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	05/29/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility did not ensure Resident #26 was assessed to self-administer medications. This affected one resident (Resident #36) of two residents reviewed for self-administering medications. Facility census was 59. Findings include: Record review for Resident #26 revealed an admission date of 04/25/17 with diagnoses of legal blindness, acquired absence of one eye, and peripheral vascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 was cognitively intact and had severe vision impairment. Review of the physician orders revealed Resident #26 self-administered, without supervision, Calcium-Vitamin D tablet 600-400 mg twice a day, Ammonium Lactate 12% Lotion topically to bilateral legs twice a day, and Omega-3 1000 mg soft gel once daily. Physician orders also contained an order Resident #26 was able to have medications at bedside with a start date of 11/30/21. Review of Medication Self-Administration Safety Screen assessment dated [DATE] determined Resident #26 may self-administer medications unsupervised however there had not been an updated assessment completed since that time. Interview on 05/19/25 at 9:40 A.M. with [NAME] President of Clinical Operations revealed an initial self-administration assessment was to be completed and then annually thereafter and confirmed Resident #26 did not have an updated self-administration assessment completed. Review of the Administering Medications Policy revised December 2012 revealed residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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 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 review, observation and interview, the facility failed to ensure a properly functioning elevator to accommodate resident needs. This affected three (Residents #6, #11 and #35) of 20 residents reviewed for environmental accommodation of needs. The facility census was 59. Findings include: Review of the medical record for Resident #6 revealed an admission date of 07/01/24 with diagnoses including morbid obesity, need for assistance with personal care, muscle weakness and difficulty walking. Review of the care plan dated 07/02/24 for Resident #6 revealed he had self care deficit and needed assistance from staff for activities of daily living. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #6, under section F, revealed it was very important to do his favorite activities and somewhat important to do things with a group of people. He was noted to have intact cognition. Review of the medical record for Resident #11 revealed an admission date of 03/02/17 with diagnoses including heart failure, morbid obesity, muscle weakness and need for assistance with personal care. Review of the care plan dated 03/02/17 for Resident #11 revealed he had self care deficit and needed assistance from staff for activities of daily living. Review of the comprehensive MDS 3.0 assessment dated [DATE] for Resident #11, under section F, revealed it was very important to go outside to get fresh air when the weather was good. He was noted to have intact cognition Review of the medical record for Resident #35 revealed an admission date of 04/18/24 with diagnoses including diabetes mellitus, depression and paraplegia (paralysis of lower half of the body). Review of the care plan dated 04/18/24 for Resident #35 revealed he had self care deficit and needed assistance from staff for activities of daily living. Review of the comprehensive MDS 3.0 assessment dated [DATE] for Resident #35, under section F, revealed it was very important to do his favorite activities and do activities with a group of people. Review of documentation for elevator concerns including invoices from the elevator service company dated from 11/08/24 to 05/13/25, incident with the fire department with elevator rescue and an employee in-service revealed the facility had been having elevator concerns to both elevators since 11/08/24. Review of the documentation revealed: -11/08/24 invoice-Elevator one was not responding, stuck on unknown floor and the doors closed. It was unoccupied. Elevator technician adjusted the light tray and elevator one was still in service. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/09/24 invoice-Elevator preventative maintenance. -01/08/25 invoice-Elevator one and two, preventative entrapment, elevators not responding. Both elevators stuck on unknown floors. The doors were closed on both elevators. The elevators were unoccupied. Elevator technician emptied pit buckets on both cars and then checked operations. -01/24/25 invoice-Preventative maintenance. -02/14/25 invoice-Elevator one was not responding. The elevator was stuck in between floors. The doors were closed and the elevator was unoccupied. Elevator one was down for a light ray unit and the part was on order. -03/04/25 invoice-Elevator two was not responding at 1:09 P.M. It was stuck on the first floor with the doors closed and unoccupied. Elevator technician replaced switches to both door locks and car doors and repaired the car door track on elevator one. The pit was cleaned and emptied on elevator two. -03/04/25 invoice-Elevator one and two were not responding at 6:44 P.M. Both elevators were stuck on unknown floors, doors closed and unoccupied. The elevators were reset by the facility and running at the time of the elevator technician's arrival. The elevator technician run both cars and was unable to find an issue. They left both elevators in service. -03/06/25 invoice-Performed safety test on the elevators and there were no concerns. -03/10/25 invoice-Elevator two was not responding and stuck on the first floor with the doors closed and unoccupied. The low oil sensor had tripped. The elevator technician ran elevator two it tripped again. After trying again, elevator two was working. The elevator technician stated the valve may need replaced soon. -03/11/25 invoice-Elevator two was not responding. Elevator technician replaced the top and bottom boards and adjusted the valve. -03/14/25 invoice-Elevators one and two were not responding and stuck on the second floor with the doors closed and unoccupied. The elevator technician found a loose wire on a coil. -03/15/25 invoice -Elevator two was going up but not coming back to the first floor. The elevator was stuck on the first floor with the doors closed, though still in use. The elevator technician stated the car had a low oil timer and reset the car and it was left in service. -03/18/25 invoice-Elevators one and two were not responding. Both elevators were stuck on the first floor with the doors closed and unoccupied. Elevator technician reset the low oil and updated their office about the valve replacement (noted on 03/10/25). -03/19/25 invoice-Preventative maintenance. The elevator technician replaced the power board. -03/24/25 invoice-Elevator two was not responding. The photo eye was not working and had shut down the elevator and was stuck on the first floor with the doors closed. Elevator technician was unable to find any concerns. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/09/25 invoice-Elevator two was not responding and stuck on an unknown floor with the doors closed and unoccupied. The elevator technician stated the motor read good. They updated the facility to contact an electrician about incoming power issues. -04/11/25 invoice-Elevator two was not responding and stuck on the first floor with the doors closed and unoccupied. Elevator technician stated the elevator was having low leg amp faults (indicating a voltage/connection problem). The elevator was taken completely out of service. -05/04/25 Fire Department Incident stated at 1:24 P.M. they were notified of possible entrapment in a stalled elevator car. The fire department arrived at the facility at 1:29 P.M. Upon arrival, the person had already been removed from the elevator car and the elevator was working properly. -05/06/25 invoice-Elevator two had motor and valve replacement. Elevator two was still out of service. -05/08/25 invoice-Performed preventative maintenance. -05/13/25 invoice-A call was placed to the elevator service company stating elevator one was not responding to first floor call and was stuck on the second floor, doors closed. -Review of elevator in-service, undated, revealed The elevator is currently in repair and should be completed shortly. In the meantime, please be aware of the following: Mindful to push the elevator back down to the first floor, remember resident and families are waiting for the elevator, your assistance is appreciated to expedite not only family and resident needs but also coworkers and supplies. Any questions, please contact your Administrator or Director of Nursing. Observation on 05/12/25 at 8:15 A.M. of the facility elevators revealed elevator two (bigger elevator) was out of service. Elevator one was working, however, when getting into the elevator there was a sign posted stating When exiting the elevator please send it back to the first floor, per maintenance. Interview on 05/12/25 at 9:59 A.M. with Licensed Practical Nurse (LPN) #114 stated elevator two was broken. She stated someone did come to look at it but it was still out of order. She stated elevator one did not work properly. LPN #114 stated when the elevator was used and taken to the second floor, whoever was exiting the elevator had to push the button one to send it back to the first floor or it would be stuck on the second floor. She stated if the one button was not pushed, residents had to wait long periods of time and then staff would have to call to the second floor for someone to go into the elevator and press button one so it would return to the first floor. Interview on 05/12/25 at 10:00 A.M. with the Director of Nursing (DON) revealed she was unaware of the concerns with elevator one. She stated she did not know staff/residents had to press one when they were exiting the second floor to ensure the elevator would return to the first floor. Interview on 05/12/25 at 10:34 A.M. with LPN #100 verified elevator one was not working properly. She stated it would be stuck on the second floor if the resident, visitor or staff member did not push the one button to return it to the first floor. She stated Resident #6 was unable to fit into elevator one because the size of his wheelchair. LPN #100 stated most of the activities were done on the second floor. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/12/25 at 10:40 A.M. with Resident #6 verified his chair was too big to fit onto elevator one. He stated if he had assistance from staff, they could fold his wheelchair and he could stand up in the elevator. Resident #6 stated due to staff taking too long to come assist him, he had not asked to go upstairs to the second floor activities. Observation on 05/12/25 at 2:16 P.M. of elevator one. The button had been pushed and residents were waiting to go to the second floor. Approximately five minutes later, at 2:21 P.M., the elevator door opened and immediately shut not allowing residents to get off of the elevator onto the first floor. Interview on 05/12/25 at 2:48 P.M. with Regional Maintenance Director (RMD) #169 revealed the elevator company was here on 05/09/25 to fix elevator two. He stated they replaced the motor but it had not corrected the problem and had to order another part, a starter. He stated they were waiting for it to be installed later this week. He stated he was unaware of concerns with elevator one. Interview on 05/13/25 at 8:30 A.M. with Resident #11 revealed his motorized wheelchair was too big for elevator one. He stated he was unable to go downstairs and outside and felt isolated. He had concerns with being trapped in elevator one as it had gotten stuck with someone inside it. Interview on 05/13/25 at 10:08 A.M. with Resident #35 revealed he liked to go to the second floor for activities. However, he stated he would not use elevator one because he doesn't want to get stuck in the elevator because it was not functioning properly. Interview on 05/13/25 at 12:00 P.M. with Elevator Repair Supervisor #170 provided an email timeline for elevator two's repair. He also stated on 04/09/25 his service technician recommended an electrician which is the protocol when they get a power glitch in the building. He stated at that time the motor was fine and it lead the technician to believe it was the incoming power. He verified elevator two had been out of service since 04/11/25. He also stated he was not updated about elevator one's concern with not coming back to the first floor when called unless the one button inside the elevator was pushed on the second floor. He stated he believed the issue with elevator one was unrelated to the concerns of elevator two. Review of the email dated 05/13/25 from Elevator Repair Supervisor #170 revealed the last service call for elevator two was on 04/11/25. The pump motor was ordered on 04/15/25 and they fixed the elevator on 05/06/25. The elevator company scheduled an inspection on 05/09/25 with the state and it was noted the starter was not working. Interview on 05/13/25 at 1:39 P.M. with the Maintenance Director #138 verified he placed the elevator sign in elevator one related to pushing the button to go back to the first floor after arriving to the second floor. He also verified the staff in-service was done prior to 04/14/25 but was unable to give the exact date. He stated the facility did not call an electrician on 04/09/25 because the elevator technician had changed his mind about needing an electrician. He was unable to provide documentation stating this. He stated he could not recall staff or residents being stuck on the elevator. Maintenance Director #138 verified he had not called the elevator service company regarding elevator one's concern until today. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/13/25 at 1:39 P.M. with RMD #169 revealed elevator one's opening was 35 inches. He stated Resident #11's motorized wheelchair was 30.5 inches. He stated the arm would need removed off of the chair for him to get into the elevator. Interview on 05/13/25 at 2:10 P.M. with the Administrator revealed most activities were held on the second floor. She stated they did provide some activities on the first floor and provided activity calendars to show which activities were on the first floor. Reviewed April 2025 and May 2025 activity calendars with the Administrator which revealed all activities were held in the activity room on the second floor unless indicated. There were seven activities out of 182 activities held on the first floor in April 2025. There were seven activities out of 184 activities in May 2025 held on the first floor. Interview on 05/13/25 at 3:16 P.M. with RMD #169 revealed Resident #6's wheel chair measured 40 inches and would not fit through the doors. Interview on 05/14/25 at 11:47 A.M. with Assistant Fire Chief #204 verified the fire department was called on 05/04/25 for an entrapment in elevator one. He stated when they arrived, the facility had gotten the elevator open. He was unsure if it was a resident or staff member who was entrapped on the elevator. Interview on 05/15/25 at 12:26 P.M. with RMD #169 stated on 05/04/25 there were no residents or staff entrapped on the elevator. A staff member had called the fire department because the elevator was stuck and she believed there was a resident or staff person in the elevator car. He stated the facility was able to send the elevator to the first floor and the doors opened before the fire department arrived. RMD #169 stated on 04/11/25 the elevator technician did not want to service elevator one because it was working and they did not want both elevators broke at the same time. He verified there was no documentation stating this. He stated he would provide a statement from the elevator technician. RMD #169 stated he believes elevator one issue was related to elevator two. He stated when elevator one is taken to the second floor and then someone on the first floor pushes the button, the elevator system believes elevator two is there and that is why elevator one does not return to the first floor without pushing the button. Interview on 05/15/25 at 2:50 P.M. with RMD #169 revealed the elevator technician refused to make a statement related to elevator one. However, he provided a statement from Elevator Repair Supervisor #170. Review of the emailed statement dated 05/15/25 at 2:57 P.M. from Elevator Repair Supervisor #170 revealed he had spoken to the normal routine elevator technician who serviced the building. He stated the dispatch problem with elevator one had been going on for quite some time and only when elevator two was out of service and the power was removed. Elevator Repair Supervisor #170 stated his technician stated he had attempted to correct elevator one's issue but both elevators shut down. He stated the technician instructed the building to put a sign in elevator one until elevator two was fixed so they would have a working elevator. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/15/25 at 3:46 P.M. with RMD #169 of the elevators revealed the elevator technicians had left elevator two in between floors. RMD #169 stated elevator one should be able to be called to the first floor by the button on the first floor. This surveyor went to the second floor in elevator one and did not push the first floor button to return the elevator. RMD #169 pushed the up button on the first floor and elevator one did not return to the first floor verifying there was still an issue with elevator one. This deficiency represents non-compliance investigated under Complaint Number OH00162143 and Complaint Number OH00161946.

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	365355	A. Building B. Wing	05/29/2025

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to ensure residents received complete and accurate notices of Medicare non-coverage when their skilled services ended. This affected one (Resident #59) of four residents reviewed for liability notices. The facility census was 59. Findings include: Review of the medical record for Resident #59 revealed an admission date of 12/02/24 with diagnoses including heart disease, history of falling and chronic obstructive pulmonary disease. Resident #59 remained in the facility after discontinuation of Medicare A services. Review of the Notice of Medicare Non-Coverage (NOMNC) signed and dated by Resident #59 on 02/21/25 revealed his last covered day for Medicare A services was on 02/24/25. The notice did not provide the type of services that were being discontinued, who he should contact for an appeal or their phone number. Interview on 05/22/25 at 11:26 A.M. with [NAME] President of Operations (VPO) #172 verified Resident #59's NOMNC dated 02/21/25 was not complete and accurate as it did not state the type of services ending, who he should contact for an appeal or their phone number.

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	365355	A. Building B. Wing	05/29/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain resident room water temperatures at a comfortable level. This affected five (Residents #7, #19, #27, #32 and #49) out of seven resident rooms tested for water temperatures. The facility census was 59. Findings include: Review of the last audit of water temperatures obtained by the facility was noted to be on 04/02/25 and 04/18/25. Temperatures were noted to be between 113.8 and 116.1. Observation on 05/14/25 at 9:20 A.M. of incontinence care to Resident #19 revealed she stated the water was cold. Certified Nursing Assistant (CNA) #135 stated he had let the water run for five minutes and Resident #19 wanted her water really hot. Observation on 05/14/25 at 9:44 A.M. and 9:45 A.M. of hot water temperatures revealed rooms [ROOM NUMBERS] were of required temperatures between 105 and 120 degrees Fahrenheit. On 05/14/25 at 9:50 A.M. observed water temperatures with CNA #125. room [ROOM NUMBER] (Residents #19 and #49) and room [ROOM NUMBER] (Resident #27) shared a bathroom. The water temperature was noted to be 88 degrees Fahrenheit after allowing the water to run for five minutes. room [ROOM NUMBER] (Resident #32) and room [ROOM NUMBER] (Resident #7) shared a bathroom. The water temperature was noted to be 96 degrees Fahrenheit after allowing the water to run for five minutes. CNA #125 verified the water temperatures and stated this was how the water usually felt while providing care.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a self-reported incident (SRI), review of the facility policy, record review and interview, the facility failed to prevent staff-to-resident physical abuse. This affected one resident (#49) out of seven residents reviewed for abuse. Facility census was 59. Findings include: Review of Resident #49's medical record revealed an admission date of 02/20/25 and diagnoses including schizoaffective disorder, anxiety, depression, anemia and post-traumatic stress disorder. Review of an admission minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was cognitively intact, had disorganized thinking, had an ostomy and was frequently incontinent of urine. Review of a nurses' note dated 04/02/25 at 9:07 P.M. authored by Licensed Practical Nurse (LPN) #176 revealed the following information: 'This nurse was sitting behind the nursing station charting and preparing medication. The resident tried to go down the elevator with another resident and this nurse stated to resident she could not go down by herself and smoke, she had to wait until smoke break when the staff member was ready to take them down to smoke. Resident #49 started to get agitated and start yelling at this nurse, this nurse stated if she continued to yell and cause a scene she will not be allowed to go down to smoke. Resident #49 became more agitated and stated, (expletive) you can't tell me, I can't go smoke. This nurse said I do have that right and before I knew it because I was looking down at the computer. This nurse witnessed Resident #49 jump up out of her wheelchair and throw water on this nurse, after throwing the water she fell back in her wheelchair and spilled the rest of the water from the cup on her lap. After falling back in the wheelchair one staff member (not identified) tried to calm her down and roll her back down to her bedroom and the other staff member (not identified) cleaned the water up off the floor. Resident #49 stated she was calling the police and saying this nurse poured water on her, but this nurse never poured any water on resident. Resident went down and smoked with other residents and staff member, so this nurse thought everything was over and Resident #49 went in her room and called the police. This nurse spoke with police and showed them where resident poured water on this nurse, they spoke with resident and staff members that witness the incident and they left the facility.' Review of a SRI dated 04/03/25 at 3:17 A.M. revealed an allegation of physical abuse involving Resident #49 and LPN #176. Resident #49 alleged LPN #176 threw water on her on 04/02/25 between 8:00 P.M. to 8:30 P. M. The facility determined the allegation of physical abuse to be unsubstantiated as Resident #49 had demanded to have a cigarette outside of designated smoking times. Resident #49 was advised of the next scheduled time and threw water on the nurse while her back was turned. Resident #49 was provided time to smoke per the remainder of the scheduled and posted times. Review of the facility's investigation corresponding to the SRI revealed the following information: • (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement dated 04/04/25 for Certified Nursing Assistant (CNA) #149 written by Previous Director of Nursing (PDON) #175 revealed the following information: I interviewed the staff member CNA #149 regarding the matter involving Resident #49 and LPN #176. CNA #149 stated the incident occurred prior to his arrival to that evening's shift and he did not witness the incident. • Review of an unauthored resident statement dated 04/07/25 denied abuse. • Review of an undated resident statement for Resident #11 denied abuse. • Review of an undated resident statement for Resident #60 denied abuse. • Review of an undated and unauthored resident statement denied abuse. Interview on 05/14/25 at 4:31 P.M. with CNA #135 recounted the altercation between LPN #176 and Resident #49. Resident #49 wanted to go smoke and LPN #176 stated no as it was not smoke break. Resident #49 called LPN #176 names (not specified) then put water on LPN #176. LPN #176 then put ice water on Resident #49 from her cup. The police were called, Resident #49 was sent to her room and he finished his shift. CNA #135 stated LPN #175 was terminated after the altercation. Interviews on 05/15/25 at 8:36 A.M. and 9:20 A.M. with Regional Director of Operations (RDO) #196 revealed she was unable to provide a complete investigation regarding the SRI and provided the surveyor with several resident statements and one staff statement. RDO #196 confirmed the available investigation was not evidence of a thorough investigation. Interview on 05/15/25 at 9:28 A.M. with Resident #49 confirmed there was an issue with a nurse and water at the facility. Resident #49 stated she asked the nurse (could not name) when smoke break was. Resident #49 stated I don't know if someone already did something to her or she was having a bad night, but she jumped up and did not want to be bothered. She was in the middle of something and then threw water at me, it was a full 16 ounce Styrofoam cup of cold water and ice. My whole gown was soaked. Resident #49 stated while she had not seen this nurse since, she stated she was crying and shocked a nurse would do this to a patient. When asked if she felt safe, Resident #49 stated she did not know how to feel. Phone interview on 05/15/25 at 10:57 A.M. with LPN #176 revealed she last worked at the facility on 04/02/25. The night of the incident, Resident #49 wanted to go outside and smoke and she had told the resident she could not smoke alone. Resident #49 then poured water on her. LPN #176 denied pouring water back on Resident #49 and stated she was suspended on 04/02/25 then terminated for not de-escalating the situation. LPN #176 indicated there had been plenty of staff around the time of the altercation for witness statements. (continued on next page)

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	05/29/2025

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview on 05/15/25 at 12:48 P.M. with RDO #196 revealed allegations of abuse were to be reported to the Administrator or Director of Nursing (DON) right away so if staff were involved, they could be suspended timely. RDO #196 provided time punches for LPN #176 which indicated she worked out her shift before clocking out on 04/03/25 at 7:59 A.M. RDO #196 was made aware the facility submitted their SRI on 04/03/25 at 3:17 A.M. and the SRI reported the incident had occurred on 04/02/25 at 8:30 P.M. RDO #196 stated while she was not present at the time of the incident, based on the SRI and LPN #176's time punches, the allegation was not reported timely and LPN #176 should have been suspended immediately after the allegation was made and reported and LPN #176 should not have been allowed to work out the remainder of her shift until 04/03/25 at 7:59 A.M. During an interview on 05/19/25 at 8:00 A.M. [NAME] President of Operations (VPO) #172 was made aware that staff and resident interviews completed due to an insufficient facility SRI investigation had indicated staff to resident abuse had occurred with LPN #176 and Resident #49 on 04/02/25. VPO #172 confirmed Resident #49 also told them the incident had occurred when they did additional interviews last week and did not disagree. Interview on 05/19/25 at 8:34 A.M. with LPN #127 revealed the night of the incident, she was working on the first floor and let the police into the facility. LPN #127 stated Resident #49 did come down stairs and she said she was wet but she could not actually recall if Resident #49 appeared wet. Interview on 05/19/25 at 8:39 A.M. with CNA #180 revealed he was present the night of the incident where Resident #49 put water on LPN #176, then LPN #176 put water back on Resident #49. Resident #49 got mad, told someone (not named) and the police were called and went upstairs. CNA #180 confirmed LPN #176 worked the rest of the night and was still on site when he clocked out at the end of his shift. Review of the facility policy, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, revised 11/01/19 revealed the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property including injuries of unknown source in accordance with this policy. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the resident representative and any treatment provided. Appropriate quality assurance documentation should be completed as well. The person investigating the incident should generally take the following actions: interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident and employees who worked closely with the accused employees and/or alleged victim the day of the incident. if there are no direct witnesses then the interviews may be expanded. For example, to cover all employees on the unit or as appropriate, the shift. Obtain a statement from the resident if possible, the accused and each witness .review the resident's records and if the accused is an employee, then review his/her employment records. If a staff member is accused or suspected of abuse, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. This deficiency represents noncompliance investigated under Complaint Number OH00165671.

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	365355	A. Building B. Wing	05/29/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that as needed psychotropic medication orders were limited to 14 days for Resident #4. This affected one resident (Resident #4) out of five residents reviewed for unnecessary medications. The facility census was 59. Findings include: Review of Resident #4's medical records revealed an admission date of 04/30/24. Diagnoses included bipolar, schizoaffective disorder, restlessness and agitation. Review of Resident #4's physician's orders revealed an order dated 04/17/25 for Hydroxyzine (antipsychotic) 25 milligrams (mg) by mouth every 8 (eight) hours as needed for anxiety without a stop date. Review of Resident #4's MDS assessment dated [DATE] revealed cognitive impairment. Review of (Resident #4's) medication administration record (MAR) revealed that Resident #4 received Hydroxyzine on 04/27/25 and 04/29/25. Review of Resident #4's care plan dated 05/01/24 revealed the use of psychotropic medication for behavior management with interventions, monitor for side effects and, effectiveness, monitor, document, and report any adverse reactions of psychotropic medication. Interview on 05/15/25 at 2:15 P.M. with Registered Nurse (RN)/Regional Director of Clinical Services (RDCS) #166 verified that the Hydroxyzine order did not have a stop date and that PRN psychotropic medications should have a fourteen day stop date. Review of the facility policy titled Antipsychotic Medication Use dated 12/26 revealed that the need to continue an as needed psychotropic medications beyond fourteen days required that the practitioner document the rationale for the extended order.

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	365355	A. Building B. Wing	05/29/2025

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on personnel file review, interview, and review of facility policy, the facility did not ensure staff hired were free of disqualifying offenses. This affected two out of 11 personnel files reviewed for background checks and had the potential to affect all 59 residents in the facility. Findings include: Review of personnel files on 05/15/25 at 1:07 P.M. with Human Resource Manager #143 revealed the following areas of concern: Review of Certified Nursing Assistant (CNA) #125 personnel file revealed a date of hire of 11/06/24. Review of CNA #125's background report dated 12/03/24 revealed a charge dated 09/18/23 for aggravated robbery (2911.11) and aggravated assault (2903.12). The report revealed an additional charge on 10/25/24 for domestic violence (2919.25). All three charges occurred in the state of Ohio. Review of Maintenance Supervisor #138's personnel file revealed a date of hire of 01/28/25. Review of Maintenance Supervisor background report dated 02/18/25 revealed a charge dated 09/28/81 for aggravated robbery (2911.01) and a charge dated 05/17/1990 for drug abuse (2925.11). Both occurred in the state of Ohio. Interview with Human Resource Manager #143 verified the above findings at the time of discovery and confirmed the identified disqualifying offenses were disregarded. Human Resource Manager #143 provided a copy of Ohio Administrative Code Rule 3701-13-05 Disqualifying Offenses for Hiring of Direct Care Provider Employees which was used in determining CNA #125 and Maintenance Supervisor #138 should have been disqualified from employment at the facility. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revised 11/01/19 revealed as part of the screening process the facility must conduct background checks in accordance with Ohio Law and the facility's policy and verify that the applicant is not excluded from any federally funded programs. This deficiency represents non-compliance investigated under Complaint Number OH00165671.

