STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365828	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Gardens Rehabilitation & Care Center	18810 Harvard Ave Cleveland, OH 44122

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure residents needs and preferences were met regarding appropriate linens on beds and maintaining bathing equipment for use to accommodate resident preference. This affected two residents (#105 and #22) of 13 residents reviewed for accommodation of needs. The facility census was 107.Findings include:1. Record review for Resident #105 revealed an admission date of 10/24/24. Diagnoses included dislocation of an unspecified knee, morbid severe obesity, and encounter for orthopedic aftercare. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #105 was cognitively intact. Resident #105 had impairment on one side of the lower extremities, used a wheelchair for mobility, required set up or clean up assist with toileting hygiene, supervision or touch assist with personal hygiene, and partial/moderate assist with bed mobility and transfers. Observation on 02/24/26 at 10:25 A.M. revealed Resident #105 was lying in bed with her eyes closed. The bed was noted to be a bariatric (larger bed) bed and there was no fitted sheet on the mattress. Resident #105 was resting on the bare mattress.Observation and interview 02/24/26 at 4:33 P.M. revealed Resident #105 was still lying in her bed directly on the mattress with no fitted sheet under her. Resident #105 stated, They do not have a lot of bed sheets, the fitted ones. I have to lay on the bare mattress and I do not like it but they are always running out. Resident #105 revealed she does not refuse the sheet; the facility just does not have them available and revealed they also frequently run out of gowns and towels. Observation and interview on 02/24/26 at 4:46 P.M. with Licensed Practical Nurse (LPN) #637 confirmed Resident #105 was lying on the bare mattress. Observation of the available linens on the south halls where Resident #105 resided confirmed there were no bariatric fitted sheets available. Observation and interview on 02/24/26 at 4:52 P.M. with the Director of Nursing (DON) of the North linen closet and the second floor confirmed there were no bariatric fitted sheets. The DON confirmed there were no bariatric fitted sheets in the residential areas for staff to use. Observation of the laundry area located in the basement of the facility with the DON revealed, after searching, Housekeeping/Laundry Director #540 found two bariatric fitted sheets.2. Record review for Resident #22 revealed an admission date of 12/18/24. Diagnosis included cerebral infarction, cellulitis, type two diabetes mellitus, and morbid, severe obesity. Review of the MDS assessment dated [DATE] revealed Resident #22 was cognitively intact. Resident #22 had impairment on one side of the upper extremities and both sides of the lower extremities and was dependent for bathing and showers. Review of the care plan initiated 12/19/24 revealed Resident #22 had an activity of daily living (ADL) self-care performance deficit. Interventions included Resident #22 required assistance with ADLs (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed and to honor the resident's choices and preferences whenever possible. Record review of the activity interview for daily preference document for Resident #22 dated 12/21/24 revealed for the question asking how important it was to the resident to choose between a tub bath, shower, bed bath, or sponge bath, Resident #22 answered it was very important. Record review of the resident preference evaluation for Resident #22 dated 08/23/25 revealed it was very important to Resident #22 to choose between a tub bath, shower, bed bath, or sponge bath and revealed Resident #22 chose (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a shower as his preference.Review of the shower records from 12/01/26 through 02/27/26 for Resident #22 revealed Resident #22 only received bed baths during that period.Interview on 02/25/26 at 10:00 A.M. with Resident #22 revealed he had not received a shower in the past two and a half to three months. Resident #22 confirmed he could only take a shower using the shower bed due to his physical condition and revealed he was told by the staff he could not receive a shower because the shower bed was broken. Resident #22 was only able to receive bed baths as he did not feel as clean and preferred showers. Observation and interview on 02/25/26 at 10:06 A.M. with LPN #541 of the shower bed confirmed the bed was missing pins that held the frame together. LPN #541 confirmed Resident #22 was unable to receive showers due to the shower bed being the only shower bed in the facility. LPN #541 revealed the bed had been broke at least a few weeks. Interview on 02/25/26 at 10:26 A.M. with Certified Nurse Aide (CNA) #575 revealed the shower bed Resident #22 used had not been working for at least a couple months.Interview on 02/25/26 at 11:47 A.M. with the Administrator revealed there were issues with the shower bed and stated it was not working a month or so, maybe a little more. This deficiency represents non-compliance investigated under Complaint Number 2710289.