STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365310	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of North Olmsted	23225 Lorain Rd North Olmsted, OH 44070

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, family and staff interview, and review of facility policy, the facility failed to ensure a resident met the criteria to be admitted to and reside on the secured unit This affected one (Resident #77) of three residents reviewed for abuse. The facility census was 75. Findings include: Record review for Resident #77 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included anoxic brain damage, intracranial injury with loss of consciousness, aphasia, encephalopathy, attention deficit hyperactivity disorder, anxiety disorder, muscle weakness, dysphagia, dysphonia, restlessness and agitation, violent behavior, traumatic brain injury (TBI), bipolar disorder, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 was severely cognitively impaired. Resident #77 had no impairment to the upper or lower extremities, used a wheelchair for mobility, supervision or touch assist with eating, dependent on staff for toileting hygiene, bed mobility, transfers, and wheelchair mobility, and required substantial /maximal assistants for personal hygiene. Review of the elopement review dated 02/12/25 completed by Licensed Practical Nurse (LPN) #321 revealed Resident #77 was at low risk for elopement. There were no behaviors of wandering or exit seeking exhibited by Resident #77 documented in the medical record. There was no documentation why Resident #77 was placed on the memory care unit. Telephone interview on 02/24/25 at 1:20 P.M. with Resident #77's Parent stated her son was young and suffered an anoxic brain injury. She was looking for a facility that could address her son's bipolar disorder, provide her son therapy and socialize with peers near his age. Resident #77's Parent stated she was assured by the Admissions Coordinator of all the above. A final decision was made for a room on the second floor near the nursing station and where there were residents near his age. Upon admission at the facility on 02/11/25, Resident #77 and his Parent were made aware the room on the second floor was not ready so he would have to stay in the secured unit located on the first floor. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/24/25 at 1:52 P.M. with Licensed Practical Nurse (LPN) #300 confirmed Resident #77 resided in the secured unit. LPN #300 stated Resident #77 would not have been able to exit seek or leave the facility, Resident #77 required total assistance. There were no residents residing in the secured unit near Resident #77's age. Interview on 02/24/25 at 2:07 P.M. with Admissions Coordinator (AC) #388 stated on the day Resident #77 was admitted to the facility, there was only one room in the building ready. AC #388 stated It takes a while to get the rooms cleaned and ready. AC #388 told them upstairs was available but then AC #388 wanted to try Resident #77 in the secured unit because of his seizure type because he would get more attention in the secured unit. Admissions Coordinator #388 stated she made the decisions where residents would be admitted to in the facility, she had no medical training and she was not aware of any specific guidelines for admission to the secured unit. AC #388 stated she felt due to a diagnosis of seizure disorder, and even though Resident #77 had no history of wandering or exit seeking, Resident #77 should be admitted to the secured unit. Telephone interview on 02/25/25 at 1:20 P.M. with Medical Director #423 stated he did not determine where residents were admitted to in the facility. The secured unit would be for residents who was a threat to leave the facility or had dementia. It would be a case by case determination. Review of the facility policy for the secured unit titled, Name of Facility revised 10/13/20 revealed the policy is to provide a safe environment for all residents living in the secure care unit. To prevent accidents related to wandering and elopement. A resident's risk related to wandering and elopement will be evaluated as part of the preadmission evaluation and upon any residents change in condition or functionality. All exit doors are alarmed /code locked and remain activated 24 hours a day. This deficiency represents non-compliance investigated under Complaint Number OH00162710.

