STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365381	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wickliffe Country Place	1919 Bishop Rd Wickliffe, OH 44092

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 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 facility staff and pharmacy staff interview, medical record review, review of Self- Reported Incident (SRI) #264042 and facility policy review the facility failed to thoroughly investigate a missing controlled medication for one resident. This affected one (#181) of one resident reviewed for misappropriation of medications. The facility census was 114. Findings include: Record review for Resident #181 revealed an admission date of 06/04/25 and a discharge date of 09/03/25. Diagnoses included bipolar disorder and schizoaffective disorder. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #181 was cognitively intact. Resident #181 had little interest or pleasure in doing things and was feeling down, depressed or hopeless. Resident #181 used a wheelchair for mobility and was independent for eating and personal hygiene. Resident #181 had non-traumatic brain dysfunction, bipolar disorder and schizophrenia. Review of the physician order for Resident #181 dated 07/19/25 revealed an order for clonazepam (classified as a Schedule IV prescription benzodiazepine) oral table disintegrating 0.25 milligrams (mg), give one tablet by mouth two times a day for bipolar disorder. The scheduled times to be administered were morning and evening. Review of the Resident #181's Medication Administration Record (MAR) for August 2025 revealed from 08/01/25 through 08/09/25 Resident #181 received 15 of the 18 ordered doses of clonazepam. On 08/04/25 the MAR revealed the evening dose had an R documented with initials. Review of the chart code on the MAR revealed the R indicated the resident refused the medication. Additionally, on 08/05/25 and 08/06/25 the morning dose had an R documented. On 08/10/25 the morning dose and the evening dose, had OT documented on the MAR. The chart code indicated OT indicated Other; On 08/11/25 the evening dose had an OT documented; 08/12/25, 08/13/25, and 08/14/24 the morning dose had an OT documented. An R was documented 08/12/25 and 08/13/25 for the evening dose. Review of the MAR indicated Clonazepam was administered from 08/14/25 evening dose as ordered through 08/24/25 when Resident #181 was admitted to the hospital. Review of the med pass note for Resident #181 dated 08/10/25 at 7:57 A.M. completed by Licensed Practical Nurse (LPN) #275 revealed clonazepam oral tablet disintegrating 0.25 mg give one tablet by mouth two times a day for bipolar (disorder) - medication on order. Review of the med pass note for Resident #181 dated 08/10/25 at 6:36 P.M. completed by LPN #346 revealed clonazepam oral tablet disintegrating 0.25 mg give one tablet by mouth two times a day for bipolar - on order. Review of the med pass note for Resident #181 dated 08/11/25 at 9:29 A.M. completed by LPN #347 revealed clonazepam oral tablet disintegrating 0.25 mg give 1 tablet by mouth two times a day for bipolar. The pharmacy has indicated that it is too soon to refill the requested medication supply below. Clonazepam oral tablet disintegrating 0.25 mg give one tablet by mouth two times a day for bipolar. Patient has requested refill too soon. Order will be dispensed on 08/21/25. Review of the med pass note dated 08/11/25 at 6:27 P.M. completed by Nurse Manager Assistant Director of Nursing (ADON), Staff Development/Registered Nurse (RN) #355 revealed clonazepam oral tablet disintegrating 0.25 mg give one tablet by mouth two times a day for bipolar (disorder). Medication unavailable however R (resident) refused all medications from this nurse. Review of the med pass note dated 08/14/25 at 8:59 A.M. completed by LPN #347 revealed clonazepam oral tablet disintegrating 0.25 mg give one tablet by mouth two times a day for bipolar - waiting on pharmacy. Review of the Certified Nurse Practitioner (CNP) Note for Resident #181 dated 08/14/25 at 11:51 P.M. completed by CNP #390 revealed chief complaint: N/V (nausea and vomiting), anxiety, follow up chest pain, and (congestive heart failure) CHF. She is resting quietly in bed. Reports feeling ok. No chest pain endorsed at time of exam. Continue current meds and treatments. Monitor. Addendum- anxious this afternoon. Per nurse, family called 911, but (Resident #181) refused to go. Did not leave facility. Awaiting klonopin (trade name for Clonazepam) from pharmacy. Review of the Self-Reported Incident (SRI) Tracking #264042 dated 08/14/25 at 1:36 P.M. with a date of discovery 08/14/25 and a category of Misappropriation and a brief description of the staff nurse identified medication unavailable. When calling pharmacy for medication, pharmacy stated the medication was delivered to the facility. Staff unable to locate medication at the facility. Alleged/suspected perpetrator was facility staff or other care provider. Resident remained at the facility at baseline. The Narrative Summary of the incident included interviewed the nurse that signed for receiving the medication when delivered to the facility. The report indicated the facility replaced the medication at the facility cost. Resident #181 was interviewed when asked if she refused medication, which medication she refused and why. The report indicated like residents were interviewed with no negative findings and staff

