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 Healthcare 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 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. **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 (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 into Resident #87's change in condition and his death to provide for State Survey Agency review. The facility did not provide any documentation of corrective actions completed by facility after their investigation. On [DATE] an ad hoc QAPI was held to discuss the incident with Resident #87 and reviewed plan for education and ongoing monitoring. Members in attendance included the Administrator, the DON, ADON #813, LPN #410, LPN #503, Social Service Director (SSD) #920, RDCO #417 and Medical Director #435. This will be reviewed at monthly QA meeting for the next six months. By [DATE], the DON educated all licensed nurses on completion and documentation of assessments with emphasis on obtaining current vital signs when assessing resident, CPR policy with emphasis on identifying code status, CPR/Ohio DNR comfort care and DNR CC Arrest policies with emphasis on immediately initiating CPR after verification of a CPR code status, and overhead announcement of code. 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 DON/designee. Starting on [DATE], DON/designee will complete mock code blue audits, three times a week for four weeks across various shifts. Concerns will be addressed in real time and discussed at monthly QA meetings. Starting on [DATE], DON/designee will review three assessments per week for four weeks across various shifts to validate assessment accuracy and completion of vital signs. Starting [DATE], DON/designee will continue ongoing audit of at least five residents' nurse's notes to be reviewed daily for five days/week for 12 weeks during daily clinical meetings 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 QA meetings. Starting [DATE], when the initiation of CPR is required, a Code Event Minutes form will be completed by a designated scribe with time resident is found and time CPR is initiated. These minutes will be reviewed by DON/designee after the Code Event Minutes form is completed, and any concerns will be addressed as appropriate. Although the Immediate Jeopardy was removed, the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #87's closed medical record revealed an admission date of [DATE] and diagnoses included obstructive sleep apnea, hyperlipidemia, weakness, non-pressure chronic ulcer of other part of left lower leg with other specified severity, peripheral vascular disease, chronic kidney disease stage three, chronic obstructive pulmonary disease (COPD), edema and other acute osteomyelitis to bilateral ankles and feet. Review of Resident #87's plan of care for COPD dated [DATE] revealed Resident #87 had (continued on next page)

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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.	Fire Department to the facility on [DATE] at 11:54 P.M. revealed dispatch had gotten a call from Resident #87 for a 911 call from his room. Resident #87 stated he fell and needed assistance getting up, and they do have paramedics en route. LPN #423 answered the facility's telephone and stated she would check to find out what was going on. There was no documentation in the resident's medical record of a nursing assessment including vital signs obtained at this time and the telephone call received by the local police department was not documented in the medical record. Review of an EMS telephone call on [DATE] at 12:02 A.M. revealed Resident #87 called 911 back, the nurse just came in and said he sent 911 away. Dispatch told Resident #87 that staff told EMS they were not needed. Resident #87 stated he had been sitting there for six hours, no pain medications, and the nurse refused to do his bandaging on his feet. A telephone call was then placed to the facility and LPN #423 answered. Dispatch stated Resident #87 called 911 again and was on the other telephone line. LPN #423 stated EMS just left and said they were not going to take him; if they had known he had called they would never have come out. LPN #423 reported that Resident #87 did not fall, he was sitting in a chair, and she was not sure what they could do in that moment. EMS said they would not take him. Dispatch said Resident #87 was on the other line advising he could not stand up for hours. LPN #423 stated Resident #87's nurse [RN #422] was to be in his room with him to do a dressing change. Dispatch said they would talk to Resident #87. Resident #87 stated no nurse was in the room with him. Dispatch stated a male nurse was on his way to him. Resident #87 stated RN #422 has refused to bandage his legs for six hours and now he was gathering supplies, and the resident didn't know how long that takes. Dispatch stated the paramedics were there and staff were advising EMS that Resident #87 did not need transported to the hospital and she called and spoke with staff again. Resident #87 reported no one else was in his room. Dispatch asked to speak to whoever was in the room and RN #422 got on the line and identified himself as Resident #87's nurse [RN #422]. Dispatch told RN #422 that Resident #87 kept calling and he replied, yeah, there was not an emergency. Resident #87 yelled in the background, yes, there is. RN #422 then