STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365594	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Euclid Beach	16101 Euclid Beach Blvd Cleveland, OH 44110

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review the facility failed to ensure the physician was notified of resident changes in condition. This affected two residents (#13 and #85) of 22 residents reviewed for change in condition. The facility census was 53.Findings include:1.Review of the closed medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, asthma, hemiplegia/hemiparesis after a stroke affecting the left nondominant side, congestive heart failure, atrial fibrillation, rectal cancer, and heart disease. Review of the physician's orders for Resident #13 revealed an order written on [DATE] for the resident to be a full code (perform all life saving interventions). An order was written on [DATE] to admit to hospice with a terminal diagnosis of hypertensive heart disease and chronic kidney disease with heart failure. Hospice was to be notified of all changes, falls, medication errors, equipment issues, and death. Review of Resident #13's care plan revised on [DATE] revealed the resident had chosen to be a full code. Review of the comprehensive significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact, rejected care daily, and had a life expectancy of less than six months. The assessment revealed the resident was receiving hospice services. Review of the nursing progress notes revealed Licensed Practical Nurse (LPN) #506 documented on [DATE] at 3:31 P.M. revealed Resident #13 had a coffee ground emesis. His blood pressure was low at 87/60, his pulse was high at 114 beats per minutes, and his oxygen level on room air was 93%. LPN #506 notified the unnamed hospice nurse on who informed her HRN #700 would come to the facility to assess the resident. The documentation did not indicate MD #614 was notified of the resident's status. Review of a note dated [DATE] at 8:20 P.M. (recorded as a late entry on [DATE] at 4:31 P. M.) revealed on [DATE] at 5:40 P.M., LPN #521 was notified by Hospice Registered Nurse (HRN) #700 that Resident #13 was absent of vital signs. LPN #521 documented that, upon verification of the resident's code status of full code, emergency protocol was initiated. A Code Blue (a medical emergency signal indicating a cardiac or respiratory arrest) was paged overhead. A second nurse and a certified nurse aide (CNA) came to assist with the emergency bringing the crash cart (a cart where lifesaving equipment is stored) with them. The second nurse went to call 911 and print out the paperwork needed. Approximately 10 minutes after calling 911, EMS arrived and took over CPR. EMS was not notified that the resident was on hospice but there was still a full code. LPN #521 documented after several rounds of CPR, the lead EMS called the emergency physician and confirmed the time of death. Interview with Medical Director (MD) #614 on [DATE] at 12:27 P.M. revealed Resident #13 was a full code but his wishes were not congruous with his physical status. It was an ongoing conversation between the resident and hospice. MD #614 said Resident #13 was not ready to accept his desire to be a full code did not match with his not wanting to go to the hospital again, especially since he had just been discharged from the hospital recently. MD #614 said he was not made aware by the facility that Resident #13 had a coffee ground emesis, had been hypotensive and tachycardic that day. All he was told was that the resident had vomited and then felt better. If he had been notified of the resident's condition he would have advised Resident #13 be sent to the emergency room (ER) for evaluation since he was a full code. 2.Resident #85 was admitted to the facility on [DATE] with diagnoses including diabetes, COPD, heart disease, high blood pressure, and hemiplegia and hemiparesis to the left nondominant side following a stroke. Review of the physician's orders for Resident #85 revealed an order dated [DATE] for the resident to be a full code. Review of the comprehensive quarterly MDS 3.0 assessment, dated [DATE], revealed Resident #85 was independent for all personal care, had no pain, and did not have a life expectancy of less than six months. The resident had now wounds and was receiving no special treatment of any sort. Review of the nursing progress notes for Resident #85 revealed on [DATE] at 10:20 A. M. LPN #634 was in the resident's room during morning medication administration. Resident #85 complained of chest pain and constipation. LPN #634 checked the resident's vital signs and obtained a blood pressure of 140/80, a heart rate of 84, and an oxygenation level of 96% on room air. LPN #634 advised the resident to go to the emergency room (ER) by 911. Resident #85 refused saying he knew his pain was due to being constipated. The resident was offered an as needed breathing treatment and Miralax for the constipation. LPN #634 documented on [DATE] at 11:03 A.M. that she was notified by housekeeping Resident #85 was on the floor in the bathroom. Upon entering the bathroom LPN #634 found the resident lying face down on the floor and was unresponsive. LPN #634 attempted to obtain vitals without success but the resident did have a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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, staff and resident interviews, observation, and review of the facility policy, the facility failed to ensure Resident #3, #29, #45, #49, #53, #63, #41, #7, #44, #1, #2, and #5 were provided assistance with activities of daily living for showering. This affected 12 residents (#3, #29, #45, #49, #53, #63, #41, #7, #44, #1, #2, and #5) of 22 resident records reviewed for activities of daily living. The facility identified 44 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #16, #18, #19, #20, #21, #22, #23, #25, #27, #29, #30, #32, #36, #39, #40, #41, #42, #43, #44, #45, #47, #49, #50, #51, #52, #53, #54, #55, #61, #62, and #63) who required staff assistance for showers and bathing. The facility census was 53. Findings include: 1. Review of the medical record for Resident #3 revealed an original admission date of 04/15/23. Diagnoses included but were not limited to end stage renal disease with dependence upon renal dialysis, type two diabetes mellitus with retinopathy, morbid obesity, hemiplegia and hemiparesis. Review of the 05/27/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #3 revealed intact cognition and Resident #3 was dependent on staff for bathing. Review of the facility resident shower book revealed Resident #3's room number was not listed on any of the shower schedules for any day or any of the three shifts. No evidence was found for any shower sheets for Resident #3 from 06/01/25 to 08/26/25. Review of the medical record shower/bath task for Resident #3 for the past thirty days from 07/28/25 to 08/28/25 revealed one recorded shower on 07/28/25. An interview on 08/28/25 at 7:55 A.M. with Resident #3 revealed he was supposed to get showers on Tuesdays and Thursdays but did not always get his showers twice a week. Resident #3 stated he did not get a shower yesterday and was hoping to get a shower today. 