STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366275	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northfield Village Retirement Community	10267 Northfield Road Northfield, OH 44067

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on record review and staff interview the facility failed to complete a state specific Pre-Admission Screen and Resident Review (PASRR) form within thirty days of admission as required. This affected one (Resident #61) of two residents (Residents #41 and #61) reviewed for PASRR. The facility census was 56. Findings include: Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included but were not limited to post traumatic stress disorder, tinea unguium, diabetes mellitus and vitreous degeneration. Review of the Medicare Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #61 was dependent on staff for most activities of daily living (ADLs). Further review of the medical record revealed no evidence a State of Ohio PASRR form was completed as required for Resident #61. A PASRR form was in the medical record from the state of Kentucky dated 01/22/24. Interview on 03/11/24 at 1:43 P.M. with Licensed Social Worker #873 verified an Ohio PASRR screen was not completed for Resident #61 as required.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on observation, interview, medical record and facility policy review, the facility failed to ensure preventative interventions were in place for treatment of pressure injury of left heel. This affected one Resident (#39) of three reviewed for pressure injuries. The facility census was 56. Findings include: Review of the medical record for Resident #39 revealed admitted [DATE] and diagnoses including polyneuropathy, diabetes mellitus, left ankle and foot osteomyelitis, moderate protein calorie malnutrition, peripheral vascular disease, and congestive heart failure. Review of the plan of care dated 12/23/23 revealed Resident #39 had impaired skin integrity related to pressure injury to left heel. Interventions included to elevate heels off surface of mattress. Review of Medicare Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #39 was dependent on staff for rolling left and right, sitting to lying, and lying to sitting. Resident #39 was at risk of developing pressure injuries and had one or more unhealed pressure injuries. Review of Braden Scale for Predicting Pressure Sore Risk Original assessment dated [DATE] revealed Resident #39 was at moderate risk for pressure injury. Review of the physician's order dated 02/16/24 revealed to float bilateral heels off surface of mattress when in bed and order dated 02/17/24 revealed to encourage resident to wear Prevalon heel boots (pressure off loading boots) at all times while in bed. Review of the Treatment Administration Records (TARs) from February 2024 and March 2024 revealed no documented refusals of floating bilateral heels off surface of mattress while in bed. Review of progress note dated 03/04/24 revealed Resident #39 had refused to wear Prevalon boots but was agreeable to having heels floated. Review of the Wound Evaluation and Management Summary dated 03/06/24 revealed Resident #39 had a stage two pressure injury to left medial heel measuring 1.5 centimeter (cm) length, 1.0 cm width, and 0.1 cm depth. Recommendations included off-load wound and pressure off-loading boot. Observation on 03/11/24 at 8:59 A.M. revealed Resident #39 was in bed with the head of bed raised for breakfast meal. Resident #39's bare feet were pressed against the foot board of bed frame. There was no evidence of offloading measures in place at time of observation. Interview on 03/11/24 at 9:06 A.M. with Licensed Practical Nurse (LPN) #826 revealed she was the assigned nurse for Resident #39. LPN #826 confirmed Resident #39 had left heel pressure injury. LPN #826 indicated Resident #39 was supposed to have pillow to float bilateral heels while in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/11/24 at 9:10 A.M. with LPN #826 verified Resident #39's bare feet were pressed against the foot board of bed frame. LPN #826 verified there were no pressure off-loading measures in place at time of observation. Review of the facility policy, Pressure Ulcer Risk and Skin Assessment revised 06/08/15 revealed resident specific interventions would be implemented for those residents deemed at risk for skin impairment.