stated yeah, there's not an emergency, it would be a waste to send people and dispatch indicated EMS just got back in the station. Dispatch stated to advise Resident #87, if he keeps calling, they must send somebody out. RN #422 stated he would try; there was only so much that RN #422 can do and was not able to take Resident #87's telephone (which he implied he could not remove the resident's access to telephone). Dispatch stated at some point they would have to send somebody like police out; they would have to send someone. Resident #87 can be heard in the background saying, if you would do your job. Dispatch started to say, If he is being unreasonable. RN #422 then stated, Well I did not commit a crime. and dispatch indicated per protocol, they would have to send someone out to do a welfare check and she did not indicate anything had been done wrong. There was no evidence this EMS call was documented in Resident #87's medical record. The EMS run sheet dated [DATE] revealed a call received at 1:58 A.M. for a cardiac arrest for Resident #87. EMS was on the scene at 2:05 A.M. Resident #87 was unconscious, drooling, not breathing and had delayed skin capillary refill with pale, cyanotic skin. No blood pressure or pulse could be found. Upon arrival at the scene, Resident #87 was supine on the floor receiving CPR from nursing home staff. Staff stated Resident #87 fell from chair while being changed by nurse and when nurse left to get help to lift him, Resident #87 was found unresponsive and not breathing. No palpable pulse could be felt. Approximate arrest time was 1:55 A.M. Manual CPR was taken over by EMS with ventilations given via bag valve mask ventilation (BVM). Resident #87 was intubated and the cardiac monitor showed asystole (cardiac flatline), then pulseless electrical activity (PEA), then ventricular fibrillation (VFIB) then PEA. Resident #87 was taken to the hospital. Disposition of the call was identified as dead after arrival, resident dead at scene-resuscitation attempted with transport. Review of an EMS call dated [DATE] at 1:58 A.M. revealed a female voice (CNA #620 upon review of the facility's telephone list) was at the facility and they had a resident (Resident #87) that was not responsive and had no pulse or anything and provided the room number. Dispatch asked if a nurse was in there with the resident and CNA #620 indicated RN (continued on next page)

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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.	checked the pulse (time not given), and a pulse was present (vital signs not recorded); after rechecking the pulse, RN #422 stated no pulse was present, so CPR was initiated (no time given). Review of CNA #620's typed witness statement dated [DATE] revealed on or after 2:00 A.M., CNA #620 was doing rounds. CNA #620 came out of a nearby resident's room and noticed CNA #509 standing by Resident #87's door and he motioned for CNA #509 to come help. CNA #509 asked where RN #422 was, CNA #509 mentioned RN #422 went to get another nurse for help. When LPN #905 and LPN #423 arrived (time not given), CNA #620 and CNA #509 were instructed to clear the room. EMS was called and compressions were started (time not given). Review of LPN #905's witness statement dated [DATE] revealed LPN #905 did not recall much from that night but did remember someone had called the police. LPN #905 ran to the front to observe if Resident #87 was on the floor (time not given). Once LPN #905 noted Resident #87 was not on the floor, she went back to report findings to EMS. LPN #905 stated EMS arrived and stated they could not take Resident #87 if there was nothing reported. EMS never entered Resident #87's room. As the night progressed (time not given), RN #422 stated Resident #87 called the police on him again. When LPN #905 entered the building (time not given), everyone was running towards Resident #87's room and was asking for her help. When LPN #905 ran to Resident #87's room, LPN #905 saw Resident #87 on the floor, his arms were above his head, and he had on a nasal cannula. LPN #905 observed the crash cart outside the door and chest compressions were being performed (staff not identified). After a while EMS ran in (time not given) to continue to assist with CPR. Review of CNA #609's typed witness statement dated [DATE] revealed Resident #87 called EMS around 12:00 A.M. and did not see him go out with EMS upon arrival. CNA #609 asked Resident #87 why he did not go to the hospital, and he responded he did not want to. Later on, that night (no time given), RN #422 informed CNA #609 that Resident #87 was down on the floor. When CNA #609 went into the room to assist, Resident #87 was positioned on the floor with his back against his chair. LPN #905 and LPN #423 arrived (time not given), and CNA #609 got the crash cart to assist. Review of an undated and unauthored document regarding Resident #87 revealed the following information: - On [DATE] (no time listed) RN #422 reported doing a dressing change for Resident #87, went to get assistance and when he returned, Resident #87 was unresponsive. CPR was initiated and continued until EMS arrived and took over CPR. Resident #87 was sent to the ER. - On [DATE] (no time listed) Resident #54 (Resident #87 was his former roommate) said he wanted to talk with the Administrator and the DON. Resident #54 had monitored the care of Resident #87 and reported the approximate time of Resident #87 requesting and receiving pain medications. Resident #54 also believed EMS had been called on two different occasions but believed they had been turned away as they never came into the room. This was concerning to Resident #54, but the concerns reported did not rise to the level of abuse/neglect without further investigation. RN #422 was suspended pending investigation. - No date listed. An investigation was initiated, other residents were assessed with no concerns, staff statements were obtained, and the facility requested the EMS run report.