STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365355	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Mayfield Village	6757 Mayfield Rd Mayfield Heights, OH 44124

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview the facility failed to provide Resident #32's guardian with the results of the investigation of Resident #32's allegation of abuse in a timely manner. This affected one out of three residents reviewed for allegations of abuse. The facility census was 55.Findings include:A review of Resident #32's clinical record revealed an admission date of 05/24/24 with diagnoses including psychosis, malnutrition, severe dementia with agitation, cognitive communication deficit, drug induced dyskinesia (involuntary, uncontrolled muscle movements), mood disorder, bipolar disorder, and anxiety.Resident #32's dated 05/20/24 indicated Minimum Data Det (MDS) assessment indicated she had no behaviors including hallucinations, delusions or behavioral symptoms including physical and verbal aggression. The MDS assessment indicated Resident #32 exhibited refusal of care behavior almost daily.Resident #32's plan of care initiated on 09/18/24 revealed Resident #32 resided on the secured nursing unit due to decreased safety awareness, increased confusion, poor decision-making skills and previous history of elopement. Interventions on the plan of care included to encourage Resident #32 to attend activities of interest, maintain a consistent routine and monitor for exit seeking behavior.There was no documentation in Resident #32's clinical record to indicate an altercation had occurred between Resident #47 and Resident #32, Resident #32's allegation of abuse, or of contact with Resident #32's guardian regarding his concerns with Resident #32's allegation of abuse and other concerns. There was no documentation that Resident #32's guardian was notified of the results of the investigation of Resident #32's allegation of physical abuse.A review of a Self-Reported Incident (tracking number 263445) dated 07/30/25 revealed Resident #32 alleged Resident #47 had assaulted her in her room. An investigation was conducted with staff and resident interviews obtained which revealed no altercation had occurred. The investigation revealed Resident #47 was wandering aimlessly in the hallways of the secured unit and had entered Resident #32's room. When staff redirected Resident #47 away from Resident #32's room, Resident #47 began swinging his arms. The investigation concluded Resident #47 did not hit or assault Resident #32.An interview with Resident #32's guardian on 08/26/25 at 11:02 A.M. revealed he was visiting with Resident #32 on 07/30/25 when she alleged that Resident #47 had assaulted her in her room. Resident #32's guardian notified Assistant Director of Nursing (ADON) #61 and asked to have the facility notify him of the results when the investigation was completed.A review of Resident #32's guardian's progress notes indicated during his visit on 07/30/25 with Resident #32 she had alleged Resident #47 had assaulted her in her room several times. Resident #32's guardian notified the Administrator ADON #61 and Social Service Designee (SSD) #63 of the allegation of physical abuse. The progress note indicated the administrative staff would provide Resident #32's guardian with an update of the results of the investigation. Resident #32's guardian's progress notes indicated on 07/31/25 and 08/04/25 Resident #32's guardian sent an email to the SSD #63 asking for an update of the results of the investigation of Resident #32's allegation of physical abuse. Resident #32's guardian received one email from SSD #63 which revealed Resident #32 would receive her athletic shoes as requested on 08/04/25. There were no additional emails received from the facility to notify Resident #32's guardian of the results of Resident #32's physical assault allegation investigation.An interview with Administrator, SSD #63 and Resident #32's guardian on 08/26/25 at 11:02 A.M. verified they had not notified Resident #32's guardian of the results of the investigation of Resident #32's allegation of physical abuse. The Administrator and SSD #63 verified the above findings and proceeded to inform Resident #32's guardian of the results of Resident #32's physical abuse investigation.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review and interview the facility failed to honor Resident #24's food preferences and failed to ensure the food items served for meals were consistent with the planned four-week menu. This affected one resident (Resident #24) out of three residents reviewed for food preferences and had the potential to affect all the residents in the facility. The facility census was 55.Findings include:1. A review of Resident #24's clinical record revealed an admission date of 01/24/24 with diagnoses including chronic non-pressure ulcers to the left foot/heel, diabetes mellitus, malnutrition, morbid obesity, cognitive communication deficit, lumbar disc displacement, arthritis, cellulitis, atrial fibrillation (irregular heart rhythm), high cholesterol, macular degeneration of the right eye, and cataract.A review of Resident #24's physician orders dated 08/01/25 to 08/31/25 revealed a diet order dated 01/14/25 for a regular diet, regular texture, and thin liquids. A review of Resident #24's plan of care revised on 01/17/25 revealed Resident #24 had a nutritional problem or potential nutritional problem related to obesity as per Resident #24 preferred grilled cheese sandwiches for lunch and peanut butter and jelly for dinner. Interventions on the plan of care indicated to provide Resident #24 with meals according to the diet order.A review of Resident #24's daily meal ticket for breakfast revealed his Food Likes included two pieces of white toast, two scrambled eggs, cold cereal (Fruit Loops or Raisin Bran) and three servings of margarine. Instructions on the meal ticket included to provide the scrambled eggs with cheese, two pieces of white toast and Raisin Bran or Fruit Loops for breakfast, a grilled cheese sandwich for lunch and a peanut butter and jelly sandwich for dinner.An interview with Resident #24 on 08/26/25 at 3:15 P.M. revealed concerns about the meal service in the facility. Resident #24 stated he had very specific preferences for his breakfast meal in the facility. Resident #24 stated the kitchen staff do not read the meal tickets before placing the food items on his plate. Resident #24 stated on 08/24/25 he received two sausage links and one piece of bread with butter for