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	01/29/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident and staff interview, and facility policy review, the facility failed to maintain the resident environment and equipment in a safe, sanitary, and homelike manner. This affected 29 (#2, #3, #6, #7, #8, #10, #14, #18, #20, #22, #24, #26, #28, #29, #30, #31, #51, #53, #57, #58, #59, #63, #71, #76, #77, #81, #85, #94, and #103) of 86 residents residing in the facility. The census was 86.Findings include:1. Observation of Building B during facility tour on 01/29/26 at 10:33 A.M. through 12:35 P.M., conducted with the Director of Nursing (DON), revealed the hallway outside of the dining room on the first floor had multiple unattached hand railings and missing hand railing end caps. A chair in the hallway was heavily stained and dirty. There were multiple cracks in the tiles between the dining room and nurses station estimated to 10.0 feet long by 7.0 feet wide, and the floor boards along hallway were stained and not fully attached to the wall. The second floor dining room had multiple areas of water stains on the ceiling tiles and the mechanical lift in the 100 Hall was dirty and rusted. The DON confirmed the facility had tried to clean the lift but the rust would not come off. Observation in Resident #103 and Resident #24's bathroom were two broken wall tiles, a 1.0 inch (in.) long by 1.0 in. wide hole in the wall above the floor trim, and a 1.5 in. long by 1.0 in. wide dent to the right of the entry door. The siding around the door was cracked and broken on the left side. There were also numerous scuffs and scraps throughout the walls and a 1.0 in. long by 1.0 in. wide hole by Resident #24's bed and the cable outlet was not properly attached to the wall. The wall trim below the furnace vents was unattached from the wall. Observation of Resident #85's room revealed multiple brown water stains on the bathroom ceiling tiles. Observation of Resident #94's floor revealed cracks in multiple areas and yellow stains throughout flooring. There were also two holes in the bathroom door and a large chip in the wall tile by the toilet. Observation of Resident #30's bathroom floor revealed four missing tiles, the furnace vents had large splatter stains, and the floor trim underneath was unattached from the wall. The wall air conditioning unit insulation plate was broken and unattached and the floor in the right corner had rust and cracks. The ceiling had large brown stains on the tile and brown dried liquid stains that had dripped from the ceiling. The light cover was completely unattached from the fixture. Interview with Resident #30 during the observation revealed he thought there was a leak from an upstairs toilet. Resident #8 and Resident #18's bathroom had no door. Resident #8's dresser drawers were broken and the light above the bed was not fully attached to the fixture. The privacy curtains in the room would not move along the tracks. Resident #8's telephone outlet cover was unattached from the wall Interview with Resident #8 during the observation stated the electrical outlet next to the telephone outlet did not work. At that time, the DON tested the outlet and confirmed it was not working properly. There was also a 2.0 in. long by 4.0 in. wide piece of tile missing beside Resident #8's bed and a 1.0 in. long by 1.0 in. wide hole in the wall across from the bed. Resident #18 had eight yellowish ceiling tiles and rust was along the ceiling trim near the window. There was a 1.0 in. long by 1.0 in. wide hole in the ceiling tile. There were dark brown stains around the ceiling light and on the tiles around light. The window had a crack on the outside panel and the wall air conditioner (AC) unit was covered with plastic and duct tape due to cold air seeping in. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued observation of Building B with the DON revealed Resident #7 had a 1.0 in. long by 3.0 in. wide tile missing by the entry way door. Resident #31's room had a 1.0 in. long by 3.0 in. wide hole in the tiles in the entry way into the bathroom. Also, the wall AC unit trim was missing on the right side. Observation of Resident #22 and Resident #53's bathroom door revealed chipped paint and stains. The inside of the bathroom door had a 0.5 in. long by 0.5 in. wide hole. The drywall had been patched in the bathroom but was not sanded down or repainted. The floor by Resident #53's dresser was chipped and the light fixture about the bed was missing the end cap. Resident #26's room had a 2.0 in. long by 5.0 in. wide chip in the floor by the closet. The wall AC unit cover was being held in place with duct tape, the light was completely unattached from the fixture, broken and cracked, and there was a 12 foot long brown water stain on the ceiling tiles by the window. Resident #81's room had a 0.5 in. long by 0.5 in. wide hole in the wall above the bed. The wall AC unit had a towel taped over it, the window blinds had a towel taped to them, and the window had a bed sheet taped over the window with plastic wrap, a metal piece, and screws along the window seal with cold air was coming in. There was duct tape along the sashes of the two windows. Interview with Resident #81 revealed he would like to be able to look out the window and it had been like that since he moved into the room. Observation by the portable heater attached to the wall was a 1.0 foot long by 1.0 foot wide area and a 4.0 in. long by 6.0 in. wide area where the paint was chipped. Continued observation revealed Resident #20's room wall AC unit was covered with plastic