STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366362	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Woods Care & Rehab Center	27705 Westchester Parkway 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on interview and Payroll Based Journal the facility failed to have sufficient staffing. This had the potential to affect all 81 residents.Findings include:Review of the Payroll Based Journal report revealed the facility had a one-star staffing rating and was identified with low weekend staffing for Fiscal Year Quarter One 2026 (October 1, 2025 through December 31, 2025). Interview on 06/08/26 at 11:07 A.M. with Administrator revealed the facility identified insufficient staffing related to low Registered Nurse (RN) hours for July through September 2025. The deficient practice was corrected on 04/01/26 when the facility implemented the following corrective actions: -In September 2025 the company conducted a wage analysis for all departments.-Administrator and designees actively recruited RNs for day and night shifts by using online job postings, attending job fairs, word of mouth from current employees and offering referral bonuses throughout the quarter.-On 02/15/26 Administrator compared July-September 2025 staffing to October-December 2025 staffing revealing an increase in overall PPD for new reporting period. -On 02/15/26 Quality Assurance (QA) team, including Administrator, identified a cause for low RN coverage due to staff returning to school which opened up more full-time positions along with RN staff being unable to change weekends to fill openings.-Administrator educated clinical staff (Director of Nursing, two Assistant DONs (ADON) and Unit Manager on need for eight hours of RN coverage seven days a week on 02/15/26.-Administrator audited schedules and punch details for four weeks from 02/16/26 to 03/15/26 with eight-hour RN coverage for each week.-Facility audited quarterly staffing to ensure minimum qualifications were met ending on 03/31/26.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure accurate advanced directive information was accurate throughout the medical record. This affected one (Resident #36) of one resident reviewed for advanced directives. The facility census was 81.Review of the medical record revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of brain, dementia, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 had moderately cognitive impairment and required supervision for activities of daily living (ADLs).Review of the physicians' orders for Resident #36 revealed an order dated [DATE] for Do Not Resuscitate Comfort Care (DNRCC) code status signifying cardiopulmonary resuscitative (CPR) measures were not to be conducted in case of cardiac or respiratory arrest.Review of the paper chart revealed a full code status for Resident #36 without evidence of the DNRCC order.Interview on [DATE] at 4:26 P.M. with Licensed Practical Nurse (LPN) #320 verified Resident #36's medical records did not match as the electronic chart stated DNRCC, and the hard chart stated Full Code.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Resident #31 and #56 were free from unnecessary psychotropic medications. This affected two residents (Residents #31 and #56) of five residents for unnecessary medications. The facility census was 81. Findings include: 1. Review of the medical record for Resident #31 revealed an admission date of 04/20/26 with diagnoses to include diabetes mellitus, parkinsonism, and psychotic disorder with delusions. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/24/24, revealed the resident had intact cognition. The resident required set up for eating and supervision for other activities of daily living (ADLs). Review of the care plan for Resident #31 dated 04/20/26 revealed that Resident #31 experienced alteration in mood and behavior. Interventions included but were not limited to offer snacks, offer reassurance, provide activities, and medicate as ordered. Review of the physicians' orders for May 2026 revealed orders for one tablet of 0.5 milligrams (mg) of Lorazepam (anti-anxiety medication) by mouth every four hours as needed (PRN) for agitation related to dementia with behavioral disturbance, psychotic disorder with delusions and was ordered one tablet of 25 mg of Hydroxyzine (antihistamine to relieve anxiety) HCL by mouth every four hours PRN for agitation, anxiousness. Review of Resident #31's Medication Administration Record (MAR) revealed Resident #31 received PRN Lorazepam on 05/30/26 at 7:33 P.M., 06/01/26 at 12:53 P.M., 06/01/26 at 5:47 P.M., and 06/02/26 at 8:43 A.M., and PRN Hydroxyzine on 05/30/26 at 7:33 A.M., 06/01/26 at 8:28 A.M., 06/01/26 at 5:47 P.M. The medical record did not contain evidence the reason the medication was given or non-pharmacological intervention attempted prior to administration of the PRNs. Interview on 06/03/26 at 8:48 A.M. with Director of Nursing (DON) verified that Resident #31 was ordered one tablet of 0.5 milligrams (mg) of Lorazepam by mouth every four hours as needed (PRN) for agitation related to dementia with behavioral disturbance, psychotic disorder with delusions and was ordered one tablet