| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365048 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Westlake | 26520 Center Ridge Rd<br>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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>(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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interviews, Self-Reported Incident (SRI) review, and facility policy review, the facility failed to implement policy and procedure for an allegation of verbal abuse. This affected one resident (#20) of three residents reviewed for verbal abuse. The facility census was 99.Findings include: Review of the medical record for Resident #20 revealed she was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of endometrium, malignant neoplasm of cerebral meninges, and dementia.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was alert and oriented to person, place and time and was modified independent for tasks regarding daily life. Review of the care plan dated 12/03/25 revealed Resident #20 had a behavior problem related to refusal of care and medications and was accusatory toward staff. Interventions included, but was not limited to, allowing Resident #20 to verbalize her needs, two staff present for all care, and observing for behavior episodes while attempting to determine the underlying cause considering location, time of day, persons involved, and situations. Interview on 12/09/25 at 2:45 P.M. with Resident #20 revealed she was not treated with respect and dignity during her stay at the facility. There were Certified Nursing Assistants (CNAs) that were vicious towards her and used profanity when speaking to her or when providing care. The CNAs involved typically worked the night shift, but she did not want to say their names as she was worried they would find out. Resident #20 described the CNAs involved as being African American women of average size and worked on nights. Resident #20 also revealed she had reported it to staff before with no resolution. Interview on 12/10/25 at 9:04 A.M. with CNA #445 revealed Resident #20 had informed her that staff were rude to her and not treating her right. Resident #20 also stated it was during the second and third shifts that staff would treat her rudely and make her uncomfortable. CNA #445 did not recall the day or time but did inform the nurse at the time Resident #20 informed her.Interview on 12/10/25 at 9:29 A.M. with CNA #409 revealed Resident #20 had reported to her that staff were being rude and using profanity towards her, usually on the night shift. Resident #20 did not feel comfortable saying the actual names of staff. CNA #409 stated she immediately reported it to the nurse at the time.Interview on 12/10/25 at 12:09 P.M. with Licensed Practical Nurse (LPN) #312 revealed Resident #20 informed her that staff were rude and short with her. LPN #312 stated she reported it to the Administrator.Interview on 12/10/25 at 11:44 A.M. with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #329 revealed all staff were educated and in-serviced regarding the abuse policies and protocols. The Administrator stated once an allegation of abuse was reported, the alleged perpetrator was suspended pending investigation, an SRI was initiated and an investigation was started. The Administrator, DON, and ADON #329 revealed they were unaware of any allegations of abuse regarding Resident #20 however, they were aware that Resident #20 claimed abuse at a previous facility. ADON #329 questioned about what administrative staff were informed of the alleged abuse due to not being aware of the allegation, however, confirmed and verified regardless of what staff were informed, all allegations of abuse should be reported and investigated.Interview on 12/10/25 at 2:33 P.M. with Social Worker Case Manager (SWCM) #459 revealed Resident #20 had been admitted to the hospital and subsequently readmitted to the facility. During her hospital stay, Resident #20 informed SWCM #459 that she was being verbally abused in the facility and it had been occurring daily. SWCM #459 stated Resident #20 did not want to reveal the names of facility staff who she identified as CNAs. SWCM #459 contacted the facility on 10/27/25 and informed them of the alleged verbal abuse to ensure they completed their own thorough investigation. SWCM #459 also revealed he informed the facility's Hospital Liaison (HL), HL #460, about Resident #20's allegation of verbal abuse.Interview on 12/11/25 at 10:37 A.M. with HL #460 revealed he visited various local hospitals to speak with case managers regarding facility residents' plans for either discharge or to return to the facility. HL #460 spoke to SWCM #459 regarding Resident #20's stay at the facility and financial liability concerns. HL #460 recalled speaking mostly in regard to Resident #20 returning to the