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	12/17/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews and review of manufacturer instructions, the failed to ensure Resident #22's stoma supplies were available timely and failed to ensure Resident #75 had a working television. This affected two (Residents #65 and #75) of four residents reviewed accommodation of needs. The facility census was 75. Findings include: 1. Review of Resident #22's medical record revealed an admission date of 01/08/25 and diagnoses included vascular dementia, atherosclerotic heart disease and secondary malignant neoplasm of unspecified urinary organs. Review of Resident #22's care plan revised on 10/22/25 included Resident #22 had a urostomy related to neoplasm of the urinary organs. Resident #22 had frequent fixations on the urostomy bag by touching it, opening it, and trying to empty it and had urinary leakage on his clothing and bedding. Staff would re-direct as needed. Resident #22 would show no signs and symptoms of urinary infection through the review date. Interventions included urostomy bag was to be changed as needed; urostomy care daily and as needed; monitor and document intake and output per facility policy. Review of Resident #22's quarterly MDS assessment dated [DATE] revealed Resident #22 had severe cognitive impairment. Resident #22 used a walker and was dependent on staff for toileting and personal hygiene. Resident #22 required supervision or touching assistance for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and walking 10 feet once standing. Resident #22 had an ostomy and was frequently incontinent of bowel. Review of the facility invoices dated 11/21/25 and delivered 11/25/25, 12/01/25 and delivered 12/02/25 and 12/08/25 and delivered 12/09/25 revealed Resident #22's ostomy supplies were ordered and delivered to the facility. Review of Resident #22's Treatment Administration Record (TAR) dated 12/03/25 at 1:18 A.M., 12/05/25 at 11:07 P.M., 12/06/25 at 5:35 P.M. and 12/08/25 at 1:39 P.M. revealed Resident #22's urostomy bag was changed. Observation on 12/10/25 at 8:26 A.M. of Resident #22 revealed he was sitting on the side of his bed and was only wearing an undershirt and an incontinence brief. Resident #22 had a urostomy and the urostomy pouch was more than half full and the urine was clear and yellow. Observation on 12/10/25 at 9:22 A.M. of Resident #22 revealed he was lying on his bed and was wearing an incontinence brief and an undershirt. Resident #22's urostomy pouch was almost completely full of clear, dark, yellow urine. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Gardens of North Olmsted	23225 Lorain Rd North Olmsted, OH 44070

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/10/25 at 10:15 A.M. of Resident #22 with the Director of Nursing (DON) revealed he was lying on his bed and was wearing an undershirt and an incontinence brief. Resident #22's urostomy bag was almost completely full of dark, yellow, clear urine. The DON confirmed Resident #22's urostomy pouch was more than one half to one third full and should have been emptied. The DON stated Resident #22 often only wanted to wear an incontinence brief and an undershirt when he was in his room. Interview on 12/10/25 at 12:24 P.M. of Licensed Practical Nurse (LPN) #225 revealed around the beginning to middle of October 2025 there was an issue with his (Resident #22) bags not being the right ones. LPN #225 stated she sometimes worked in the secured unit and the aides were having issues trying to get the bags to stick and they would leak. The aides said the urostomy pouches the facility gave Resident #22 were not the correct pouches. LPN #225 indicated she spoke with Assistant Director of Nursing/Registered Nurse (ADON/RN) #200, and Scheduler/Supplies (SS) #230 about Resident #22's incorrect pouches, and she was told they were working on getting the correct pouches. LPN #225 stated two weeks later Resident #22's correct urostomy pouches were not in his room, and his bags were still leaking. LPN #225 indicated she did not know what happened, why it took so long to get the correct pouches, and why the company was not contacted. Resident #22's daughter was highly concerned about Resident #22 not having the correct pouches, and LPN #225 stated she kept asking why the correct pouches were not available. LPN #225 stated Resident #22's daughter made phone calls to the facility because she was so upset. LPN #225 stated she no longer worked for the facility, she put her notice in and left toward the end of October. LPN #225 indicated there was a lot of miscommunication at the facility, and she was beat up for wanting to do the right thing. Interview on 12/11/25 at 9:10 A.M. of SS #230 revealed Resident #22's stoma supplies needed to be special ordered. SS #230 stated she ordered one box per week and there was initially a problem getting the correct ostomy supplies due to insurance reasons. SS #230 stated the family had back ordered a lot of supplies and the facility did not have to order Resident #22's ostomy supplies right away. SS #230 stated she did not know about it until there was an issue with Resident #22's stoma supplies. SS #230 stated she had placed three orders so far and the problem came up about a month and half to two months ago when Resident #22's nurse told her he did not have the correct stoma supplies. SS #230 stated initially the facility sent a generic brand of urostomy pouches rather than the one Resident #22 used, and this was probably done because the generic brand urostomy pouches were less expensive. SS #230 stated she had to really argue to get Resident #22's brand name urostomy pouches. SS #230 stated she was not sure why Resident #22 could not use the generic brand of urostomy pouches. SS #230 stated it took a while for the insurance company to approve Resident #22's brand name stoma supplies. Interview on 12/11/25 at 9:24 A.M. of Business Office Manager (BOM) #231 revealed she had to contact Resident #22's stoma manufacturer around the beginning of November 2025 and give them his Medicaid information because they kept saying he was not eligible to have his supplies covered. BOM #231 stated she thought it delayed the whole process because the stoma manufacturer company had to restart the order after she called them and provided Resident #22's Medicaid number. (continued on next page)

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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/11/25 at 9:29 A.M. of the Administrator revealed Resident #22's family supplied his ostomy supplies when he was admitted to the facility. The Administrator stated she was not working in the facility when Resident #22 was admitted , and neither was the DON. Both of them were not hired until months after Resident #22 was admitted . The Administrator stated the previous administration did not ensure Resident #22 had the correct stoma supplies available when he needed them, and she did not find out there was an issue until Resident #22 was almost out of the correct urostomy pouches. The facility generic brand of urostomy pouch did not work out for Resident #22 because the bottom of the generic pouch had a plastic piece with a kind of pin that could be turned on and off to empty the pouch. Resident #22 fiddled with the plastic piece and the pin would fall out and urine would leak onto Resident #22's clothes and bed linens. The Administrator indicated it took some time to have Resident #22's insurance approve the purchase of the correct urostomy pouches and Resident #22 had to use the generic pouches. The Administrator stated Resident #22's daughter was upset that Resident #22 ran out of the correct pouches and had to use the generic pouches that often leaked. The Administrator stated Resident #22 was ordered the same, exact stoma pouches he was using when admitted to the facility, but the insurance company would not pre-cut them because he was now living in a facility where the nurses were able to do that. Interview on 12/15/25 at 4:34 P.M. of Guardian #242 revealed she was also Resident #22's daughter. Guardian #242 stated there was quite a bit of staff turnover at the facility, and it was hard for Resident #22 to have continuity of care. Guardian #242 indicated when you don't have regulars working, it is a problem. Guardian #242 stated there was an issue with Resident #22's insurance approving his stoma supplies, and he still did not have the correct stoma supplies. Guardian #242 stated the pouches she brought to the facility were pre-cut to fit Resident #22's stoma, and now he was getting the correct pouches, but they were not pre-cut. Guardian #242 stated she brought quite a few boxes of urostomy pouches to the facility when he was admitted and told the previous administration and nurses what brand of stoma pouches were needed. Guardian #242 stated she was very frustrated over the whole situation. Guardian #242 stated she showed multiple nurses how to put the bags on correctly and sometimes they went through two weeks of bags in a day or two because they did not put the pouch on right. Guardian #242 stated she was not told when Resident #22 ran out of his stoma pouches. Interview on 12/16/25 at 1:25 P.M. of CNA #252 revealed she was often assigned to care for Resident #22. CNA #252 stated she checked Resident #22's stoma pouch every hour when she made rounds and emptied it when it was one half full and needed to be emptied. CNA #252 indicated when it was not emptied timely Resident #22 often pulled and fiddled with the bag causing it to leak. Review of the undated manufacturer instructions revealed it was important to empty the pouch whenever it reached one third to one half full. 2. Review of Resident #75's medical record revealed an admission date of 07/29/21 with diagnoses including polyosteoarthritis, type two diabetes mellitus with diabetic peripheral angiopathy without gangrene, diabetes mellitus with other ophthalmic complication, and schizophrenia. Review of Resident #75's care plan revised 06/26/25 included Resident #75 preferred to do self-initiated activities like watching television, especially sports. Resident #75 would participate in three to five activities weekly for socialization. Interventions included discussing with Resident #75 the joys of local sports teams wins and losses; provide Resident #75 with a calendar of scheduled activities. (continued on next page)

