STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365796	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Healthcare Campus	4401 W 150th Street Cleveland, OH 44135

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 facility policy review, the facility failed to ensure Resident #43's allegation of staff-to-resident physical abuse was timely reported to the State Agency. This affected one resident (#43) out of three residents reviewed for abuse. The facility census was 89.Findings include: Review of Resident #43's medical record revealed an admission date of 06/04/24 and diagnoses included cardiac arrest, schizophrenia, and cognitive communication deficit.Review of Resident #43's care plan dated 12/05/24 included Resident #43 had the potential to demonstrate verbally abusive behaviors related to poor impulse control. Resident #43 would verbalize understanding of the need to control verbally abusive behavior. Interventions included to assess Resident #43's coping skills and support system; assess Resident #43's understanding of the situation and allow time for Resident #43 to express self and feelings towards the situation.Review of Resident #43's Minimum Data Set annual assessment dated [DATE] revealed Resident #43 had moderate cognitive impairment. Resident #43 had no impairment of her upper and lower extremities and did not use a cane or walker. Resident #43 required setup or clean-up assistance with toileting hygiene and oral hygiene, and supervision or touching assistance with bathing and dressing. Resident #43 had no physical or verbal behavioral symptoms over the seven day look back period. Resident #43 rejected evaluation or care four to six days over the seven day look back period.Review of Resident #43's medical record including progress notes and assessments dated 08/04/25 at 7:00 P.M. through 08/07/25 at 4:11 P.M. did not reveal evidence of Resident #43's statement that Certified Nursing Assistant (CNA) #203 grabbed her cheek and pinched it during the smoke break on 08/04/25 at 7:00 P.M. There was no evidence Resident #43's cheek was evaluated for pain, injury, bruising and swelling. There was no evidence Resident #43's physician, nurse practitioner, or family member was notified of the allegation. There was no evidence vital signs were checked or that Resident #43 was monitored after the allegation was made. Review of Resident #43's progress notes dated 08/04/25 at 7:00 P.M. through 08/11/25 at 11:20 A.M. did not reveal evidence Resident #43 was evaluated by a physician or nurse practitioner.Review of the facility Self Reported Incident Form dated 08/05/25 at 11:36 A.M. revealed on 08/04/25 at 7:00 P.M., an incident occurred in the smoke room. On 08/05/25, in the morning, Resident #43 stated to Unit Manager (UM) #200 that CNA #203 grabbed and pinched her cheek last night. CNA #203 was not on duty when the allegation was made. UM #200 noted no injury to Resident #43's jaw or cheek. The Administrator was notified of the allegation. The Administrator notified NP #201 immediately and no new orders were given. A message was left on Family Member (FM) #202's phone and CNA #203 was interviewed. Residents #20 and #28 were in the smoke room with Resident #43 and CNA #203 at the time of the incident and were interviewed. Other staff were interviewed. One resident (Resident #20) stated CNA #203 put her hand near Resident #43's face and one resident (Resident #28) did not remember anything happened. Resident #43 was monitored by UM #200 and the nursing staff during the week. FM #202 called the facility on 08/06/25 and stated she was not notified of the allegation. The Administrator called FM #202 and informed her a call was placed the morning of 08/05/25 and UM #200 left a message as well. FM #202 stated she did not receive the messages. FM #202 was informed of Resident #43's allegation, informed CNA #203 was suspended pending an investigation, and that no injury was noted by UM #200 or the charge nurse. The Administrator visited with Resident #43 on 08/07/25, discussed the investigation and CNA #203 was off the schedule during the investigation. Resident #43 stated several times she apologized to CNA #203 for calling her an expletive, and stated CNA #203 pinched her cheek. There was no edema or bruising noted to Resident #43's cheek. Resident #43 stated she was okay with CNA #203 continuing to work her unit and was happy she was suspended for a few days. As a result of the investigation, the facility educated CNA #203 for how to better handle a situation when she was called a name by a resident. Education was previously scheduled for 08/11/25 by the facility psychiatry service and topics included resident behaviors, mental illness, and de-escalation techniques. On 08/08/25, the Administrator requested the in-service also included how to manage reactions when being yelled at by residents or being called names. CNA #203 attended the in-service. CNA #203 was given a break from the behavioral unit and was scheduled to work on other nursing units. Psychiatric NP was notified of the incident and was asked to evaluate Resident #43 on 08/11/25. Due to no evidence that CNA #203 touched Resident #43, no injury was noted, and there was no intention to harm Resident #43, the facility could not determine if abuse occurred. Abuse was not suspected.Review of Resident #43's Allegation of Abuse or Neglect