- On [DATE], Admissions #705 called Family Member (FM) #425 to offer condolences. No questions, concerns or requests were made at this time.- From [DATE] to [DATE] (inaccurate dates) it was determined from statements collected that RN #422 stated EMS arrived at the facility because Resident #87 had called them, stating he had fallen. RN #422 had gone to Resident #87's room and talked with Resident #87 who had not fallen and went back to the desk to report this information to EMS. EMS left the facility. Later that night (no time listed) EMS called the facility and stated they received a call from Resident #87; RN #422 talked to EMS and told them Resident #87 was okay. Later than night (no time listed) RN #422 was completing a treatment on Resident #87 when he went unresponsive and was lowered to the floor. RN #422 alerted staff (not specified, no time listed) for additional assistance. At that time (not listed) Resident #87 had a pulse. At some point while trying to place Resident #87 in the bed, he lost his pulse and respirations, and EMS was called, and CPR was initiated. EMS arrived, continued CPR and took Resident #87 to the hospital. A discrepancy was identified regarding RN #[TRUNCA

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 diagnosed with left femur fracture, right femur fracture, fibula fracture, and tibia fracture. The plan was to transfer Resident #90 to Hospital #2 for level II trauma on 02/06/25. The hospital documentation included Resident #90 told the hospital (staff) she had a bowel movement and was turned on her side to be cleaned up. The resident stated she told the CNA to be careful because she felt she was going to fall. The resident stated she then fell off the bed and injured her bilateral legs and hips. An attempt to receive medical record information from Hospital #2 for review during the survey was unsuccessful. Interview on 08/13/25 at 10:25 A.M. with Corporate Regional Nurse #421 on 02/05/25 at the time of the fall, CNA #432 was trying to put a clean incontinence product (Depends) under Resident #90 and pushed down too hard and Resident #90 fell out of bed. Interview on 08/14/25 at 3:17 P.M. with Resident #90's sister revealed Resident #90 fell out of bed (on 02/05/25) when personal care was being provided by CNA #432. The sister stated Resident #90 told her that CNA #432 kept scooting her closer to the edge of the bed and Resident #90 told CNA #432 to stop. The sister reported the resident's legs were on the edge of the bed and gravity took over and she could not stop her legs from falling. The resident's bed was also in a high position since care was being provided. The sister revealed Resident #90 was holding onto the grab bar, but her legs fell off the bed and she landed on her knees. Resident #90 was taken to the local hospital and had to be transported to a bigger hospital due to her injuries. The resident's sister reported Resident #90 broke both knees, tibias, fibulas and femurs and broke her left ankle. Resident #90's sister stated Resident #90's left ankle was not being fixed until the other injuries could be taken care of. Interview on 08/13/25 at 3:04 P.M. with Registered Nurse (RN) #507 revealed she had provided care to Resident #90 during the resident's stay at the facility. The RN revealed Resident #90 had an air mattress (prior to and following the hospitalization in January 2025), and the mattress was based upon the resident's weight. The nurse was to check every shift the settings on the air mattress and document it on the TAR. The RN revealed this was the policy for any resident (including Resident #90) with an air mattress. Interview on 08/18/2025 at 10:25 A.M. with LPN #614 revealed on 02/05/25 she was the nurse on duty and it was at the end of her shift when Resident #90 sustained a fall. The LPN revealed CNA #432 was providing incontinence care to Resident #90 and the CNA rolled her to far and Resident #90 fell out of bed on to her knees. In regard to the use of an air mattress, the LPN revealed staff were to check the air mattress every shift for proper inflation and if there was an issue with the mattress it would beep to alert staff. Interview on 08/18/25 at 12:00 P.M. with the Director of Nursing (DON) verified Resident #90 was hospitalized from [DATE] to 01/08/25 and upon return the physician orders for the resident's air mattress were not resumed. However, the resident continued to have the air mattress in place. The DON verified there was no documentation of the nurse's monitoring Resident #90's air mattress between 01/08/25 and 02/05/25 to ensure proper inflation was maintained or evidence the functionality of the air mattress was included as part of the investigation of the resident's fall. An attempt to interview CNA #432 during the survey was unsuccessful. Review of the facility's undated policy titled Specialty Mattresses revealed the nurse would validate the bed was functional, plugged into the proper outlet and the cords and bed were in good working condition. Review of the facility's undated policy titled Routine Resident Care revealed the facility would provide routine daily care by a CNA with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to maintaining proper body position and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	alignment for all residents. This deficiency represents non-compliance investigated under Complaint Number 2574706, Complaint Number OH00165814 (1317322), Complaint Number OH00162622 (1317319), and OH00162278 (1317317).