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	365355	A. Building B. Wing	05/29/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel file review, interview, and review of facility policy, the facility failed to implement their abuse policy and procedure regarding checking potential applicants against the Ohio Nurse Aide Registry and ensuring all staff received a background check prior to employment This affected seven out of 11 personnel files reviewed for nurse aide registry checks and had the potential to affect all 59 residents in the facility. Findings include: 1. Review of the personnel files on 05/15/25 at 1:07 P.M. with Human Resource Manager #143 identified the following concerns: Review of the personnel file for Activity Director #132 revealed a hire date of 12/13/24. Further review of the personnel record did not reveal evidence a nurse aide registry search was completed. Review of the personnel file for Licensed Practical Nurse (LPN) #114 revealed a hire date 10/23/24. Review of the nurse aide registry check revealed it was not completed until 05/13/25. Review of the personnel file for Maintenance Supervisor #138 revealed a date of hire of 01/28/25. Review of the nurse aide registry check revealed it was not completed until 05/13/25. Review of the personnel file for Human Resource Manager #143 revealed a hire date of 04/24/25. Further review of the file revealed the nurse aide registry check was not completed until 05/12/25. Review of the personnel file for Business Office Manager #142 revealed a hire date of 02/24/25. Review of the nurse aide registry check revealed it was not completed until 05/13/25. Review of the personnel file for CNA #125 revealed a hire date of 11/06/24. Review of the nurse aide registry check revealed it was not completed until 12/28/25. Interview with Human Resource Manager #143 at the time of the discovery confirmed the identified findings and that she completed the nurse aide registry checks when they were unable to be located in the file during a review. Review of the Abuse, Neglect, Exploitation, & Misappropriation of Resident Property policy revised 11/01/2019 revealed screening is part of the procedure and prior to hiring a new employee, the facility would check with the Ohio nurse assistant registry and any other nurse assistant registries that the facility has reason to believe contain information on an individual, prior to using the individual as a nurse assistant. Review of Hiring Policy revised January 2008 revealed where appropriate, background investigations may be conducted on persons making application for employment with this facility and on current employees. 2. Record review of Licensed Practical Nurse (LPN) #114's personnel file revealed a date of hire 10/23/24. Further review of the personnel file revealed no evidence a background check was completed. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/15/25 at 1:07 P.M. with Human Resource Manager #143 confirmed the personnel file for LPN #114 did not contain evidence a background check was completed. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revised 11/01/19 revealed as part of the screening process the facility must conduct background checks in accordance with Ohio Law and the facility's policy and verify that the applicant is not excluded from any federally funded programs. This deficiency represents non-compliance investigated under Complaint Number OH00165671.

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	365355	A. Building B. Wing	05/29/2025

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of self-reported incidents (SRIs), interview and review of the facility policy, the facility failed to timely report allegations of abuse. This affected three residents (#6, #25 and #49) of seven residents reviewed for abuse. Facility census was 59. Findings include: 1. Review of Resident #49's medical record revealed an admission date of 02/20/25 and diagnoses including schizoaffective disorder, anxiety, depression, anemia and post-traumatic stress disorder. Review of an admission minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was cognitively intact, had disorganized thinking, had an ostomy and was frequently incontinent of urine. Review of a nurses' note dated 04/02/25 at 9:07 P.M. authored by Licensed Practical Nurse (LPN) #176 revealed the following information: 'This nurse was sitting behind the nursing station charting and preparing medication. The resident tried to go down the elevator with another resident and this nurse stated to resident she could not go down by herself and smoke, she had to wait until smoke break when the staff member was ready to take them down to smoke. Resident #49 started to get agitated and start yelling at this nurse, this nurse stated if she continued to yell and cause a scene she will not be allowed to go down to smoke. Resident #49 became more agitated and stated, [expletive] you can't tell me, I can't go smoke. This nurse said I do have that right and before I knew it because I was looking down at the computer. This nurse witnessed Resident #49 jump up out of her wheelchair and throw water on this nurse, after throwing the water she fell back in her wheelchair and spilled the rest of the water from the cup on her lap. After falling back in the wheelchair one staff member (not identified) tried to calm her down and roll her back down to her bedroom and the other staff member (not identified) cleaned the water up off the floor. Resident #49 stated she was calling the police and saying this nurse poured water on her, but this nurse never poured any water on the resident. Resident went down and smoked with other residents and staff member, so this nurse thought everything was over and Resident #49 went in her room and called the police. This nurse spoke with police and showed them where resident poured water on this nurse, they spoke with resident and staff members that witness the incident and they left the facility.' Review of a SRI dated 04/03/25 at 3:17 A.M. revealed an allegation of physical abuse involving Resident #49 and LPN #176. Resident #49 alleged LPN #176 threw water on her on 04/02/25 between 8:00 P.M. to 8:30 P. M. The facility determined the allegation of physical abuse to be unsubstantiated as Resident #49 had demanded to have a cigarette outside of designated smoking times. Resident #49 was advised of the next scheduled time and threw water on the nurse while her back was turned. Resident #49 was provided time to smoke per the remainder of the scheduled and posted times. Interview on 05/14/25 at 4:31 P.M. with CNA #135 recounted the altercation between LPN #176 and Resident #49. Resident #49 wanted to go smoke and LPN #176 stated no as it was not smoke break. Resident #49 called LPN #176 names (not specified) then put water on LPN #176. LPN #176 then put ice water on Resident #49 from her cup. The police were called, Resident #49 was sent to her room and he finished his shift. CNA #135 stated LPN #175 was terminated after the altercation. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/25 at 9:28 A.M. with Resident #49 confirmed there was an issue with a nurse and water at the facility. Resident #49 stated she asked the nurse (could not name) when smoke break was. Resident #49 stated I don't know if someone already did something to her or she was having a bad night, but she jumped up and did not want to be bothered. She was in the middle of something and then threw water at me, it was a full 16 ounce Styrofoam cup of cold water and ice. My whole gown was soaked. Resident #49 stated while she had not seen this nurse since, she stated she was crying and shocked a nurse would do this to a patient. When asked if she felt safe, Resident #49 stated she did not know how to feel. Phone interview on 05/15/25 at 10:57 A.M. with LPN #176 revealed she last worked at the facility on 04/02/25. The night of the incident, Resident #49 wanted to go outside and smoke and she had told the resident she could not smoke alone. Resident #49 then poured water on her. LPN #176 denied pouring water back on Resident #49 and stated she was suspended on 04/02/25 then terminated for not de-escalating the situation. LPN #176 indicated there had been plenty of staff around the time of the altercation for witness statements. Follow-up interview on 05/15/25 at 12:48 P.M. with RDO #196 revealed allegations of abuse were to be reported to the Administrator or Director of Nursing (DON) right away so if staff were involved, they could be suspended timely. RDO #196 provided time punches for LPN #176 which indicated she worked out her shift before clocking out on 04/03/25 at 7:59 A.M. RDO #196 was made aware the facility submitted their SRI on 04/03/25 at 3:17 A.M. and the SRI reported the incident had occurred on 04/02/25 at 8:30 P.M. RDO #196 stated while she was not present at the time of the incident, based on the SRI and LPN #176's time punches, the allegation was not reported timely and LPN #176 should have been suspended immediately after the allegation was made and reported and confirmed LPN #176 should not have been allowed to work out the remainder of her shift until 04/03/25 at 7:59 A.M. Interview on 05/19/25 at 8:39 A.M. with CNA #180 revealed he was present the night of the incident where Resident #49 put water on LPN #176, then LPN #176 put water back on Resident #49. Resident #49 got mad, told someone (not named) and the police were called and went upstairs. CNA #180 confirmed LPN #176 worked the rest of the night and was still on site when he clocked out at the end of his shift. 2. Review of the medical record for Resident #6 revealed an admission date of 07/01/24. Diagnoses included but were not limited to chronic obstructive pulmonary disorder, depression, schizoaffective disorder, anxiety, and intermittent explosive disorder. Review of 04/02/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Behaviors were not noted. Resident #6 was noted to require set up for activities of daily living and was independent to wheel 150 feet in his wheelchair. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's care plan last revised on 11/12/24 revealed a diagnosis of depression and suicidal ideations. Interventions included but were not limited to Psych consultation, educate on interventions for triggers and reassurance, notify the physician of any changes or decline with mood triggers. Resident #6 has potential for behavioral problems related to personality disorder, post traumatic stress disorder, attention deficit hyperactivity disorder (ADHD), autism, Malingerer (attention seeking behaviors), gender identity disorder and explosive disorder. Intervention added on 03/05/25 was to assist the resident to develop more appropriate methods of coping and interacting. Encourage resident to express feelings appropriately. Review of the medical record for Resident #25 revealed an admission date of 10/04/23. Diagnoses included but were not limited to unspecified dementia with behaviors, morbid obesity, hypertensive chronic kidney disease, nicotine dependence and delusional disorders. Review of the 04/09/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #25 revealed severe cognitive impairment. Resident #25 was noted to require set up for activities of daily living. Review of the 01/16/25 smoking safety assessment for Resident #25 revealed cognitive loss, resident able to light cigarette, requires facility to store lighter and cigarettes and requires supervision while smoking. Review of Resident #25's care plan dated 04/04/24 with last revision on 04/18/25 revealed change in mental status or acute confusional state related to hallucinations and new diagnosis of dementia with mood disturbance. Interventions listed were to administer medications as ordered, attempt to keep environmental noise/stimulation to a minimum, and medication review. Review of nursing progress notes for Resident #25 did not reveal any evidence of a progress note following the incident that occurred between Resident #6 and #25. Review of the 05/12/25 smoking safety assessment for Resident #6 revealed smoking supervision is required, and facility is to store cigarettes and lighter. Review of nursing progress note dated 05/10/25 timed at 11:32 A.M. for Resident #6 revealed and altercation occurred between Resident #6 and another resident (Resident #25). Resident #25 asked Resident #6 for a light for her cigarette from Resident #6. Resident #6 responded that he would not use his cigarette to light hers and they should not be sharing cigarettes. Resident #25 became upset and attempted to throw a chair at Resident #6. Resident #6 stated he feared for his life and hit Resident #25. Following the altercation, staff intervened promptly and separated both residents to ensure their safety and to de-escalate the situation. Review of the 05/11/25 facility form title Self-Reported Incident Form for SRI tracking number (#) 260252 revealed a resident-to-resident altercation between Resident #6 and #25. Incident was noted to occur on 05/10/25 while Resident #6 and #25 were outside on the smoking patio during a supervised smoke break. According to statements, while out on smoke break, Resident #6 made physical contact with Resident #25 because she asked for a cigarette. Staff intervened and residents were immediately separated. A head-to-toe assessment was completed on Resident #6 and #25 with no noted concerns. Social services met with both residents and neither resident stated suffering any negative psychosocial effects from the incident. The allegation was found to be unsubstantiated due to inconclusive evidence of abuse. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Self-Reported Incident (SRI) # 260252 revealed it was opened on 05/11/25 at 1:37 P.M. under the category of physical abuse between two residents; Residents #6 and #25. Interview on 05/14/25 at 12:55 P.M. with Regional Director of Clinical Services #166 confirmed she opened SRI 260252 when she was made aware and confirmed it was not opened within the appropriate time frame for state reporting as it was over 24 hours from the time the progress note was written before the SRI was opened. Interview on 05/20/25 at 3:17 P.M. with Licensed Practical Nurse (LPN) #114 revealed Resident #6 came to her and stated Resident #25 wanted to use his cigarette to light her cigarette. Resident #6 declined, and Resident #25 got angry and attempted to pick up a chair to hit Resident #6. Resident #6 stated he swung in self-defense and hit Resident #25. LPN #114 stated they separated Resident #6 and #25 and reported the incident to Resident #25's nurse. LPN #114 stated she told the previous Director of Nursing (DON) following the incident, completed the risk assessment form and slid it under the Director of Nursing's door. Review of the 11/01/19 revised facility policy called; Abuse, Neglect, Exploitation and Misappropriation of Resident Property revealed it is the policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property in accordance with this policy. Facility staff should immediately report all such allegations to the Administrator/designee and to the Ohio Department of Health. The Administrator or his/her designee will notify ODH of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or possible, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. This deficiency represents non-compliance investigated under Complaint Number OH00165671.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 thoroughly investigate allegations of abuse. This affected one resident (#49) of seven residents reviewed for abuse. Facility census was 59. Findings include: Review of Resident #49's medical record revealed an admission date of 02/20/25 and diagnoses including schizoaffective disorder, anxiety, depression, anemia and post-traumatic stress disorder. Review of an admission minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was cognitively intact, had disorganized thinking, had an ostomy and was frequently incontinent of urine. Review of a nurses' note dated 04/02/25 at 9:07 P.M. authored by Licensed Practical Nurse (LPN) #176 revealed the following information: 'This nurse was sitting behind the nursing station charting and preparing medication. The resident tried to go down the elevator with another resident and this nurse stated to resident she could not go down by herself and smoke, she had to wait until smoke break when the staff member was ready to take them down to smoke. Resident #49 started to get agitated and start yelling at this nurse, this nurse stated if she continued to yell and cause a scene she will not be allowed to go down to smoke. Resident #49 became more agitated and stated, b**** you can't tell me, I can't go smoke. This nurse said I do have that right and before I knew it because I was looking down at the computer. This nurse witnessed Resident #49 jump up out of her wheelchair and throw water on this nurse, after throwing the water she fell back in her wheelchair and spilled the rest of the water from the cup on her lap. After falling back in the wheelchair one staff member (not identified) tried to calm her down and roll her back down to her bedroom and the other staff member (not identified) cleaned the water up off the floor. Resident #49 stated she was calling the police and saying this nurse poured water on her, but this nurse never poured any water on the resident. Resident went down and smoked with other residents and staff member, so this nurse thought everything was over and Resident #49 went in her room and called the police. This nurse spoke with police and showed them where resident poured water on this nurse, they spoke with resident and staff members that witness the incident and they left the facility.' Review of a SRI dated 04/03/25 at 3:17 A.M. revealed an allegation of physical abuse involving Resident #49 and LPN #176. Resident #49 alleged LPN #176 threw water on her on 04/02/25 between 8:00 P.M. to 8:30 P.M. The facility determined the allegation of physical abuse to be unsubstantiated as Resident #49 had demanded to have a cigarette outside of designated smoking times. Resident #49 was advised of the next scheduled time and threw water on the nurse while her back was turned. Resident #49 was provided time to smoke per the remainder of the scheduled and posted times. Review of the facility's investigation corresponding to the SRI revealed the following information: • (continued on next page)

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	05/29/2025

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement dated 04/04/25 for Certified Nursing Assistant (CNA) #149 written by Previous Director of Nursing (PDON) #175 revealed the following information: I interviewed the staff member CNA #149 regarding the matter involving Resident #49 and LPN #176. CNA #149 stated the incident occurred prior to his arrival to that evening's shift and he did not witness the incident. • Review of an unauthored resident statement dated 04/07/25 denied abuse. • Review of an undated resident statement for Resident #11 denied abuse. • Review of an undated resident statement for Resident #60 denied abuse. • Review of an undated and unauthored resident statement denied abuse. Interview on 05/14/25 at 4:31 P.M. with CNA #135 recounted the altercation between LPN #176 and Resident #49. Resident #49 wanted to go smoke and LPN #176 stated no as it was not smoke break. Resident #49 called LPN #176 names (not specified) then put water on LPN #176. LPN #176 then put ice water on Resident #49 from her cup. The police were called, Resident #49 was sent to her room and he finished his shift. CNA #135 stated LPN #175 was terminated after the altercation. Interviews on 05/15/25 at 8:36 A.M. and 9:20 A.M. with Regional Director of Operations (RDO) #196 revealed she was unable to provide a complete investigation regarding the SRI and provided the surveyor with several resident statements and one staff statement. RDO #196 confirmed the available investigation was not evidence of a thorough investigation. Interview on 05/15/25 at 9:28 A.M. with Resident #49 confirmed there was an issue with a nurse and water at the facility. Resident #49 stated she asked the nurse (could not name) when smoke break was. Resident #49 stated I don't know if someone already did something to her or she was having a bad night, but she jumped up and did not want to be bothered. She was in the middle of something and then threw water at me, it was a full 16 ounce Styrofoam cup of cold water and ice. My whole gown was soaked. Resident #49 stated while she had not seen this nurse since, she stated she was crying and shocked a nurse would do this to a patient. When asked if she felt safe, Resident #49 stated she did not know how to feel. Phone interview on 05/15/25 at 10:57 A.M. with LPN #176 revealed she last worked at the facility on 04/02/25. The night of the incident, Resident #49 wanted to go outside and smoke and she had told the resident she could not smoke alone. Resident #49 then poured water on her. LPN #176 denied pouring water back on Resident #49 and stated she was suspended on 04/02/25 then terminated for not de-escalating the situation. LPN #176 indicated there had been plenty of staff around the time of the altercation for witness statements. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 at 8:00 A.M. [NAME] President of Operations (VPO) #172 was made aware that staff and resident interviews completed due to an insufficient facility SRI investigation had indicated staff to resident abuse had occurred with LPN #176 and Resident #49 on 04/02/25. VPO #172 did not disagree and shared as a company, all SRIs had to be scanned and emailed for review by upper management but because RDO #196 had been onsite at the facility, no scanning of the SRI investigation had been completed thus no further documentation regarding the SRI was available for surveyor review. Interview on 05/19/25 at 8:39 A.M. with CNA #180 revealed he was present the night of the incident where Resident #49 put water on LPN #176, then LPN #176 put water back on Resident #49. Resident #49 got mad, told someone (not named) and the police were called and went upstairs. CNA #180 confirmed LPN #176 worked the rest of the night and was still on site when he clocked out at the end of his shift. Review of the facility policy, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, revised 11/01/19 revealed the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property including injuries of unknown source in accordance with this policy. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the resident representative and any treatment provided. Appropriate quality assurance documentation should be completed as well. The person investigating the incident should generally take the following actions: interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident and employees who worked closely with the accused employees and/or alleged victim the day of the incident. if there are no direct witnesses then the interviews may be expanded. For example, to cover all employees on the unit or as appropriate, the shift. Obtain a statement from the resident if possible, the accused and each witness. Evidence of the investigation should be documented. This deficiency represents noncompliance investigated under Complaint Number OH00165671.

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	365355	A. Building B. Wing	05/29/2025

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Review of Resident #1's medical record revealed an admission date of 03/27/20 and diagnoses including paraplegia, moderate protein-calorie malnutrition, hemiplegia and hemiparesis, depression, hypertension, constipation and dementia without behavioral disturbance. Review of Resident #1's census data revealed hospitalizations on 12/17/23, 08/27/24, 12/23/24, 12/31/24 and 05/08/25. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had moderate cognitive impairment, required set up for eating and was dependent on staff for most other activities of daily living. Review of eInteract assessments for Resident #1 revealed transfers to the hospital on [DATE] (nephrostomy malfunction) and 05/08/25 (nephrostomy and suprapubic catheters non-functioning). Interview on 05/22/25 at 7:40 A.M. with [NAME] President of Operations (VPO) #172 verified she was unable to provide evidence of ombudsman notification relative to Resident #1's transfers to the hospital on [DATE], 08/27/24, 12/23/24, 12/31/24 and 05/08/25. Follow-up interviews on 05/22/25 at 9:22 A.M. and 9:48 A.M. with VPO #172 confirmed the facility only had bed-hold notices relative to Resident #1's hospitalizations in 2025 and could not provide additional notices for his hospitalizations in 2023 and 2024. Review of the December 2016 revised facility policy called Transfer or Discharge Notice revealed a written discharge notice will be provided to the resident and/or his or her representative as soon as it is practicable but before the transfer or discharge from the facility. A copy of the notice will be sent to the Office of the State Long Term Care Ombudsmen and the reason for the transfer or discharge will be documented in the resident's medical record. 5. Review of Resident #58's closed medical record revealed an admission date of 04/01/25 with diagnoses including intellectual disabilities, bipolar disorder, hypertension, impulse disorder, autism and vitamin D deficiency. Review of Resident #58's admission minimum data set (MDS) 3.0 assessment revealed Resident #58 had a memory problem and displayed physical behaviors, verbal behaviors and rejected care one to three days in the look-back period. Review of the last available progress note dated 05/07/25 at 2:21 A.M. revealed Resident #58 had returned to the facility at 2:18 A.M. and was currently in bed in her room. No new orders received upon discharge. Will monitor. Review of the last assessment dated [DATE] at 8:06 A.M. revealed Resident #58 was combative against staff and was sent to the hospital. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview on 05/13/25 at 10:20 A.M. with Registered Nurse (RN)/Regional Director of Clinical Services (RDCS) #166 verified there should have been a progress note documenting Resident #58's return to the hospital on [DATE]. RN/RDCS #166 indicated Resident #58 remained hospitalized as of the time of the interview. Review of the policy, Discharging the Resident, revised December 2016 revealed the following information should be recorded in the resident's medical record: the date and the time the discharge was made, the name/title of the individuals who assisted in the discharge and the signature and title of the person recording the data. Based on medical record review, evidence of facility Ombudsmen notifications and interviews, the facility failed to ensure the Long-Term Care Ombudsmen was notified of resident transfers and discharges from the facility, failed to provide bed hold notices as required for Resident #1, #64, #66 and #68, and failed to ensure Resident #58's transfer to the hospital was documented. This affected five residents (resident #1, #58, #64, #66, and #68) of five residents reviewed for transfer and discharge requirements. Findings include: 1. Review of the closed medical record for Resident #64 revealed an admission date of 03/12/25 and a discharge date of 03/13/25. No diagnoses were listed in the medical record. Review of the medical record for Resident #64 revealed an admission at 3:00 P.M. on 03/12/25. Review of the nursing progress note dated 03/13/25 at 5:42 A.M. revealed Resident #64 yelling at staff and stating he wanted to leave now. Nurse contacted the Director of Nursing and spoke with the physician who gave permission to send Resident #64 to the hospital. The nurse contacted emergency medical services (EMS) for transport and when they arrived Resident #64 declined to go until he had a cigarette. EMS stated they could not wait. Resident #64 declined to go with EMS and stated he would get his own ride to the hospital and went outside to smoke. Resident #64 was noted to leave the facility against medical advice (AMA) and refused to sign the AMA paper prior to leaving. Interview on 05/15/25 at 8:38 A.M. with Regional Director of Operations #196 confirmed since Resident #64 left the facility AMA, they did not send notification to the Ombudsmen following Resident #64's discharge as required. 2. Record review for Resident #66 revealed an admission date of 04/21/22 with diagnoses of chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, type II diabetes with diabetic neuropathy, and morbid severe obesity. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively intact and dependent for oral hygiene, toileting hygiene, dressing, bed mobility, and transfers. Review of the progress notes revealed Resident #66 was admitted to the hospital on [DATE] due to low hemoglobin levels (5.1). Resident #66 remained in the hospital and was discharged by the facility on 04/13/25. Reason for discharge was not documented in the resident record. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview on 05/20/25 at 8:43 A.M. with [NAME] Office Manager #142 revealed Resident #66 was discharged from the facility on 04/13/25 due to exhausting bed hold days. Written notification of bed hold days was provided at the time of the interview. Interview on 05/22/25 at 10:39 A.M. with [NAME] President of Clinical Services #182 confirmed the facility was unable to provide documentation that a copy of the notice of transfer/discharge was provided to a representative of the Office of the Long-Term Care Ombudsman. 3. Record review for Resident # 68 revealed an admission date of 01/08/25 with diagnoses of acute osteomyelitis left ankle and foot, malignant neoplasm of prostate, end stage renal disease, and type II diabetes mellitus. Review of the Discharge MDS dated [DATE] revealed Resident #68 was cognitively intact and required maximal assistance with showering, dressing, personal hygiene, and toilet transfers and required moderate assistance for toilet hygiene. Review of the progress note dated 01/25/25 at 10:20 A.M. revealed Resident #68 discharged from the facility against medical advice. Interview on 05/22/25 at 10:39 A.M. with [NAME] President of Clinical Services #182 confirmed the facility was unable to provide documentation that a copy of the notice of transfer/discharge was provided to a representative of the Office of the Long-Term Care Ombudsman.

