STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366373	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Westlake Village	28450 Westlake Village Drive Westlake, OH 44145

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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 0558 Level of Harm - Potential for minimal harm Residents Affected - Many	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, resident record review, and review of resident council minutes, the facility failed to ensure a sufficient supply of washcloths and towels available for morning care and as needed. This affected one resident (Resident #26) with the potential to affect all residents residing at the facility.Findings include:Record review for Resident #26 revealed an admission date of 03/19/26 with diagnosis including myocardial infarction, muscle weakness, pressure ulcer of right buttocks stage three, and pressure ulcer left buttocks stage two. Review of the Modification of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 was cognitively intact and was occasionally incontinent of urine. Resident #26 used a walker for mobility, required substantial/maximal assistants for toileting hygiene, partial/moderate assistants for upper and lower body dressing, and personal hygiene. Resident #26 had an unhealed pressure ulcer, was at risk for pressure ulcers and received pressure ulcer care. Review of the care plan dated 03/26/26 revealed Resident #26 had potential for pressure ulcer development related to a stage three pressure ulcer to the right buttocks and a stage two pressure ulcer to the left buttocks. Interventions included to provide incontinence care as needed.Review of the care plan dated 03/19/26 revealed Resident #26 had an activity of daily living (ADL) self-care performance deficit related to muscle weakness. Interventions included to provide the resident with short simple instructions such as hold your washcloth in your hand. Put soap on your washcloth, wash your face, etc.Observation on 04/16/26 at 7:38 A.M. of Certified Nursing Assistant (CNA) #430 provide morning care for Resident #26 revealed Resident #26 ambulated to the bathroom with use of her walker and assistants from CNA #430. Observation revealed CNA #430 used a disposable wipe to wash Resident #26's face. CNA #430 revealed there were no clean washcloths or towels to wash her residents or dry them so she has to use the disposable wipes intended for incontinence care to wash their entire body. CNA #430 revealed this happens several days a week and sometimes they don't get any washcloths or towels until after she leaves at 2:00 P.M.; Resident #26 made a grumbling sound and revealed she would at least like a washcloth for her face. Observation revealed CNA #430 continued washing Resident #26's entire body with disposable wipes. Observation on 04/16/26 at 8:02 A.M. with CNA #430 of both the linen closets on the first floor, A and B hall revealed there were no washcloths or towels available for use. CNA #430 confirmed those were the only storage areas used for wash cloth and towel storage on the first floor.Observation on 04/16/26 at 8:08 A.M. with CNA #415 of both the linen closets on the second floor, A and B hall revealed there were no washcloths or towels available for use. CNA #415 confirmed those were the only storage areas used for wash cloth and towel storage on the second floor and revealed, We don't have washcloths or towels, laundry came and picked up the soiled linen, they will wash them then bring them back. CNA #415 revealed the staff had disposable wipes to clean residents' bottoms when they were incontinent, but the residents would have to wait until laundry washed the washcloths and towels to get the rest of their body washed up for the day.Observation on 04/16/26 at 8:30 A.M. with Director of Housekeeping #331 revealed the laundry personnel transported the laundry in a large bin from each soiled utility room in the skilled nursing facility to the laundry area located through the assisted living section of the facility. Director of Housekeeping #331 confirmed (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 0558 Level of Harm - Potential for minimal harm Residents Affected - Many	the skilled nursing facility had two resident floors and two closets on each floor where the washcloths and towels were stored for residents' use. The laundry personnel worked a total of eight hours a day, their shift began somewhere between 7:00 and 8:00 A.M.; When they arrived, they washed the tablecloths and napkins first. Director of Housekeeping #331 confirmed the staff had no clean towels or wash cloths this morning for any residents residing in the skilled nursing facility and revealed she ordered linens monthly and the staff threw most of them away. Director of Housekeeping #331 confirmed the lack of washcloths and towels was an ongoing problem, staff expressed to her two to three times a week that they had no towels or washcloths available to wash residents. Director of Housekeeping #331 confirmed she did not have