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and review of the facility policy, the facility failed to ensure expired foods were disposed of timely. This had the potential to affect 79 residents who the facility identified receive meals from the kitchen, and Residents #6 and Resident #45 were ordered nothing-by-mouth. The facility census was 81.Findings included: Observation of the kitchen on 08/11/25 starting at 9:28 A.M. with Dietary Manager (DM) #418 revealed the following areas of concern: in the walk-in cooler, there was an expired case of sour cream packets dated 07/14/25 and an expired jar of Dijon mustard dated 03/27/25; in the dry stock room, there was an expired jar of Dijon mustard dated 03/27/25 and an expired container of bread crumbs dated 06/06/25. in the resident refrigerator, there was an expired jug of prune juice dated 07/03/25. DM #418 verified the sour cream packets, jars of Dijon mustard, bread crumbs, and prune juice were expired and indicated he or his staff was to go through food storage weekly and dispose of out of date foods at that time. The facility identified Residents #6 and #45 did not receive food from the kitchen because their diet orders were nothing-by-mouth. Review of the facility's policy titled Receiving revised February 2023 revealed all foods will be stored in a manner that ensures appropriate and timely utilization based on the principles of first-in, first-out (FIFO) inventory management.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to implement and maintain a comprehensive Quality Assurance Improvement Program (QAPI) program and plan to address care issues and/or concerns in the facility. This had the potential to affect all 81 residents who reside in the facility. The facility census was 81.Findings included: Review of the Quality Assurance (QA) committee attendance records for the previous 12 months revealed QA meetings were held on [DATE], [DATE], [DATE] and [DATE]. The findings for the annual survey, in conjunction with multiple complaint allegations, dated [DATE] revealed noncompliance in the area of abuse resulting 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. There was also noncompliance found in the area of quality of care resulting in actual harm to Resident #90, who required substantial/maximal staff assistance to roll left and right and was dependent on staff for toileting was improperly rolled from the elevated bed and Resident #90 fell to the floor, sustaining multiple fractures including left and right femur (leg bone between your hip and thigh, the longest, heaviest, and strongest bone in the body and it takes a tremendous force to break your femur) fractures, fibula fracture (smaller out bone of the lower leg) and tibia fracture (shinbone) and required hospitalization on [DATE]. The facility was unable to provide evidence, including documentation, of its ongoing QAPI program's implementation with the neglect of Resident #87 and Resident #90's fall. Interview on [DATE] at 11:52 A.M. with the Administrator confirmed there were no evidence including documentation that the QAPI program implementation with the neglect of Resident #87 and Resident #90's fall. Review of the facility's undated policy titled QAPI (Quality Assurance Performance Improvement) Plan revealed the facility would provide resident centered care that meets the psychosocial, physical and emotional needs of the residents. Safety of residents, staff and visitors is a primary focus of the facility. Regulations require that the facility have an ongoing QA, process improvement plan to monitor the quality of resident care. QAPI data is used not only to identify quality and safety problems, but to also identify other opportunities for improvement, and then setting priorities for action. QAPI focuses on identifying and undertaking systemic change to eliminate problems after the root cause is determined.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and staff interview, the facility failed to ensure Quality Assurance (QA) meetings were held at least quarterly with the Medical Director present, to address care issues/concerns in the facility. This had the potential to affect all 81 residents who reside in the facility. Findings included: Review of the QA committee attendance records for the previous 12 months revealed the facility held four QA meetings in four consecutive months on 04/25/25, 05/05/25, 06/02/25, and 07/07/25. The facility had no other records of QA meetings held from 09/01/25 to 03/31/25. Interview on 08/20/25 at 11:52 A.M. with the Administrator confirmed there were no other QA meetings documented, and she had no evidence that the meetings had taken place and if the Medical Director was present. Review of the facility's undated document titled QAPI (Quality Assurance Performance Improvement) Plan revealed the facility had a policy in place that the facility would have a QAPI meeting every month with required members present.