facility and there was a possibility SWCM #459 could have mentioned Resident #20's allegation of verbal abuse. HL #460 revealed being customer service focused during the encounter with SWCM #459 and could have overheard the information. HL #460 stated being aware of the abuse policies and protocols and could not confirm or deny he was informed of Resident #20's allegation of verbal abuse.Review of the Ohio Department of Health (ODH) certification and licensure webpage for reporting abuse, neglect, and/or misappropriation, revealed no SRIs related to an allegation of verbal abuse |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interviews, Self-Reported Incident (SRI) review, and facility policy review, the facility failed to report an allegation of verbal abuse. This affected one resident (#20) of three residents reviewed for verbal abuse. The facility census was 99.Findings include:Review of the medical record for Resident #20 revealed she was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of endometrium, malignant neoplasm of cerebral meninges, and dementia.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was alert and oriented to person, place and time and was modified independent for tasks regarding daily life.Review of the care plan dated 12/03/25 revealed Resident #20 had a behavior problem related to refusal of care and medications and was accusatory toward staff. Interventions included, but was not limited to, allowing Resident #20 to verbalize her needs, two staff present for all care, and observing for behavior episodes while attempting to determine the underlying cause considering location, time of day, persons involved, and situations. Interview on 12/09/25 at 2:45 P.M. with Resident #20 revealed she was not treated with respect and dignity during her stay at the facility. There were Certified Nursing Assistants (CNAs) that were vicious towards her and used profanity when speaking to her or when providing care. The CNAs involved typically worked the night shift, but she did not want to say their names as she was worried they would find out. Resident #20 described the CNAs involved as being African American women of average size and worked on nights. Resident #20 also revealed she had reported it to staff before with no resolution.Interview on 12/10/25 at 9:04 A.M. with CNA #445 revealed Resident #20 had informed her that staff were rude to her and not treating her right. Resident #20 also stated it was during the second and third shifts that staff would treat her rudely and make her uncomfortable. CNA #445 did not recall the day or time but did inform the nurse at the time Resident #20 informed her. CNA #445 confirmed she was aware of the abuse policies and protocols. Interview on 12/10/25 at 9:29 A.M. with CNA #409 revealed Resident #20 had reported to her that staff were being rude and using profanity towards her, usually on the night shift. Resident #20 did not feel comfortable saying the actual names of staff. CNA #409 stated she immediately reported it to the nurse at the time. CNA #409 confirmed she was aware of the abuse policies and protocols. Interview on 12/10/25 at 12:09 P.M. with Licensed Practical Nurse (LPN) #312 revealed Resident #20 informed her that staff were rude and short with her. LPN #312 stated she reported it to the Administrator. LPN #312 confirmed she was aware of the abuse policies and protocols. Interview on 12/10/25 at 11:44 A.M. with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #329 revealed all staff were educated and in-serviced regarding the abuse policies and protocols. The Administrator stated once an allegation of abuse was reported, the alleged perpetrator was suspended pending investigation, an SRI was initiated and an investigation was started. The Administrator, DON, and ADON #329 revealed they were unaware of any allegations of abuse regarding Resident #20 however, they were aware that Resident #20 claimed abuse at a previous facility. ADON #329 questioned about what administrative staff were informed of the alleged abuse due to not being aware of the allegation, however, confirmed and verified regardless of what staff were informed, all allegations of abuse should be reported and investigated.Interview on 12/10/25 at 2:33 P.M. with Social Worker Case Manager (SWCM) #459 revealed Resident #20 had been admitted to the hospital and subsequently readmitted to the facility. During her hospital stay, Resident #20 informed SWCM #459 that she was being verbally abused in the facility and it had been occurring daily. 