any backup supply in stock either, she was waiting on the next shipment.Interview on 04/16/26 at 8:54 A.M. with Registered Nurse (RN) #390 confirmed there were days there were no washcloths or towels in the mornings. RN #390 stated, Residents just can't wash up except wipes for their bottoms, they said staff were throwing them away, I never seen that.Interview on 04/16/26 at 9:00 A.M. with Resident #43 revealed there are times there are no washcloths or towels to wash up in the mornings and stated, Lots of times I like to wash up and can't, it makes me feel awful.Interview on 04/16/26 at 9:30 A.M. with Administrator confirmed he was aware of residents not having enough washcloths and towels available for resident use daily. Administrator confirmed it was an ongoing issue especially when agency staff worked, they put them in the trash or hoard them in some residents rooms.Interview on 04/16/26 at 12:07 A.M. with Resident #51 revealed, There are mornings I can't wash because there are no washcloths or towels, I have had to use paper towels, it's terrible.Review of the Resident Council Meeting minutes dated 01/20/26 at 1:30 P.M. revealed the list of old business unresolved included towels for showers. Under the Summary of Issues was documented not enough towels and toilet paper in residents' bathrooms and for showers. Review of the section titled, Review of Prior Council Meeting revealed they met with Administrator about towel issue.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure Resident #24 was provided with timely incontinence care. This affected one resident (Resident #24) of three residents reviewed for incontinence. The facility census was 58.Findings include:Record review for Resident #24 revealed an admission date of 02/08/25. Diagnosis included chronic kidney disease, muscle weakness, overactive bladder, anxiety disorder, and polyneuropathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was severely cognitively impaired. Resident #24 was always incontinent of bowel and bladder, required substantial/maximal assistants for bed mobility, dependent for chair/bed to chair transfer and had no ulcers, wounds or skin problems.Review of the care plan dated 03/19/26 revealed Resident #24 had bladder incontinence. Interventions included checking the resident as required for incontinence. Wash, rinse and dry perineum.Interview and observation on 04/20/26 at 9:05 A.M. revealed Resident #24 was awake, lying in bed. Resident #24's room smelled of stool. Resident #24 revealed she pooped a little and revealed the girl said she would be back in, in a little bit. Observation on 04/20/26 at 9:34 A.M. revealed Licensed Practical Nurse (LPN) #408 entered Resident #24's room and applied a powder under the bilateral breast then exited the room. LPN #408 revealed Resident #24 was alert and oriented to person, place, and time with moments of confusion.Observation on 04/20/26 at 10:00 A.M. with Certified Nursing Assistant (CNA)/Scheduler #301of incontinence care revealed Resident #24 had a large bowel movement that extended up into the peri area. The bed pad and sheet also was soiled with stool/urine. CNA #301 revealed she started the shift at 8:00 A.M. and someone else was covering until she arrived. She had not been in to see Resident #24 yet. Observation after removing the stool revealed Resident #24's crease in her right and left thigh was red and open on the crease lines. The buttocks was deep red and excoriated covering the entire buttocks to the lower back. CNA #301 completed peri care and applied A&D ointment.Interview on 04/20/26 at 10:00 A.M. with CNA #431 revealed she started her shift at 6:30 A.M. and there was a call off, so it was her and one other CNA that was also agency staff. She did not realize and it was not on her schedule that she was supposed to cover Resident #24's room until another CNA arrived. CNA #431 revealed she did take Resident #24's breakfast tray in but she did not check or change her and revealed she did tell her someone would be with her. CNA #431 stated, I did not know her or that I was supposed to have her.Interview on 04/20/26 at 11:02 A.M. with Director of Nursing (DON) revealed residents should be checked on frequently for incontinence, no more than two hours, more frequently if needed. Each resident should always have an assigned aid, if a resident is lying in stool, they should be changed immediately. Review of the facility policy titled, Perineal Care revised September 2005 revealed the purpose of the procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.This deficiency represents non-compliance investigated under Complaint Number 2684091, 2907090 and 1400671.