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	05/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to respect and honor a resident's choice to not have care provided by Certified Nursing Assistant (CNA) #588. This affected one resident (Resident #39) of three residents reviewed for respect and dignity. The facility census was 78. Findings include:Record review for Resident #39 revealed an admission date of 07/25/23. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was moderately cognitively impaired, used a wheelchair for mobility, was always incontinent of urine and occasionally incontinent of bowel. Resident #39 was dependent for toileting hygiene and bed mobility.Observation on 05/12/26 at 2:18 P.M. revealed Resident #39 was lying in bed. Interview with Resident #39 at the time of the observation revealed she was incontinent and waiting for staff to assist with care.Interview on 05/12/26 at 2:39 P.M. with CNA #511 revealed she did not normally have Resident #39 on her routine assignment. Resident #39 was on another CNA's assignment, but when CNA #588 worked, like today, she (CNA #511) had to add Resident #39 to her assignment because Resident #39 did not want CNA #588 caring for her. Observation at the time of the interview revealed CNA #511 gathered supplies for incontinence care and entered Resident #39's room. Wound Nurse #539 then entered Resident #39's room and reminded CNA #511 to wear her Personal Protective Equipment (PPE). After donning the PPE, CNA #511 began to care for Resident #39. CNA #588 entered the room. Resident #39 looked up at CNA #511 and stated loudly, I don't want her in here. CNA #511 stated, Shhh, while shaking her head no and whispered, It will be alright. Resident #39 looked up at CNA #511 with her mouth opened and her eyebrows crunched but did not respond. CNA #588 assisted with incontinence care for Resident #39 including turning and repositioning. Interview on 05/12/26 at 3:35 P.M. with Resident #39 who complained in a loud and angry tone, I didn't want her (CNA #588) in here. I said that and she stayed anyway. I did not want her here. She cussed at me before that's why. I didn't want her here. Resident #39 stated a while back, CNA #588 had cursed at her, then stated, It made me feel bad. They didn't listen to me. I don't understand why she is in here when I asked her not to be. She cussed me out. I cried so hard. She came back and apologized, but I just don't want her in here. Resident #39 appeared stressed during the interview and became teary eyed.Interview on 05/12/26 at 3:39 P.M. with CNA #511 who stated, We were told we had to have two staff because the resident makes up stories, so someone else had to be there. When asked about the response she gave to Resident #39 during care, CNA #511 stated, I didn't know what to say. There had to be two. CNA #511 revealed she never told anyone about Resident #39 not wanting CNA #588 to work with her because she thought everyone else already knew.Interview on 05/12/26 at 4:41 P.M. with Director of Nursing (DON) revealed residents were allowed to request not to have a certain staff member provide care, and that it was their right. DON stated she was not aware Resident #39 did not want care provided by CNA #588. This deficiency represents non-compliance investigated under Complaint Number 2803899.

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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(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. Based on record review, interviews, and review of the facility policy, the facility failed to complete a Self-Reported Incident (SRI) when an allegation of verbal abuse was reported involving Certified Nursing Assistant (CNA) #588 cursing at Resident #39. This affected one resident (Resident #39) of three residents reviewed for abuse. The facility census was 78.Findings include:Record review for Resident #39 revealed an admission date of 07/25/23. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Interview on 05/12/26 at 3:35 P.M. with Resident #39 revealed a while back, CNA #588 cursed at her and stated, It made me feel bad. They didn't listen to me. I don't understand why she is in here when I asked her not to be. She cussed me out. I cried so hard. She came back and apologized, but I just don't want her in here. Resident #39 appeared stressed during the interview and became teary eyed.During an interview on 05/12/26 at 4:41 P.M. with the Director of Nursing (DON) notification was made by informing the DON of Resident #39's allegation of CNA #588 cursing at her and making her cry. The allegation was discussed and DON twice repeated Resident #39's concern, stating an investigation was needed.Review of the facility Self-Reported Incidents (SRI) made to the State Agency from 05/12/26 to 05/14/26 revealed an SRI was not initiated for the abuse allegation made by Resident #39 on 05/12/26. Interview on 05/14/26 at 8:42 A.M. with DON and Administrator revealed the Administrator confirmed if a resident made an allegation that a CNA cursed at her making the resident cry, an SRI should have been opened. DON confirmed she was notified on 05/12/26 of the allegation regarding CNA #588 cursing at Resident #39 and making her cry. Administrator confirmed that an SRI was not opened.Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, undated revealed all incidents and allegations of abuse, neglect, exploitation, mistreatment, misappropriation of resident property, and injuries of unknown source must be reported to the State Agency no later than two hours after the allegation is made. All other allegations (without injury) must be reported as soon as possible, but no later than 24 hours after the staff member becomes aware of the incident or allegation. This deficiency represents non-compliance investigated under Master Complaint Number 3000374.

