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	01/14/2026

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 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 observation, interview, record review and review of the facility policy, the facility failed to provide timely incontinence care for Resident #48 and #96, and failed to ensure Resident #18, #50, 64 and #87 received showers/bathing as scheduled. This affected six residents (Resident #18, #48, #50, #64, #87 and #96) of seven residents reviewed for assistance with activities of daily living (ADL). The facility census was 91.Findings included:1. Review of the closed medical record for Resident #96 revealed an admission date of 05/13/25 and a discharge date of 08/11/25. Diagnosis included spinal stenosis, muscle weakness, need for assistants with personal care, repeated falls, and schizoaffective disorder bipolar type. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #96 had no behaviors exhibited, was not on a toileting program, was always incontinent of urine and frequently incontinent of bowel. Resident #96 had no impairment of the upper or lower extremities, used a wheelchair for mobility, required supervision or touching assistance for sit to stand, partial moderate assistants for chair/bed to chair transfer, required substantial/maximal assistants with toileting hygiene, supervision or touch assist with upper body dressing and was dependent for lower body dressing and personal hygiene. Review of the care plan dated 05/18/25 revealed Resident #96 had a self-care deficit related to need for staff assistants with various activities of daily living and transfers. Interventions included one to two assists required with assistive device for ambulation and one to two assist required for toileting. The care plan dated 05/28/25 revealed Resident #96 was on diuretic therapy related to edema. Resident #96 was also at risk for falls related to unsteady gait and repeated falls. Interventions included anticipating and meeting the resident ' s needs, be sure the resident ' s call light is within reach and encourage the resident to use it for assistants as needed. Resident #96 needed prompt response to all requests for assistants. Interview on 01/07/26 at 2:35 P.M. with Licensed Practical Nurse (LPN) #303 revealed she recalled Resident #96 and revealed, One day (Resident #96) wanted changed when we were doing the dining room at mealtime. It was the middle of lunch, we told him let us finish passing trays and we turned his call light off and he turned it right back on, he removed his soiled brief and threw it in the hallway. LPN #303 revealed the Certified Nursing Assistant (CNA) was CNA #237 and after the occurrence CNA #237 went and reported to her. LPN #303 stated, If a resident needs go to the bathroom during meals, the resident has to wait, that ' s the policy. I said to him (Resident #96) that ' s not appropriate, he said they always make me wait, he was upset and did not like being here. Interview on 01/07/26 at 2:51 P.M. with CNA #237 revealed she recalled the incident with Resident #96. CNA #237 stated, We were in the middle passing lunch, me and (Central Supply/CNA #245) were on the floor, and he (Resident #96) was coming back from smoking. We were in the middle of tray passes and he wanted us to change him, I said (Resident #96) you know we don ' t do patient care during tray pass. I said give us a second till I finish. He rolled to his room, the trays just came when he asked, we have around 48 trays to pass, so (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he needed to wait; he went to his room, I am passing trays, he turned on the bathroom call light, I took his meal tray in and said you can turn your call light off, I will come back when I am finished passing trays. I was in the dining room when he hit his call light again, on my way walking down he threw the soiled brief with urine in the hall. I seen the brief in the hall he was yelling so I went to go get (LPN #303). The policy is no patient care during meal passes. Interview on 01/07/26 at 3:00 P.M. with Central Supply/CNA #245 who confirmed she recalled the situation with Resident #96. Central Supply/CNA #245 stated, He (Resident #96) asked me to change him, I am unsure time of day, if I was passing trays I would say give me a second, I was told no personal care including incontinent care while meals were going on. I really can ' t remember the rest but he did want changed. Interview on 01/08/26 at 8:24 A.M. with Resident #33 revealed Resident #33 was in bed eating her breakfast. Resident #33 revealed she was not changed yet today and was incontinent but needed to wait until after breakfast. Resident #33 stated, You have to wait during meals to get changed because they have to feed people. Interview on 01/08/26 at 8:30 A.M. with Resident #41 who stated, I was told if I go during meals I have to wait to get changed until after the meal is over, it makes me feel not good, but there aren ' t very many people so they can ' t. 2. Record review for Resident #48 revealed an admission date of 02/14/24. Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, need for assistance with personal care, and fibromyalgia. Review of the quarterly MDS dated [DATE] revealed Resident #48 was moderately cognitively impaired. Resident #48 was frequently incontinent of bowel and bladder, used a motorized wheelchair for mobility, was dependant for toileting hygiene, toilet transfer, and substantial/maximal assistants for chair/bed to chair transfer. Review of the care plan for Resident #48 dated 02/19/24 revealed Resident #48 displayed frequent incontinence of bowel. Interventions included to check for incontinence, clean and dry skin if wet or soiled. Resident #48 also had frequent bladder incontinence. Interventions included to check and change Resident #48 every two hours and as needed. Cleanse peri area with each incontinent episode. Interview and observation on 01/08/26 at 8:32 A.M. with Resident #48 revealed Resident #48 was up in an electric wheelchair exiting her room. Resident #48 revealed she sleeps in the wheelchair every night per her