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Gardens of North Olmsted	23225 Lorain Rd North Olmsted, OH 44070

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #75's quarterly MDS assessment dated [DATE] included Resident #75 had severe cognitive impairment. Resident #75 required partial to moderate assistance with toileting hygiene and dressing. Resident #75 required substantial to maximal assistance with personal hygiene. Review of Resident #75's progress notes dated 12/14/25 through 12/15/25 did not reveal evidence Resident #75 was temporarily moved to the first-floor nursing unit due to a water pipe break. Observation on 12/15/25 at 3:16 P.M. of Resident #75 revealed he was lying on his bed. Resident #75 stated a pipe burst, and water came into his room yesterday and he had to be moved to a different room, and the room he was moved to did not have a television in it. Resident #75 stated no one helped me last night, but I don't remember needing help. Observation on 12/15/25 at 3:28 P.M. of room [ROOM NUMBER] with the Administrator confirmed the television was not working properly. The Administrator confirmed Resident #75 did not have evidence in the medical records including progress notes that he was temporarily moved due to a water pipe break. The Administrator stated there should be documentation, but maybe because it was an urgent situation the nurses did not document anything about the move. This deficiency represents noncompliance investigated under Complaint Numbers 2668004 and 2654942.

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Gardens of North Olmsted	23225 Lorain Rd North Olmsted, OH 44070

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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 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)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the missing items log, observation, interviews and facility policy review, the facility failed to report and allegation of misappropriation for Resident #22 to the State agency. This affected one (Resident #22) of three residents reviewed for misappropriation. The facility census was 75. Findings include:Review of the medical record for Resident #22 revealed an admission date of 01/08/25. Diagnoses included heart disease, dementia, anxiety and depression.Review of the progress note dated 06/29/25 at 1:09 P.M. revealed Resident #22's daughter reported the resident's phone had been stolen a few weeks prior and she had not yet heard from management regarding the matter. She also reported an abdominal binder missing from the resident's room. Resident #22's daughter purchased another iPhone for the resident which was to be placed in the medication cart for the resident to use when he wished.Review of the social services note dated 6/30/25 at 12:31 P.M. revealed Resident #22's daughter stated her nephew told her Resident #22's phone was missing on 06/12/25. Staff conducted a search of the unit and did not find the phone. Family then reported the phone had not been stolen but was missing, along with the abdominal binder. Review of the missing items log for June 2025 revealed a phone was listed as missing for Resident #22 on 06/30/25 with was replaced on the same date by Resident #22's daughter.Review of the care plan dated 09/09/25 revealed Resident #22's dentures had been missing since 03/07/25.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was severely cognitively impaired. He required setup help for eating, substantial assistance for oral care, showering and dressing and was dependent on staff for toileting and personal hygiene.Interview on 12/09/25 at 12:12 P.M. with Licensed Practical Nurse (LPN) #208 revealed she was aware Resident #22 had a phone, but she could not confirm if he currently had one. Observation of the top drawer of the nurses station as well as the medication cart revealed there was no phone belonging to Resident #22. LPN #208 confirmed she was aware Resident #22 had two phones since he had been admitted as well as an abdominal binder but could not locate the items and could not confirm if the items had ever been reported as missing.Interview on 12/09/25 at 12:15 PM with Certified Nurse Aide (CNA) #209 revealed she was aware Resident #22 had a phone when he was first admitted to the facility which he used to communicate with his daughter, but she had not seen it in months, could not confirm it had ever been reported missing, and did not know its current whereabouts.Interview on 12/09/25 at 1:04 P.M. with CNA #215 revealed he believed Resident #22 had dentures but did not wear them. Observation at the time of the interview with Resident #22's permission revealed no evidence of dentures in any of Resident #22's drawers or in his bathroom. CNA #215 revealed he thought he remembered seeing Resident #22 wear dentures but not since he was first admitted .Interview on 12/10/25 at 9:40 A.M. with the Administrator and Regional Registered Nurse (RN) #202 confirmed missing items, outside of articles of clothing and items considered of low value, would be reported on a concern form or a self-reported incident (SRI).Interview on 12/10/25 at 12:54 P.M. with the Administrator confirmed no SRI had been completed for Resident #22's missing phones, dentures or abdominal binder. She confirmed Resident #22's care plan indicated his dentures had been missing since 03/07/25 but could provide no evidence it had been reported to Administration. Resident #22 currently did not have a phone and there was no evidence when it had gone missing or if the facility had attempted to remedy the situation, therefore they could not definitively say if the items were misappropriated or misplaced.Interview on 12/17/25 at 11:38 A.M. with the Administrator revealed staff were expected to report missing items immediately so an investigation could be initiated.Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19, revealed alleged violations of abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property would be reported immediately to the administrator or designee. If the allegation involves serious bodily injury, it should be reported to Ohio Department of Health (ODH) immediately, but not later than two hours after the allegation is made. All other allegations will be reported to ODH as soon as possible, but in no event later than 24 hours from the time the allegation was made known to a staff member. Review of the facility admission packet revealed the facility provided reasonable security for resident property, and the facility would insure up to $100 against the loss of valuable items such as jewelry or money if they were deposited with the management or placed in locked storage in the resident's room when it was not in use.This deficiency represents noncompliance investigated under Complaint Number 2654942 and is a recite to the survey completed on 11/13/25.

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	365310	A. Building B. Wing	12/17/2025