and cold air could be felt. The toilet was not fully attached to the floor and was crooked. The rim around the toilet was brown and stained. There were multiple chips in the paint by the bed and the bathroom door was heavily scuffed. Resident #58's room had five dry wall patches that were not painted over, the light fixture was unattached, three ceiling tiles had brown water stains, the bathroom vanity was missing a door, there was missing floor tile in the bathroom, and trim below the bed was unattached to the wall. Resident #57's room had a 2.0 in. long by 2.0 in. wide crack along the floor and the bathroom door was extremely scuffed on the lower part. Resident #71's bathroom had a 6.0 in. long by 8.0 in wide stain on the ceiling tile and multiple chipped tiles in the floor. Resident #2's room cork board above the bed was splattered with a dry liquid. The wall AC unit did not have a trim panel and the vent cover was severely broken and missing pieces in several areas. The light fixture was not attached above the bed. The ceiling tile above the sprinkler had a 10.0 in. long by 5.0 in. wide water stain. The bathroom was missing a light bulb. The bathroom ceiling tiles had an 18.0 in. long by 12.0 in. wide water stain. The bathroom vanity doors were broken and unaligned, and the shelves inside the vanity had laminate peeling off with large pieces missing. The paper towel holder had been replaced and the wall was not repainted. Resident #29's room had splatter on the ceiling above the bed. There was various water stains on the ceiling tiles estimated to be 2.0 feet long by 2.0 feet wide. The light above the bed was not attached to the fixture and the bathroom floor had two tiles missing and a 4.0 in. long by 4.0 in/ wide wall tile was missing across from the toilet. Continued observation revealed Resident #10's room had various large water stains on the ceiling tiles. The bathroom vanity latch was rusted and the lament on the shelves was peeling off. The seal along the vanity and the sink was cracked. Resident #63's room ceiling tile above the window had a 2.5 feet long by 1.0 feet wide stain and a 6.0 in. long by 4.0 in. wide hole in the bathroom door was repaired with white medical tape. The inside of the bathroom door had severe wood chipping along the entire width of door. Resident #28's room had a 1.0 foot long by 1.0 foot wide water stain on the ceiling tile, the bathroom ceiling tiles had a 12 in. long by 8.0 in. wide water stain, the toilet paper holder was broken and missing pieces, and the toilet paper roll was on the vanity. Resident #76's room grab bar by the toilet was rusted, the bedroom wall had a 1.0 foot long by 1.0 foot wide black adhesive residue and missing floor tile, the paper towel holder in the bathroom was not attached fully to the wall and was not level and the paper towels were placed on top of the toilet, and floor tile was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing in the bathroom. The was also drywall by the soap dispenser that had been fixed but not painted. Resident #3's room had a large ceiling tile stain above bed and the wall AC unit was missing trim on the left side. Resident #14's room had trim missing from the entry door and outside of the bathroom, there was a 10.0 in. long by 5.0 in. wide hole in the tile, the bathroom vanity handle was missing, and the laminate placed over the tile floor was coming up. Resident #77's room had no bathroom door or curtain, the bathroom floor had five tiles missing, and there was a large rusted splatter stain on the ceiling outside of the bathroom and on the privacy curtain track. Resident #6's room window unit was missing trim and had exposing broken dry wall with pieces flaking off. Interview with the DON on 01/29/26 between 10:33 A.M. and 12:35 P.M. confirmed all of the above findings at the time of discovery. 2. Observation on 01/27/26 at 11:25 A.M., of Resident #51's wheelchair noted the vinyl on the right and left arm rest cushion was missing and underlying foam padding was exposed. Interview with Resident #51 at the time of the discovery stated the right and left arm rest cushions had the foam padding exposed for a long time. Interview on 01/28/26 at 4:30 P.M. with Certified Nurse Aide (CNA) #321 confirmed the vinyl on Resident #51's bilateral wheelchair arm rests was gone and the foam padding was exposed. She stated staff document issues like that on the computer to let the correct department know of an issue. She stated the maintenance and physical therapy departments were aware, but could not provide any documentation as she did not let anyone know. Interview on 01/29/26 at 12:24 P.M. with License Practical Nurse (LPN) #324 confirmed the bilateral arm rests on Resident #51's wheelchair had foam padding exposed. Interview on 01/29/26 at 12:33 P.M with Director of Rehabilitation (DOR) #334 revealed she did not know about Resident #51 needing new bilateral wheelchair arm rests. Observation with DOR #334 on 01/29/26 at 12:41 P.M. verified the bilateral arm rests on Resident #51's wheelchair needed replaced as the vinyl was gone and the foam padding was exposed. She stated she did not know Resident #51's bilateral arm rests were so worn and stated wheelchairs were checked monthly to ensure they were in good working condition. 