2. Review of the medical record for Resident #29 revealed an admission date of 05/04/21. Diagnoses included but were not limited to unspecified fracture of left lower leg, type two diabetes mellitus with proliferative diabetic retinopathy with bilateral macular edema, stage two chronic kidney disease (CKD), vascular dementia, and hemiplegia and hemiparesis. Review of the 06/22/25 quarterly MDS 3.0 assessment for Resident #29 revealed severe cognitive impairment. Resident #29 was noted to require maximum assistance with bathing. Review of Resident #29's care plan, last reviewed 07/08/25, revealed an activity of daily living (ADLs) performance deficit related to diagnosis of hemiplegia and hemiparesis. Resident #29 was noted to require maximum assistance with bathing. Review of the shower schedule for Resident #29 revealed showers were to be given on Wednesday and Saturday on second shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower sheets for Resident #29 from 06/01/25 to 08/26/25 revealed a shower sheet for 06/04/25, 06/21/25, 07/09/25, and 07/22/25. No additional sheets were found in the facility shower sheet book. Review of the electronic medical record (EMR) shower/bath task tab for Resident #29 revealed for the past 30 days between 07/28/25 to 08/28/25 a bed bath on 07/31/25 and on 08/14/25. No additional bathing was recorded under the task. 3. Review of the medical record for Resident #45 revealed an admission date of 11/23/17. Diagnoses included but were not limited to chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD) , vascular dementia and schizophrenia. Review of the 06/11/25 quarterly MDS 3.0 assessment for Resident #45 revealed intact cognition and set up required for bathing. Review of the care plan last reviewed on 07/08/25 for Resident #45 revealed an ADL self-care deficit related to severe vascular dementia and impaired balance. Resident #45 was noted to require set up for bathing. Review of the shower schedule for Resident #45 revealed showers were to be completed on Wednesdays and Saturdays on second shift. Review of the facility shower book revealed no shower sheets for Resident #45. Review of the EMR shower/bath task tab for Resident #45 revealed no recorded showers for the past 30 days between 07/28/25 to 08/28/25. An observation on 08/28/25 at 8:11 A.M. of Resident #45 revealed his hair was heavily oily and he presented as unkempt as if he had not had a shower in some time. Resident #45 was alert, but did not participate in an interview. 4. Review of the medical record for Resident #49 revealed an admission date of 12/12/23. Diagnoses included but were not limited to malignant neoplasm of lower lob of right bronchus, chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition and anorexia. Review of the 08/09/25 annual MDS 3.0 assessment for Resident #49 revealed intact cognition and dependence on staff for bathing. Review of the care plan for Resident #49, date initiated 03/01/23, revealed a self-care performance deficit related to impaired cognitive function and COPD. Resident #49 was noted to be dependent upon staff for bathing. Review of the shower book revealed Resident #49 was scheduled to receive showers on Mondays and Thursdays during the second shift. Review of the shower sheets for Resident #49 from 06/01/25 to 08/26/25 revealed a shower sheet for 06/02/25, 06/04/25, 06/09/25, 06/12/25, 06/16/25, 07/31/25, 08/11/25, and a refusal on 08/25/25. No additional shower sheets were found. Review of the EMR shower/bath task tab for Resident #49 revealed no recorded bathing for the past 30 days from 07/28/25 to 08/28/25. An interview on 08/28/25 at 9:32 A.M. with Resident #49 revealed he would give himself a bath. When asked if the staff assisted him with showers, Resident #49 stated he was not sure. 5. Review of the medical record for Resident #53 revealed an admission date of 09/08/23. Diagnoses included but were not limited to hemiplegia and hemiparesis affecting left non-dominant side, and type two diabetes mellitus. Review of the 08/15/25 annual MDS 3.0 assessment for Resident #53 revealed intact cognition and moderate assistance required for bathing. Review of the care plan for Resident #53, date initiated 09/14/23, revealed ADL self-care deficits which required moderate assistance from staff for bathing. Review of the facility shower schedule revealed Resident #53 was scheduled to be bathed on Tuesdays and Fridays. Review of the shower sheets for Resident #53 from 06/01/25 to 08/26/25 revealed shower sheets for 06/10/25, 06/17/25, 06/24/25, 07/22/25, 07/29/25. No additional shower sheets for Resident #53 were found in the shower book. Review of the EMR shower/bath task tab for Resident #53 revealed a bed bath on 08/01/25 and a bath on 08/24/25. No additional bathing was recorded under the task section for Resident #53. An interview on 08/28/25 at 7:52 A.M. with Resident #53 revealed Resident #53 stated they were not getting showers twice a week. Resident #53 stated maybe once a week they would get a shower but definitely not twice a week and they would like a shower twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the medical record for Resident #63 revealed and admission date of 07/28/25. Diagnoses included but were not limited to displaced bimalleolar fracture of right lower leg, COPD, malignant neoplasm of unspecified site of female breast, and stage three CKD. Review of the 08/04/25 admission MDS 3.0 assessment for Resident #63 revealed intact cognition and maximum assistance required for bathing. Review of the care plan for Resident #63, last reviewed on 08/11/25, revealed a self-care deficit related to right leg fracture, COPD and CKD and was dependent upon staff for bathing. Review of the facility shower schedule revealed Resident #63 was scheduled for showers on Tuesdays and Friday on third shift. Review of the facility shower book from 07/28/25 to 08/26/25 revealed no recorded shower sheets. Review of the EMR shower/bath task tab for Resident #63 revealed a shower on 07/29/25, 07/31/25, 08/05/25, and 08/21/25 for the past 30 days from 07/28/25 to 08/28/25. An interview on 08/28/25 at 9:51 A.M. with Licensed Practical Nurse (LPN) #607 revealed LPN #607 stated they thought Resident #63 was independent for showering. 7. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease , human immunodeficiency virus (HIV) hemiplegia and hemiparesis affected left side and generalized muscle weakness. Review of Resident #41's MDS 3.0 assessment, dated 06/24/25, revealed the resident was substantial/maximal assistance for showering bathing. Resident #41 had a Brief Mental Status of 14, revealing he was cognitively intact. Review of the care plan dated 06/18/25 revealed Resident #41 had an ADL self-care performance deficit related to diagnoses of hemiplegia/hemiparesis, congestive heart failure, schizophrenia, muscle wasting and tremors. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Bathing assistance with one to two staff members. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule revealed Resident #41 should have had showers on Wednesday and Saturdays during the first shift during the week. Review of the shower book for July and August 2025, revealed Resident #41 had no showers during the Months of July and August 2025. Resident #41 was offered a shower on 07/09/25 and refused. Review of the EMR task tab for bath/shower from 08/03/25 to 09/03/25, revealed the resident had a bed bath on 08/24/25; no other showers or refusals given for the last 30 Days for Resident #41, were documented in the tasks. An interview on 09/02/2025 at 12:01P.M. with Resident #41 confirmed he had not been receiving the showers as scheduled. 8. Resident #7 was admitted to the facility on [DATE] with diagnoses including human immunodeficiency virus (HIV), generalized muscle weakness, morbid obesity, and need for assistance with personal care. Review of Resident #7's MDS 3.0 assessment dated [DATE] revealed the resident was dependent on staff for showering bathing. Resident #7 was severely cognitively impaired and could not answer the Brief Interview for Mental Status. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care revised 06/19/25, revealed Resident #7 had ADL self-care performance deficit and was at risk for skin breakdown due to decreased mobility, desensitization of skin, incontinence, impaired cognition and communication, pain management needs, risk of medication side effects, and diagnoses of hemiplegia. Interventions included skin assessments to be done weekly and as needed. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule book revealed Resident #7's room did not have shower days scheduled. Review of the facility shower book for July and August 2025, revealed Resident #7 had no showers given or offered for all of July or August 2025. Review of the EMR task tab for shower/bath revealed Resident #7 had no other showers or bed baths documented for the last 30 Days between 08/03/25 to 09/03/25. 