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, and facility policy review, the facility failed to perform hand hygiene between residents and after glove use during medication administration. This affected five residents (#51, #63 #76, #110, and #111) observed for medication administration. The facility census was 81. Findings included: 1. Observation on 08/12/25 at 7:43 A.M. during medication administration revealed Licensed Practical Nurse (LPN) #814 opened the locked medication cart and pulled the medication cards and bottles for Resident #76. LPN #814 then placed each prescribed medication dose into the medication cup. LPN #814 then signed off medications in the electronic medical record and proceeded directly to administer pulled medications to Resident #76. LPN #814 did not perform hand hygiene prior to administering medications to Resident #76, or after contact with Resident #76 and the environment. Additionally, LPN #814 was subsequently observed to administer medication to Residents #111 and #110 without performing any hand hygiene between each resident's medication administrations. Observation on 08/12/25 at 8:06 A.M. revealed LPN #814 was wearing gloves and obtained Resident #63's a blood glucose (accu check). LPN #814 did not perform hand hygiene prior to donning gloves or after removing gloves after the blood glucose check was obtained for Resident #63. Interview with LPN #814 on 08/12/25 at 8:09 A.M. verified she had not performed hand hygiene as required during medication administration to Residents #76, #110, and #111 or during blood glucose check for Resident #63. LPN #110 stated she forgot. 2. Observation on 08/12/25 at 8:20 A.M. revealed LPN #914 did not perform hand hygiene prior to administering Resident #51's medications. LPN #914 was not observed performing hand hygiene prior to or after resident medication administration. Interview with LPN #914 at 8:30 A.M. verified she had forgotten to perform hand hygiene before and after contract with residents and the environment as required. Interview with Director of Nursing (DON) and Regional Director #417 on 08/12/25 at 11:30 A.M. verified all staff were to follow the facility's medication administration policy and complete hand hygiene before and after administering medications, and prior to next resident contact. Review of facility's undated policy titled Medication Administration revealed staff must perform appropriate hand hygiene before beginning medication administration, observe standard precautions including safe sharps use, and perform hand hygiene before and after each resident's medication is administered.

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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.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review, resident and staff interviews, and facility policy review, the facility failed to notify each resident that received Medicaid benefits when their resident reached $200 less than the Supplemental Security Income (SSI) resource limit. This affected two residents (#28 and #45) of six residents reviewed for resident funds. The facility census was 81.Findings included: 1. Review of the medical record for Resident #28 revealed an admission date of 06/07/23 and Medicaid was a payor source. The resident was the primary financial contact and was cognitively intact. Review of Resident #28's resident fund account's quarterly statement revealed a current balance on 08/14/25 of $2,372.91. The quarterly period statement of 04/01/25 through 06/27/25 revealed a balance of $2,372.91. The facility provided no documentation to prove Resident #28 had received a spend down notification. Interview on 08/18/25 at 10:31 P.M. with Resident #28 revealed he was not aware of how much he had in the account. Interview on 08/18/25 at 11:59 A.M. with Business Office Manager (BOM) #612 confirmed there was no documented proof that spend down letters had been sent to Resident #28. BOM #612 stated she has only been at facility for six weeks and was still catching up from previous manager. BOM #612 verified that extra monies should have been transferred to Resident #28 Qualified Income Trust (QIT) account. 2. Review of medical record for Resident #45 revealed an admission date of 07/20/18 and Medicaid was the payor source. Resident #45 was not interviewable. Review of Resident #45's resident fund account's quarterly statement revealed a balance of $4,186.56 for the period of 04/01/25 through 06/27/25. The current balance on 08/14/25 was $4,186.56. There was no documented evidence that Resident #45 had received a spend down notification. Interview on 08/18/25 at 11:59 A.M. with Business Office Manager (BOM) #612 confirmed there was no documented proof that spend down letters had been sent to Resident #45.BOM #612 stated she has only been at facility for six weeks and was still catching up from previous manager. BOM #612 verified Resident #45 should have received a spend down letter. Review of the facility policy Resident Fund Management (RFMS) Policy, revised 10/13/21, revealed the business office was to notify all Medicaid residents when the asset limit was approaching.