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	365355	A. Building B. Wing	05/29/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehension assessments were accurately completed. This affected five (Residents #34, #39, #51, #59 and #69) out of 40 residents reviewed for Minimum Data Set (MDS) 3.0 assessments. The facility census was 59. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy (seizures), cognitive communication deficit, need for assistance with personal care and history of encephalitis (inflammation of the brain). Review of the census for Resident #51 revealed he was admitted to the hospital from [DATE] through 03/06/25. Review of the nursing readmission assessment dated [DATE] for Resident #51 revealed he had no skin issues noted. Review of the weekly skin assessment on 03/12/25 for Resident #51 revealed his skin was intact. Review of the MDS 3.0 assessment for Resident #51 dated 03/31/25, discharge return anticipated, revealed section M stated he had a Stage III pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) present on admission. Interview on 05/19/25 at 11:30 A.M. with the Director of Nursing (DON) verified Resident #51's MDS from 03/31/25 was incorrect as his Stage III pressure ulcer to his buttocks was not present on admission. 2. Review of the medical record for Resident #59 revealed an admission date of 12/02/24 with diagnoses including rheumatoid arthritis, chronic obstructive pulmonary disease, heart disease and history of falling. Review of the nursing progress note dated 02/22/25 revealed Resident #59 was independent for bed mobility, transfers, eating, toileting, hygiene and walking. Review of the nursing progress note dated 02/24/25 revealed Resident #59 needed supervision for bed mobility and was independent for transfers, eating, hygiene and toileting. Review of the quarterly MDS 3.0 assessment for Resident #59 dated 03/11/25 revealed on section GG he needed set-up assistance for eating and was dependent on staff for toileting, showers, rolling and transfers. The assessment stated he did not walk. Interview on 05/22/25 at 9:06 A.M. with the [NAME] President of Operations (VPO) #172 verified Resident #59's MDS assessment on 03/11/25 was incorrect as he was not dependent on staff for activities of daily living. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #69 revealed an admission date of 06/13/24 with diagnoses including diabetes mellitus and cognitive communication deficit. Review of the Medication Administration Record for December 2024 revealed Resident #69 received Insulin Glargine (medication for high blood sugar) from 12/11/24 through 12/31/24 every day upon rising. Review of the quarterly MDS 3.0 assessment for Resident #69 dated 12/21/24 revealed on section N question N350 for how many days of insulin injections were received during the last seven days, the question was answered only one. Interview on 05/20/25 at 2:20 P.M. with the [NAME] President of Clinical Services #182 verified Resident #69's MDS assessment on 12/21/24 was incorrect as she received seven insulin injections from 12/15/24 through 12/21/24.4. Review of the medical record for Resident #34 revealed and admission date of 07/29/22. Diagnoses included but were not limited to osteonecrosis, gastrostomy, history of malignant neoplasm of other sites of lip, oral cavity and pharynx and nicotine dependence. Review of the 05/09/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #34 revealed a Brief Interview for Mental Status (BIMS) of 0 which indicated severe cognitive impairment and was independent for activities of daily living. Resident #34 was not noted to have significant weight changes and was using a feeding tube for over 51% of his nutrition needs and was receiving fluid intake of over 501 cubic centimeters (cc) of fluid via the enteral tube daily. Review of the 02/05/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #34 revealed he revealed a Brief Interview for Mental Status (BIMS) of 0 which indicated severe cognitive impairment and was independent for activities of daily living. Resident #34 was noted to have significant weight loss and was using a feeding tube for over 51% of his nutrition needs and was receiving fluid intake of over 501 cubic centimeters (cc) of fluid via the enteral tube daily. Review of the 02/06/25 BIMS assessment for Resident #34 revealed it was in progress, not completed and had a score of 11 which indicated moderate cognitive impairment. Review of the 05/08/25 BIMS assessment for Resident #34 revealed a score of 0 which indicated severe cognitive impairment. Interview on 05/13/25 at 2:25 P.M. with Licensed Practical Nurse (LPN) #131 confirmed Resident #34 refuses his enteral feeding and drinks them orally. LPN #131 stated the nurse take the enteral feeding into Resident #34's room and he consumes it orally at his leisure. LPN #131 also stated Resident #34 is non-compliant with his nothing by mouth (NPO) status and consumes foods orally without a diet order. LPN #131 stated she had reported it to the previous Director of Nursing (DON) about five months ago and continued to document his refusals of enteral feeding. Interview on 05/13/25 at 3:33 P.M. with Regional Director of Clinical Services #166 confirmed she was unaware Resident #34 was refusing his enteral feeding and was consuming it orally, and was unaware staff were leaving the enteral feeding bottles in Resident #34's room. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/25 at 11:07 A.M. with LPN #131 revealed she attempted to provide an enteral feeding flush for Resident #34. Resident #34 was observed to be making hand gestures pushing away and was attempting to speak but surveyor was unable to understand what Resident #34 was saying. Interview with LPN #131 following the observation revealed she was able to understand Resident #34. Resident #34 did not want the enteral flush and did not want to be bothered. Interview on 05/15/25 at 6:13 A.M. with Certified Nursing Assistant #123 revealed Resident #34 will frequently refuse care, will use his call light and will answer yes and no questions and will point to things to get his needs made known. Interview on 05/15/25 at 6:38 A.M. with Registered Nurse (RN) #153 revealed Resident #34 will not allow staff to administer his enteral feeding or flushes. Resident #34 will ask for his enteral feeding and does not want staff assistance. RN #153 confirmed she did not know how much Resident #34 was consuming of his enteral tube feeding whether via the percutaneous endoscopic gastrostomy (PEG) tube or orally and stated he usually drinks it orally. Phone interview on 05/15/25 at 9:14 A.M. with Registered Dietitian (RD) #181 revealed Resident #34 is NPO and uses a PEG tube. RD #181 stated she was unaware Resident #34 was refusing his enteral feeding or consuming his enteral feeding orally. RD #181 confirmed she had marked section K on the quarterly assessment for 02/05/25 and 05/09/25 for Resident #34 as receiving over 51% of his nutrition and 501 cc or more for hydration via the PEG tube. Interview on 05/15/25 at 9:47 A.M. with Director of Rehab #151 revealed Resident #34 refuses to participate in the BIMS assessment and therefore is coded as a 0. Interview on 05/20/25 at 1:57 P.M. with [NAME] President of Operations (VPO) #172 confirmed Social Worker (SW) #192 stated the answers for the BIMS assessment on the MDS were all no's and confirmed she did not write a progress note to explain. VPO #172 confirmed SW #192 should have checked Resident #34 was not assessed due to refusals on the MDS and should not have entered a BIMS of 0. VPO #172 also confirmed Resident #34 was not consuming >51% of his nutrition via the feeding tube or receiving at least 501 cc of fluid from enteral tube flushes due to resident refusals and confirmed the facility did not have a physician order for Resident #34 to consume nutrition orally. 5. Review of medical record for Resident # 39 revealed and admission date of 5/25/22 with diagnoses including unspecified dementia with severe anxiety, history of falling, moderate protein-calorie malnutrition, adult failure to thrive, encounter for palliative care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #39 section M indicated that there were no pressure ulcer/sores documented, the assessment noted that there were no interventions in place to prevent the ulcer/sores. Review of Nursing Weekly Wound Observation Tool dated 4/28/25 revealed that Resident #39 was identified with a pressure wound classified as an unstageable pressure which indicates that the wound is closed and unable to determine the depth of the wound at this time with measurement of 0.2 x 0.1 centimeters. Review of Braden Scale Prediction Pressure Sore Tool dated 4/11/25 for Resident #39 revealed the resident was at very high risk for a pressure sore. (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician's orders for Resident #39 revealed wound treatments were in place dated 4/29/25 to clean area with normal saline, pat dry and apply Triad Cream. Interview on 05/14/25 at 8:16 A.M. with Regional Director of Clinical Services #166 verified Resident #39 was totally dependent on care and the MDS dated [DATE] was not accurate and Resident #39 did have an identified pressure area during the look back period of the assessment. Review of the facilities policy titled Minimum Data Set (MDS) Policy not dated, outlines how the long-term facility collects, uses, and reports resident assessment date. It ensures standardized and comprehensive assessments are conducted using the plan of care and documentation to ensure the best practices are maintained.

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	365355	A. Building B. Wing	05/29/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident #49's medical record revealed an admission date of 02/20/25 and diagnoses including schizoaffective disorder, anxiety, depression, anemia and post-traumatic stress disorder. Review of an admission minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was cognitively intact, had disorganized thinking, had an ostomy and was frequently incontinent of urine. Review of a plan of care dated 02/25/25 revealed Resident #49 had an alteration in gastrointestinal status related to ostomy. Interventions were listed including: Avoid lying down for at least one hour after eating; Keep head of bed elevated; Encourage to stand/sit upright after meals; Discuss with the resident/family/caregivers any concerns/fears/issues related to gastro-intestinal distress; Empty ostomy every shift and as needed (PRN); Encourage the resident to avoid alcohol, smoking, coffee (even decaffeinated), fatty foods, chocolate, citrus juices, [NAME], tomato products, garlic and onions; Encourage a bland diet; Give medications as ordered; Monitor/document side effects and effectiveness; Provide ostomy care as ordered; The plan of care did not indicate Resident #49 was involved with completing her own colostomy care. Interview on 05/13/25 at 3:29 P.M. with Resident #49 revealed she had a colostomy and she emptied it herself. Resident #49 stated the facility staff gave her new supplies and she was also able to change the colostomy appliance herself. Interview on 05/14/25 at 9:14 A.M., with Certified Nursing Assistant (CNA) #135 revealed Resident #49 did her own colostomy care. Interview on 05/14/25 at 10:26 A.M. with Licensed Practical Nurse (LPN) #131 revealed Resident #49 preferred to complete her own colostomy care and staff would provide her with the needed supplies to do so. Interview on 05/15/25 at 2:37 P.M. with Registered Nurse (RN)/Regional Director of Clinical Services (RDCS) #166 verified Resident #49 did her own colostomy care and confirmed there was not a care plan in place relative to Resident #49's self-management of her colostomy and should have been. Review of the facility policy, Care Plans, Comprehensive Person-Centered, revised December 2016, revealed the plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, build on the resident's strengths and reflect the resident's expressed wishes regarding care and treatment goals. The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS). (continued on next page)

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	05/29/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff interview, and policy review the facility did not ensure self-administration of medication for Resident #26 and self-management of colostomy for Resident #49 were included in the care plan. This affected two of 40 resident records reviewed for comprehensive care plans. Facility census was 59. Findings include: 1. Record review for Resident #26 revealed an admission date of 04/25/17 with diagnoses of legal blindness, acquired absence of right eye, peripheral vascular disease, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 was cognitively intact, had severe vision impairment, and required set up assistance for eating and showers. Review of the physician orders revealed an order for Fish Oil Capsule 1000 mg one time a day unsupervised self-administration; Calcium-Vitamin D Tablet 600-400 mg two times a day unsupervised self-administration; Systane Gel 0.4-0.3% one drop in eye every 6 hours as needed may keep at bedside; able to have medications at bedside per MD with a start date of 11/30/21. Review of the care plan revealed self-administration of medications was not included in the care plan. Interview on 05/19/25 at 9:50 A.M. with Licensed Practical Nurse (LPN) #108 confirmed Resident #26 self-administered medications. Interview on 05/19/25 at 10:10 A.M. with [NAME] President of Clinical Services #182 revealed the facility did not have a self-administration of medication policy. Interview on 05/22/25 at 11:35 A.M. with [NAME] President of Operations #172 confirmed self-administration of medications for Resident #26 was not care planned. Review of the Administering Medications Policy revised December 2012 revealed residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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	365355	A. Building B. Wing	05/29/2025

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure showers were completed as scheduled and per resident preference. This affected two (Residents #27 and #59) out of two residents reviewed for showers who required less than or equal to limited assistance. The facility census was 59. Findings include: 1. Review of the medical record for Resident #59 revealed an admission date of 12/02/24 with diagnoses including heart disease, history of falling and chronic obstructive pulmonary disease. Review of the nursing admission assessment dated [DATE] revealed Resident #59 was independent for eating, toileting, and bed mobility. He needed supervision for transferring and dressing. He needed limited staff assistance for personal hygiene and physical help only with the transfer for bathing. Review of the facility shower schedule, undated, revealed Resident #59 was to receive showers on Mondays and Thursdays on night shift. Interview on 05/12/25 at 10:11 A.M. with Resident #59 revealed he did not receive showers as scheduled. He stated his family had to help him shave as he could not get assistance from staff. Review of Resident #59's shower sheets with [NAME] President of Operations (VPO) #172 on 05/22/25 at 10:40 A.M. revealed the facility was only able to provide two shower sheets for the dates from 02/22/25 through 05/22/25. On 04/07/25 Resident #59 received a bed bath and on 04/17/25 the sheet was blank and did not indicate if he received a shower or bed bath. VPO #172 verified there was no further documentation related to Resident #59 receiving showers.2. Review of the medical record for Resident #27 revealed an admission date of 05/01/24. Review of the diagnoses included but were not limited to adjustment disorder, chronic respiratory failure, morbid obesity, dysphagia and depression. Review of the 05/09/25 annual Minimum Data Set (MDS) 3.0 for Resident #27 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. Resident #27 was noted to require moderate assistance from staff for bathing, dressing, and personal hygiene. Review of the facility shower schedule revealed Resident #27 was supposed to receive showers on Tuesdays and Fridays. Review of the shower sheets for Resident #27 provided by the facility revealed a shower provided on 03/07/25, 03/17/25, 03/24/25, 04/04/25, 04/10/25, 04/24/25, 05/02/25, and 05/12/25. Out of 21 scheduled showers to be given for Resident #27, the facility was only able to provide evidence for eight bathing opportunities. Interview on 05/12/25 at 10:26 A.M. with Resident #27 revealed she stated she was not getting her scheduled showers and was told to wash up in the sink. Interview on 05/14/25 at 8:01 A.M. with Resident #27 stated she was waiting for a shower as she did not receive her scheduled shower yesterday. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/14/25 at 8:13 A.M. with Certified Nursing Assistant (CNA) #135 revealed Resident #27 is a one assist for showers. CNA #135 confirmed if the shower aide gets pulled to assist on the floor, they are not able to complete all scheduled showers. If staff are unable to complete their scheduled showers, they are to let the oncoming staff know. CNA #135 stated he was not made aware Resident #27 did not receive her shower yesterday as scheduled. Interview on 05/19/25 at 6:42 A.M. with Director of Clinical Services #166 confirmed showers were not being given as scheduled for Resident #27. Review of the October 2010 revised facility policy called; Shower/Tub Bath revealed the date and time of the shower/tub bath and person who assisted with it should be recorded on the resident's Activities of Daily Living record and or in the resident medical record. If the resident refused the shower/tub bath, the reason(s) why should be documented.

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	365355	A. Building B. Wing	05/29/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, observation and interview, the facility failed to ensure dependent residents were assisted with activities of daily living. This affected four (Residents #21, #24, #39 and #51) of nine reviewed for activities of daily living for dependent residents. The facility census was 59. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy, cognitive communication deficit and need for assistance with personal care. Review of the care plan dated 07/09/24 for Resident #51 revealed he was at increased risk for malnutrition related to medications, seizures, weakness, dysphagia, mechanically altered diet and pocketing food. Interventions included for staff to assist with all meals. Review of the nursing readmission assessment dated [DATE] for Resident #51 revealed he was totally dependent on staff for eating. Observation on 05/19/25 at 12:00 P.M. of Resident #51 revealed his meal tray for lunch was delivered to his room. It was placed on his tray table across the room from his bed. Observation on 05/19/25 at 12:45 P.M. of Resident #51 revealed his meal tray for lunch was still sitting on his tray table untouched. Interview on 05/19/25 at 12:50 P.M. with Licensed Practical Nurse (LPN) #188 verified Resident #51's tray arrived at 12:00 P.M. She stated herself and one aide were on the floor to assist the two residents who needed assist with meals. She stated she was in the dining room as well. She verified staff had not assisted him with his meal. Observation on 05/20/25 at 8:00 A.M. of Resident #51 revealed his meal tray for breakfast was delivered to his room and was placed on his tray table. He was noted to still be in bed. Observation on 05/20/25 at 9:30 A.M. with Registered Nurse (RN) #186 revealed Resident #51's meal tray for breakfast was still sitting on his tray table untouched and the resident was in bed. She verified Resident #51 should have been up in his wheel chair and assisted with breakfast when the tray came at 8:00 A.M.2. Review of the medical record for Resident #21 revealed and admission date of 6/25/24 with diagnosis of post traumatic seizures, acute respiratory failure, need assistance with personal care, repeated falls, depression, osteoarthritis. Review of Resident #21's physician orders dated 06/25/24 revealed his showers were to be on Monday and Thursday on day shift or as needed. There was a bulletin posted by the resident's bed that indicated those are shower days. Review of the care plan dated 03/11/25 revealed the resident had a self-care deficit with the goals for the resident to be cleaned and well-groomed while requiring assistance of one. Resident #21's care plan did not indicate he refused care. (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's quarterly Minimum Data Set (MDS) assessment dated [DATE] under section E revealed the resident needed assistance with bathing. Review of the shower sheets for the last 30 days from 04/01/25 to 05/01/25 revealed on 04/03/25, 04/07/25, and 04/14/25 Resident #21 refused his showers. The resident missed nine out of the 12 showers scheduled to be given. Review of the plan of care record documented by certified nursing assistants (CNA) from 04/01/25 to 05/01/25 revealed the resident only had one shower on 04/17/25 with a signed shower sheet indicating he refused the shower. Observation of Resident #21 on 05/12/25 at 9:45 A.M. revealed the resident looked unkept. He was unshaven and had spots of dried food on his shirt. When the resident if he gets baths when he wants them, he stated it depends on what you call a bath. He revealed he gets washed up sometime with staff but wants showers twice a week like when he first got to the facility. The resident had dirty long nails that he wanted trimmed. Resident #21 revealed he washes up in the sink most of the time. Interview with Regional Nurse #166 on 05/13/25 at 2:25 P.M. confirmed there was no documentation the resident refused care and showers were not completed for the nine days missing out of the month. Review of facility process titled Shower/Tub Bath, dated 05/19/25, revealed facility promoted cleanliness, comfort for the resident, and observe the skin. When the bath is completed, the medical record should be updated with the date and time the bathing occurred. The name and title of person assisting the resident and any skin issues identified be reported to the nurse. These were to be completed two times a week or more per the resident's preference. 3. Review of the medical record for Resident #24 revealed an admission date of 01/03/17 with diagnoses of chronic heart failure, dementia, type 2 diabetes, muscle weakness, alcohol abuse, chronic kidney disease. Review of Resident #24's care plan dated 02/06/25 revealed the resident had a self-care deficit related to cognitive and physical deficits and requires assistance with activities of daily living. Review of Resident #24's CNA documentation on 04/24/25 revealed the resident required extensive assistance with bathing as needed. Review of Resident #24's shower sheets that were available for the last 30 days 04/01/25 to 05/01/25 revealed the resident had only two documented showers on a shower sheet and three in the electronic medical record. Observation of Resident #24 on 05/12/25 at 9:24 A.M. revealed the resident lying in bed with long, dirty fingernails, and the resident was unshaven. Observation of a shower schedule on the bulletin board in the resident's room revealed his showers were to be 7:00 A.M. to 7:00 P.M. on Monday and Thursdays. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/25 at 8:45 A.M. Resident #24 was observed with long dirty fingernails and an unkept appearance. When asking the resident if he wanted to shave and take a shower, he stated he wanted his nails cut and clean clothes on. The resident had a dark blue sweatshirt with a brown striped shirt underneath. Resident #24 had on plaid blue pajama like pants on and dirty yellow grip socks. Interview with Regional Director of Nursing #166 on 05/13/25 at 1:45 P.M. confirmed the resident did not have showers at least two times a week and did look unkept. She instructed a CNA to assist the resident in the shower and provide nail care. Observation of Resident #24 on 05/14/25 at 10:39 A.M. revealed the resident in the same clothes as the day before with his nails still long and dirty. The resident had a dark blue sweatshirt with a brown striped shirt underneath. Resident #24 had on plaid blue pajama like pants on and dirty yellow grip socks. Interview on 05/15/25 at 10:29 A.M. with Registered Nurse (RN) #193 confirmed Resident #24 did have long fingernails and was unshaven. She also stated the point of care documentation the CNA's are to do does not reflect an accurate picture of the resident's documented showers, and they were expected to provide signed shower sheets. Review of facility process titled Shower/Tub Bath dated 05/19/25 revealed the facility promoted cleanliness, comfort for the resident, and observe the skin. When the bath was completed, the medical record should be updated with the date and time the bathing occurred. The name and title of person assisting the resident and any skin issues identified be reported to the nurse. These were to be completed two times a week or more per the resident's preference. 4. Review of the medical record for Resident #39 revealed an admission date of 5/22/22 with diagnoses of unspecified dementia with severe anxiety, moderate protein calorie malnutrition, history of falls, palliative care, and hyperlipidemia. Review of Resident #39's care plan dated 02/06/25 revealed the resident required total assistance with activities of daily living and bathing with a severe physical and cognitive decline. Review of the medical record on 05/14/25 at 3:25 P.M. revealed Resident #39 was charted as able to perform bathing on her own, and CNA # 183 documented she was totally dependent on staff. Observation of Resident #39 on 05/12/25 at 11:58 A.M. revealed the resident was in a tilt back chair with a green sweater with dried food on it. Her nails were long and appeared to have dried food or dirt under them. Observation of Resident #39 on 5/13/25 at 9:26 A.M. with CNA #183 confirmed the resident needed washed up and she believed the Hospice aide would come and give her a bath but was not able to say when that occurred. Interview with Regional Director of Nursing #166 on 05/14/25 at 8:16 A.M. revealed there were no paper shower sheets for Resident #39 or any documentation in the medical record to verify showers were completed. She stated the resident was given a bed bath every day by the staff but could not provide documentation. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/14/25 at 9:10 A.M. with Regional Director of Nursing #166 revealed that there was no hospice documentation available to indicate if Resident #39 was provided care by a hospice that may have performed bathing for the resident. Review of facility process titled Shower/Tub Bath dated 05/19/25 revealed the facility promoted cleanliness, comfort for the resident, and observe the skin. When the bath was completed, the medical record should be updated with the date and time the bathing occurred. The name and title of person assisting the resident and any skin issues identified be reported to the nurse. These were to be completed two times a week or more per the resident's preference.

