

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Rae Ann Suburban		STREET ADDRESS, CITY, STATE, ZIP CODE 29505 Detroit 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of facility self-reported incident (SRI) including investigation, observations, staff and resident interviews and review of facility Abuse, Neglect, and Misappropriation policy, the facility failed to ensure residents were free from misappropriation of property. This affected eight residents (#21, #77, #86, #88, #89, #90, #91 and #92) of 10 residents reviewed for abuse. The facility census was 81. Findings include: Review of the facility Self-Reported Incident (SRI) tracking number 264428 and 264635 revealed the following information. Review of the Police Investigative Report dated [DATE] revealed the police received a report of suspected fraud on [DATE] involving Certified Nursing Assistant (CNA) #310. The police interviewed previous Resident #88 on [DATE] who reported she had closed her previous debit card due to fraudulent activity that occurred months ago and most of the charges were from Insta Cart. Resident #88 informed the police that she had been a previous resident at the facility in [DATE] and did remember her purse being upside down on the floor one day at the facility. The facility was not aware of allegations at this time. Review of the police Investigative Report titled Supplement dated [DATE] revealed the police received more information about CNA #310 receiving packages from Amazon with Resident #91 and Resident #89 credit card information uploaded into her Amazon account. Police reviewed the transactions tab and found charges to Resident #88 credit card as well. At this time the police called the facility and confirmed Resident #91 was currently a resident at the facility and Resident #89 had passed away. The police came to the facility and interviewed Resident #91 who reported to the police that her card had previous fraudulent activity and the facilities Business Office had assisted her with reporting the fraud to her bank and canceling her card. Between [DATE] to [DATE] an employee questionnaire was distributed to staff members regarding any knowledge of the alleged fraud and all responses were negative. In addition, five residents were interviewed regarding their feelings of safety within the facility and the security of their personal belongings, with no residents reporting any concerns regarding theft of missing property. The facility unsubstantiated the SRI at this time. On [DATE] the DON requested a copy of the police report and received the report from the police department on [DATE]. The police report identified CNA #310 as the alleged perpetrator of the credit card fraud. At this time, CNA #310 was working and was immediately removed from the floor and interviewed by the Administrator, Director of Nursing (DON) and Human Resources. During the interview CNA # 310 admitted to obtaining Resident #91 credit card number and using the card without authorization. CNA #310 was terminated immediately and escorted from the facility. The facility updated the police department, Ohio Department of Health, the nurse aide registry and the facility medical director. On [DATE] the facility was notified by Resident #86 that there was a suspicious charge on her Cash App account on [DATE]. The facility updated the police department and opened SRI 264635 at this time. On [DATE] the facility was notified by Resident #21 that his bank called about fraudulent charges. Resident #21 had his bank card in possession. The account had a balance of \$0 and the charge were denied. The facility updated the (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and interview the facility failed to ensure a medication rate less than five percent. This affected two (Resident #9 and Resident #56) out of four residents observed during medication administration. The facility census was 81. Findings include: An observation on 06/16/26 between 7:15 A.M. and 8:00 A.M. of four licensed nurses (Licensed Practical Nurse (LPN) #310, LPN #309, LPN #311, Registered Nurse (RN) #312) administer medications to Resident # 9, Resident #56, Resident #74 and Resident #75 with 31 opportunities for error revealed three errors observed. This resulted in a medication error rate of 10 percent. 1. A review of Resident #56's clinical record revealed an admission date of 05/28/24 with diagnoses including heart failure, neurocognitive disorder, diabetes mellitus, major depressive disorder with severe psychotic symptoms, high blood pressure and cholesterol, thyrotoxicosis, post-traumatic stress disorder, peripheral vascular disease, suicidal ideation, dental caries, cognitive communication deficit, malingering (To pretend or exaggerate incapacity or illness), dementia and insomnia. A review of Resident #56's care plan initiated on 02/28/25 revealed Resident #56 had cognitive impairment with aggressive behaviors, a problem with communication, and needed assistance with medication administration, and activities of daily living tasks. A review of Resident #56's physician orders dated 06/01/26 to 06/30/26 indicated the above medications were to be administered in the morning including the following medication before breakfast: Insulin Lispro injection solution, inject 4 units subcutaneously before meals in addition to sliding scale coverage. Insulin Lispro injection solution per sliding scale four times a day: If blood sugar measured 110 to 150 mg/dL give 0 units If blood sugar measured 151 to 200 mg/dL give 2 units If blood sugar measured 201 to 250 mg/dL give 4 units If blood sugar measured 251 to 300 mg/dL give 6 units If blood sugar measured 301 to 350 mg/dL give 8 units If blood sugar measured 351 to 400 mg/dL give 10 units If blood sugar measured greater than or