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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. Based on record review, interviews, and review of facility policy, the facility failed to initiate an abuse investigation for an allegation of verbal abuse and take action to prevent further mistreatment by the alleged perpetrator (CNA #588) pending the outcome of the investigation. This affected one resident (Resident #39) of three residents reviewed for abuse. The facility census was 78.Findings include:Record review for Resident #39 revealed an admission date of 07/25/23. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Interview on 05/12/26 at 3:35 P.M. with Resident #39 revealed a while back, CNA #588 cursed at her and stated, It made me feel bad. They didn't listen to me. I don't understand why she is in here when I asked her not to be. She cussed me out. I cried so hard. She came back and apologized, but I just don't want her in here. Resident #39 appeared stressed during the interview and became teary eyed.During an interview on 05/12/26 at 4:41 P.M. with the Director of Nursing (DON) notification was made by informing the DON of Resident #39's allegation of CNA #588 cursing at her and making her cry. The allegation was discussed and DON twice repeated Resident #39's concern, stating an investigation was needed.During a follow-up interview on 05/13/26 at 8:59 A.M., the DON stated, I did talk to (CNA #588) this morning. I have not talked to the resident (Resident #39) yet. (CNA #588) said that was never a thing. I guess there was something a week ago where the resident called her out of her name. (CNA #511) said (Resident #39) preferred her. The last piece of the puzzle is I will talk to the resident. My understanding is (Resident #39) just wants (CNA #511) instead of (CNA #588).Interview on 05/13/26 at 12:48 P.M. with CNA #588 who was observed working on the second floor where Resident #39 resided revealed she started her shift as usual at 7:00 A.M. CNA #588 verified the DON talked to her after the start of the shift and told her if a resident asked her to leave then she needed to leave.Interview on 05/14/26 at 8:42 A.M. with DON and Administrator revealed the Administrator confirmed if a resident made an allegation that a CNA cursed at her making the resident cry, an SRI (Self-Reported Incident) should have been opened, the CNA should have been suspended, and an investigation initiated. DON confirmed she was notified on 05/12/26 of the allegation regarding CNA #588 cursing at Resident #39 and making her cry. Administrator confirmed that an SRI was not opened, CNA #588 was not suspended, and an investigation was not initiated per the facility policy on abuse.Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, undated, revealed an investigation of abuse must be completed within five (5) working days, unless special circumstances require more time. The person conducting the investigation should generally complete the following actions: interview the resident, the accused, and all witnesses, and if no direct witnesses exist, interviews may be expanded to all employees on the unit or shift; obtain written statements from the residents (if possible), the accused, and each witness; review the residents' records; and if the accused is an employee, the facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. All evidence gathered during the investigation must be documented.This deficiency represents non-compliance investigated under Master Complaint Number 3000374.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review, the facility failed to provide timely incontinence care for Resident #10 who was dependent on staff for toileting hygiene and incontinence of bowel resulting in being left in a soiled incontinence brief, having dried stool on the skin for extended periods, and prolonged exposure to stool odors. This affected one resident (Resident #10) of three residents reviewed for incontinence care. The facility census was 78.Findings include:Record review for Resident #10 revealed an admission date of 03/03/26, with diagnoses including gastrostomy malfunction, hemiplegia and hemiparesis, muscle weakness, and a need for assistance with personal care. Review of the fiveˆday Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had an indwelling catheter, was always incontinent of stool, had oneˆsided upper and lower extremity impairment, and was dependent on toileting hygiene.Review of the care plan revised 03/16/26 revealed the resident was at risk for skin breakdown due to decreased mobility, desensitized skin, and bowel incontinence, with interventions including keeping the skin clean, dry, and odorˆfree, and checking for incontinence with cleansing and drying of the skin when wet or soiled.Observation on 05/11/26 at 2:04 P.M. revealed a strong odor of stool upon entering Resident #10's room. The resident was lying in bed with food on his chest. Interview at the time of the observation with Resident #10 stated the last time he had been checked or changed was at 8:00 A.M. Observation on 05/11/26 at 2:06 P.M. with Certified Nursing Assistant (CNA) #521 of Resident #10 revealed deep skin creases on the resident's back from the positioning pad, dried stool on the skin, and redness of the buttocks. CNA #521 confirmed Resident #10 had finished eating approximately 35 minutes earlier but had not been changed prior to or after the meal.Interview on 05/11/26 at 2:24 P.M. with CNA #521, who was identified as Resident #10's primary CNA, stated the unit was shortˆstaffed. She reported Resident #10 was last changed at 8:00 AM. She further stated that staff were not allowed to check and change during meals, and if residents became incontinent during meals or during tray pass, they have to wait. The CNA reported she went on break immediately after lunch, so Resident #10 was not checked or changed. She also reported a lack of teamwork and stated she had three people to feed and no assistance from other staff so residents who needed to be changed just had to wait.Observation on 05/14/26 at 1:58 P.M. revealed a strong foul odor of stool upon entering Resident #10's room. Interview at the time of the observation with Resident #10 stated the last time he had been changed was at 10:30 A.M. Interview on 05/14/26 at 1:59 P.M. with CNA #701, who was in the hall stated she had last checked the resident at 11:00 AM and stated, He always smells like that. He is tube fed. When asked to check the resident again due to the strong odor, CNA #701 replied she was going on break and would check the resident when she returned, asking, You really want me to do it right now? I am doing my rounds. When I get back from break, okay? You okay with that? CNA #701 then turned and walked down the main hall exiting the unit. There was no nurse available on the unit at that time. One CNA (#701) was on break and the other was giving a shower. During an interview on 05/14/26 at 2:12 P.M. with Regional Clinical Nurse (RCN) #590, Resident #10's need for assistance was reported. RCN #590 entered Resident #10's room and confirmed the presence of stool. Additional interview on 05/14/26 at 2:38 P.M. with RCN #590 confirmed she smelled stool when she went into the room and stated staff were to assist residents with incontinence care whenever they needed it.Review of the facility policy titled, Urinary Continence and Incontinence - Assessment and Management, revised September 2010, revealed when a resident was always incontinent, staff would utilize a check and change strategy which involved checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals were to maintain dignity and comfort and to protect the skin.The deficiency represents non-compliance investigated under Master Complaint Number 3000374 and Complaint Number 2800362.

