STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365048	A. Building B. Wing	09/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westlake	26520 Center Ridge Rd Westlake, OH 44145

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, review of a facility investigation, review of email documents, review of self-reported incidents (SRIs), and review of a facility policy, the facility failed to ensure residents were free from misappropriation. This affected one (#75) of four residents reviewed for misappropriation. The facility census was 95. Findings Include: Review of Resident #75's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), pneumonia and epilepsy. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #75 was cognitively intact and required one-person physical assistance for his activities of daily living. Further review of the medical record revealed Resident #75 was discharged to a nursing facility closer to his family on 07/15/24. Review of a self-reported incident dated 07/10/24 revealed, on 7/10/24, a detective visited the facility to discuss an investigation that was occurring with his agency, and reported a box of Zofran (anti-nausea medication) prescribed to Resident #75 had been found at the house of a facility staff member, Licensed Practical Nurse (LPN) #975. The detective indicated the medication was discovered during a search of LPN #975's home and was taken as evidence. The label on the medication indicated it belonged to Resident #75. The detective further informed the facility he interviewed Resident #75 and he acknowledged that it was his medication from home that was brought to the facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated facility investigation document revealed a detective came to the facility on [DATE] to investigate a box of Zofran in Resident #75's name. There medication prescription was for 30 pills, there were 28 pills in the box, and the box was enclosed in an evidence bag. The detective asked to speak to Resident #75 with facility staff present during the interview. During the interview, Resident #75 told the detective he got the medications at home via mail and when he went to the hospital, his private duty nurse packed his medications up and sent them to the hospital with the resident. When Resident #75 arrived to the facility from the hospital the box of medication also came to the facility and was placed in the medication room. Further review of the investigation document revealed Resident #75 was admitted to the facility around shift change and the admitting nurse remember the resident coming with bottles of medications and also came with narcotic medications which were inventoried and then destroyed due to new orders. The next nurse completed the rest of Resident #75's admission, and that nurse was LPN #975. Review of an email document from LPN #975 dated 07/12/24 at 1:13 A.M. revealed LPN #975 confessed to taking Resident #75's Zofran from the facility to use for personal use with intension to return it to the facility. Interview with the Administrator on 09/14/24 at 11:11 A.M. confirmed a detective came to the facility to investigate LPN #975 being in possession of Resident #75's Zofran and, through investigation, it was verified the medication was taken from the facility by LPN #975. Review of the policy titled, Abuse-Identification Types, dated 7/18/23, revealed the resident has the right to be free from abuse, neglect, and misappropriation of resident property This deficiency represents non-compliance investigated under Complaint Number OH00156875.