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on record review and interview the facility failed to provide an appropriate diagnosis for the use of an antipsychotic. This affected one resident (Resident #45) out of five residents (#18, #39, #45, #50, and #271) reviewed for unnecessary medications. The facility census was 56. Findings include: Review of Resident #45's medical record revealed the resident was admitted on [DATE]. Diagnoses included but were not limited to restlessness and agitation, dysphagia, diabetes mellitus, and Alzheimer's disease. Review of Resident #45's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment, no behaviors were noted and required substantial assistance for activities of daily living (ADLs). Further review of the MDS revealed Resident #45 received an antipsychotic and there was no indication as to why in section N of the assessment. Review of Resident #45's physician orders for March 2024 revealed an order for divalproex sodium (anticonvulsant also used to treat mania) tablet delayed release 125 milligrams (mg) give two capsules by mouth two times a day related to unspecified signs and symptoms involving cognitive functions following cerebral infarction. Further review of the physician's orders revealed an order for mirtazapine (antidepressant) tablet 7.5 mg give one tablet by mouth one time a day related to Alzheimer's disease. Review of current resident diagnoses revealed Resident #45 did not have an active diagnosis seizures or depression in the medical chart. Interview on 03/11/24 at 3:40 P.M. with MDS Nurse #844 verified there was no evidence the use of mirtazapine and divalproex was being used to treat a specific condition as diagnosed and documented in the medical record.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, interviews, and review of information from the Medscape website, the facility failed to ensure laboratory tests were completed as ordered for Resident #271 and Resident #64. This affected two residents (Resident #271 and Resident #64) of 21 residents whose medical records were reviewed for laboratory test results. Findings include: 1. Review of the medical record revealed Resident #271 was admitted to the facility on [DATE]. Diagnoses included left foot amputation, osteomyelitis, diabetes, right leg above the knee amputation, and peripheral vascular disease. Review of the physician's orders dated 02/28/24 revealed Resident #271 had an order for Vancomycin (antibiotic) 1000 milligrams every 12 hours until 03/22/24 dated 02/28/24. Review of the physician's orders dated 02/29/24 revealed Resident #271 had an order for a Vancomycin trough every Monday and fax the results to the physician (trough concentrations are recommended for therapeutic monitoring of Vancomycin. Trough levels are drawn prior to the administration of dose). Review of the laboratory report dated 03/04/24 revealed the collection time for the Vancomycin trough was at 11:10 A.M. It was reported within normal limits at 15.2. Review of the Admission Minimum Data Set assessment dated [DATE] revealed Resident #271 had intact cognition. Review of the physician's orders dated 03/11/24 revealed Resident #271 had orders to hold the morning dose of Vancomycin until the laboratory drew sample on laboratory days for Vancomycin level and a Vancomycin trough one time on 03/12/24. Review of the March Medication administration record revealed Resident #271 was administered Vancomycin at 6:02 A.M. on 03/11/24. Review of the laboratory report dated 03/11/24 revealed the collection time for the Vancomycin trough was at 7:52 A.M. (after the dose was administered) It was reported at high at 38.5 (normal 10-20). Review of the March Medication Administration Record (MAR) revealed Resident #271 was administered Vancomycin at 5:12 A.M. on 03/12/24; however, the administration time was lined out due to the resident later refused the dose because they had started the Vancomycin before the laboratory test (trough level) was obtained. Review of the Laboratory report dated 03/12/24 revealed the collection time for the Vancomycin trough was at 6:35 A.M. It was reported low at 9.9. (continued on next page)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 9:4 5 A.M. an interview with Resident #271 (who was visibly upset) revealed she was upset that the facility gave her Vancomycin prior to her blood being drawn yesterday (03/12/24) in the morning. Resident #271 stated that on Monday (03/11/24), her Vancomycin laboratory results were high, so she had to get the test done again yesterday (03/12/24). She stated they told her it was elevated because they gave her the Vancomycin prior to her laboratory tests being drawn on 03/11/24, so going forward, they would draw the laboratory tests first then administer the Vancomycin. Resident #271 stated they did the same thing on Tuesday (03/12/24), they administered her Vancomycin prior to her laboratory tests being drawn so she was upset and refused the rest of