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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 observation, interview, record review, and review of facility policy, the facility failed to maintain a safe environment by permitting smoking materials (lighters, tobacco paraphernalia and vapes) in resident rooms which violated facility policy and safe smoking protocols. This affected five residents (Residents #6, #31, #60, #73 and #74) of six residents reviewed for smoking. The facility census was 78. Findings include:1. Record review for Resident #31 revealed an admission date of 10/24/25. Diagnoses included post-traumatic stress disorder, schizophrenia, and cannabis use. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was severely cognitively impaired, required set up or clean up assistance with eating, bed mobility and partial to moderate assistance with toileting hygiene. Resident #31 had physical behavioral symptoms directed towards others one to three out of seven days and had verbal symptoms directed towards others four to six out of seven days. Review of the care plan dated 10/27/25 revealed Resident #31 had a history of smoking in the community, was a current vape user in the facility, and was non-compliant with vape materials. Interventions included completing a smoking evaluation per facility guidelines, not leaving unattended while vaping, and following the facility smoking policy. Review of the Smoking Policy Resident Acknowledgement signed by Resident #31's Guardian dated 10/28/25 revealed the facility established and maintained safe resident smoking practices. Any resident with restricted smoking privileges who required monitoring would always have the direct supervision of staff while smoking. Residents were not permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. Electronic cigarettes and chargers were considered smoking articles and not to be kept in the resident's possession. E-cigarette use in the resident's room was prohibited.Observation on 05/11/26 at 10:32 A.M. revealed a vape was setting on top of the stand in Resident #31's room. The room had a strong odor of a recently used vape. Interview at the time of the observation with Resident #31 confirmed she used the vape in her room whenever she wanted. Observation on 05/11/26 at 10:50 A.M. with Certified Nursing Assistant (CNA) #513 confirmed Resident #31 had a vape stored in her room. Interview at the time of the observation with CNA #513 stated the resident had several vapes in her room, and Resident #31 had used the vape in her room unattended since she was admitted to the facility, having always been allowed to vape.Interview on 05/12/26 at 9:35 A.M. with Licensed Practical Nurse (LPN) #536 confirmed she was Resident #31's primary care nurse and stated Resident #31's family member sent her vapes in the mail as Resident #31 was allowed to vape in her room unattended.Interview on 05/12/26 at 9:50 A.M. with Social Worker Designee (SWD) #584 revealed if a resident smoked cigarettes or used a vape, they must go outside. SWD #584 stated Resident #31 had behavioral issues and did not fully understand the rules. After reviewing the smoking policy provided by SWD #584, it revealed the resident was not allowed to keep the vapes in her room. SWD #584 confirmed it was the current policy she gave to all new residents and no smoking materials were allowed to be kept with any residents on their person or in their room while residing in the facility.2. Record review for Resident #6 revealed an admission date of 09/02/25. Diagnoses included spinal stenosis, muscle weakness, schizoaffective disorder bipolar type, and nicotine dependence. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #6 was mildly cognitively impaired. Resident #6 used a wheelchair and/or walker for mobility.Review of the care plan dated 09/03/25 revealed Resident #6 had a history of smoking in the community, was a current smoker in the facility, and was non-compliant with smoking materials. Interventions included to not leave unattended while smoking, and to follow the facility smoking policy. Review of the Smoking Safety Screen dated 03/23/26 at 1:53 P.M. revealed Resident #6 was able to smoke following the facility policy. Resident #6 agreed to the facility policy for smoking.Review of the Smoking Policy Resident Acknowledgement completed by SWD #584 and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signed by Resident #6 dated 10/01/25 revealed residents were not permitted to keep in their possession any cigarettes, pipes, tobacco, and other smoking articles. Observation on 05/13/26 at 9:15 A.M. revealed Resident #6 was in the facility courtyard smoking cigarettes with three other residents (Residents #60, #73 and #74). Housekeeping Supervisor (HS) #567 monitored. Resident #6 took a clear sandwich bag which contained multiple cigarettes out of his shirt pocket, and then took a lighter out of his pants pocket, lit his cigarette, before putting the items back into his pockets.Observation on 05/13/26 at 9:37 A.M. revealed Resident #6 was sitting in a chair in his room. Interview at the time of the observation with Resident #6 confirmed he kept his cigarettes and lighter in his room. Resident #6 then pulled his baggie of cigarettes and lighter out of his coat pocket to reveal it.Interview on 05/13/26 at 9:44 A.M. with HS #567 revealed each resident who smoked had a locked box in which their smoking materials were kept, and it was stored in a large cabinet. The staff kept the keys to the cabinet so smoking materials were secure. No residents were permitted to keep smoking materials including cigarettes and lighters in their room.Interview on 05/13/26 at 9:47 A.M. with HS #567 confirmed she found Resident #6's cigarettes and lighter in his room. Observation at the time of the interview with HS #567 of the cabinet used