resuscitate (DNR) comfort care (CC) and DNR CC Arrest policies- with emphasis on immediately initiating CPR after verification of a CPR code status, and wound care. All new hire nurses will be educated during the new hire orientation process by DON/designee. All borrowed nurses from sister facilities will be educated prior to shift start by DON/designee. Ongoing education will be completed during quarterly all-staff meetings by Director of Nursing/designee. On [DATE], Acting DON #424 educated CNAs on documentation and CPR with emphasis on their supportive role by the direction of the nurse. On [DATE], Acting DON #424 reviewed all resident's nursing notes for the last 30 days that had a change in condition to validate timely and correct treatment. Timely and correct treatment was based on nursing standards for the specific situation. On [DATE], Acting DON #424 completed whole-house code status audit to ensure orders and care plans were updated and current. All resident code statuses are current and can be found in the resident header of the electronic medical record (EMR). Starting [DATE], DON/designee completed ongoing audit of nurses notes to be reviewed daily (five days per week) during daily clinical meeting to monitor for change of condition, and appropriate assessment/treatment completed, up to and including CPR. Any concerns noted will be addressed immediately. Results will be reviewed at monthly Quality Assurance Performance Improvement (QAPI) meetings. On [DATE], Licensed Practical Nurse (LPN) #503 completed a mock code blue drill which included four other staff during the day shift. On [DATE], RN #422 was terminated for performance and policy violations. Upon investigation, it was determined RN #422 was uncooperative during the investigation process. RN #422 failed to provide an accurate description of what occurred and failed to follow the facility's policies and procedures regarding documentation. On [DATE] at 9:57 A.M., an interview with the Administrator stated the facility had no additional information related to their investigation

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff and family interview and policy review, the facility failed to develop and implement a comprehensive and individualized fall prevention program to ensure Resident #90 was provided adequate assistance during care to prevent a fall with major injury. Actual harm occurred 02/05/25 when Resident #90, who required substantial/maximal staff assistance with bed mobility (rolling left and right) and was dependent on staff for toileting sustained a fall from an elevated bed during the provision of care. As a result of the fall the resident suffered left and right femur fractures, a fibula fracture and a tibia fracture requiring hospitalization and medical intervention. This affected one resident (#90) of three residents reviewed for falls. The facility census was 81. Findings include: Review of the closed medical record for Resident #90 revealed an admission date 11/15/13 with a discharge date of 02/14/25. Resident #90 had diagnoses including severe obesity, chronic respiratory failure, age related osteoporosis with current pathological fracture and type II diabetes mellitus. Resident #90 had been hospitalized from [DATE] to and returned to the facility on [DATE]. Review of the care plan dated 03/29/22 revealed Resident #90 was at risk for falls related to gait, balance problems, incontinence, weakness, vertigo and dizziness. Interventions included ensuring the bed locks were engaged. Review of the physician's orders dated 02/26/23 revealed an order to place an air mattress to bed and check inflation every shift. This order was discontinued on 01/06/25 when Resident #90 was discharged to the hospital. Resident #90 returned to the facility on [DATE]. Upon re-admission there was no physician order in place for the resident to have an air mattress to the bed. In addition, review of the treatment administration record (TAR) and medication administration record (MAR) revealed no documentation the resident's air mattress was checked for inflation from 01/08/25 to 02/05/25. Review of the admission evaluation dated 01/08/25 revealed Resident #90 was at risk for falls. Review of the plan of care dated 01/10/25 revealed Resident #90 had impaired skin integrity, or was at risk for altered skin integrity related to impaired mobility, incontinence, refusing to get out of bed, morbid obesity, diabetes, dry skin, lymphedema and fragile skin. Interventions included to provide appropriate off-loading air mattress. Monitor inflation every shift. The care plan also revealed Resident #90 had a self-care performance deficit, and required assistance with activities of daily living (ADL) related to impaired mobility, morbid obesity and disease process. Interventions included one person assistance for toileting and bed mobility and mechanical lift for transfers with two persons assistance. Review of a change of condition assessment dated [DATE] at 4:20 P.M. revealed Resident #90 fell out of bed and landed on her knees on the floor, with a complaint of pain. Review of a pain observation tool dated 02/05/25 (following the fall) revealed Resident #90 verbalized severe pain to the left leg and left knee. Review of unusual occurrence documentation dated 02/05/25 at 4:20 P.M. revealed Licensed Practical Nurse (LPN) #614 was called to Resident #90's room by Certified Nursing Assistant (CNA) #432. Resident #90 was observed on floor, facing bed with both legs folded underneath the resident. Resident #90 stated she did not hit her head. Resident #90 complained of pain to bilateral lower extremities. LPN #614 called 911 while two additional nurses remained in the room. The documentation revealed Resident #90 was alert and oriented times three. Review of a witness statement for CNA #432, written by LPN #614 on 02/05/25 at 5:13 P.M. revealed Resident #90 was rolled to right of bed to have brief place under her, during incontinent care of bowel. Resident #90's lower body rolled off the bed. Resident #90 was hanging on to grab bar. Resident #90 did not hit her head. The witness statement did not include any information about the resident's air mattress. Review of a witness statement dated 02/05/25 from LPN #614 revealed she was called into Resident #90's room by CNA #432. Upon entering the room Resident #90 was observed on the floor facing the wall with both legs underneath her. Resident #90's head was at roommate's foot board. Resident #90 complained of pain to both legs. Resident #90 was left in room with two other nurses while LPN #614 went and notified Director of Nursing (DON) and called 911. Resident #90 stated CNA #432 was providing incontinence care and Resident #90 rolled off the bed because CNA #432 moved her too far. Staff assisted Emergency Medical Service (EMS) and Resident #90 was transferred to hospital for evaluation. The witness statement did not include any information about the resident's air mattress. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had intact cognition. The assessment revealed Resident #90 was dependent on staff for toileting and required substantial/maximal staff assistance to roll left and right. Resident #90 was frequently incontinent with bowels and had an indwelling catheter. Review of documentation from Hospital #1 revealed Resident #90 was