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the missing items log, observation, interviews and facility policy review, the facility failed to thoroughly investigate missing items for Resident #22. This affected one Resident #22) of three residents reviewed for misappropriation. The facility census was 75.Findings include:Review of the medical record for Resident #22 revealed an admission date of 01/08/25. Diagnoses included heart disease, dementia, anxiety and depression.Review of the progress note dated 06/29/25 at 1:09 P.M. revealed Resident #22's daughter reported the resident's phone had been stolen a few weeks prior and she had not yet heard from management regarding the matter. She also reported an abdominal binder missing from the resident's room. Resident #22's daughter purchased another iPhone for the resident which was to be placed in the medication cart for the resident to use when he wished.Review of the social services note dated 6/30/25 at 12:31 P.M. revealed Resident #22's daughter stated her nephew told her Resident #22's phone was missing on 06/12/25. Staff conducted a search of the unit and did not find the phone. Family then reported the phone had not been stolen but was missing, along with the abdominal binder.Review of the missing items log for June 2025 revealed a phone was listed as missing for Resident #22 on 06/30/25 with was replaced on the same date by Resident #22's daughter.Review of the care plan dated 09/09/25 revealed Resident #22's dentures had been missing since 03/07/25.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was severely cognitively impaired. He required setup help for eating, substantial assistance for oral care, showering and dressing and was dependent on staff for toileting and personal hygiene.Interview on 12/09/25 at 12:12 P.M. with Licensed Practical Nurse (LPN) #208 revealed she was aware Resident #22 had a phone, but she could not confirm if he currently had one. Observation of the top drawer of the nurses station as well as the medication cart revealed there was no phone belonging to Resident #22. LPN #208 confirmed she was aware Resident #22 had two phones since he had been admitted as well as an abdominal binder but could not locate the items and could not confirm if the items had ever been reported as missing.Interview on 12/09/25 at 12:15 PM with Certified Nurse Aide (CNA) #209 revealed she was aware Resident #22 had a phone when he was first admitted to the facility which he used to communicate with his daughter, but she had not seen it in months, could not confirm it had ever been reported missing, and did not know its current whereabouts.Interview on 12/09/25 at 1:04 P.M. with CNA #215 revealed he believed Resident #22 had dentures but did not wear them. Observation at the time of the interview with Resident #22's permission revealed no evidence of dentures in any of Resident #22's drawers or in his bathroom. CNA #215 revealed he thought he remembered seeing Resident #22 wear dentures but not since he was first admitted .Interview on 12/10/25 at 9:40 A.M. with the Administrator and Regional Registered Nurse (RN) #202 confirmed missing items, outside of articles of clothing and items considered of low value, would be reported on a concern form or a self-reported incident (SRI).Interview on 12/10/25 at 12:54 P.M. with the Administrator confirmed no SRI or investigation had been completed for Resident #22's missing phones, dentures or abdominal binder. She confirmed Resident #22's care plan indicated his dentures had been missing since 03/07/25 but could provide no evidence it had been reported to or investigated by Administration. Resident #22 currently did not have a phone and there was no evidence when it had gone missing or if the facility had attempted to remedy the situation, therefore they could not definitively say if the items were misappropriated or misplaced.Interview on 12/17/25 at 11:38 A.M. with the Administrator revealed staff were expected to report missing items immediately so an investigation could be initiated.Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19, revealed alleged violations of abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property would be investigated to include interviews with the resident, witnesses or anyone coming in close contact with the resident, review of the residents medical record, and the investigation would be documented.This deficiency represents noncompliance investigated under Complaint Number 2654942.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to ensure Resident #33's care conference was scheduled during the required timeframe. This affected one (Resident #33) of three residents reviewed for care conferences and had the potential to affect 10 additional residents (Resident's #6, #11, #14, #16, #23, #30, #33, #41, #45, #58, #75) identified by the facility as needing to have a care plan scheduled. The facility census was 75.Findings include:Review of Resident #33's medical record revealed an admission date of 07/09/20 with diagnoses including type two diabetes mellitus, multiple sclerosis, and neuromuscular dysfunction of the bladder. Review of Resident #33's care plan revised 06/26/25 included Resident #33's discharge plan related to long term care. Resident #33's care needs would continue to be met per plan of care daily. Interventions included providing care according to care plans to enhance optimum well-being; reassessing care needs to monitor potential for discharge as needed.Review of Resident #33's progress notes dated 07/02/25 through 12/11/25 did not reveal evidence Resident #33 had a care conference.Review of the Facility Care Conference Schedule dated 09/01/25 through 12/15/25 revealed no evidence Resident #33 had a care conference scheduled. Further review revealed Resident #33 had a care conference due in July, but there was no evidence Resident #33 had a care conference due in October.Review of Resident #33's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had moderate cognitive impairment. Resident #33 had an impairment on both sides of the lower extremities. Resident #33 was dependent on staff for toileting hygiene, bathing, and needed substantial to maximal assistance with personal hygiene. Resident #33 had an indwelling catheter and was occasionally incontinent of bowel. Interview on 12/11/25 at 12:25 P.M. of Social Services Designee (SSD) #216 revealed she arranged resident care conferences every three months and attendees were almost always the resident, the nursing staff, and sometimes the Administrator and Activities Director. SSD #216 stated she always contacted families and gave two dates and times to choose the care conference time. Once the care conference date and time were chosen, she wrote a note in the resident's electronic record. Interview on 12/11/25 at 3:00 P.M. of SSD #216 revealed she had just learned two weeks ago that care conferences were supposed to be every three months, and she thought they were supposed to be scheduled once a year. SSD #216 stated she was playing catch up. SSD #216 stated she had only been working as the SSD for a couple months, did not have much training, and was kind of learning as I go. SSD #216 indicated the previous SSD was way behind in the resident care conferences. SSD #216 stated if a resident needed a care conference and it was brought to her attention, she scheduled it right away. She stated Resident #33's mother who is also his Power of Attorney (POA) called about getting talk therapy via Viaquest and she wanted him to see a dentist and an outside primary care physician, but she did not bring up a need for a care conference. SSD #216 confirmed Resident #33 needed a care conference scheduled, and she was waiting until he returned from the hospital to get it scheduled. SSD #216 confirmed Resident's #6, #11, #14, #16, #23, #30, #33, #41, #45, #58, #75 needed to have a care conference scheduled. Observation on 12/16/25 at 9:00 A.M. of Resident #33 with Certified Nursing Assistant (CNA) #237 revealed the door to Resident #33's room was closed. Resident #33 was lying in bed with his eyes closed and did not appear to be in distress. CNA #237 stated Resident #33 did not like to have his care completed until late morning or early afternoon. Review of the facility policy titled Care Planning Interdisciplinary Team included a comprehensive care plan for each resident was developed within seven days of completion of the resident assessment (MDS). The care plan was based on the resident's comprehensive assessment and was developed by a care planning, Interdisciplinary Team (IDT) which included but was not limited to the resident's attending physician, the registered nurse (RN) responsible for the resident, the dietary manager or dietitian, the social services worker, the activity director, the Director of Nursing (DON), therapist, the charge nurse, nursing assistants and others as appropriate or necessary to meet the needs of the resident. The resident, the resident's family and, or the resident's legal representative, guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. This deficiency represents noncompliance investigated under Complaint Number 2581614.

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	12/17/2025

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

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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. (continued on next page)