of 25 mg of Hydroxyzine HCL by mouth every four hours PRN for agitation, anxiousness. DON revealed nurses were to document why PRN medication was given in the progress notes or in the electronic medication administration record (e-MAR). DON revealed staff have a behavior book on the units, to document behaviors and interventions that were tried when residents show a behavior that did not work. She stated nurses may also document within the 24-hour report given between staff. DON verified that no documentation as to why Resident #31 was administered PRN Lorazepam on 05/30/26 at 7:33 P.M., 06/01/26 at 12:53 P.M., 06/01/26 at 5:47 P.M., and 06/02/26 at 8:43 A.M. DON also verified that there was no documentation as to why Resident #31 was administered PRN Hydroxyzine on 05/30/26 at 7:33 A.M., 06/01/26 at 8:28 A.M., 06/01/26 at 5:47 P.M. Interview on 06/03/26 at 9:28 A.M. with Assistant Director of Nursing (ADON) #283 revealed the last documented entry for Resident #31 in the psych behavior book was 05/18/26 and there were no behaviors noted for Resident #31 in the nurses' 24-hour reports for 05/30/26, 05/31/26, 06/01/26, or 06/02/26. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/26 at 10:33 A.M. with Psych Certified Nurse Practitioner (PCNP) #401 revealed she looks for documentation for the use of PRN medications. Interview on 06/03/26 at 4:00 P.M. with Regional Administrator (RA) #330 revealed Licensed Practical Nurse (LPN) #320 wrote a late progress note for 06/02/26 about why she gave the PRN Lorazepam and PRN Hydroxyzine given at the same time. Review of the late entry progress note, documented on 06/03/26 at 3:26 P.M. with an effective date of 06/02/26 at 10:14 A.M. revealed LPN #320 documented prior to administering medication, Resident #31 was showing signs of agitation and was combative with LPN #320 while attempting to get his blood sugar. First attempt was unsuccessful. During second attempt resident swung at LPN #320. LPN #320 stated to his aide that when she was ready to help him with his activities of daily living (ADLs) to come get them for assistance. Aide and nurse approached once again as the resident began to swing, hit, and kick them. Per nursing judgement both Ativan (Lorazepam) and Vistaril (Hydroxyzine) given at the same time. 2. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] with relevant diagnoses of cognitive communication deficit, delusional disorder, dementia, and anxiety disorder. Review of the MDS 3.0 5-day assessment dated [DATE] and the MDS 3.0 Quarterly assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 04 (severe cognitive impairment), and assistance with activities of daily living (ADL) ranging from staff supervision to substantial staff assistance. Review of the medical record care plan, revealed a care plan for a risk of adverse effects related to psychoactive medications. Interventions included to utilized the PRN medications only after non-drug measures are ineffective. The care plan did not include individualized non-pharmacological interventions to assist the resident before PRN medications are administered. On 05/13/26, Resident #56 was ordered Vistaril (antihistamine to relieve anxiety) oral capsule 25 milligram by mouth PRN every 8 hours for anxiety/agitation. Review of the MAR for May 2026, revealed Resident #56 received one dose of Vistaril 25 mg on 05/16/26 at 10:01 P.M., 05/17/26 at 7:36 P.M., 05/20/26 at 8:01 P.M., and on 05/31/26 at 2:30 P.M. Review of the medical record progress notes on 05/16/25 at 10:01 P.M. by LPN #213, on 05/17/26 at 7:36 P.M by LPN #315, on 05/20/26 at 8:01 P.M. by LPN #315, revealed no documentation regarding attempted non-pharmacological interventions prior to medicating the resident. Interview with DON on 06/03/26 at 9:00 A.M. verified the findings.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to administer insulin medication per physician orders. This affected one resident (Resident #77) out of three residents reviewed for insulin medication. Facility census was 81.Findings include:Review of the medical record for Resident #77 revealed an admission date of 04/03/25. Diagnoses included but were not limited to vascular dementia, type 2 diabetes mellitus and congestive heart failure.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had intact cognition. Review of the physician orders dated February 2026 for Resident #77 revealed an order for Insulin Glargine subcutaneous Solution 100 units per milliliter (Units/ML), inject 28 units subcutaneous (SQ) one time a day for diabetes mellitus.Review of the February 2026 medication administration records (MARS) and treatment administration records (TARS) revealed Insulin Glargine subcutaneous Solution 100 Units/ML, inject 28 units SQ one time a day for diabetes mellitus for 02/09/26 had a #9 code, which means see nurses note.Review of the nurses notes dated 02/09/26 at 10:30 A.M. revealed Registered Nurse (RN) #406 contacted pharmacy regarding the insulin Glargine not being available. Interview on 06/01/2026 at 10:28 A.M. with Resident #77 revealed he gets insulin in the morning, but it was not always timely, and one time his insulin was not available.Interview on 06/01/26 at 11:41 A.M. with RN #406 confirmed she worked on 02/09/26 and Resident #77's insulin was not available. RN #406 confirmed he did not receive his insulin that day.Interview on 06/03/26 at 10:04 A.M. with Director of Nursing (DON) confirmed Resident #77 did not receive his insulin due to it not being available.Review of facility policy, Medication Administration, Insulin Administration, revised 06/21/2017, revealed insulin is a high-risk drug and warrants additional precautions for the safe and effective administration. This deficiency represents non-compliance investigated under Complaint Number 2747704.