equal to 401 give 10 units and notify the physician. A review of Resident #56's Medication Administration Record (MAR) for June 2026 revealed the Lispro 4 units insulin was scheduled to be administered before meals at 8:00 A.M., 12:00 P.M. and 4:30 P.M. The Lispro sliding scale insulin was scheduled before meals three times a day and at bedtime. During an observation on 06/16/26 at 7:45 A.M. LPN #311 was seen administering medications to Resident #56. LPN #311 dispensed the following medications in a medication cup: Jardiance 25 milligrams (mg) (used to lower blood sugar level) one half an oral tablet (12.5 mg) Bisoprolol fumarate 5 mg one half oral tablet (2.5 mg) (blood pressure medication) Methimazole 5 mg oral tablet (thyroid medication) Spironolactone 25 mg oral tablet (reduce swelling and control high blood pressure) one half tablet (12.5 mg) Sacubitril-valsartan 49-51 mg one oral tablet (blood pressure medication) LPN #311 acknowledged that there were five medication tablets in the medication cup. LPN #311 entered Resident #56's room and obtained his blood sugar level which measured 217 mg/dL. LPN #311 proceeded to administer the oral medication tablets (above listed medications) to Resident #56. Resident #56 consumed the medications and LPN #311 exited Resident #56's room and performed hand hygiene. LPN #311 was asked if she had completed the medication administration for all medications and treatments that were scheduled to be administered at this time. LPN #311 stated all the medications that had been administered were scheduled at this time and no additional medications or treatments were due to be administered. LPN #311 then proceeded to administer medications to Resident #3. At the time of the observation staff were delivering the breakfast meal to the nursing units from the kitchen. An interview with LPN #311 on 06/16/26 at 9:00 A.M. verified she had not administered Resident #56's Lispro insulin medication that was scheduled to be administered at the same time as Resident #56's oral medications earlier in the morning before she started to administer medications to Resident #3. A review of the facility policy titled Administering Medications dated 2001 revealed the policy interpretation and implementation indicated medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label three times to verify the right resident, right (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, right dosage, right time and right method (route) of administration before giving the medication.2. A review of Resident #9's clinical record revealed an admission date of 02/10/23 with diagnoses including intellectual disabilities, high blood pressure, osteoarthritis with lateral subluxation of the patella, fracture of metatarsal bones of the left foot, neurocognitive disorder, diabetes mellitus, adjustment and mood disorder, anxiety and depression.A review of Resident #9's care plan initiated on 02/13/23 revealed Resident #9 had impaired cognitive function with communication problem and needed assistance with medication administration and activities of daily living tasks.A review of Resident #9's physician orders for June 2026 revealed to administer the following medications in the morning:Cyanocobalamin (vitamin B12) 500 micrograms (mcg) 2 tablets orally one time a day for supplementFerrous sulfate 325 milligrams (mg)orally once a day for supplement for anemiaFolic acid 1 mg orally once a day for supplementLactobacillus oral capsule once a day for supplementLasix 20 mg oral tablet once a day for edema (swelling)multivitamins administer one tablet once a day for supplementThiamine Hydrochloride 100 mg oral tablet once a day for supplementVitamin C 500 mg tablet once a day for supplementClonazepam 1 mg oral tablet twice a day for anxietyVitamin D3 1.25 mg oral tablet for supplementColace 100 mg oral capsule twice a day for constipationDivalproex Sodium 500 mg oral delayed release tablet two times a day for neurocognitive disorder.Metoprolol Tartrate 100 mg oral tablet two times a day for high blood pressure and hold if the systolic blood pressure was less than 100 millimeter of mercury (mmHg) or if heart rate was less than 60 beats per minute.Insulin Lispro (1 unit dial) subcutaneous solution pen-injector 100 units/milliliter (ml) for diabetes mellitus, inject per sliding scale:If blood sugar measured 151 to 200 mg/dL give 2 unitsIf blood sugar measured 201 to 250 mg/dL give 3 unitsIf blood sugar measured 251 to 300 mf/dL give 4 unitsIf blood sugar measured 301 to 350 mg/dL give 5 unitsIf blood sugar measured 351 to 400 mg/dL give 6 unitsIf blood sugar measured greater than or equal to 401 notify the physician.Insulin Lispro (1 unit dial) subcutaneous solution pen-injector 100 units/milliliter (ml), inject 30 units subcutaneously three times a day for diabetes mellitusAn observation of RN #312 on 06/16/26 at 7:55 A.M. administer medications to Resident #9 revealed RN #312 dispensed the above listed oral medications in a medication cup including the Divalproex Sodium delayed release medication and crushed the medications. RN #312 proceeded to place the crushed medications in a medication cup and mixed pudding with the medications and then administered the medications mixed in pudding to Resident #9.An interview with RN #312 on 06/16/26 at 9:00 A.M. revealed she should not have crushed the delayed released Divalproex medications with the other medications. RN #312 checked the medication card and verified the medication card indicated the Divalproex was a delayed release medication. A review of the facility policy titled Administering Medications dated 2001 revealed the policy interpretation and implementation indicated medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.This deficiency represents non-compliance