9. Review of the medical record for Resident #44 revealed an admission date of 04/27/07 with diagnoses including hemiplegia and hemiparesis affecting the right dominant side, COPD, morbid obesity, major depressive disorder, peripheral vascular disease, and essential hypertension. Review of Resident #44's quarterly MDS 3.0 assessment dated [DATE] revealed the resident was dependent on staff assistance for showering bathing. Resident #44 had a Brief Mental Status was 14, which revealed the resident was cognitively intact. Review of the plan of care revised 07/09/25 revealed Resident #44 had an ADL performance deficit, was at risk for skin breakdown due to decreased mobility, incontinence, desensitization of skin, pain management needs, risk of medication side effects, and diagnoses of cerebral vascular accident. Interventions included: report changes in ADL abilities to the nurse and the physician as needed. The resident needs staff assistance with ADL including dressing, grooming, personal hygiene, and oral care. Staff to monitor signs and symptoms of skin breakdown and notify appropriate staff, and skin assessments to be done weekly and as needed. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule revealed the Resident #44 should have had showers on Mondays and Thursdays during the first shift during the week. Review of the shower book for July and August 2025, revealed Resident #44 had one shower offered on 07/31/25. There were no other showers/bed baths offered, refused, or given. Review of the EMR shower/bath task tab revealed Resident #44 had no showers/bed baths or refusals given for the last 30 days from 08/03/25 to 09/03/25. 10. Record review for Resident #1 revealed an admission date of 03/25/25. Diagnoses included altered mental status, acute kidney failure, unspecified sequelae of cerebral infarction and need for assistance with personal care. Record review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #1 was severely cognitively impaired. He did not have any functional limitation in range of motion. There was no impairment for upper or lower extremities on either side. He used a wheelchair. He required partial to moderate assistance for shower/bathing and supervision or touching assistance for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 05/19/25 revealed Resident #1 had an ADL self-care performance deficit related to diagnoses of above knee amputation, history of falls, hypertension, orthostatic hypotension, pneumonia, cardiovascular accident (CVA), hyperlipidemia and insomnia. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule for Resident #1 revealed shower days were every Monday and Thursday. Record review of the shower sheet book revealed Resident #1 was showered/bathed 06/09/25, 06/12/25, 06/16/25, 06/19/25, 07/07/25, 07/10/25, 07/22/25 and 07/31/25. Review of the documentation for Resident #1 in the EMR shower/bath task tab for the last 30 days between 08/03/25 and 09/03/25 revealed a bed bath on 08/24 and a refusal on 09/01. 11. Review of the medical record for Resident #2 revealed an admission date of 01/14/25 with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, diabetes mellitus type two, need for assistance with personal care, age related cataract bilaterally, hypertensive retinopathy bilaterally and dementia. Record review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #2 was severely cognitively impaired. He had functional limitations in range of motion impairment on both sides. He was dependent on staff for all ADLs. Review of the care plan dated 06/27/25 revealed Resident #2 had an ADL self-care performance deficit related to dementia, cardiovascular accident with right side hemiplegia. He had limited mobility and dysphagia with need for tube feeding due to eating nothing by mouth. Interventions specific to bathing/showering were to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. The resident wa totally dependent on staff to provide bath/shower as necessary. Review of the shower schedule for Resident #2 revealed his shower days were Tuesday and Friday. Review of shower sheets in the shower book revealed Resident #2 was bathed 06/06/25, 06/10/25 and 06/24/25. Review of the shower/bath task tab in the EMR for the last 30 days between 08/03/25 and 09/03/25 revealed a single bed bath on 08/06/24. 12. Review of the medical record for Resident #5 revealed an admission date of 08/30/23. Diagnoses included quadriplegia C5-C7 incomplete, personal history of malignant of neoplasm of prostate, pressure ulcer of left buttock stage three and need for assistance with personal care. Record review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #5 had intact cognition. He had functional limitations in range of motion (ROM) impairment on both sides of the upper and lower extremity. He used a wheelchair. He was independent for eating. He required substantial/maximal assistance from staff for upper body dressing and was dependent on staff for all other ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 07/11/25 revealed Resident #5 had ADL self-care performance deficits related to C6 spinal cord injury with incomplete quadriplegia. Interventions, specifically for bathing/showering revealed checking nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule for Resident #5 revealed shower days were every Wednesday and Saturday. Review of the shower sheet book for Resident #5 revealed showers on 05/07/25, 05/10/25, 05/14/25, 06/21/25 and 07/08/25. There were no shower sheets for August 2025. Review of the EMR under the shower/bath task tab revealed Resident #05 was given a bed bath on 08/24/25 during the last 30 days from 08/03/25 to 09/03/25. An interview with Licensed Practical Nurse (LPN) #510 on 08/26/25 at 10:25 A.M. confirmed there was a shower book kept on the second floor of the facility for residents who lived on both the first and second floor. If a resident received a shower, a shower sheet was filled out and kept in the shower book. An interview on 08/28/25 at 8:00 A.M. with Certified Nursing Assistant (CNA) #541 revealed the shower book should have a shower schedule for each resident. After completing a shower, staff would fill out a shower sheet and complete the shower task in the EMR under the shower/bath tab. The shower sheet was given to the nurse. If the CNA noticed anything abnormal with the resident during the shower, the nurse would be notified to observe the resident. An interview with CNA #563 on 08/28/25 at 8:18 A.M. revealed a shower aide was assigned to showers and worked Monday through Friday for eight hours. CNA #563 stated she worked some weekends and picked up as an aide too. CNA #563 stated the shower schedule was in the shower book. CNA #563 stated she filled out a refusal form if a shower was refused by the resident and filled out a shower sheet every time she gave a shower. CNA #563 stated she provided showers for all the residents on the second floor which consisted of four halls so she could have 12 showers to do in one shift. CNA #563 stated she had been pulled to go out on appointments with residents during the month of August and had not been able to complete her showers. In her absence, the aides were supposed to complete their resident showers if she was not there. Sometimes they are short staffed and have three aides instead of five so she gets pulled to be an aide rather than the shower aide. CNA #563 stated the aides were instructed that when there was no assigned shower aide, they are all responsible to complete their resident's shower. An interview on 09/03/25 at 11:00 A.M. with a follow up interview at 1:30 P.M. with DON #581 confirmed she had provided the complete book of shower sheets and was unable to provide additional evidence of showers provided to Resident #3, #29, #45, #49, #53, #63, #41, #7, #44, #1, #2, and #5. DON #581 verified the information in the shower book and in the EMR under the task tab revealed what was charted was what was completed. (continued on next page)

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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	Review of the facility policy, Shower/Tub Bath, dated 10/2010, revealed the purpose of this procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The following information should be recorded on the resident's Activity of Daily Living (ADL) record and/or in the resident's medical record: date and time the shower/tub was performed, name and title of the individual who assisted the resident with the shower/tub bath, all assessment data obtained during the shower/tub bath, how the resident tolerated the shower/tub bath, if the resident refused, what intervention was taken and the signature with title of the person recording the data. This deficiency represents noncompliance investigated under Complaint Number 1381901.

