STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365305	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willoughby Post Acute	37603 Euclid Ave Willoughby, OH 44094

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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the medical record, Employee Counseling Form review and review of the facility policy, the facility did not ensure fall interventions were implemented including proper staff assistance with bed mobility and toileting per the Kardex (summary of resident's information for reference) and the care plan. This affected one (Resident #12) out of three residents reviewed for falls. The facility census was 136. Findings include: Review of the medical record for Resident #12 revealed an admission date of 06/27/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, congestive heart failure, chronic obstructive pulmonary disease, aphasic (a language disorder affecting resident's ability to communicate), and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition and had impairment on one side to her upper and lower extremities. She was dependent on staff for most of her activities of daily living (ADL) including toileting hygiene and rolling left and right in bed. She was frequently incontinent of urine and always incontinent of bowel. Review of the care plan dated 05/21/25 revealed Resident #12 had bladder and bowel incontinence. Interventions included provide incontinence care on rounds and upon request. Review of the care plan dated 05/21/25 revealed Resident #12 had actual ADL decline and required staff assistance related to hemiplegia, anxiety, weakness and aphasia. Interventions included Resident #12 was totally dependent of two staff for bed mobility and toileting and she utilized a mechanical lift (a device designed to safely transfer a resident) for transfers. Review of the care plan dated 06/27/25 revealed Resident #12 was at risk for falls. Interventions included assistance with transfers, locomotion and mobility, do not leave resident in sitting position in bed, low bed, perimeter mattress, and staff education was provided on 07/28/25. Review of the nursing note dated 07/25/25 at 8:43 P.M. and completed by Registered Nurse (RN) #601 revealed Resident #12 was assessed for injuries, and she complained of right shoulder and jaw pain. Resident #12 and Certified Nursing Assistant (CNA) #611 stated she hit her head. The note revealed the Primary Care Physician (PCP) #900 and hospice were notified and ordered to send the resident to the emergency room (ER) for further evaluation. Review of the nursing note dated 07/26/25 at 12:40 A.M. and completed by RN #601 revealed Resident #12 rolled out of bed during patient care and hit her head. Review of the witness statement dated 07/26/25 that was taken by RN #601 from CNA #611 revealed, I was providing patient care when resident (Resident #12) rolled out of bed on the opposite side of the bed. The statement also revealed Resident #12 hit her head during the fall and CNA #611 yelled for help, and staff came to assist. Review of nursing note dated 07/26/25 at 4:17 A.M. and completed by RN #617 revealed Resident #12 returned from the ER with no injuries, including no fractures. Her vital signs were stable, and she was monitored at frequent intervals. Review of the Interdisciplinary Team (IDT) progress note dated 07/28/25 and completed by Licensed Practical Nurse (LPN)/ Unit Manager #610 revealed on 07/25/25 at approximately 8:00 P.M. Resident #12 had fallen out of bed during patient care. She was assessed and complained of right shoulder and jaw pain. The note revealed that staff stated she hit her head. PCP #900 was notified and ordered Resident #12 to go to the ER for further evaluation. The note revealed the fall intervention included that staff (CNA #611) was educated. Review of the Employee Counseling Form dated 07/28/25 revealed CNA #611 received a disciplinary action form from the Director of Nursing (DON) as he failed to follow a resident's care plan and Kardex resulting in a fall. CNA #611 was re-educated on use of Kardex and would follow the Kardex to ensure resident safety. Review of the Kardex as of 07/30/25 revealed Resident #12 was to be offered toileting on rounds and upon request and provided incontinence care on rounds and upon request. The Kardex revealed Resident #12 required total dependence of two staff for bed mobility and toileting. Observation on 07/30/25 at 3:17 P.M. revealed CNA #607 walked into Resident #12's room to provide incontinence care. She proceeded to don gloves, pulled back the sheet and rolled Resident #12 over towards the window. CNA #12 provided incontinence care and then rolled her back until she was lying flat on her back. Interview on 07/30/25 at 3:25 P.M. with CNA #607 verified she had turned Resident #12 and provided incontinence care by herself. She revealed she always completed Resident #12's care, including bed mobility and toileting hygiene, by herself. Interview on 07/30/25 at 3:31 P.M. and 3:45 P.M. with LPN/ Unit Manager #610 revealed on 07/25/25 at approximately 8:00 P.M. CNA #611 was providing incontinence care and rolled Resident #12 away from him towards the window resulting in Resident #12 falling out of bed onto the floor hitting her head. She revealed RN #601 assessed Resident #12 and she had