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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** 42011 Based on observation, resident and staff interview, record review, and review of the facility policy, the facility failed to ensure the residents who were dependent on staff for activities of daily living received assistance with showers and personal hygiene. This affected two (Resident #24 and #70) of three residents reviewed for activities of daily living. The facility census was 75. Findings include: 1. Record review for Resident #24 revealed an admitted [DATE]. Diagnosis included fibromyalgia, hemiplegia and hemiparesis following cerebral infarction, and muscle weakness. Review of the care plan dated 08/22/23 revealed Resident #24 had an activity of daily living self care performance deficit due to decline in physical and cognitive function. Interventions included bathing and showering, check nail length and trim and clean on bath day and as necessary and provide a sponge bath when a full bath or shower cannot be tolerated. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 was dependent on staff for showers/bathing and personal hygiene. Review of the shower schedule revealed Resident #24's showers/baths were due every Wednesday and Saturday. The shower records for Resident #24 from 01/01/25 through 02/24/25 revealed Resident #24 did not receive the scheduled shower/bath on 01/11/25, 01/25/25, 02/05/25, 02/12/25, 02/19/25, or 02/22/25. There were 16 opportunities during this review period and Resident #24 missed six showers/baths. There were no documented make up days for these scheduled shower/baths that were not offered or given. Observation and interview on 02/24/25 at 9:06 A.M. revealed Resident #24 had a foul body odor. Resident #24's fingernails were long, painted, and corroded with a dark brown substance on the underneath. Resident #24 stated she was not receiving her baths twice a week consistently as scheduled. Interview on 02/25/25 at 10:20 A.M. with the Director of Nursing (DON) stated when showers/baths are completed or refused, a shower sheet was filled out. If the resident refused the bath/shower, a second attempt by the certified nursing assistant (CNA) would be made. Then if the resident still refused, the nurse should attempt, then document in the progress note and on the shower sheet the refusal. At times, the shower aids were pulled to the floor then the floor CNAs should give their own showers. The DON confirmed there were no more shower sheets or documentation for Resident #24 to reflect showers were offered or given. The DON confirmed if they were offered, even if refused, they should be documented. 2. Record review for Resident #70 revealed an admitted [DATE]. Diagnoses included asthma, lymphedema, and type two diabetes mellitus. Review of the care plan for Resident #70 dated 11/27/24 revealed Resident #70 had a self care deficit related to morbid obesity. Interventions included to encourage the resident to do as much as possible for self as able and to set up bath items and put out clothes as needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 was cognitively intact. Resident #70 required substantial/maximal assistance with showers/bathing and personal hygiene. Review of the shower schedule revealed Resident #24's showers/baths were due every Tuesday and Friday. Review of the shower sheets from 01/01/25 through 02/24/25 revealed Resident #70 did not receive the scheduled shower/bath on 01/03/25, 01/14/25, 01/17/25, 01/21/25, 02/14/25, and 02/21/25. There were 16 opportunities during this review period and Resident #24 missed six showers/baths. There were no documented make up days for these scheduled shower/baths that were not offered or given. Observation and interview on 02/24/25 at 10:41 A.M. revealed Resident #70 was sitting up in bed. Resident #70 had a foul strong body odor. Resident #24's fingernails were embedded with a dark substance. Resident #70 stated sometimes staff were too busy to give her a shower. Interview on 02/24/25 at 11:23 A.M. with Certified Nursing Assistant (CNA) #304 stated she was scheduled to be a full time shower aid. CNA #304 stated when there were call offs at the facility and no other staff would pick up, she would be pulled to the floor. When she was pulled to the floor, each CNA would be responsible to complete the residents on their assignments scheduled showers. CNA #304 stated when showers/baths were completed, a shower sheet would be filled out even if the resident refused. Interview on 02/25/25 at 10:20 A.M. with the Director of Nursing (DON) stated when showers/baths are completed or refused, a shower sheet was filled out. If the resident refused the bath/shower, a second attempt by the certified nursing assistant (CNA) would be made. Then if the resident still refused, the nurse should attempt, then document in the progress note and on the shower sheet the refusal. At times, the shower aids were pulled to the floor then the floor CNAs should give their own showers. The DON confirmed there were no more shower sheets or documentation for Resident #70 to reflect showers were offered or given. The DON confirmed if they were offered, even if refused, they should be documented. Review of the facility policy titled Activities of Daily Living, Supporting, revised March 2018, revealed residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. This was an incidental finding during the complaint survey.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42011 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure the staff covered their hair exposed while working with or around food in the kitchen area. This had the potential to affect all 75 residents residing at the facility who receive food from the kitchen. Findings include: Observation on 02/24/25 at 9:21 A.M. with Dietary Manager #341 of the kitchen area and food storage area revealed Dietary Manager #341 wore his hair net on top of his head with his long dreadlocks outside of the hairnet. Dietary Manager #341, Dietary Aid #314 and Dietary [NAME] #302 had beards that were uncovered while in the kitchen. Observation on 02/24/25 at 11:26 A.M. of the food service line revealed Dietary Manager #341 wore his hair net on top of his head with his long dreadlocks outside of the hairnet while in the kitchen during meal service. Dietary [NAME] #302 was serving the food on the plates with his beard uncovered. Dietary Aid #314 was assisting in the tray line with his beard uncovered. Dietary [NAME] #302 stated they don't have beard covers. Interview on 02/24/25 at 11:37 A.M. with Administrator stated when staff work in the kitchen, if they have a beard, they are supposed to wear beard nets, and all the hair should be under the hair net. Review of the facility policy titled Hair Covering Policy undated revealed all dietary staff are required to wear effective hair restraints that cover all exposed body hair including facial hair and head hair. Hair restraints will be worn prior to entering the kitchen and may be removed after leaving the kitchen. This deficiency represents non-compliance investigated under Complaint Number OH00161306.