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	365594	A. Building B. Wing	09/23/2025

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of emergency medical services (EMS) run report, staff interview, and facility policy review, the facility failed to initiate Cardiopulmonary Resuscitation or timely call EMS for Resident #13, a resident with advance directives for a Full Code status (indication for healthcare providers to perform all possible lift-saving measures in the event of a cardiac or respiratory arrest). This resulted in Immediate Jeopardy and Actual Harm/Subsequent Death on [DATE] at 5:40 P.M. when Resident #13 was found unresponsive and Licensed Practical Nurse (LPN) #521 failed to initiate CPR. EMS was not called until [DATE] at 6:23 P.M. and arrived at the facility at 6:32 P.M. Upon arrival, EMS determined Resident #13 was deceased , CPR was not in progress by facility staff and EMS were informed Resident #13 had been pronounced deceased in the facility at 5:40 P.M. This affected one resident (#13) of ten residents reviewed for death. The facility census was 53. On [DATE] at 1:27 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) #615 were notified Immediate Jeopardy began on [DATE] at 5:40 P.M. when Resident #13 was found unresponsive and Licensed Practical Nurse (LPN) #521 failed to initiate CPR or timely summon EMS services. The resident, who had advance directives for a Full Code status was subsequently pronounced deceased at the facility. The Immediate Jeopardy was abated on [DATE] when the facility implemented the following corrective actions: On [DATE] at 1:00 P.M. Managerial staff, Regional Director of Clinical Services (RDCS) #601, the Administrator, and the DON met and reviewed data collaboratively. A root cause analysis was conducted and system failure identified LPN #521 did not know Resident #13's code status and did not initiate CPR. On [DATE] at 2:00 P.M. the Administrator and DON received education from [NAME] President of Clinical Services (VPCS) #618 and [NAME] President of Operations (VPO) #617 on the following topics: where to locate advanced directives, CPR policy, Code Blue Flow Sheet, that hospice was not a code status and that advanced directives still need checked. The staff were educated to check the bed board, with a new process to add code status daily for staff and contracted service providers was also provided. Staff were educated to check the bed board, change of condition, communication during a code the crash cart, and staffing assignments. On [DATE] at 3:00 P.M. an Ad Hoc Quality Assurance and Performance Improvement (QAPI) was held. The meeting was held with the Administrator, the DON, Minimum Data Set (MDS) Coordinator #613, Medical Director (MD) #614, Dietary Director #602, Social Services Director #557, Medical Records #582, Activity Director #513, ADON #615, Human Resources Director (HRD) #520, Director of Rehabilitation (DoR) #565, Wound Care LPN #603, and Environmental Services Director (ESD) #550. The Administrator and the DON educated management on where to locate advanced directives, the facility CPR policy, Code Blue Flow Sheet, that hospice was not a code status and that advanced directives still needed checked, and new bed board process to add code status daily for staff. Contracted service providers would be educated to check the bed board, change of condition, communication during a code, crash cart, and staffing assignments. A Root Cause analysis was reviewed. The facility would give each service provider a memo upon entering the building that stated the facility's new process, they were to sign off on the sign off sheet that they were given the memo and had read and understood. In addition, the facility would be emailing all appropriate service providers the memo. On [DATE] at 3:30 P.M. 32 Certified Nurse Aides (CNAs), 19 LPNs, four Registered Nurses (RN), seven housekeepers, six receptionists,16 therapists, and 2 activity employees were educated on where to locate advanced directives, CPR policy, Code Blue Flow Sheet, that hospice is not a code status and advanced directives still need checked, and the new bed board process to add code status daily for staff. Contracted service providers will be educated to check the bed board, change of condition, communication during a code and crash cart, and staffing assignments by ADON #615 and the DON. On [DATE] at 4:00 P.M. a whole house audit for 58 residents' code status orders were reviewed for accuracy by ADON #615. This would be reviewed daily during clinical meetings, and the DON/designee would update and check the code status for new admissions. On [DATE] at 4:30 P.M. 58 resident care plans were reviewed for accuracy by MDS Coordinator #613. On [DATE], ADON #615 audited all current nurse's CPR certification records to ensure nursing staff had current CPR certification. No nurses were permitted to work until their active CPR certification was verified by Administration. On [DATE] at 8:00 A.M. Former Director of Nursing (FDON) #604 ran the 72-hour audit report on 58 residents to assess for change of condition that was not addressed. No issues were identified. The DON/designee would audit the 24 hour and 72-hour report. On [DATE] at 10:30 A

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, closed record review, review of emergency medical services (EMS) run reports, review of the facility assessment and floor plan, review of facility staffing, policy review and interview, the facility failed to accurately assess and provide timely and necessary medical intervention for residents identified to have an acute change in condition. In addition, the facility failed to provide basic life support (BLS) and Cardiopulmonary Resuscitation (CPR) in accordance with BLS/CPR standards of practice, failed to maintain adequate staffing resources to allow for efficient and effective emergency response to residents' with cardiopulmonary arrest, and failed to have effective systems in place for staff to obtain timely assistance during a CPR code. This resulted in Immediate Jeopardy and Actual Harm/Subsequent Death for Resident #13, #58 and #74. This affected three residents (#13, #58, and #74) of 22 residents reviewed for change in condition. The facility census was 53. Immediate Jeopardy began on [DATE] at approximately 12:30 A.M. when Resident #74 was assessed to have shortness of breath with a low oxygen saturation (71%). The nurse on duty failed to notify the physician or provide adequate intervention. The resident's oxygen saturation remained low (85% and 89%) when checked following the administration of aerosol treatment and application of Bilevel Positive Airway Pressure (BiPAP) (a noninvasive ventilation system to administer supplemental oxygen) with no evidence of physician notification or medical intervention. At approximately 2:10 A.M. the resident was found on the floor of his room. Licensed Practical Nurse (LPN) #532 began CPR per the resident's advance directives; however, the LPN did not check to see if the resident had a pulse prior to implementation. The other nurse on duty (LPN #633) took over 30 minutes to call 911 causing a delay in emergency medical services (EMS) response/assistance. EMS arrived at the facility at 2:57 A.M. and transported Resident #74 to a local hospital where he was pronounced deceased on arrival at the emergency room (ER) at 3:33 A.M. The Immediate Jeopardy continued on [DATE] when Resident #58 told Registered Nurse (RN) #511 she was having respiratory distress. RN #511 did not check the resident's vital signs before administering treatment and then left the resident unattended to get oxygen. When RN #511 returned, Resident #58 was unresponsive. Without assessing the resident's vital signs, RN #511 again left the resident to go to another floor to get help. Upon return to the resident's room, CPR was initiated without first assessing to see if the resident had a pulse and without use of a backboard (a necessary component to CPR which provides a firm, non-compressible surface and reduces mattress displacement allowing for effective compressions). EMS arrived onsite and took over CPR at 3:10 A.M. Resident #58 was subsequently pronounced deceased on arrival at the emergency room (ER) at 3:45 A.M. The unit Resident #58 resided on at the facility had just opened in [DATE] with single occupancy rooms for skilled residents. There was no staffing plan for this unit in the facility assessment. In addition, there was no communication system in place for emergent situations and staff working on the unit had to physically leave the unit to go to the second floor to get additional staff assistance when/if needed. The Immediate Jeopardy continued on [DATE] at 1:04 P.M. when LPN #506 failed to notify Medical Director (MD) #614 or provide medical intervention when Resident #13, (who had advance directives for a Full Code status) was assessed to have an acute change in medical condition. The resident