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation and facility policy review, the facility failed to ensure food was served at appetizing temperatures. This had the potential to affect 57 of 58 residents in the facility as Resident #37 did not receive meals by mouth.Findings include:Review of Food Committee meeting notes from 01/20/26, 02/04/26 and 03/03/26 revealed residents had complaints about food temperatures for room tray deliveries. The meeting on 02/04/26 residents met with Associate Dietary Manager #311 to discuss adjusting the food route for tray deliveries. The meeting on 03/04/26 revealed dietary was working on a new route for room tray deliveries.Interview on 04/14/26 at 4:08 P.M. with Resident #50 revealed the food was seasoned good but was not always warm enough and the staff would not heat it up. Resident revealed she brought a microwave to heat her food up, but staff would not allow her to have it so she had to eat the food the way it was.Interview on 04/14/26 at 4:20 P.M. with Director of Dining Services (DDS) #318 revealed facility cooks all food in the main kitchen and brings food to satellite kitchens on the first and second floors. Food is placed on steam tables and served to residents eating in the dining room and then staff plates food for residents eating in their rooms and delivers trays to their rooms. DDS #318 revealed there were previous issues with food remaining warm during COVID when they were using Styrofoam plates, but they have insulated plates and plate covers that help with keeping the food warm.Observation on 04/15/26 at 11:21 A.M. of lunch tray line with DDS #318 revealed a food cart left main kitchen at 11:32 A.M. and arrived on the 2nd floor satellite kitchen at 11:37 A.M. Server #440 and Server #441 placed table pans into the steam table at 11:43 A.M. and checked temperatures. Facility had a program where the thermometer automatically puts food temperatures into the computer system. At 11:58 A.M. staff started plating food for residents eating in the 2nd floor dining room. At 12:22 P.M. Server #441 started plating food for residents eating in their rooms. Server #441 was plating almost all food, cooking substitutes and adding side items to trays. Server #440 did not add drinks to the trays until after the food was plated. The first cart of room trays for rooms 221-228 left the satellite kitchen at 12:37 P.M. room [ROOM NUMBER] tray was on cart for 15 minutes before leaving the kitchen. Lunch for the 2nd floor was finished being served at 12:58 P.M. DDS #318 confirmed the observations.Observation and interviews on 04/16/26 at 12:00 P.M. of the 2nd floor tray line revealed at 12:45 P.M. a test tray was plated by Server #317 and placed on the last cart of trays. The cart left the satellite kitchen at 12:50 P.M. with Dinning Services Coordinator #443 and trays for room [ROOM NUMBER] and 229 were delivered. Test tray was taken off cart at 12:51 P.M. by DDS #318 who took the following temperatures: Crumb baked sole at 147 degrees Fahrenheit (F), chicken tenders at 120 F, green beans at 109 F, braised lima beans at 119 F, fruit at 56 F, and cream of cauliflower soup at 131 F.Each food item was tested and revealed the crumb baked sole was warm, the cream of cauliflower soup, braised lima beans and chicken tenders were lukewarm. The green beans were not warm. DDS #318 was allergic to fish but did try the green beans and confirmed they were not warm. Interview with DDS #318 revealed staff will serve the room trays before the dining room to see if this helps with food temperatures.Review of facility policy titled Food and Beverage Temperature Control with a last revised date of 2/26 revealed food and beverage temperatures must be maintained during transport of food.This deficiency represents non-compliance investigated under Complaint Number 1400647.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of the facility policy, the facility failed to implement an infection control program that properly tracked infection to prevent transmission of scabies and failed to ensure infection control procedures were maintained at all times. This affected two residents (Resident #26 and #38) and had the potential to affect all 58 residents in the facility.Findings include:1.Record review for Resident #38 revealed an admission date of [DATE] with diagnosis including infection and inflammatory reaction due to internal left hip prosthesis, subsequent encounter and aftercare following joint replacement surgery. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. Resident #38 had impairment on one side of the lower extremities, had medically complex conditions, had intravenous (IV) access and received IV medications. Review of the care plan dated [DATE] revealed Resident #38 required enhanced barrier precautions (EBP) related to a midline used for IV antibiotics. Interventions revealed staff to use personal protective equipment (PPE) (Hand hygiene, gloves and gown) when providing high contact care activities. Review of the physician orders revealed Resident #38 had an order dated [DATE] for Cefazolin Sodium intravenous solution reconstituted two grams IV every eight hours for prosthetic joint infection until [DATE]. Normal saline flush IV solution 0.9% use 10 milliliters (ml) IV every eight hours for line maintenance. Flush with 10 ml pre and post IV med administration. An additional order was written on [DATE] for EBP for midline every shift. Observation during medication administration on [DATE] at 2:01 P.M. revealed Licensed Practical Nurse (LPN) #402 flushed Resident #38's midline catheter with 10 ml of normal saline after cefazolin solution completed infusion. Observation revealed LPN #402 never donned an isolation gown during the procedure. Observation after completion with LPN #402 of the EBP sign on Resident #38's entrance doorway revealed everyone must wear gloves and a gown for the following high contact resident activities (which included) device care and use. LPN #402 reviewed the sign and confirmed she never donned an isolation gown while disconnecting the IV antibiotic and flushing Resident #38's IV line with saline solution. 