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42011 Based on observation, resident and staff interview, record review, and review of the facility policy, the facility failed to ensure residents' living environment including resident rooms, dining room, and smoking area were kept clean and homelike. This had the potential to affect all 75 residents residing in the facility. Findings include: 1. Observation and interview on 02/24/25 at 9:50 A.M. of the facility outdoor smoking area with Maintenance Assistant #412 revealed two trash cans overflowing onto the ground with styrofoam cups, papers, multiple empty cigarette packs, cigarette butts and multiple used disposable gloves. Several cigarette butts were lying on every area of the grounds. Food particles including scrambled eggs, bread, and unidentified particles were on the ground. There were two bottles of salad dressing and cheese sauce on an outside window ledge inside the smoking area courtyard. Multiple used disposable gloves were lying in different areas on the ground. Maintenance Assistant #412 stated the smoking area gets like this sometimes. Interview on 02/25/25 at 8:58 A.M. with Administrator stated the facility was working on a plan that included who would be responsible for keeping the residents smoking area clean. A list of residents who utilized the area for smoking included nine residents, (Resident #4, #17, #20, #30, #45, #49, #57, #64, and #72). 2. Interview and observation on 02/24/25 at 9:53 A.M. with Certified Nursing Assistant (CNA) #353 stated there were no residents who ate in the dining room for breakfast that day (02/24/25). CNA #353 stated all residents ate in their rooms. Observation of the dining room with CNA #353 revealed upon entering the dining room, there was a trash can overflowing with trash from meal trays. The lid on the trash can was unable to close due to the overflowing trash. Dried food particles covered the lid on the inside and out. There were food crumbs and particles on the floor throughout the dining room. A soiled plunger and soiled dustpan sat in the corner of the dining room near where tables and chairs sat. CNA #353 stated the overflowing trash and dirty floor was from the dinner meal the previous day. Observation on 02/24/25 at 4:49 P.M. of the dining room revealed three residents, Resident #74, #9, and #12 remained in the dining room eating their dinner meal. Observation revealed the soiled plunger and soiled dustpan were still in the corner in the dining room near where residents were eating their meal. All three residents stated it was unappealing to have a dirty plunger and dustpan in the dining room where they ate. Observation and interview on 02/24/25 at 4:54 P.M. with Registered Nurse (RN) #386 verified the soiled plunger and dustpan in the dining room near where residents were eating. Interview on 02/25/25 at 421 P.M. with the Administrator stated a toilet plunger and dustpan should not be in the dining room and the dining room should be cleaned after every meal. The Administrator and Director of Nursing (DON) revealed all residents were able to eat in the dining room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observation and interview on 02/24/25 at 9:13 A.M. revealed Resident #66 was resting in bed. Resident #66's floor had scattered dirt particles, food and trash scattered throughout the floor. The room had a strong foul odor of body odor and urine. The top drawer of the nightstand was partially broke and the front of the drawer was dangling from one side. The bathroom floor had a puddle of urine on the floor partially dried. Activity Assistant #384 was present and verified the odors, dirty room, broken drawer and partially dried puddle of urine on the bathroom floor. Observation and interview on 02/24/25 at 10:00 A.M. with Certified Nursing Assistant (CNA) #329 of Resident #36's room revealed the room had nine large built in drawers. All nine drawers had multiple chips, scrapes and dents. The bottom three drawers had broken off large chips of wood. Observation and interview on 02/24/25 at 10:05 A.M. with Assistant Director of Nursing (ADON) #342 of Resident #54's room revealed Resident #54 was lying in bed resting. An outlet cover was missing on the wall and wires were exposed. ADON #342 confirmed the cover was missing and there were exposed wires. Resident #54 confirmed the outlet had been left exposed for an undetermined amount of time. Observation and interview on 02/24/25 at 10:10 A.M. with ADON #342 revealed a strong body odor in Resident #45's room. Observation revealed partially eaten dried up food on the nightstand and microwave. There was also dirty silverware with food particles on them throughout the room. An open stick of partially used butter was lying on top of the microwave that was sitting on top of the refrigerator. ADON #342 verified the microwave was working. Upon opening the door, the light came on, food was splattered covering the entire inside of the microwave and door. Food crumbs and liquid spills were on top of the microwave and under the microwave (top of refrigerator). Inside the refrigerator was a small open freezer with multiple inches of ice buildup. The refrigerator held multiple food items, multiple spills on the bottom of the refrigerator. Observation and interview on 02/24/35 at 1:52 P.M. with Licensed Practical Nurse (LPN) #300 stated Former Resident #77's room was now ready for a resident to move in and stated no other resident was admitted to or resided in the room after Resident #77 discharged from the facility on 02/13/25. Observation of the room with LPN #300 revealed there were still soiled sheets and blankets on the unmade bed. There was partially cup of water and trash on the table. The trash can still had trash not emptied in it. The floor was sticky with visible spills and the bathroom had not been cleaned. LPN #300 confirmed the room had not been cleaned since Resident #77 transferred to the hospital on 02/13/25. LPN #300 stated the room was not ready for a new admission. Interview on 02/25/25 at 3:04 P.M. with Housekeeper #298 revealed resident rooms were cleaned two times a week. Review of the facility policy titled Cleaning and Disinfecting Resident Rooms revised August 2013 revealed housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. This deficiency represents non-compliance investigated under Complaint Numbers OH00161306 and OH00162710.