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	05/29/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident #48's medical records revealed an admission date of 01/30/25. Diagnoses included cognitive deficits, schizoaffective and bipolar. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had intact cognition. Review of progress note dated 05/02/25 timed 10:30 P.M. authored by Registered Nurse (RN) #156 revealed Resident #48 had returned from the hospital with diagnoses of aggressive behaviors. No progress note had been authored prior to Resident #48's hospital discharge and no change in condition assessments had been documented. Interview on 05/20/25 at 12:35 P.M. with [NAME] President of Operations (VPO) #172 and Regional Registered Nurse (RRN) #182 revealed if a resident had a change in condition a change in condition assessment should be documented as well as a progress note. Review of Resident #48's medical records with VPO #172 and RRN #182 at time of interview confirmed no documentation regarding Resident #48's hospitalization. 3. Review of Resident #65's medical records revealed an admission date of 03/21/25 and a discharge date of 04/09/25. Diagnoses included convulsions, stoke and traumatic brain injury. Review of MDS assessment dated [DATE] revealed Resident #65 had intact cognition. Review of progress note dated 04/09/25 timed 5:28 A.M. authored by Licensed Practical Nurse (LPN) #144 revealed during med pass at approximately 9:00 P.M. Resident #65's son was present and had ran down the hallway yelling Resident #65 had called him and stated she felt as if she was going to have a seizure. Progress note stated Resident #65 appeared drowsy and Resident #65 appeared to have had a seizure for approximately 30 seconds and Resident #65's son was present. Review of progress note dated 04/09/25 timed 7:22 A.M. authored by LPN #144 revealed blood pressures had been obtained as were 72/55, 62/35, and 54/29 (normal readings are 120/80). Review of progress note dated 04/11/25 timed 6:22 P.M. authored by LPN #202 revealed she had attempted to contact the hospital for an admitting diagnoses. No progress note was authored prior to hospital admission. Interview on 05/14/25 at 7:53 A.M. with LPN #144 revealed she was present the evening of 04/09/25 and stated Resident #65's son had come yelling the hall Resident #65 had a seizure. LPN #144 stated she had immediately went to Resident #65's room and Resident #65 appeared to be drowsy and her blood pressure was low. Review of progress note with LPN #144 confirmed she had documented she had observed Resident #65 having a seizure, however LPN #144 stated she had not actually observed a seizure and stated she had based the information on Resident #65's son and stated she should not have documented information she had not observed. (continued on next page)

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	05/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/25 at 12:35 P.M. with VPO #172 and RRN #182 revealed nursing assessments were to be based on the nurses observations and actual assessment. VPO #172 confirmed LPN #144's progress note had included an observation of Resident #65's seizure and VPO #172 had been informed LPN #144 had stated she had not actually observed Resident #65 have a seizure. VPO #172 stated LPN #144 should not have documented information she had not observed. Review of facility policy titled Change in a Residents' Condition or Status, revised 12/2016 revealed prior to notifying the physician, the nurse will make a detailed observation and gather relevant information. The nurse was also to record information relative to changes in the residents status in the residents medical records. Based on medical record review, interview and facility policy and contract reviews, the facility failed to ensure quality of care and treatment for tube feeding management for Resident #34, and monitoring change in condition for Resident #48 and appropriate care for change in condition and hospitalization for Resident #65. This affected one resident (Resident #34) of one resident reviewed for tube feeding, and two resident (Resident #48 and Resident #65) of five residents reviewed for change in condition. The facility census was 59. Findings include: 1. Review of the medical record for Resident #34 revealed and admission date of 07/29/22. Diagnoses included but were not limited to osteonecrosis, gastrostomy, history of malignant neoplasm of other sites of lip, oral cavity and pharynx and nicotine dependence. Review of the physician order dated 07/29/22 for Resident #34 revealed an order for Nothing by Mouth (NPO) diet, Nothing by mouth (NPO) texture, and Nothing by mouth (NPO) consistency. Review of the physician order dated 07/29/22 for Resident #34 revealed an order to cleanse the enteral tube every night shift with normal saline solution, pat dry and apply a split gauze as needed on night shift. Review of the physician order dated 07/29/22 for Resident #34 revealed an order to monitor the enteral feeding tub each shift for pain, redness or swelling. Review of the physician order dated 07/29/22 for Resident #34 revealed an order each shift to flush the enteral feeding tube with 30 milliliters water before and after medication administration and 5-10 milliliters of water between each medication. Review of the 08/15/22 physician progress noted and order for Resident #34 revealed an order for a bolus of Isosource 1.5 calorie enteral feeding of 250 milliliters (mL) given six times a day to provide 2250 calories due to cancer of the oropharynx. It was noted the need for enteral feeding would not likely be resolved and the necessity of the enteral feeding would be permanent. Review of the physician order dated 11/28/22 for Resident #34 revealed an order to administer a 250 milliliters (mL) bolus of Isosource or Jevity 1.5 via the enteral tube every four hours. (continued on next page)

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	05/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/09/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #34 revealed he had severe cognitive impairment and was independent for activities of daily living. Resident #34 was not noted to have significant weight changes and was using a feeding tube for over 51% of his nutrition needs. Review of the physician order dated 05/06/25 for Resident #34 revealed an order for weekly weights every Tuesday. Review of the medical record for Resident #34 revealed no evidence of physician visit notes other than 08/03/22 admission and a follow up on 08/15/22. Review of the most recent SLP evaluation for Resident #34 completed on 02/27/23 revealed oropharyngeal dysphagia with elevated risk of aspiration due to impaired swallowing. Resident #34 was noted to have continued oropharyngeal dysphagia due to very limited muscle function, anterior loss due to poor labial closure, loss of majority of bolus to the pyriforms due to weak lingual function. Trace stasis on posterior superior pharyngeal wall and soft palate. Post swallow residue in the pharynx that patient must sense as he elicits multiple re-swallows effortfully in attempt to clear with some success. The risk of aspiration was noted to be quite high. Review of the care plan for Resident #34 created on 03/28/23 and last revised on 03/26/25 revealed Resident #34 has an alteration in gastrointestinal status related to PEG tube placement related to diagnosis of history of lips, oral cavity and pharynx cancer. Interventions listed were to avoid foods or beverages that then irritate esophageal lining such as alcohol, chocolate, caffeine, acidic or spicy foods, fried or fatty foods. Review of the care plan for Resident #34 created on 08/18/23 and last revised on 06/06/24 revealed Resident #34 requires a tube feeding due to dysphagia and being NPO. Complicating factors include a history of resident pulling out feeding tube, resistance to having tube replaced. Interventions listed were clean peg tube site every shift and as needed, elevate HOB 30-45 degrees during tube feeding and medication administration and for one hour after feeding. Monitor/document/report as needed any signs/symptoms of infection at tube site. Provide local care to G-tube site as ordered and monitor for signs and symptoms of infection. Review of the care plan dated 10/30/23 with no new revisions prior to the annual survey revealed Resident #34 is non-compliant with tube feeding and NPO diet. Resident #34 will refuse to allow the nurse to administer bolus tube feeding and prefer to do it himself or take it orally. Resident #34 also refuses water flushes and treatments to the PEG site. Interventions listed were to monitor for signs and symptoms of aspiration. Notify the physician when the resident is non-compliant with diet. Provide the diet ordered for the resident for each meal. Review of the care plan for Resident #34 created on 08/16/24 revealed Resident #34 has a nutritional problem or potential nutritional problem related to peg tube related to resident is non-compliant with NPO status. Interventions listed were to administer medications as ordered. Monitor and document for side effects and effectiveness. Explain and reinforce to the resident the importance of maintaining the diet ordered, encourage resident to comply and explain consequences of refusal, obesity, malnutrition risk factors. (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the therapy screening assessments dated 11/13/24 and 02/17/25 for Resident #34 revealed he refused to participate and was noted to continue with the NPO diet orders per hospital orders. Review of the care plan created on 03/26/25 revealed Resident #34 has a swallowing problem related to dysphagia and NPO. Interventions included all staff to be informed of resident's special dietary and safety needs. Monitor for shortness of breath, choking, labored respirations, lung congestion. Monitor/document/report as needed any signs of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing or refusing to eat. Review of the nursing progress notes from 01/01/25 to 05/21/25 revealed almost daily refusals of medication administrations, tube feeding administration and flushes, care of the percutaneous endoscopic gastrostomy (PEG) tube. Review of the 05/25 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #34 revealed some of the administrations were marked as give and some were marked as refusals. Upon further review, the corresponding nursing progress notes for the dates indicated as administered revealed resident refusals, so it was unclear how many times medications, flushes were given, and unclear amounts of tube feeding were given. The order for weekly weights was not listed on the 05/2025 MAR for monitoring or completion. Interview on 05/13/25 at 2:25 P.M. with Licensed Practical Nurse (LPN) #131 revealed Resident #34 refuses administration of his enteral feeding, that he drinks it himself and the physician is aware. LPN #131 stated the nurses take the enteral feeding bottles into his room and Resident #34 consumes it as his leisure and the amount of feeding consumed is unknown. LPN #131 stated she was not aware of a signed medical waiver and is aware Resident #34 is noncompliant with his NPO diet and consumes other foods orally. LPN #131 stated she had reported it to the previous Director of Nursing (DON) about five months ago and the DON stated she was going to work on it and to continue to document his refusals in the progress notes. LPN #131 stated no changes were made by the previous DON and she continued to document each shift of Resident #34's refusals of medications, flushes and enteral feedings. LPN #131 stated there has only been once she has administered Tylenol via the enteral tube due to Resident #34's report of pain, but otherwise he always refuses to allow her to administer his medications or treatments. Interview on 05/13/25 at 3:24 P.M. with LPN #161 revealed she had previously notified Physician #187 about Resident #34's refusals of medications and enteral feeding. LPN #161 stated Physician #187 stated it was better for him to take it orally rather than not at all but was never given an order to allow him to consume it orally. Interview on 05/13/25 at 3:33 P.M. with Regional Director of Clinical Services (RDCS) # 166 revealed she was unaware staff were providing Resident #34's the bottles of enteral feeding to consume them orally and was unaware they were leaving it in the room and not observing him while he consumed it. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 05/13/25 at 3:34 P.M. with Physician #187 revealed if he were made aware of a resident refusing to take his tube feeding, he would have ordered a swallow study due to the history of dysphagia. Physician #187 stated he was aware Resident #34 was consuming the tube feeding orally and had not changed the physician orders to allow for oral consumption for safety reasons as it was still recommended for Resident #34 to be NPO. Physician #187 stated he was not aware of a medical waiver signed by Resident #34. Phone interview on 05/13/25 at 3:41 P.M. with Medical Director #190 stated she did not recall being made aware of Resident #34 consuming his enteral feed orally. Since Medical Director #190 is not his primary physician, she has not seen Resident #34. During the conversation Medical Director #190 gave an order to switch Resident #34 from enteral feeding to oral intake, and stated she was unaware if the previous medical director had given an order for oral consumption of the tube feeding since she had only been the medical director for a few months. Observation on 05/13/25 at 3:48 P.M. of Resident #34's room revealed 13 full unopened eight-ounce bottles of Jevity 1.5 calorie enteral feedings. Observation also revealed an empty pizza box underneath Resident #34's bed. Review of physician order dated 05/13/25 timed at 11:00 P.M. for Resident #34 revealed an order per physician resident can consume enteral nutrition orally each shift for supplement. Observation on 05/14/25 at 11:07 A.M. of LPN #131 attempting to administer enteral tube care and enteral feeding administration revealed Resident #34 was making hand gestures pushing aware and was attempting to speak but was not able to be understood. LPN #131 stated she understood him to state he did not want the flush and was asking why people keep coming in to ask him about his enteral flush. LPN #131 stated Resident #34 stated he did not want to be bothered. Observation on 05/14/25 at 1:28 P.M. with Regional Culinary Director #167 revealed in Resident #34's room a mini refrigerator that had visible mold in the refrigerator, dried spills and stains on the inside as well as outside of the refrigerator. The following items were found inside the refrigerator: -(four) one half cups of chocolate pudding with use by date of 12/2024. -one 10-ounce bag of peanut butter chocolate chips with a use by date of 03/2024 -12 pack of one ounce Baby [NAME] cheese with a use by date of 03/23/23 -(four) eight-ounce containers of Isosource 1.5 with use by date of 09/23/25 Following the observation, Regional Culinary Director # 167 confirmed the above findings and stated since there had been turnover in the dietary department in the past few months, she was unaware Resident #34, who was NPO and should not have had a refrigerator, had a refrigerator in his room and the contents were not being monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/25 at 6:38 A.M. with Registered Nurse (RN) #153 revealed Resident #34 rarely takes medications but will sometimes request Tylenol for pain and allow her to administer it in the enteral tube. Resident #34 refuses to allow staff to flush his peg tube or administer the enteral feeding. Resident #34 will ask for the enteral feeding product but does not want staff to administer it and will ask staff to leave. RN #153 stated she was unsure how much Resident #34 was consuming since he told them to leave. Interview on 05/15/25 at 9:47 A.M. with Director of Rehab #151 revealed since Resident #34 refuses to participate in the therapy services, the NPO order from the hospital still stands. Phone interview on 05/15/25 at 9:14 A.M. with Registered Dietitian (RD) #181 stated Resident #34 is NPO and uses a feeding tube. RD #181 stated she was not aware Resident #34 was refusing his tube feeding nor that he was orally consuming it. RD #181 stated she reviews the nursing progress notes and no staff had made her aware Resident #34 was orally consuming the enteral feeding despite being NPO. RD #181 stated she speaks with the nurses but has not spoken with the resident, only seen him in the hall. RD #131 stated she was unaware Resident #34 had a refrigerator in his room with food in it. RD #131 stated she had not spoken to Resident #34's POA since there were no noted weight changes and had not inquired about signing a medical waiver. RD #131 stated weekly weights were not completed following the order on 05/06/25 and was unsure if there had been a significant weight loss. Phone interview on 05/15/25 at 11:14 A.M. with Physician #187 revealed he was aware Resident #34 was refusing medications and his enteral feeding for quite a few months and was aware Resident #34 was consuming it orally, but the hospital notes showed he was resistant to evaluations. Physician #187 stated Resident #34 has impaired judgement but has not been declared incompetent and Resident #34 has previously responded he does not want to follow instructions. Physician #187 stated he had last seen Resident #34 on 04/24/25 and had not made any order changes. Observation on 05/15/25 at 2:16 P.M. in Resident #34's room revealed Resident #34 laying in bed with his shirt off. Observation of the PEG tube revealed it was red, inflamed and crusty around the insertion site with no visible dressing. Attempt was made to speak with Resident #34, but responses were unable to be understood. Interview on 05/15/25 at 2:26 P.M. with Medical Director #190 revealed she had spoken with Physician #187 and was told Resident #34 had some psychological issues, was a smoker and had cancer surgery. Resident #34 was NPO with a PEG tube following surgery. Resident #34 was non-compliant while in the hospital. Resident #34 was known to drink the enteral feeding orally but should be NPO and encourage enteral feeding with pureed pleasure foods. Physician #187 agreed it was okay to consume the enteral feeding orally as Resident #34 was not following medical recommendations. Resident #34 was not noted to have pneumonia or aspiration for at least six to seven months. Physician # #187 stated Resident #34 was his own person and able to make his own decisions. Medical Director #190 stated the primary physician is responsible to offer a medical waiver and confirmed she had not physically seen Resident #34 prior to giving the order for Resident #34 to consume his enteral feeding orally and stated she spoke with Physician #187 afterwards and Physician #187 agreed with the order to allow Resident #34 to consume his enteral feeding orally. Interview on 05/19/25 at 7:50 A.M. with [NAME] President of Clinical Services (VPCS) #182 confirmed she was unable to provide evidence of physician notes for Resident #32 other than admission visit on 08/03/22 and 08/15/22. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/25 at 12:32 P.M. with [NAME] President of Operations (VPO) confirmed physician ordered weekly weights for Resident #34 were not being completed weekly and refusals were not being documented consistently. Interview on 05/22/25 at 9:58 A.M. with Certified Nursing Assistant #191 revealed Resident #34 frequently refuses care. CNA #191 stated Resident #34 has asked her for bottles of enteral feeding, and she has taken them to him, but she left after giving the bottles to Resident #34 and never observed how much he drank or if he had any difficulties with consuming them. Review of the January 2014 revised facility policy called Enteral Nutrition revealed the physician and the interdisciplinary team will review the rationale for the placement of the feeding tube, the resident's current clinical and nutritional status, and the treatment goals and wishes of the resident. The decision to continue or discontinue between the interdisciplinary team, the physician and the resident. The dietitian will monitor residents who are receiving enteral feedings and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. The nursing staff and physician will monitor the residents for signs of symptoms of inadequate nutrition, altered hydration, hypo or hyperglycemia and altered electrolytes. The nursing staff and physician will also monitor the resident for worsening of conditions that place the resident at risk for the above. Residents receiving enteral nutrition will be periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments will be documented, and changes will be made to the care plan. Input from the resident or legal representative will be included in the assessment.This deficiency represents non-compliance investigated under Complaint Numbers OH00164538, OH00162143, and OH00161946.

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	365355	A. Building B. Wing	05/29/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on medical record review, review of ancillary appointments and interviews, the facility failed to coordinate a follow up vision appointment for Resident #27 as required. This had the potential to affect one resident (Resident #27) of two residents reviewed for vision. Findings include: Review of the medical record for Resident #27 revealed an admission date of 05/01/24. Review of the diagnoses included but were not limited to adjustment disorder, chronic respiratory failure, morbid obesity, dysphagia and depression. Review of the 05/09/25 annual Minimum Data Set (MDS) 3.0 for Resident #27 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. Resident #27 was noted to require moderate assistance from staff for bathing, dressing, and personal hygiene. Resident #27 was noted to have adequate vision and wear corrective lenses. Review of the facility ancillary appointment list revealed Resident #27 had a vision appointment at the facility on 03/03/25 and 04/24/25. Review of the eye doctor visit note dated 03/03/25 for Resident #27 revealed a diagnosis of end stage macular degeneration and an order and an appointment with the retina specialist. Review of the nursing progress note dated 03/03/25 timed at 3:43 P.M. revealed Resident #27 was seen by the eye doctor and eye doctor wanted Resident #27 to be seen for follow up with local retinal specialist in the next one to two weeks. Review of the physician order dated 03/03/25 for Resident #27 revealed an order to refer Resident #27 to local retinal specialist for diagnosis of macular degeneration. Appointment to be scheduled within one to two weeks from 03/04/25. Review of the nursing progress note dated 03/09/25 timed at 6:40 P.M. for Resident #27 revealed there was noted swelling under Resident #27's right and left eye around 5:40 P.M. Resident #27 was observed eating a lot of salty foods with family. The physician was notified and stated to monitor the swelling under residents' eye and to call back it if progresses. Interview on 05/19/25 at 10:41 A.M. with Resident #27 revealed when she saw the eye doctor at the facility, he recommended her to see a retina specialist immediately. Resident #27 stated she has requested the appointment several times, but she has not been seen yet or been told of an upcoming scheduled appointment. Interview on 05/19/25 at 11:44 A.M. with [NAME] President of Clinical Services #182 confirmed she was unable to provide evidence of a scheduled or completed appointment for Resident #27 for the retina specialist as physician ordered on 03/03/25. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 05/22/25 at 11:45 A.M. with Licensed Practical Nurse (LPN) #146 confirmed she entered the physician order for an appointment to be scheduled for a retina specialist for Resident #27 on 03/03/25. LPN #146 stated she gave the order to the unit manager the same day to schedule the appointment and was unsure what happened after that. LPN #146 stated the unit manager no longer works at the facility. Review of the December 2008 revised facility policy titled, Referrals, Social Services, revealed social services would collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. Social services would document the referral in the resident's medical record. Social services would help arrange transportation to outside agencies, clinical appointments, etc., as appropriate.

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	365355	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of Resident #8's medical records revealed an admission date of 02/13/25 with diagnoses including bilateral lower extremity ulcers and pressure ulcer of the left heel. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had intact cognition. Resident #8 required maximum (staff) assistance with bathing and personal hygiene. Review of care plan dated 04/23/25 revealed Resident #8 had a pressure ulcer to the left heel. Interventions included administer treatments as ordered. Review of physician orders for May 2025 revealed Resident #8 was ordered to cleanse left heel with normal saline, apply collagen (wound dressing used to promote healing), cover with an absorbent pad and wrap with gauze daily and as needed. Interview on 05/12/25 at 12:40 P.M. with Wound Nurse Practitioner (WNP) #189 revealed Resident #8 had a pressure ulcer to his left heel that was present on admission. WNP #189 stated she had not seen Resident #8 in approximately three weeks and stated another nurse practitioner had been following him. Observation of wound care with WNP #189 and Licensed Practical Nurse (LPN) #108 at time of interview, revealed LPN #108 had removed Resident #8's sock to his left foot and no dressing or wound care treatments were on. WNP #189 stated Resident #8 was supposed to have had collagen, an absorbent pad and a gauze to the area. Further observation revealed Resident #8's left heel had a large amount of dried crusted debris around the area. WNP #189 stated Resident #8's wound care was to be completed daily and also as needed. Review of the facility policy titled, Prevention of Pressure Ulcers/Injuries, revised July 2017, revealed the facility was to review the resident's care plan and identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The facility was to evaluate, report and document potential changes of the skin and then review the interventions and strategies for effectiveness on an ongoing basis. This deficiency represents non-compliance investigated under Complaint Number OH00164012 and Complaint Number OH00161946. Based on observation, record review, facility policy review and interview, the facility failed to implement an adequate and effective pressure ulcer prevention program to promote healing and ensure Resident #39 and Resident #51, both of whom were cognitively impaired, dependent on staff for activities of daily living and incontinent of bowel and bladder, received timely and necessary pressure ulcer prevention care and treatment. The facility also failed to provide wound care as ordered for Resident #8. This affected three residents (#8, #39 and #51) of seven residents reviewed for pressure ulcers. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Actual Harm for Resident #51 occurred on 04/23/25 when nursing staff identified a pressure wound (no staging was identified) on Resident #51's buttocks which was noted to occur from prolonged sitting in his chair without adequate repositioning and then failed to implement effective interventions and provide timely and necessary treatment to prevent further deterioration of the wound to a Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer. Actual Harm for Resident #39 occurred on 05/05/25 after nursing staff failed to perform a weekly skin assessment to identify and implement effective interventions to prevent a compromised area on Resident #39's coccyx area from deteriorating to an Unstageable (full-thickness tissue loss with the base of the ulcer covered by slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) in the wound bed) pressure ulcer. The ulcer was subsequently classified as a Stage III pressure ulcer. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy (seizures), cognitive communication deficit, need for assistance with personal care and history of encephalitis (inflammation of the brain). Review of the care plan dated 05/07/24 (and last updated on 04/29/25) for Resident #51 revealed the resident had the potential for skin impairment related to self-care deficit and bladder and bowel incontinence. There was no mention of the resident having a Stage III pressure ulcer that was facility acquired on 04/23/25. Interventions to prevent skin breakdown included to encourage turning and repositioning with rounds, use house barrier cream with each incontinence episode, pressure reduction cushion to the wheelchair, pressure reduction mattress to the bed (dated 04/18/24), encourage to float heels as tolerated and Prevalon boots to bilateral heels while in bed (03/11/25). The last intervention added to the care plan was on 04/29/25 for an albumin level (laboratory testing) to be obtained when clinically indicated. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 had severely impaired cognition. The assessment revealed the resident was dependent on staff for activities of daily living including rolling left to right in bed, transfers, and toileting. The MDS assessment revealed the resident had no pressure ulcers. Review of the MDS 3.0 assessment dated [DATE], for discharge return anticipated, revealed Resident #51 had one pressure ulcer Stage III that was present on previous admission or entry to the facility. Review of the Braden Scale (tool used to assess a resident's risk of developing pressure ulcers), dated 03/31/25 revealed Resident #51 was at high risk for developing pressure ulcers. Review of the nursing progress note dated 04/23/25 at 1:17 P.M. revealed a pressure wound was on Resident #51's buttocks. Licensed Practical Nurse (LPN) #114 stated she believed it may have resulted from prolonged sitting in his chair without adequate repositioning. She stated she updated the physician and received an order for Triad Wound Paste to be applied to the buttocks. LPN #114 stated she would be ordering a donut cushion to enhance comfort and reduce pressure while the resident was seated. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the weekly wound observation tool dated 04/23/25 for Resident #51 revealed the resident had a Stage I (non-open superficial reddening of the skin that may appear red, blue or purple which does not turn white when pressed on) pressure ulcer to the gluteal region and it was worsening. It was noted to measure 2. 0 centimeters (cm) in length by (x) 2.5 cm in width with no depth. Review of the physician order dated 04/23/25 revealed an order to clean the buttocks with normal saline and apply Triad Cream daily. Review of the nursing progress note dated 04/28/25 at 2:38 P.M. by Registered Nurse (RN) #175, who was also the previous Director of Nursing (DON), revealed the area (unknown area) was assessed by the wound care practitioner on 04/28/25 and was classified as moisture associated skin damage (MASD). Review of the wound care practitioner's progress note dated 04/28/25 at 8:32 A.M. revealed she had seen Resident #51's right lateral ankle Stage III pressure. However, there was no assessment for the pressure ulcer to the resident's buttocks at this time. Review of the weekly wound observation tool dated 04/28/25 revealed the resident's buttocks was not assessed. Review of the nursing progress note dated 04/28/25 at 2:48 P.M. by RN #175, revealed Resident #51 was seen by the wound care practitioner on 04/28/25 and an area was noted to be MASD. The location of the are was not noted. The nursing progress note stated therapy was made aware for a pressure reducing assistive device, all parties were made aware, an order for albumin level was ordered and air mattress was in place. The same progress note was again made on 04/29/25 at 2:50 P.M. Review of the physician order dated 05/01/25 for Resident #51 revealed an order to recommend the resident was in a chair two to three hours max at a time, can tilt all the way back to offload weight from sacrum. Review of the weekly skin assessment dated [DATE] revealed Resident #51 had a Stage I pressure ulcer to the sacrum that measured 2 cm x 2.2 cm x 0 cm. Review of the weekly wound observation tool dated 05/05/25 revealed Resident #51 had a Stage III pressure ulcer to his right upper buttocks that was acquired on 05/05/25 and this was the first observation of the area. It was noted to have moderate drainage and measure 3.5 cm x 2.7 cm x 0.3 cm. Review of the wound care practitioner's progress note dated 05/05/25 revealed Resident #51 was seen for a new open area on the right buttock. Wound Nurse Practitioner #189 noted the resident had a Stage III pressure ulcer that was acquired in-house. It measured 3.5 cm x 2.7 x 0.3 cm. There was moderate drainage and had 80 percent (%) granulation tissue with 10% slough and 10% pink tissue. She provided a new order to clean the area with normal saline, apply medi-honey and calcium alginate (type of wound treatment) and cover with clean and dry dressing every day and as needed starting on 05/06/25. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #51 was at risk for developing pressure ulcers and had one or more pressure ulcers. The assessment reflected the resident had two pressure ulcers that were Stage III with one of them being present on admission or reentry. (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 05/13/25 at 10:57 A.M. of wound care to Resident #51 by the DON and RN #193 revealed Resident #51 did not have a dressing on his right buttock. The DON verified the dressing was not in place as ordered. The area to the right buttock measured 3 cm x 3 cm x 0.1 cm. Interview on 05/19/25 at 11:35 A.M. with the DON verified Resident #51's pressure ulcer to his buttocks was not properly assessed and treated since the pressure ulcer had been discovered on 04/23/25 until the wound nurse saw it on 05/05/25 (the area was the same and not new on 05/05/25). She verified Wound Nurse Practitioner #189 had not assessed the area to his buttocks until 05/05/25 and the nursing progress note on 04/28/25 and 04/29/25 were incorrect stating he had seen the wound nurse and the skin impairment was MASD. Attempted interview on 05/19/25 at 11:45 A.M. with Wound Nurse Practitioner #189 was unsuccessful. No return contact was made. Interview on 05/19/25 at 11:35 A.M. with the DON verified Resident #51's care plan was not updated related to the pressure ulcer to his buttocks nor were new interventions added. Observation on 05/19/25 at 12:50 P.M. of Resident #51 revealed he was in bed but did not have heel boots on as ordered. Licensed Practical Nurse (LPN) #106 verified staff had not placed his heel boots on when he was assisted to bed and the heel boots were on a stand next to the bed. Observation on 05/20/25 at 7:30 A.M. of Resident #51 revealed the resident's air mattress was alarming and alerting staff that it was not working correctly. The resident also did not have on his heel boots. On 05/20/25 at 8:14 A.M., the air mattress was still alarming. On 05/20/25 at 9:30 A.M. Resident #51's air mattress was still alarming and was noted to not be fully inflated. Registered Nurse (RN) #186 verified the resident's heel boots were not on and the air mattress was not functioning correctly. Interview on 05/20/25 at 12:08 P.M. with LPN #114 revealed she was the nurse who originally saw Resident #51's pressure ulcer to his buttocks. She stated she updated the DON, physician and Resident #51's mother related to the new open area. She stated she determined the open area was from the resident sitting for prolonged periods without being repositioned. Review of the facility policy titled, Prevention of Pressure Ulcers/Injuries, revised July 2017, revealed the facility was to review the resident's care plan and identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The facility was to evaluate, report and document potential changes of the skin and then review the interventions and strategies for effectiveness on an ongoing basis.2. Review of Resident # 39's medical record revealed an admission date of 05/26/22 with diagnoses including unspecified dementia with severe anxiety, moderate protein - calorie malnutrition, adult failure to thrive, and palliative care. Review of Resident #39's Hospice Care Plan dated 08/14/23 revealed an air mattress was ordered to be placed on Resident #39's bed for pressure ulcer prevention. Review of the facility care plan dated 04/23/25 revealed the plan of care did not include an air mattress for pressure ulcer intervention. Review of Resident #39's Braden Scale dated 04/11/25 revealed the resident was at very high risk for pressure ulcer development. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #39's weekly wound assessment dated [DATE] revealed there were no skin issues identified. The weekly wound assessment due on 04/25/25 was not completed. Review of Resident #39's care plan dated 04/23/25 revealed the resident was at risk for skin breakdown with an intervention for nursing as well as Hospice to visit and provide care, assistance, and evaluation. Review of Resident # 39's Hospice observation note dated 04/28/25 (for comprehensive assessment) by the RN revealed the resident's skin was intact. Review of Resident #39's progress note dated 04/29/25 revealed the nurse identified an area on the resident's sacrum documented as an in-facility acquired area. This was the first observation of the area, noting it was dry with no drainage, no odor, and measured 0.2 cm x 0.1 cm x 0 cm with no inflammation. The progress note did not identify what kind of wound it was. Treatment was noted to cleanse with normal saline and apply Triad Cream. There was no indication Resident #39's family was notified of the area identified. Review of Resident #39's weekly skin assessment dated [DATE] revealed the resident's skin was intact with no new or active pressure areas (However, this appeared to be inaccurate based on the 04/29/25 progress note). Review of Resident #39's Braden Scale dated 04/30/25 revealed Resident #39 was at a moderate risk for pressure ulcer development. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #39 had dementia, with anxiety, and was always incontinent with bowel and bladder. Resident #39 was totally dependent on staff for toileting hygiene, rolling and transfers. Resident #39 was at risk for developing pressure ulcers and no pressure ulcers were noted on the assessment. Review of Resident #39's Wound Nurse Practitioner (NP) initial assessment dated [DATE] revealed the resident had a Deep Tissue Pressure Injury (DTI) on the sacrum measuring 5.3 cm x 3.0 cm with an undetermined depth. The NP recommended a pressure reducing mattress and treatment for the injury. There was no evidence in Resident #39's medical record the pressure reducing mattress was implemented. Review of Wound Nurse Practitioner assessment dated [DATE] revealed Resident #39's wound was a Stage III pressure ulcer on the coccyx (contradicting the sacrum location on 05/05/25) with decreased size of 3.7 cm x 4 cm x 0.2 cm, clustered wound, base/tissue was 70% granulation tissue and 30% scabbed and crusted of the wound. The treatment was to clean with normal saline, pat dry, apply Triad, with a clean dry dressing. Review of a Hospice Nurse assessment dated [DATE] revealed the resident was observed in a Broda chair, pleasant, but confused, and skin was intact. Review of weekly skin assessment dated [DATE], completed by LPN #114, revealed an observation of a coccyx pressure ulcer which assessed the ulcer as being an unstageable wound with measurements of 5.1 cm x 3.5 cm with no depth. The treatment remained the same. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 05/13/25 at 10:25 A.M. of Resident #39's coccyx area with LPN #114 revealed the resident did not have a dressing on her coccyx with no visible cream or ointment on the coccyx area at that time. The resident was not observed on a pressure reducing mattress. Review of Resident #39's medical record on 05/13/25 at 11:00 A.M. with LPN #114 revealed the wound treatment was documented as being completed and LPN # 114 verified she had not done the dressing but had signed it off as completed. A telephone interview on 05/15/25 at 10:58 A.M. with LPN #114 who completed the initial observation of Resident #39's pressure injury on 04/29/25 and the weekly skin assessment on 04/30/25 revealed LPN # 114 notified Resident #39's doctor of the pressure ulcer injury and tried a phone number for the Hospice company but stated that the phone number was not working. She stated she was instructed to give a guesstimate of the size of the wound by the previous Director of Nursing. LPN # 114's revealed the assessment of the wound on 04/29/25 was pink and non-blanchable, and the assessment dated [DATE] documented as skin intact was an error. LPN # 114 revealed she had not had any interaction or report given to the Hospice Nurse on 05/12/25 when the Hospice Nurse assessment indicated Resident #39's skin was intact when there was a Stage III pressure ulcer. A telephone interview on 05/15/25 at 11:12 A.M. with Hospice Registered Nurse #186 regarding her assessment of Resident #39 skin documentation dated 05/12/25 revealed Resident #39 was in her chair and the resident's skin was not assessed. Hospice RN #186 stated she was unaware the resident had a pressure ulcer. A telephone interview on 05/15/25 at 11:30 A.M. with Certified Nurse Practitioner (CNP) Wound Nurse #191 revealed Resident #39 was first assessed for a pressure wound on 05/05/25 as an unstageable deep tissue injury (DTI) area, and each time the resident was assessed, the resident was found without treatments in place. CNP Wound Nurse #191 revealed on 05/12/25 the resident's wound was observed as a Stage III pressure area that was opened with granulated tissue visible. CNP Wound Nurse #191 revealed she was unaware that Resident #39 was receiving hospice care. Interview on 05/14/25 at 2:25 P.M. with Regional Director of Clinical Services #166 revealed Resident #39 should have had an air mattress placed on the bed as soon as a skin issue was observed and it was not in place as it should be. A telephone interview with Hospice Registered Nurse #177 on 05/15/25 at 11:12 A.M. revealed Resident #39 was to have an air mattress on her bed according to the hospice care plan. Observation on 05/15/25 at 12:35 P.M. of Resident #39 with Regional Director of Clinical Services #166 revealed the air mattress was not in place but it was on the Hospice care plan dated 08/14/23 to be a preventive measure for pressure injuries. Interview on 05/19/25 at 1:25 P.M. with [NAME] President (VP) of Operations #172 verified Resident#39's wound assessment by CNP Wound Nurse #191 on 05/12/25 revealed the pressure area was a Stage III pressure area and was opened and Resident #39's weekly wound assessment dated [DATE] noted Resident #39 had an unstageable pressure area with measurements of 5.3 cm x 3.1 cm with undetermined depth. VP of Operations #172 could not identify what contributed to Resident #39's wound deterioration from a Stage III to an unstageable pressure ulcer. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The review of the facility undated policy titled, Pressure Injury Prevention and Management, revealed the facility was committed to the prevention of pressure areas and develop evidence-based interventions for the prevention would include communication with disciplines that provide care and interventions for the residents. Interventions would include repositioning, relieving pressure devices as ordered, preventative skin orders, and treatments timely with notification to all parties involved in the resident's care.