to store smoking supplies revealed the cabinet was kept in the lounge area near the exit where residents went outside to smoke. HS #567 verified the cabinet was not locked, no staff were monitoring the unlocked cabinet with the smoking supplies, and residents had access to the unlocked cabinet.3. Record review for Resident #60 revealed an admission date of 10/09/25. Diagnoses included polyosteoarthritis, unspecified dementia, and nicotine dependance.Review of the Quarterly MDS assessment dated [DATE] revealed Resident #60 was cognitively intact, used a wheelchair for mobility, and required supervision or touch assistance with personal hygiene.Review of the care plan dated 10/09/25 revealed Resident #60 had a history of smoking in the community and was a current smoker in the facility. Interventions included following the facility smoking policy. Review of the Smoking Safety Screen dated 04/06/26 at 9:03 A.M. completed by SWD #584 revealed Resident #60 was safe to smoke with supervision, and per facility policy smoking for all residents was supervised during smoke times.Review of Resident #60's medical record for the Smoking Policy Resident Acknowledgement revealed there was none in the medical record.Observation on 05/13/26 at 9:34 A.M. revealed Resident #60 was sitting in a chair in his room. Resident #60 removed a partially smoked cigarette and lighter from his coat pocket. Interview on 05/13/26 at 11:25 A.M. with Regional Director of Operations (RDO) #589 verified residents should not have cigarettes or lighters in their room. Interview on 05/13/26 at 10:04 A.M. with HS #567 confirmed Resident #60 kept his cigarettes and lighter in his room.4. Record review for Resident #73 revealed an admission date of 12/04/25. Diagnoses included malignant neoplasms of the upper lobe left bronchus or lung, chronic obstructive pulmonary disease, and nicotine dependence. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #73 was cognitively intact. Resident #73 required setup or clean up assistance with eating, and supervision or touching assistance with chair/bed to chair transfers. Review of the care plan dated 12/04/25 revealed Resident #73 had a history of smoking in the community and was a current smoker in the facility. Interventions included to complete a smoking evaluation per the facility guidelines, do not leave unattended while smoking, and to follow the facility smoking policy. Review of the facility Smoking Safety Screen dated 03/05/26 revealed Resident #73 agreed to the facility policy for smoking.Review of the Smoking Policy Resident Acknowledgement completed by SWD #584 and signed by Resident #73 dated 12/05/25 revealed residents were not permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. Observation and interview on 05/13/26 at 9:57 A.M. confirmed Resident #73 kept his lighter in his pants pocket while unattended in his room.Observation and interview on 05/13/26 at 4:01 P.M. with HS #567 confirmed Resident #73 kept his cigarettes and lighter in his room. 5. Record review for Resident #74 revealed an admission date of 02/13/25. Diagnoses included syncope and collapse and nicotine dependence. Review of the Annual MDS assessment dated [DATE] revealed Resident #74 was cognitively intact and used a wheelchair and/or walker for mobility.Review of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan dated 02/13/25 revealed Resident #74 had a history of smoking in the community, was a current smoker in the facility, and non-compliant with smoking materials. Interventions included not leaving unattended while smoking. Review of the Smoking Safety Screen for Resident #74 dated 04/03/26 at 8:41 A.M. completed by SWD #584 revealed Resident #74 was safe to smoke with supervision.Review of the Smoking Policy Resident Acknowledgement completed by SWD #584 and signed by Resident #74 dated 10/01/25 revealed residents were not permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. Observation and interview on 05/13/26 at 10:01 A.M. revealed Resident #74 kept his cigarettes in his top dresser drawer and his lighter in his pants pocket. Interview on 05/13/26 at 10:13 A.M. with HS #567 confirmed Resident #74 had his cigarettes and lighter stored in his room. This deficiency represents non-compliance investigated under Complaint Number 2983197.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, resident and staff interviews, and review of daily staff schedules, staff time punch detail, daily posted nurse staffing, the Facility Assessment (FA), and the Payroll Based Journal (PBJ) report, the facility failed to have sufficient staffing. This affected one resident (Resident #10) reviewed for incontinence care, five residents (Residents #2, #29, #52, #67 and #78) who voiced staffing concerns, and had the potential to affect all 78 residents residing in the facility. Findings include:1. Review of the PBJ report for the third quarter of 2025 revealed the facility had a one-star staffing rating and was identified with low weekend staffing.2. Review of the FA, not dated, revealed the following:The average daily census was 73. The facility was to staff licensed nurses providing non-direct care as follows: one full-time day shift Registered Nurse (RN) as a Director of Nursing (DON); one full-time day shift RN as an Assistant Director of Nursing (ADON); one full-time day shift Unit Manager (UM) either an RN or Licensed Practical Nurse (LPN); and one full-time day shift RN as a Minimum Data Set (MDS) Coordinator. The facility was to staff licensed nurses and Certified Nursing Assistants (CNAs) providing direct care as follows: one LPN or RN charge nurse for every 20 residents for each shift, first shift 7:00 A.M. to 3:30 P.M. (eight hours), second shift 3:00 P.M. to 11:00 P.M. (eight hours), and third shift 11:00 P.M. to 7:30 A.M. (eight hours); one CNA for every ten to 13 residents