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	365811	A. Building B. Wing	08/27/2025

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Northwestern Healthcare Center	570 North Rocky River Drive Berea, OH 44017

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, and facility policy review, the facility failed to ensure care plans were timely updated and care conferences were held quarterly with the resident and/or family. This affected two residents (#49 and #58) of three residents reviewed for care plans. The facility census was 81. Findings included: 1.Review of the medical record for Resident #49 revealed she was admitted to the facility on [DATE]. Diagnoses that included type II diabetes mellitus with ketoacidosis without coma and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had some cognition impairment. Review of the care plan dated 07/09/25 revealed Resident #49 had an ADL self-care performance deficit due to impaired cognition, weakness and poor safety awareness. Resident #49 was independent with showers and/or bathing with assistance required based on time of day, mood, pain, or fatigue and adjust as indicated. Review of the progress note date 07/16/25 at 1:00 A.M. revealed Resident #49 was confused to the point she would urinate on the floor and was unable to care for herself. Interview on 08/11/25 at 10:34 A.M. stated she was overdue for a shower and needed assistance at this time due to her feet being swollen. Interview and observation on 08/11/25 at 10:36 A.M. with Certified Nurse Assistant (CNA) #520 revealed Resident #49 sitting up in bed with her blood-stained gown. CNA #520 stated she was unsure when Resident #49 was last showered, had a change of clothes, and not sure how long she was in her blood-stained gown. CNA #520 asked Resident #49 if she wanted a shower. Resident #49 replied to CNA #520 stating she has been wanting a shower but needed help because her feet were swollen. Interview on 08/14/25 at 2:21 P.M. with CNA #901 revealed Resident #49 required assistance with ADLs including showers and baths. Interview on 08/14/25 at 2:22 P.M. with CNA #516 revealed Resident #49 always required assistance with her ADLs. CNA #516 revealed she typically provided shower care for Resident #49 when she worked her shift, however, she could not speak to other staff members and on days she did not work. Interview on 08/18/25 at 4:45 P.M. with Licensed Practical Nurse (LPN) #610 during review of Resident #49 electronic medical record (EMR), revealed Resident #49 required assistance with ADLs including showers. LPN #610 stated Resident #49 fluctuated between stand-by assist to one-person assist daily. LPN #610 revealed Resident #49's care plan indicated she was independent with ADLs. LPN #610 confirmed Resident #49's care plan should have been updated to reflect the change in care need assistance. Review of the facility's undated document titled Plan of Care Overview revealed the facility had a policy in place to initiate, review and revise the care plan of residents as the resident's condition (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	warrant. 2. Review of the open medical record for Resident #58 revealed and admission date 09/18/24. Diagnoses included front temporal neurocognitive disorder, depression, anxiety, and altered mental status. Review of the care conference note dated 11/11/24 at 10:40 A.M. revealed Resident #58 and guardian via telephone, social worker and Director of Nursing (DON) who attended the care conference. This was the last time a care conference was provided for Resident #58. Interview on 08/11/25 at 9:41 A.M. with Resident #58 revealed she has not been asked to attend a care conference this year. Interview on 08/14/25 at 9:38 A.M. with Social Worker Designee (SWD) #920 stated care conferences were completed yearly, quarterly and 72 hours on admission. SWD #920 stated the whole 'team', resident and family/guardian are asked if they want to attend the care conference. The SWD #920 verified she could not find any documentation that a care conference was held for Resident #58 after 11/11/24. SWD #920 confirmed there should have been two care conferences completed this year, and none was completed for Resident #58. Review of the facility's undated policy titled Plan of Care Overview revealed care plans would be held quarterly and/or with significant changes in care, support the residents right to participate in treatment and care planning, schedule meeting to accommodate resident's representative and plan adequate meeting time for decision making and discussion.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, and facility policy review, the facility failed to ensure the residents received proper treatment and assistive devices to maintain hearing abilities. This affected one (#49) of one reviewed for ancillary services. The facility census was 81. Findings included: Review of the medical record for Resident #49 revealed she was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus with ketoacidosis without coma and chronic obstructive pulmonary disease. Review of the physician orders dated 12/24/24 revealed a current order for consultations for audiology as needed. Review of the progress note dated 04/15/25 at 1:41 P.M. revealed Resident #49's brother requested appointments for audiology, optometry, and dental appointments. Resident #49 was being put on the list to be seen for these services. