STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365392	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky River Gardens Rehab and Nursing Ctr	4102 Rocky River Dr Cleveland, OH 44135

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 39333 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, closed record review, review of hospital records, review of a protective order, review of a police report, facility policy review and interview, the facility failed to provide adequate supervision and comprehensive individualized interventions to prevent an unauthorized leave of absence (LOA) for Resident #200, who was under adult protection services (APS) with a guardian and guardian directive which prohibited Resident #200's husband from taking the resident off facility premises or into his vehicle. This resulted in Immediate Jeopardy and actual harm/death beginning on [DATE] at approximately 6:00 P.M. when Resident #200's husband took the resident outside the facility and then left the facility grounds with the resident in his vehicle without staff knowledge. Resident #200 was found deceased by local police on [DATE] approximately 1.5 miles from the facility with a gunshot wound to the head. Resident #200's husband was also deceased with an apparent self-inflicted gunshot wound to the head. This affected one resident (#200) of one sampled resident with a protective order reviewed for safety/supervision. The facility identified that 24 residents (#1, #2, #4, #5, #11, #25, #26, #27, #29, #30, #31, #41, #45, #50, #63, #70, #72, #74, #77, #79, #82, #94, #98, and #100) who had guardians and no additional residents with protection orders in place. On [DATE] at 2:58 P.M. the Administrator, by [NAME] President of Operations (VPO) #303, [NAME] President of Clinicals (VPC) #304, and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at 6:00 P.M. when staff failed to prevent Resident #200's husband from taking the resident off facility premises (as per a guardian directive). On [DATE] Resident #200 was found deceased by local police approximately 1.5 miles from the facility with a gunshot wound to the head. The Immediate Jeopardy was removed and the deficiency corrected on [DATE] when the facility implemented the following correction actions: On [DATE] at 10:29 P.M. Licensed Practical Nurse (LPN) #300 notified the DON Resident #200 was not in the facility. The DON instructed LPN #300 to notify Physician #302 and Adult Protective Services (APS) Guardian #320. On [DATE] at 10:53 P.M. LPN #300 notified Physician #302 and left a voicemail to return call to facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Rocky River Gardens Rehab and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Rocky River Dr Cleveland, OH 44135	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:54 P.M. the DON attempted to contact Resident #200's husband and left a voicemail asking him to return the call as soon as possible. On [DATE] at 10:55 P.M. the DON attempted to contact Resident #200's husband again but did not leave a voice mail. On [DATE] at 10:55 P.M. LPN #300 notified APS Guardian #320 that Resident #200 was not in facility. On [DATE] at 11:20 P.M. the DON notified the local police department of an unauthorized LOA for Resident #200. On [DATE] at 11:45 P.M. the DON arrived at facility and spoke with Police Officer (PO) #322 regarding the situation and supplied him with Resident #200's face sheet and diagnosis list. Officer #322 assigned report #[DATE]. On [DATE] between 9:45 A.M. and 10:00 A.M. a root cause analysis was conducted by VPO #303, VPC #304, Regional Director of Operations (RDO) #305, Regional Director of Clinical Services (RDCS) #306, Administrator, and DON related to the incident. System failure was identified as failure to ensure LOA sign-out was monitored and failure to adequately supervise Resident #200's LOA. On [DATE] at 10:05 A.M. VPCS #304 and VPO #303 educated the DON and Administrator on the facility adequate supervision of residents, LOA procedure, and facility abuse/neglect policy. On [DATE] at 10:10 A.M. the DON spoke with PO #322 from the local police department and received an update that Resident #200 had expired. On [DATE] at 10:25 A.M. the DON and Administrator educated all department heads on adequate supervision of residents, abuse/neglect policy and LOA procedure. The LOA procedure included that LOA books must be in secured location behind each nurse's station and the front desk, employee must verify LOA status via bed board (list of all residents by room number, payer and LOA status) resident or responsible party must sign out on the book with estimated return time. If the resident is not back by the estimated time, the facility will make contact and ask for an updated return time. On [DATE] at 10:49 A.M. RDCS #306 reviewed all residents' medical records for guardian status, to ensure appropriate LOA orders and any protective orders were in place and care planned. The facility identified 24 Residents (#1, #2, #4, #5, #11, #25, #26, #27, #29, #30, #31, #41, #45, #50, #63, #70, #72, #74, #77, #79, #82, #94, #98, and #100) with