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and Ohio Board of Pharmacy guidance, the facility failed to ensure medications were not left unattended at the bedside and narcotic medications were disposed of timely. This affected one resident (Resident #19) of three reviewed for drug storage and one resident (Resident #85) of three residents reviewed for narcotic disposal. The facility census was 81Findings include:1. Review of Resident #19's medical records revealed an admission date of 03/04/26. Diagnoses included diabetes, chronic pain, depression, anxiety and hypertension (high blood pressure).Review of Resident #19'squarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had intact cognition. Resident #19 required substantial assistance with toileting, bathing and partial assistance with personal hygiene. Review of Resident #19's physician orders for June 2026 revealed an order for Fluticasone Propionate Suspension 50 microgram/actuation (MCG/ACT) to administer 2 sprays in each nostril one time a day for congestion. Observation and interview on 06/03/26 at 8:36A.M., during medication administration, revealed a bottle of Propionate Suspension 50 MCG/ACT medication was on Resident #19's bedside table. Resident #19 reported she keeps her nasal spray in her room and administers herself. Interview on 06/03/26 at 8:37 A.M. with Licensed Practical Nurse (LPN) #224 confirmed resident #19 is not permitted to have the nasal drops in her room and removed the drops from the room.Interview on 06/03/26 at 10:12 A.M. with Director of Nursing (DON) confirmed medications are not permitted in resident rooms, unless they have been assessed to self-administer and have a physicians or nurse practitioner order to do so safely. DON revealed Resident #19 was not able to self administer medication. Review of facility policy, Medication Storage, revised 07/23/2019, revealed medication are to be stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff member authorized to administer medication. Medication rooms, carts, and medication supplies are locked or attended by personnel with authorized access. Review of facility policy, Self-Administration of Medication, undated, revealed each resident who desires to self-administer medication is permitted to do so if the interdisciplinary team has determined the practice would be safe for the resident and other residents in the facility. Further stated, upon request, offered opportunity to self-administer medications once physician and interdisciplinary team concur the practice is safe.2. Review of the closed medical record for Resident #85 revealed an admission date of 01/26/26 and a discharge date of 01/31/26. Diagnoses included but were not limited to holiday relief care (respite care), congestive heart failure, and palliative care. Review of the physician orders for January 2026 revealed an order for Morphine Sulfate oral Solution 20 milligram (MG)/per 5 milliliter (ML) (30 ML) to administer 0.25 ml by mouth (PO) every four (4) hours as needed for pain (PRN) and Ativan oral tablet one (1) milligram administer 1 tablet po two times a day for restlessness and Lorazepam 0.5 mg administer 0.5 mg po every six (6) hours prn. Review of the Medication Administration Records (MARS) and Treatment Administration Records (TARS) for January 2026 revealed medications were administered per physician orders.Review of the document, Controlled Substance Disposal Log dated 02/10/26 revealed Lorazepam 1 mg tablet, 53 pills were disposed of, Lorazepam 0.5 mg tablet 60 pills were disposed of, and Morphine Concentrate 20mg/ml 30 ml was disposed of. Signatures with witnesses included Director of Nursing (DON, Assistant Director of Nursing/RN #203 and ADON/Licensed Practical Nurse (LPN) #283. The medications were disposed of 10 days after Resident #85 was discharged .Interview on 06/01/26 at 11:41 A.M. with Registered Nurse (RN) #406 confirmed Resident #85's narcotic medication were not disposed of immediately after her discharge. RN #406 revealed on 02/09/26 when she worked she gave the medications to Director of Nursing (DON). Interview on 06/03/26 at 10:12 A.M. and 06/04/26 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	at 6:50 A.M. with DON confirmed Resident #85's narcotics were not disposed of timely after discontinued use. DON reported she was discharged on 01/31/26 and narcotics were disposed of on 02/10/26, after RN #406 gave her the narcotics. DON reported it was too long to dispose of and should have been disposed of sooner. DON further stated once a resident is discharged the