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had some cognition impairment and had minimal difficulty related to hearing. Review of the care plan dated 07/09/25 revealed Resident #49 had an activities of daily living (ADL) self-care performance deficit due to impaired cognition, weakness and poor safety awareness and was at risk for communication related to dementia. Interventions included allow adequate time to respond, turn off television and/or radio to reduce environment noise and observe effectiveness of communication. The progress note dated 07/16/25 at 1:00 A.M. revealed Resident #49 stated her mood had not been great due to issues with hearing and vision. Resident #49 stated she was angry due to her hearing and vision not being fixed and being depressed about her limited hearing. The progress note dated 07/28/25 at 1:00 A.M. revealed Resident #49 stated her hearing was bad. The progress note dated 07/29/25 at 1:00 A.M. revealed Resident #49 had vertigo. The progress notes dated 08/08/25 at 1:00 A.M. revealed Resident #49 stated she was unable to hear well and had been self-isolating in her room and sleeping most of the day. Review of the patient list for the last audiology visit dated 01/13/25 revealed Resident #49 was not seen. Interview on 08/11/25 at 10:34 A.M. with Resident #49 revealed her hearing was bad and the facility staff were not doing anything about it. Resident #49 stated sometimes staff ignored her and focused on other residents. Interview and observation on 08/11/25 at 10:36 A.M. with Certified Nurse Assistant (CNA) #520 revealed she was not aware of when the last time Resident #49 was seen by the audiologist. CNA #520 stated Resident #49 was unable to hear that well and staff were required to speak louder when talking to her. Resident #49 stated, during interview with CNA #520, If y'all are talking to me, y'all need to speak up. Resident #49 was also observed placing her right hand behind her right ear and stated, I don't know what y'all are saying, but I hope it's something good. CNA #520 confirmed Resident #49 had hearing difficulty. Interview on 08/12/25 at 3:56 P.M. with Social Service Director (SSD) #920 revealed she was responsible for handling dental, vision, audiology and podiatry appointments. SSD #920 stated staff members consisting of nurses, CNAs, management, or anyone that was aware, would inform her if a resident required or requested ancillary services and she would add them to the list to be seen on the next upcoming visit unless it was an emergency. SSD #920 revealed vision services were every three months, and they had already been into the facility a few weeks ago. Follow-up interview on 08/13/25 at 12:15 P.M. with SSD #920 revealed Resident #49 had no history of being seen by the audiologist and was not on the upcoming list to be seen. SSD #920 stated there were no upcoming dates for the audiologist. SSD #920 confirmed Resident #49 requested and needed to be seen by the audiologist and confirmed Resident #49 had no prior or upcoming appointments scheduled. Review of the facility's undated document titled Resident Rights revealed the facility had a policy in place that residents would receive personal care including, but not limited to, attending to needs in a timely fashion.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and observation, the facility failed to ensure the residents received timely and proper treatments for foot care. This affected one (#49) one resident reviewed for podiatry. The facility census was 81.Findings included: Review of the medical record for Resident #49 revealed she was admitted to the facility on [DATE]. Diagnoses which included type II diabetes mellitus with ketoacidosis without coma and chronic obstructive pulmonary disease. Review of the physician orders dated 12/24/24 revealed a current order for consultations for podiatry as needed. Review of the patient list for the last podiatry visit dated 06/27/25 revealed Resident #49 was not seen. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was alert and oriented with some cognition impairment. Observation and interview on 08/11/25 at 10:34 A.M. revealed Resident #49 was lying in bed in a gown and her toenails on both her left and right feet were long, brittle and brown in color. Resident #49 stated she was overdue for a shower and needed assistance at this time due to her feet being swollen. Resident #49 stated she liked her fingernails long but not her toenails and sometimes staff ignored her and focused on other residents. Interview and observation on 08/11/25 at 10:36 A.M. with Certified Nurse Assistant (CNA) #520 confirmed Resident #49 had long toenails. CNA #520 stated the CNAs were responsible for cutting resident's nails unless they were diabetic. CNA #520 revealed the podiatrist visited the facility and cut the toenails of all residents that required it or requested it. Interview on 08/12/25 at 3:56 P.M. with Social Service Director (SSD) #920 revealed she was responsible for handling dental, vision, audiology and podiatry appointments. SSD #920 revealed staff members consisting of nurses, CNAs, management, or anyone that was aware, would inform her if a resident required or requested ancillary services and she would add them to the list to be seen on the next upcoming visit unless it was an emergency. SSD #920 revealed the podiatrist visited the facility once since 07/30/25 and the next visit was scheduled for 08/20/25. Follow-up interview on 08/13/25 at 12:15 P.M. with SSD #920 confirmed Resident #49 had no history of being seen by the podiatrist and was not on the upcoming list to be seen. Review of the facility's undated document titled Resident Rights revealed the facility had a policy in place that residents would receive personal care including, but not limited to, nail care and/or clipping. Review of the document revealed the facility did not implement the policy.