guardians. There were no additional residents currently residing in the facility who had protection orders. On [DATE] from 11:00 A.M. through 4:00 P.M. the DON, Assistant Director of Nursing (ADON) #308, LPN #309, Human Resource Director (HR) #310, Dietary Manager (DM) #311, Director of Rehabilitation (DOR) #312, Housekeeping Supervisor #313, Activities Director (AD) #314 educated their departments so that all staff were in-serviced on the facility adequate supervision of residents, LOA procedure, and facility abuse/neglect policy. Staff who were not in the building received a phone call with the information. On [DATE] at 11:15 A.M. Admissions Director #315, reviewed and updated the facility bed board per LOA orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rocky River Gardens Rehab and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Rocky River Dr Cleveland, OH 44135	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:30 A.M. the DON updated the LOA sign-out books with a new form to include anticipated return time at all nurse's stations and the front desk. On [DATE] at 11:45 A.M. LPN #309 updated and implemented the nurse report sheets at all nurse's stations. The nurse report was updated to include the report of residents on LOA. On [DATE] at 2:33 P.M. Physician #303 was informed of the situation surrounding Resident #200's death by the DON. On [DATE] at 2:41 P.M. Medical Director #316 was notified of Resident #200's death and a Quality Assurance and Performance Improvement (QAPI) meeting was held with the interdisciplinary team (IDT) including Medical Director #316, Physician #302, Administrator, DON , AD #314, HR #310, LPN #309, Maintenance Director #317, Admissions #315, and Maintenance Assistant #318 to review root cause analysis, facility interventions, facility policies, and facility response. The Administrator educated attendees on the policy if an order was obtained that allowed outside visits on facility property or with contingencies such as: not allowed to sit in car, the outside visit must occur during supervised smoke times so staff were still able to supervise that the order restrictions were being followed, the adequate supervision of residents with orders, LOA procedure, and facility abuse/neglect policy. Orders must be complete and thorough with details that the facility would be able to follow. If any orders were received that were unable to followed or that could not be met and managed, the facility must call the prescriber/person back and explain why the order could not be followed and get a new or updated order. All communication for clarifying orders must be documented in Point Click Care (PCC) (electronic medical record). If any order comes that the facility is questioning the manageability, a call must be placed to regional staff for review. This included all orders for medications, LOA, protective orders, treatments, etc. On [DATE] at 3:55 P.M. APS Guardian #320 was notified by the DON of the situation surrounding the death of Resident #200. On [DATE] at 4:00 P.M. LPN #319 reviewed LOA orders, protective orders and LOA care plans for accuracy and updated as necessary. No other residents currently had protective orders. Audits were initiated the week of [DATE] for bed board completion and accuracy. Audits would be conducted five times a week for four weeks then weekly for four weeks and randomly thereafter by the Administrator or designee. Audits were initiated the week of [DATE] for completion and accuracy of LOA books. Audits would be conducted five times a week for four weeks then weekly for four weeks and randomly thereafter by the Administrator or designee. Audits were initiated the week of [DATE] for accuracy and completion of nursing report sheets. Audits would be conducted five times a week for four weeks then weekly for four weeks and randomly thereafter by the DON or designee. Audits were initiated the week of [DATE] for new admission or existing residents for new or revised protective orders, guardian status, and updated LOA orders to reflect in the residents' care plans. Audits would be conducted five times a week for four weeks then weekly for four weeks and randomly thereafter by the Social Worker or designee. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audits were initiated the week of [DATE] for new admission or existing residents with a mental health diagnosis to ensure they were offered psychological services. Audits would be conducted five times a week for four weeks then weekly for four weeks and randomly thereafter by the DON or designee. Observational audits were initiated on [DATE] of ten residents who required supervision of care to ensure monitoring was effective. Audits would be conducted five times a week for four weeks then weekly for four weeks and randomly thereafter by the DON or designee. Interviews on [DATE] and [DATE] at various times from 6:45 A.M. through 4:00 P.M. with Registered Nurse (RN) #569, Housekeeper #524, LPN #595, RN #557, Certified Nursing Assistant (C.N.A.) #571, C.N.A. #611, C.N.A. #588 and Receptionist #618 revealed that they were in-serviced on elopement, abuse, and