on first shift; one CNA for every 13 to 18 residents on second shift; one CNA for every 17 to 20 residents on third shift; and one CNA as a shower aide from 7:00 A.M. to 3:00 P.M. every Monday through Saturday.The total number of direct care hours per resident day was to be 3.0, excluding in-service, orientation and meeting time.Review of staff schedules revealed it was divided into three eight-hour shifts. Schedules selected for review were based upon dates received from interviews and/or complaint allegations. The following dates were reviewed for sufficient staffing: 01/15/26, 04/14/26, 04/24/26, 04/27/26, 04/28/26 and 05/10/26. These schedules were reconciled with staff punch detail and daily posted staffing. The results were reviewed with Administrator and/or DON which revealed the following findings:a. The time punch detail dated 01/15/26 revealed there was no shower aide for day shift. There were three nurses on day shift, and two nurses on night shift. Only two of the seven CNAs on day shift worked eight hours. DON was the RN for the eight-hour requirement, and the facility census was 79. Review of the daily posted nurse staffing for 01/15/26 revealed the number of hours for day shift CNAs was 92; however, the actual hours were 58. The total number of direct care hours per resident day (PPD) was 2.66.b. The time punch detail dated 04/14/26 revealed there were three nurses on day shift and three on the night shift. DON was the RN for the eight-hour requirement.Review of the daily posted nurse staffing for 04/14/26 revealed the number of hours for RNs was eight for day shift and eight for night shift; however, the actual hours were eight total which were covered by the DON.c. The time punch detail dated 04/24/26 revealed there were three and one-half nurses on day shift and two nurses on night shift. DON was the RN for the eight-hour requirement. The census was 78.Review of the daily posted nurse staffing for 04/24/26 revealed the number of hours for RNs was eight for day shift and eight for night shift; however, the actual hours were eight total which were covered by the DON. The PPD was 2.88.d. The time punch detail dated 04/27/26 revealed there were three nurses on day shift and two nurses on night shift. The DON worked three hours in the evening to pass medications. The census was 79.Review of the daily posted nurse staffing for 04/27/26 revealed the number of hours for CNAs day shift was 80; however, the actual hours were 69.5. The number of hours for CNAs night shift was 70; however, the actual hours were 49.75. The number of hours for LPNs day shift was 32; however, the actual hours were 31. The number of hours for LPNs night shift hours was 32; however, the actual hours were 19.50. The PPD was 2.55.e. The time punch detail dated 04/28/26 revealed there were three nurses on day shift and two nurses after 11:30 P.M. until Wound Nurse (WN)/LPN #539 came in from 2:43 A.M. until 4:20 A.M. The census was 78.Review of the daily posted nurse staffing for 04/28/26 (continued on next page)

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	365310	A. Building B. Wing	05/18/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed the number of hours for CNAs day shift was 92; however, the actual hours were 72.75. The number of hours for LPNs day shift was 36; however, the actual hours were 34. The number of hours for RNs night shift was 16; however, the actual hours were four.f. The time punch detail dated 05/10/26 revealed there were three nurses on day shift including the DON and WN/LPN #539 who both worked as staff nurses, and three nurses at night. The census was 80.Review of the daily posted nurse staffing for 05/10/26 revealed the number of hours for CNAs day shift was 82; however, the actual hours were 76.25. The number of hours for LPNs day shift was 40; however, the actual hours were 31. The number of hours for RNs day shift was eight hours completed by DON. The number of hours for RNs night shift was 12 hours; however, the actual hours were zero.Interview on 05/18/26 at 2:11 P.M. with Administrator revealed she was aware there was a staffing issue. She verified she reported the necessary information for the PBJ and did the schedules as there was no one in that position at the time. Review of the daily posted nurse staffing with her revealed some were done per person while others were done by hours. Administrator verified the FA stated a one to 20 ratio for nurses to residents which equaled 3.9 nurses for a census of 78. She also verified the facility set the PPD at 3.0 in the FA. Administrator stated not being aware of what the FA said about staffing ratios prior to this.3. Review of additional staff schedules and time punch detail for DON revealed she worked as a staff nurse on 04/08/26 from 9:11 A.M. to 7:00 P.M.; 04/11/26 from 7:08 A.M. to 7:24 P.M.; 04/20/26 from 08:41 A.M. to 7:38 P.M., 04/21/26 from 8:48 A.M. to 8:35 P.M., 04/22/26 from 8:00 A.M. to 6:37 P.M., 04/25/26 from 3:44 P.M. to 6:00 P.M., 04/27/26 from 8:36 P.M. to 11:30 P.M., 04/29/26 from 7:44 A.M. to 11:31 P.M, and 05/01/26 from 10:14 A.M. to 11:12 P.M. Interview on 05/11/26 at 4:30 P.M. with DON verified she worked the above hours as a floor nurse.Review of the facility daily census revealed it was 83 on 04/08/26, 83 on 04/11/26, 80 on 04/20/26, 80 on 04/21/26, 78 on 04/22/26, 78 on 04/25/26, 79 on 04/27/26, 79 on 04/29/26 and 90 on 05/01/26.Interview on 05/18/26 at 4:13 P.M. with DON verified she did not know what the expectation was for the DON covering the floor. She stated, I just come in. When asked about what risks there were for having only two nurses at night she stated none. She stated she had worked with only two nurses at night and said they were working within their standard. It was not normal but not unheard of to have only two nurses on night shift. DON stated she