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview, the facility failed to ensure the physical environment was maintained in a clean, sanitary, and homelike manner. This affected 28 (#17, #34, #37, #38, #39, #43, #47, #50, #52, #53, #54, #58, #63, #64, #74, #77, #81, #83, #86, #87, #90, #92, #98, #99, #104, #107, #141, and #162) of 107 residents residing in the facility. The census was 107. Findings Include:1. Observation of Resident #64's room on 02/25/26 at 11:46 A.M. revealed no bathroom door was present.Interview with Licensed Practical Nurse (LPN) #634 on 02/26/25 at 11:50 A.M. verified the lack of a bathroom door in Resident #64's room.2. Observation of the facility environment with Housekeeping Director #700 on 02/26/26 between 1:15 P.M. and 1:45 P.M. revealed the air vent in Resident #50's room was heavily rusted; the privacy curtains in Resident #39, Resident #52, Resident #58, Resident #63, Resident #77, Resident #87, Resident #92, and Resident #107's rooms were visibly stained; the tile flooring in Resident #99 and Resident #162's room contained unidentified substance on the floor and visible staining; Resident #34 and Resident #90's room had thick dust accumulation on the ceiling, Resident #90's supplemental feeding administration pole had a large amount of dried supplement residue; the windowsill in Resident #141's room had a large brown stain; the air conditioning units in Resident #98 and Resident #104's room contained a bird nest and birds could be heard chirping from within the unit; Resident #53's fall mat was torn, worn, and soiled; Resident #54's dresser was missing drawers and the toilet in the room had brown staining; Resident #83's sink in the living area was cracked; Resident #64's light over the bed had a visible crack, and Resident #43's headboard was broken off and was resting beside the bed.Further observation on 02/26/26 between 1:15 P.M. and 1:45 P.M. revealed the closet doors were missing in the rooms for Resident #17, Resident #37, Resident #38, Resident #47, Resident #52, Resident #54, Resident #58, Resident #74, Resident #81, Resident #86, Resident #87, and Resident #92.The above findings were confirmed by Housekeeping Director #700 during the environmental tour on 02/26/26 at the time of discovery. This deficiency represents non-compliance investigated under Complaint Number 2671148 and Complaint Number 2659118.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, review of medication administration audit reports, and review of a facility policy, the facility failed to ensure pain medications were administered as ordered to effectively manage a resident's pain. This affected one (#11) of seven residents reviewed for medication administration. The facility census was 107.Findings include:Record review for Resident #11 revealed an admission date of 10/30/25. Diagnoses included pain in the left hip; unilateral primary osteoarthritis, left knee; intervertebral disc degeneration; lumbar back pain; and pain in the right foot.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact and had pain frequently.Review of the care plan for Resident #11 dated 11/03/25 revealed Resident #11 was at risk for back pain, fatigue, anxiety, and bone pain. An intervention included to administer medications as prescribed.Review of the physician orders for January and February 2026 revealed Resident #11 had active orders for the narcotic pain medication oxycodone extended release (ER) 12 hour abuse deterrent 10 milligrams (mg), give 10 mg by mouth two times a day scheduled for upon rising and at 7:00 P.M. for pain. The order was initiated on 01/06/26. Resident #11 was also ordered oxycodone 10 mg by mouth every four (4) hours as needed for pain on 11/07/25 and oxycodone five (5) mg by mouth every 4 hours as needed for mile to moderate pain on 02/10/26. On 10/31/25, the resident was ordered a lidocaine external 4 percent (%) patch topically to the effected area upon rising for pain. On 02/18/26, the resident was ordered the muscle relaxing medication Baclofen 10 mg by mouth three times daily scheduled for upon rising, at dinner, and 7:00 P.M. Further review of Resident #11's physician orders revealed