choice. Observation revealed Resident #48 ' s pants were saturated/wet in the front. Resident #48 confirmed she was wet with urine and revealed staff had not changed her yet today. Resident #48 stated, The staff are doing breakfast so they are not allowed to change me. I am resident council president, they told us they can ' t change us during meals, they are not allowed during feeding hours. I can ' t see it or feel it because I am paralyzed from my waist down. Interview on 01/08/26 at 8:35 A.M. with CNA #225 revealed she started her shift at 7:00 A.M. and worked 12 to 16-hour shifts, and after breakfast she started changing her residents. CNA #225 stated We can ' t change residents during meals, it ' s the policy. Interview on 01/08/26 at 9:15 A.M. with CNA #225 revealed Resident #48 was just changed. CNA #225 confirmed Resident #48 was wet with urine including her pants and this was her first incontinence care for Resident #48 since start of her shift. Interview on 01/08/26 at 2:32 P.M. with Resident #48 revealed the last time staff checked or changed her was 'around 9:00 A.M. Resident #48 revealed she did not sleep well the previous night, so she slept most of the day.Observation of incontinence care for Resident #48 on 01/08/26 at 2:48 P.M. provided by CNA #223 revealed the outside of the front and back of Resident #48 ' s pants were saturated. The pad on the seat of Resident #48 ' s chair was heavily soiled with urine and stool. The brief Resident #48 was wearing was heavily soiled with urine and stool and Resident #48 had stool down her side and in her peri area. CNA #223 verified she was Resident #48 ' s primary CNA and verified the last time Resident #48 was checked or changed was around 9:00 A.M.; CNA #233 revealed she usually waited for Resident #48 to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tell her when she needed changed. Resident #48 revealed to the CNA she was sleeping all day and did not realize she needed changed. Resident #48 revealed some CNA ' s check her to see if she needed changed and some do not. Resident #48 revealed she would not mind if they woke her up to change her. Observation revealed Resident #48 ' s buttocks and upper thighs had creased in several areas from sitting in the chair without moving for several hours, the inner buttocks was deep red. Resident #48 stated, I don ' t know when I go, that ' s the problem. Interview on 01/08/26 at 5:00 P.M. with Administrator and DON revealed the DON had been employed for approximately one month. DON revealed a resident could receive incontinent care during meals if needed. Administrator revealed the best practice would be for the staff to check and change the residents before the meal then confirmed it also should be done as needed. 3. Record review for Resident #18 revealed an admission date of 09/11/21. Diagnoses included chronic diastolic congestive heart failure (CHF), muscle weakness, and need for assistance with personal care. Review of the quarterly MDS dated [DATE] revealed Resident #18 was cognitively intact. Resident #18 was frequently incontinent of urine and was dependent for showers/bathing, personal hygiene and toileting hygiene. Review of the care plan dated 09/29/21 revealed Resident #18 had an activity of daily living (ADL) self-care performance and mobility deficit related to weakness. Resident #18 required assistance by two staff with daily bathing and biweekly shower and as necessary. Review of the shower schedule revealed Resident #18 had showers scheduled on Tuesday and Friday. Interview on 01/06/26 at 1:56 P.M. with Resident #18 revealed she had not been receiving her showers/bed baths routinely as scheduled. Interview on 01/06/26 at 3:57 P.M. with CNA #227 revealed Residents ' have been complaining about their showers/baths not getting done. Record review on 01/12/26 at 10:22 A.M. of the Shower/Tub bath/ Bed Bath sheets provided by the DON and reviewed with DON for Resident #18 from 10/14/25 through 01/06/26 revealed there was no shower record for Resident #18 for 10/17/25, 10/31/25, 11/07/25, 11/14/25, 11/21/25, 11/28/25, 12/16/25, 12/19/25, 12/23/25, 12/26/25, 12/30/25, and 01/02/26. DON revealed when a resident received a shower or bath or refused a shower or bath, a shower sheet would be completed and signed by the CNA and then the nurse would also sign to verify the result. DON also confirmed the electronic medical record where CNA ' s also documented had the same results with the exception of some CNA ' s document every shift that a resident received a bath/shower and confirmed those were inaccurate. DON confirmed Resident #18 would not have received or been offered her shower/bath as scheduled for the time period reviewed. 4. Record review for Resident #87 revealed an admission date of 01/30/25. Diagnoses included spinal stenosis, muscle weakness, and need for assistants with personal care. Review of the quarterly MDS dated [DATE] revealed Resident #87 was cognitively intact. Resident #87 required substantial/maximal assistants with showers/bathing. Review of the care plan dated 07/28/25 revealed Resident #87 had an ADL self-care performance deficit related to impaired balance and limited mobility. Interventions included the resident required assistance by staff with bathing. Interview on 01/07/26 at 9:52 A.M. with Resident #87 revealed the staff did not give her her scheduled showers consistently on shower days stating, They say there ' s not enough staff. Resident revealed she never refused showers/baths and revealed it was upsetting when she could not have them.Review of the shower schedule revealed Resident #87 was scheduled showers on Mondays and Thursdays. Review of the Shower/Tub bath/ Bed Bath sheets for Resident #87 from 10/09/25 through 01/06/26 revealed Resident #87 did not receive or offered a bath or shower on 10/13/25, 11/10/25, (refused 11/17/25), 11/24/25, 11/27/25, 12/15/25, 12/18/25, (Refused 12/25/25), and 01/05/26. Interview and record review on 01/12/26 at 2:30 P.M. with the DON verified the shower sheets for Resident #87 were all there, there were no more and the days were accurate for when the Resident #87 received or was