2. Record review for Resident #26 revealed an admission date of [DATE] with diagnosis including myocardial infarction, muscle weakness, pressure ulcer of right buttocks stage three, and pressure ulcer left buttocks stage two. Review of the Modification of the admission MDS assessment dated [DATE] revealed Resident #26 was cognitively intact and was occasionally incontinent of urine. Resident #26 used a walker for mobility, required substantial/maximal assistants for toileting hygiene, partial/moderate assistants for upper and lower body dressing, personal hygiene, sitting to a standing position, and supervision or touching assistants to walk 10 feet once standing. Resident #26 had an unhealed pressure ulcer, was at risk for pressure ulcers and received pressure ulcer care. Review of the care plan dated [DATE] revealed Resident #26 had potential for pressure ulcer development related to a stage three pressure ulcer to the right buttocks and a stage two pressure ulcer to the left buttocks. Interventions included to provide incontinence care as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current physician orders for Resident #26 revealed an order dated [DATE] for treatment to the buttocks, cleanse with normal saline, pat dry, apply [NAME] to the wound bed and cover with foam every evening shift. An additional order dated [DATE] revealed Resident #26 was to have Enhanced Barrier Precautions – wounds every shift. Observation on [DATE] at 7:38 A.M. of Certified Nursing Assistant (CNA) #430 provide morning care for Resident #26 revealed Resident #26 required hands on care while in bed to sit up then stand. Resident #26 then ambulated to the bathroom with use of her walker and assistants from CNA #430. Once Resident #26 reached the toilet, CNA #430 removed Resident #26's soiled (urine) brief. Observation revealed Resident #26 had a dressing on both the right and left buttocks. Both dressings had the edges rolling up and were not fully intact. Observation revealed CNA #430 never donned an isolation gown during care. CNA #430 confirmed Resident #26 had wounds on her buttocks. CNA #430 continued with washing Resident #26's face, arms, legs, and buttock/peri area, dressed and groomed Resident #26, walked her back to her bedside chair in her room then made her bed. Observation on [DATE] at 8:02 A.M. with CNA #430 revealed a sign near the entrance door of Resident #26's room. The sign read EBP, wear gloves and gown for the following high contact resident care activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care and wound care. CNA #430 confirmed she did not donn an isolation gown while providing any of the morning care observed for Resident #26. Observation on [DATE] at 11:25 A.M. of LPN #366 provide wound care to Resident #26's right and left buttocks revealed CNA #430 was present to assist with positioning Resident #26. Both CNA #430 and LPN #366 donned an isolation gown and gloves prior to care. After completing wound care to the left side of the buttocks, LPN #366 removed her gloves, left her isolation gown on, used hand sanitizer and exited the room (with the isolation gown on) revealing she needed more treatment supplies. LPN #366 closed the door behind her. After approximately three to four minutes, LPN #366 opened the door and donned a new isolation gown. LPN #366 revealed she threw the previous gown in the treatment cart trash. LPN #366 then completed Resident #26's wound care. Resident #26 stated, This is the first time any staff wore a gown for anything. Observation revealed upon exiting the room with LPN #366, the soiled gown LPN #366 previously removed was partially hanging out of the trash can that was connected to the treatment cart. Interview on [DATE] at 9:19 A.M. with DON revealed isolation gowns were to be removed and disposed of in the trash can prior to exiting a resident room on EBP. Review of the facility policy titled, Enhanced Barrier Precautions Policy dated [DATE] revealed EBP should be used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organism (MDRO's) to residents. EBP are used in conjunction with standard precautions and expand to the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO's to associate hand and clothing. Examples of care activities include providing AM or PM care including oral care, dressing, bathing, grooming. Taking the resident to the toilet or providing peri care, doing dressing changes or providing bed mobility. 