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	365355	A. Building B. Wing	05/29/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 4. Review of Resident #60's medical records revealed an admission date of 01/21/25. Diagnoses included dementia, muscle weakness and need for personal care assistance. Review of care plan dated 04/23/25 revealed Resident #60 resided on the secured unit related to decreased safety awareness. Resident #60 was a smoker. Interventions included instruct resident on the facility policy on smoking and notify charge nurse if it is suspected resident had violated smoking policy and Resident #60 required supervision while smoking. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had intact cognition. Review of smoking assessment dated [DATE] revealed Resident #60 was safe to smoke with supervision. Review of progress note dated 04/30/25 timed 12:24 P.M. authored by Licensed Practical Nurse (LPN) #108 revealed Resident #60 had been suspected of smoking in his room. Observation on 05/15/25 at 8:24 A.M. revealed a strong odor of cigarette smoking outside of Resident #60's room. At time of observation Resident #60 was observed to have been exiting his room. Upon entering Resident #60's room the odor of cigarettes had been stronger and a cloud of smoke was observed in the room. Further observation revealed Resident #60's toilet had ashes inside. At time of observation Certified Nursing Assistant (CNA) #109 stated she had observed the odor of cigarettes in the hallway outside of Resident #60's room and stated she had informed the Unit Manager (UM) #200. At 8:38 A.M. UM #200 and LPN #193 entered Resident #60's room and had begun to search for smoking materials and Resident #60 had denied he had smoked in his room. At 8:44 A.M. Regional Registered Nurse (RRN) #166 had entered Resident #60's room and had begun to search Resident #60 and a lighter was found by RRN #166. RRN #166 stated residents were not permitted to have smoking materials on them and staff was to collect any materials after smoke breaks. 5. Review of Resident #53's medical record revealed an admission date of 01/24/24 and diagnoses including type two diabetes, morbid obesity, non-pressure chronic ulcer of left heel and midfoot, arthritis and atrial fibrillation. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 was cognitively intact, required staff set-up for activities of daily living and did not reject care. Review of Resident #53's physician's orders as of 05/14/25 revealed an order dated 10/13/24 for leave of absence (LOA) without supervision every 24 hours as needed for LOA. Review of a progress note dated 05/01/25 at 6:19 P.M. and authored by Licensed Practical Nurse (LPN) #131 revealed Resident #53 was compliant with taking evening medications. No mood or behaviors were witnessed by or reported to this nurse. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 05/02/25 at 2:34 A.M. and authored by Registered Nurse (RN) #105 revealed Resident #53 went to LOA, he did not return, nurse tried to contact him by phone no answer, the facility checked two other contacts and they didn't know where he went. Review of a progress note dated 05/02/25 at 3:35 A.M. and authored by RN #105 revealed police called and let the facility know Resident #53 went to the hospital and they were keeping him, nurse would call for follow up. Review of a progress note dated 05/02/25 at 3:18 P.M. and authored by RN #171 revealed this nurse spoke with the Cleveland Clinic Staff at the Euclid Hospital Campus. Staff stated to this nurse, the resident was seen here in the emergency department at this campus last night, but the resident has not been admitted and here that person is no longer here at this campus. Resident #53 had not returned to the facility at this time. Nursing staff aware. Review of a progress note dated 05/02/25 at 9:52 P.M. revealed Resident #53 returned to the facility at 9:50 P.M. Review of the second floor LOA book revealed on 05/01/25, Resident #53 left at 2:30 P.M., did not mark a return date or time but double lines were drawn and a line was placed in the signature column on the form. Continued review of the LOA book revealed on 05/02/25, double lines were drawn instead of a time and Resident #53 was documented as returning at 9:00 P.M. and had the resident's signature. The LOA book did not indicate any expected time of return for Resident #53 for any date documented. Interview on 05/14/25 at 10:26 A.M. with LPN #131 revealed Resident #53 had an order for LOA so was allowed to sign himself out in the LOA book on the second floor. LPN #131 stated residents were supposed to write down the time they expected to come back, which Resident #53 did not do. If staff were not at the nurses' station where the LOA book was located at when he left staff were to look for Resident #53 and see if his car was gone. LPN #13 stated if residents put an expected time on the LOA log and that time passed, staff were to call the resident to determine their whereabouts. Interview on 05/14/25 at 11:22 A.M. with Regional Director of Operations (RDO) #196 revealed nursing staff were supposed to check the LOA books but would not provide a set time frame for how often staff were to check the LOA books. During the interview, RDO #196 was shown Resident #53's LOA logs where expected return dates/times were not provided which went against the facility's LOA policy but showed that Resident #53 came back to the facility on or before midnight most nights. Follow-up interview on 05/14/25 at 11:53 A.M. with RDO #196 and [NAME] President of Operations (VPO) #172 revealed Resident #53 refused to write his expected time of return as in the past, staff called his brother when he did not return to the facility and he did not like that. RDO #196 and VPO #172 stated staff were to contact a resident out on LOA prior to the midnight census, then the Director of Nursing (DON) would be text-messaged, which would drive the next steps to be taken. RDO #196 and VPO #172 did not provide more information regarding Resident #53's LOA and unknown whereabouts on 05/01/25 during the interview. Interview on 05/14/25 at 12:43 P.M. with Certified Nursing Assistant (CNA) #137 revealed he never saw Resident #53 leave or sign out. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/14/25 at 1:03 P.M. with RN #171 revealed she was aware of Resident #53's hospitalization on 05/01/25 as the police had called the facility to let them know. RN #171 stated Resident #53 was allowed to come and go but had to be back to the facility by 12:00 A.M. RN #171 stated she had worked on 05/01/25 from 8:00 A.M. to 4:00 P.M. and was not aware Resident #53 had been gone as they did not check the LOA books until the morning when it would be discussed at the stand-up meeting. RN #171 stated Resident #53 would often not tell staff were he was going or how long he would be gone for his LOA. RN #171 stated on 05/02/25 she had called several hospitals to see where Resident #53 was at to try to find out where he went and stated overall the DON or on-call nurse should have been contacted regarding this issue. Interview was attempted with RN #105 on 05/14/25 at 1:13 P.M. but was not successful. Review of the facility policy, Signing Residents Out, revised August 2006 revealed a sign out register is located at each nurses' station. Registers must indicate the resident's expected time of return. The policy did not address when staff were to reach out to residents to determine their whearabouts following a LOA without returning to the facility. This deficiency represents noncompliance investigated under Complaint Number OH00161946. 3. Review of the medical record for Resident #25 revealed an admission date of 10/04/23. Diagnoses included but were not limited to unspecified dementia with behaviors, morbid obesity, hypertensive chronic kidney disease, nicotine dependence and delusional disorders. Review of the 10/17/23 care plan which was last updated on 04/18/25 for Resident #25 revealed Resident #25 was a current smoker in the facility. On 07/01/24, it was noted Resident #25 was to have gone against building smoking policy a few times. Interventions included Resident will use smoking materials safely and smoke safely in designated areas which were initiated on 04/18/25. Interventions listed were to complete smoking evaluation per facility guidelines and resident will follow facility smoking policy. Review of the 01/16/25 smoking safety assessment for Resident #25 revealed cognitive loss, resident able to light cigarette, requires facility to store lighter and cigarettes and required supervision while smoking. Review of the 04/09/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #25 revealed severe cognitive impairment. Resident #25 was noted to require set up for activities of daily living. Observation on 05/12/25 at 1:28 P.M. revealed Resident #25 riding in the facility elevator. Resident #25 was observed to reach inside her shirt into her bra pulling out a cigarette. Interview at the time of the observation with Resident #25 when asked if she was supposed to have cigarettes in her possession revealed Resident #25 stated, yes, I paid for them. Resident #25 was then observed exiting the elevator near the receptionist office and went directly out to the smoking patio. At the receptionist area, Activities Director #132 was observed handing out cigarettes to residents and telling them to wait to go out to the smoking area, but residents were observed obtaining their smoking items, leaving and going out to the smoking area without supervision. Six residents were observed out on the smoking patio with no staff supervision. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 05/12/25 at 1:40 P.M. with Regional Director of Clinical Services (RDCS) #166 confirmed six residents were out on the smoking patio without staff supervision. RDCS #166 confirmed Resident #25 was observed out on the smoking patio with a pack of cigarettes in her bra and a lighter in her possession. Additional residents identified out on the smoking patio unsupervised were Residents #3, #6, #7, #8, #25 and #35. Review of the current smoking safety assessments for Residents #3, #6, #7, #8, #25 and #35 revealed all of them required supervision for smoking. Interview on 05/12/25 at 4:28 P.M. with Activities Director #132 confirmed the smoking items are kept in a locked box inside a locked cabinet in the reception area. Activities Director #132 confirmed residents line up in the hallway and are to wait until a staff member is present to take them to the smoking area and light their cigarettes. Activities Director #132 also confirmed while passing out cigarettes this afternoon, residents were taking their cigarettes and going out to the smoking area and were using each other to light cigarettes without staff supervision. Review of the December 2016 revised facility policy called; Smoking Policy-Residents revealed any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Residents are not permitted to keep cigarettes, pipes, tobacco and other smoking articles in their possession. Based on observation, record review, interview, and policy review, the facility failed to ensure Resident #21 and Resident #24's had interventions in place to prevent falls, safe smoking practices were in place for supervised smokers, and proper measures were taken to ensure Resident #53's safety on leave of absences. This affected 10 residents (#3, #6, #7, #8, #21, #24, #25, #35, #53, and #60) of 19 residents reviewed for accidents. The census was 59. Actual harm occurred on 04/29/25 when Resident #21, who was identified to have poor safety awareness in a motorized wheelchair (which had been provided by therapy) and had a history of falls between 03/05/25 and 04/28/25 from the motorized wheelchair, sustained a fall resulting in increased pain and transfer to the emergency room for evaluation. The resident was diagnosed with a closed fracture of the fibula as a result of the fall. Prior to the fall with fracture, the facility failed to properly/adequately assess the resident's safe use of the motorized wheelchair and failed to implement effective and individualized interventions to decrease the resident's risk of falls with injury. Findings include: 1. Review of Resident #21's medical record revealed an admission date of 06/25/25 with diagnoses of post traumatic seizure, acute respiratory failure, type two diabetes, unspecified asthma, repeated falls, and need for assistance for personal care. Review of the fall records for Resident #21 revealed the resident had been given a motorized wheelchair on 02/15/25 from the therapy department. There was no safety screen documented at the time of the resident receiving the chair. Review of Resident #21's falls since 02/15/25 revealed six of Resident #21's eight falls occurred from the motorized wheelchair without evidence of effective and/or individualized interventions being implemented to address the resident's safety in the wheelchair. This included falls on 03/05/25, 03/19/25, 04/08/25, 04/13/25, 04/28/25, and 04/29/25. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #21's Therapy Screen sheets dated 03/05/25 revealed the resident had poor safety awareness. The therapy evaluation and treatment plan for 03/05/25 to 04/04/25 included a goal to increase strength and stability during gait and transfers. The resident had poor balance with standing and reaching. The therapy screen did not include a treatment plan to include the resident's motorized wheelchair. Review of Resident #21's care plan dated 03/25/25 revealed the resident had numerous falls with multiple interventions listed. However, the care plan was not updated since 03/25/25 and did not include the motorized wheelchair or interventions specific to the resident's care needs and/or safety/fall risk related to the use of the motorized wheelchair. Review of a therapy screen sheet dated 04/13/25 revealed Resident #21 had poor safety awareness in wheelchair; however, there was no evidence Resident #21's safety using the motorized wheelchair was assessed/evaluated or had any type of interventions/treatment associated with it. Review of Resident #21's progress note dated 04/29/25 at 2:17 P.M. revealed the resident was observed in front of his bed on the floor with complaint of leg pain. The doctor was called and ordered to transport to the emergency room for an x-ray. Review of Resident #21's hospital record dated 04/29/25 revealed the resident had a fall from a wheelchair and was diagnosed with close fracture of the left fibula on the distal end that did not require surgery. The resident was released with a walking boot for the closed fracture and was to follow-up with orthopedics on 05/15/25 at 10:00 A.M. Review of Resident #21's progress note dated 04/29/25 at 8:59 P.M. revealed the resident returned from the emergency room with a walking boot on the right foot with a diagnosis of closed fracture of the distal end of the fibula. The resident was encouraged to keep his chair in a locked position when transferring and to have his room moved closer to the nurses' station. The residents' room was at the end of the hall. Observation on 05/12/25 at 10:44 A.M. of Resident #21 revealed the resident had a walking brace on his left lower leg and a wheelchair in front of him. The resident had a motorized wheelchair in the corner of the room with no batteries on it to use. Resident #21 stated that he had fallen from the chair and his finger got stuck on the power button and he ran over his leg with the chair and the facility took the chair away. Interview on 05/13/25 at 3:25 P.M. with Regional Director of Clinical Services #166 confirmed the plan of care for Resident #21 was not updated with fall/safety interventions related to the use of a motorized wheelchair or following falls from the motorized wheelchair. Interview on 05/19/25 at 12:49 P.M. with Therapy Director #106 revealed Resident #21 was on therapy case load regularly and they worked on cognition and the resident's balance (which was poor). The director revealed Resident #21 had poor wheelchair safety and verified the resident was not assessed to use the motoroized wheelchair safely when a change was identified on 04/13/25. (continued on next page)

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	05/29/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/21/25 at 8:00 A.M. with [NAME] President (VP) of Operations #172 revealed Resident #21 declined to move his room after the fall on 04/29/25 and confirmed the facility did not assess Resident #21 for motorized wheelchair safety before the fall with fracture on 04/29/25. VP of Operations #172 confirmed the resident had numerous falls from the motorized wheelchair without preventive (individualized and effective) interventions in place. A review of the facility undated policy titled, Fall intervention and Management Program revealed all residents were to be screened for fall risk and interventions put in place as needed. All falls were to be reviewed by the interdisciplinary team and intervention suggestions made with the best interest and safety of the resident. 2. Review of the medical record for Resident #24 revealed an admission date of 01/08/21 with diagnoses that include chronic congestive heart failure type 2 diabetes, severe protein- calorie malnutrition, frequent falls, dementia. Review of Resident #24's care plan dated 04/23/25 revealed the resident was at risk for falls related to decreased cognition, weakness and malnutrition and a perimeter mattress was ordered on 01/15/21 and added again on 04/23/25 for a fall intervention. Observation of Resident #24 on 05/12/25 at 11:00 P.M. revealed a frail man with loose fitting clothes and his breakfast in front of him untouched. There was a sign on the bathroom door stating to call for assistance posted. There were no other fall interventions visible. Observation on 05/15/25 at 11:17 A.M. with Regional Nurse #166 revealed Resident #24 did not have a perimeter mattress in place. Interview with Regional Nurse #166 at the time of the observation confirmed Resident #24's care plan had a perimeter mattress as an intervention from a fall on 4/23/25 and verified it was to be put in place on 01/15/21 as an intervention. A review of the facility undated policy titled, Fall Intervention and Management Program revealed all residents were to be screened for fall risk and interventions put in place as needed. All falls were to be reviewed by the interdisciplinary team and intervention suggestions made with the best interest and safety of the resident.

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	365355	A. Building B. Wing	05/29/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure adequate catheter care and positioning of a urinary catheter bag. This affected one resident (#9) of one observed for catheter care. The facility census was 59. Findings include: Review of Resident #9's medical records revealed an admission date of 04/09/25. Diagnoses included neuromuscular bladder, infection related to indwelling urethral catheter and need for personal care assistance. Review of care plan dated 04/14/25 revealed Resident #9 had an indwelling urinary catheter. Interventions included monitor for signs and symptoms urinary tract infection that included cloudiness, foul smelling urine and deepening of urine color. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had impaired cognition. Resident #9 had a indwelling urinary catheter and required maximum assistance with toileting. Review of physician orders for May 2025 for Resident #9 revealed to provide catheter care every shift and as needed. Observation on 05/12/25 at 10:08 A.M. revealed Resident #9 was in a wheelchair in his room and appeared to be sleeping. Resident #9's urinary catheter bag was observed in Resident #9's lap and a had a large amount of thick sediment in the tubing. Observation on 05/14/25 at 7:49 A.M. revealed Resident #9 was sleeping in bed and the urinary catheter bag was observed on the floor under Resident #9's bed. Observation on 05/14/25 at 9:56 A.M. revealed Resident #9's urinary catheter remained on the floor. Interview with Resident #9 at time of observation revealed staff had not provided him with care as of yet and Resident #9 was unable to state when he had last received care. Observation on 05/14/25 at 10:00 A.M. with Certified Nursing Assistant (CNA) #109 confirmed Resident #9's catheter bag was on the floor and had a large amount of thick sediment in the tubing CNA #109 stated she had not provided Resident #9 with care since the start of her shift at 7:00 A.M. and stated urinary catheter bag should not be placed on the floor. Further observation of catheter care with CNA #109 for Resident #9 revealed catheter insertion site and tubing had black dried debris around it. CNA #109 stated she was unable to state when Resident #9 had last received catheter care and stated catheter care should be done at least every shift. Review of facility policy titled Catheter Care, Urinary revised 09/14 revealed urinary catheter bags were to be positioned lower than the level of the bladder and drainage bags were to be kept off the floor.