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HL #460 revealed being customer service focused during the encounter with SWCM #459 and could have overheard the information. HL #460 stated being aware of the abuse policies and protocols and could not confirm or deny he was informed of Resident #20's allegation of verbal abuse.Review of the Ohio Department of Health |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interviews, Self-Reported Incident (SRI) review, and facility policy review, the facility failed to respond appropriately to an allegation of verbal abuse. This affected one resident (#20) of three residents reviewed for verbal abuse. The facility census was 99.Findings include:Review of the medical record for Resident #20 revealed she was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of endometrium, malignant neoplasm of cerebral meninges, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was alert and oriented to person, place and time and was modified independent for tasks regarding daily life. 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Interview on 12/10/25 at 12:09 P.M. with Licensed Practical Nurse (LPN) #312 revealed Resident #20 informed her that staff were rude and short with her. LPN #312 stated she reported it to the Administrator. LPN #312 confirmed she was aware of the abuse policies and protocols. Interview on 12/10/25 at 11:44 A.M. with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #329 revealed all staff were educated and in-serviced regarding the abuse policies and protocols. The Administrator stated once an allegation of abuse was reported, the alleged perpetrator was suspended pending investigation, an SRI was initiated and an investigation was started. The Administrator, DON, and ADON #329 revealed they were unaware of any allegations of abuse regarding Resident #20 however, they were aware that Resident #20 claimed abuse at a previous facility. ADON #329 questioned about what administrative staff were informed of the alleged abuse due to not being aware of the allegation, however, confirmed and verified regardless of what staff were informed, all allegations of abuse should be reported and investigated. Interview on 12/10/25 at 2:33 P.M. with Social Worker Case Manager (SWCM) #459 revealed Resident #20 had been admitted to the hospital and subsequently readmitted to the facility. During her hospital stay, Resident #20 informed SWCM #459 that she was being verbally abused in the facility and it had been occurring daily. SWCM #459 stated Resident #20 did not want to reveal the names of facility staff who she identified as CNAs. SWCM #459 contacted the facility on 10/27/25 and informed them of the alleged verbal abuse to ensure they completed their own thorough investigation. SWCM #459 also revealed he informed the facility's Hospital Liaison (HL), HL #460, about Resident #20's allegation of verbal abuse. Interview on 12/11/25 at 10:37 A.M. with HL #460 revealed he visited various local hospitals to speak with case managers regarding facility residents' plans for either discharge or to return to the facility. HL #460 spoke to SWCM #459 regarding Resident #20's stay at the facility and financial liability concerns. HL #460 recalled speaking mostly in regard to Resident #20 returning to the facility and there was a possibility SWCM #459 could have mentioned Resident #20's allegation of verbal abuse. HL #460 revealed being customer service focused during the encounter with SWCM #459 and could have overheard the information. HL #460 stated being aware of the abuse policies and protocols and could not confirm or deny he was informed of Resident #20's |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of employee personnel files, staff interviews, and facility policy review, the facility failed to ensure three of five sampled staff members were certified in Cardio-Pulmonary Resuscitation (CPR). This had the potential to affect all residents residing in the facility. The facility census was 99.Findings include: 1. Review of the personnel file for Certified Nursing Assistant (CNA) #445 revealed she was hired on [DATE]. CNA #445 had no current CPR certification.Interview on [DATE] at 3:20 P.M. with CNA #445 revealed she was not currently certified in CPR. CNA #445's CPR certification expired in [DATE].2. Review of the personnel file for Registered Nurse (RN) #301 revealed she was hired on [DATE]. RN #301 had no current CPR certification. Interview on [DATE] at 3:25 P.M. with RN #301 revealed she was not currently certified in CPR. RN #301's CPR certification expired in [DATE].3. Review of the personnel file for Licensed Practical Nurse (LPN) #312 revealed she was hired on [DATE]. LPN #312 had no current CPR certification.Interview on [DATE] at 3:30 P. M. with the Director of Nursing (DON) verified CNA #445, RN #301 and LPN #312 were not currently certified in CPR. The DON revealed she was aware CNA #445's CPR certification expired in [DATE] and RN #301's CPR certification expired in [DATE]. The DON stated she was not aware of the date of expiration for LPN #312. The DON confirmed CNA #445, LPN #312, and RN #301 were all still currently on the schedule and actively working