3. Review of facility infection control log from [DATE] to [DATE] revealed Resident #63 was diagnosed with Norwegian Scabies on [DATE] and treated with Ivermectin 5 tablets for 3 weeks. No other residents were listed on the control log for being treated with Norwegian scabies or scabies. Review of medical record for Resident #63 revealed the resident was admitted on [DATE] and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired on [DATE]. Resident diagnosis included traumatic subdural hemorrhage, traumatic subarachnoid hemorrhage, chronic diastolic heart failure, dementia, essential tremor, lymphedema, and essential hypertension. Review of the progress notes revealed resident had a rash on [DATE], dermatology was consulted and resident was ordered diclofenac cream and appeared to be improving. A Physician Progress Note dated [DATE] revealed rash was improving, resident was not scratching and had been prescribed Atarax 25 Milligrams (MG) every 6 hours as needed and Diclofenac cream. A Nursing Progress Note dated [DATE] revealed facility Medical Director #445 was notified that Resident #63 rash was unchanged and itchy. Resident was ordered Singular 10 mg daily. A Nursing Progress Note dated [DATE] revealed Medical Director #445 had seen resident regarding rash and ordered: labs, Itraconazole 100 mg for 10 days, Terbinafine cream to chest for 10 days and Clotrimazole Betamethasone cream for 10 days. A Nursing Progress Note dated [DATE] revealed Resident #63 had returned from dermatology appointment and was diagnosed with Norwegian scabies. Previous orders were discontinued, resident was prescribed Ivermectin 3 MG for 3 weeks and to be placed in contact isolation. Review of e-mail sent by DON #422 dated [DATE] at 9:00 P.M. revealed staff was notified of a confirmed case of scabies in the building. DON #422 requested assistance with showering residents after their treatment and wiping the cream off. In addition, Also, if any staff member that would like to take Ivermectin prophylactically then please reach out to either me or Administrator. We will provide those medications. The e-mail also included a link from the Centers for Disease Control titled Clinical Overview of Crusted scabies. Review of Resident #22 medical record revealed an admission date of [DATE] with diagnosis that included: other fracture of first lumbar vertebra, other fracture of second lumbar vertebra, history of falling, multiple fractures of ribs, muscle weakness, dysphagia, cirrhosis of liver and scabies. A Nursing Progress Note dated [DATE] revealed resident had complained about her back being itchy but no redness or rash noted. A Physician Progress Note dated [DATE] revealed Resident #22 had complaints of rash on her back but no rash was present on exam. A Nursing Progress Note dated [DATE] revealed resident had a rash all over and was ordered Prednisone 20 MG daily for 5 days, Hydrocortisone cream and Benadryl. A Comprehensive Nursing Note dated [DATE] revealed resident had returned from a dermatology appointment, was diagnosed with scabies and ordered Ivermectin, Triamcinolone 0.1 %, and Permethrin 5 %. Resident was placed in contact precautions. Review of Resident #54 medical chart revealed a Nurse Progress Note dated [DATE] stating resident had a redness to his legs that were hot to the touch. Resident was ordered Ivermectin Oral Tablet 3 MG on [DATE] for treatment of scabies. Review of facility infection control log from [DATE] to [DATE] revealed neither Resident #22 nor Resident #54 were listed on the infection control log for scabies. Interview on [DATE] at 9:20 A.M. with Social Worker #325 revealed there was a scabies outbreak, she thinks it was only on the 2nd floor and did not think any staff had scabies from the outbreak. Interview on [DATE] at 9:44 A.M. with the Administrator and DON #422 revealed the facility coordinated with local health department and their Medical Director #445. The original case was in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] and the second case was in [DATE]. DON #422 revealed the scabies case in September was Resident #22. She said no staff had symptoms or signs of scabies and no staff was treated prophylactically. Interview on [DATE] at 11:18 A.M. with Disease Investigator (DI) #446 from the Cuyahoga County Board of Health (CCBH) revealed the facility notified them on [DATE] of six cases of suspected scabies and provided treatment dates for the other residents that were treated on [DATE]. DI #446 recommended the facility to treat residents on the unit and staff that provided patient care on multiple residents. In addition, recommended facility treat staff and residents on the infected unit and those who were in common areas. DI #446 revealed he would have liked the facility to be more aggressive with the prophylactic treatment but that CCBH cannot enforce this recommendation. He said one case of scabies does not need to be reported to the