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	365355	A. Building B. Wing	05/29/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview, observation and record reviews, the facility failed to implement nutritional intervention to address a significant weight change for Resident #62. This affected one resident (Resident #62) of one reviewed for nutrition. Facility census was 59. Findings include: Review of Resident #62's hospital admission record dated 02/11/25 revealed a weight of 178 pounds (lbs.). Review of the medical record for Resident #62 revealed an admission date of 02/26/25 with diagnosis of Alzheimer's disease, diabetes mellitus type two, bipolar disorder. Review of Resident #62's care plan dated 03/04/25 revealed that resident was at risk for malnutrition. Interventions included monitor weights and notify of any significant changes. Review of the Minimum Data Set (MDS) assessment for Resident #62 dated 03/05/25 revealed the resident had impaired cognition. Resident #62 required set-up assistance for eating. Review of Resident #62 weights obtained at the facility revealed the following: 02/26/25 at 178.0 lbs., 03/07/25 at 178.1 lbs., 03/27/25 at 145.2 lbs. (18.43 percent weight loss in 30 days), 03/31/25 at 145.6 lbs., and 04/07/25 at 146 lbs. Review of Resident #62's medical record revealed no evidence the resident's physician was notified of the resident's significant weight loss. Review of current physician's orders for Resident #62 revealed an order for weekly weights beginning on 03/26/25 times four weeks. Review of progress note dated 04/01/25 for Resident #62 authored by Registered Dietician (RD) #181 revealed a significant weight loss was identified with the accuracy of the weights being questioned by the RD. The note further indicated the resident's current diet was a regular diet, regular texture and thin liquid consistency with 100% of diet consumed at mealtimes. RD #181 recommended continuing weekly monitoring of weights. Interview on 05/14/25 at 8:20 A.M. with Certified Nursing Assistant (CNA) #109 revealed Resident #62 usually ate 75% of meals and required set-up assistance with cueing to remain on task due to cognitive impairment. CNA #109 further stated weights are obtained by the CNAs and required weekly weights were communicated to them by the nurse on the unit. Observation of Resident #62 on 05/14/25 at 8:40 A.M. revealed the resident was eating breakfast. Resident #62 consumed approximately 90% of her meal. Resident #62 made no additional requests for alternative food and voiced no complaint about the meal served. Interview on 05/15/25 at 8:27 A.M. with CNA #109 revealed she had obtained Resident #62's weight which was 141 lbs. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/25 at 09:08 A.M. with RD #181 revealed she did not believe that Resident #62's original weight was accurate and was eating 100% of her meals. Review of facility policy titled Weight Assessment and Intervention dated 01/10/23 revealed that the physician and the multidisciplinary team will identify weight loss or increasing the risk of weight loss. Individualized care plans shall address identified causes of weight loss, goals and benchmarks for improvement and time frames with parameters for monitoring and reassessment.

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	365355	A. Building B. Wing	05/29/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, interview, and facility policy, the facility failed to ensure Resident #165's respiratory status was properly monitored and oxygen was administered per physician orders. This affected one resident (Resident #165) of two residents reviewed for respiratory services. Findings include: Review of Resident #165's medical record revealed and admission date of 04/03/25 with diagnoses including unspecified injury to cervical spine, quadriplegia C1-C4, tracheostomy, major depressive disorder. Review of Resident #165's physician admission orders revealed oxygen at two liters humidified air via trach mask to maintain oxygen level equal or greater than 92%., suction every shift and as needed, change trach inner canula monthly and as needed. Review of Resident #165 medical record dated 04/03/25 to 05/13/25 revealed the oxygen order and suction order were not transcribed on the medical record to document when completed and monitored. Review of Resident #165's vitals record revealed there was limited oxygen readings documented in the medical record. Interview on 05/20/25 at 1:53 P.M. with Registered Nurse #186 confirmed there were no oxygen orders or suction orders for Resident #165. Interview on 05/20/25 at 12:45 P.M. with [NAME] President of Clinical Services #182 confirmed the medical record was not correct and the orders were not transcribed resulting in limited documentation of the respiratory condition of Resident #165. Review of the facility policy titled, Pulse Oximetry (Assessing Oxygen Saturation), undated, revealed the purpose of monitoring the oxygen saturation is to ensure the needs of the resident are assessed and monitored for respiratory changes of altered respirations, difficulty breathing, abnormal breath sounds so ensure that intervention can be put into place to ensure respiratory system is maintained.

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	365355	A. Building B. Wing	05/29/2025

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on the medical record review, physician visit records and interviews, the facility failed to ensure physician visits were provided as required for Resident #34. This had the potential to affect one resident (Resident #34) of 40 residents reviewed for physician services. Findings include: Review of the medical record for Resident #34 revealed and admission date of 07/29/22 with diagnoses included but were not limited to osteonecrosis, gastrostomy, history of malignant neoplasm of other sites of lip, oral cavity and pharynx and nicotine dependence. Review of the 05/09/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #34 revealed he had severe cognitive impairment and was independent for activities of daily living. Resident #34 was not noted to have significant weight changes and was using a feeding tube for over 51 percent (%) of his nutrition needs. Review of the medical record for Resident #34 revealed an admission physician visit completed on 08/03/22 and a physician order fax dated 08/19/22 for enteral tube feeding orders for Resident #34. No other physician visits were found for review. Phone interview on 05/15/25 at 11:14 A.M. with Physician #187 stated he had last completed a visit on 04/24/25 and had sent over the physician notes to the facility via email. Interview on 05/15/25 at 11:34 A.M. with [NAME] President of Clinical Services # 184 confirmed she was unable to provide evidence of physician visits as required for Resident #34 other than 08/03/22 and the physician order fax dated 08/19/22. This deficiency represents non-compliance investigated under Complaint Number OH00164538.

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	365355	A. Building B. Wing	05/29/2025

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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 and interview, the facility failed to ensure medications were obtained timely from the pharmacy and administered as ordered. This affected one (Resident #51) of five residents reviewed for medications received from the pharmacy. The facility census was 59. Findings include: Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy (seizures), cognitive communication deficit, need for assistance with personal care and history of encephalitis (inflammation of the brain). Review of the nursing progress notes reviewed from 03/31/25 to 05/12/25 revealed Resident #51 did not receive medications as ordered at times due to the facility not having them from the pharmacy and the physician not being notified. These included: -Clobazam (seizure medication) 15 milligrams (mg) on 04/03/25 at 4:34 A.M., medication on order. -Clobazam 5 mg on 04/06/25 at 3:16 A.M., medication on order. -Enoxaparin Sodium Injection Prefilled Syringe 40 mg/0.4 milliliters (mL) (blood thinner medication) on 04/16/25 at 6:02 P.M., medication on order. -Phenobarbital (medication for epilepsy) 64.8 mg on 04/17/25 at 4:57 P.M., medication on order. -Phenobarbital 64.8 mg on 04/21/25 at 4:56 A.M., medication on order. -Phenobarbital 64.8 mg on 04/21/25 at 3:20 P.M., medication on order. -Enoxaparin Sodium Injection Prefilled Syringe 40 mg/0.4 milliliters (mL) (blood thinner medication) on 05/05/25 at 8:33 P.M., medication on order. Review of the Medication Administration Record (MAR) for April 2025 and May 2025 for Resident #51 revealed nursing staff documented the medications listed above were not administered. Interview on 05/15/25 at 11:28 A.M. with the Director of Nursing (DON) verified the above findings of Resident #51's medications not being available from the pharmacy. Review of the facility policy titled, Pharmacy Services, revised April 2010, revealed the pharmacy would supply medications that were needed and deliver the medications to the facility. This deficiency represents non-compliance investigated under Complaint Number OH00162143, Complaint Number OH00162063 and Complaint Number OH00162053.

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	365355	A. Building B. Wing	05/29/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review and review of the facility policy, the facility failed to timely address pharmacy recommendations. This affected two residents (#11 and #51) of five residents reviewed for unnecessary medications. Facility census was 59. Findings include: 1. Review of medical record for Resident #11 revealed an admission date of 03/02/17 and diagnoses including asthma, type two diabetes, morbid obesity, generalized anxiety disorder, gout, insomnia, depression, vitamin D deficiency and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #11's historical physician's orders revealed an order dated 11/24/22 for Xanax tablet 0. 25 milligram (mg) give one tablet by mouth one time a day for anxiety. The order was discontinued on 12/30/24. Review of a medication review dated 06/13/24 identified Resident #11 was receiving Xanax 0.25 mg daily for anxiety, Buspirone Hydrochloride 10 mg daily for anxiety and Bupropion Hydrochloride extended release 12-hour 150 mg twice a day for depression. The pharmacist's recommendation stated 'if warranted and not contraindicated suggest a trial discontinuation by taper of Xanax while titrating buspirone upward.' A checkmark under prescriber response indicated 'agree' with an unidentifiable signature and no date. Review of a medication review dated 12/09/24 identified Resident #11 was receiving Xanax 0.25 mg daily for anxiety, Buspirone Hydrochloride 10 mg daily for anxiety and Bupropion Hydrochloride extended release 12-hour 150 mg twice a day for depression. The pharmacist's recommendation stated 'if warranted and not contraindicated suggest a trial discontinuation by taper of Xanax.' A checkmark under prescriber response indicated 'other' with no signature and a notation that Xanax was discontinued on 12/30/24 and buspirone and bupropion remained unchanged. Review of Resident #11's nurses' notes from June 2024 through December 2024 did not mention the above pharmacy recommendations. Interview on 05/20/25 at 11:00 A.M. with Registered Nurse (RN)/Vice President of Clinical Services (VPCS) #182 verified Resident #11's pharmacy recommendation for discontinuing Xanax was not addressed in a timely manner. RN/VPCS #182 stated the expectation at the facility was for recommendations to be addressed within 30 days. Review of the facility policy, Medication Regimen Reviews, revised April 2007 revealed routine reviews would be done monthly. The Consultant Pharmacist will provide a written report to physicians for each resident with an identified irregularity. If the physician does not provide a pertinent response, or the consultant pharmacist identifies no action had been taken, he/she will then contact the Medical Director or the Administrator. 2. Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy (seizures), cognitive communication deficit, need for assistance with personal care and history of encephalitis (inflammation of the brain). (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Note To Attending Physician/Prescriber, dated 09/09/24 from the pharmacist revealed Resident #51 was receiving Trazodone (medication for depression) 50 milligrams (mg) three times a day. The pharmacist had recommended administering every eight hours and monitoring for adverse side effects associated with use including blurred vision, dizziness, fatigue, drowsiness and falls. The physician did not answer the recommendation and a note on the side of the paper stated the medication was discontinued on 12/31/24. Review of the After Visit Summary from the hospital dated 12/23/24 to 12/31/24 revealed the physician at the hospital had discontinued Resident #51's Trazodone in an effort to decrease complaints of lethargy. Review of the Note To Attending Physician/Prescriber, dated 02/07/25 from the pharmacist revealed Resident #51 was on Enoxaparin Sodium Injection Prefilled Syringe Kit 40 mg/0.4 milliliters (mL) every 24 hours for anticoagulant. The pharmacist had recommended to clarify the duration of use and to monitor for Complete Blood Count (CBC) and for signs and symptoms of bleeding. The physician answered the recommendation approximately two months later on 04/06/25 and stated Resident #51 was on the medication indefinitely. Interview on 05/15/25 at 11:28 A.M. with the Director of Nursing (DON) verified the above findings of Resident #51's pharmacist reviews not being addressed timely by the facility and physician. Review of the facility policy titled, Medication Regimen Reviews, revised April 2007, revealed the pharmacist would perform a medication regiment review monthly. The pharmacist would then document their findings and provide a written report to the physician for each resident with an identified irregularity.

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	365355	A. Building B. Wing	05/29/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on record review, observation and interview, the facility failed to ensure medication error rate was less than five percent. There were a total of 26 medication opportunities observed with two medication errors resulting in a 7.69% medication error rate. This affected one (Resident #55) out of two residents observed for medication administration. The facility census was 59. Findings include: Review of the medical record for Resident #55 revealed an admission date of 11/14/23 with diagnoses including diabetes, hypertension and depression. Review of the physician's orders dated 05/12/25 for Resident #55 revealed she was to receive the following medications upon rising: Blood sugar check; blood pressure check; Amlodipine 5 milligrams (mg) for hypertension; Cholecalciferol 1,000 units, give 2, for supplement; Claritin 10 mg for allergies; Flomax 0.4 mg for overactive bladder; Januvia 50 mg for diabetes; Lisinopril 20 mg for hypertension; Pantoprazole 40 mg for gastroesophageal reflux disease; Potassium Chloride 20 milliequivalents (meq) for low potassium; Sertraline 100 mg, give 2, for depression; Vibegron 75 mg for overactive bladder; Buspirone 10 mg for anxiety; Docusate Sodium 100 mg for constipation; Metformin 500 mg for diabetes; Metoprolol Tartrate 25 mg for hypertension; Creon 6000-19000 units for digestive aid, Gabapentin 300 mg for nerve pain; Sodium Bicarbonate 650 mg for electrolytes and Artificial Tears for dry eyes. Observation on 05/12/25 at 9:00 A.M. with Licensed Practical Nurse (LPN) #100 of medication administration to Resident #55 revealed LPN #100 obtained her blood sugar and blood pressure. LPN #100 then proceeded to administer Amlodipine 5 mg, Cholecalciferol 1,000 units (2), Flomax 0.4 mg, Januvia 50 mg, Pantoprazole 40 mg, Potassium Chloride 20 meq, Sertraline 100 mg (2), Vibegron 75 mg, Buspirone 10 mg, Docusate Sodium 100 mg, Metformin 500 mg, Metoprolol Tartrate 25 mg, Creon 6000-19000 units, Gabapentin 300 mg, Sodium Bicarbonate 650 mg and Artificial Tears for dry eye. LPN #100 verified she had a total of 16 different medications in her cup and a total of 18 pills. Interview on 05/12/25 at 3:49 P.M. with LPN #100 verified she had not administered Resident #55's Lisinopril 20 mg and Claritin 10 mg during the medication administration observed by this surveyor. Review of the facility policy titled, Administering Medications, dated December 2012, revealed medications must be administered in accordance with the physician's orders. This deficiency represents non-compliance investigated under Complaint Number OH00162143, Complaint Number OH00162063 and Complaint Number OH00162053.

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	05/29/2025

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. Based on record review and interview, the facility failed to ensure Resident #51's laboratory testing was completed as ordered. This affected one (Resident #51) of four residents reviewed for laboratory orders. The facility census was 59. Findings include: Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy (seizures), cognitive communication deficit, need for assistance with personal care and history of encephalitis (inflammation of the brain). Review of the physician's orders for Resident #51 for active laboratory orders revealed he was to have an Albumin level every Wednesday for pressure ulcer dated 04/30/25 for four weeks; Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) was ordered every two weeks dated 03/30/25; CBC with differential and BMP weekly dated 02/12/25; Depakote levels monthly while taking the medication dated 10/08/24; and CBC, BMP, Ammonia level, Iron and Liver Function every six months and Valproic Acid, Iron, and Phenobarbital level every three months dated 10/01/24. Review of the electronic medical record and physical hard chart for Resident #51 revealed the laboratory orders listed above were not completed as the physician had ordered. The only laboratory findings available in the medical record were for 11/01/24 (BMP, CBC with differential and Phenobarbital), 03/14/25 (BMP, CBC with differential and Phenobarbital) and 04/03/25 (Comprehensive Metabolic Panel, CBC with differential, Phenobarbital and Valproic Acid level). On the 03/14/25 laboratory findings, the physician had been updated and stated to repeat the testing in one week, which was not completed. Interview on 05/14/25 at 3:25 P.M. with the Director of Nursing and Registered Nurse (RN) #193 regarding Resident #51's laboratory reports revealed only 11/01/24, 03/14/25 and 04/03/25 were present in the medical record. The DON verified laboratory data dated 12/12/24, 12/20/24 and 02/21/25 were not present in the medical record nor had the physician been updated on those laboratory findings. RN #193 was observed to be printing those results off of the laboratory services website when the surveyor was in the room. The DON was unable to provide any other laboratory testing that had been completed.

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	05/29/2025

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

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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 medical record review, dietary tray ticket review and interview, the facility failed to ensure resident preferences were honored and updated as required for Resident #27. This affected one resident (Resident #27) of five residents reviewed for food. The facility census was 59. Findings include: Review of the medical record for Resident #27 revealed an admission date of 05/01/24. Review of the diagnoses included but were not limited to adjustment disorder, chronic respiratory failure, morbid obesity, dysphagia and depression. Review of the 05/09/25 annual Minimum Data Set (MDS) 3.0 for Resident #27 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. Resident #27 was noted to require set up for meals. Review of the physician ordered diet for Resident #27 dated 05/06/25 revealed regular diet with regular texture with thin liquids. No oatmeal, prefers cold cereal, request chef's salad for upgraded diet. Review of the care plan last updated 02/21/25 for Resident #27 revealed a nutritional problem related to obesity. Interventions were to provide and serve diet as ordered. Monitor intake and record each meal. Interview on 05/12/25 at 10:42 A.M. with Resident #27 revealed she has told staff food preferences, but preferences have not been updated. Resident #27 stated she asks for cold cereal but does not get it and receives oatmeal which she was told staff she does not like. Observation at the time of the interview with Resident #27 revealed her diet tray ticket from breakfast revealed no preferences or dislikes listed. Phone interview on 05/21/25 at 10:13 A.M. with Registered Dietitian (RD) #181 revealed she completes the nutrition assessments but the Dietary Manager completes and updates resident preferences. RD #181 stated she does not attend nor review the dining committee minutes, as the Dietary Manager is responsible for completing the meetings and addressing dietary concerns. Interview on 05/21/25 at 1:05 P.M. with Regional Dietary Manager (RDM) #167 revealed there has been several changes in the Dietary Manager position in the past few months. RDM #167 stated the dietary manager is supposed to visit residents at least quarterly for their preferences or additionally if there is a reported food concern. RDM #167 confirmed she has not been visiting the residents to obtain resident preferences since she started on 03/22/25 and was unsure if the previous dietary managers had been visiting residents to update their preferences. RDM #167 also confirmed Resident #27's ticket did not have any preferences or dislikes listed and did not match the preferences listed on the physician diet order. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy called Resident Food Preferences revealed individual food preferences will be assess upon admission and communicated to the interdisciplinary team. When possible, staff will interview the residents directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the residents' eating preferences in the care plan. This deficiency represents non-compliance investigated under Complaint Number OH00164012 and Complaint Number OH00162063.

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	365355	A. Building B. Wing	05/29/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility cleaning logs, and interviews, the facility failed to ensure the kitchen was maintained in a clean sanitary manner. This had the potential to affect all residents receiving food from the kitchen. The facility identified one resident (Resident #34) who received nothing by mouth. The facility census was 59. Findings include: During the initial kitchen tour completed on 05/12/25 from 8:35 A.M. to 9:00 A.M. with Dietary Manager #113 the following concerns were identified: - a one-gallon size Ziploc bag with a leftover ham portion which weighed approximately two pounds that was dated 04/28/25. -five-pound box of sliced mushrooms that had visible dark brown spots on the sliced mushrooms which were dated 04/24/25. -clear plastic container with red liquid inside that was thought to be fruit punch which was unlabeled and undated. -six-quart and three-quart clear plastic container with what appeared to be gravy inside that was unlabeled and undated. -six-quart clear plastic container with leftover cooked peas inside that was unlabeled and undated. -six-quart clear plastic container with what appeared to be mashed potatoes that was unlabeled and undated. -Observation of the reach in oven revealed it was heavily soiled with caked on blackened food on the bottom, the front and sides were also visibly soiled, and the handles were greasy upon touching the handles. -Observation of the six-burner gas cooktop revealed it was heavily soiled around the burners and soiled on the front of the oven below. -Observation of the dishwasher revealed the front of the dishwasher was soiled and had food debris on the front of it. -Observation of the sink near the oven revealed (two) eight-pound pork loins thawing in the sink without being covered in water -Observation of the kitchen floor revealed the tile was dirty and did not appear to have been swept or mopped. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview at the time of the observations with Dietary Manager #113 revealed she just started two weeks ago, had two kitchen employees call off this morning and was waiting for their replacements to arrive. Dietary Manager #113 confirmed the above findings, stated she did not have kitchen cleaning logs to review, and had just created a kitchen cleaning schedule last week but had not implemented it yet. Dietary Manager #113 also confirmed she was aware the pork loins were not thawing in a safe manner. Observation on 05/14/25 at 1:28 P.M. with Regional Culinary Director #167 of the second-floor activity room refrigerator which was used for resident foods revealed: -an unopened 32-ounce med pas vanilla shake with a best by date of 03/16/25 -a 30-ounce container of grape jelly with a use by date of 03/28/25 -a 22-ounce container of strawberry syrup with a use by date of 03/22/25 -two undated and unlabeled leftover containers with visible mold in both containers -four (12-ounce) containers of juice with use by date of 09/05/24 -a six-ounce container of yogurt with a use by date of 12/06/24 Regional Culinary Director #167 confirmed the above findings at the time of observation. Observation on 05/14/25 at 1:42 P.M. with Regional Culinary Director #167 of Resident #34's (who has a diet order of nothing by mouth) personal room refrigerator revealed visible mold in the refrigerator, dried liquid spills, dark colored stains inside as well as the outside area around the refrigerator. Inside of the refrigerator the following concerns were found: -(four) unopened one-half cup containers of chocolate pudding with a use by date of 12/24 -(one) unopened 10-ounce bag of peanut butter chocolate chips with a use by date of 03/24 -(four) eight-ounce unopened containers of Isosource 1.5 enteral feeding with an expiration date of 09/23/25 Interview at the time of the observation with Regional Culinary Director #167 confirmed since Resident #34 had a physician diet order for nothing by mouth she was unsure why the refrigerator was in the room and confirmed the above items should have been disposed of and the enteral feedings should have been stored by the nursing staff. Observation on 05/21/25 at 2:00 P.M. in the kitchen revealed Dietary Aide #118, who had longer hair with short dread locks, not wearing a hair net. Dietary Aide #118 confirmed he was supposed to be wearing a hair net in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy called Sanitation/Infection Control revealed the Dietary Manager is responsible for supervising all sanitation and housekeeping procedures within the dietary department. Frozen food is to be thawed in the refrigerator not at room temperature. Leftover foods are placed in shallow containers, dated, labeled and chilled rapidly. These are used within 48 hours. A clean department is essential for good sanitation. The department includes the equipment, materials that are used, floors, and walls. To maintain high environmental sanitation standards, the following practices are suggestive but not all-inclusive. All work and storage areas are clean, well-lit and orderly. Walls, ceiling and floors are cleaned routinely and is a required task found on the cleaning schedule. All cooking equipment, door seals, and surfaces of grills, burners and ovens are wiped daily and thoroughly cleaned regularly. Light daily cleaning is required for steam table wells, refrigerator, range and grill, floor and mats, sink, garbage disposal, and ovens. Outside doors on steamers and freezers are wiped off, as are splashed on the equipment and walls. Review of the undated facility policy called Food Brought in by Visitors revealed if food is brought in, all perishable food in resident's rooms shall be in tightly closed containers, labeled and dated well. Review of the facility undated facility policy called; Hair Covering Policy revealed proper hair coverings will be worn at all times in the kitchen. All dietary staff are required to wear effective hair restraints that cover all exposed body hair including facial hair and hear hair.