offered a shower/bath. 5. Record review for Resident #64 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed an admission date of 03/15/24. Diagnoses included chronic respiratory failure with hypoxia, muscle weakness, and need for assistance with personal care. Review of the census form included Res #64 was hospitalized on [DATE] and returned 10/17/25. Review of the quarterly MDS dated [DATE] revealed Resident #64 was cognitively intact. Resident #64 used a wheelchair for mobility and was dependent for bathing/showers. Review of the care plan dated 07/18/24 revealed Resident #64 required staff assistants for bathing and showering. Review of the shower schedule revealed Resident #64 was scheduled for showers on Tuesdays and Fridays on the 7:00 A.M. to 7:00 P.M. shift. Interview on 01/07/26 at 10:37 A.M. with Resident #64 revealed, I been begging for a bath for three days, there ' s no hot water they say, I don ' t get washed up period, they only give me one shower a month. I am not getting bed baths, sometimes they ask me in the middle of the night if I want to take my shower, I don ' t want take it in the middle night. I want it in the daytime; I tell them don ' t wake me up in the middle of the night to take a bath. Record review of the Shower/Tub bath/ Bed Bath sheets for 10/14/25 through 01/06/26 revealed Resident #64 ' s scheduled shower sheets were completed and signed as completed. Review of the shower record revealed on 10/14/25 Resident #64 received her shower, however, this would not have been possible because Resident #64 was hospitalized . Review of the shower sheet completed and signed by CNA #235 on 12/09/25 compared to a shower sheet dated 01/06/26 on which there was a signature for CNA #235 that was written twice on top of each other and did not match CNA #235's signature from 12/09/25, the 01/06/26 shower sheet indicated Resident #64 received a bed bath. Interview on 01/12/26 at 1:10 P.M. with DON confirmed Resident #64 was not in facility at the time the shower sheet was documented as completed on 10/14/25. DON revealed night shift showers should not be offered after 11:00 P.M. unless it was a resident preference and confirmed CNA #235 ' s signature dated 01/06/26 did not match the signature dated 12/09/25. Phone interview on 01/12/26 at 1:45 P.M. with CNA #235 revealed she did not have Resident #64 on 01/06/26 so she did not know if she received the shower/bath and confirmed she did not sign the shower sheet on 01/06/26. Interview on 01/12/26 at 2:10 P.M. with Scheduler #245 confirmed CNA #235 did not have Resident #64 on 01/06/26 and revealed CNA #237 had her on that day. Interview on 01/12/26 at 2:20 P.M. with CNA #237 confirmed she had Resident #64 on 01/06/26 and confirmed she did not give her her scheduled bath or shower and she did not sign the shower sheet stating, she would have signed her own name. CNA #237 revealed she did not remember why she did not offer or give the shower/bath on 01/06/26. 6. Record review for Resident #50 revealed an admission date of 09/24/20. Diagnoses included systemic lupus erythematosus, need for assistants with personal care, cerebral palsy and muscle weakness. Review of the quarterly MDS dated [DATE] revealed Resident #50 was cognitively intact. Resident #50 used a wheelchair for mobility and required substantial/maximal assistants for bathing/showering. Review of the care plan dated 11/11/20 revealed Resident #50 had an ADL self-care performance deficit related to impaired balance. Interventions included to provide sponge bath when a full bath or shower cannot be tolerated.Review of the shower schedule revealed Resident #50 was scheduled showers on Wednesday and Saturday. Interview on 01/08/26 at 8:40 A.M. with Resident #50 revealed she did not have a shower in three weeks. Observation revealed Resident #50 ' s hair was very oily. Resident #50 stated, It makes me feel disgusting, I told the Administrator this is bull (expletive). Resident #50 stated she was not showered due to hot water issues on her unit. Record review of the Shower/Tub bath/ Bed Bath sheets for Resident #50 revealed a shower was refused on 01/03/26 and 01/07/26. Both sheets were signed by CNA #225. Review of the shower sheets revealed the nurse signature was difficult to read for both days. Interview on 01/08/26 at 12:00 P.M. with the DON revealed she was unable to read the Nurse signature that signed the shower sheets on 01/03/26 and 01/07/26. Interview and review of the Shower/Tub (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bath/ Bed Bath sheets on 01/08/26 at 12:10 P.M. dated 01/03/26 and 01/07/26 for Resident #50 with LPN #286 and CNA #225 revealed CNA #225 stated Resident #50 never refused her showers on either of those dates. CNA #225 became upset and loudly questioned, Who signed my name? That is not my signature (while pointing at the shower sheets dated 01/03/26 and 01/07/26) she did not refuse, that is a lie, there was no hot water, look here is my signature (pointing out the signature on the shower sheet for Resident #50 dated 11/03/25) it looks nothing like that. LPN #286 confirmed the signatures signed on 01/03/26 and 01/07/26 did not resemble the signature dated 11/03/25. Interview on 01/08/26 at 12:36 P.M. with the DON revealed each resident should receive a minimum of two showers/baths per week and confirmed the third floor had a hot water issue since 12/23/25 and revealed if the water was not warm enough to bath in, it would not be considered the resident was refusing the shower. The resident would not be expected to take a cold shower or bed bath. The CNA should document the resident did not receive the bath or shower instead of the resident refused. DON confirmed no other staff member should sign a signature for a CNA except the CNA providing the care. Review of the facility policy titled, Shower/Tub Bath revised October 2010 revealed the purpose of the procedures are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident ' s skin. Be sure the bath area is at a comfortable temperature for the resident. The deficiency represents noncompliance investigated under Complaint number 2690478 and 1360479.