3. Observation on 01/28/26 at 4:30 P.M. revealed Resident #59's right arm rest on the wheelchair was totally gone leaving only a screw left in place. The left arm rest had a large area where the black vinyl was rubbed off/missing and the foam padding was exposed. Interview at the time of the observation with CNA #321 verified the condition of the resident's left arm rest and the missing right arm rest, and stated the maintenance or therapy department was notified via the computer, but could not provide the document to verify the date of notification. Interview on 01/29/26 at 12:41 P.M. with DOR #334 revealed she did not know about Resident #59's bilateral wheelchair arm rests until 01/28/26 in the late afternoon and put a new arm rest on the wheelchair right away. Review of facility policy titled, Homelike Environment, dated February 2021, revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident family interview, and staff interview, the facility failed to develop resident-centered care plans to address all relevant physical and mental conditions. This affected two (#44 and #58) of 24 sampled residents reviewed for care plans. The facility census was 84.Findings include: 1. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included post-traumatic stress disorder (PTSD), schizophrenia, and dementia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was severely cognitively impaired and required hands-on assistance of two staff persons for completion of activities of daily living. Interview with Resident #58's family member on 01/28/26 at 2:45 P.M. revealed the resident had a history of PTSD related to multiple traumatic events, including a traumatic birth and adverse childhood experiences in her home country. The family member further stated institutional, hospital-like environments are a significant trigger for Resident #58's distress and behavioral symptoms due to past trauma associated with her birth. Resident #58 also grew up in a city that was the site of multiple military battles during World War II, further contributing to her trauma history. Review of the care plan for Resident #58 revealed no problems, goals, or interventions related to Resident #58's PTSD diagnosis. Interview with the Administrator on 01/28/26 at 3:00 P.M. verified the facility did not address interventions specific to Resident #58's PTSD diagnosis in the resident's comprehensive care plan. 2. Review of Resident #44's medical record revealed the resident was admitted on [DATE]. Diagnoses including osteomyelitis of the right ankle and foot, diabetes, chronic obstructive pulmonary disease, acute kidney failure, hypertension, peripheral vascular disease, and cellulitis. Review of Resident #44's MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #44's medical record revealed a physician order dated 11/13/25 for the facility to provide two female staff, together, at all times for resident interactions due to inappropriate behaviors. Interview on 01/29/26 at 1:22 P.M. with Licensed Practical Nurse (LPN) #334 confirmed there was no care plan developed to address the order for the facility to provide two people at all times for Resident #44's care.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and resident family interview, the facility failed to ensure a resident was timely and accurately assessed for trauma-informed care needs. This affected one (#58) of one residents reviewed for post-traumatic stress disorder. The facility census was 84.Findings include:Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included post-traumatic stress disorder (PTSD), schizophrenia, and dementia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was severely cognitively impaired and required hands-on assistance of two staff persons for completion of activities of daily living.Interview with Resident #58's family member on 01/28/26 at 2:45 P.M. revealed the resident had a history of PTSD related to multiple traumatic events, including a traumatic birth and adverse childhood experiences in her home country. The family member further stated institutional, hospital-like environments are a significant trigger for Resident #58's distress and behavioral symptoms due to past trauma associated with her birth. Resident #58 also grew up in a city that was the site of multiple military battles during World War II, further contributing to her trauma history.Review of Resident #58's inital trauma screen document dated 09/17/25 revealed the facility answered, No, to the resident having a diagnosis of or history of traumatic events, despite the resident's documented PTSD diagnosis and the trauma history discussed during Resident #58's family member interview.Interview with the Administrator on 01/28/26 at 3:00 P.M. confirmed the facility did not accurately assess Resident #58 for trauma history or trauma-informed care needs.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on personnel record review and staff interview, the facility failed to ensure a performance evaluation was completed for nurse aides at least every 12 months. This deficient practice had the potential to affect all 84 residents residing in the facility. The facility census was 84.Findings include:Review of Certified Nurse Aide (CNA) #371's personnel file on 01/29/26 at 10:30 A.M. revealed a hire date of 08/14/24. There was no evidence of an evaluation performed at least every 12 months for CNA #371. Interview on 01/29/26 at 11:00 A.M. with Human Resources Director (HRD) #701 verified there was no evidence of a performance review at least every 12 months CNA #371 in the personnel file.Review of a document provided by HRD #701 on 01/29/26 at 1:15 P.M. titled, 90-day Employee Evaluation, for CNA #371 revealed a 90-day evaluation dated and signed by CNA #371 on 12/10/25.Interview on 01/29/26 at 1:15 P.M. with HRD #701 verified the date of the evaluation was greater than 12 months from the date of CNA #371's hire.