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	365355	A. Building B. Wing	05/29/2025

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #27 revealed an admission date of 05/01/24. Review of the diagnoses included but were not limited to adjustment disorder, chronic respiratory failure, morbid obesity, dysphagia and depression. Review of the 05/09/25 annual Minimum Data Set (MDS) 3.0 for Resident #27 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. Resident #27 was noted to require moderate assistance from staff for bathing, dressing, and personal hygiene. Review of the nursing progress note dated 04/05/25 revealed Resident #27 was given two tablets of 500 milligram (mg) of Tylenol for pain in her right knee. Review of the nursing progress note dated 04/09/25 timed at 12:10 A.M. revealed Resident #27 was given two 500 mg of Tylenol for leg pain that was not relieved by repositioning. Review of the physician order dated 04/16/25 for Resident #27 revealed an order for an ultrasound of the right knee for painful lump. Review of the 04/16/25 ultrasound result for Resident #27 revealed an ultrasound study of the soft tissues of the right knee was obtained in several views. It was noted there was a 3.5 x 2.0 centimeter (cm) well circumscribed anechoic mass in the popliteal region with enhanced through transmission. This was noted to be consistent with a benign [NAME] cyst. No other mass was noted and no abnormal doppler flow. Review of nursing progress notes revealed no progress note related to ultrasound being ordered. Review of the nursing progress note dated 04/22/25 revealed the results from the ultrasound came back and revealed Resident #27 had a 3.5 cm benign [NAME] cyst behind her right knee. The physician was notified with no new orders obtained. Review of physician order dated 05/06/25 for Resident #27 revealed an order for an ortho consult for right knee pain and baker cyst. No evidence was found for a corresponding nursing progress note. Review of the nursing progress note dated 05/14/25 for Resident #27 revealed she was given two tablets of 500 mg Tylenol related to leg pain not relieved by repositioning. Interview on 05/19/25 at 10:41 A.M. with Resident #27 revealed she had an x-ray at the facility about six weeks ago for a baker's cyst and has not had the suggested follow up. Interview on 05/21/25 at 11:20 A.M. with Licensed Practical Nurse (LPN) #131 revealed she entered the order on 05/06/25 for an ortho consult for Resident #27 but the appointment was supposed to be scheduled by the Unit Manager. LPN #131 confirmed no appointment was scheduled following the order and had not been completed. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2008 revised facility policy called Referrals, Social Services revealed social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that had been ordered by the physician. Social services will document the referral in the resident's medical record. Social services will help arrange transportation to outside agencies, clinical appointments, etc., as appropriate. This deficiency represents non-compliance investigated under Complaint Number OH00164012 and Complaint Number OH00162053. Based on record review and staff interviews, the facility did not ensure Resident #27 had orthopedic appointments scheduled as ordered and Resident #66 was transported to nephrology appointments as scheduled. This affected two residents (Resident #27 and Resident #66) of the two resident records reviewed for appointment coordination. Findings include: 1. Record review for Resident #66 revealed an admission date of 04/21/22 with diagnoses of chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, type II diabetes with diabetic neuropathy, morbid severe obesity, and chronic kidney disease stage 4. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively intact and was dependent with oral hygiene, toileting hygiene, dressing, bed mobility, and transfers. Review of weights in the medical record revealed Resident #66 weighed 462 pounds (lbs.) as of 03/07/25. Review of the progress note dated 03/03/25 at 2:07 P.M. from Licensed Practical Nurse (LPN) #114 revealed nephrology appointment was rescheduled for 03/17/25 at 1:00 P.M. at the Cleveland Clinic Mentor Family Center. Review of progress note dated 03/17/25 at 2:29 P.M. from LPN #114 revealed nephrology appointment was rescheduled for 04/30/25 at 8:20 A.M. at Hillcrest Hospital. Interview on 05/20/25 at 8:18 A.M. with Receptionist #204 revealed the receptionist assisted with coordinating transportation to outside appointments for Resident #66 and maintained a binder of transportation requests forms for which transportation was confirmed. Due to her size, only one or two of the four outside transportation companies used could accommodate her and transport her to appointments. Review of the March transportation requests revealed transportation was confirmed for an appointment scheduled 03/03/25 at 11:00 A.M. however, under the section labeled Transportation Information it was noted appointment cancelled due to being in hospital. Interview on 05/20/25 at 8:43 A.M. with [NAME] Office Manager (BOM) #142 revealed Resident #66 had three hospitalizations: 02/08/25 to 02/13/25, 02/16/25 to 02/24/25, and 03/24/25 to 04/13/25 when discharged due to exhausting bed hold days. BOM #142 confirmed Resident #66 was not hospitalized on [DATE] and 03/17/25 appointment dates. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/25 at 9:10 A.M. with [NAME] President of Clinical Services #182 confirmed Resident #66 was not hospitalized for 03/03/24 and 03/17/24 appointments with nephrology. Interview on 05/20/25 at 10:44 A.M. with [NAME] President of Operations #172 revealed there were not many transportations companies that offered bariatric transportation and explained that some vehicles had specific weight limits which included the resident and their wheelchair and/or other equipment. Interview on 05/20/25 at 9:39 A.M. with Registered Nurse (RN) #171 confirmed appointments for Resident #66 were rescheduled due to transportation issues but was unable to recall any specifics related to dates of appointments, transportation providers, and reasons for cancelling/rescheduling appointments. Interview on 05/22/25 at 11:45 A.M. with LPN #114 confirmed the nephrology appointment was rescheduled because the facility had issues with transportation and confirmed it was rescheduled twice, the second time, it was scheduled one month in advance. Review of the Transportation, Diagnostic Services policy revised December 2008 revealed the facility would assist residents in arranging transportation to/from diagnostic appointments when necessary.

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	365355	A. Building B. Wing	05/29/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 8. Review of Resident #53's medical record revealed an admission date of 01/24/24 and diagnoses including type two diabetes, morbid obesity, non-pressure chronic ulcer of left heel and midfoot, arthritis and atrial fibrillation. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 was cognitively intact, required staff set-up for activities of daily living and did not reject care. Review of Resident #53's physician's orders relative to wound care as of 05/14/25 revealed an order dated 01/14/25 for wound type and site sub fifth MTH left lower extremity cleanse with normal saline, apply alginate, maintain affixed padding with pad edges against the wound edges and cover with ABD pad then wrap with kerlex daily and as needed (PRN) every day shift every Tuesday, Thursday Saturday for treatment; an order dated 01/22/25 for horseshoe adhesive padding for the foot-place on the foot daily with changes around the wound to keep the pressure off; an order dated 03/14/25 for left foot dressing change with alginate every other day (Sunday, Tuesday and Thursday) one time a day every other day for wound care; an order dated 04/05/25 for dressing changes to be done for the left foot wound every other day with the following dressing: gauze, Kerlix, ace, and Alginate/Restore/Silver Alginate in the morning every Tuesday, Thursday and Saturday for wound care prior to 11:00 A.M. per resident request; an order dated 04/05/25 for dorsal wound #2 and the second nail bed of the right foot is to receive the bandaid with neosporin or similiar topical antibiotic every one to two days in the morning every Tuesday, Thursday, and Saturday for wound care; an order dated 04/13/25 for continue dressing changes-left foot as per noted, in the morning every other day for dressing changes;and an order dated 05/07/25 to document clinical refusals every day and night shift for clinical compliance. Interview on 05/15/25 at 12:21 P.M. with Registered Nurse (RN)/Regional Director of Clinical Services (RDCS) #166 verified it was unclear which dressing staff were to apply to Resident #53's wounds and stated the wound nurse was responsible for discontinuing previous treatment orders which had not been done as of the time of the interview. This deficiency represents noncompliance investigated under Complaint Number OH00161946 and Complaint Number OH00165671. Based on record review, staff interview, and policy review the facility failed to ensure an accurate and complete medical record for all residents. This affected eight residents (#21, #26, #35, #39, #51, #52, #53, #165) of 40 resident records reviewed for completion and accuracy. Findings include: 1. Review of Resident #21's medical record revealed an admission date of 6/25/25 with diagnoses of post traumatic seizure, acute respiratory failure, type two diabetes, unspecified asthma, repeated falls, and need for assistance for personal care. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's physician orders for May 2025 revealed orders for Aspirin EC 81 milligram give one time a day in the A.M., Hyzaar 50-12.5 milligram give one time a day in A.M., Amlodipine 2.5 milligram give two times a day in the A.M. and evening, Gabapentin 100 milligram in the morning and at bedtime, Phenytoin extended capsule 100 milligram give two times a day in A.M. and evening, and Phenobarbital 32.4 milligram three times as day in A.M., afternoon, and evening. Review of the Medication Administration Record (MAR) for May 2025 for Resident #21 revealed he did not receive any of the above listed medications on 05/08/25. Review of the nursing progress notes for Resident #21 for 05/08/25 revealed there was no documentation as to why he did not receive his medications listed above. Interview on 05/14/25 at 12:50 P.M. with the DON verified Resident #21 did not receive the medications listed above on 05/08/25. She stated their electronic medical record system was not working on the first floor but was working properly on the second floor. She stated the computer problem was fixed during the time of medication administration for upon rising and she was unable to state why staff did not administer Resident #21's medications. She was unable to provide any documentation of the medications being administered. 2. Review of the medical record for Resident #39 revealed an admission date of 5/22/22 with diagnoses of unspecified dementia with severe anxiety, moderate protein calorie malnutrition, history of falls, Palliative care, hyperlipidemia. Review of Resident #39's May 2025 physician orders revealed orders for Depakote sprinkles delayed release 125 milligrams two times a day in A.M. and in the evening, Nuedexta 20-10 milligram two times a day in the A.M. and evening, Nystatin Powder 100,000 units per grams two times a day in the A.M. and evening, Ativan 1 milligrams three times a day at 9:00 A.M., 2:00 P.M., and 9:00 P.M. Review of the Medication Administration Record (MAR) for May 2025 for Resident #39 revealed he did not receive any of the above listed medications on 05/08/25. Review of the nursing progress notes for Resident #39 for 05/08/25 revealed there was no documentation as to why he did not receive his medications listed above. Interview on 05/14/25 at 12:50 P.M. with the DON verified Resident #39 did not receive the medications listed above on 05/08/25. She stated their electronic medical record system was not working on the first floor but was working properly on the second floor. She stated the computer problem was fixed during the time of medication administration for upon rising and she was unable to state why staff did not administer Resident #39's medications. She was unable to provide any documentation of the medications being administered. 3. Review of Resident #165's medical record revealed and admission date of 4/3/25 with diagnoses including unspecified injury to cervical spine, quadriplegia C1-C4, tracheostomy, major depressive disorder. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #165's May 2025 physician orders revealed orders for Metamucil fiber packet 51.7 percent, give two times a day, day and evening, Senna tablet 8.6 milligrams give two times a day, day and evening, Acetaminophen 500 milligrams, give three times a day in A.M., afternoon, and evening, Baclofen 20 milligrams three times a day, A.M., afternoon, evening, Pregabalin 150 milligrams three times a day, A.M., afternoon, evening, Valproic Acid, give 15 millimeters three times a day, A.M., afternoon, and evening, Verapamil 40 milligrams every eight hours, Midodrine five milligrams every 12 hours, Oxycodone five milligrams per milliliters every six hours, Aspirin 81 milligrams in the A.M., and Enoxaparin Injection 40 milligrams per 0.4 milliliters in the morning . Review of the Medication Administration Record (MAR) for May 2025 for Resident #165 revealed he did not receive any of the above listed medications on 05/08/25. Review of the nursing progress notes for Resident #165 for 05/08/25 revealed there was no documentation as to why he did not receive his medications listed above. Interview on 05/14/25 at 12:50 P.M. with the DON verified Resident #165 did not receive the medications listed above on 05/08/25. She stated their electronic medical record system was not working on the first floor but was working properly on the second floor. She stated the computer problem was fixed during the time of medication administration for upon rising and she was unable to state why staff did not administer Resident #165's medications. She was unable to provide any documentation of the medications being administered. 4. Review of the medical record for Resident #35 revealed an admission date of 04/18/24 with diagnoses including diabetes mellitus, depression and paraplegia (paralysis of lower half of the body). Review of the physician's orders for May 2025 for Resident #35 revealed his orders included Lantus (medication for high blood sugar) 80 units upon rising, Eliquis 5 milligrams (mg) at 11:00 A.M., Hydralazine (medication for high blood pressure and improving blood flow) 50 mg at 11:00 A.M. with blood pressure check, Metformin (medication for high blood sugar) 1,000 mg at 11:00 A.M., Novolog sliding scale insulin (medication for high blood sugar) upon rising with blood sugar check and Novolog 15 units at 10:00 A.M., 1:00 P.M. and 6:00 P.M. Review of the Medication Administration Record (MAR) for May 2025 for Resident #35 revealed he did not receive any of the above listed medications on 05/08/25. Review of the nursing progress notes for Resident #35 for 05/08/25 revealed there was no documentation as to why he did not receive his medications listed above. Interview on 05/14/25 at 12:50 P.M. with the Director of Nursing (DON) verified Resident #35 did not receive the medications listed above on 05/08/25. She stated their electronic medical record system was not working on the first floor but was working properly on the second floor. She stated the computer problem was fixed during the time of medication administration for upon rising and she was unable to state why staff did not administer Resident #35's medications. She was unable to provide any documentation of the medications being administered. Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders including required time frame. (continued on next page)

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	05/29/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the medical record for Resident #51 revealed an admission date of 05/06/24 with diagnoses including epilepsy (seizures), cognitive communication deficit, need for assistance with personal care and history of encephalitis (inflammation of the brain). Review of the physician's orders for May 2025 for Resident #51 revealed his orders included Amantadine (medication for encephalitis) 100 mg upon rising, Clobazam (medication for seizures) 15 mg on dayshift, Keppra (medication for seizures) 2,000 mg upon rising, Risperdal (for epileptic psychosis) 2 mg upon rising, Divalproex (medication for seizures) 1,500 mg upon rising and at noon, Methocarbamol (medication for muscle spasms) 500 mg upon rising and at noon and Phenobarbital (medication for epilepsy) 64.8 mg at 9:00 A.M. and 2:00 P.M. Review of the Medication Administration Record (MAR) for May 2025 for Resident #51 revealed he did not receive any of the above listed medications on 05/08/25. Review of the nursing progress notes for Resident #51 for 05/08/25 revealed there was no documentation as to why he did not receive his medications listed above. Interview on 05/14/25 at 12:50 P.M. with the DON verified Resident #51 did not receive the medications listed above on 05/08/25. She stated their electronic medical record system was not working on the first floor but was working properly on the second floor. She stated the computer problem was fixed during the time of medication administration for upon rising and she was unable to state why staff did not administer Resident #51's medications. She was unable to provide any documentation of the medications being administered. Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders including required time frame. 6. Record review for Resident #26 revealed an admission date of 04/25/17 with diagnoses of legal blindness, acquired absence of one eye, and peripheral vascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 was cognitively intact and had severe vision impairment. Review of the April 2025 Medication Administration Record (MAR) revealed Resident #26 had an order for a pain evaluation every shift for monitoring of patient's pain. Further review of the MAR revealed evaluation was not completed 04/14/25 night shift, 04/15/25 day shift, and 04/16/25 day shift. Review of the Treatment Administration Record (TAR) revealed an order for bowel documentation every shift, document any behaviors observed every shift, and may offer patient eye covering option every shift for dignity. Further review of the TAR revealed documentation was not completed 04/14/25 night shift, 04/15/25 day shift, and 04/16/25 day shift. Review of the physician orders for May 2025 revealed Resident #26 had an order for both Fish Oil 1000 mg (Omega-3 Fatty Acids) one time a day and Omega-3 1000 mg softgel one time a day self-administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May MAR revealed both were administered from 05/01/25 to 05/19/25. Interview on 05/14/25 at 12:00 P.M. with [NAME] President of Operations #172 confirmed staff were unable to document intermittently from 04/14/25 to 04/16/25 due to the technical issues which resulted in missing documentation from that time period on the MAR and TAR for Resident #26. [NAME] President of Operations #172 revealed the facility's Information Technology (IT) department confirmed there was an intermittent Point Click Care outage from 04/14/25 to 04/16/25 due to critical cabling run in the building having gone bad. To resolve the issue, IT worked with a wiring vendor to have a new cable run installed to replace the old one. Email communications with IT were reviewed at the time of the interview. Interview on 05/19/25 at 9:50 A.M. with Licensed Practical Nurse (LPN) #108 confirmed there was no over the counter Omega-3 on the medication cart however LPN #108 provided one punch card from the pharmacy for Omega-3 capsules that still had 30 pills on it. Interview on 05/19/25 at 9:54 A.M. with Resident #26 revealed Resident #26 self-administered all of his medications including Omega-3 and confirmed the nurse did not administer any pills to him. 7. Record review revealed Resident #52 was admitted [DATE] with diagnoses of malignant neoplasm of colon, morbid severe obesity, aphasia, hemiplegia and hemiparesis, and type II diabetes with diabetic neuropathy. Review of the Quarterly Minimum Data Set (MDS) revealed Resident #52 had a mild cognitive impairment, required maximal assistance with bed mobility, and was dependent for all other activities of daily living. Review of the April Medication Administration Record (MAR) revealed an order for Amlodipine 10 mg one time a day, Buproprion HCL ER on e tablet once a day, Citalopram Hydrobromide 20 mg one tablet once a day, and Humalog KwikPen inject 12 units subcutaneously three times a day. Further review of the MAR revealed documentation was not completed 04/15/25 and 04/16/25. There was no documentation the following medications were administered 04/14/25: Atorvastatin Calcium Tablet 40 mg 1 tablet at bedtime, Dulcolax Rectal Suppository 10 mg 1 suppository rectally at bedtime, Lantus SoloStar 30 units subcutaneously at bedtime, Metoprolol Succinate ER 1 tablet at bedtime, There was no documentation the following medications were administered from 04/14/25 night, 04/15/25 day shift, and 04/16/25 day shift: Calmoseptine Ointment 0.44-20.6% apply topically two times, Docusate Sodium Tablet 100mg one capsule two times a day, Eliquis 5 mg two times a day, Miralax 17 gm 1 scoop two times a day, Assess pain every shift, Gabapentin 300 mg three times a day, Humalog KwikPen per sliding scale, Acetaminophen tablet 325 mg every 4 hours. There was no documentation the following medications were administered 05/03/25: Lantus SoloStar Subcutaneous Solution Pen Injector 100 unit/ml inject 30 units subcutaneously at bedtime, Metoprolol Succinate ER 1 tablet by mouth at bedtime, Humalog KwikPen per sliding scale four times a day (bedtime dose only), Acetaminophen 325 mg by mouth every 4 hours for pain (evening dose only). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/14/25 at 12:00 P.M. with [NAME] President of Operations #172 revealed their Information Technology (IT) department confirmed there was a Point Click Care outage from 04/14/25 to 04/16/25 due to critical cabling run in the building having gone bad. To resolve the issue, IT worked with a wiring vendor to have a new cable run installed to replace the old one. [NAME] President of Operations #172 also confirmed staff were unable to document intermittently due to the service issues. Email communications with IT were reviewed at the time of the interview. Interview on 05/21/25 at 8:31 A.M. with Registered Nurse (RN) #156 confirmed she work the night shift on 05/02/25 and 05/03/25 but was unable to recall if there were any service issues but did report there had been recent service issues but was unable to recall when. RN #156 reported from memory the following medications were administered: Atorvastatin, Metoprolol, Protonix, Lantus, and Humalog but could not say for certain they were signed off as having been administered. RN #156 denied their were any days Resident #52 did not receive his medications. Review of the Medication Administration Policy revised December 2012 revealed the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to coordinate Resident #39's care and services with hospice to ensure continuity of care. This affected one resident (Resident #39) of one resident reviewed for hospice. Findings include: Review of the medical record for Resident #39 revealed an admission date of 05/22/22 with diagnoses of unspecified dementia with severe anxiety, moderate protein calorie malnutrition, history of falls, palliative care, hyperlipidemia. Review of Resident #39's medical record indicated that the resident had been admitted to Palliative Care on 1/30/23 for adult failure to thrive. Review of Resident #39's medical record of the hospice care plan dated 05/07/24 indicated that the resident required assistance of one for feeding. There were no other focus or interventions in place for the care plan. Review of Resident #39's care plan dated 04/23/25 revealed the resident was at risk for skin breakdown with an intervention for nursing as well as Hospice to visit and provide care, assistance, and evaluation. Review of Resident # 39's Hospice observation note dated 04/28/25 (for comprehensive assessment) by the Registered Nurse (RN) revealed the resident's skin was intact. Review of Resident #39's progress note dated 04/29/25 revealed the nurse identified an area on the resident's sacrum documented as an in-facility acquired area. This was the first observation of the area, noting it was dry with no drainage, no odor, and measured 0.2 cm x 0.1 cm x 0 cm with no inflammation. The progress note did not identify what kind of wound it was. Treatment was noted to cleanse with normal saline and apply Triad Cream. There was no indication Hospice was notified of the area identified. Review of Resident #39's Wound Nurse Practitioner (NP) initial assessment dated [DATE] revealed the resident had a Deep Tissue Pressure Injury (DTI) on the sacrum measuring 5.3 cm x 3.0 cm with an undetermined depth. The NP recommended a pressure reducing mattress and treatment for the injury. There was no evidence in Resident #39's medical record the pressure reducing mattress was implemented. Review of Wound Nurse Practitioner assessment dated [DATE] revealed Resident #39's wound was a Stage III pressure ulcer on the coccyx (contradicting the sacrum location on 05/05/25) with decreased size of 3.7 cm x 4 cm x 0.2 cm, clustered wound, base/tissue was 70% granulation tissue and 30% scabbed and crusted of the wound. The treatment was to clean with normal saline, pat dry, apply Triad, with a clean dry dressing. There was no indication Hospice was notified of the area identified. Review of a Hospice Nurse assessment dated [DATE] revealed the resident was observed in a Broda chair, pleasant, but confused, and skin was intact. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of weekly skin assessment dated [DATE], completed by Licensed Practical Nurse (LPN) #114, revealed an observation of a coccyx pressure ulcer which assessed the ulcer as being an unstageable wound with measurements of 5.1 cm x 3.5 cm with no depth. The treatment remained the same. There was no indication Hospice was notified of the area identified. Review of Resident #39's paper medical record on 05/13/25 revealed there was no hospice documentation in the medical record other than the initial signed agreement for hospice dated 1/30/23. Interview with LPN # 106 on 5/13/25 at 7:59 A.M. verified that she frequently works on the unit Resident #39 resides and she has not had any contact or updates from hospice regarding the resident's care. She stated that when there is a change, she tries to call the number to update but there is no answer. When asked if she shared that information with management, she replied to the question as no. Interview with Regional Director of Nursing #166 on 05/13/25 at 9:32 A.M. revealed that there was not a communication binder from hospice that could be reviewed on visits and care plans, or contact information needed for changes of conditions. A telephone interview on 05/15/25 at 10:58 A.M. with LPN #114 who completed the initial observation of Resident #39's pressure injury on 04/29/25 and the weekly skin assessment on 04/30/25 revealed LPN # 114 notified Resident #39's doctor of the pressure ulcer injury and tried a phone number for the Hospice company but stated that the phone number was not working. LPN # 114 revealed she had not had any interaction or report given to the Hospice Nurse on 05/12/25 when the Hospice Nurse assessment indicated Resident #39's skin was intact when there was a Stage III pressure ulcer. A telephone interview on 05/15/25 at 11:12 A.M. with Hospice Registered Nurse #186 revealed she was the primary person that comes to see Resident #39 and does assessments. She revealed she does not normally communicate with the nurses or aides when she does her visits and could not remember if she contacts the resident's family. Hospice Registered Nurse #186 regarding her assessment of Resident #39 skin documentation dated 05/12/25 revealed Resident #39 was in her chair and the resident's skin was not assessed. Hospice RN #186 stated she was unaware the resident had a pressure ulcer. A telephone interview with Resident #39's husband on 5/20/25 at 9:15 A.M. revealed he had not heard from Hospice Services since she was signed up, he guesses they are doing a good job. When asked if he is part of the hospice care plan meetings, he stated no, he and his son visit 2 times a week and has not seen any hospice care takers according to the husband. A telephone interview on 05/20/25 at 10:26 A.M. with the Chief Operating Officer of Buckeye Hospice stated the expectations were all staff have a three-touch point communication when they are in the facility. There is a communication binder that the staff are to sign in and write a small summary of details and communicate with the Director of Nursing at the entrance and exit from the facility. She did confirm these steps and requirements were not being made and that there was not a comprehensive care plan for the resident at that time. Review of the facility policy titled, Hospice Program, undated, revealed the facility would work in conjunction with the hospice company to communicate and facility care to the resident and provide involvement with the families. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospice Services contract dated 05/01/22 revealed the hospice company agreed to provide interdisciplinary care and treatment of the terminally ill patient to continue life with minimal disruption.

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	365355	A. Building B. Wing	05/29/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, facility policy and procedure review and interview the facility failed to ensure their Quality Assurance and Performance Improvement (QAPI) committee identified and followed through on concerns timely. This had the potential to affect all 59 residents in the facility. Findings include: Review of the facility QAPI minutes and Performance Improvement Plan (PIP) documentation revealed the following plans without continued corrective action, evidence the plan was revised when necessary or changed once identified to be ineffective: 1. Review of a QAPI plan dated 07/29/24 revealed an action plan related to late administration of medications. A root cause, responsible party and action steps were listed including an audit plan. No resolution date was listed and there was no additional information provided such as audits to verify the correction plan was completed. During the current annual survey, deficiencies were cited regarding medication administration and significant medication errors. 2. Review of a second QAPI plan dated 07/29/24 revealed an action plan related to the failure to complete wound assessments and weekly skin assessments timely. A root cause, responsible party and action steps were listed including an audit plan. A resolution date was listed as 07/29/24 for staff education and disciplinary action for the wound nurse but there was no additional information provided such as audits to verify the correction plan was completed. During the current annual survey, deficiencies were cited regarding pressure areas. 3. Review of a QAPI plan dated 11/15/24 revealed an action plan related to late administration of medications. A root cause, responsible party and action steps were listed including an audit plan. A resolution date was listed as 11/15/24 for staff education but there was no additional information provided such as audits to verify the correction plan was completed. During the current annual survey, deficiencies were cited regarding medication administration and significant medication errors. 4. Review of two QAPI plans dated 01/02/25 revealed two action plans related to residents' falls with fractures. A root cause, responsible party and action steps were listed including an audit plan. All steps except the audits had a resolution date of 01/02/25. No audits were available to verify the correction plan was completed. During the current annual survey, deficiencies were cited regarding falls with major injury. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews on 05/22/25 at 11:39 A.M. and 12:47 P.M. with Regional Director of Operations (RDO) #196, Registered Nurse (RN)/Vice President of Clinical Services (VPCS) #182 and [NAME] President of Operations (VPO) #172 revealed the facility's Administrator was responsible for implementing and overseeing any auditing put into place as part of quality assurance (QA). If audits were not working well, the QA team would need to meet again to discuss and alter the course of action. RDO #196 was unaware of the lack of follow-through including audits and oversight with the facility's self-identified concerns regarding medication administration, pressure areas and falls with major injury reviewed during the annual survey until this date [05/22/25] and reiterated the facility's Administrator was responsible for QA follow-up. VPO #172 confirmed there were no audits corresponding to the above QAPI plans available for surveyor review. Review of the facility policy, QAPI Program, revised April 2014, revealed the facility shall develop, implement and maintain an ongoing, facility-wide Quality Assurance and Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Performance Improvement Projects (PIPs) are initiated when problems are identified and PIPs involve systematically gathering information to clarify issues and to intervene for improvements. Adverse events are traced, monitored and investigated as they occur and action plans are implemented to prevent recurrence of adverse events the facility would plan, conduct and document PIPs.