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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)

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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 observation, interview, record review, and facility policy review, the facility failed to ensure a comprehensive investigation for Resident #43's allegation of staff-to-resident physical abuse was completed. This affected one resident (#43) out of three residents reviewed for abuse. The facility census was 89.Findings include: Review of Resident #43's medical record revealed an admission date of 06/04/24 and diagnoses included cardiac arrest, schizophrenia, and cognitive communication deficit.Review of Resident #43's care plan dated 12/05/24 included Resident #43 had the potential to demonstrate verbally abusive behaviors related to poor impulse control. Resident #43 would verbalize understanding of the need to control verbally abusive behavior. Interventions included to assess Resident #43's coping skills and support system; assess Resident #43's understanding of the situation and allow time for Resident #43 to express self and feelings towards the situation.Review of Resident #43's Minimum Data Set annual assessment dated [DATE] revealed Resident #43 had moderate cognitive impairment. Resident #43 had no impairment of her upper and lower extremities and did not use a cane or walker. Resident #43 required setup or clean-up assistance with toileting hygiene and oral hygiene, and supervision or touching assistance with bathing and dressing. Resident #43 had no physical or verbal behavioral symptoms over the seven day look back period. Resident #43 rejected evaluation or care four to six days over the seven day look back period.Review of Resident #43's medical record including progress notes and assessments dated 08/04/25 at 7:00 P.M. through 08/07/25 at 4:11 P.M. did not reveal evidence of Resident #43's statement that Certified Nursing Assistant (CNA) #203 grabbed her cheek and pinched it during the smoke break on 08/04/25 at 7:00 P.M. There was no evidence Resident #43's cheek was evaluated for pain, injury, bruising and swelling. There was no evidence Resident #43's physician, nurse practitioner, or family member was notified of the allegation. There was no evidence vital signs were checked or that Resident #43 was monitored after the allegation was made. Review of Resident #43's progress notes dated 08/04/25 at 7:00 P.M. through 08/11/25 at 11:20 A.M. did not reveal evidence Resident #43 was evaluated by a physician or nurse practitioner.Review of the facility Self Reported Incident Form dated 08/05/25 at 11:36 A.M. revealed on 08/04/25 at 7:00 P.M., an incident occurred in the smoke room. On 08/05/25, in the morning, Resident #43 stated to Unit Manager (UM) #200 that CNA #203 grabbed and pinched her cheek last night. CNA #203 was not on duty when the allegation was made. UM #200 noted no injury to Resident #43's jaw or cheek. The Administrator was notified of the allegation. The Administrator notified NP #201 immediately and no new orders were given. A message was left on Family Member (FM) #202's phone and CNA #203 was interviewed. Residents #20 and #28 were in the smoke room with Resident #43 and CNA #203 at the time of the incident and were interviewed. Other staff were interviewed. One resident (Resident #20) stated CNA #203 put her hand near Resident #43's face and one resident (Resident #28) did not remember anything happened. Resident #43 was monitored by UM #200 and the nursing staff during the week. FM #202 called the facility on 08/06/25 and stated she was not notified of the allegation. The Administrator called FM #202 and informed her a call was placed the morning of 08/05/25 and UM #200 left a message as well. FM #202 stated she did not receive the messages. FM #202 was informed of Resident #43's allegation, informed CNA #203 was suspended pending an investigation, and that no injury was noted by UM #200 or the charge nurse. The Administrator visited with Resident #43 on 08/07/25, discussed the investigation and CNA #203 was