visitation. Review of signed in-service sheets dated [DATE] verified employees were in-serviced on resident supervision with all tasks according to their plan of care, missing residents' best practice, LOA books, and LOAs with restrictions. Findings include: Review of the closed medical record for Resident #200 revealed an admitted [DATE] and a re-admitted [DATE] with diagnoses including unspecified psychosis not due a substance, Crohn's disease, generalized anxiety disorder, depression, and delusional disorder. Based on review of a police report, Resident #200 was pronounced deceased on [DATE] as a result of a gunshot wound to the head. The circumstances surrounding Resident #200's death was not included as part of the resident's medical record. Review of Resident #200's hospital admitting paperwork dated [DATE] revealed the resident had been hospitalized for treatment of acute psychosis. Resident #200 was brought to the hospital emergency department on [DATE] from home as she reportedly been increasingly confused and paranoid. She presented it to the hospital after a stress-induced seizure after a fight with her husband. Resident #200 presented to her primary care provider (PCP) on [DATE] with a right arm injury stating her husband slammed a metal door on her arm and held it closed causing multiple abrasions. She declined hospital and police at that time and was returned home. She and her husband continued to argue, the police were notified by neighbors, and Resident #200 was brought to hospital. Resident #200 was a poor historian. She had multiple visits to the hospital with psychosis and paranoia (mostly regarding her husband). Adult Protective Services (APS) had been involved with Resident #200 since 2013 related to the resident's accusations of abuse from her husband. The resident lived with her husband for over [AGE] years, and police visited the home multiple times due to domestic complaints. Upon examination, Resident #200 appeared drowsy but does engage. She voiced fear and paranoia of her husband. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #200 was cognitively intact and required set up for activities of daily living. Resident #200 did use a wheelchair but could transfer herself. Review of a protective order dated [DATE] revealed Resident #200 needed protective services, was incapacitated and that there was no person authorized by law or court to give consent (for the resident). It was ordered that APS would be authorized by law or court to be able to give consent. It was further ordered that APS should have the authority to consent to medical treatment and nursing home admission. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Rocky River Gardens Rehab and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 4102 Rocky River Dr Cleveland, OH 44135	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Social Service note dated [DATE] revealed Social Service Designee (SSD) #800 attempted to call APS Guardian #320 multiple times for discharge instructions for the resident. The note indicated this was an APS case, and the resident was not allowed to leave with her husband, but they were insisting on her leaving the facility and going home. A message was left with APS Guardian #320, and APS stated that he would reach out Friday or Monday. Review of the progress note dated [DATE] at 2:47 P.M. revealed the Administrator spoke to APS Guardian #320, (a temporary guardian), about Resident #200's husband being able to walk Resident #200 around the building. APS Guardian #320 stated that it was okay. They note indicated, per the APS Guardian, they were not allowed to leave the premises, but they could walk outside around the building. Review of a social services note dated [DATE] at 2:48 P.M. revealed Social Service Designee (SSD) #800 spoke with APS Guardian #320 regarding visitation by Resident #200's husband. The note revealed as of this date, Resident #200's husband was informed he was not allowed to sit in his car with his wife, and that they could just walk around the building. The note reflected third floor nursing (where the resident resided) and the front desk were notified. Review of Resident #200's medical record revealed no care plan was implemented for visitation, the resident's protection order and/or any restriction(s) on visitation with the resident's husband. In addition, there were no interventions initiated to ensure the resident was adequately supervised or her whereabouts monitored as it pertained to visitation with the resident's husband and per APS Guardian #320's directive. Review of the facility LOA logbook revealed on [DATE] Resident #200's husband signed in at 6:00 P.M. Record review revealed no nursing progress notes were written from [DATE] at 6:00 P.M. through [DATE] at 2:42 A.M. Review of a nursing progress note, created on [DATE] at 2:42 A.M. with an effective date of [DATE] at 9:28 P. M. (the police report below notes a time of 11:28 P.M.) authored by LPN #300 revealed she arrived to Resident #200's room and noticed Resident #200 wasn't in the room. The note indicated she looked in the bathroom and the resident was not there. Staff did a building search inside and outside. Resident #200's frequent visitor (identified to be her husband) was contacted with no answer. A voicemail was left. The nurse reached out to the DON, contacted the local police who arrived at the facility at 11:39 P.M., and a report was made. APS Guardian #320 was made aware of the situation. The note included will have dayshift follow up. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a police report (report #,d+[DATE]) dated [DATE] revealed the local police were called to the facility at 11:28 P.M. for a missing person [Resident #200]. Officer #322 spoke with LPN #300, who reported Resident #200 left the faciity on [DATE], between the approximate hours of 6:28 P.M. and 11:26 P.M. LPN #300 continued to state Resident #200 had a court ordered guardian [APS Guardian #320] and was not permitted to leave the property, without her guardian's permission. LPN #300 stated at approximately 11:26 P.M. she went to Resident 200's room to administer her night medications. It was at this time she realized Resident #200 was missing from her room. LPN #300 then stated that when she checked the visitor logbook, she observed that Resident #200's husband had signed the logbook as arrived for a visit. LPN #300 stated she then attempted to call the resident's husband by phone but received no response. She then proceeded outside and located Resident #200's wheelchair hidden behind bushes, in the rear parking lot of the facility. Officer #322 interviewed other staff members, and they believed the husband took Resident #200 in his car. Officer #322 drove by the husband's house and there was no activity. Officer #322 called the local medical examiner's office and was informed Resident #200 and her husband were found dead at a nearby golf course. The officer closed the report on [DATE] at 4:02 A.M. The report did not state the actual time Resident #200 and her husband her found deceased . Information provided by the facility during the investigation revealed on [DATE] between 9:45 A.M. and 10:00 A.M. a root cause analysis was conducted by VPO #303, VPC #304, Regional Director of Operations (RDO) #305, Regional Director of Clinical Services (RDCS) #306, the Administrator, and DON related to the incident. System failure was identified as failure to ensure LOA sign-out was monitored and failure to adequately supervise Resident #200's LOA. Interview on [DATE] at 8:15 A.M. with Receptionist #618 revealed the facility had a list of residents who could not go on LOAs. The list changed frequently. Receptionist #618 revealed Resident #200 was not allowed to go out on LOAs at first but then the resident's guardian allowed her to go outside the facility building with her husband if she did not get into the car or leave the premises. Receptionist #618 revealed the resident's husband would always park down on the right side (outside the facility), and she could not see the car. She stated she was not on duty on [DATE] at the time of the incident. During the interview, Receptionist #618 revealed she was responsible to ensure Resident #200 did not get in her husband's car when they were outside; however, she again reiterated she was not present in the facility at the time of the incident on [DATE]. Observation on [DATE] at 8:20 A.M. from front desk revealed no parked cars were visible from the front desk. Interview on [DATE] at 10:48 A.M., with the DON verified the content of the social service notes which directed (per the APS Guardian) that Resident #200 could not be in car with her husband. The DON stated the facility did not have a person assigned to supervise Resident #200 when she went outside. He stated the receptionist knew the husband should not have taken Resident #200 off the premises. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Information from APS revealed Resident #200 had been an active client with APS as of [DATE]. An APS investigation validated physical abuse (with a history of domestic violence) and self-neglect involving Resident #200. This resulted in APS pursuing a Protective Service Order (PSO) which made APS the temporary decision maker for the client. The resident was subsequently placed at the facility while APS pursued getting the client a guardian. The resident's husband was not pleased with either the PSO or the decision to place the resident in the facility. Following admission and during the resident's stay in the facility, APS was in regular contact with the resident's husband and the facility concerning visitation issues. Resident #200's husband wanted to take the resident out and away from the facility, but he could not be trusted to return her, so eventually the facility was directed by APS that the husband could visit, but he was not allowed to take her away from the facility. Interview with APS Guardian #320 on [DATE] at 2:44 P.M. revealed APS the facility told him that they would watch Resident #200 on the grounds. He stated the facility told him that they try not to limit visitors. Interview on [DATE] at 3:42 P.M. with LPN #580 revealed Resident #200 did not say much but