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	12/17/2025

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to ensure Resident's #41, #58 and #73 were provided with appropriate care and services. This affected three residents (Resident's #41, #58 and #73) out of four residents reviewed for activities of daily living (ADL) care for dependent residents. The facility census was 75.Findings include:1. Review of the medical record for Resident #58 revealed an admission date of 07/25/23. Diagnoses included respiratory failure, diabetes, stroke affecting the left, non-dominant side, depression, heart failure, reduced mobility and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment data 09/29/25 revealed Resident #58 was moderately cognitively impaired. She required setup help for eating and was dependent on staff for oral care, toileting, showering, dressing and personal hygiene.Review of the care plan dated 09/29/25 revealed Resident #58 had an activities of daily living (ADL) self-care performance deficit. Interventions included encouraging the resident to participate to the fullest extent possible, encouraging the resident to use the call light for assistance, discussing with the resident or family any concerns regarding the loss of independence or decline in functioning and monitoring for any potential improvements or changes in function.Observation on 12/15/25 at 1:28 P.M. on the 200 unit revealed Resident #58's call light had been activated. Certified Nurse Aide (CNA) #233 was observed entering Resident #58's room at 1:51 P.M. She turned off Resident #58's call light and exited her room, stating she would be right back. CNA #229 was observed entering Resident #58's room at 1:55 P.M. Interview with CNA #229 when she exited Resident #58's room revealed she reported she was providing incontinence care. She confirmed call lights could be answered by any employee and should be done within approximately 15 minutes but admitted that was not always possible. She revealed she had just finished providing incontinence care for another resident who required two people for assistance, which caused a delay in care for other residents. She confirmed Resident's #58's call light was not responded to in a timely manner.Interview on 12/16/25 at 8:01 A.M. with CNA #233 confirmed she responded to Resident #58's call light on 12/15/25 to provide her with incontinence care. She revealed she tried to answer call lights within 10 minutes but was aware Resident #58 had waited longer than that the previous day. She confirmed there were two CNAs on the floor providing incontinence care to another resident who required two staff for care, causing a delay in care for other residents.Interview on 12/16/25 at 8:07 A.M. with the Resident #58 confirmed sometimes she had to wait up to three hours to get changed when she was incontinent. She could not confirm if she had waited an extensive period of time for incontinence care on the previous day.2. Review of Resident #73's medical record revealed an admission date of 11/11/25 with diagnoses including chronic respiratory failure with hypoxia, type two diabetes mellitus, and morbid obesity due to excess calories.Review of Resident #73's admission Charting dated 11/11/25 included Resident #73 had a small skin tear on the posterior right thigh.Review of Resident #73's progress notes dated 11/11/25 through 12/16/25 did not reveal evidence Resident #73 had an open area of the left buttock about the size of a nickel. Review of Resident #73's care plan dated 11/12/25 included Resident #73 was at risk for skin breakdown related to diabetes mellitus. Resident #73 had a right armpit fungal area and a right rear thigh abrasion. Resident #73 would have no avoidable skin breakdown. Interventions included apply lotion, moisture barrier cream as needed; house barrier cream with each episode of incontinence; observe skin for redness or open areas and notify the nurse; skin assessment as needed.Review of Resident #73's physician orders dated 11/12/25 revealed zinc oxide external paste 20 percent, apply to right rear thigh topically every shift for skin care of the bilateral inner thighs and buttocks.Review of Resident #73's admission MDS assessment dated [DATE] revealed Resident #73 was cognitively intact and was dependent on staff for oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. Resident #73 was always incontinent of urine and frequently incontinent of bowel. Resident #73 did not reject care during the seven-day assessment look-back period.Interview on 12/15/25 at 2:09 P.M. of CNA #229 revealed last night (12/14/25) three residents including Resident #73 were moved to the first floor for a pipe break. All three residents were incontinent and the aides on the second floor were not told the three residents were temporarily moved to the first floor, and the three residents, including Resident #73, were not provided care. CNA #229 stated she was texted about an hour ago by the first-floor aide that she needed to take care of three residents, including Resident #73, because it smelled like a barnyard.Interview on 12/15/25 at 3:28 P.M. of the Administrator confirmed there was a leak in the upstairs nourishment room, someone tried to turn a

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	12/17/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	365310	A. Building B. Wing	12/17/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of hospice records, interview and facility policy review, the facility failed to ensure changes in conditions were properly addressed for Residents #76 and #77. This affected two (Residents #76 and #77) of three residents reviewed for change in condition. The facility census was 75.Findings include:1. Review of the medical record for Resident #76 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included bipolar disorder, morbid obesity, stroke affecting the right dominant side, communication deficit, traumatic brain injury, depression and impulse disorder.Review of the quarterly Minimum Data Set (MDS) assessment date at [DATE] revealed Resident #76 was moderately cognitively impaired. She required setup help for eating and oral care, supervision for dressing, toileting and hygiene and partial assistance for showering.Review of the physicians' orders for [DATE] revealed Resident #76 had a full code status (medical instruction for full resuscitation efforts such as cardiopulmonary resuscitation (CPR), intubation or life support if a patient's heart stops or they stop breathing) beginning on [DATE].Review of the progress note dated [DATE] at 6:25 P.M. created by Licensed Practical Nurse (LPN) #211 revealed Resident #76 began grabbing at the left side of her chest and reporting chest pain. Vital signs were taken at the time, and her blood pressure was 152/79, pulse 83, respirations 18, temperature 98.1 degrees Fahrenheit (F) and pulse ox 97% on room air. The resident refused transportation to the hospital for evaluation on multiple attempts with the administrator present and the resident's mother on the phone. She was given an antacid, and the primary care physician was notified.Review of the progress note dated [DATE] at 7:30 P.M. created by LPN #211 revealed Resident #76 was found on the floor in her restroom. When asked what happened, she stated she didn't know and shook her head side to side while laughing. Resident #76 was assessed for injury and no injuries were found. Her vital signs were obtained, and her blood pressure was 135/81, respirations 18, heart rate 89 and pulse ox 97% on room air. The resident was told she may need to go to the hospital for evaluation and immediately declined. The Administrator and physician were notified.Review of the progress note dated [DATE] at 11:56 P.M. created by LPN #210 revealed Resident #76 was found unresponsive sitting in her wheelchair next to her bed. She did not have a pulse, and CPR was immediately initiated. 911 was called and arrived within 10 minutes; the emergency response team took over and left after unsuccessfully attempting CPR. The physician, nurse practitioner, Administrator, Director of Nursing (DON) and the residents' mother were notified.Interview on [DATE] at 9:27 A.M. with LPN #210 Revealed he worked the 11:00 P.M. to 7:00 A.M. shift on [DATE]. When making rounds on his residents, he found Resident #76 unresponsive in her wheelchair which was not normal for her. He checked her pulse and when he could not find one, he started CPR and asked another nurse to call 911 and bring the crash cart. When he started his shift, he was told she presented with general discomfort and illness throughout the day but had been refusing assessments and vital signs.Interview on [DATE] at 11:01 A.M. with Quality Assurance Registered Nurse (QA RN) #203 revealed she was aware of the change in condition and subsequent death of Resident #76 and knew it had been a problem. As a result of the investigation, LPN #211 was terminated. She confirmed Resident #76 should not have been given an antacid prior to calling the physician or without an order, and any resident with a full code status should have emergency services called, even though residents had the right to refuse to go to the hospital once emergency services arrived. QA RN #203 confirmed the facility should have documented follow up care including assessments or refusals, as soon as Resident #76 began reporting chest pain.2. Review of the medical record for Resident #77 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, reduced mobility, communication deficit, insomnia, history of falling, bladder dysfunction, kidney disease, heart failure and depression.Review of the quarterly MDS assessment dated [DATE] revealed Resident #77 was moderately cognitively impaired. He required setup help for eating and was dependent on staff for oral care, toileting, showering, dressing and personal hygiene. He was incontinent of bowel and bladder.Review of the physician's orders for [DATE] revealed Resident #77 had been receiving hospice services since [DATE], and had elected and Advanced Directive (AD) code status of full code on [DATE].Review of the narrative note dated [DATE] at 3:35 A.M. created by Registered Nurse (RN) #212 revealed Resident #77 presented with unresponsiveness, altered mental status and abnormal breathing. His vital signs were obtained, and his blood pressure was 113/58, pulse 81, respiration 16, pulse ox 94% on three liters of oxygen. The nurse practitioner (NP) was notified and

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	12/17/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews and facility policy review, the facility failed to ensure fall assessments were completed, falls were documented in the medical record, fall prevention interventions were in place, and fall investigations were thorough. This affected four (Residents #18, #22, #52 and #76) of five residents reviewed for falls. The facility census was 75. Findings include: 1. Review of Resident #52's medical record revealed an admission date of 02/13/25 with diagnoses including syncope and collapse, history of falling, anxiety disorder and type two diabetes mellitus with diabetic neuropathy. Review of Resident #52's Morse Fall Scale dated 07/30/25 revealed Resident #52 was at high risk for falling. Review of Resident #52's progress notes dated 07/31/25 through 08/04/25 did not reveal evidence Resident #52 experienced a fall on 08/01/25. Review of Resident #52's Falls Best Practice investigation dated 08/01/25 at 8:30 P.M. revealed the investigation was not found in Resident #52's hard chart or electronic record but was provided by the Director of Nursing (DON). The investigation revealed Resident #52 was sitting on the side of the bed, and the wheelchair was next to his bed. Resident #52 reached out to grab the wheelchair to stand up, the wheelchair rolled back, and Resident #52 slid to the floor. Resident #52 stated I was trying to just get up. The fall was a witnessed fall. Resident #52 was attempting to self-transfer, and his wheelchair brakes were unlocked. Review of Resident #52's assessments revealed on 08/01/25 a pain assessment was completed for a fall incident and included no evidence Resident #52 experienced a fall, exception charting was completed with no evidence Resident #52 had a fall, and a Morse Fall Scale revealed Resident #52 was at high risk for falling. Review of Resident #52's progress notes and assessments dated 08/01/25 through 08/04/25 did not reveal evidence of follow-up assessments or progress notes for Resident #52's fall on 08/01/25. Review of Resident #52's Fall Scene Investigation Report dated 08/12/25 at 6:10 P.M. included Resident #52 slipped and was found on the floor in the bathroom. The toilet contained urine and feces. The fall was unwitnessed. A new intervention was to provide non-skid strips to the bathroom floor. A witness statement from the nurse included Resident #52 was found lying on his left side on the floor in the bathroom. Resident #52 was assisted to the wheelchair, vital signs were obtained and a neurological check was completed. Review of Resident #52's progress notes dated 08/12/25 at 8:17 P.M. included Resident #52 was found on the bathroom floor. Resident #52 stated he lost his balance from the urine on the floor. Resident #52 stated he was okay and was not in pain. There was no evidence that range of motion were checked. (continued on next page)