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, staff interview and recipe review, the facility failed to prepare purees per standards of practice to ensure nutritional value. This had the potential to affect two residents (#32 and #37) who the facility identified to receive pureed meals at the facility. The facility census was 81.Findings included: Observation and interview on 08/12/25 starting at 10:48 A.M. revealed [NAME] #420 placed four chicken thighs and two, two-ounce ladles of chicken gravy (total of four ounces) into the food processor and blended. [NAME] #420 then added four to eight ounces hot water from a pan on the stove to the mixture in the food processor and blended. [NAME] #420 then added four ounces of thickener to the mixture and blended. [NAME] #420 indicated he needed two purees so prepared two portions. When asked why he added hot water to the puree, [NAME] #420 stated there was no broth to add today and sometimes he would add gravy to thin down the pureed product. Interview on 08/12/25 at 10:55 A.M. with Dietary Manager (DM) #418 verified staff were not to add hot water to purees and confirmed [NAME] #420 did not follow the recipe as written as the recipe stated to add broth or gravy to thin the product if needed. Review of the undated recipe, Chicken, Marinated (Thigh), listed ingredients as chicken and Italian salad dressing. Instructions for pureed directed to measure desired number of servings into food processor. Blend until smooth. Add broth or gravy if product needs thinning. Add commercial thickener if product needs thickening. Observation on 08/12/25 starting at 10:56 A.M. revealed [NAME] #420 placed eight cups of corn with milk and butter, and eight cups of water into the food processor and blended. [NAME] #420 added two, four-ounce scoops of thickener to the processor and blended. Interview on 08/12/25 at 10:55 A.M. with DM #418 verified staff were not to add hot water to purees. Review of the undated recipe, Corn, Cream Style, listed ingredients as cream style, canned corn. Instructions for pureed directed to measure out desired number of servings into food processor. Blend until smooth. Add liquid (not specified) if product needs thinning. Add commercial thickener if product needs thickening. Review of a diet list dated 08/11/25 identified Resident #32 and Resident #37 as receiving pureed food.

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F 0835 Level of Harm - Potential for minimal harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, staff interview, and facility policy review, the facility failed to administer the facility to employ enough laundry staff to the meet the needs of the residents. This had the potential to affect all 81 residents residing in the facility.Findings included: Observation of the soiled linen room on 08/12/25 at 6:28 A.M. with Laundry Aide (LA) #430 present, located on the Back-South hall revealed two yellow bins, uncovered, and overflowing with yellow and brown-stained towels, sheets, gowns, and clothing. Located on the floor, in various areas, there were five open bags, unsealed, of overflowing yellow and brown-stained towels, sheets, gowns, and clothing. LA #430 confirmed the bins were uncovered and overflowing with dirty linens. Observation of the soiled linen room on 08/12/25 at 7:02 A.M. located on the Front-South hall revealed multiple bags of soiled linen, open and unsealed. Interview on 08/12/25 at 7:02 A.M. with LA #430 revealed the soiled linen had not been taken care of in a couple of days. LA #430 stated she could not explain why the soiled linen was in its current state because she was not scheduled to work and was called in to assist the facility with laundry services. LA #430 revealed there was no one scheduled to work the laundry until 2:00 P.M. or 3:00 P.M. LA #430 confirmed the Front-South had multiple bags of soiled linen, open and unsealed. LA #430 stated the certified nursing assistants (CNAs) were having a hard time finding clean linens because of the piled high of soiled linens. Review of the facility document titled Laundry Handling & Processing Policy reviewed 02/01/25 revealed the facility had a policy in place to reduce the risk of disease transmission based on principles of hygiene, common sense, and the Centers for Disease Control (CDC) guidance.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on review of facility documents and staff interview, the facility failed to ensure they had a transfer agreement with one ore more hospitals. This had the potential to affect all 81 residents residing in the facility. Findings included: An entrance conference meeting for an annual and complaint survey occurred on 08/11/25 at 8:45 A.M. with the Administrator. At the time of the meeting, various documents were requested including the facility transfer agreement. Review of various documents and continued requests for the transfer agreement during the annual and complaint survey returned no results. Interview on 08/21/25 at 12:30 P.M. with the Administrator confirmed the facility did not have a transfer agreement with one or more hospitals.