had coffee ground emesis, was hypotensive (blood pressure of 87/60 (normal ranges from 120/80)), tachycardic (pulse of 114 (normal ranges from 60 to 100 beats per minute (bpm)), and an oxygenation level of 93 percent (%) (normal ranges from 95 to 100%) on room air. At 5:40 P.M., Resident #13 was found unresponsive with no intervention provided. EMS were not contacted until [DATE] at 6:23 P.M. and arrived at the facility at 6:32 P.M. Upon arrival, EMS determined Resident #13 was deceased , CPR was not in progress by facility staff, and EMS was informed that Resident #13 had been pronounced deceased at the facility at 5:40 P.M. On [DATE] at 4:20 P.M. the Director of Nursing (DON), Administrator, Regional Director of Clinical Services (RDCS) #601, and Regional Director of Operations (RDO) #559 were notified Immediate Jeopardy began on [DATE] at 2:10 A.M., when the facility failed to ensure comprehensive systems were in place to timely identify and provide necessary intervention to Resident #74 who experienced an acute change in condition resulting in the resident's death. The Immediate Jeopardy continued on [DATE] and [DATE] when the facility continued to ensure comprehensive systems were in place to timely identify and provide necessary intervention to residents (#58 and #13) who experienced an acute change in condition resulting in resident death. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 4:30 P.M. during a

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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 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. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure Resident #29 was provided corrective lens and vision care appointments per physician orders. This affected one resident (Resident #29) of one resident reviewed for vision services. The facility census was 53.Findings include:Review of the medical record for Resident #29 revealed an admission date of [DATE] with diagnoses including diabetes mellitus with proliferative diabetic retinopathy with bilateral macular edema.Review of the [DATE] quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #29 revealed a Brief Interview of Mental Status (BIMS) score of four out of 15 which indicated severe cognitive impairment. Resident #29 was noted under Section B to have adequate vision with corrective lenses. Review of the care plan for Resident #29 which was last reviewed on [DATE] revealed impaired visual function related to hypertension and diabetes. Interventions listed were to arrange consultation with an eye care practitioner as required. Review of the physician order dated [DATE] from Resident #29's optometrist revealed a prescription for glasses with an expiration date of [DATE]. Review of the physician order dated [DATE] for Resident #29 revealed an order for an optometrist appointment on [DATE] at 9:10 A.M.Review of the nursing progress notes from [DATE] to [DATE] did not reveal any evidence that Resident #29 went to the appointment with the optometrist on [DATE] or if it had been rescheduled within that time frame. Review of the outside ophthalmologist physician notes dated [DATE] for Resident #29 revealed a diagnosis of proliferative diabetic retinopathy of both eyes with macular edema associated with type two diabetes mellitus and bilateral pseudophakia (condition where the natural lens of the eye has been replaced with an artificial intraocular lens). Recommendations were to return for a follow-up appointment in five to seven months.Review of the physician order dated [DATE] revealed an order for an eye appointment at the outside ophthalmologist on [DATE] at 8:15 A.M.Further review of the medical record for Resident #29 revealed no documentation to show he attended the [DATE] ophthalmologist appointment. Review of the nursing progress notes for Resident #29 did not reveal any evidence of why Resident #29 did not attend the physician ordered appointment on [DATE] or if it was rescheduled.A phone interview was conducted on [DATE] at 3:58 P.M. with Resident #29's Power of Attorney (POA) and revealed she had reported Resident #29's missing glasses last week but had not heard any additional information since then. Resident #29's POA stated he went on a leave of absence (LOA) from the facility in mid-July, did not have his glasses on when he was picked up and she had not seen the glasses during recent visits.An observation on [DATE] at 4:15 P.M. of Resident #29 revealed he was sitting up in his bed and was not wearing his glasses. Interview at the time of the observation with Resident #29 revealed his glasses had been missing for a while but he was unsure how long.An observation on [DATE] at 4:20 P.M. with Certified Nursing Aide (CNA) #562 revealed she was unable to locate Resident #29's glasses in his room and was unaware his glasses were missing.An interview on [DATE] at 7:26 A.M. with Director of Nursing (DON) #581 confirmed she was made aware of Resident #29's missing glasses yesterday and was unable to order replacement glasses because his prescription was expired. DON #581 stated there was a physician order dated [DATE] to schedule an eye exam with no directions specified in the order. DON #581 confirmed the nurse should have called to schedule an eye exam when the order was placed. An interview on [DATE] at 9:10 A.M. with DON #581 confirmed she was unable to provide additional evidence related to the [DATE] eye appointment for Resident #29 or why it was not kept or rescheduled.An interview on [DATE] at 1:45 P.M. with Regional Director of Clinical Services (RDCS) #601 and Regional Director of Operations (RDO) #599 confirmed the facility was unable to provide evidence why Resident #29 did not attend the [DATE] ophthalmologist appointment or why a follow up had not been scheduled since then. Interview on [DATE] at 2:47 P.M. with RDCS #601and RDO #599 confirmed they were unable to provide a facility policy related to vision appointments, ancillary appointments or physician orders being followed.This deficiency represents noncompliance investigated under Complaint Number 1381901 and Complaint Number 1381896.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, clinical nursing assistant orientation program staff sign off review, interview and facility policy review, the facility failed to ensure appropriate supervision was provided for residents requiring supervision while smoking and failed to ensure residents did not have smoking items in their personal possession. This affected two residents (Resident #45 and #49) of three residents reviewed for smoking. The facility identified 26 residents (Residents #4, #5, #6, #7, #12, #13, #14, #15, #17, #18, #22, #26, #40, #41, #43, #44, #45, #49, #50, #51, #52, #53, #54, #60, #61, and #63) who smoked. The facility census was 53. Findings include:Observation on 08/18/25 at 2:25 P.M. of the outside smoking area revealed three residents (Resident #45, #49 and #60) smoking outside without supervision. At the time of the observation, the Administrator confirmed residents were without staff supervision and stated he did not know if those resident's required supervision, but if they required supervised smoking, a staff member should have been present. Review of the facility approved smoking times included 9:10 A.M.-9:30 A.M., 11:00 A.M.-11:20 A.M., 1:30 P.M.-1:50 P.M., 3:30-3:50 P.M., 6:30 P.M.-6:50 P.M. and 7:40 P.M.-8:00 P.M. Review of the 08/19/25 facility resident smoker list revealed only two residents (Resident #12 and #51) of 26 residents listed as requiring smoking supervision. (However, Residents #12 and #51 were also assessed as requiring supervision).1. Review of the medical record for Resident #45 revealed and admission date of 11/23/17. Diagnoses included acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), vascular dementia, schizophrenia and nicotine dependence. Review of the 02/06/25 signed facility smoking policy resident contract for Resident #45 revealed any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Residents with restricted smoking privileges are not permitted to keep cigarettes, and other smoking articles in their possession. Review of the 05/29/25 smoking safety screen for Resident #45 revealed supervision was required for safe smoking. Review of the 06/11/25 Minimum Data Set (MDS) 3.0 assessment for Resident #45 revealed intact cognition. Resident #45 was noted to require supervision for walking 150 feet and was independent for most activities of daily living (ADL). Review of the care plan for Resident #45 which was last reviewed on 07/08/25 revealed Resident #45 had a history of smoking in the community and in the facility. Interventions listed included complete a smoking evaluation per facility guidelines, and the resident will follow the facility smoking policy. Observation on 08/28/25 at 8:11 A. M. in Resident #45's room revealed Resident #45 sitting on his bed and an empty pack of cigarettes and a lighter on his bedside table. Interview at the time of the observation with Resident #45 revealed he did not have any more cigarettes but had taken the cigarette lighter from a table in the outside smoking area and was going to dispose of it but had not done it yet. At the time of the observation, Director of Nursing (DON) #581 confirmed the smoking items in Resident #45's room and confirmed he was not supposed to have smoking items in his possession. 