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	365310	A. Building B. Wing	12/17/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #52's medical record including progress notes and assessments dated 08/12/25 at 8:17 P.M. through 08/14/25 did not reveal evidence vital signs were checked, did not reveal evidence neurological checks were completed, did not reveal evidence follow up progress notes were completed related to the fall, or evidence a comprehensive pain assessment was completed. Review of Resident #52's progress notes dated 08/13/25 at 3:42 P.M. included Resident #52 was reviewed by the IDT (interdisciplinary team). The care plan was reviewed, and a new intervention was added to provide non-skid strips to the bathroom floor. Review of Resident #52's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact. Resident #52 had no impairment of the upper and lower extremities and used a walker. Resident #52 required partial to moderate assistance with toileting and personal hygiene and required substantial to maximal assistance with bathing. Resident #52 was occasionally incontinent of urine and always continent of bowel. Walking ten feet was not attempted due to medical condition or safety concerns. Review of the facility incident log revealed Resident #52 experienced falls without major injury on 08/17/25, 09/02/25, and 10/29/25. Review of Resident #52's progress notes, assessments and the facility incident log dated 10/18/25 through 10/24/25 did not reveal evidence Resident #52 experienced a fall. Review of Resident #52's Nurse Practitioner Progress Notes dated 10/24/25 included Resident #52 had a fall last Saturday (10/18/25) without any immediate reported injuries. On 10/24/25, Resident #52 was complaining of pain in the groin and bilateral hip pain. Resident #52 had a fall one week ago, and an order for an x-ray of Resident #52's bilateral hips was placed. Review of Resident #52's physician orders dated 10/24/25 and placed in the orders by Licensed Practical Nurse (LPN) #206 revealed STAT (immediate) x-ray of bilateral hips and pelvis. Diagnosis was status post fall and pain. Review of Resident #52's progress notes dated 10/25/25 at 6:40 P.M. revealed an x-ray was obtained of Resident #52's bilateral hips and pelvis related to pain. Results did not show a fracture or dislocation. Follow up showed mild osteoarthritis of the left hip joint. Observation on 12/09/25 at 11:26 A.M. of Resident #52 with LPN #206 revealed Resident #52 was sitting on the side of his bed, he was dressed, his hair was disheveled, and he had a grumpy look on his face. Resident #52 did not want to talk at this time. LPN #206 stated that was typical behavior for Resident #52, and sometimes he had verbally abusive behaviors. LPN #206 stated Resident #52 was sometimes compliant with his fall interventions and sometimes he was not and it just depended on the day. Observation of Resident #52's room did not reveal non-skid strips in the bathroom or to the left side of Resident #52's bed. LPN #206 confirmed the room did not have non-skid strips in the bathroom or the left side of the bed and stated, I do not think he is supposed to have non-skid strips. LPN #206 revealed she was not aware Resident #52 had interventions for non-skid strips on the bathroom floor and to the left side of his bed. (continued on next page)

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	12/17/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/09/25 at 2:35 P.M. of the DON revealed when a resident had a fall the resident's record should include a progress note with details of the fall, whether the fall was witnessed or unwitnessed, if neurological checks were initiated and when the resident's physician and family were notified of the fall. The progress note should include vital signs. The DON stated a fall packet should be filled out and the investigation should include witness statements. If the resident had a change before the fall, that should be documented. The resident's range of motion should be evaluated and if the resident had pain. The DON indicated the pain assessment was a one-time assessment after the fall unless the resident was having pain. If the resident had pain, the resident should be given something for pain if non-pharmacological interventions were unsuccessful, and the pain should be assessed once a shift. The DON stated the facility did status post fall notes every shift for three days. The DON stated the facility completed exception charting, and after the fall the IDT met and had five days to close out the fall. Interview on 12/09/25 at 3:37 P.M. of the DON and Assistant Director of Nursing/Registered Nurse (ADON/RN) #200 confirmed Resident #52's falls in his medical record did not have evidence comprehensive assessments were completed. The DON stated she did a lot of education in the past few months regarding documentation for falls and proper fall procedures. The DON stated she was not in the facility the week of 10/18/25 through 10/24/25 and had no knowledge of Resident #52 having a fall on 10/18/25. ADON/RN #200 stated Resident #52 might have just said that and he has a BIMS (Brief Interview for Mental Status) of 15, but he says stuff. The DON confirmed Resident #52 did not have non-skid strips in the bathroom and to the left side of his bed. Interview on 12/09/25 at 3:53 P.M. of LPN #206 revealed she contacted the nurse practitioner (NP) and got the x-ray ordered because Resident #52 said his hips hurt. LPN #206 revealed she did not know if Resident #52 experienced a fall on 10/18/25, but he wanted an x-ray. Interview on 12/09/25 at 4:22 P.M. of LPN/Wound Nurse (LPN/WN) #223 revealed she reported the x-ray results to NP #227 but did not know anything about Resident #18 experiencing a fall on 10/18/25. 2. Review of Resident #22's medical record revealed an admission date of 01/08/25 with diagnoses including vascular dementia, atherosclerotic heart disease and secondary malignant neoplasm of unspecified urinary organs. Review of Resident #22's care plan revised on 08/13/25 included Resident #22 was at risk for falls related to vascular dementia, poor safety awareness and other diagnoses. On 07/29/25, Resident #22 was moved close to the nurse's station. Resident #22 would have no significant fall related injury. Interventions included therapy services to target increased balance, community mobility and stairs; keeping the room free of clutter. Review of Resident #22's Morse Fall Scale dated 09/16/25 revealed Resident #22 was at high risk for falling. Review of the facility incident log revealed Resident #22 experienced a fall on 10/22/25 at 11:00 P.M. Review of Resident #22's progress notes dated 10/22/25 did not reveal evidence Resident #22 experienced a fall on 10/22/25 at 11:00 P.M. (continued on next page)