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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 - Minimal harm or potential for 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** Based on observation, interview, record review, and review of the facility policy revealed the facility failed to ensure interventions for fall prevention were in place for Resident #84 and #50. This affected two residents (#84 and #50) of three residents reviewed for falls. The facility census was 91.Findings included:1. Record review for Resident #84 revealed an admission date of 02/01/22. Diagnoses included unspecified dementia, cognitive communication deficit, need for assistance with personal care, abnormalities of gait and mobility, and muscle weakness. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 was moderately cognitively impaired. Resident #84 used a walker and wheelchair for mobility, was occasionally incontinent of urine and frequently incontinent of bowel, required supervision or touch assistance for toileting hygiene, bed mobility, chair/bed to chair transfer, walking 50 feet and making two turns, and propelling the wheelchair. Resident #84 has had falls since admission/entry or reentry or prior assessment and had one injury. Review of the Morse Fall scale dated 12/02/25 revealed Resident #84 was at high risk for falling. Review of the care plan for Resident #84 dated 05/20/22 revealed Resident #84 was at risk for falls. Interventions included call don't fall signage to resident room, bed in lowest position, and nonskid strips in front of the bed. Observation and interview on 01/08/26 at 11:07 A.M. with Certified Nursing Assistant (CNA) #210 revealed Resident #84 was at risk for falls. Observation with CNA #210 revealed Resident #84 was lying in her bed. Observation revealed, and CNA #210 verified the bed was not in a low position, there was no call don ' t fall signage and CNA #210 revealed she did not remember ever seeing one. CNA #210 also verified the bed was over top of the non-skid strips. 2. Record review for Resident #50 revealed an admission date of 09/24/20. Diagnoses included systemic lupus, erythematosus, need for assistance with personal care, cerebral palsy and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. Resident #50 used a wheelchair for mobility, required supervision or touch assistants for bed mobility and required partial/moderate assistants for chair/bed to chair transfer. Resident #50 had two or more falls since admission /entry/reentry or prior to assessment. Review of the care plan date initiated 11/11/20 revealed Resident #50 was at risk for falls related to impaired balance, use of psychotropic medications, history of TIA, and impulsive behaviors. Interventions dated 01/26/21 included applying dycem to the wheelchair. Review of the fall risk assessment dated [DATE] revealed Resident #50 was at moderate risk falling. Observation on 01/08/26 at 2:20 P.M. with Licensed Practical Nurse (LPN) #279 revealed Resident #50 was sitting up in her chair. Resident #50 transferred to her bed. LPN #279 confirmed there was no dycem in Resident #50 ' s chair. Resident #50 revealed she did not ever remember having dycem in her wheelchair. LPN #279 searched Resident #50 ' s room and revealed there was no dycem in her room. Record review with LPN #279 confirmed Resident #50 ' s care plan included staff were to apply dycem to the chair. Review of the progress note for Resident #50 dated 01/09/26 at 5:48 P.M. completed by LPN #279 revealed another nurse found resident (#50) on the floor in another resident room. The note included dycem in place in chair. Review of the care plan dated 11/11/20 (at risk for falls) revealed on 01/09/26 applying dycem to the wheelchair was added again (located on the care plan interventions twice 01/26/21 and 01/09/26). Interview on 01/12/26 at 12:14 P.M. with LPN #279 revealed when Resident #50 was found on the floor on 01/09/26, she did not have dycem in the chair. Dycem was applied to the chair after Resident #50 was found on the floor as an intervention. LPN #279 confirmed the note documented on 01/09/26 at 5:48 P.M. revealed dycem in place in chair and confirmed this was not until after Resident #50 was found on the floor. Review of the facility policy titled, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessing Falls and Their Causes revised October 2010 revealed the purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Preparation included to review the resident care plan to assess for any special needs of the resident. Falls are the leading cause of morbidity and mortality among the elderly in nursing homes. Residents must be assessed timely for potential causes of falls. When a resident falls, the following information should be recorded in the resident ' s medical record to include appropriate interventions taken to prevent future falls. The deficiency represents noncompliance investigated under complaint number 1360476