shifts throughout the facility. Review of the facility policy titled, Cardiopulmonary Resuscitation (CPR) Policy, revised [DATE] revealed the facility would ensure staff would be properly trained and/or certified in CPR to be able to provide CPR until emergency medical services arrived, and staff were to maintain current CPR certification. This deficiency represents non-compliance investigated under Complaint Number 1369332 (OH00164444). |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>Based on review of employee personnel files and staff interviews, the facility failed to ensure two of five staff members received annual performance reviews. This had the potential to affect all residents residing in the facility. The facility census was 99.Findings include: 1. Review of the personnel file for Certified Nursing Assistant (CNA) #445 revealed she was hired on 09/24/20. CNA #445 did not have a current annual performance review in place.Interview on 12/11/25 at 3:20 P.M. with CNA #445 revealed she did not have a current annual review completed.2. Review of the personnel file for CNA #331 revealed she was hired on 06/24/11. CNA #331 did not have a current annual performance review in place.Interview on 12/11/25 at 3:30 P.M. with the Director of Nursing (DON) confirmed CNAs #331 and #445 did not have annual performance reviews in place. The DON verified both CNAs were still currently on the schedule and actively working shifts throughout the facility. After evidence of annual performance reviews was requested, the DON stated that CNA #445 was currently actively participating in her annual review at the time of the interview and CNA #331 would receive her annual review soon. This deficiency represents non-compliance investigated under Complaint Number 1369332 (OH00164444). |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, record review, and interview, the facility failed to administer medications according to physician orders and manufacturer instructions. This affected two residents (#16 and #21) out of three residents reviewed for medication administration. The facility census was 99.Findings include:1. Observation of a medication administration pass for Resident #16 on 12/09/25 at 10:00 A.M. by Registered Nurse (RN) #301 revealed the nurse drew one pill out of a digoxin 125 microgram (mcg) container which had attached pharmacist instructions to hold the medication if the heart rate was under 60 beats per minute (BPM). The nurse administered the medication without checking the resident's heart rate.Record review of Resident #16 revealed an order dated 11/27/25 for 125 mcg of digoxin to be given daily for heart failure, and to hold the dose for a heart rate under 60 BPM.Interview on 12/09/25 at 10:08 A.M. with RN #301 confirmed the above findings, and verified Resident #16's heart rate was not checked prior to medication administration. Observation at the time of the interview revealed the nurse assessed the resident's heart rate and found it to be above 60 BPM.2. Observation of a medication administration pass for Resident #21 on 12/09/25 at 10:13 A.M. by RN #301 revealed the nurse drew a Dulera inhaler (a combination medication typically used for asthma treatment) from the medication cart and stated the resident was to receive two actuations (puffs). The nurse brought the inhaler in for Resident #21 (who was sitting at their bedside), set the inhaler down on the tray table, and entered the bathroom to wash her hands. While the nurse washed her hands, Resident #21 picked up the inhaler, put the mouthpiece between their lips, pushed the actuator twice rapidly, then took a sharp breath and exhaled without holding their breath. RN #301 returned from the bathroom after the resident finished administering the inhaler and then continued with her medication administration pass. Neither the resident nor the nurse shook the inhaler before use, and the resident did not rinse and spit after using the inhaler. Record review of Resident #21 revealed an order dated 07/01/25 for two puffs of Dulera inhalation to be given twice per day.Review of the manufacturer's patient information form for Dulera dated June 2025 revealed users should shake the inhaler before use, wait 30 seconds between puffs, inhale slowly with each puff and hold the breath for ten seconds, and rinse the mouth after use.Interview on 12/09/25 at 12:41 P.M. with RN #301 confirmed the above findings.Review of the medication administration policy dated 04/01/22 revealed inhalers were to be shaken before use. After one puff, the user was to wait either one minute or according to manufacturer instructions before taking another.The above findings identified two medication errors out of 33 medication administrations observed, creating a total error rate of 6.1%.This deficiency represents noncompliance investigated under Complaint Number 2562490. |