the Vancomycin. On 03/13/24 at 9:57 A.M. an interview with Regional Nurse #893 with the Administrator present revealed Resident #271 came to them with a concern yesterday (03/12/24) about her antibiotic. She stated the nurse administered Resident #271's Vancomycin prior to the lab draw. The nurse started the Vancomycin, then went to sign it off on the MAR and noticed the order was put into the computer for the day before (03/11/24), she went into the room and stopped the Vancomycin infusion. Regional Nurse #893 stated it was only infusing for about a minute. Regional Nurse # 893 stated after the Vancomycin trough was drawn, the nurse went back into the room and Resident #271 refused the rest of the Vancomycin. On 03/13/24 at 2:50 P.M. an interview with Regional Nurse #893 confirmed the Vancomycin on 03/11/24 and 03/12/24 was given prior to the Vancomycin trough being drawn for Resident #271. However, she stated there was not an order prior to 03/11/24 to actually draw the Vancomycin trough before the Vancomycin was given. Review of the Medscape website revealed Vancomycin trough levels were to be drawn less than or equal to 30 minutes before the next dose. 2. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE]. Diagnoses included necrotizing fasciitis, right above the knee amputation, acute kidney disease, anemia, diabetes, hypotension, benign prostatic hyperplasia, retention of urine, bacteremia, cirrhosis of the liver, pulmonary hypertension, atrial fibrillation, liver disease, hypertension, aortic ectasia, and cardiomegaly. Review of the Admission Minimum Data Set assessment dated [DATE] revealed Resident #64 had moderately impaired cognition. Review of the physician's orders from 02/13/24 through 03/13/24 revealed Resident #64 did not have an order for a prealbumin level. Review of the laboratory results from 02/13/24 through 03/13/24 revealed Resident #64 did not have a prealbumin level done. Review of the Wound Physician's notes from 02/28/24 revealed an initial wound evaluation for Resident #64. Physician #894 had orders a prealbumin level for Resident #64. On 03/13/24 at 11:43 A.M. an interview with Regional Nurse #892 confirmed the prealbumin level had not been done on 02/28/24; however, she stated the physician had canceled the order when he visited on 03/06/24. Regional Nurse #892 verified the prealbumin level should have been done prior to 03/06/24. (continued on next page)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 3:40 P.M. an interview with Physician #894 revealed he wrote the order on 02/28/24 for a prealbumin level. He stated he came back in on 03/06/24 and saw it had not been done. He stated he then found out the facility had a dietitian following Resident #64 so he canceled the order on 03/06/24. He stated he expected the prealbumin level to be done when he ordered it, he would have already had the results and would not have had to cancel the order.

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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. 44457 Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary kitchen area. This had the potential to affect all residents receiving meals from the kitchen. The facility identified two Residents(#6 and #33) who do not receive food by mouth. The facility census was 56. Findings include: Observations on 03/10/24 at 8:15 A.M. of facility kitchen revealed in the walk-in cooler there was three plastic containers with lids containing Salisbury steaks, carrots, and hard-boiled eggs without a label or date, two metal pans covered with foil containing unidentified pureed substances without a label or date and a tray of uncovered fruit cups without a label or date. There was a splatter of food residue on the wall behind coffee machine and a dried coffee spill on floor in front of coffee machine. There was dark brown grease build up on the walls and floors behind and below dish machine area. There was dark brown grease build up and food debris observed below a rack containing plastic wares in dish machine area. There was dark brown grease build up and food debris on the floor and walls behind the steamer, oven, range top, and flat top grill. Interview on 03/10/24 at 8:25 A.M. with Dietary Cook #829 confirmed findings in walk-in cooler and cleanliness of walls and floors behind and below food prepartion equipement. Review of facility policy Date Marking undated revealed any ready-to-eat food prepared and held in refrigeration shall be date marked. Review of facility policy General Food Preparation and Handling dated 2010 revealed the kitchen and its equipment would be kept clean. The policy indicated food would be kept covered for storage.