did go outside with her husband. LPN #580 stated Resident #200 was not supposed to leave the premises. The LPN provided no additional information as to how staff were to ensure the resident did not leave the premises with her husband or how staff monitored the resident's whereabouts when the husband was visiting with her, or they were outside. Interview on [DATE] at 3:18 P.M. with Certified Nursing Assistant (CAN) #571 revealed during the resident's admission, she had become more social and was starting to talk. CNA #571 was aware Resident #200's husband visited a lot, and that the resident did go outside with him. CNA #571 denied the resident having any other visitors besides her husband. The CNA stated she was aware Resident #200 was not supposed to leave the premises. The CNA provided no additional information as to how staff were to ensure the resident did not leave the premises with her husband or how staff monitored the resident's whereabouts when the husband was visiting with her, or they were outside Interview on [DATE] at 3:28 P.M. with CNA #611 revealed Resident #200 was very quiet and stayed in her room. CNA #611revealed the resident's husband did visit a lot and he took her off the floor. The CNA stated she was aware the resident was not supposed to leave the grounds with her husband. The CNA provided no additional information as to how staff were to ensure the resident did not leave the premises with her husband or how staff monitored the resident's whereabouts when the husband was visiting with her, or they were outside Interview on [DATE] at 3:33 P.M. with CNA #588 revealed Resident #200 was becoming more social and starting to talk. Resident #200's husband visited a lot, and she went outside with him. CNA #588 stated Resident #200 had no other visitors, and Resident #200 was not supposed to leave the premises. The CNA provided no additional information as to how staff were to ensure the resident did not leave the premises with her husband or how staff monitored the resident's whereabouts when the husband was visiting with her, or they were outside Review of the facility policy dated [DATE] titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, revealed the facility would not tolerate neglect of any resident. The definition of neglect was the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid harm, pain, mental anguish, or emotional distress. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00160035 and Complaint Number OH00160019.

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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 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** 39973 Based on interview, record review and review of the facility policy, the facility did not ensure appropriate monitoring of Resident #201's ability to urinate and/or signs of urinary discomfort after the removal of an indwelling urinary catheter (a hollow flexible tube that collects urine from the bladder and leads to a drainage bag). This finding affected one (Resident #201) of three residents reviewed for urinary catheters. The facility census was 97. Findings include: Review of Resident #201's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including acute kidney failure, benign prostatic hyperplasia without lower urinary tract symptoms, and lymphedema. Review of Resident #201's October 2024 physician orders revealed an order dated 10/13/24 to provide urinary catheter care every shift; an order dated 10/13/24 for a 16 French Foley catheter with a 10 milliliters (ml) balloon; an order dated 10/13/24 for the catheter to be changed as needed if leaking or occluded; an order dated 10/13/24 to discontinue the Foley catheter and start the bowel and bladder program for three days. Review of Resident #201's October 2024 Documentation Survey Report of the Bowel and Bladder Tracking revealed the form had time slots to document Resident #201's bowel and bladder episodes including 12:00 A. M., 2:00 A.M., 4:00 A.M., 6:00 A.M., 8:00 A.M., 10:00 A.M., 12:00 P.M., 2:00 P.M., 4:00 P.M., 6:00 P.M., 8:00 P.M. and 10:00 P.M. Further review of Resident #201's Documentation Survey Report revealed on 10/12/24, the tracking for the 8:00 A.M., 10:00 A.M., 12:00 P.M. and 2:00 P.M. time slots (all documented at 12:54 P.M.) revealed the resident was continent of urine, continent of bowel, independent with toilet use (self-performance) and no setup or physical help was required from staff for toilet use (support provided). The documentation did not include the amount of urine that Resident #201 voided during these time slots. The 4:00 P.M., 6:00 P.M., 8:00 P.M. and 10:00 P.M. time slots were blank. The documentation on 10/13/24 for 12:00 A.M., 2:00 A.M., 4:00 A.M. and 6:00 A.M. (all entries documented at 6:08 A.M.) stated not applicable (n/a). The 8:00 A.M. time slot (documented at 7:15 A.M.) revealed the resident did not urinate, had no bowel movements, required total dependence with one person assist. The Documentation Survey Report revealed Resident #201 from 10/12/24 at 4:00 P.M. to 10/13/24 at 7:34 A.M. when the resident was discharged to the hospital (approximately 14.5 hours) there was no documented evidence that the resident urinated. Review of Resident #201's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and had an indwelling urinary catheter. He required partial to moderate assistance with toileting hygiene. Review of the nursing note dated 10/12/24 at 6:15 A.M. and authored by Registered Nurse (RN) #589 revealed Resident #201's urinary catheter was removed at this time, and education was provided to the resident on voiding and when to alert staff if he did not urinate. Resident #201 voiced understanding and the oncoming nurse was made aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Rocky River Gardens Rehab and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Rocky River Dr Cleveland, OH 44135	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing notes dated from 10/12/24 at 6:15 A.M. to 10/13/24 at 7:34 A.M. there was no further documentation regarding if Resident #201 was assessed after his indwelling urinary catheter was removed including if he urinated, if he had any discomfort, amount that he urinated, and/or any bladder/abdominal assessment. Review of Resident #201's Situation-Background-Assessment-Recommendation (SBAR) form at 10/13/24 at 7:34 A.M. authored by RN #585 indicated the resident complained of pain with the recommendation to send to the emergency room (ER). Review of the After Visit Summary dated 10/13/24 revealed Resident #201 was seen in the hospital emergency room by Physician Assistant (PA) #950 and diagnosed Resident #201 with urinary retention and urinary tract infection (UTI) with hematuria (blood in urine). PA #950 ordered an indwelling urinary catheter until follow up with the urologist and prescribed Macrobid (antibiotic) for urinary tract infection. Review of Resident #201's readmission progress note dated 10/13/24 at 12:22 P.M. authored by RN #585 indicated the resident was sent to the hospital at 7:00 A.M. and returned to the facility at 12:00 P.M. The resident had a diagnosis of urinary retention, and a 16 French Foley catheter was placed. A new order for Macrobid 100 milligrams (mg) twice daily for seven days due to a UTI was ordered. The physician and family were made aware. The Foley catheter was patent and draining yellow urine. Interview on 12/02/24 at 2:33 P.M. with [NAME] President of Operations #303 verified from the time the catheter was removed on 10/12/24 at 6:15 A.M. until 10/12/24 at 4:00 P.M. the staff documented that he was continent of urine but that there was no documented evidence of the amount that he had urinated and/or if he was having any difficulty with urination. She also verified Resident 201's October 2024 Documentation Survey Report of the Bowel and Bladder Tracking revealed he did not urinate per the documentation from 10/12/24 at 4:00 P.M. to 10/13/24 at 7:34 A.M. (approximately 14.5 hours) and that the documentation on 10/12/24 for 4:00 P.M., 6:00 P.M., 8:00 P.M. and 10:00 P.M. time slots were blank. She verified that there was no documentation after his urinary catheter was removed on 10/12/24 at 6:15 A.M. including if he was voiding without difficulty, amount he was voiding, any pain, and/or any bladder/abdominal assessment until on 10/13/24 at 7:34 A.M. when it was documented he was sent to the hospital for pain. Interview on 12/02/24 at 3:03 P.M. with Resident #201 revealed the facility removed his urinary catheter on 10/12/24 early in the morning, and he had not urinated. He revealed no staff including a nurse had ever checked on him including checking if he voided, if he had any discomfort, and/or completed any bladder/abdominal assessment. He revealed that after he had not voided for a prolonged period, he contacted the emergency rescue squad (EMS) to transport him to the hospital. He revealed he had not communicated with the nurse that he had contacted EMS until they arrived as he felt that if they did not care enough to check on him, then why should he let them know he had contacted EMS to take him to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365392	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky River Gardens Rehab and Nursing Ctr	4102 Rocky River Dr Cleveland, OH 44135

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled, Behavioral Programs and Toileting Plans for Urinary Incontinence last revised October 2010 indicated the purpose of the procedure was to provide guidelines for the initiation and monitoring of behavioral interventions and/or toileting plan for the resident with urinary incontinence. The policy revealed the staff would monitor, record, and evaluate information about the residents' bladder habits including voiding pattern (frequency, volume, time, quality of urine stream, and pain or discomfort. The policy revealed to notify the supervisor if the resident refused the procedure and to report other information in accordance with facility policy and professional standards of practice. There was nothing in the policy in regard to monitoring after a urinary catheter was discontinued. This deficiency represents non-compliance investigated under Complaint Number OH00159584.