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of the facility policy the facility failed to ensure medications were stored in a safe, secure manner. This had the potential to affect all 32 residents residing on the second floor excluding five residents (#3, #23, #40, #60 and #70) the facility identified as needing assistance with mobility, and 45 residents residing on the third floor excluding six residents (#2, #41, #51, #52, #74, and #77) the facility identified as requiring assistance with mobility. The facility census was 91.Findings included:Observation on 01/08/26 at 8:15 A.M. revealed the Medication Cart located on the third floor, North hall was unlocked. Observation revealed no staff were visible, Resident #50 was sitting in a chair nearby and additional residents were observed in the halls. Observation on 01/08/26 at 8:20 A.M. revealed Licensed Practical Nurse (LPN) # 297 returned to the Medication cart. LPN #297 stated, Oh, I was just down the hall doing my blood sugars. LPN #297 verified the Medication cart was left unlocked when she stepped away to do blood sugars. Observation on 01/12/26 at 9:33 A.M. revealed the Medication Cart located on the second floor near the nurse station was left unlocked. No staff were visible. Residents were observed in the halls and near the nurses station. Observation on 01/12/26 at 9:37 A.M. with LPN #297 verified the medication cart was left unattended while LPN #297 stepped away from the cart. Review of the facility policy titled, Storage of Medications revised April 2007 revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Compartments including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. The deficiency represents noncompliance investigated under complaint number 2614805

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Rocky River Gardens Rehab and Nursing Ctr	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of the facility policy, the facility failed to ensure accurate and complete documentation for Resident #50 and Resident #64. This affected two residents (#50 and #64) of eleven residents reviewed for records. The facility census was 91.Findings included: 1. Record review for Resident #64 revealed an admission date of 03/15/24. Diagnoses included chronic respiratory failure with hypoxia, muscle weakness, and need for assistance with personal care. Review of the census form included Res #64 was hospitalized on [DATE] and returned 10/17/25. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 was cognitively intact. Resident #64 used a wheelchair for mobility and was dependent for bathing/showers. Review of the care plan dated 07/18/24 revealed Resident #64 required staff assistants for bathing and showering. Interview on 01/07/26 at 10:37 A.M. with Resident #64 revealed, I been begging for a bath for three days, there ' s no hot water they say, I don ' t get washed up period, they only give me one shower a month. Record review of the Shower/Tub bath/ Bed Bath sheets for 10/14/25 through 01/06/26 revealed Resident #64 ' s scheduled shower sheets were completed and signed as completed. Review of the shower record revealed on 10/14/25 Resident #64 received her shower, however, this would not have been possible because Resident #64 was hospitalized . Review of the shower sheet completed and signed by Certified Nursing Assistant (CNA) #235 on 12/09/25 compared to a shower sheet dated 01/06/26 on which there was a signature for CNA #235 that was written twice on top of each other and did not match CNA #235's signature from 12/09/25, the 01/06/26 shower sheet indicated Resident #64 received a bed bath. Interview on 01/12/26 at 1:10 P.M. with Director of Nursing (DON) confirmed Resident #64 was not in facility at the time the shower sheet was documented as completed on 10/14/25. DON confirmed CNA #235 ' s signature dated 01/06/26 did not match the signature dated 12/09/25. Phone interview on 01/12/26 at 1:45 P.M. with CNA #235 revealed she did not have Resident #64 on 01/06/26 so she did not know if she received the shower/bath and confirmed she did not sign the shower sheet on 01/06/26. Interview on 01/12/26 at 2:10 P.M. with Scheduler #245 confirmed CNA #235 did not have Resident #64 on 01/06/26 and revealed CNA #237 had her on that day. Interview on 01/12/26 at 2:20 P.M. with CNA #237 confirmed she had Resident #64 on 01/06/26 and confirmed she did not give her her scheduled bath or shower and she did not sign the shower sheet stating, she would have signed her own name. CNA #237 revealed she did not remember why she did not offer or give the shower/bath on 01/06/26. 2. Record review for Resident #50 revealed an admission date of 09/24/20. Diagnoses included systemic lupus erythematosus, need for assistance with personal care, cerebral palsy and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. Resident #50 used a wheelchair for mobility and required substantial/maximal assistants for bathing/showering. Review of the care plan dated 11/11/20 revealed Resident #50 had an activity of daily living (ADL) self-care performance deficit related to impaired balance. Interventions included to provide sponge bath when a full bath or shower cannot be tolerated. Interview on 01/08/26 at 8:40 A.M. with Resident #50 revealed she did not have a shower in three weeks. Observation revealed Resident #50 ' s hair was very oily. Resident #50 stated, It makes me feel disgusting, I told the Administrator this is bull (expletive). Resident #50 stated she was not showered due to hot water issues on her unit. Record review of the Shower/Tub bath/ Bed Bath sheets for Resident #50 revealed a shower was refused on 01/03/26 and 01/07/26. Both sheets were signed by CNA #225. Review of the shower sheets revealed the nurse signature was difficult to read for both days. Interview on 01/08/26 at 12:00 P.M. with the DON revealed she was unable to read the Nurse signature that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signed the shower sheets on 01/03/26 and 01/07/26. Interview and review of the Shower/Tub bath/ Bed Bath sheets on 01/08/26 at 12:10 P.M. dated 