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	02/26/2026

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 0689 Level of Harm - Minimal harm or potential for 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 record review, interview and facility policy review, the facility failed to ensure fall interventions were in place and failed to ensure a thorough fall investigation was conducted for Resident #15. This affected one (Resident #15) of three residents reviewed for accidents. The facility census was 100.Findings include: Review of the medical record for Resident #15 revealed an admission date of 02/12/25. Diagnoses included vascular dementia, anxiety, osteoarthritis of right shoulder, congestive heart failure, contracture of right hand, dysphagia and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had impaired cognition. The resident was dependent on staff for bed mobility, transfers, and ambulation. Review of the plan of care dated 01/02/26 revealed Resident #15 was at risk for falls due to dementia with cognitive deficits, anxiety and depression with behaviors and a history of falls. Interventions included nonskid socks at all times, a low bed for safety, bed against the wall, and a fall mat to the floor next to the bed.Review of the fall risk assessment dated [DATE] revealed Resident #15 was at a high risk for falls.Review of physician orders for February 2026 identified orders for a mat to the left side of the bed, bilateral gab bars, and Resident #15 was to be assisted out of bed early in the morning.Review of the nurse's notes dated 02/13/26 at 10:38 P.M. Registered Nurse (RN) #347 entered Resident #15's room to administer evening medications and heard screaming. (Resident #90, who has cognitive impairment who wanders throughout the unit, in and out of other resident's rooms and plays with bed remotes, was in Resident #15's room at the time RN #347 entered the room). Resident #15 was observed lying on the floor in a pool of blood actively bleeding from the right side of her forehead and nose. The resident was assessed, and Emergency Medical Services (EMS) was called. The Director of Nursing (DON), physician and family were notified. The progress note did not state Resident #90 was found in Resident #15's room. (Per interview below with RN #347, Resident #90, who has cognitive impairment who wanders throughout the unit, in and out of other resident's rooms and plays with bed remotes, was in Resident #15's room at the time RN #347 entered the room. Resident #90 was care planned for frequent wandering into other residents' rooms and was combative with redirection).Review of the fall investigation dated 02/13/26 revealed witness statements from the DON and Certified Nursing Assistant (CNA) #252. There were no witness statements from CNA # 280, RN #347 or CNA #285, who were also working at the time of the incident. The risk report listed predisposing environmental factors as other. The risk report stated to describe other. There was no documentation of the other predisposing factors. There was no documentation to indicate if the fall mat was in place. There was no documentation that Resident #90 was found in Resident #15's room at the time of the fall and/or that Resident #90 was care planned for frequent wandering into other residents' rooms and was combative with redirection.Interview on 02/23/26 at 6:34 A.M. RN #349 started on 02/13/26 at 6:45 P.M. and she and CNA #252 put Resident #15 to bed. The bed was in the lowest position with one bolster on the left side due to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Westlake		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 having an order for the bed to be against the wall when they left the room. After 7:00 P.M. she heard a scream, and she and CNA #280 entered the room and found the bed in a medium position. CNA #252 got towels and applied pressure, and EMS was called. RN #349 stated Resident #90 was in Resident #15's room at the time of the incident, and she plays with bed remotes and was particular to this room. RN #349 stated she did not write out a witness statement due to the progress note being her statement.Interview with the DON on 02/25/26 at 3:32 P.M. verified there was an order for mat to floor, and it was not in place at the time of Resident #15's fall. The DON also verified the fall investigation lacked information including predisposing factors and did not contain all witness statements from all staff on the unit.Review of the facility policy titled Fall Management, dated 06/04/20, revealed avoidable accident include implantation of interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current standard of practice in order to eliminate the risk or reduce the risk of an accident.This deficiency represents non-compliance investigated under Master Complaint Number 2787463 and Complaint Number 274652.

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	365048	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate documentation related to behaviors in Resident #90's medical record This affected one (Resident #90) of three residents reviewed for accuracy of documentation related to behaviors. The facility census was 100.Findings include:Review of the medical record for Resident #90 revealed an admission date of 10/07/22. Diagnoses included Alzheimer's, wandering, anxiety, type II diabetes, and depression.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had impaired cognition. The resident was independent for ambulation and required assistance for toilet and shower transfers. Resident #90 had inattention and disorganized thinking behavior that was continuously present and did not fluctuate. Additional behaviors included physical, verbal, wandering, and behaviors directed towards others hitting or scratching, and rummaging.Review of the plan of care for Resident #90 dated 01/22/26 revealed the resident had behavior problems related to frequent wandering into other residents' rooms and was combative with redirection. Interventions included intervene as necessary to protect the rights and safety of others. Document interventions and provide sensory items and domestic chores as needed.Review of the progress notes for Resident #90 dated from 01/23/26 through 2/20/26 revealed no behavior notes stating Resident #90 was found in Resident #15's room playing with Resident#15's bed remote and/or bed bolster. (Staff alleged that Resident #90 was in Resident #15's room playing with Resident #15's bed remote and bed bolster on 02/13/26 at the time of Resident #15's fall).Review of the behavior tracking task for Resident #90 from 01/23/26 through 02/23/26 revealed there was no documentation of behaviors on 02/13/26. Review of the Interdisciplinary Team (IDT) summary note for Resident #15 dated 02/16/26 revealed the Resident #15 was found on the floor bleeding and yelling out. The certified nursing assistant (CNA) and nurse report that they had recently assisted Resident #15 to bed and positioned her according to her plan of care (low bed, bed against wall and bolster to the open side of the bed). The bed was in a low position. After re-entering room, Resident #15's bed was found in a different position than previously set and there was another resident (Resident #90) found in the room.Interview with the Director of Nursing (DON) on 02/25/26 at 3:32 P.M. stated the nurses do behavior tracking in the progress notes and CNA's document behaviors under task tab of the electronic medical record. The DON verified there was no behavior note in Resident #90's medical record for 02/13/25 stating she was in Resident #15's room playing with her bed remote or bed bolster at the time of Resident #15's accident as alleged.The deficiency represents non-compliance investigated under Complaint Number 2746452.