breakfast. Resident #24 stated his meal ticket clearly indicated the food items he was supposed to receive for each meal in the facility were the same every day. Resident #24 stated he had complained to the Assistant Director of Nursing (ADON) #61 and had sent her a picture of the breakfast meal he was served on 08/24/25. A review of the facility's four-week menu cycle revealed the planned breakfast food items on 08/24/25 included breakfast casserole, cereal of choice, coffee cake, coffee/tea, 8 ounces of milk of choice and juice of choice was planned to be served to the residents.An interview 0n 08/26/25 at 10:47 A.M. with ADON #61 verified Resident #24 had complained about the food he received for breakfast on 08/24/25. ADON #61 verified Resident #61 did not receive the breakfast food items as indicated on his meal ticket.An interview with [NAME] #62 indicated Resident #24 had very specific foods that were to be served for each meal in the facility which did not change day to day. [NAME] #2 verified the food items Resident #24 received for breakfast on 08/24/25 was not what was listed on his meal ticket or what was planned on the menu for the breakfast meal.2. An observation on 08/26/25 at 8:30 A.M. of the breakfast meal service revealed the residents were served scrambled eggs or one to two hard cooked egg disc(s), one piece of raisin toast, oatmeal, one small orange, grape juice and milk.A review of the week number four on the four-week menu cycle revealed the food items planned to serve included an egg sandwich, cereal of choice, banana, coffee/tea, 8 ounces of milk of choice, juice of choice, margarine and jelly.An interview on 08/26/25 at 8:45 A. M. with the Kitchen Manager (KM) #63 verified the above findings and indicated the kitchen staff had replaced the banana with an orange because the banana was not delivered with the other food items on the most recent food order for the facility. KM #63 was unable to explain why the kitchen staff had not served the planned breakfast sandwich and verified the food items were available to serve the residents the breakfast meal food items as planned on the menu for 08/26/25.This deficiency represents non-compliance investigated under Complaint Number 2577029.

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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. Based on record review and interview the facility failed to maintain a complete accurate medical record for Resident #32. This affected one out of three residents reviewed for abuse. The facility census was 55. Findings include:A review of Resident #32's clinical record revealed an admission date of 05/24/24 with diagnoses including psychosis, malnutrition, severe dementia with agitation, cognitive communication deficit, drug induced dyskinesia (involuntary, uncontrolled muscle movements), mood disorder, bipolar disorder, and anxiety.Resident #32's dated 05/20/24 indicated Minimum Data Det (MDS) assessment indicated she had no behaviors including hallucinations, delusions or behavioral symptoms including physical and verbal aggression. The MDS assessment indicated Resident #32 exhibited refusal of care behavior almost daily. Resident #32's plan of care initiated on 09/18/24 revealed Resident #32 resided on the secured nursing unit due to decreased safety awareness, increased confusion, poor decision-making skills and previous history of elopement. Interventions on the plan of care included to encourage Resident #32 to attend activities of interest, maintain a consistent routine and monitor for exit seeking behavior.There was no documentation in Resident #32's clinical record to indicate an altercation had occurred between Resident #47 and Resident #32, Resident #32's allegation of abuse, or of contact with Resident #32's guardian regarding his concerns with Resident #32's allegation of abuse and other concerns. There was no documentation that Resident #32's guardian was notified of the results of the investigation of Resident #32's allegation of physical abuse.A review of a Self-Reported Incident (tracking number 263445) dated 07/30/25 indicated Resident #32 alleged Resident #47 had assaulted her in her room. An investigation was conducted with staff and resident interviews obtained which revealed no altercation had occurred. The investigation revealed Resident #47 was wandering aimlessly in the hallways of the secured unit and had entered Resident #32's room. When staff redirected Resident #47 away from Resident #32's room, Resident #47 began swinging his arms. The investigation concluded Resident #47 did not hit or assault Resident #32.An interview with Resident #32 on 08/25/25 at 2:30 P.M. revealed she stated a man had assaulted her in her room. Resident #32 pointed to Resident #47 and indicated this was the man who assaulted her physically in her room. Resident #32 was unable to state when this incident happened or addition details regarding the incident. Resident #32 stated she had informed the ADON #63 of the allegation of physical abuse.An interview with Resident #32's guardian on 08/26/25 at 11:02 A.M. revealed he was visiting with Resident #32 on 07/30/25 when she alleged that Resident #47 had assaulted her in her room. Resident #32's guardian notified Assistant Director of Nursing (ADON) #61 and asked to have the facility notify him of the results when the investigation was completed.A review of Resident #32's guardian's progress notes indicated during his visit on 07/30/25 with Resident #32 she had alleged Resident #47 had assaulted her in her room several times. Resident #32's guardian notified the Administrator ADON #61 and Social Service Designee (SSD) #63 of the allegation of physical abuse. The progress note indicated the administrative staff would provide Resident #32's guardian with an update of the results of the investigation. Resident #32's guardian's progress notes indicated on 07/31/25, 08/04/25 Resident #32's guardian sent an email to the SSD #63 asking for an update of the results of the investigation of Resident #32's allegation of physical abuse. Resident #32's guardian received one email from SSD #63 which revealed Resident #32 would receive her athletic shoes as requested on 08/04/25. There were no additional emails received from the facility to notify Resident #32's guardian of the results of Resident #32's physical assault allegation investigation.An interview with Administrator, SSD #63 and Resident #32's guardian on 08/26/25 at 11:02 A.M. verified the facility had not maintained an accurate, complete medical record for Resident #32.