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	365310	A. Building B. Wing	12/17/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #22's Pain assessment dated [DATE] at 11:27 P.M. included Resident #22 did not have pain or hurting at any time in the last five days; however, the assessment stated Resident #22's speech was garbled. There was no evidence Resident #22 was assessed for indicators of pain or possible pain such as facial expressions, non-verbal sounds. Review of Resident #22's progress notes, vital signs tab and assessments dated 10/22/25 through 10/24/25 at 1:57 A.M. did not reveal evidence Resident #22's vital signs were checked and no evidence additional assessments were completed. Review of Resident #22's progress notes dated 10/23/25 at 2:08 P.M. included Resident #22 was eating Jello in his room when he got up and slipped on the Jello and fell to the floor. Resident #22 obtained a skin tear to the left elbow. Staff assisted Resident #22 to bed after assessing for injury. New intervention was to have therapy work with Resident #22 on transfers. Review of Resident #22's quarterly MDS assessment dated [DATE] revealed Resident #22 had severe cognitive impairment. Resident #22 used a walker and was dependent on staff for toileting and personal hygiene. Resident #22 required supervision or touching assistance for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and walking 10 feet once standing. Resident #22 had an ostomy and was frequently incontinent of bowel. Review of Resident #22's medical record including progress notes, assessments, physician orders did not reveal evidence Resident #22's left elbow skin tear had a treatment ordered or was evaluated and had a treatment in place. There was no evidence that the size of the skin tear was documented or evidence of a description of the area. Interview on 12/10/25 at 10:19 A.M. of the DON revealed Resident #22 had a lot of falls and the falls had increased as his dementia progressed. The DON confirmed Resident #22 had a fall on 10/22/25 and there was no evidence of the fall in his progress notes until 10/23/25, and there were no vital signs recorded. The DON stated vital signs were documented in risk management but confirmed they were not recorded in Resident #22's medical record. Observation on 12/16/25 at 8:25 A.M. of Resident #22 revealed he was walking in the hall and was using a walker. Resident #22 had clean clothes, hair was combed and he was pleasant and answered questions. Interview on 12/17/25 at 1:15 P.M. of LPN/WN #223 confirmed on 10/23/25 Resident #22 had a left elbow skin tear. LPN/WN #223 stated she assessed the area, it was small and did not require a treatment order. LPN/WN #223 confirmed there was no evidence she evaluated the left elbow skin tear in Resident #22's medical record. 3. Review of Resident #18's medical record revealed an admission date of 02/23/23 with diagnoses including Alzheimer's disease, dementia, and history of falling. Review of Resident #18's care plan revised 02/17/25 included Resident #18 was at risk for injury related to falls due to history of falls, impaired cognition with poor safety awareness and other diagnoses. Resident #18 would not sustain serious injury through the review date. Interventions included to encourage wheelchair use; educate Resident #18, family, caregivers about safety reminders and what to do if a fall occurred. (continued on next page)

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	365310	A. Building B. Wing	12/17/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #18's quarterly MDS assessment dated [DATE] revealed Resident #18 had severe cognitive impairment. Resident #18 used a wheelchair and was dependent on staff for toileting and required partial to moderate assistance with personal hygiene. Resident #18 required supervision or touching assistance for the ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed, and walking 10 feet. Review of the facility incident log revealed Resident #18 experienced a fall on 08/22/25 at 4:15 P.M. Review of Resident #18's progress notes dated 08/22/25 through 08/23/25 at 5:17 A.M. did not reveal evidence Resident #18 had a fall. There were no vital signs recorded, no details of the fall, no comprehensive fall assessment including range of motion. Review of Resident #18's progress notes dated 08/23/25 at 5:17 A.M. included Resident #18 was status post a fall, he had no complaints of pain, and no new injury noted. Observation on 12/10/25 at 8:36 A.M. revealed Resident #18 was sitting at a table near the nurse's station, his eyes were closed and he appeared to be sleeping. LPN #251 stated we like to keep him close because he needed help with mobility and he liked to be by the nurse's station. Interview on 12/10/25 at 10:19 A.M. of the DON confirmed Resident #18 had a fall on 08/22/25 at 4:15 P.M. and there were no progress notes stating details of the fall, no vital signs were recorded, and no evidence if Resident #18's fall was witnessed or unwitnessed. The DON indicated she had provided the staff with a lot of education regarding documentation and proper fall procedures. Review of the undated policy titled Falls and Fall Risk, Managing included based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If a resident had just fallen or was found on the floor without a witness to the event, nursing staff would record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities. Once an assessment ruled out significant injury, nursing staff would help the resident to a comfortable sitting, lying, or standing position and then document relevant details. Nursing staff would observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and would document findings in the medical record. Documentation would include any observed signs or symptoms of pain, swelling, bruising, deformity, and, or decreased mobility, and any changes in level of responsiveness, consciousness and overall function. It would note the presence or absence of significant findings. After an observed or probable fall, the staff would clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. 4. Review of the medical record for Resident #76 revealed an admission date of 08/01/25 and a discharge date of 11/26/25. Diagnoses included bipolar disorder, morbid obesity, stroke affecting the right dominant side, communication deficit, traumatic brain injury, depression and impulse disorder. Review of the care plan dated 08/03/25 revealed Resident #76 was at risk for falls. Interventions included ensuring nonskid footwear was in use, keeping the call light in reach, keeping frequently used items within reach and keeping her room free of clutter. (continued on next page)