nurse is to pull the medication immediately and give to the DON to dispose of immediately.Review of Ohio Board of Pharmacy guidance, titled, Drug Enforcement Administration Rules on Pharmaceutical Drug Collection, updated 08/20/24 revealed under question 7) Can a long term care facility dispose of pharmaceutical drugs on behalf of an ultimate user who resides, or has resided, at that facility? the guidance indicates, Yes. Long term care facilities may dispose of pharmaceutical drugs on behalf of an ultimate user who resides, or has resided, at that facility through an authorized collection receptacle (maintained by an authorized hospital/clinic or retail pharmacy) located at the facility. When disposing of such controlled substances by transferring those substances into a collection receptacle, such disposal must occur immediately, but no longer than three business days after the discontinuation of use by the ultimate user. Discontinuation of use includes a permanent discontinuation of use as directed by the prescriber, as a result of the resident's transfer from the long-term care facility, or as a result of death. Links included: (S 1317.80 Collection receptacles at long-term care facilities) (S 1317.30 Authorization to collect from non-registrants).Review of the Drug Enforcement Administration, Chapter 2, Part 1317 - Disposal, Subpart B - disposal of Controlled Substances, revealed for a long-term care facility to dispose of controlled substances shall occur immediately, but no longer than three business days after discontinuation. This deficiency represents non-compliance investigated under Complaint Number 2747704.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, the facility failed to honor food preferences. This affected three residents (#35, #55, and #71) out of three residents for food preferences. The facility census was 81. Findings include:1. Review of the medical record for Resident #35 revealed an admission date of 07/01/24. Diagnoses included but are not limited to dementia, anxiety disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/03/26, revealed the resident had severely impaired cognition. The resident required supervision for eating and other activities of daily living (ADLs). Review of physician's orders for June 2026 revealed Resident #35 received a consistent vegetarian diet, regular texture with thin consistency liquids. Review of the Resident #35's diet tray ticket revealed Resident #35 received vegetarian diet, regular texture with thin consistency liquids. Resident #35's diet ticket stated that she wanted cottage cheese. Observation and interview on 06/02/26 at 11:55 A.M. revealed Resident #35's tray was put into the food cart. Resident #35's tray did not have cottage cheese on her tray. [NAME] #281 stated that Resident #35 did not want the cottage cheese anymore but stated that it was not documented anywhere to the best of her knowledge. Dietary Manager (DM) # 239 stated to [NAME] #281 that Resident #35 is to get her cottage cheese. This was verified by Dietary Aide #218 at time of observation. 2. Review of the medical record for Resident #55 revealed an admission date of 07/25/25. Diagnoses included but not limited to Alzheimer's Disease, diabetes mellitus, and hypopituitarism. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/07/26, revealed the resident had severely impaired cognition. The resident required set up for eating. Review of physician's orders for June 2026 revealed Resident #55 received a low concentrated sweet, regular texture with thin consistency liquids small portions. Review of the Resident #55's diet tray ticket revealed Resident #55 received low concentrated sweet, regular texture with thin consistency liquids small portions. Resident #55's diet ticket stated he wanted soup on tray. Observation and interview on 06/02/26 at 11:53 A.M. revealed Resident #55's tray was put into the food cart. Resident #55's tray did not have soup on his tray. This was verified by Dietary Aide #218 at time of observation. 3. Review of the medical record for Resident #71 revealed an admission date of 01/23/24. Diagnoses included but not limited to anxiety disorder, diabetes mellitus, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/05/26, revealed the resident had intact cognition. The resident required set up for eating. Review of physician's orders for June 2026 revealed Resident #71 received a low concentrated sweet, regular texture with thin consistency liquids small portions. Review of the Resident #71's diet tray ticket revealed Resident #71 received low concentrated sweet, cut up food texture with thin consistency liquids small portions. Resident #71's diet ticket stated that she did not want canned fruit. Observation and interview on 06/02/26 at 12:09 P.M. revealed Resident #71's tray was put into the food cart. Resident #71's tray had canned fruit on her tray, but her ticket stated that she does not like canned fruit. Resident #71 asked for a salad but did not have salad dressing on the tray as a condiment. This was verified by Dietary Aide #218 at time of observation. This deficiency represents non-compliance investigated under Complaint Number 2629657.