

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER Gardens of North Olmsted		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident elopement was reported to the State Agency as required. This affected one resident (Resident #129) of three residents reviewed for elopement. The facility census was 76. Findings include: Review of the medical record for Resident #129 revealed an admission date of 05/13/22. Diagnoses included but were not limited to chronic obstructive pulmonary disease, alcohol dependence with alcohol induced persisting dementia, alcohol dependence with alcohol induced psychotic disorder with hallucinations, moderate dementia with psychotic disturbance and age-related bilateral cataracts. Review of Resident #129's care plan last reviewed on 08/21/25 indicated Resident #129 was at risk for elopement due to being disoriented to place, have impaired safety awareness and dementia with wandering behaviors. Interventions listed were to distract resident from wandering and intervene as appropriate. Offer various activities throughout the day and provide structured activities. Resident #129 was also noted to have impaired cognitive function and thought processes related to alcoholic dementia with a history of hallucination, long and short-term memory loss and poor decision making. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] for Resident #129 revealed a Brief Interview of Mental Status (BIMS) score of 09 which indicated moderate cognitive impairment. Review of activities of daily living (ADLs) revealed Resident #129 required supervision for toileting, bathing, dressing and hygiene. Resident #129 was noted to be independent for walking 150 feet. No alarms or wander guards were noted on the assessment Review of the elopement assessment dated [DATE] for Resident #129 revealed a score of 8 which indicated he was low risk for elopement. Review of the endangered missing adult alert dated 11/09/25 timed at 9:19 P.M. revealed a missing adult alert was issued for Resident #129. Review of the nursing progress notes for Resident #129 revealed no notes related to Resident #129 being missing from or returning to the facility. Interview on 11/12/25 at 12:18 P.M. with the Administrator confirmed the facility did not notify the State Agency following being notified Resident was missing from the facility via email nor did the facility open a self-reported incident through the Ohio Department of Health's Certification and Licensure System. The Administrator confirmed she was investigating the incident and the investigation remained in progress. Review of the December 2007 revised facility policy titled Elopements revealed staff shall investigate and report all cases of missing residents. If an employee discovers that a resident is missing from the facility, he/she shall determine if the resident is out on an authorized leave or pass. If the resident was not authorized to leave, initiate a search of the building and premises. If the resident is not located, notify the Administrator and Director of Nursing Service, the resident's legal representative, physician, law enforcement officials and voluntary agencies. Upon return of the resident, the Director of Nursing Services shall complete and file an incident report and document relevant information in the resident's medical record. The policy was vague did not mention reporting elopements to the state agency. Review of the 11/01/2019 revised facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property revealed neglect is the failure of the facility, its employees or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. The Administrator or his/her designee will notify Ohio Department of Health (ODH) of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident or Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible but not later than twenty-four hours (24) hours from the allegations was made known to the staff member. This deficiency represents non-compliance investigated under Complaint Number 2664258.</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff and resident interviews, review of the in-progress facility investigation, review of a local police report, review of local weather reports, and facility policy review, the facility failed to prevent an elopement for one resident (Resident #129) of three residents reviewed for elopement. The facility census was 76. Findings include: Review of the medical record for Resident #129 revealed an admission date of 05/13/22. Diagnoses included but were not limited to chronic obstructive pulmonary disease, alcohol dependence with alcohol induced persisting dementia, alcohol dependence with alcohol induced psychotic disorder with hallucinations, moderate dementia with psychotic disturbance and age-related bilateral cataracts. Review of Resident #129's care plan last reviewed on 08/21/25 indicated Resident #129 was at risk for elopement due to being disoriented to place, have impaired safety awareness and dementia with wandering behaviors. Interventions listed were to distract resident from wandering and intervene as appropriate. Offer various activities throughout the day and provide structured activities. Resident #129 was also noted to have impaired cognitive function and thought processes related to alcoholic dementia with a history of hallucination, long and short-term memory loss and poor decision making. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] for Resident #129 revealed a Brief Interview of Mental Status (BIMS) score of 09 which indicated moderate cognitive impairment. Review of activities of daily living (ADLs) revealed Resident #129 required supervision for toileting, bathing, dressing and hygiene. Resident #129 was noted to be independent for walking 150 feet. No alarms or wander guards were noted on the assessment Review of the elopement assessment dated [DATE] for Resident #129 revealed a score of 8 which indicated he was low risk for elopement. Review of physician orders for November 2025 did not reveal any physician orders related to requiring a secured unit or safety monitoring devices. Review of the endangered missing adult alert dated 11/09/25 timed at 9:19 P.M. revealed a missing adult alert was issued for Resident #129. Review of the hospital after visit summary dated 11/10/25 printed at 4:11 P.M. for Resident #129 revealed a diagnosis of moderate dementia associated with alcoholism with mood disturbance, right hip pain, and confusion. The resident received an intravenous infusion for electrolyte replacement. Laboratory testing and a urinalysis were completed. Imaging tests including a computed tomography (CT) scan of his brain, a chest x-ray, electrocardiogram, and an x-ray of his right femur and leg were completed. The after visit summary noted there were no medication changes or follow up appointments needed and he was released from the emergency room. Review of the nursing progress notes for Resident #129 did not reveal any evidence of documentation related to the resident being observed missing, notifications being made, the resident being found and taken to the hospital, or returning to the facility. The last entered progress note was on 10/26/25 related to a pharmacy review and the following note was dated 11/12/25 timed at 3:08 A.M. indicating Resident #129 was alert times one to two (indicating to person and place), was easily redirected, and showed some confusion. Review of a local police report dated 11/09/25 timed at 6:50 P.M. revealed the officer was dispatched to the facility at 6:56 P.M. and arrived at the facility at 7:07 P.M. The officer was dispatched to the facility for a missing resident who was last seen at approximately 2:00 P.M. Upon arrival at the facility, the officer spoke to the receptionist and then to the nurse. According to multiple nurses, Resident #129 was last seen around 12:00 P.M. A nurse went to check on Resident #129 around 6:00 P.M. and discovered he was missing. Resident #129 was last seen wearing a blue, black and white flannel shirt, a baseball cap and light-colored jeans. The report noted the nurse mentioned it was the first time Resident #129 had left the facility. Nearby businesses were checked. Additional information was added to the report on 11/10/25 at approximately 9:30 A.M. when an officer was dispatched to a local hospital for a report of a missing person having been found. The officer met with Resident #129 and Social Services Designee (SSD) #316. SSD #316 stated she left the facility on [DATE] around 8:30 A.M. to search for Resident #129. SSD #316 went to his last known address and upon turning onto the road, SSD #316 saw Resident #129 walking down a driveway and immediately made contact with him. SSD #316 stated she made contact with Resident #129 around 9:20 A.M. SSD #316 stated once Resident #129 was in her car, she took him to the hospital. Resident #129 told SSD #316 he had walked to his house and slept in his car in the garage. Resident #129 stated someone began yelling at him, so Resident #129 started to leave the area. SSD #316 stated Resident #129 did not appear injured but did state his hip was hurting him. Resident #129 was noted sneaking to a nurse at the hospital and did not know what month it was. SSD #316 stated once</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure complete medical records were maintained for one resident (Resident #129) of three records reviewed for accurate and complete medical records. The facility census was 76. Findings include: Review of the medical record for Resident #129 revealed an admission date of 05/13/22. Diagnoses included but were not limited to chronic obstructive pulmonary disease, alcohol dependence with alcohol induced persisting dementia, alcohol dependence with alcohol induced psychotic disorder with hallucinations, moderate dementia with psychotic disturbance and age-related bilateral cataracts. 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The report noted the nurse mentioned it was the first time Resident #129 had left the facility. Nearby businesses were checked. Additional information was added to the report on 11/10/25 at approximately 9:30 A.M. when an officer was dispatched to a local hospital for a report of a missing person having been found. The officer met with Resident #129 and Social Services Designee (SSD) #316. SSD #316 stated she left the facility on [DATE] around 8:30 A.M. to search for Resident #129. SSD #316 went to his last known address and upon turning onto the road, SSD #316 saw Resident #129 walking down a driveway and immediately made contact with him. SSD #316 stated she made contact with Resident #129 around 9:20 A.M. SSD #316 stated once Resident #129 was in her car, she took him to the hospital. Resident #129 told SSD #316 he had walked to his house and slept in his car in the garage. Resident #129 stated someone began yelling at him, so Resident #129 started to leave the area. SSD #316 stated Resident #129 did not appear injured but did state his hip was hurting him. Resident #129 was noted speaking to a nurse at the hospital and did not know what month it was. SSD #316 stated once Resident #129 was cleared she would take him back to the facility. Review of the nursing progress notes for Resident #129 did not reveal any evidence of documentation related to the resident being observed missing, notifications being made, the resident being found, being taken to the hospital, or returning to the facility. The last entered progress note was on 10/26/25 related to a pharmacy review and the following note was dated 11/12/25 timed at 3:08 A.M. indicating Resident #129 was alert and oriented times one to two (indicating to person and place), was easily redirected, and showed some confusion. Interview on 11/13/25 at 9:02 A.M. with Assistant Director of Nursing (ADON) #339 confirmed she did not feel it was necessary to write a progress note for a resident being identified as missing from the facility or document notifications to the family, physician, or police. Interview on 11/13/25 at 9:20 A.M. with the Director of Nursing (DON) #326 confirmed documentation should be done at least every couple of days for a wellness note to ensure resident is at baseline or if there have been any noted changes. DON #326 confirmed no progress notes were documented for Resident #129 related to the resident's elopement on 11/09/25. Interview on 11/13/25 at 9:48 A.M. with the Administrator confirmed following Resident #129 being identified as missing from the facility on 11/09/25 staff should have</p>		