the resident was ordered the pain medication Lyrica oral capsule 75 mg by mouth three times a day (scheduled for 6:00 A.M., 2:00 P.M., and 10:00 P.M.). This order was initiated on 11/20/25 and discontinued 02/19/26. Resident #11 was also ordered muscle relaxing medication methocarbamol 750 mg by mouth three times daily which was initiated on 02/16/26 and discontinued on 02/18/26 at 8:26 P.M.Review of the medication administration time codes provided by the Director of Nursing (DON) revealed upon rising was between 6:00 A.M. to 10:00 A.M. or between 7:00 A.M. to 11:00 A.M.; dinner was between 2:00 P.M. to 5:00 P.M.; and bedtime was between 7:00 P.M. to 11:00 P.M.Review of the medication administration audit report for January 2026 and February 2026 for Resident #11 revealed the audit report included the actual time each medication was administered. Further review of the audit report revealed on 01/02/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:10 P.M.; on 01/03/26 lidocaine 4% patch ordered for upon rising was administered at 1:43 P.M.; on 01/03/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:06 P.M.; on 01/04/26 lidocaine 4% patch ordered for upon rising was administered at 1:12 P.M.; on 01/06/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:47 P.M.; on 01/06/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 01/07/26 at 7:43 A.M.; on 01/08/26 lidocaine 4% patch ordered for upon rising was administered at 12:18 P.M.; on 01/08/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:38 P.M.; on 01/09/26 oxycodone ER 10 mg ordered for upon rising was administered at 1:20 P.M.; on 01/09/26 lidocaine 4% patch ordered for upon rising was administered at 1:19 P.M.; on 01/10/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 01/11/26 at 6:52 A.M. (The 6:00 A.M. dose was also administered on 01/11/26 at 6:51 A.M.); on 01/11/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:33 P.M.; on 01/12/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 5:02 P.M.; on 01/12/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 01/13/26 at 12:12 A.M. (an as needed dose of oxycodone 10 mg was administered on 01/12/26 at 9:25 P.M.); on 01/13/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered at 11:14 P.M. for a pain rated a six out of 10; on 01/14/26 lidocaine 4% patch ordered for upon rising was administered at 2:08 P.M.; on 01/14/26 oxycodone ER 10 mg ordered for 7:00 P.M. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was administered on 01/15/26 at 12:54 A.M. (an as needed dose of oxycodone 10 mg was given at 9:55 P.M. for pain rated a seven out of 10); on 01/15/26 oxycodone ER 10 mg ordered for upon rising was administered at 11:26 P.M. with a pain rating of 10 out of 10; on 01/16/26 lidocaine 4% patch ordered for upon rising was administered at 12:06 P.M.; on 01/16/26 oxycodone ER 10 mg ordered for upon rising was administered at 12:07 P.M. and the resident rated pain a 10 out of 10; on 01/19/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 01/20/26 at 8:51 A.M. and rated pain a seven out of 10; and on 01/19/26 Lyrica 75 mg was to be administered at 7:00 P.M. and was administered on 01/20/26 at 8:50 A.M. (The 6:00 A.M. dose was documented as administered on 01/20/26 at 8:49 A.M.)Review of the electronic medication administration record (e-MAR) progress note revealed on 01/21/26 Lyrica to be administered at 6:00 A.M. and 2:00 P.M. was not available. Review of the e-MAR progress note revealed on 01/22/26 Lyrica to be administered at 2:00 P.M. was not available. Review of the MAR revealed Resident #11 rated her pain a six out of 10. Review of the e-MAR progress note revealed on 01/23/26 Lyrica to be administered at 6:00 A.M., 2:00 P.M., and 10:00 P.M. was not available. Review of the MAR revealed Resident #11 rated her pain a 10 out of 10 for all shifts.Further review of Resident #11's MARs and medication audit reports for January and February 2026 revealed on 01/24/26 oxycodone ER 10 mg ordered for upon rising was administered at 4:21 P.M. (The oxycodone scheduled to be administered at 7:00 P.M. was documented as administered on 01/24/26 at 7:07 A.M.); on 01/24/26 lidocaine 4% patch ordered for upon rising was administered at 4:21 P.M.; on 01/25/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 5:27 P.M.; on 01/26/26 oxycodone ER 10 mg ordered for upon rising was administered at 6:46 P.M.; on 01/26/26 lidocaine 4% patch ordered for upon rising was administered at 6:46 P.M.; on 01/28/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 01/29/26 at 4:08 A.M. (The 6:00 A.M. dose was administered at 6:22 A.M.); on 02/03/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 02/04/26 at 1:04 A.M.; on 