2. Review of the medical record for Resident #49 revealed an admission date of 12/12/23. Diagnoses included malignant neoplasm of lower lobe of the right lung, COPD and nicotine dependence. Review of the 02/06/25 signed facility smoking policy resident contract for Resident #49 revealed any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Residents with restricted smoking privileges are not permitted to keep cigarettes, and other smoking articles in their possession. Review of the 05/29/25 smoking safety screen for Resident #49 revealed supervision was required for safe smoking. Review of Resident #49's care plan last reviewed on 06/12/25 revealed Resident #49 had a history of smoking in the community and in the facility. Interventions listed included complete a smoking evaluation per facility guidelines, and the resident will follow the facility smoking policy. Review of the 08/09/25 quarterly MDS 3.0 assessment revealed Resident #49 had intact cognition and was independent for ADL. Interview on 08/28/25 at 8:30 A.M. with Resident #49 who was sitting in his wheelchair next to the nurses' station revealed he thought he was at a credit union and was looking for donations. When Resident #49 was asked where he kept his money, Resident #49 proceeded to roll up the seat cushion on the left side of his wheelchair which revealed a pack of cigarettes. DON #581 was standing at the nurses' station at the time of the observation and confirmed Resident #49 had cigarettes in his possession and was not supposed to. Review of the undated clinical nursing assistant orientation program staff sign off sheet revealed staff are oriented to resident smoking locations, times, protocols and safety as part of the 'on the floor' competencies. Review of the facility policy called Smoking Policy-Residents Acknowledgement, revised December 2016, revealed prior to and upon

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and facility assessment review, the facility failed to maintain sufficient levels of competent staff to ensure residents received the care needed to maintain the highest quality of life. This affected two residents (#58 and #74) and had the potential to affect six additional residents (#22, #26, #31, #35, #46, and #61) who resided on the first floor unit of the facility. The facility census was 53.Findings include:1. Review of the closed medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including diabetes, chronic obstructive pulmonary disease (COPD), schizophrenia, depression, dependence on supplemental oxygen, heart disease, and a history of a stroke without residual effects from the stroke. Review of the physician's orders for Resident #74 revealed the following: An order dated [DATE] for one puff of a Ventolin inhaler every six hours as needed for asthma, and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligrams (mg) per 3 milliliters to be inhaled every six hours as needed for wheezing. An advance directive order dated [DATE] for a Full Code (attempt all life-saving treatment) if his heart were to stop beating. An order dated [DATE] for oxygen to be administered continuously at four liters per minute via nasal cannula. An order written [DATE] to apply Bilevel Positive Airway Pressure (BiPAP) (a noninvasive ventilation system to administer supplemental oxygen) 45 minutes intermittently as often as possible throughout the day, every three hours for low oxygen levels. Review of the Medicare five-day comprehensive Minimum Data Set (MDS) 3.0 assessment for Resident #74 dated [DATE] revealed the resident was severely cognitively impaired, became short of breath when lying flat, and received oxygen as well as non-invasive ventilation. Review of the care plan related to Advance Directives for Resident #74, last revised on [DATE] revealed to implement full code measures per the resident's request. Review of a nursing progress note for Resident #74 dated [DATE] at 4:00 A.M. revealed LPN #532 documented at the start of her shift the resident was alert and oriented. At approximately 12:30 A.M., Resident #74 was lying flat. LPN #532 elevated the resident's head of the bed and checked his oxygen level. The resident's oxygen level was 71% (abnormal low). LPN #532 had Resident #74 use his as needed Ventolin and Ipratropium aerosol for shortness of breath. Upon completion of the breathing treatment, LPN #532 re-checked the resident's oxygen level, and it had increased to 85% (which remained below normal range). The note included LPN #532 applied the resident's BiPAP around 1:00 A.M. then re-checked his oxygen level after using it for a short while, and his oxygen level increased to 89% (remained below normal range). There was no evidence the physician was notified or evidence of adequate intervention to address this change in the resident's condition. Continued review of the nursing progress note authored by LPN #532 revealed at 2:10 A.M., LPN #532 went to check on Resident #74 and was met in the hallway by Resident #74's roommate who informed the nurse that Resident #74 was on the floor. The progress note revealed LPN #532 immediately began CPR with CNA #610 assisting with the code. The CNA re-applied Resident #74's oxygen. The note included at 2:38 A.M., 911 (EMS) was called to transport the resident to the hospital. CPR continued until EMS arrived and took over care. LPN #532 notified the Director of Nursing (DON), the Assistant Director of Nursing (ADON) the Medical Director (MD), and the resident's next of kin regarding what happened and his transport to the local emergency room (ER). LPN #532 documented on [DATE] at 4:28 A.M. that she contacted the ER and was informed Resident #74 had passed away. Review of the EMS Run Report, dated [DATE], revealed EMS received a call from the facility at 2:44 A.M. and arrived at the facility at 2:57 A.M. Resident #74 was found by EMS with CPR being performed on the floor by facility staff. After EMS arrived, they confirmed asystole (no pulse) on a monitor, they took over CPR and transported Resident #74 to the local hospital emergency room where he was pronounced dead on arrival at 3:33 A.M. An interview with LPN #532 on [DATE] at 4:09 P.M. revealed she always worked the night shift from 11:00 P.M. to 7:00 A.M. and she was typically assigned to work on the second floor. She verified she was the nurse assigned to care for Resident #74 on ([DATE]) the night the resident coded and passed away. LPN #532 stated on this night she had the resident sit up on the edge of his bed, she gave him his inhaler and then breathing treatment for shortness of breath. LPN #532 stated she felt Resident #74 was feeling better after his breathing treatment. LPN #532 said about an hour later she went to see how the resident was feeling and was informed by Resident #74's roommate that the resident was on the floor. LPN #532 said she yelled for help immediately and CNA #610 said she was CPR certified and offered to help. LPN #532 said she did not check to see if Resident #74 had a pulse, she just started CPR. LPN #532 stated that LPN #633 called 911

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Gardens of Euclid Beach	16101 Euclid Beach Blvd Cleveland, OH 44110

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and review of the facility policy, the facility failed to ensure medications in the medication cart were labeled and stored in proper containers. This had the potential to affect 30 Residents (#2, #6, #8, #16, #18, #19, #20, #21, #22, #23, #25, #26, #30, #31, #33, #35, #36, #37, #39, #42, #43, #44, #45, #46, #47, #49, #50, #52, #60, and #61) who received medications from the medication carts reviewed. The facility census was 53. Findings include:Observation on 08/20/25 at 3:15 P.M. of the medication cart on the sycamore hall revealed there were 15 loose pills of various shapes and colors in the bottom of the medication cart. Interview on 08/20/25 at 3:15 P.M. with Registered Nurse (RN) #606 and Licensed Practical Nurse (LPN) #559 confirmed 15 loose pills of various shapes and colors in the bottom of the medication cart for the sycamore hall. RN #606 & LPN #559 confirmed they were not able to identify the 15 pills nor to whom the 15 pills were prescribed. Observation on 08/20/25 at 3:21 P.M. of the crystal [NAME] hall medication cart revealed there were 20 loose pills of various shapes and colors in the bottom of the medication cart. Interview on 08/20/25 at 3:21 P.M. with LPN #607 confirmed 20 loose pills of various shapes and colors in the bottom the nurse of the crystal [NAME] hall medication cart. LPN #607 confirmed she was not able to identify the 20 pills nor to whom the 20 pills were prescribed. Observation on 08/20/25 at 3:47 P.M. of the carousel hall revealed there were 5 loose pills of various shapes and colors in the bottom of the medication cart. Interview on 08/20/25 at 3:47 P.M. with LPN #578 confirmed five loose pills of various shapes and colors in the bottom of the medication cart for the carousel hall cart confirmed she was not able to identify the five pills nor to whom the five pills were prescribed. Review of the facility policy titled, Storage of Medications, dated 04/07, revealed drugs and biologicals should be stored in the packaging in which they are received and the nursing staff is responsible for maintaining medication storage. This deficiency represents non-compliance investigated under Complaint Number 2578214.