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	04/15/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility policy review, the facility failed to maintain safety during assisted ambulation, resulting in a fall. This affected one resident (#57) of three residents reviewed for falls. The facility census was 102.Findings include: Review of the medical record for Resident #57 revealed an admission date of 07/29/23 and diagnoses including Alzheimer's disease, dementia, generalized anxiety disorder, repeated falls, and abnormalities of gait and mobility.Review of the plan of care revised on 12/13/23 revealed Resident #57 has had an actual fall. Interventions include therapy evaluation and treatment as ordered, inquire for family input, bed against wall, call before fall signage in clear view, complete fall assessments, educate family and resident on fall risk, ensure appropriate footwear when out of bed, evaluate risk factors, and inform resident staff will assist her to the bathroom and with transfers.Review of Physical Therapy Discharge Summary from 08/21/25 revealed at time of discharge, Resident #57 was able to ambulate with a front-wheeled walker for 150 feet with supervision/touching assistance.Review of the Fall Risk Evaluation dated 01/20/26 revealed Resident #57 was not considered at high risk for falls.Review of the plan of care revised on 02/17/26 revealed Resident #57 required assistance with activities of daily, utilized wheelchair for locomotion, and may require assistance with locomotion. Interventions included assist resident to bathroom following meals, assist with activities of daily living, resident requires assistance with toileting hygiene and transfers, assist with one to two staff for bed mobility/transfers/toileting, may use sit-to-stand lift during episodes of fatigue, provide necessary equipment and adequate time for self-participation in daily care, and up in wheelchair for all meals.Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #57 had moderately impaired cognition. Resident #57 used a wheelchair for mobility within in the last seven days prior to the assessment. Resident #57 required partial moderate assistance for transfers and sit-to-stand. Resident #57 required supervision touching assistance for wheelchair use of 50 feet and 150 feet. Resident #57 was evaluated as not applicable for walking 10 feet.Review of nurse aide charting from 03/23/26 to 04/02/26 revealed for walking 10 feet, Resident #57 required partial/moderate assistance (helper provides less than half of the effort, lifts/holds/supports trunk or limbs) on 03/23/26, 03/24/26, and 03/25/26 and substantial/maximal assistance (helper does more than half of the effort, lifts/holds/supports trunk or limbs) on 03/28/26, 03/29/26, and 04/01/26. Nurse aide charting for walk in room revealed Resident #57 required limited assistance (staff provide guided maneuvering of limbs or other non-weight bearing assist) on 03/23/26, 03/24/26, and 03/25/26 and extensive assistance (staff provide weight-bearing support) on 03/28/26, 03/29/26, 03/30/26 and 04/01/26.Review of the Functional Abilities and Goals assessment dated [DATE] revealed Resident #57 required substantial/maximal assistance for moving from a sitting to a standing position. Walking 10 feet was not attempted due to medical condition or safety concerns.Review of the Fall Risk Evaluation dated 04/02/26 revealed Resident #57 was not considered at high risk for falls.Review of the Fall Investigation Report dated 04/02/26 revealed Resident #57 had fall in her room while using a walker. Resident #57 was noted to be alert and (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oriented to person and place. Resident #57 hit the back of her head and was sent to the hospital. There was no pain reported. The fall was witnessed by Certified Nursing Assistant (CNA) #812. Resident #57's physician and responsible party were notified.Review of a Pain Assessment/Evaluation dated 04/02/26 revealed Resident #57 had a fall. Resident #57's pain score was zero out of 10. Review of Post Fall Observations (72 Hour Documentation) dated 04/02/26 revealed Resident #57's blood pressure was 142/84, temperature was 97.8 degrees, pulse was 86, and oxygen saturation was 97 percent on room air. Resident #57 had not had a change in ADL ability from pre-fall activity. Resident #57 was alert and oriented.Review of a Fall Incident Report dated 04/02/26 revealed at 7:40 A.M., CNA #812 informed Licensed Practical Nurse (LPN) #809 that Resident #57 had fallen. Resident #57 was observed lying on her left side in front of her bed. Resident #57 stated she was attempting to go to the bathroom with a walker and lost balance and fell to floor. Resident #57 stated she had hit the back of her head. There were no apparent injuries noted and Resident #57 did not lose consciousness at time of fall.Review of a Witness Statement Form undated revealed CNA #812 stated she was assisting Resident #57 to the bathroom with a walker. CNA #812 noted there was a mechanical lift in the room which was in the way. CNA #812 stated while keeping a hand on Resident #57, she pushed the mechanical lift out of the way for an easier pathway. Resident #57 lost her balance and fell to the floor.Review of an Interdisciplinary Team (IDT) note dated 04/02/26 revealed Resident #57's fall was reviewed. Resident #57 was walking to the bathroom with a walker and lost her balance and fell. Resident #57 was sent to hospital for evaluation. A new fall intervention was added to post a ?call before fall' sign in room to remind the resident to ask for assistance.Interview on 04/13/26 at 12:19 P.M. with CNA #812 revealed she was assisting