STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365310	A. Building B. Wing	02/17/2026

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure staff obtained proper Cardiopulmonary Recusation (CPR) certification for healthcare providers. This had the potential affect 59 Residents (#1, #2, #3, #4, #9, #11, #13, #14, #15, #16, #17,#19, #20, #21, #22, #23, #28, #30, #31, #33 ,#34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #48, #50,#52, #53, #56, #57, #59, #61, #62, #63, #64, #65, #69, #70, #73, #74, #75, #76, #77, #81, #83, #84, #86, #88, #89, and #91) who had elected for an advance directive of full code status . The facility census was 91. Findings include: Review of the staff certifications for CPR certification revealed the following:Review of Licensed Practical Nurse (LPN) #101's personnel record revealed a date of hire of [DATE]. There was no CPR certification contained in LPN #101's personnel record.Review of LPN #107's personnel record revealed a date of hire of [DATE]. The CPR certification included adult, child, infant and automatic electronic defibrillator (AED). The completion date was [DATE] with a renewal date of [DATE]. The card did not include an indication that the training course covered basic life support (BLS) and did not indicate it was a certification for healthcare providers.Review of LPN #111's personnel record revealed a date of hire of [DATE]. There was no CPR certification contained in LPN #111's personnel record.Review of Registered Nurse (RN) #114's personnel record revealed a date of hire of [DATE]. There was no CPR certification contained in RN #114's personnel record.Review of LPN #115's personnel record revealed a date of hire of [DATE]. The CPR certification included adult, child, infant and AED. The completion date was [DATE] and renewal date of [DATE]. The course did not include Basic Life Support (BLS) and did not indicate it was a certification for healthcare providers.Review of LPN #116's personnel record revealed a date of hire of [DATE]. The CPR certification included adult, child, infant and AED. The completion date was [DATE] and renewal date of [DATE]. The course did not include Basic Life Support (BLS) and did not indicate it was a certification for healthcare providers.Review of LPN #118's personnel record revealed a date of hire of [DATE]. There was no CPR certification contained in LPN #118's personnel record.Review of LPN #120's personnel record revealed a date of hire of [DATE]. The CPR certification included adult, child, infant and AED. The completion date was [DATE] and renewal date of [DATE]. The course did not include Basic Life Support (BLS) and did not indicate it was a certification for healthcare providers.Interview on [DATE] at 9:38 A.M. with the Director of Nursing (DON) verified RN #114, and LPNs #101, #111, and #118 had no current CPR certification on file. Additionally, the DON confirmed LPNs #107, #115, #116, and #120's CPR certification did not include BLS or have a designation that it was a certification for healthcare providers.Review of the policy titled Licensure, Certification, and Registration of Personnel revise [DATE] stated Personnel who require a license, certification, or registration to perform their duties must present verification of such license/certification registration to the Human Resources Director prior to or upon employment.Review of the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy titled Emergency Procedure Cardiopulmonary Resuscitation revised [DATE] stated Resuscitation (CPR) for key clinical staff member who will direct resuscitative efforts, including non-licensed personnel will obtain and or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR).This deficiency represents non-compliance investigated under Master Complaint Number 2733342 and Complaint Number 2717021.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview, review of emergency medical services (EMS) run report, review of the facility's timeline and investigation, and facility policy review, the facility failed to ensure a resident's change in condition was timely addressed. This affected one resident (#34) of three residents reviewed for changes in condition. The facility census was 91. Findings include:Review of the closed medical record for Resident #34 revealed an admission date of [DATE] with medical diagnoses including presence of a tracheostomy (a surgically-created opening in the neck through which an airway is established; it involves inserting a tube to bypass the upper airway), chronic respiratory failure with hypoxia, malignant neoplasm (cancer) of the larynx, malnutrition, gastrostomy status, and gastroesophageal reflux disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact and was dependent on staff for toileting, showers, and transfers. The resident received enteral nutrition via a feeding tube, oxygen therapy, tracheostomy care, and suctioning. Review of the Care Plan dated [DATE] revealed Resident #34 had altered respiratory status and difficulty breathing related to tracheal squamous cell cancer and chronic hypoxia. Interventions including administering humidified oxygen via tracheostomy mask to maintain oxygen saturation level of 92 percent (%) and providing oral suction to clear secretion and elevate the head of the bed for easier breathing. Review of Resident #34's physician orders revealed an order date [DATE] for full code status, indicating resuscitation efforts were to be provided (up to and including cardiopulmonary resuscitation (CPR)) in the event or cardiac or respiratory arrest. Review of Resident #34's medical record revealed he elected for hospice services on [DATE]. Review of Resident #34's physician orders revealed an order dated [DATE], initiated after electing for hospice services, to discontinue all laboratory testing and do not hospitalize. Review of the facility's investigation and timeline revealed on [DATE] at 5:50 A.M., Resident #34's tracheostomy inner cannula had come dislodged. At 5:55 A.M., the (unnamed) Certified Nursing Assistant (CNA) alerted the nurse that the resident had difficulty breathing. At 6:06 A.M., staff went to get another nurse in the building. At 6:10 A.M., CPR was initiated and EMS was called. At 6:15 A.M., EMS