was not familiar with the FA. When asked about how on-call worked, she stated it listed at the bottom of the schedule who was on-call. The calls then escalated from the first on-call nurse to the second, to the Administrator and then the Regional Nurse. DON verified the ADON/RN's last day was 04/22/26. The only RNs the facility had were the DON and two RNs from other buildings. The MDS nurse was an RN but did not work on the floor.4. Review of additional staff schedules and time punch details for WN/LPN #539 revealed she worked as the floor nurse on 04/05/26 from 2:52 P.M. to 8:20 P.M., 04/11/26 from 10 A.M. to 7:41 P.M., 04/12/26 from 1:51 P.M. to 7:31 P.M., 04/16/26 from 10:09 A.M. to 11:41 P.M., 04/16/26 from 9:42 A.M. to 11:13 P.M., 04/18/26 from 3:30 P.M. to 11:38 P.M., 04/19/26 from 9:15 A.M. to 7:00 P.M., 04/25/26 from 3:00 P.M. to 11:31 P.M., 04/26/26 from 8:46 P.M. to 5:11 P.M. and 04/29/26 from 2:43 A.M. to 04:20 A.M. then 11:00 A.M. to 11:07 P.M.Interview on 05/12/26 at 4:10 P.M. with WN/LPN #539 verified she worked the above hours as a floor nurse and not as the wound nurse.5. Interview on 05/12/26 at 3:32 P.M. with Regional Clinical Nurse (RCN) #590 verified she worked on 05/02/26 from 7:00 P.M. to 12:30 A.M. and 05/09/26 from 7:00 P.M. to 11:30 P.M. due to staffing issues.6. Observation on 05/11/26 at 2:04 P.M. revealed a strong odor of stool upon entering Resident #10's room. The resident was lying in bed with food on his chest. Interview at the time of the observation with Resident #10 stated the last time he had been checked or changed was at 8:00 A.M. Observation on 05/11/26 at 2:06 P.M. with CNA #521 of Resident #10 revealed deep skin creases on the resident's back from the positioning pad, dried stool on the skin, and redness of the buttocks. CNA #521 confirmed Resident #10 had finished eating approximately 35 minutes earlier but had not been changed prior to or after the meal.Interview on 05/11/26 at 2:24 P.M. with CNA #521, who was identified as Resident #10's primary CNA, stated the unit was shortˆstaffed. She reported Resident (continued on next page)

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	365310	A. Building B. Wing	05/18/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#10 was last changed at 8:00 AM. She further stated that staff were not allowed to check and change during meals, and if residents became incontinent during meals or during tray pass, they have to wait. The CNA reported she went on break immediately after lunch, so Resident #10 was not checked or changed. She also reported a lack of teamwork and stated she had three people to feed and no assistance from other staff so residents who needed to be changed just had to wait.Observation on 05/14/26 at 1:58 P.M. revealed a strong foul odor of stool upon entering Resident #10's room. Interview at the time of the observation with Resident #10 stated the last time he had been changed was at 10:30 A.M. Interview on 05/14/26 at 1:59 P.M. with CNA #701, who was in the hall stated she had last checked the resident at 11:00 AM and stated, He always smells like that. He is tube fed. When asked to check the resident again due to the strong odor, CNA #701 replied she was going on break and would check the resident when she returned, asking, You really want me to do it right now? I am doing my rounds. When I get back from break, okay? You okay with that? CNA #701 then turned and walked down the main hall exiting the unit. There was no nurse available on the unit at that time. One CNA (#701) was on break and the other was giving a shower. Interview on 05/14/26 at 2:03 P.M. with Resident #10 revealed he could not feel when he had a bowel movement.During an interview on 05/14/26 at 2:12 P.M. with RCN #590, Resident #10's need for assistance was reported. RCN #590 entered Resident #10's room and confirmed the presence of stool. Additional interview on 05/14/26 at 2:38 P.M. with RCN #590 confirmed she smelled stool when she went into the room and stated staff were to assist residents with incontinence care whenever they needed it.7. Phone interview on 05/12/26 at 1:49 P.M. with Former RN #606 confirmed she worked on 04/28/26, and stated she worked the first floor, secured unit at 3:00 P.M. She was told to cover the second floor at shift change (around 7:00 P.M) after the scheduled nurse left after 15 minutes. She stated by 11:30 P.M. there was no replacement for her, so she notified the two other nurses (LPN #531 and LPN #543) on the first floor. She stated both refused to take the keys from her. In the meantime, she tried to get ahold of the on-call nurse which was WN/LPN #539 and the DON without success. She stated she did get ahold of the Administrator at one point. Former RN #606 stated the Administrator told her the other two nurses would need to split her assignment, but she stated both nurses refused a second time. So, she took it upon herself to take the medication cart keys to the local police station stating others had done it before. She told the police someone would be by to pick them up. She stated she had not heard from DON or WN/LPN #539 when she left around midnight, but the facility called her the next day and terminated her.Phone interview on 05/12/26 at 2:21 P.M. with LPN #531 revealed she came into work on 04/28/26 at 7:00 P.M. She was going to work on the secured unit when Former LPN #537, who was supposed to be on the second floor at 7:00 P.M., came to the first floor and told her she was going home. LPN #531 called the Administrator. LPN #531 then told Former RN #606 she would have to go upstairs while the other two nurses split the first floor. She stated that Former RN #606 was scheduled to leave at 11:00 P.M. Administrator texted LPN #531 stating someone was coming in but then they cancelled shortly after that. Former RN #606 came down at 11:27 P.M. and tried