health department. Interview on [DATE] at 3:08 P.M. with Administrator and DON #422 revealed that the previous staff person who was filling out the infection control log was no longer at the facility. DON #422 revealed that when the report for infectious disease in their electronic medical record system, Point Click Care, was ran it did not pull dermatologicals. She said this was the reason that the other residents that were treated for scabies were not listed on the infection control log. Interview on [DATE] at 2:24 P.M. with Administrator and DON #422 revealed 16 residents were treated for scabies, including six residents that had active rashes. DON #422 said there at 16 rooms on A Hall on the second floor and 14 room on B Hall. The residents with rashes and Resident #62 were all on A Hall and they provided prophylaxis treatment to all residents on that hall. Residents that received treatment were: Resident #43, Resident #40, Resident #32, Resident #25, Resident #21, Resident #16, Resident #20, Resident #15, Resident #6, Resident #54 and Resident #24. Previous residents that received treatment were: Resident #64, Resident #65, Resident #66 and Resident #67. Interview on [DATE] at 3:40 P.M. with DON #422 confirmed that residents were not on log for scabies. DON #422 provided the infection control map for [DATE] that had Resident #22 room [ROOM NUMBER] highlighted in orange with scabies written on it. DON #422 revealed facility needed to do a better job of tracking infections. Interview on [DATE] at 10:58 A.M. with the Administer revealed the [DATE] scabies outbreak was communicated to staff by the facility directors. He did not have information confirming staff was informed of the scabies outbreak. He said contact tracing was done for 7-days from diagnosis, and he would try to find documentation. Interview on [DATE] at 12:18 P.M. with the Administrator revealed all emails regarding contact tracing and other communication regarding the scabies outbreak were automatically deleted from their system after six months. He provided screen shots from his text message conversation with Executive Director #447 regarding contact tracing not revealing where Resident #63 got scabies from. Administrator said previous LPN #448 had contacted families and he was not sure were this was documented. Resident #22 and Resident #63 medical record included notes that family was updated but no further documentation was available regarding other residents families and visitors being informed of the scabies outbreak. Interview on [DATE] at 1:46 P.M. with the DON #422 regarding Excel document titled Review of facility Infection Line Listing 2025 revealed she thinks the associates listed as receiving treatment were the staff members that received treatment in [DATE] scabies outbreak. DON #422 revealed due (continued on next page)

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	366373	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Westlake Village	28450 Westlake Village Drive Westlake, OH 44145

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to emails deleting after six months she was not positive if this was from the [DATE] or [DATE] outbreak or if this was the most updated list. She said during one of the outbreaks no staff took the treatment. Interview on [DATE] at 2:29 P.M. with the Administrator revealed he spoke with the CCDH and they can provide the emails between facility and CCDH. Administrator confirmed the facilities records regarding the scabies outbreak was not saved correctly an emails, documents, in-services, treatments and other relevant information was either unable to be provided or provided in pieces. Some information provided, the facility was unable to confirm if they were from the [DATE] or [DATE] outbreak. Interview on [DATE] at 2:29 P.M. with DI #449 from the CCDH revealed the facility had been having skin issues since [DATE]. She said the facility took a while to provide the line list and that when they received the information it was not very detailed. DI #449 sent the Final Report dated [DATE] and the Line List provided by the facility. Review of the Final Report written by DI #449 revealed CCBH was notified by the facility on [DATE] of an outbreak of a dermatological condition. The facility reported six residents that were experiencing ongoing rashes. Further review revealed: The index case had a history of multiple skin issues dating back to [DATE], which were undiagnosed. The index case was medically diagnosed with crusted scabies and received prophylactic treatment. All other residents were prophylactically treated, and their skin conditions have not worsened since treatment. However, no other residents report a crusted rash. Resident #63 received a diagnosis of crusted scabies but all other cases did not received skin scarping test to confirm diagnosis. The section titled: Epidemiological Investigation Findings revealed the following information The onset date for the cluster of rash cases started approximately two weeks prior to reporting date, exact