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	365355	A. Building B. Wing	05/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident #9's medical records revealed an admission date of 04/09/25. Diagnoses included infection related to indwelling urethral catheter, neuromuscular bladder and need for personal care assistance. Review of care plan dated 04/14/25 revealed Resident #9 had an indwelling urinary catheter. Interventions included monitor for signs and symptoms urinary tract infection that included cloudiness, foul smelling urine and deepening of urine color. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had an indwelling urinary catheter. Review of physician orders for May 2025 revealed Resident #9 was on enhanced barrier precautions (EBP) related to indwelling medical device. Observation on 05/14/25 at 7:49 A.M. revealed Resident #9 was sleeping in bed and the urinary catheter bag was observed on the floor under Resident #9's bed. Sign was posted outside Resident #9's door that indicated Resident #9 was on enhanced barrier precautions, as well as an isolation bin that contained personal protective equipment (PPE), that included gown, gloves and face masks. Observation on 05/14/25 at 9:56 A.M. revealed Resident #9's urinary catheter remained on the floor. Observation on 05/14/25 at 10:00 A.M. with Certified Nursing Assistant (CNA) #109 confirmed Resident #9's catheter bag was on the floor. CNA #109 stated she had not provided Resident #9 with care since the start of her shift at 7:00 A.M. and stated urinary catheter bag should not be placed on the floor. Further observation of catheter care with CNA #109 for Resident #9 revealed catheter insertion site and tubing had black dried debris around it. CNA #109 stated she was unable to state when Resident #9 had last received catheter care and stated catheter care should be done at least every shift. CNA #109 had not donned PPE prior to entering Resident #9's room or during catheter care. Interview with CNA #109 at time of observation confirmed Resident #9 was on EBP and PPE should have been worn during catheter care. Review of facility policy titled Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed residents with indwelling medical devices EBP were indicated. EBP included the use of gown and gloves during high contact resident care.Based on personnel file review, staff interview, and observation the facility failed to ensure pre-employment tuberculosis testing was completed timely for all staff, enhanced barrier infection control precautions were followed during Resident #9's catheter care, and hand hygiene was properly performed during Resident #165's medication administration. This had the potential to affect all 59 residents in the facility. Findings include: 1. Review of personnel file for CNA #191 revealed a hire date of 07/23/24. Further review of the personnel record revealed it did not contain evidence pre-employment tuberculosis testing had been completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the personnel record for LPN #161 revealed a hire date of 05/07/24. Further review of the personnel record revealed tuberculosis testing was not completed until 10/10/24 by an outside provider. Review of the personnel record for Activity Director #132 revealed a hire date of 12/13/24. Further review of the personnel record revealed tuberculosis testing was not completed until 12/18/24. Record review of Licensed Practical Nurse (LPN) #114's personnel file revealed a date of hire 10/23/24. Further review of the personnel record revealed tuberculosis testing was not completed until 12/26/24. Interview on 05/15/25 at 1:07 P.M. with Human Resource Manager #143 confirmed the identified findings. 3. Observation of medication administration on 05/12/25 at 8:55 A.M. revealed LPN # 114 began the medication pass without performing hand hygiene. The nurse went into Resident #165's to administer medication. LPN #114 placed gloves on her hands and administered pills in a cup to the resident, after the administration the nurse went out of the resident's room with gloves on, walked up the hall to the medication cart and retrieved Enoxaparin injection for the resident with the gloves still on. The nurse administered the injection to Resident #165 at 9:05 A.M. with the same gloves on. When the injection was completed, LPN #114 left the residents room and walked back up the hall to the medication cart then took the gloves off. The nurse did not complete hand hygiene. Interview at 9:10 A.M. on 05/12/25 with LPN #114 revealed the nurse was a new nurse and she stated that she didn't think about hand hygiene during or after the medication administration. Interview with Regional Director of Nursing Services #166 on 05/12/25 at 9:15 A.M. revealed the nurse should have performed hand hygiene before the medication administration, before the gloves were placed on the nurses' hands, and after the gloves were removed in Resident #165's room and hands cleaned before leaving the room. She stated infection control is a priority in the facility. Review of the facility policy titled Handwashing/ Hand Hygiene, dated August 2015, revealed the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel should follow the handwashing/ hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is the final step after removing protective equipment.

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	05/29/2025

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, facility policy review, review of Centers for Disease Control and Prevention (CDC) guidance and interview the facility failed to ensure residents were were offered, screened, educated and received influenza and pnuemocicccal vaccinations as required. This affected five residents (#3, #8, #11, #21 and #60) of five reviewed for vaccinations with the potential to affect all 59 residents residing in the facility. Findings include: 1. Review of Resident #3's medical records revealed an admission date of 05/17/24. Diagnoses included dementia, schizophrenia and muscle weakness. Review of Resident #3's immunization records revealed no documentation related to influenza or pnuemocicccal vaccinations, consent/declination of the vaccination or education provided on the vaccines. Interview on 05/19/25 at 2:48 P.M. with [NAME] President of Operations (VPO) #172 and Regional Registered Nurse (RRN) #182 revealed they were unable to locate the vaccination records, refusals or education for Residents #3. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of facility policy titled Influenza Vaccine revised 08/16 revealed for residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. A residents refusal of the vaccination will be documented and placed in the residents medical records. Review of facility policy titled Pneumococcal Vaccine revised 08/16 revealed prior to or upon admission residents will be assessed for eligibility to receive the pnuemocicccal vaccinations and will be offered the vaccine series within thirty days of admission unless contraindicated. Residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. Review online Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination dated 10/26/24 revealed the following: CDC recommends pneumococcal vaccination for children younger than 5 years and adults 50 years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #8's medical records revealed an admission date of 02/13/25. Diagnoses included schizophrenia cognitive deficits and muscle weakness. Review of Resident #8's immunization records revealed no documentation related to influenza or pnuemociccal vaccinations, consent/declination of the vaccination or education provided on the vaccines. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 revealed they were unable to locate the vaccination records, refusals or education for Residents #8. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of facility policy titled Influenza Vaccine revised 08/16 revealed for residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. A residents refusal of the vaccination will be documented and placed in the residents medical records. Review of facility policy titled Pneumococcal Vaccine revised 08/16 revealed prior to or upon admission residents will be assessed for eligibility to receive the pnuemociccal vaccinations and will be offered the vaccine series within thirty days of admission unless contraindicated. Residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. Review online Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination dated 10/26/24 revealed the following: CDC recommends pneumococcal vaccination for children younger than 5 years and adults 50 years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident. 3. Review of Resident #11's medical records revealed an admission date of 03/02/17. Diagnoses included congestive heart failure, asthma and morbid obesity. Review of Resident #11's immunization records revealed no documentation related to influenza or pnuemociccal vaccinations, consent/declination of the vaccination or education provided on the vaccines. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 revealed they were unable to locate the vaccination records, refusals or education for Residents #11. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Influenza Vaccine revised 08/16 revealed for residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. A residents refusal of the vaccination will be documented and placed in the residents medical records. Review of facility policy titled Pneumococcal Vaccine revised 08/16 revealed prior to or upon admission residents will be assessed for eligibility to receive the pnuemocicccal vaccinations and will be offered the vaccine series within thirty days of admission unless contraindicated. Residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. Review online Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination dated 10/26/24 revealed the following: CDC recommends pneumococcal vaccination for children younger than 5 years and adults 50 years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident. 4. Review of Resident #21's medical records revealed an admission date of 06/25/24. Diagnoses included diabetes, respiratory failure and asthma. Review of Resident #21's immunization records revealed no documentation related to influenza or pnuemocicccal vaccinations, consent/declination of the vaccination or education provided on the vaccines. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 revealed they were unable to locate the vaccination records, refusals or education for Residents #21. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of facility policy titled Influenza Vaccine revised 08/16 revealed for residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. A residents refusal of the vaccination will be documented and placed in the residents medical records. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Pneumococcal Vaccine revised 08/16 revealed prior to or upon admission residents will be assessed for eligibility to receive the pnuemociccal vaccinations and will be offered the vaccine series within thirty days of admission unless contraindicated. Residents who had received the vaccine the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the residents medical records. Review online Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination dated 10/26/24 revealed the following: CDC recommends pneumococcal vaccination for children younger than 5 years and adults 50 years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident. 5. Review of Resident #60's medical records revealed an admission date of 01/21/25. Diagnoses included dementia, chronic obstructive pulmonary disease (COPD) and cognitive deficits. Review of Resident #60's immunization records revealed no documentation related to influenza or pnuemociccal vaccinations, consent/declination of the vaccination or education provided on the vaccines. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 revealed they were unable to locate the vaccination records, refusals or education for Residents #60. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review online Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination dated 10/26/24 revealed the following: CDC recommends pneumococcal vaccination for children younger than 5 years and adults 50 years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident.

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	365355	A. Building B. Wing	05/29/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review, review of Centers for Disease Control and Prevention (CDC) guidance and interview the facility failed to ensure residents were screened for immunization, educated on the risk and benefit of receiving the COVID-19 vaccine, or were offered and received COVID-19 vaccinations as required. This affected five residents (#3, #8, #11, #21 and #60) of five reviewed for vaccinations. The facility census was 59. Findings include: 1. Review of Resident #3's medical records revealed an admission date of 05/17/24. Diagnoses included dementia, schizophrenia and muscle weakness. Review of Resident #3's immunization records revealed no documentation related to COVID-19 vaccinations, including consent/declination of the vaccination or education provided on the vaccine. Interview on 05/19/25 at 2:48 P.M. with [NAME] President of Operations (VPO) #172 and Regional Registered Nurse (RRN) #182 stated they were unable to locate the vaccination records, refusals or education for Residents #3, #8, #11, #21, and #60. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines dated 01/07/25 revealed everyone over six months of age should receive the 2024 to 2025 COVID-19 vaccination to best protect from currently circulating stains. Review of the CDC guidance on COVID-19 dated 03/10/25 revealed the COVID-19 vaccination was recommended for prevention of severe health outcomes. 2. Review of Resident #8's medical records revealed an admission date of 02/13/25. Diagnoses included schizophrenia cognitive deficits and muscle weakness. Review of Resident #8's immunization records revealed no documentation related to COVID-19 vaccinations, including consent/declination of the vaccination or education provided on the vaccine. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 stated they were unable to locate the vaccination records, refusals or education for Resident #8. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines dated 01/07/25 revealed everyone over six months of age should receive the 2024 to 2025 COVID-19 vaccination to best protect from currently circulating stains. Review of the CDC guidance on COVID-19 dated 03/10/25 revealed the COVID-19 vaccination was recommended for prevention of severe health outcomes. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of Resident #11's medical records revealed an admission date of 03/02/17. Diagnoses included congestive heart failure, asthma and morbid obesity. Review of Resident #11's immunization records revealed no documentation related to COVID-19 vaccinations, including consent/declination of the vaccination or education provided on the vaccine. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 stated they were unable to locate the vaccination records, refusals or education for Resident #11. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines dated 01/07/25 revealed everyone over six months of age should receive the 2024 to 2025 COVID-19 vaccination to best protect from currently circulating stains. Review of the CDC guidance on COVID-19 dated 03/10/25 revealed the COVID-19 vaccination was recommended for prevention of severe health outcomes. 4. Review of Resident #21's medical records revealed an admission date of 06/25/24. Diagnoses included diabetes, respiratory failure and asthma. Review of Resident #21's immunization records revealed no documentation related to COVID-19 vaccinations, including consent/declination of the vaccination or education provided on the vaccine. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 stated they were unable to locate the vaccination records, refusals or education for Resident #21. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines dated 01/07/25 revealed everyone over six months of age should receive the 2024 to 2025 COVID-19 vaccination to best protect from currently circulating stains. Review of the CDC guidance on COVID-19 dated 03/10/25 revealed the COVID-19 vaccination was recommended for prevention of severe health outcomes. 5. Review of Resident #60's medical records revealed an admission date of 01/21/25. Diagnoses included dementia, chronic obstructive pulmonary disease (COPD) and cognitive deficits. Review of Resident #60's immunization records revealed no documentation related to COVID-19 vaccinations, including consent/declination of the vaccination or education provided on the vaccine. Interview on 05/19/25 at 2:48 P.M. with VPO #172 and RRN #182 stated they were unable to locate the vaccination records, refusals or education for Resident #60. VPO #172 and RRN #182 further confirmed no documented evidence was included in the residents electronic medical records. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines dated 01/07/25 revealed everyone over six months of age should receive the 2024 to 2025 COVID-19 vaccination to best protect from currently circulating stains. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the CDC guidance on COVID-19 dated 03/10/25 revealed the COVID-19 vaccination was recommended for prevention of severe health outcomes.

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	365355	A. Building B. Wing	05/29/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on record review, observation and interview, the facility failed to ensure the elevators were working in a safe operation condition. This had the potential to affect all 59 residents residing in the facility. Findings include: Review of documentation for elevator concerns including invoices from the elevator service company dated from 11/08/24 to 05/13/25, incident with the fire department with elevator rescue and an employee in-service revealed the facility had been having elevator concerns to both elevators since 11/08/24. Review of the documentation revealed: -11/08/24 invoice-Elevator one was not responding, stuck on unknown floor and the doors closed. It was unoccupied. Elevator technician adjusted the light tray and elevator one was still in service. -12/09/24 invoice-Elevator preventative maintenance. -01/08/25 invoice-Elevator one and two, preventative entrapment, elevators not responding. Both elevators stuck on unknown floors. The doors were closed on both elevators. The elevators were unoccupied. Elevator technician emptied pit buckets on both cars and then checked operations. -01/24/25 invoice-Preventative maintenance. -02/14/25 invoice-Elevator one was not responding. The elevator was stuck in between floors. The doors were closed and the elevator was unoccupied. Elevator one was down for a light ray unit and the part was on order. -03/04/25 invoice-Elevator two was not responding at 1:09 P.M. It was stuck on the first floor with the doors closed and unoccupied. Elevator technician replaced switches to both door locks and car doors and repaired the car door track on elevator one. The pit was cleaned and emptied on elevator two. -03/04/25 invoice-Elevator one and two were not responding at 6:44 P.M. Both elevators were stuck on unknown floors, doors closed and unoccupied. The elevators were reset by the facility and running at the time of the elevator technician's arrival. The elevator technician run both cars and was unable to find an issue. They left both elevators in service. -03/06/25 invoice-Performed safety test on the elevators and there were no concerns. -03/10/25 invoice-Elevator two was not responding and stuck on the first floor with the doors closed and unoccupied. The low oil sensor had tripped. The elevator technician ran elevator two it tripped again. After trying again, elevator two was working. The elevator technician stated the valve may need replaced soon. -03/11/25 invoice-Elevator two was not responding. Elevator technician replaced the top and bottom boards and adjusted the valve. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-03/14/25 invoice-Elevators one and two were not responding and stuck on the second floor with the doors closed and unoccupied. The elevator technician found a loose wire on a coil. -03/15/25 invoice -Elevator two was going up but not coming back to the first floor. The elevator was stuck on the first floor with the doors closed, though still in use. The elevator technician stated the car had a low oil timer and reset the car and it was left in service. -03/18/25 invoice-Elevators one and two were not responding. Both elevators were stuck on the first floor with the doors closed and unoccupied. Elevator technician reset the low oil and updated their office about the valve replacement (noted on 03/10/25). -03/19/25 invoice-Preventative maintenance. The elevator technician replaced the power board. -03/24/25 invoice-Elevator two was not responding. The photo eye was not working and had shut down the elevator and was stuck on the first floor with the doors closed. Elevator technician was unable to find any concerns. -04/09/25 invoice-Elevator two was not responding and stuck on an unknown floor with the doors closed and unoccupied. The elevator technician stated the motor read good. They updated the facility to contact an electrician about incoming power issues. -04/11/25 invoice-Elevator two was not responding and stuck on the first floor with the doors closed and unoccupied. Elevator technician stated the elevator was having low leg amp faults (indicating a voltage/connection problem). The elevator was taken completely out of service. -05/04/25 Fire Department Incident stated at 1:24 P.M. they were notified of possible entrapment in a stalled elevator car. The fire department arrived at the facility at 1:29 P.M. Upon arrival, the person had already been removed from the elevator car and the elevator was working properly. -05/06/25 invoice-Elevator two had motor and valve replacement. Elevator two was still out of service. -05/08/25 invoice-Performed preventative maintenance. -05/13/25 invoice-A call was placed to the elevator service company stating elevator one was not responding to first floor call and was stuck on the second floor, doors closed. -Review of elevator in-service, undated, revealed The elevator is currently in repair and should be completed shortly. In the meantime, please be aware of the following: Mindful to push the elevator back down to the first floor, remember resident and families are waiting for the elevator, your assistance is appreciated to expedite not only family and resident needs but also coworkers and supplies. Any questions, please contact your Administrator or Director of Nursing. Observation on 05/12/25 at 8:15 A.M. of the facility elevators revealed elevator two (bigger elevator) was out of service. Elevator one was working, however, when getting into the elevator there was a sign posted stating When exiting the elevator please send it back to the first floor, per maintenance. (continued on next page)

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	05/29/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/12/25 at 9:59 A.M. with Licensed Practical Nurse (LPN) #114 stated elevator two was broken. She stated someone did come to look at it but it was still out of order. She stated elevator one did not work properly. LPN #114 stated when the elevator was used and taken to the second floor, whoever was exiting the elevator had to push the button one to send it back to the first floor or it would be stuck on the second floor. She stated if the one button was not pushed, residents had to wait long periods of time and then staff would have to call to the second floor for someone to go into the elevator and press button one so it would return to the first floor. Interview on 05/12/25 at 10:00 A.M. with the Director of Nursing (DON) revealed she was unaware of the concerns with elevator one. She stated she did not know staff/residents had to press one when they were exiting the second floor to ensure the elevator would return to the first floor. Interview on 05/12/25 at 10:34 A.M. with LPN #100 verified elevator one was not working properly. She stated it would be stuck on the second floor if the resident, visitor or staff member did not push the one button to return it to the first floor. She stated Resident #6 was unable to fit into elevator one because the size of his wheelchair. LPN #100 stated most of the activities were done on the second floor. Observation on 05/12/25 at 2:16 P.M. of elevator one. The button had been pushed and residents were waiting to go to the second floor. Approximately five minutes later, at 2:21 P.M., the elevator door opened and immediately shut not allowing residents to get off of the elevator onto the first floor. Interview on 05/12/25 at 2:48 P.M. with Regional Maintenance Director (RMD) #169 revealed the elevator company was here on 05/09/25 to fix elevator two. He stated they replaced the motor but it had not corrected the problem and had to order another part, a starter. He stated they were waiting for it to be installed later this week. He stated he was unaware of concerns with elevator one. Interview on 05/13/25 at 12:00 P.M. with Elevator Repair Supervisor #170 provided an email timeline for elevator two's repair. He also stated on 04/09/25 his service technician recommended an electrician which is the protocol when they get a power glitch in the building. He stated at that time the motor was fine and it lead the technician to believe it was the incoming power. He verified elevator two had been out of service since 04/11/25. He also stated he was not updated about elevator one's concern with not coming back to the first floor when called unless the one button inside the elevator was pushed on the second floor. He stated he believed the issue with elevator one was unrelated to the concerns of elevator two. Review of the email dated 05/13/25 from Elevator Repair Supervisor #170 revealed the last service call for elevator two was on 04/11/25. The pump motor was ordered on 04/15/25 and they fixed the elevator on 05/06/25. The elevator company scheduled an inspection on 05/09/25 with the state and it was noted the starter was not working. (continued on next page)

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	05/29/2025

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

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/13/25 at 1:39 P.M. with the Maintenance Director #138 verified he placed the elevator sign in elevator one related to pushing the button to go back to the first floor after arriving to the second floor. He also verified the staff in-service was done prior to 04/14/25 but was unable to give the exact date. He stated the facility did not call an electrician on 04/09/25 because the elevator technician had changed his mind about needing an electrician. He was unable to provide documentation stating this. He stated he could not recall staff or residents being stuck on the elevator. Maintenance Director #138 verified he had not called the elevator service company regarding elevator one's concern until today. Interview on 05/13/25 at 1:39 P.M. with RMD #169 revealed elevator one's opening was 35 inches. He stated Resident #11's motorized wheelchair was 30.5 inches. He stated the arm would need removed off of the chair for him to get into the elevator. Interview on 05/14/25 at 11:47 A.M. with Assistant Fire Chief #204 verified the fire department was called on 05/04/25 for an entrapment in elevator one. He stated when they arrived, the facility had gotten the elevator open. He was unsure if it was a resident or staff member who was entrapped on the elevator. Interview on 05/15/25 at 12:26 P.M. with RMD #169 stated on 05/04/25 there were no residents or staff entrapped on the elevator. A staff member had called the fire department because the elevator was stuck and she believed there was a resident or staff person in the elevator car. He stated the facility was able to send the elevator to the first floor and the doors opened before the fire department arrived. RMD #169 stated on 04/11/25 the elevator technician did not want to service elevator one because it was working and they did not want both elevators broke at the same time. He verified there was no documentation stating this. He stated he would provide a statement from the elevator technician. RMD #169 stated he believes elevator one issue was related to elevator two. He stated when elevator one is taken to the second floor and then someone on the first floor pushes the button, the elevator system believes elevator two is there and that is why elevator one does not return to the first floor without pushing the button. Interview on 05/15/25 at 2:50 P.M. with RMD #169 revealed the elevator technician refused to make a statement related to elevator one. However, he provided a statement from Elevator Repair Supervisor #170. Review of the emailed statement dated 05/15/25 at 2:57 P.M. from Elevator Repair Supervisor #170 revealed he had spoken to the normal routine elevator technician who serviced the building. He stated the dispatch problem with elevator one had been going on for quite some time and only when elevator two was out of service and the power was removed. Elevator Repair Supervisor #170 stated his technician stated he had attempted to correct elevator one's issue but both elevators shut down. He stated the technician instructed the building to put a sign in elevator one until elevator two was fixed so they would have a working elevator. Observation on 05/15/25 at 3:46 P.M. with RMD #169 of the elevators revealed the elevator technicians had left elevator two in between floors. RMD #169 stated elevator one should be able to be called to the first floor by the button on the first floor. This surveyor went to the second floor in elevator one and did not push the first floor button to return the elevator. RMD #169 pushed the up button on the first floor and elevator one did not return to the first floor verifying there was still an issue with elevator one. (continued on next page)

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	365355	A. Building B. Wing	05/29/2025

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Gardens of Mayfield Village	6757 Mayfield Rd Mayfield Heights, OH 44124

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents non-compliance investigated under Complaint Number OH00161946 and Complaint Number OH00162143.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a clean, sanitary and safe environment. This had the potential to affect all 59 residents residing in the facility. The facility census was 59. Findings include: Initial observation of the facility on 05/12/25 at 8:15 A.M. of the first floor revealed the bathroom on the first floor toilet paper holder was broken off. The Director of Nursing (DON) was present and verified the finding. On the second floor on the memory care unit there was noted to be strong odors of urine and bowel. The ice machine on the blue hall noted to have water leaking around it with towels and bath blankets laying on the floor to soak up the water that had leaked. Observation on 05/12/25 at 9:04 A.M. of Resident #45's room revealed the resident was not present in room. The bed linens were observed to have been heavily soiled and were odorous. The call light was observed across the room on the floor. On 05/12/25 at 9:18 A.M. returned to Resident #45's room with Licensed Practical Nurse (LPN) #108 and she verified the above findings. Observation on 05/12/25 at 10:05 A.M. revealed room [ROOM NUMBER], which was unoccupied, to have food debris and soiled depends in the room. Observation on 05/12/25 at 10:08 A.M. of Resident #9's room revealed his room to have debris on the floor and a bed pan underneath his bed that had not been cleaned of bowel and urine. Observation on 05/12/25 at 10:30 A.M. of Resident #35's room revealed his trash can beside his bed was full of dirty towels. Surrounding the trash can on the floor there was a dirty fitted bed sheet and bath blanket. There was also an empty urinal lying on the floor approximately two feet from the end of the bed. Resident #35 stated the staff on night shift had come in and assisted him with care but never returned to clean up his room. On 05/12/25 at 10:32 A.M. the Business Office Manager (BOM) #142 verified the findings as above. Observation on 05/12/25 at 10:31 A.M. of Resident #26's room revealed trash under his bed. Observation on 05/12/25 at 11:12 A.M. of Resident #17's room revealed the floor had food debris and there were paper towels on the floor. Observation on 05/14/25 at 7:30 A.M. of the first floor bathroom revealed there was no toilet paper and the trash was overflowing onto the floor. Interview on 05/15/25 at 9:39 A.M. with Housekeeper #174 revealed she had worked at the facility for one month. She stated there was not enough staff in housekeeping to ensure the facility was clean. She verified resident rooms were not being cleaned everyday. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/20/25 at 12:32 P.M. of the 2nd floor nurse's station revealed the handrails to have food, band-aids, trash, paperclips, staples and straws in it. LPN #131 was present and verified the findings. She stated the housekeeping staff were not cleaning the resident rooms and common areas every day. Review of the facility policy titled, Cleaning and Disinfecting Residents' Rooms, revised August 2013, revealed housekeeping surfaces such as floors and tabletops would be cleaned on a regular basis as well as environmental surfaces. This deficiency represents non-compliance investigated under Complaint Number OH00164538, Complaint Number OH00162143, Complaint Number OH00162053 and Complaint Number OH00161946.