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician ordered labs were completed timely as required. This affected one resident (Resident #53) of 22 residents reviewed for physician orders. The facility census was 53. Findings include:Review of the medical record for Resident #53 revealed an admission date of 09/08/23. Diagnoses included hemiplegia and hemiparesis affecting the left non-dominant side, type II diabetes mellitus, history of suicidal behavior, alcohol abuse and cocaine abuse. Review of the physician order dated 11/21/23 for Resident #53 revealed an order for a BMP (Basic Metabolic Panel) and CBC (Complete Blood Count) to be completed every three months with no further directions specified. Review of the medical record for Resident #53 revealed no evidence of a BMP or CBC being completed on 07/15/25 as ordered. Review of the care plan last reviewed on 07/23/25 for Resident #53 revealed resident at risk for adverse effects related to use of psychoactive medications and diagnosis of depression. Resident #53 also had a diagnosis of depression related to pain management needs. Intervention for both listed included obtain lab results as ordered and notify the physician of abnormal values. Review of the 08/15/25 annual Minimum Data Set (MDS) 3.0 assessment for Resident #53 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated moderate cognitive impairment. Resident #53 was also noted to have a diagnosis of depression and received antidepressant, antiplatelet and anticonvulsant medications. Interview on 08/25/25 at 3:14 P.M. with Regional Director of Clinical [NAME] (RDCS) #601 confirmed the BMP and CBC was last completed on 04/15/25 but was unable to provide evidence that the BMP and CBC were completed as physician ordered on 07/2025. Interview on 09/03/25 at 2:47 P.M. with RDCS #601and Regional Director of Operations (RDO) #599 confirmed they were unable to provide a facility policy related to physician orders being followed. This deficiency represents noncompliance investigated under Complaint Number 1381901.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interviews, record review and review of facility policy, the facility failed to ensure the policy pertaining to use and storage of food in resident room refrigerators was implemented and addressed temperature monitoring for food safety. This affected four residents (Residents #4, # 9, #43, and #44) of four residents reviewed for personal food storage. The facility identified seven residents (Residents #4, #9, #16, #36, #43, #44 and #47) as storing food in room refrigerators. The facility census was 53. Findings include: 1. Review of the medical record for Resident #44 revealed an admission date of 08/20/09. Diagnoses included hemiplegia and hemiparesis, morbid obesity and polyneuropathy. Review of the 07/15/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #44 revealed he was cognitively intact, received a no added salt (NAS) diet, and required set up for meals. An observation on 08/21/25 at 1:45 P.M. with Regional Dietary Manager (RDM) #598 revealed Resident #44's refrigerator had a plastic sleeve on the outside of it with an undated temperature monitoring log with the first eighteen days completed. The temperature monitoring logs behind it were dated from January, February and March 2025. No additional temperature logs were found. An interview on 08/21/25 at 1:40 P.M. with the Administrator revealed the maintenance department was to monitor the resident room refrigerators and there were three residents with refrigerators in their rooms. The Administrator did not identify the three residents. An interview on 08/21/25 at 1:40 P.M. with Licensed Practical Nurse (LPN) #521 revealed there were four residents (Residents #4, #9, #43, and #44) on the second floor with refrigerators in their rooms. An interview on 08/21/25 at 2:44 P.M. with Maintenance #538 revealed Certified Nurse Aides (CNAs) were responsible to monitor resident refrigerator temperatures. An interview on 08/21/25 at 2:47 P.M. with CNA #523 revealed CNA #523 stated it was the nurses' responsibility to check the resident refrigerator temperatures. An interview on 08/21/25 at 2:51 P.M. with LPN #521 revealed she was never told to check resident room refrigerators or monitor refrigerator temperatures. LPN #521 stated upon further checking there were seven residents with resident room refrigerators (Residents #4, #9, #16, #36, #43, #44, and #47). An interview on 08/28/25 at 10:02 A.M. with Resident #44 revealed “sometimes” the staff checked his refrigerator and he did not think it was checked weekly. 2. Review of the medical record for Resident #43 revealed an admission date of 08/01/20. Diagnoses included chronic obstructive pulmonary disease, dysphagia, hemiplegia and hemiparesis. Review of the 07/22/25 five-day admission MDS 3.0 assessment revealed intact cognition. Resident #43 was noted to receive a regular diet, require set up for meals and was dependent upon staff for activities of daily living (ADL). An observation on 08/21/25 at 1:47 P.M. with RDM #598 of Resident #43's room refrigerator revealed no temperature monitoring logs in or around the refrigerator. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 08/28/25 at 10:04 A.M. with Resident #43 revealed she was unaware if anyone was monitoring her room refrigerator and had never observed someone checking the refrigerator. 3. Review of the medical record for Resident #9 revealed an admission date of 09/09/24. Diagnoses included gastroparesis, chronic obstructive pulmonary disease and type II diabetes mellitus. Review of the 06/18/25 quarterly MDS 3.0 assessment for Resident #9 revealed intact cognition. Resident #9 was noted to receive a NAS, Reduced Concentrated Sweets diet, was independent for meals and dependent on staff for ADL. An observation on 08/21/25 at 1:49 P.M. with RDM #598 of Resident #9's room refrigerator revealed no temperature monitoring logs on and around the refrigerator. Interview at the time of observation with Resident #9 revealed no one had checked his refrigerator “in a long time”. An interview on 08/28/25 at 10:06 A.M. with Resident #9 revealed someone had checked his refrigerator yesterday but was unsure the last time prior to yesterday whether the temperature or the items inside were checked. 4. Review of the medical record for Resident #4 revealed an admission date of 03/20/25. Diagnoses included multiple sclerosis, morbid obesity and type two diabetes mellitus. Review of the 07/01/25 quarterly MDS 3.0 assessment for Resident #4 revealed intact cognition. Resident #4 was noted to receive a regular diet, required set-up for meals and was dependent upon staff for ADL. An observation on 08/21/25 at 1:54 P.M. with RDM #598 of Resident #4's room refrigerator revealed no temperature monitoring log on or around the refrigerator. A 12.05-ounce (oz) plastic container of pre-prepared beef stew was found and had an expiration date of 07/03/25, an eight-ounce container of parmesan cheese was found with an expiration date of 08/19/23. Interview with RDM #598 at the time of the observation verified the findings. An interview on 08/28/25 at 10:08 A.M. with Resident #4 revealed she was unsure if anyone ever checked her refrigerator or monitored temperatures and stated if they had then it was not being done consistently. Review of the facility policy titled Food Brought in for Patients and Residents, dated 11/27/17, revealed food brought to residents by family or visitors will be handled and stored in a safe and sanitary manner and may be stored in personal refrigerators in resident rooms. Food items that require refrigeration must be labeled, dated and will be held in the refrigerator for three days after the date on the label then discarded by staff. Foods considered unsafe or beyond the expiration date will be discarded by staff. The policy did not specify any procedure or instructions related to maintaining and monitoring safe food temperatures in resident room refrigerators. This deficiency represents non-compliance investigated under Complaint Number 2578214.