off the schedule during the investigation. Resident #43 stated several times she apologized to CNA #203 for calling her an expletive, and stated CNA #203 pinched her cheek. There was no edema or bruising noted to Resident #43's cheek. Resident #43 stated she was okay with CNA #203 continuing to work her unit and was happy she was suspended for a few days. As a result of the investigation, the facility educated CNA #203 for how to better handle a situation when she was called a name by a resident. Education was previously scheduled for 08/11/25 by the facility psychiatry service and topics included resident behaviors, mental illness, and de-escalation techniques. On 08/08/25, the Administrator requested the in-service also included how to manage reactions when being yelled at by residents or being called names. CNA #203 attended the in-service. CNA #203 was given a break from the behavioral unit and was scheduled to work on other nursing units. Psychiatric NP was notified of the incident and was asked to evaluate Resident #43 on 08/11/25. Due to no evidence that CNA #203 touched Resident #43, no injury was noted, and there was no intention to harm Resident #43, the facility could not determine if abuse occurred. Abuse was not suspected.Review of Resident #43's Allegation of Abuse or Neglect

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 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, and record review, the facility failed to ensure Resident #43 was administered medication per physician order and that medication was accurately documented in the medical record. This affected one resident (#43) out of one resident reviewed for medication administration. The facility census was 89.Findings include: Review of Resident #43's medical record revealed an admission date of 06/04/24 and diagnoses included cardiac arrest, schizophrenia, and cognitive communication deficit.Review of Resident #43's care plan dated 08/21/24 included Resident #43 had the potential for pain related to falls. Resident #43 would voice adequate relief of pain or the ability to cope with incompletely-relieved pain through the review date. Interventions included to administer analgesia medications per orders, give one-half hour before treatments or care, anticipate the need for pain relief, and respond timely to any complaint of pain.Review of Resident #43's Minimum Data Set annual assessment dated [DATE] revealed Resident #43 had moderate cognitive impairment. Resident #43 had no impairment of her upper and lower extremities and did not use a cane or walker. Resident #43 required setup or clean-up assistance with toileting hygiene and oral hygiene, and supervision or touching assistance with bathing and dressing. Resident #43 had no physical or verbal behavioral symptoms over the seven day look back period. Resident #43 rejected evaluation or care four to six days over the seven day look back period.Review of Resident #43's physician orders dated 08/01/25 through 08/20/25 did not reveal orders for Tylenol (an over the counter mild pain reliever and fever reducer).Review of Resident #43's Medication Administration Record (MAR) dated 08/01/25 through 08/20/25 did not reveal Resident #43 was administered Tylenol for pain. Further review did not reveal non-pharmacological interventions were attempted for pain.Review of Resident #43's medical record including progress notes and assessments dated 08/04/25 at 7:00 P.M. through 08/07/25 at 4:11 P.M. did not reveal evidence of Resident #43's statement that CNA #203 grabbed her cheek and pinched it during the smoke break on 08/04/25 at 7:00 P.M. There was no evidence Resident #43's cheek was evaluated for pain, injury, bruising and swelling. There was no evidence Resident #43's physician, nurse practitioner, or family member was notified of the allegation. There was no evidence vital signs were checked or Resident #43 was monitored after the allegation was made. Review of the facility Self Reported Incident Form dated 08/05/25 at 11:36 A.M. revealed on 08/04/25 at 7:00 P.M., an incident occurred in the smoke room. On 08/05/25, in the morning, Resident #43 stated to Unit Manager (UM) #200 that CNA #203 grabbed and pinched her cheek last night. CNA #203 was not on duty when the allegation was made. UM #200 noted no injury to Resident #43's jaw or cheek. The Administrator was notified of the allegation. The Administrator notified NP #201 immediately and no new orders were given. A message was left on Family Member (FM) #202's phone and CNA #203 was interviewed. Residents #20 and #28 were in the smoke room with Resident #43 and CNA #203 at the time of the incident and were interviewed. Other staff were interviewed. 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