Resident #57 to get up and walk to bathroom with a walker. CNA #812 stated she was behind Resident #57 and noticed a mechanical lift leg was in the way, so CNA #812 pushed the mechanical lift out of the way. CNA #812 stated Resident #57 lost her balance and fell backwards. CNA #812 stated she had a hand near Resident #57's lower back. CNA #812 stated she did not use a gait belt (a belt worn around a patient's waist to provide caregivers a secure and comfortable grip for assistance with standing, walking, or transfers) during the ambulation or transfer. CNA #812 stated she notified the nurse who assessed Resident #57. CNA #812 stated she did not see any injuries or hear Resident #57 complain of pain. CNA #812 stated this was how she normally walked with Resident #57 and stated she had never used the sit-to-stand lift with Resident #57.Interview on 04/13/26 at 12:25 P.M. with Director of Rehabilitation #813 revealed Resident #57 had not been seen by therapy since August 2025. Director of Rehab #813 stated when Resident #57 discharged from therapy, she could safety ambulate with a walker and staff by contact guard assistance. Director of Rehab #813 stated when therapy staff ambulated with residents, they use a gait belt, and it would be recommended the nurse aides use gait belts as well.Interview on 04/13/26 at 2:33 P.M. with LPN #809 revealed she was not Resident #57's assigned nurse on 04/02/26, however CNA #812 had notified her when Resident #57 fell. LPN #809 stated she found Resident #57 lying on her left side on the floor with no visible injuries. LPN #809 stated Resident #57 reported hitting her head during the fall however was not in any pain. LPN #809 stated she called Resident #57's representative who requested Resident #57 be sent to the hospital for evaluation. LPN #809 stated she knew CNA #812 was in the room when Resident #57, but was unsure what type and amount of assistance the CNA was providing.Interview on 04/13/26 at 3:12 P.M. with the Director of Nursing (DON) revealed nurse aide staff do not use gait belts for Resident #57 and a hand to the back would be appropriate. The DON stated CNA #812 was educated to ensure all obstacles were out of the way before ambulating with a resident. The DON reported the documentation of nurse aides, care planning, MDS, and functional assessment was incorrect and insisted Resident #57 could ambulate by supervision with touching assistance. The DON reported Resident #57 remained out at the hospital.Follow up interview on 04/13/26 at 4:00 P.M. with Director of Rehab #813 revealed supervision with touching assist could be hands-on or hands-off. Director of Rehab #813 stated she felt it was appropriate for CNA #812 to push the mechanical lift out of the way (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and take hands off Resident #57 during ambulation. Director of Rehab #813 did not address questioning of how directly removing hands from Resident #57 during ambulation resulted in fall. Director of Rehab #813 did not address the current differences in functional ability charting compared to a therapy discharge from August 2025.Interview on 04/14/26 at 10:25 A.M. with the DON revealed there was no policy to address ambulation or transfers of residents.Review of facility policy Fall Prevention Policy dated November 2024 revealed staff would take proactive measures to ensure resident safety and minimize fall risk. Procedures for fall prevention included keeping walkways clear and free of clutter, encouraging residents to use assistive devices, and using proper transfer techniques and gait belts as needed.This deficiency represents non-compliance investigated under Master Complaint Number 2979859.

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, review of informational articles from American Cancer Society, and interview the facility failed to develop and implement a system for identifying, monitoring, and caring for Resident #3's implanted venous access device (a port placed under the skin for use to administer intravenous treatments to mitigate risk for infection. This affected one resident (#3) of three residents reviewed for vascular access devices. The facility census was 102.Actual Harm occurred on 03/04/26 when Resident #3 was identified by a non-facility oncology nurse at an outside appointment to have a dressing to an implanted venous access device that was heavily soiled. Resident #3 was assessed to be weak and dizzy and was transferred to the emergency room where the resident was admitted to the intensive care unit (ICU) for sepsis (a blood culture from the implanted venous access device revealed gram-positive cocci bacteria). On 02/20/26 Resident #3 had returned from the hospital with an implanted venous access device that remained accessed by a Huber (a non-coring needle used to access a subcutaneous implanted port used under sterile conditions.) needle and covered with a dressing. The facility's failure to identify the accessed device resulted in the device remaining accessed and without routine monitoring or site care until 03/04/26. Resident #3 remained in the hospital until 03/12/26.Findings include:Review of the medical record for Resident #3 revealed an admission date of 12/04/25 with diagnoses including personal history of malignant neoplasm of large intestine, malignant neoplasm of rectosigmoid junction, malignant neoplasm of colon, peritoneal abscess, anemia, sepsis, iron deficiency anemia, elevated white blood cell count, severe protein calorie malnutrition, artificial openings of urinary tract status, acquired absence of parts of the digestive tract, and candidal stomatitis.Review of the clinical census for Resident #3 