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, record review, job description review, and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all residents residing in the facility. The facility census was 53. Findings include: A review of the facility job description labeled Administrator revealed the purpose of the position was to establish and maintain systems that were effective and efficient to operate the facility in a manner to safely meet the residents' needs in compliance with federal, state, and local requirements. The job description further stated the administrator would determine the personnel requirements of the facility and hire or arrange for sufficient staff to implement the facility policies and procedures. The administrator would develop a monitoring system to assure compliance with federal, state and local requirements. Specific requirements were as follows: Established systems to enforce the facility policies and procedures Establish written personnel policies and individual job descriptions Supervise all department supervisors and administrative staff Develop one-to-one relationships with residents and families Assume responsibility for ensuring that equipment is in operating orderA review of the facility job description labeled Director of Nursing (DON) revealed the purpose of the position was to provide nursing management, set resident care standards for all direct care providers and provide complete supervision and management of the nursing department. The job description further stated the Director of Nursing would assess resident needs and interview, hire and terminate adequate nursing personnel, set resident care standards in accordance with accepted current standards of care to provide high quality of care to residents, supervise and manage all aspects of the nursing department and assess direct and supervise residents' care needs.A review of the facility job description labeled Maintenance Supervisor revealed the purpose of the position was to develop and implement facility maintenance policies and procedures. The job description further stated the Maintenance Supervisor shall develop and implement a monitoring system for the maintenance department and make recommendations for implementation to assure compliance with federal, state and local requirements. The Maintenance Supervisor would supervise the entire operation of the maintenance department. On 08/18/25 at 9:36 A.M. an interview with the Regional Director of Operations (RDO) #599, Licensed Nursing Home Administrator (LNHA) #600 and Director of Clinical Services #601 revealed LNHA #600 had been at the position for one week. The interview further revealed there had been six previous administrators over the past year. RDO #559 stated the Director of Nursing was new in the position as well. RDO #559 stated the previous administrator and director of nursing were transferred to a sister facility 08/13/25.A review of an email from [NAME] President of Operations #617 to RDO #599 dated 08/18/25 with the subject listed as Euclid Administrators revealed a total of seven LNHAs in the last year. LNHA #631 from 03/20/24 to 08/25/24 LNHA #630 from 08/26/24 to 11/25/24 LNHA #629 from 11/25/24 to 02/11/25 LNHA #628 from 02/12/25 to 07/14/25 LNHA #627 from 07/14/25 to 08/09/25 LNHA #626 from 08/09/25 to 08/13/25 and LNHA #600 from 08/13/25 through current.A review of a document titled; Director List for the Last Year revealed there were four DONs in the last year: Registered Nurse (RN) #623 from 02/01/24 to 03/10/25 RN #622 from 03/10/25 to 04/07/25 RN #604 from 04/07/25 to 08/11/25 and RN #581 from 08/10/25 through current.A review of a document titled; Maintenance Directors revealed three Maintenance Directors in the last year: Maintenance Director (MD) #624 from 04/15/24 to 05/31/25 MD #625 from 05/22/25 to 08/09/25 and MD #538 from 08/09/25 through current.During the annual and complaint surveys, observations, record reviews, and interviews, resulted in concerns related to the overall operation of the facility including but not limited to, care planning, environmental and equipment concerns, activities of daily living care, treatment to maintain vision, laboratory services, accurate facility assessment, documentation issues, staff orientation and training, quality assurance committee, resident food storage, accident prevention, infection control regarding oxygen tubing, pharmacy reviews, food storage, dignity, quality of care and medication storage. The facility failed to provide evidence that administrative staff, including the Administrator and/or DON, had effective systems in place to timely identify and correct quality, care and environmental concerns. A. The facility failed to ensure an accurate care plan was indicative of oxygen use for one resident (Resident #55) of three reviewed for oxygen use. B. The facility failed to ensure a clean and sanitary homelike environment and failed to ensure garbage was disposed of properly. This had the potential to affect all residents residing in the facility.C. The facility failed to initiate Cardiopulmonary Resuscitation (CPR) or call emergency medical services (EMS) for Resident #13 resulting in immediate

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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. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure a clean and sanitary homelike environment was provided for residents. This had the potential to affect all residents residing in the facility. The facility census was 53.Findings include:On 08/18/25 between 12:00 P.M. and 1:45 P.M. an initial observational tour of the building was conducted. room [ROOM NUMBER] was noted to have pealing wallpaper and a missing corner piece protector on the left side of the wall between the television stand and the bathroom that exposed the bare wall. The bathroom floor was noted to be coming up. A piece of vinyl approximately six foot by five foot was noted on the bathroom wall across from the toilet that was curved onto the left side of the wall. The toilet was noted to be dirty. There were two full urinals hanging off the garbage can by the bed. There were gnats crawling at the sink and in a wash basin. The aforementioned was verified by Housekeeping and Laundry Supervisor #550 at the time of the observation. room [ROOM NUMBER] was noted to have a ceiling tile with a large brown stain on it that appeared to be wet. Resident #31 stated it was reported to the Administrator several days ago and maintenance came to fix it. Resident #31 further stated the ceiling tile was replaced but the pipes were not looked at as to a possible cause.On 08/19/25 at 10:35 A.M. peeling wallpaper by the second-floor elevator exposing the wall was noted. room [ROOM NUMBER] was noted to have visible rust around the sink in the room. The wall between the door and the sink was noted to have gouges and large black scuffs on it. The aforementioned was verified by [NAME] President of Plant Operations (VPO) #605 and Maintenance Director (MD) #538 at the time of the observation. VPO #605 also verified the bathroom wall damage in room [ROOM NUMBER] noted on 08/18/25. VPO #605 stated the curving piece of vinyl that was placed on the wall across from the toilet was not a proper fix for possible wall damage. VPO #605 stated the vinyl sheet should have been cut and pieced at the corner. Further interview with VPO #605 revealed there are no regular cite visits by him in regard to general upkeep and cleanliness of the building. VPO #605 stated a mock survey was conducted in April of this year and a general inspection was in July. An interview with MD #538 revealed he was only in his role for two weeks.On 08/19/25 at 11:30 A.M. an interview with Regional Director of Operations (RDO) #599 revealed room rounds are done and recorded on Room Round sheetsOn 08/27/25 between 10:00 A.M. and 11:15 A.M. an extensive tour of the building was conducted with the following findings: A brown stained ceiling tile in the bathroom of room [ROOM NUMBER] was noted and verified by Certified Nurse Assistant #621. room [ROOM NUMBER] was noted to have visible dirt and debris behind the door extending outward to be visible on the other side of the door. room [ROOM NUMBER] was noted to have visible dirt and debris behind the door extending outward to be visible on the other side of the door and the window curtains were not hung correctly. room [ROOM NUMBER] was noted to have visible dirt and debris behind the door extending outward to be visible on the other side of the door. The toilet was not clean with visible dirt under the inner rim. A built up dirt ring was noted within the toilet bowl. room [ROOM NUMBER] was noted to have a large dried red substance on the floor that appeared to be sauce. The privacy curtain was soiled. room [ROOM NUMBER] had a gouged and damaged wall between the television stand and the bathroom. room [ROOM NUMBER] was noted to have chipped tile on the floor. Peeling paint was noted by the baseboard and closet door. There was no baseboard between the television stand and the bathroom. The wall was exposed. room [ROOM NUMBER] was noted to have peeling paint on the wall. There was no baseboard on the wall between the closet and door exposing the wall. The top of the heating unit had built up visible dirt. room [ROOM NUMBER] had built up visible dirt on the heating unit. The bathroom had peeling wall paper with exposed wall to the left of the sink. There was visible dirt on top of the backsplash of the bathroom sink. room [ROOM NUMBER] had visible dirt and debris behind the door. room [ROOM NUMBER] had visible dirt and debris behind the door. room [ROOM NUMBER] had visible dirt and debris behind the door. There was no baseboard between the entry door and the closet. The wall was exposed with a hole in it. The privacy curtain was not hung correctly. room [ROOM NUMBER] had peeling wallpaper Above the closet and below the sink. The privacy curtain was torn. The baseboard between the sink and closet was coming off. The window curtains were not hung correctly. There was rust noted around the sink. Built up dirt and debris was noted behind the entry door and coming out from under the closet. There was built up dust on top of the heating unit. room [ROOM NUMBER] was noted to have a privacy curtain that was not hung correctly. There was wall damage noted to the left of the entry door in the hall between the lower rail and baseboard. room