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, review of manufacture guidelines and facility policy review, the facility failed to ensure residents were free from significant medication error. This affected two (Residents #133, and #137) out of seven residents observed and/or reviewed for medication administration. The facility census was 136. Findings include: 1. Review of the closed medical record for Resident #137 revealed an admission date of 06/28/25, and he was discharged home on [DATE]. His diagnoses included motor-vehicle accident with multiple fractures, diabetes and hypertension. Review of the After Visit Summary revealed on 06/28/25 Resident #137 was discharged from the hospital to the facility with the following medication orders: lispro insulin 100 units per milliliter (ml) inject zero to ten units subcutaneously (SQ) three times a day before meals as directed per insulin instructions. The last dose given at the hospital per the discharge instructions was on 06/28/25 at 1:24 P.M. The orders also included Lantus insulin 100 units per ml inject 10 units SQ once daily at bedtime. The last dose was given at the hospital on [DATE] at 9:15 P.M. Review of the nursing note dated 06/28/25 at 11:36 P.M. and completed by Licensed Practical Nurse (LPN) #606 revealed Resident #137 was admitted at approximately 6:30 P.M. He had an allergy to penicillin and had multiple fractures including to his bilateral femurs and nasal bone. Vital signs were obtained, but there was no documentation a blood sugar was taken. There was no documentation regarding Resident #137's insulin and that the orders were verified with Primary Care Physician (PCP) #900. Review of the blood sugars from admission on [DATE] to discharge on [DATE] revealed the first blood sugar documented for Resident #137 was on 06/30/25 at 9:29 A.M., and it was 165. Review of Nurse Practitioner (NP) #901's progress note dated 06/30/25 at 12:13 P.M. revealed Resident #137 had a diagnosis of diabetes, and she ordered lispro insulin before meals SQ per sliding scale and Lantus 10 units SQ at night. Review of Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #137 had intact cognition, and he received insulin. Interview on 07/30/25 at 1:55 A.M. with the Director of Nursing (DON) verified per the After Visit Summary from the hospital Resident #137 was to be on lispro insulin 100 units per ml inject zero to ten units SQ three times a day before meals as directed per insulin instructions and Lantus insulin 100 units per ml inject 10 units SQ once daily at bedtime. She verified these orders were not transcribed, and there was no documentation in the medical record that PCP #900 was contacted upon Resident #137's admission and verified there was no documentation stating Resident #137's insulin was discontinued. She verified the first documentation Resident #137's blood sugar was checked was on 06/30/25 at 9:29 A.M. and he had not received insulin until 06/30/25 (two days after he was admitted). Interview on 07/30/24 at 2:08 P.M. and 3:58 P.M. with LPN #606 revealed she did not remember anything regarding Resident #137's admission including if she contacted PCP #900 to verify Resident 137's admission orders, and/or anything regarding his insulin orders from the hospital including what was on the After Visit Summary. LPN #606 revealed she did not know why Resident #137's insulin orders were not transcribed on admission. She revealed she did not remember day to day as she went from unit to unit. She revealed if it was not documented that she contacted PCP #900 then she probably did not. 2. Review of the medical record for Resident #133 revealed an admission date of 08/03/23 with diagnoses including dementia, diabetes, and hypertension. Review of the July 2025 physician orders revealed Resident #133 had an order for metoprolol succinate extended release (ER) give 25 milligram (mg) tablet one time a day for hypertension. There was no physician order to crush her medication. Review of the annual MDS assessment dated [DATE] revealed Resident #133 had impaired cognition. Observation on 07/30/25 at 8:35 A.M. revealed LPN #600 crushed Resident #133's medications including the Metoprolol Extended Release (ER) 25 mg. The only medication she did not crush was her ferrous sulfate which she placed whole in applesauce. She then placed the crushed medications in the applesauce and