02/04/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:22 P.M.; on 02/05/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 02/06/26 at 3:37 A.M.; on 02/05/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 02/06/26 at 3:36 A.M.; on 02/09/26 oxycodone ER 10 mg ordered for upon rising was not administered; on 02/09/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 6:22 P.M.; on 02/18/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:47 P.M.; on 02/18/26 methocarbamol 750 mg was to be administered at 4:00 P.M. was not administered; on 02/20/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 02/21/26 at 3:26 A.M.; on 02/20/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered on 02/21/26 at 3:26 A.M.; on 02/22/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered on 02/22/26 at 10:25 P.M.; on 02/23/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered on 02/24/26 at 12:21 A.M.; on 02/25/26 oxycodone ER 10 mg ordered for upon rising was administered at 12:12 P.M.; and on 02/25/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered at 11:45 P.M.Record review of Resident #11's nursing progress notes for January and February 2026 revealed no documentation of reasons for late medication administration on all occasions with exception as documented above. Interview on 02/26/26 at 9:23 A.M. with Resident #11 stated the facility did not always administer her pain medications on time. Resident #11 revealed she had chronic back pain and was able to tolerate pain some of the time. Resident #11 revealed she was receiving therapy with a goal to return home, and she needed to keep her pain tolerable to be able to complete her therapy. Resident #11 stated when her pain rating was at a five or six out of 10, she could not tolerate it without intervention. Interview on 03/03/26 at 12:49 P.M. with the DON verified the late times for Resident #11 pain medication administration in January and February 2026 for the above mentioned dates and medications. The DON revealed she had never seen a medication administration audit report before and was not aware the medications were being administered late. The DON stated she did not know why Resident #11's pain medications were administered late. Review of the facility policy titled, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administering Medication, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame.This deficiency represents non-compliance investigated under Complaint Number 2639149 and Complaint Number 2603969.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of staffing schedules and timecard punches, review of resident census data, and staff interview, the facility failed to ensure a registered nurse worked in the facility for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 107 residents residing in the facility. The census was 107. Findings include: Review of the facility staffing schedules and staff timecard punches dated from 12/25/25 through 12/31/25, revealed there was no registered nurse (RN) working in the facility on 12/25/25 and 12/31/25. Review of the facility census data for 12/25/25 and 13/31/25 revealed 97 were residing in the facility on those dates.Interview on 02/24/26 at 3:18 P.M. with the Director of Nursing (DON) verified there was no RN coverage on 12/25/25 and 12/31/25. She stated she was the only RN in the building on those days.This deficiency represents non-compliance investigated under Complaint Number 2671148 and Complaint Number 2603969.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, and staff interview, the facility failed to ensure all hot foods were served at adequate and palatable temperatures. This had the potential to affect 105 residents who received meals from the facility. The facility identified Resident #8 and Resident #67 received no food from the kitchen. The facility census was 107. Findings include: Interview with Resident #11 on 02/23/26 at 1:58 P.M. revealed the food was cold all the time. Interview with Resident #6 on 02/24/26 at 8:50 A.M. revealed the food was never hot.Observation and interview of a test meal tray with Dietary Manager (DM) #526 on 02/24/26 at 12:41 P.M. revealed the tray consisted of a chicken breast filet, rice, peas and carrots, and a grape drink. Temperatures were obtained in the presence of DM #526 with the food temperatures including the chicken breast was 122 degrees Fahrenheit (F), the peas and carrots were 122 degrees F, and the rice was 141 degrees F. The chicken and the peas and carrots were warm but not hot when consumed. DM #526 verified the findings of the test tray at the time of observation.This deficiency represents non-compliance investigated under Complaint Number 2671148.