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 0695 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, record review and review of the facility policy revealed the facility failed to assure trach supplies were available and care and treatment was completed. This affected one (#52) of one resident reviewed for trach supplies and treatment. The facility census was 114.Findings include: Record review for Resident #52 revealed an admission date of 03/06/24. Diagnoses included encounter for attention to tracheostomy (a direct opening or stoma through the neck into the windpipe (trachea) allowing a tube to be inserted to provide an airway), dysphagia, weakness, unspecified psychosis, obsessive compulsive disorder, post-traumatic stress disorder and obstructive sleep apnea. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #52 was moderately cognitively impaired. Resident #52 had no rejection of care and required set up or clean up assistants with eating and oral hygiene. Resident #52 had a tracheostomy and received tracheostomy care. Review of the care plan for Resident #52 dated 03/07/24 revealed Resident #52 has a trach (a common shorthand term for tracheostomy) and is at risk for ineffective breathing patterns as evidence by shortness of breath and labored respirations. Interventions included to administer medications and respiratory treatments as ordered; monitor for effectiveness and adverse reactions of medications/treatments. Review of the Physician orders for Resident #52 revealed an order dated 03/07/24 to change trach inner cannula daily and as needed every night shift. An additional order dated 03/07/24 revealed trach care BID (two times a day) and prn (as needed) every day and evening shift. Review of the Treatment Administration Record for 09/01/25 through 09/15/25 for Resident #52 revealed the treatments to Resident #52's trach (including to change trach inner cannula daily and trach care BID and prn every day and evening shift) were documented on the TAR by facility nurses as completed as ordered. Observation and interview on 09/15/25 at 10:30 A.M. with Resident #52 revealed Resident #52 was sitting up in bed. Observation revealed Resident #52 had a trach intact and secured with trach ties. Resident #52 revealed he ran out of trach ties for his trach about a month ago. Resident #52 revealed the staff were aware there were no trach ties available. Observation revealed Resident #52's trach ties were dingy in color and appeared to be soiled. Interview on 09/15/25 at 10:32 A.M. with Registered Nurse (RN) Assistant Director of Nursing (ADON) #364 revealed the Respiratory Therapist (RT) ordered Resident #52's trach supplies. RN ADON #364 revealed there were trach supplies available including trach ties kept in Resident #52's room. Observation revealed RN ADON #364 went to Resident #52's room and searched the room for trach supplies. RN ADON #364 confirmed there were no trach supplies in Resident #52's room. RN ADON #364 then went to the nurses station and approached Licensed Practical Nurse (LPN) #266. LPN #266 confirmed she was Resident #52's primary nurse. LPN #266 stated when asked about trach ties, I think we have some. Observation revealed LPN #266 looked in the medication cart and treatment cart and confirmed she was unable to find trach ties. LPN #266 also confirmed she was unable to find inner cannulas or a spare trach. RN ADON #364 revealed she would text RT to find out where the supplies were kept. Observation revealed RN ADON #364 went back into Resident #52's room and again looked for trach supplies. Resident #52 confirmed there were no supplies in the room. Resident #52 then removed his inner cannula in front of RN ADON #364 and revealed the inner cannula had not been changed in weeks. Observation revealed the inner cannula was soiled and discolored. RN ADON #364 confirmed the inner cannula was more soiled than usual and confirmed the neck ties were also soiled. RN ADON #364 confirmed there were no trach supplies on the hall and revealed there was some in the supply room downstairs in the basement. RN ADON #364 revealed Resident #52 was the only resident with a trach. Observation at 10:45 A.M. revealed RN ADON #364 searched the central supply room and revealed she was not sure where the trach supplies were. RN ADON #364 then looked on the assessment and revealed Resident #52 was to have a Shiley 7.5 trach. Central Supply Personnel #367 then entered and directed where the trach supplies would be located. Observation revealed at 10:50 A.M. RN ADON #364 found where trach supplies were located. RN ADON #364 confirmed all the trach supplies were there that was needed for Resident #52 except trach ties and confirmed there were no trach ties available. RN ADON #364 took trach supplies to the nursing station. RN ADON #364 confirmed the amount of time taken to find the trach supplies could have been detrimental to the resident if the supplies were needed in an emergency. Interview on 09/15/25 at 10:55 A.M. with LPN #266 revealed Resident #52 did all of his own trach care and she did not have to do any of it. LPN #266 confirmed she did not monitor Resident #52 do his trach care. Interview on 09/15/25 at 11:00 A.M. with Resident #52 and RN