01/03/26 and 01/07/26 for Resident #50 with LPN #286 and CNA #225 revealed CNA #225 stated Resident #50 never refused her showers on either of those dates. CNA #225 became upset and loudly questioned, Who signed my name? That is not my signature (while pointing at the shower sheets dated 01/03/26 and 01/07/26) she did not refuse, that is a lie, there was no hot water, look here is my signature (pointing out the signature on the shower sheet for Resident #50 dated 11/03/25) it looks nothing like that. LPN #286 confirmed the signatures signed on 01/03/26 and 01/07/26 did not resemble the signature dated 11/03/25. Interview on 01/08/26 at 12:36 P.M. with the DON confirmed no other staff member should sign a signature for a CNA except the CNA providing the care. Review of the facility policy titled, Charting and Documentation revised July 2017 revealed documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. The deficiency represents noncompliance investigated under complaint number 2614805

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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** Based on observation, interview, record review, and review of the facility policy the facility failed to ensure infection control practices were maintained during care for Resident #34 and #52. This had the potential to affect all residents in the facility. The facility census was 91. Findings included: 1.Record review for Resident #52 revealed an admission date of 11/22/25. Diagnosis included post-polio syndrome, hemiplegia, lymphedema, muscle weakness and need for assistants with personal care. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #52 was cognitively intact. Resident #52 was dependent for toileting hygiene, bed mobility, and chair/bed to chair transfers. Resident #52 had two stage three pressure ulcer injuries that were present upon admission. Review of the physician orders for Resident #52 dated January 2026 revealed cleanse right hip with normal saline, dry, apply triad paste and dry dressing one time a day for wound care. Review of the care plan with date initiated of 11/29/25 revealed no mention of enhanced barrier precautions (EBP), however, a care plan for pressure ulcer care was noted with a goal to show signs of improvement and prevent infection. Observation on 01/08/26 at 9:24 A.M. of wound care for Resident #52 completed by Wound Care Nurse Licensed Practical Nurse (LPN) #303 revealed after entering Resident #52 ' s room, Wound Care Nurse LPN #303 repositioned Resident #52 in bed then removed the soiled dressing to the right hip. Wound Care Nurse LPN #303 assessed, cleaned and redressed the wound to the right hip without ever donning an isolation gown. Observation with Wound Care Nurse LPN #303 confirmed Resident #52 had a sign on the entrance door to her room revealing Enhanced Barrier Precaution (EBP) and revealed staff were to wear gloves and gown for the following high contact resident care activities which included wound care. Located in the hall next to Resident #52 ' s door was a three drawer container. Wound Care Nurse LPN #303 confirmed the container was used for isolation supplies and confirmed on top of the container used for isolation supplies was a thick layer of dust and grime with lines going down the sides which appeared to be dried liquid spills. Wound Care Nurse LPN #303 verified she never donned an isolation gown during wound care for Resident #52 and confirmed she should have. Interview on 01/13/26 at 10:15 A.M. with Resident #52 revealed, They (staff) never wear an isolation gown when providing care. 2. Record review for Resident #34 revealed an admission date of 01/30/25. Diagnoses included neuromuscular dysfunction of bladder, muscle weakness, and need for assistance with personal care. Review of the significant change MDS dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 had an indwelling catheter, frequently was incontinent of bowel, and was dependent for personal hygiene. Review of the care plan dated 05/12/25 for Resident #34 revealed EBP related to indwelling foley. Interventions included gloves and gown for high contact resident care. Review of the physician orders dated 05/03/25 for Resident #34 revealed foley (cathetar) output every shift for foley care. Observation on 01/08/26 at 3:10 P.M. of Certified Nursing Assistant (CNA) #230 emptying the urine from Resident #34 ' s indwelling catheter bag revealed CNA #230 never donned an isolation gown. CNA #230 drained 300 milliliters from the urine bag. CNA #230 confirmed he never wore an isolation gown and revealed he did not need to. Interview on 01/08/26 at 5:00 P.M. with Director of Nursing (DON) revealed if staff were providing catheter care including emptying the drainage bag, or wound care, they should donn Personal Protective Equipment (PPE) which included gloves and an isolation gown. DON confirmed CNA #230 and LPN #303 work throughout the facility and could expose all residents requiring care. Interview on 01/13/26 at 10:38 A.M. with Resident #34 revealed staff never wore an isolation gown when providing personal care including catheter care. Review of the facility policy titled, Enhanced Barrier Precautions (EBP) Policy and Procedure dated 04/01/24 revealed EBP are an infection control intervention designed to reduce (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Wounds or indwelling medical devices. EBP expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO ' s (Multi drug-resistant organisms) to staff hands and clothing. MDRO ' s may be indirectly transferred from resident to resident during these high contact care activities. Nursing Home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO ' s. This deficiency represents non-compliance as an incidental finding investigated under Complaint Number 1360479.