to give the keys but LPN #531 said she refused. She stated LPN #543 also refused. LPN #531 said she went upstairs at 12:00 A.M. which was when she found out from CNA #523 that Former RN #606 had left and took keys to the police station. LPN #531 asked LPN #543 who he called and he stated everyone, but no one answered. LPN #531 said she spoke to WN/LPN #539 at 1:40 A.M. and acknowledged situation. She stated WN/LPN #539 called back at 2:27 A.M. asking LPN #531, If I go get the keys, are you going to take them? Or corporate will have to be your third nurse. LPN #531 stated she was frustrated but said she would help. WN/LPN #539 said the DON would come in at 5:00 A.M. or 6:00 A.M. to pass medications. WN/LPN #539 showed up between 3:30 to 3:40 A.M. and took care of any medications needed. LPN #531 passed medications on the secured unit at 5:30 A.M. The Administrator arrived at 6:27 A.M. to update her. They called the DON who said she was on the way by 6:32 A.M. The day shift nurse called off. LPN #531's replacement came in however DON did not come in until 7:30 A.M. and she needed to cover two units.Phone interview on 05/12/26 at 4:00 P.M. with LPN #543 (continued on next page)

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	365310	A. Building B. Wing	05/18/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed on 04/28/26 at approximately 11:30 P.M., Former RN #606 came to him to tell him she had to leave. He stated he would get ahold of the DON or on-call nurse (WN/LPN #539). There was no answer by DON, so he sent a text message. He texted Administrator who did not answer right away. He called WN/LPN #539. He then went upstairs to tell Former RN #606, but they stated she was already gone around 12:00 A.M. He stated WN/LPN #539 came early in the morning, and he left at 7:30 A.M.Interview on 05/12/26 at 4:10 P.M. with WN/LPN #539 revealed she was the nurse who picked up the keys at the police department. She stated LPN #531 had called her around 1:30 A.M. She called DON first who said to call the RCN #591. She also got ahold of Administrator. WN/LPN #539 said it took her 30 to 40 minutes to get to the facility. She stopped at the facility first as there was an extra set of keys before picking up the other keys from the police station. She stated LPN #531 took the keys but WN/LPN #539 medicated three residents first around 3:00 A.M. WN/LPN #539 was under the impression LPN #543 was going to take the keys from Former RN #606, but she had already left.Interview on 05/12/26 at 4:24 P.M. with CNA #507 confirmed she worked on 04/28/26 when Former RN #606 took the keys to the police department. She stated the on-coming nurse never accepted the keys at 7:00 P.M. and quit that day stating, I'm not putting my license on the line. CNA #507 stated Former RN #606 went to the second floor to call the on-call nurse and DON, however no one answered. Other staff were also calling them. She stated Former RN #606 was terminated.Interview on 05/13/26 at 1:04 P.M. with LPN #537 revealed she went into the building at 7:00 P.M. to get report but the nurse (LPN #528) would not give her report. LPN #537 stated they had an issue with each other two weeks prior. She told the supervisor (LPN #543). She stated they do not have nursing management who will answer their phones, and the building was understaffed which caused delays in care.Interview on 05/18/26 at 2:13 P.M. with Administrator verified Former RN #606 was reported to the Ohio Board of Nursing for taking the keys to the police station and provided evidence of the online report.Interview on 05/18/26 at 4:00 P.M. with DON revealed she received a phone call from LPN #531 on 04/29/26 at 1:00 A.M. She stated the expectation was for nurses to count medications with each other. LPN #543 said Former RN #606 was gone by 11:22 P.M, and he denied he refused the keys. 8. Interview on 05/11/26 at 9:56 A.M. with Resident #67 revealed it frequently took over half an hour for staff to answer call lights, and they do not bring water back. Interview on 05/11/26 at 10:14 A.M. with Resident #78 revealed there was a lot of staff turnover, and call lights were not being answered.Interview on 05/11/26 at 10:20 A.M. with Resident #2 revealed staff were slow to answer call lights or change incontinence briefs.Interview on 05/11/26 at 11:17 A.M. with Resident #29 revealed there was low staffing at night and slow response to call lights.Interview on 05/11/26 at 11:46 A.M. with Resident #52 revealed there was slow response to call lights.Interview on 05/11/26 at 5:03 P.M. with CNA #504 revealed there was not enough staff, and they were short a lot. There were supposed to be three CNAs on one unit (Grand) but said it was overwhelming stating call lights took longer to answer, and passing trays and feeding residents took longer.Interview on 05/11/26 at 5:21 P.M. with LPN #542 revealed there was not enough staff. The facility did not use agency so if no one picked up, then no one covered the call-offs. Nurses helped pass trays but that put them behind on medication pass. Staff were not answering call lights in a timely manner or getting showers done.Observation on 05/11/26 at 5:29 P.M. revealed dinner trays arrived. Department heads (RCN #590, WN/LPN #539, Housekeeping Supervisor #567 and Social Service Designee #584) came to assist. Interview at the time of the observation with all of the department heads revealed they did not normally pass trays on this shift.Interview on 05/12/26 at 6:08 A.M. with LPN #540 revealed the on-call nurse (WN/LPN #539) would not come in to cover one night. She stated the on-call nurses did not answer the phone or return calls, and at times there were no nurses who remained on the secured unit and second floor.This deficiency represents non-compliance investigated under Master Complaint Number 3000374 and Complaint Number 2983197.