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	365310	A. Building B. Wing	12/17/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Morse fall scale assessment dated [DATE] revealed Resident #76 was at a high risk for falls. Review of the quarterly MDS assessment dated [DATE] revealed Resident #76 was moderately cognitively impaired. She required setup help for eating and oral care, supervision for dressing, toileting and hygiene and partial assistance for showering. Review of the progress note dated 11/26/25 at 7:30 P.M. revealed Resident #76 was on the floor in her bathroom. When asked what happened, Resident #76 stated she didn't know and began laughing and shaking her head from side to side. She was assessed for injury, and none were found. Her vital signs were obtained, and her blood pressure was 135/85, respirations 18, heart rate 89 and pulse ox 97% on room air. She denied any pain and neurological checks were initiated. The DON Administrator and physician were notified. Review of the fall investigation dated 11/26/25 revealed neurological checks were completed three times, there was no immediate intervention in place and there was no witness statement from the certified nurse aide (CNA) who found the resident on the floor. Review of the neurological assessment of flow sheet revealed neurological checks were completed for Resident #76 at 7:24 P.M., 7:39 P.M. and 7:54 P.M. All results were within normal limits. Interview on 12/04/25 at 10:10 A.M. with Quality Assurance RN (QA RN) #203 confirmed there was no evidence neurological checks had continued past 7:54 P.M., no evidence the physician was notified that they were not continued or why, no witness statement from the CNA who found Resident #76 on the floor, no immediate interventions and no evidence any follow up assessments or interventions had been attempted after the fall. She confirmed neurological checks should be in place for up to 72 hours at various intervals after a fall, or refusals documented. Review of the facility policy titled Falls and Fall Risk, Managing, dated October 2010, revealed nursing staff would observe for delayed complications of a fall for approximately 48 hours after a fall and document findings in the medical record. Documentation would include observed signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility and any changes in level of responsiveness or consciousness and overall function. Documentation would also include the presence or absence of significant findings. Documentation would also include assessment data including vital signs and obvious injuries, interventions or first aid administered, notification of the physician and family, completion of a falls risk assessment, interventions taken to prevent future falls and the signature and title of the person recording the data. This deficiency represents noncompliance investigated under Complaint Numbers 2668004 and 2654942 and is a recite to the survey completed on 11/13/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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	365310	A. Building B. Wing	12/17/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to timely identify and treat urinary tract infections for Resident's #22 and #33. This affected two residents (#22 and #33) out of three residents reviewed for urinary tract infections. The facility census was 75.Findings include:Review of Resident #22's medical record revealed an admission date of 01/08/25 and diagnoses included vascular dementia, atherosclerotic heart disease and secondary malignant neoplasm of unspecified urinary organs.Review of Resident #22's progress notes dated 10/27/25 at 2:46 A.M. revealed a urine specimen for urinalysis and culture and sensitivity was obtained and placed in the refrigerator on the first-floor nursing unit.Review of Resident #22's progress notes dated 10/28/25 at 9:00 A.M. revealed Resident #22 was not eating or drinking and was agitated and yelling. Resident #22's vital signs were checked, and a full assessment was completed. Nurse Practitioner (NP) #228 was notified and an order was given to send Resident #22 to the hospital.Review of Resident #22's After Visit Summary (AVS) for a hospital admission from 10/28/25 through 10/31/25 included Resident #22 had a diagnosis of pneumonia and needed a follow up appointment scheduled within seven days with his primary care provider (Former Medical Director #207). A physician order was given to start taking doxycycline hyclate 100 mg (milligrams) capsule, take one capsule by mouth two times a day for five days.Review of Resident #22's progress notes dated 10/31/25 at 3:15 P.M. included Resident #22's urinalysis and culture and sensitivity results were reported to the Nurse Practitioner (unidentified). An order was given to repeat a urine for urinalysis and culture and sensitivity when his antibiotics were completed. Review of Resident #22's physician orders dated 10/31/25 revealed to collect urine for urinalysis and culture and sensitivity on 11/07/25.Review of Resident #22's care plan initiated on 06/03/25 and revised on 12/08/25 included Resident #22 had a urinary tract infection, and it would be resolved without complications by the review date. Interventions included monitor, document, and report signs and symptoms of a urinary tract infection such as altered mental status, behavioral changes and foul-smelling urine.Review of Resident #22's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had severe cognitive impairment. Resident #22 used a walker and was dependent with toileting and personal hygiene. Resident #22 required supervision or touching assistance for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and walking 10 feet once standing. Resident #22 had an ostomy and was frequently incontinent of bowel. Review of Resident #22's Treatment Administration Record (TAR) dated 11/07/25 at 9:07 P.M. revealed a urine specimen for urinalysis and culture and sensitivity was collected.Review of Resident #22's medical record including progress notes and physician orders dated 11/07/25 through 12/03/25 did not reveal evidence Resident #22's urine specimen results for urinalysis and culture and sensitivity collected on 11/07/25 were either completed or reported to Resident #22's physician or nurse practitioner. Review of Resident #22's lab report which included a urine for urinalysis and culture and sensitivity was collected on 12/03/25 and reported on 12/06/25. The results included the organism enterococcus casseliflavus with presence greater than 100,000 CFU (colony forming units) per ml (milliliter), WBC (white blood cells) were six to 20 HPF (high-power field), normal was considered less than six HPF, and a moderate number of bacteria. There was a note that Medical Director #201 was notified and a new order was given for Macrobid by mouth twice daily for seven days.Review of Resident #22's physician orders and Medication Administration Record (MAR) dated 12/07/25 revealed Macrobid oral capsule 100 mg, give one capsule by mouth two times a day for urinary tract infection, and it was initiated on 12/07/25 at 9:00 A.M. Observation on 12/09/25 at 8:42 A.M. of Resident #22 with Licensed Practical Nurse (LPN) #208 revealed he was sitting in a chair in his room, and LPN #208 stated Resident #22 was waiting to be transported to an appointment. LPN #208 administered medications including Macrobid 100 mg to Resident #22. Resident #22 was in clean clothes and well groomed.Interview on 12/10/25 at 10:19 A.M. with the Director of Nursing (DON) revealed there should have been follow up by the facility after Resident #22's urine was collected on 11/07/25. The DON stated 11/07/25 was a Friday and the specimen probably was discarded because the lab did not pick up urine specimens on the weekends. The DON indicated Resident #22's urine specimen was not resent after it was discarded. The DON stated she contacted Nurse Practitioner (NP) #227 who was told Resident #22's urine test was missed due to the change in Medical Director's at the facility. Around 11/07/25 the DON indicated Former Medical Director #207 and NP #228 were no longer employed by the facility and Medical Director #201 was now the Medical Director and his Nurse Practitioner was NP #227. The DON

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	365310	A. Building B. Wing	12/17/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to transport Resident #63 to dialysis appointments as ordered. This affected one resident (#63) out of one resident reviewed for dialysis. The facility census was 75.Findings include:Review of Resident #63's medical record revealed an admission date of 11/07/25 and diagnoses included end stage renal disease, type two diabetes without complications, and vascular dementia.Review of Resident #63's Treatment Administration Record (TAR) dated 11/10/25 through 12/14/25 revealed to monitor the right chest port (for dialysis use only) for signs and symptoms of infection (redness, drainage, foul odor, swelling, inflammation) every shift. It was checked off as completed each shift. Review of Resident #63's physician orders dated 11/11/25 revealed dialysis every Tuesday, Thursday and Saturday. Pick-up time was 9:45 A.M. and drop off was at 2:30 P.M.Review of Resident #63's care plan dated 11/10/25 and revised 12/08/25 revealed Resident #63 needed dialysis related to renal failure. Resident #63 had a RIJTDC (right internal jugular tunneled dialysis catheter). Resident #63 would have immediate intervention should any signs and symptoms of complications from dialysis occur through the next review date. Interventions included to check and change the access site dressing daily and document it; monitor, document and report signs and symptoms of infection to the access site; monitor, document and report signs and symptoms of bleeding, hemorrhage, bacteremia and septic shock.Review of Resident #63's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had moderate cognitive impairment. Resident #63 used a wheelchair. Resident #63 was dependent on staff with toileting, bathing and personal hygiene. Resident #63 was frequently incontinent of urine and always incontinent of bowel. Resident #63 did not reject care during the seven-day assessment look-back period. Resident #63 required oxygen therapy and dialysis.Review of Resident #63's progress notes and assessments dated 11/11/25, 11/13/25, 11/18/25, 11/20/25, 11/22/25, 11/24/25, 11/26/25, 11/29/25, 12/02/25, 12/04/25, 12/09/25, 12/11/25, and 12/13/25 revealed no documentation indicating Resident #63 received dialysis. Review of Resident #63's progress notes dated 11/15/25 at 6:20 P.M. revealed the on-call nurse practitioner (NP) was aware of dialysis cancellation today. No new orders were given.Review of Resident #63 progress notes dated 11/17/25 at 2:50 P.M. revealed the NP was updated on Resident #63's missed dialysis and no new orders were given. Resident #63 had dialysis scheduled for 11/18/25. Resident #63 was in no distress. Review of Resident #63's physician orders dated 12/02/25 revealed dialysis was every Tuesday, Thursday and Saturday. Pick-up time was 9:00 A.M. and return pick-up was 1:45 P.M.Review of Resident #63's appointment information included Resident #63 had a dialysis appointment scheduled for 12/06/25 at 9:45 A.M. Resident #63 used a wheelchair and did not need an escort. The transportation company's pick-up time was 9:00 A.M.Review of Resident #63's progress notes dated 12/06/25 at 11:24 A.M. revealed Resident #63's transportation did not show up, and Resident #63 did not go to dialysis. The NP was notified. There was no documentation stating Resident #63 was transported to the local hospital via emergency medical services (EMS).Review of Resident #63's Prehospital Care Report Summary dated 12/06/25 at 7:07 P.M. included EMS was dispatched to the facility due to Resident #63 not feeling well. Upon arrival Resident #63 was sitting upright in bed, was alert and oriented, and had no obvious life threats or distress noted. EMS was told they were called because Resident #63 missed her dialysis appointment and was not acting like herself. Resident #63 could not elaborate on how she felt. Resident #63 was transported to the local hospital with no gross changes to her vital signs or condition.Review of Resident #63's progress notes dated 12/08/25 at 9:01 A.M. revealed Resident #63 was in the hospital.Review of Resident #63's progress notes dated 12/08/25 at 7:12 P.M. revealed Resident #63 arrived at the facility around 3:30 P.M., vital signs were within normal limits and Resident #63 denied pain.Review of Resident #63's After Visit Summary for a hospital stay from 12/06/25 through 12/08/25 included Resident #63's reason for hospitalization was missed dialysis. Resident #63 was placed in observation for missed dialysis and received two sessions of dialysis. Interview on 12/11/25 at 3:16 P.M. with Resident #54 revealed he was Resident #63's husband and Resident #63 had missed dialysis appointments while at the facility. Resident #54 stated Resident #63 did not have her dialysis appointment on 11/15/25 which caused missed dialysis for five days. Resident #54 stated on 12/06/25 Resident #63 also missed her dialysis appointment, so he called the fire department to transport Resident #63 to the hospital because she did not look like herself. Interview on 12/15/25 at 8:29 A.M. with the Administrator revealed Resident #54 and Resident #63 were recently admitted to the facility and Adult