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, and review of the facility policy, the facility failed to ensure water temperatures were maintained as required for 45 residents (Resident #1, #2, #6, #7, #9, #11, #13, #14, #15, #17, #18, #16, #24, #25, #29, #30, #31, #32, #33, #37, #41, #42, #44, #46, #47, #48, #49, #50, #51, #52, #53, #59, #61, #65, #71, #73, #74, #77, #81, #82, #83, #85, #88, #91, and #93) on the third floor and rooms were clean and maintained for Resident #7, #39 and #73. This affected 46 residents of 91 residents residing in the facility. The facility census was 91.Findings included: 1. Observation was conducted on 01/06/26 at 1:56 P.M. during an environmental tour with Maintenance Director (MD) #306 of MD #306 taking facility water temperatures using the facility thermometer on the resident occupied third floor. The water temperature in Resident #18 ' s bathroom sink reached 100 degrees Fahrenheit (F) after running for five minutes but then quickly dropped to 62 degrees. MD #306 revealed the water temperatures should be 105 degrees F to 120 degrees F and revealed the facility had been having concerns with the mixing valve. MD #306 revealed he put an order in for a rebuilt kit on 12/23/25 when he was made aware of the hot water concerns and he then went on vacation. MD #306 stated he called the company on 12/26/25 to verify the part was ordered but when he was returning from vacation, the employees at the company he ordered parts from left for vacation as he returned so he had to wait until they returned. MD #306 revealed they could use a different company but chose not to and confirmed they never called a different company to see if they could receive the service sooner. An interview with Resident #18 at the time of the observation revealed she was concerned with the hot water, the staff had to run the water for a long time to get slightly warm. Resident #18 revealed when the staff cleaned her the water felt sometimes slightly warm and sometimes cold. Resident #18 stated, It ' s been going on a long time and confirmed she told the Administrator. Observation on 01/06/26 at 2:05 P.M. with MD #306 revealed Resident #15 ' s bathroom water temperature did not reach above 54 degrees F after running for over three minutes. Observation on 01/06/26 at 2:24 P.M. with MD #306 revealed Resident #24 ' s bathroom water temperature reached 99 degrees F after six minutes. Resident #24 was present in the room and stated he gets bed baths with cold water. MD #306 stated if the water temperatures were low in three resident rooms then the temperatures would be the same for the entire third floor because it was the same water line and the pressure was not enough to sufficiently get the hot water to the third floor. Interview on 01/06/26 at 4:26 P.M. with Certified Nursing Assistant (CNA) #210 revealed residents have expressed concerns of the water temperatures not getting hot enough. Interview on 01/06/26 at 4:30 P.M. with MD #306 confirmed the first and second floors had sufficient hot water if the water ran long enough, but the third floor was not always reaching the appropriate temperature of 105 to 120 degrees F. Interview on 01/07/26 at 10:33 A.M. with CNA #221 and #237 revealed the staff have to let the water run for a while before it would get warm but sometimes it could run for hours and not get warm on the third floor. Interview on 01/08/26 at 1:25 P.M. with Administrator revealed the reason the hot water was not working correctly was because the mixing valve was broke. The facility was first made aware on 12/23/25 and ordered the part. Administrator confirmed there were no interventions put into place so residents on the third floor could wash or be washed with warm water. Administrator stated, I felt they should have used a different shower room on a different floor, I don ' t think that was connected to the staff. 2. Record review for Resident #39 revealed an admission date of 01/25/25. Diagnoses included end stage renal disease, muscle weakness and abnormalities of gait and mobility. Review of the annual Minimum Data Set (MDS) 3.0 dated 12/31/25 revealed Resident #39 was cognitively intact. Resident #39 had (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment on both sides of the lower extremities, was always incontinent of bowel and bladder, was dependent for personal hygiene, bed mobility, and chair/bed to chair transfer. Interview on 01/06/26 at 4:12 P.M. with Resident #39 revealed he was upset because his toilet would not flush and stated, It has been that way for a week, the light above his bed was not working correctly for several weeks and the socket by his bed did not have a cover since he been there. Observation with Resident #39 confirmed the toilet would not flush, there were two lights above his bed, one pointing down to the head of the bed and one pointing upward. The light pointing upward had no bulb. Resident #39 revealed he cannot use the one pointing down because when he is in bed it shined directly in his eyes and was uncomfortable to his eyes where the one that no longer worked provided the lighting he needed without hurting his eyes. Interview and observation on 01/06/26 at 4:30 P.M. with MD #306 confirmed Resident #39 ' s