administered them to Resident #133 at 8:41 A.M. Interview on 07/30/25 at 8:43 A.M. with LPN #600 verified she had crushed Resident #133's metoprolol ER and that it was ER, and there was no order to crush it. She also verified there was nothing in the medical record that the physician had approved Resident #133's metoprolol ER to be crushed. Review of the Federal Drug Administration package insert labeled, Metoprolol Succinate Extended- Release Tablets, dated December 2007, revealed Metoprolol succinate ER were intended for daily administration for the treatment of hypertension and angina (chest pain). Metoprolol succinate ER tablets were scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed. Review of the facility policy labeled, Crushing

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical record and review of facility policy revealed the facility did ensure proper infection control during incontinence care. This affected one Resident (#12) out of five residents reviewed for incontinence care. This had the potential to affect 70 residents (#1, #2, #4, #7. #9, #10, #12, #13, #15, #19, #20, #22, #25, #27, #29, #30, #31, #33, #37, #38, #39, #40, #41, #45, #46, #47, #48, #53, #54, #56, #57, #58, #60, #61, #62, #71, #57, #77, #80, #81, #83, #84, #89, #90, #91, #93, #95, #96, #97, #98, #100, #101, #102, #104, #106, #107, #111, #112, #114, #115, #116, #119, #122, #124, #129, #131, #132, #133, #134, and #125) identified by the facility as incontinent.Review of the medical record for Resident #12 revealed an admission date of 06/27/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, congestive heart failure, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition and was dependent on staff for most of her activities of daily living (ADL) including toileting hygiene and rolling left and right in bed. She was frequently incontinent of urine and always incontinent of bowel. Review of the care plan dated 05/21/25 revealed Resident #12 had bladder and bowel incontinence. Interventions included observing for changes in skin integrity and providing incontinence care on rounds and upon request. There was nothing in the care plan regarding staff applying two incontinence briefs at once. Review of the Kardex as of 07/30/25 revealed Resident #12 was to be offered toileting on rounds and upon request and provided incontinence care on rounds and upon request. There was nothing in the Kardex regarding Resident #12 wearing two incontinence briefs. Observation on 07/30/25 at 3:17 P.M. revealed Certified Nursing Assistant (CNA) #607 walked into Resident #12's room to provide incontinence care. CNA #607 revealed she had changed Resident #12 before lunch. She proceeded to don gloves, take one towel and place the towel under the faucet, wetting both ends of the towel. She did not apply soap to the towel. She then pulled back the sheet, and Resident #12 was wearing two white incontinence briefs. The first brief was moderately saturated in urine. CNA #607 denied applying two incontinent briefs when she changed her before lunch but was unable to identify who else would have changed her. CNA #607 proceeded to roll Resident #12 over towards the window and removed both incontinence briefs. She then proceeded to use one end of the towel and cleansed her buttock region which had a small amount of bowel movement. Resident #12 continued to smear bowel movement as CNA #607 wiped; therefore, CNA #607 continued to wipe with the same end of the towel. CNA #607 then, without drying Resident #12's buttocks, proceeded to apply barrier cream with her gloved hand to her buttock and rolled her back until she was lying flat on her back. CNA #607 then proceeded with the same gloved hands to take the same towel but the other end of the towel and wiped the front of her perineal area using three swipes in an upward motion. The other side of the towel that had the smears of bowel movement on it was lying on Resident #12's bilateral thighs. After she wiped the front of her perineal area, she proceeded to take her hand and in a fanning type motion went back and forth in a motion as if she was trying to air dry the area for a few seconds. She then proceeded to take barrier cream and apply to the front of her perineal area, closed her incontinent brief and proceeded to cover her up. She then proceeded to remove her gloves and perform hand hygiene. Interview on 07/30/25 at 3:25 P.M. with CNA #607 verified she used one towel to perform perineal care for Resident #12. CNA #607 was asked why she did not use soap, and she stated, I did. (This was not observed as it was only observed that she stuck the towel under the faucet to wet both ends). She verified she wet both ends of the towel. She was asked how she washed, rinsed and dried if she used the same end of the towel but CNA #607 just looked at the surveyor and did not respond. She later stated, I