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	365310	A. Building B. Wing	12/17/2025

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #22 was provided appropriate dental services. This affected one (Resident #22) of three residents reviewed for dental services. The facility census was 75.Findings include:Review of the medical record for Resident #22 revealed an admission date of 01/08/25. Diagnoses included heart disease, dementia, anxiety and depression.Review of the dental provider notes dated 07/09/25 revealed Resident #22 was seen for upper and lower dental impressions.Review of the care plan dated 09/09/25 revealed Resident #22 had oral and dental health problems and upper and lower dentures. Interventions included coordinating arrangements for dental care, following diet orders, and documenting any signs or symptoms of oral or dental problems need attention. His dentures were identified as missing on 03/07/25.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was severely cognitively impaired. He required set up help for eating, substantial assistance for oral care, showering and dressing and was dependent on staff for toileting and personal hygiene.Interview on 12/09/25 at 1:04 P.M. with Certified Nurse Aide (CNA) #215 revealed he believed Resident #22 had dentures but did not wear them. Observation at the time of the interview with Resident #22's permission revealed no evidence of dentures in any of Resident #22's drawers or in his bathroom. CNA #215 revealed he thought he remembered seeing Resident #22 wear dentures but not since he was first admitted .Interview on 12/10/25 at 1:24 P.M. with Social Service Designee (SSD) #216 revealed she was aware Resident #22 did not have dentures but was unsure at what point they were misplaced. She revealed residents should see the dentist every six months unless an issue arose such as this; she confirmed he should have been seen as quickly as possible once the facility realized his dentures were missing, and his first appointment had been 07/09/25. She revealed she had been working with dental services to get them replaced, and they were supposed to arrive 12/15/25.Review of the facility policy titled Dental Services, dated December 2016, revealed direct care staff would assist residents with denture care, including removing, cleaning and storing dentures. Dentures would be protected from loss or damage while being stored. If dentures were damaged or lost, residents would be referred for dental services within three days. If a referral could not be made within three days, appropriate documentation would be provided regarding what was being done to ensure the resident was able to eat and drink adequately while awaiting dental services, and the reason for the delay.This deficiency represents noncompliance investigator under complaint number 2654942.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, record review and interview, the facility failed to ensure food portions were appropriate and food served was palatable. This affected all residents with the exception of Resident #50, who did not consume meals from the kitchen. The facility census was 75.Findings include: Observation on 12/10/25 of lunch tray line revealed a meal of spaghetti with meat sauce, garlic bread and salad being served. Review of the food temperature log revealed the log was last updated 12/04/25 for breakfast. [NAME] #218 revealed he wrote the temperatures for the day's lunch on the wrong sheet, he revealed he wrote the temperatures on 12/03/25 at dinner. He revealed the meat sauce was 180 degrees Fahrenheit (F), the noodles were 179 degrees F, the mashed potatoes were 183 degrees F, and there was no temperature obtained for the garlic bread, fruit or salad. There were also no temperatures for the pureed meat sauce or garlic bread. [NAME] #218 confirmed not all food temperatures were obtained prior to the start of the meal being served.Continued observation of tray line on 12/10/25 revealed the pureed spaghetti with meat sauce, pureed salad and pureed garlic bread were sitting on top of the steam tables, not contained within the tables. [NAME] #219 plated each meal, serving the pureed spaghetti with meat sauce, puree garlic bread and salad on the same plate. Residents on a pureed diet received five and one-third ounces of spaghetti with meat sauce and two ounces of salad. Residents on a regular diet received two and two-thirds ounces of spaghetti, five and one-third ounces of spaghetti sauce with meat and one breadstick. As meal service continued, the spaghetti noodles began to harden and stick together, revealing hard, brown and crusty noodles. Residents on the Grand Hall received smaller portions of food as they were the last hall to be served and the food prepared was coming to an end. Interview at the time of the observation with [NAME] #219 confirmed she was trying to stretch out what little food she had left to ensure the residents on the Grand Hall received a meal.Observation of the test tray on 12/10/25 at 12:31 P.M. after the last resident was served at 12:25 P.M. consisted of pureed spaghetti with meat sauce, puree bread and salad. No concerns were identified regarding the consistency or taste of the food; however, the temperature for the pureed spaghetti was 131 degrees F, the pureed bread was 134 degrees F and the salad was 76 degrees F. [NAME] #219 confirmed she was unsure what temperature the food should be when it was served to the resident, but 76 degrees F for a salad was definitely too warm. [NAME] #219 also confirmed she was aware portion sizes were inconsistent and did not follow the recommended portion sizes provided on the spreadsheet.Review of the spreadsheet for the meal revealed portion sizes for a regular diet were six ounces of spaghetti sauce with meat, four ounces of noodles, four ounces of shredded lettuce, two ounces of breadsticks and four ounces of fruit.Review of the facility policy titled Resident Nutrition Services, dated July 2017, revealed each resident would be provided with a nourishing, palatable, well balanced meal that met their daily nutritional and special dietary needs. Nursing personnel would inspect food trays to ensure the correct meal had been delivered and that food appeared palatable and attractive and was served at a safe and appetizing temperature.This deficiency represents noncompliance investigated under Master Complaint Number 2687492.

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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. Based on observation, interview and facility policy review, the facility failed to ensure the building was in good repair and free of trash buildup. This had the potential to affect all 75 residents in the facility.Findings include: Observation on 12/09/25 at 10:42 A.M. of the basement revealed a room with two large bins of trash piled over the top as well as five to six large bags of trash on the ground. A room labeled housekeeping revealed a strong odor of mold, multiple flying insects and approximately ten clear bags filled with trash piled on top of one another, lining the left wall. Against the right wall were two large trash can sized tubs underneath a pipe running from the front of the wall toward the back of the wall which was leaking water into the tubs.Observation and interview with Laundry Aide #217 on 12/09/25 at 10:47 A.M. of the laundry area revealed water running down the brick wall next to the dryer with a black mold-like substance approximately two inches tall by 10 inches long toward the bottom of the wall. Interview at the time of the observation with Laundry Aide #217 confirmed the water running down the wall and a mold like substance beneath it. She stated the basement always had an odor of mold or mildew.Observation and interview on 12/09/25 at 1:09 P. M. with Maintenance Director #220 confirmed the pipe leaking water in the basement was a sewage pipe that he had been attempting to fix but had not been able complete successfully. He confirmed the bags piled up against the wall were trash that had not yet been taken to the dumpster and the insects flying throughout the room were fruit flies. He also confirmed the room across from the laundry room contained two large rolling bins of trash and multiple bags of trash that also had not yet been taken to the dumpster. He revealed the water running down the wall in the laundry room was due to a crack in the foundation, and the snow that had been melting was entering the building, causing the water and mold buildup.Observation and interview on 12/16/25 at 10:30 A.M. with Certified Nursing Assistant (CNA) #237 of the first-floor nursing unit shower room revealed there were two shower areas and black mold could be seen between the tiles near the floors of both shower areas. CNA #237 confirmed the observation.Review of the facility policy titled Quality of Life - Home Like Environment, dated May 2017, revealed residents would be provided a safe and comfortable home like environment including maintaining cleanliness, sanitary and odor free. This deficiency represents noncompliance investigated under Complaint Numbers 2654942, 2582046, 2581641, and 2581640.