toilet was not working and revealed he had been on vacation. Maintenance Director #306 stated, I took the bulb out (of the light socket above the bed) two or three weeks ago, didn ' t replace it because I am ordering a bunch of new lights, and the socket for the phone jack is broke, no one told me. 3. Record review for Resident #7 revealed an admission date of 07/11/24. Diagnosis included malignant neoplasm of prostate, cognitive communication deficit, and muscle weakness. Review of the quarterly MDS dated [DATE] revealed Resident #7 was moderately cognitively impaired. Resident #7 was dependent for personal hygiene, required partial/moderate assistants for bed mobility and chair/bed to chair transfers. Observation on 01/08/26 at 8:42 A.M. of Resident #7 room revealed five visible tiles under the bed was broken and had missing pieces of the tiles, the floor and floor mat next to the bed was very dirty with ground in dirt, dried spills and what appeared to be food particles, there were large areas of a thick black/brown substance that appeared to be removed floor strips and portions of the bottom of a mat still stuck to the floor, the dresser drawer had a broken handle, and dust and dried spills were on the dresser. Observation on 01/08/26 at 8:56 A.M. of Resident #7 ' s room with Administrator confirmed there were five visible tiles under the bed was broken and had missing pieces of the tiles, the floor and floor mat next to the bed was very dirty with ground in dirt, dried spills and what appeared to be food particles, there were large areas of a thick black/brown substance that appeared to be removed floor strips and portions of the bottom of a mat still stuck to the floor, the dresser drawer had a broken handle, and dust and dried spills were on the dresser. Interview on 01/12/26 at 3:30 P.M. with Resident #7 revealed, They need to clean better, I would like that if they did. 4. Record review for Resident #73 revealed an admission date of 04/22/25. Diagnoses included chronic kidney disease, muscle weakness and need for assistance with personal care. Review of the quarterly MDS assessment dated [DATE] revealed Resident #73 was cognitively intact. Resident #73 required supervision/touch assistants with personal hygiene, bed mobility and chair/bed to chair transfers. Observation on 01/08/26 at 8:44 A.M. revealed Resident #73 ' s room was very dirty, there was ground in dirt and mud throughout the floor, there were multiple trash items under the bed and protruding out from under the bed into the walkway including used tissues, dirty clothing items, crinkled papers, and wrappers. The floor had embedded dirt and grime under and beside the trash laying on the floor. There were no sheets on the mattress Resident #73 was resting on. Resident #73 revealed he preferred to lay on sheets but the sheets they do put on the bed did not fit and would not stay in place. Resident #73 confirmed his room was very dirty and stated, They wipe the middle of the floor, they don ' t really clean, there ' s no deep cleaning, it ' s been that way forever. Interview on 01/08/26 at 8:50 A.M. with CNA #223 who observed Resident #7 and #73 ' s room stated, Well it ' s disgusting, they don ' t do a good job here. CNA #223 confirmed the halls on the third floor including going around the entire nurses station was scuffed with multiple large scrapes (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that were discolored grey. The edges revealed the color of the tiles were originally a light tan color. Observation on 01/08/26 at 8:57 A.M. of Resident #73 ' s room with Administrator confirmed Resident #73 ' s room was very dirty, there was ground in dirt and mud throughout the floor, there were multiple trash items under the bed and protruding out from under the bed into the walkway including used tissues, dirty clothing items, crinkled papers, and wrappers. The floor had embedded dirt and grime under and beside the trash laying on the floor. There were no sheets on the mattress. Administrator also confirmed the halls on the third floor including going around the entire nurses station was scuffed with multiple large scrapes that were discolored grey. The edges revealed the color of the tiles were originally a light tan color. Observation and interview on 01/08/26 at 9:01 A.M. with Administrator and Housekeeping Manager #260 of Resident #7 and 73 ' s room revealed Housekeeper Manager (HM) #260 stated, This is not right. HM #260 also confirmed the condition of the floors in the hallways and around the nurses station and revealed none of the floors in the facility had a deep cleaning in over a year and stated, I have been asking for several months, it ' s been a year, we do not have the equipment or the person to do it and I keep asking and nothing happens. Interview on 01/08/26 at 9:16 A.M. with Licensed Practical Nurse (LPN) #279 stated, This building is filthy, everybody knows that. Review of the facility policy titled, Quality of Life - Homelike Environment revised May 2017 revealed residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff shall provide person centered care that emphasizes the residents ' personal needs and preferences. The facility staff and management shall maximize , to the extent possible the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment; Comfortable (minimum glare) yet adequate lighting; Clean bed and bath linens that are in good condition. This deficiency represents non-compliance investigated under Complaint Number 2690478, 1360476, and 1360479.