arrived at the facility. Review of the EMS run report dated [DATE] revealed a call was received by EMS at 6:26 A.M. The report indicated the EMS crew arrived at the facility at 6:36 A.M. and arrived at the patient at 6:38 A.M. Upon arrival, CPR was in progress by facility staff. The report indicated facility staff had witnessed the arrest after Resident #34 had taken out his tracheostomy tube and then went quickly into full arrest. The EMS report indicated EMS staff continued care and Resident #34 was transported to a local hospital. Review of Resident #34's progress notes dated [DATE] at 8:28 A.M. revealed the nurse was alerted the resident was in respiratory distress and CPR was initiated. EMS was called and the physician was notified. The note concluded by referencing the resident regained consciousness and a slight pulse before leaving the facility. The note did not specify what time the change in condition occurred or any additional details about the arrest. Further review of Resident #34's progress notes revealed he returned to the facility on [DATE]. Interview with the Corporate Quality Assurance Registered Nurse (QARN) #220 on [DATE] at 10:29 A.M. revealed she received a call on [DATE] at 7:00 A.M. that Resident #34 had coded. An investigation was conducted. The investigation identified that there was a delay in giving care to Resident #34. CNA #138 had alerted the nurse. However, the nurse went to another unit to get help and left Resident #34 alone. Interview with CNA #138 on [DATE] at 12:08 P.M. revealed on [DATE] around 5:50 A.M., she was passing water and Resident #34 waved her down and was pointing at his tracheostomy tube and noted that it was disconnected. CNA #138 notified Licensed Practical Nurse (LPN) (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#116 that Resident #34 needed him and Resident #34's tracheostomy hose was disconnected. LPN #116 was passing morning medications to other residents and replied to give him a few minutes. CNA #138 waited with Resident #34 for eight minutes and then left the room to notify CNA #140 that LPN #116 has not come to assess Resident #34. CNA#138 went on to provide care to her assigned residents. Two minutes later, LPN #116 entered Resident #34's room. Fifteen minutes later, she went back to Resident #34's room and LPN #116, LPN #119, and LPN #113 were present in the room. Resident #34's trach was pulled completely out and sitting on his chest. Resident #34 was not breathing, and CPR was initiated and EMS was called. Interview with LPN #119 on [DATE] at 12:58 P.M. revealed she was assigned to the secured unit on the first floor when LPN #116 and LPN #113 came in and notified her that Resident #34 was in respiratory distress. LPN #119 stated they were on the first floor and took the elevator up to the second floor to get to Resident #34's room. Upon entering, Resident #34 had a grey tone and was not breathing. LPN #113 grabbed the crash cart and called 911. LPN #116 started CPR. LPN #119 estimated the time to be in the 6:00 A.M. hour. Interview with LPN #113 on [DATE] at 1:15 P.M. revealed on [DATE] at approximately 6:15 A.M., LPN #116 came to her unit and stated Resident #34 had been in respiratory distress for some time. Upon entering the room, the resident was grey and had difficulty breathing. Resident #34 he took a few breaths and then stopped. There were no staff with the resident. LPN #113 estimated at 6:20 A.M., EMS was called and CPR was initiated. Interview with the Medical Director (MD) on [DATE] at 3:02 P.M. stated he was notified of Resident #34 coding. However, he was unaware of the delayed response time in addressing the resident's respiratory distress. Interview with LPN #116 on [DATE] at 11:34 A.M. revealed during shift report [on the evening of [DATE]], he had been informed Resident #34 had signed on to hospice services. At 5:30 A.M. [on [DATE]] he began his morning medication pass. LPN #116 was preparing another resident's medication across the hall when he was notified by CNA #138 that Resident #34 was having a hard time breathing. LPN #116 told CNA #138 to give him a minute to finish the resident's medication administration. Upon entering room, he observed Resident #34 in respiratory distress. LPN #116 went to suction Resident #34 when the resident was observed to pull out his whole tracheostomy tube. LPN #116 tried to re-insert the tracheostomy tube but could not. He looked out the hall for help and saw no one, so he continued to walk to a unit on the first floor to get a nurse and then to the secured unit to get another nurse. They all took the elevator back up to second floor. At that time Resident #34 was noted to not be breathing and CPR was started and EMS was called. LPN #116 reported EMS arrived within approximately ten to fifteen minutes after they were called. Interview with the Director of Nursing (DON) on [DATE] at 12:12 P.M. verified there was a delay in addressing Resident #34's change of condition on the morning of [DATE]. LPN #116 should have immediately assessed Resident #34 trach tube when alerted he was in distress instead of administering medication to another resident and confirmed a staff member should have stayed with Resident #34. The DON reported a code should have been called through the overhead paging system. The DON stated it had been difficult to come up with accurate timeline as staff statements and interviews as staff had not recorded or provided times of the incident on [DATE]. Review of the facility policy titled Change in a Resident's Condition revised [DATE] revealed a significant change of condition is a major decline or improvement in the resident status that will not normally resolve itself without intervention by staff. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the undated document Change in Condition revealed if any changes are observed, report to the nurse. The nurse will communicate pertinent changes to the doctor or nurse practitioner (NP) when observed. Staff must monitor changes and document resident's progress and responses to treatment. This (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deficiency represents non-compliance identified under Master Complaint Number 2733342 and is a recite to the survey completed on [DATE].