investigated under Complaint Number 2649735 and Complaint Number 2578786		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and facility policy the facility failed to ensure a sanitary and clean kitchen. This had the potential to affect all 81 residents. The facility census was 81. Findings include: Observation and interview on 06/15/26 from of the kitchen 9:20 A.M. to 10:00 A.M. with Kitchen Manager #307 revealed the following: -The refrigerator by the tray line had rusted shelves and the bottom of the refrigerator had crumbs and debris. -The oven had crumbs on the handles and the glass had a built-up sticky residue. -Behind the stove there was an oven mitt on the ground and other debris. -Throughout the kitchen the bottom of the tray line had crumbs and various debris. -There were two brown plastic container bins with spices under the tray line that were sticky and had debris and crumbs. None of the spices were dated and some were not standing up right, with unsecured lids causing spices to be spilling out. There was a container of BBQ sauce that said to keep refrigerated that was also in the container. Kitchen Manger #307 confirmed the BBQ should had been kept in the refrigerator. -The tray line warming table had built up brown sticky residue and other debris. -The prep table by the walk-in fridge had crumbs in the utensil drawers and the front of the drawer was dirty and sticky. The prep table had debris and brown and black residue build-up. -The ceiling had numerous black spots and dust throughout. The vent by the 2-part sink had visible black dust build-up. -The metal mobile aluminum can racks were dirty and had crumbs throughout. -There were unknown trash items underneath the fridge by the door to the dining room. -There was tile missing in the corner on the floor by the dining room door. -The walls and wall tile throughout the kitchen were dirty with built of residue and various splatter spots. -In the pull out fridge by the dining room door there was 1 container of 2.0 supplement drink with mold on the lid and one container with various splatter and a dead fly on the top. -In the walk-in refrigerator there were multiple packets of individual grapes that were moldy and multiple cantaloupes in a cardboard box were moldy. All above findings were confirmed with Kitchen Manager #307. Review of facility policy titled Sanitization with a revision date of November 2022 revealed 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair.		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and facility policy the facility failed to ensure garbage was disposed of properly. This had the potential to affect all 81 residents in the facility. The facility census was 81. Findings include: Observation and interview on 06/15/26 at 9:20 A.M. to 10:00 A.M. with Kitchen Manager #307 during the initial tour of the kitchen revealed the following observations of the outside dumpster area: -Multiple pieces of the old flooring and various trash, including plastic water bottles and other cans, were on the ground to the right of the dumpster. -Trash throughout the dumpster area including gloves and plastic wrap were on the ground. -The vent from the laundry room was blowing lint on the ground outside. -Multiple gloves, screws and various pieces of trash were around the door to the building and the dumpster. Interview and observation on 06/15/26 at 10:23 A.M. with Maintenance Director #305 revealed there was a pillowcase in the grass behind the dumpster and plastic wrap was around a tree. Review of facility policy titled Sanitization with a revision date of November 2022 revealed 14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). 15. Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests. This deficiency represents non-compliance investigated under Complaint Number 2578786.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews and facility policy the facility failed to ensure a clean and homelike environment. This had the potential to affect all 81 residents. The facility census was 81. Findings include: Interview and observation on 06/15/26 at 10:23 A.M. with Maintenance Director (MD) #305 revealed the following: -The ceiling outside of room [ROOM NUMBER] had an area estimated to be 1 1/2 feet (ft) in length of dry wall exposed. MD #305 revealed there was a ceiling leak a while ago and it was never painted over. -The wallpaper was peeling off the wall to right of room [ROOM NUMBER]. -The ceiling vent by room [ROOM NUMBER] was built up with dust. -The door by the laundry room had dust and debris built-up around the window ledges and the wall vent was dusty. -By room [ROOM NUMBER] there was a water stain on the ceiling in the area that opened up to the attic. MD #305 revealed the pipes produce condensation and will leak. He said he would paint over the area. -By Side 2 the exit door had a crack in the window on the left side of the door. -The wood wall outside of the library had wood trim panel that was unattached and sitting on the trim with exposed nails. -The wood wall panel outside of the library had heavy dust buildup and various splatter stains throughout. -The exit door by room [ROOM NUMBER] had a crack in the window on the right side. Observation and interview on 06/15/26 at 5:12 P.M. with the Administrator in the dining room revealed the ceiling fans were extremely dusty with visible black dust built up around the blades. Two of the fans were currently running above where residents were eating. Review of facility policy titled, Homelike Environment, with a revised date of February 2021 revealed the following: 1. Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. 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; This deficiency represents non-compliance investigated under Complaint Number 2578786.		