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy revealed the facility failed to ensure sufficient staff were available to timely serve meal trays for the 18 residents residing on the A unit and failed to provide timely incontinence care for three residents. This affected three (#80, #109, and #111) of three residents reviewed for incontinence care also residing on the A unit. This had the potential to affect all 18 residents (#80, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #109, #110, #111, #112, #113, #114, and #115) residing on the A Unit. The facility census was 114.Findings include: 1. Record review for Resident #80 revealed an admission date of 08/23/23. Diagnoses included multiple sclerosis, spinal stenosis, and muscle weakness. Review of the Annual Minimum Data Set (MDS) dated [DATE] for Resident #80 revealed Resident #80 had a Brief Interview of Mental Status (BIMS) score of 12 (moderately cognitively impaired). Resident #80 required set up or clean up assistance for eating, dependent for oral hygiene, toileting hygiene, and personal hygiene. Resident #80 was frequently incontinent with bowel and bladder. Review of the care plan for Resident #80 dated 08/26/23 revealed Resident #80's preferences have been identified. Resident #80 preferred showers two times a week. An additional care plan dated 07/28/24 revealed Resident #80 had an activity of daily living (ADL) self care performance deficit. Interventions included staff were to assist with completion of ADL's on a daily basis so needs were met. Review of the care plan for Resident #80 dated 08/29/23 revealed Resident #80 had bowel incontinence related to impaired mobility, physical limitations, and MS. Interventions included bladder toileting program, check for wetness before meals, after meals, every evening, and on rounds during the night. Check resident, if he or she is continent, offer to assist with toileting, if he/she is incontinent, provide incontinence care. Observation on 09/20/25 at 9:14 A.M. of the A Hall revealed Licensed Practical Nurse (LPN) #275 was passing medications. Certified Nursing Assistant (CNA) #374 was passing breakfast trays. Interview with LPN #275 revealed she was the only nurse on the hall for 18 residents and CNA #374 was the only aide. LPN #275 revealed CNA #374 was passing the breakfast trays by herself. LPN #275 stated, There's not enough staff, I am still passing medications so I can't help her much. Interview on 09/20/25 at 9:15 A.M. with CNA #374 confirmed the breakfast cart arrived about 7:40 A.M.; CNA #374 confirmed she was still passing breakfast trays. Observation revealed at 9:20 A.M. CNA #374 served the last tray on the cart, Resident #98's tray. CNA #374 did not heat the food on the tray before serving it. Observation revealed residents were served pancakes, sausage and oatmeal. Resident #98 stated, The food is cold, it's not even a little warm it's that way all time. Interview with Resident #114 stated, it is cold, its every meal. Resident #80 also confirmed his food was served cold. The facility identified the following residents resided on the A Unit and would be affected by the late meal trays, Residents #80, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #109, #110, #111, #112, #113, #114, and #115. Interview on 09/20/25 at 9:30 A.M. with CNA #374 revealed she did the best she could. CNA #374 stated, I have not even started checking and changing (residents for incontinence), there's not enough help over here, I still have to collect trays. CNA #374 confirmed her shift started at 7:00 A.M. and confirmed she will not start checking on her residents or initiating her first set of rounds for incontinence until about 10:30 A.M. because she had to answer call lights and collect (meal) trays. Observation on 09/20/25 at 10:25 A.M. with CNA #374 revealed the CNA provided incontinence care for Resident #80. At the time of the observation, it was revealed that Resident #80's fingernails were very long and embedded with a dark substance. Resident #80 had food in his beard and crumbs and pieces of food on his sheets. CNA #374 revealed that (the crumbs and pieces of food) was his pizza from the night before. Resident #80 revealed he was last changed sometime in the middle of the previous night. Resident #80's incontinence brief was saturated with urine. The brief tore apart when removing it. CNA #374 confirmed this was the first time her shift she checked Resident #80 for incontinence. Resident #80 confirmed he would not mind if his nails were trimmed and confirmed he would like them to be cleaned. CNA #374 confirmed Resident #80 did not have a history of refusing care and confirmed his nails were embedded with a dark substance. Observation revealed CNA #374 completed incontinence care for Resident #80 but did not provide nail care before confirming she completed his A.M. care. Interview on 09/20/25 at 10:52 A.M. with Dietary Manager (DM) #319 and [NAME] #340 revealed breakfast trays were delivered to the A Hall at 7:45 A.M.; DM #319 revealed she does get complaints of cold food but the staff can heat the food up in the microwave. Interview on 09/20/25 at 12:19 P.M. with Resident #115 revealed sometimes staff take two hours