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	365310	A. Building B. Wing	05/18/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of staff schedules, staff time punch detail and interview, the facility failed to ensure the Director of Nursing (DON) worked full-time as the DON and did not work as a staff nurse when the census was over 60. This had the potential to affect all 78 residents residing in the facility.Findings include:Review of staff schedules and time punch detail for DON revealed she worked as a staff nurse on 04/08/26 from 9:11 A.M. to 7:00 P.M.; 04/11/26 from 7:08 A.M. to 7:24 P.M.; 04/20/26 from 08:41 A.M. to 7:38 P.M., 04/21/26 from 8:48 A.M. to 8:35 P.M., 04/22/26 from 8:00 A.M. to 6:37 P.M., 04/25/26 from 3:44 P.M. to 6:00 P.M., 04/27/26 from 8:36 P.M. to 11:30 P.M., 04/29/26 from 7:44 A.M. to 11:31 P.M, and 05/01/26 from 10:14 A.M. to 11:12 P.M. Interview on 05/11/26 at 4:30 P.M. with DON verified she worked the above hours as a floor nurse.Review of the facility daily census revealed it was 83 on 04/08/26, 83 on 04/11/26, 80 on 04/20/26, 80 on 04/21/26, 78 on 04/22/26, 78 on 04/25/26, 79 on 04/27/26, 79 on 04/29/26 and 90 on 05/01/26.This deficiency represents non-compliance investigated under Master Complaint Number 3000374 and Complaint Number 2983197.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and review of facility menu and policy, the facility failed to ensure a physician ordered therapeutic diet was followed. This affected one resident (Resident #13) of one resident reviewed for therapeutic diets. This had the potential to affect 48 residents (Residents #3, #4, #6, #7, #10, #11, #12, #13, #14, #17, #18, #19, #24, #26, #27, #28, #29, #33, #34, #36, #37, #39, #42, #44, #45, #47, #48, #49, #50, #52, #54, #56, #59, #62, #64, #65, #66, #67, #68, #69, #70, #71, #72, #74, #75, #76, #78 and #79) who received a therapeutic diet. The facility census was 78.Findings include:Review of the medical record for Resident #13 revealed an admission date of 11/07/25. Diagnoses included but were not limited to end stage renal disease with dependence on dialysis, cognitive social or emotional deficit following stroke, vascular dementia and type II diabetes mellitus. Review of the 05/13/26 hospital discharge Minimum Data Set (MDS) 3.0 assessment for Resident #13 revealed moderate memory impairment. Resident #13 was noted to be independent for eating. Review of the 03/06/26 physician order for Resident #13 revealed a diet order of a liberalized renal diet with regular texture and thin liquids.Review of the care plan last reviewed on 03/21/26 for Resident #13 revealed the resident had a nutritional problem or potential nutritional problem related to past medical history of end stage renal disease on hemodialysis, type II diabetes mellitus and need for therapeutic diet. One of the interventions listed was to provide and serve diet as ordered.Review of the facility menu titled, Garden 2026 Spring/Summer Menus Week Four, revealed the Wednesday diet for liberalized renal diets were to receive three ounces of plain meatballs, four ounces of no salt added fluffy steamed rice, four ounces of buttered cabbage, one dinner roll, four ounces of cinnamon baked apples, four ounces of cranberry juice cocktail and margarine. Observation on 05/13/26 at 11:46 A.M. with Regional Dietary Manager (RDM) #601 confirmed the plate prepared for Resident #13 who was on a renal diet had plain meatballs, rice, spinach, a roll and cinnamon apples. RDM #601 confirmed the facility menu stated renal diets were to receive buttered cabbage instead of spinach and it had not been prepared prior to the start of tray line.Review of the November 2015 revised facility policy titled, Therapeutic Diets, revealed mechanically altered diets as well as diets modified for medical or nutritional needs were considered a therapeutic diet. Diets were determined in accordance with the residents' informed choices, preferences, treatment goals and wishes. The clinical dietitian, nursing staff and attending physician reviewed, along with other orders, the need for and resident acceptance of prescribed therapeutic diets. Routine menus were planned by the food services manager and approved by a registered dietitian for nutritional adequacy. The food services manager established and used a tray identification system to ensure that each resident received his or her diet as ordered. This deficiency represents non-compliance investigated under Complaint Number 2800362.