flipped the towel but would not provide any other details. She verified that she had cleansed her buttock first that had bowel movement then proceeded to clean the front of her perineal area with the same gloved hands. She also verified she had applied barrier cream to her buttocks and then with the same gloved hands proceeded to clean the front of her perineal area and apply barrier cream. Interview on 07/30/25 at 3:31 P.M. and 3:45 P.M. with Licensed Practical Nurse (LPN)/ Unit Manager #610 verified Resident #12 was not to have two incontinence briefs on and to her knowledge CNA #607 was the aide assigned to her so would have been the one that most likely put the two briefs on as she could not think of anyone else who would of changed her. She also verified during perineal care that CNA #607 should not have used only one towel to provide incontinence care as she should have first started with the front and provided perineal care including washing, rinsing and drying with different washcloths and/or

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility policy review, the facility did not ensure the carpeting in the hallways of all units was maintained in a clean manner. This had the potential to affect all 136 residents residing in the facility. Findings include: Observation on 07/30/25 from 8:23 A.M. to 9:23 A.M. revealed the carpeting in the hallways of all units were discolored and contained multiple black, brown stains throughout. Interview on 07/31/25 at 9:13 A.M. with Environmental Service Manager #613 revealed she was aware there were multiple stains on the carpeting on all the units. She revealed the facility had a floor technician who cleaned the carpeting routinely, but the carpeting was old, and the stains did not come up even after cleaned. She stated, the carpeting needs to be replaced. She revealed she was unsure if there were any quotes on getting the carpeting replaced or where the facility was at regarding replacing the carpeting. Environmental tour on 07/31/25 from 9:30 A.M. to 9:44 A.M. with Environmental Service Manager #613 and Administrator verified the following findings: A. Med Ridge unit revealed the carpeting near the double doors had approximately two large three feet by four feet black oblong stains. B. Entrance by the door of room [ROOM NUMBER] revealed the carpeting had a large black- brown stain approximately three feet by four feet. C. In front of room [ROOM NUMBER] it was revealed the carpeting had a black stain approximately six feet by four feet and another stain approximately three feet by three feet next to the other stain. D. In front of room [ROOM NUMBER] it was revealed the carpeting had a large brown stain circular in nature approximately three feet by three feet. E. Entrance by the doors of rooms [ROOM NUMBERS] revealed the carpeting contained large black, brown stains. F. Arcadia unit lounge area revealed the carpeting had multiple stains. G. Willow unit outside of elevator revealed the carpeting had dark, brown stains extending in front of both elevators. H. In front of room [ROOM NUMBER] the carpeting had a medium brown circular stain in the center of rug I. Near the double doors on Willow unit revealed the carpeting had approximately five feet by four feet black discolored stain. J. Entrance into the soiled utility, and stair well door entrance on Willow unit revealed the carpeting had large black discolorations K. Entrance by rooms [ROOM NUMBERS] revealed the carpeting had large black discolorations. L. Lakeside unit revealed the carpeting had black discolorations throughout the hallway of unit including the entry to the soiled utility room. M. Entrance by rooms 218, 219, 220, 221, 222, and 223 revealed there were large black discolorations on the carpeting. N. Courtside unit revealed the carpeting had discolorations throughout the hallway including outside the dining room had darker black stains. O. Entrance by rooms [ROOM NUMBER] revealed the carpeting had large black discolorations. P. Ridge unit carpeting contained black stains throughout the hallway including outside of the recreational therapy door entrance, and rooms 209, 210, 214, and 217. Interview with Administrator on 07/31/25 from 9:30 A.M. to 9:44 A.M. verified the above findings and revealed the carpeting does need replaced, and she was going to work on getting quotes. She verified she had not obtained any quotes currently nor did the facility have any active plans in process to replace the carpeting. Review of the facility policy labeled, Homelike Environment, dated 2001, revealed residents were to be provided safe, clean, comfortable and homelike environment. The facility staff and management maximize to the extent as possible a clean, sanitary and orderly environment. This deficiency represents non-compliance investigated under Complaint Number OH001276910 (OH00165788).