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, interview, and facility policy review, the facility failed to ensure pain medications were available for administration. This affected one resident (#58) of three residents reviewed for medications. The facility census was 91. Findings include: Review of the medical record for Resident #58 revealed an admission date of 09/01/24 with diagnosis of rheumatoid arthritis, failure to thrive, depression, post cholecystectomy syndrome.Review of the quarterly Minimum Data Set 3.0 dated 01/07/26 revealed the resident had intact cognition and was dependent on staff for toileting and transfers. The assessment indicated the resident had pain and received scheduled and as-needed pain medications.Review of the physicians ordered for January 2026 revealed two order for pain medication. Oxycodone (a opioid analgesic) 15 milligrams (mg) to be administered every four hours and Acetaminophen (an over-the-counter mild pain reliever) 500 mg, a pain reliever, to be administered every six hours as needed. Review of the Medication Administration Record (MAR) for January 2026 revealed on 01/20/26 Oxycodone 15 mg was sign off as not administered and to see progress note at 6:00 A.M., 10:00 A.M, 2:00 P.M. and 6:00 P.M. Review of progress notes dated 01/20/26 timed 10:07 A.M., 1:13 P.M., and 5:42 P.M. revealed the doses were not administered on 01/20/26 as the facility was waiting on the pharmacy to deliver Resident #58's Oxycodone. Continued review of Resident #58's MAR for January 2026 revealed Oxycodone 15 mg was left blank on 01/25/26 at 10:00 P.M. and 01/26/26 at 2:00 A.M., 6:00 A.M. and 2:00 P.M.Interview on 01/29/26 at 5:00 P.M. with the Director of Nursing (DON) verified Resident #58 was not administered Oxycodone on 01/20/26, 01/25/26, and 01/26/26 due to a delay with pharmacy delivery. There were no notes related to why Resident #58's Oxycodone was not administered on 01/25/26 and 01/26/25.Review of the policy Administering Medications revised December 2012 revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number 2711748.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure medical records were accurate and complete. This affected two Residents (#3 and #58) of three residents reviewed for documentation. The facility census was 91. Findings include: 1.Record review for Resident #58 revealed an admission date of 09/01/24. Diagnosis included rheumatoid arthritis, failure to thrive, depression, anxiety, and post-traumatic stress disorder.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #58 was cognitively intact and had moderate depression. Resident #58 had impairment on both sides of the upper and lower extremities and was dependent on staff for toileting hygiene, showers, and transfers.Review of the progress note dated 01/04/26 at 12:17 P.M. resident was exhibiting hallucinations and making accusations against staff, stating that staff is stealing her belongings, drugging her, and transferring her to another room against her will. The Resident also stated she called emergency medical services (EMS) and told them that people were messing with her furniture and stealing them. The note did not indicate the resident was pinked slipped (sent for psychiatric evaluation) by the physician for behaviors.Review of the hospital summary dated 01/04/26 at 6:42 P.M. revealed Resident #58 arrived at the hospital via EMS with a pink slip from facility indicating Resident #58 was agitated, threating staff, refusing care, hallucinating, and paranoid. Resident #58 was evaluated by medical and psychiatry staff and did not meet criteria for inpatient psychiatric hospitalization. 2.Record review for Resident #3 revealed an admission date of 09/01/24. Diagnosis included type II diabetes, Alzheimer's disease, cognitive communication deficit, pain in left hip, and anxiety.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively impaired and required limited assistance with eating, toileting, showering, and transferring.Review of the care plan dated 01/23/26 revealed the resident had impaired cognitive function, and impaired thought process related to Alzheimer's disease. Intervention included administer medications as order and cue, reorient and supervise as needed.Review of the Self Reported Incident (SRI) dated 01/23/25 at 3:00 P.M. revealed a resident-to-resident altercation was reported in the secured unit. Resident #3 reported Resident #19 pushed her. Staff intervened, separated both residents, and redirected them to different areas. Residents were assessed with no injuries. The self-reported incident was unsubstantiated. Review of the progress notes on 01/23/26 revealed no documentation on the allegation of the resident-to-resident abuse allegation or incident. Interview with the Director of Nursing (DON) 02/12/26 at 9:38 A.M. verified there was no documentation in the progress notes that there was allegation of resident-to-resident abuse or any altercation involving Resident #3. The DON additionally confirmed Resident #58's progress note did not indicate that the resident was pinked slipped to the hospital by the physician for behaviors.Review of the facility policy titled Charting and Documentation revised July 2017, stated the following information is to be documented in the medical record: observations, medications administer, treatment or services performed, changes in the resident condition, events, incident or accident involving the resident.This deficiency represents non-compliance investigated under Master Complaint Number 2733342 and Complaint Numbers 2729269 and 2711748 and is recite to the complaint survey completed on 11/13/25.