date unknown. The index case has been having dermatological problems since [DATE], and was initially treated for a fungal infection. All (100%) of cases and the remaining residents on the same wing/unit were treated prophylactically with permethrin cream, two doses a week apart. Demographic information on the cases were not provided by the reporting facility. The section titled: Recommendations for Controlling Disease and/or Preventing/Mitigating Exposure revealed the following: A staff member who has skin-to-skin contact with a resident that has scabies should receive prophylactic treatment, even if they are asymptomatic. Other residents within the community should receive prophylactic treatment, even if they are asymptomatic. Use of standard precautions that include good hygiene, use of personal protective equipment, and proper disposal of single use gloves. Continued surveillance of skin changes for 8 weeks after the last case is identified. Review of Excel document titled Scabies Line List provided by the facility to the CCDH not dated revealed facility provided initials, room number and date of treatment for six residents (Resident #63, Resident #16, Resident #25, Resident #65, Resident #6 and Resident #67. Resident #43, Resident #40, Resident #32, Resident #25, Resident #21, Resident #16, Resident #20, Resident #15, Resident #6, Resident #54 and Resident #24. Previous residents that received treatment were, Resident #64, Resident #65, Resident #66 and Resident #67. Resident #63 was documented as having date of onset date as [DATE]. No other residents that were treated prophylactically were listed on the line list. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided the following documents regarding the scabies outbreak: Review of Clinical Services In-Service Form-Skilled Nursing dated [DATE] revealed facility conducted an in-service on scabies with staff that also included infection control and hand hygiene. Review of facility Infection Line Listing 2025 revealed Resident #22 tested positive on [DATE] and Date of Recovery was [DATE]. Completed Associates that were treated prophylactically included LPN #402, Restorative Specialist #370, Registered Nurse (RN) #390, CNA #375, RN #365 and previous LPN Unit Manager #448. Review of facility document titled, Contact Tracing for Infectious Diseases Resident or Associate (AL/MC/SNF) with a last revision date of 09/23 included: Identifying Information, Symptoms, Signs and Significant Conditions, Exposure History, Diagnosis, Treatment and General Notes/Comments. The form dated [DATE] had Resident #22 information. The form dated [DATE] had Resident #63 information. No other residents contract tracing forms were provided. Appendix C: Scabies Outbreak Management Checklist from the Ohio Department of Health-Infectious Disease Control Manual (ODH-IDCM) Scabies Section 6 with a revised date of 11/23: revealed the following: -Section titled: Investigation and Monitoring: Daily skin assessments documented on all at-risk persons in the care of the institution/facility. This box was not checked off as completed and residents were only receiving weekly skin assessments. -Section titled: Treatment: Prophylactic treatment offered to contacts, including staff, family Appendix D: Sample Data Sheet: Data Collection Form for Scabies with a revised date of 11/2023 had no resident identifying information filled out. Exposure History section was filled out but included no date of onset of symptoms. Appendix E: Sample Staff Line List and Appendix F: Sample Patient Line List were blank and facility was unable to provide list when requested. Appendix H: Sample Provider Letter Related to Scabies Outbreaks for healthcare providers revealed the following information: Family members and other close contact should receive prophylactic scabies treatment at the same time the patient is treated. Permethrin 5% cream (Elimite) is now the recommended agent for treatment of scabies. Review of the Center's for Disease Control (CDC) guidelines titled Public Health Strategies for Crusted Scabies Outbreaks in Institutional Settings dated [DATE] revealed the surviellance includes maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; evaluate and confirm suspected cases by obtaining skin scrapings; persons with crusted scabies may not show the characteristic symptoms of scabies such as rash and itching (pruritus). Maintain ongoing surveillance for scabies among all patients/residents and staff to identify new or unsuccessfully treated cases of scabies. Control & Treatment includes maintain records with patient name, age, sex, room number, roommate(s) name(s), skin scraping status and result(s), and name(s) of all staff who provided hands-on care to the patient/resident before implementation of infection control measures: symptoms can take up to 2 months to appear in exposed persons and staff, use epidemiologic data about the distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates (continued on next page)

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