revealed multiple hospitalizations which included from 12/22/25 to 12/28/25, 01/02/26 to 01/09/26, 01/17/26 to 01/20/26, 02/17/26 to 02/20/26, 03/04/26 to 03/12/26 and 03/16/26 to 03/22/26. On 03/31/26 the resident was transferred to the hospital and had not returned at the time of the onsite survey. Review of hospital record titled History and Physical Examination dated 12/22/25 revealed Resident #3 was admitted for tachycardia and sepsis related to urinary infection. Resident #3 was noted to be anemic and required blood transfusion of one-unit of packed red blood cells (RBCs) to increase hemoglobin levels. Resident #3 was noted to have a left-sided chest implanted venous access device. Resident #3's hemoglobin level was 7.3.Review of hospital record titled Lines, Drains, Airways, and Wounds dated 12/23/25 revealed Resident #3 had an implanted single port vascular access device to the left chest that was placed on 09/19/25.Review of admission Assessment and Baseline Care Plan dated 12/29/25 revealed Resident #3 re-admitted to the facility. There was no evidence the facility had identified Resident #3 had an implanted venous access device.Review of hospital record titled History and Physical Exam dated 01/02/26 revealed Resident #3 was admitted to the hospital for complaints of painless rectal bleeding. Resident #3 was found to have increase in size of lower abdominal mass which was compatible with progression of malignancy.Review of hospital record titled Infectious Diseases Progress Note dated 01/06/26 revealed Resident #3 had an implanted venous access device to left chest. There were no external signs of infection. Blood cultures were obtained showing Methicillin-resistant Staphylococcus epidermidis (MRSE) and unable to rule out contaminants versus a venous access device related blood stream infection. It was noted the device had been sterile to date.Review of hospital record titled Lines, Drains, Airways, and Wounds dated 01/09/26 revealed Resident #3 had an implanted single port vascular access device to the left chest that was accessed on 01/02/26.Review of progress note dated 01/09/26 revealed Resident #3 re-admitted to the facility. There was no evidence the facility had identified Resident #3 had an implanted venous access device.Review of hospital record titled History and Physical Exam dated 01/18/26 revealed Resident #3 was admitted for abdominal pain and diarrhea related to Clostridioides difficile (C. diff). Resident #3 was found to have low (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	hemoglobin and hematocrit (H/H) levels of 4.5/13.7. Resident #3 received a transfusion of two units of packed RBCs to improve H/H levels. It was noted Resident #3 was unable to consistently receive chemotherapy due to recurrent infections.Review of hospital record titled Patient Handoff Communication dated 01/20/26 revealed Resident #3 had an implanted double port vascular access device to left chest that was accessed on 01/18/26.Review of progress note dated 01/20/26 revealed Resident #3 re-admitted to the facility. There was no evidence that the facility had identified Resident #3 had an implanted venous access device.Review of hospital record titled Emergency Department (ED) Provider Note dated 02/17/26 revealed Resident #3 was admitted to the hospital for evaluation of nephrostomy tubes and abdominal pain. Laboratory workup showed concern for anemia. Resident #3's H/H levels were noted to be low at 5.4/16.7. Resident #3 received a blood transfusion of two units of packed RBCs and was monitored without reaction.Review of hospital record titled History and Physical Exam dated 02/18/26 revealed Resident #3 was admitted for low H/H level of 5.4/16.7 and concern for dislodgement or obstructed nephrostomy tube. Resident #3 required a blood transfusion to address low H/H levels.Review of hospital record titled Initial Consult Gastroenterology dated 02/18/26 revealed gastroenterology was consulted for acute blood loss anemia. Resident #3 received a blood transfusion of two units of packed RBCs.Review of hospital record titled Internal Medicine Progress Notes dated 02/19/26 revealed Resident #3's H/H levels were 7.3/23.4. Resident #3 was given a blood transfusion during this admission. The note referenced Resident #3 had chronic anemia with an unclear etiology.Review of hospital record titled Palliative Medicine Initial Consult dated 02/19/26 revealed Resident #3 had not received chemotherapy since 10/28/25. It was noted chemotherapy had to be stopped due to recurrent hospital admissions with infections. A visit with infectious disease on 01/27/26 revealed no direct contraindication to resuming chemotherapy. It was noted Resident #3 had yet to have a follow-up visit with oncology and a message was sent to assist with scheduling the appointment. Review of progress note dated 02/20/26 revealed Resident #3 re-admitted to the facility. There was no evidence the facility had identified Resident #3 had an implanted venous access device.Review of the admission Assessment with Baseline Care Plan dated 02/20/26 revealed no evidence the facility had identified Resident #3 had an implanted venous access device, or that the device was accessed.Review of the Skin Observation dated 02/21/26 revealed no evidence the facility had identified Resident #3's had an accessed implanted venous access device.Review of the Skilled Assessment completed daily by facility nurses from 02/21/26 to 02/28/26 revealed no indication the facility identified Resident #3 had an accessed implanted venous device. The assessments made no mention of any site care or monitoring provided. Review of a Nurse Practitioner (NP) note dated 02/25/26 authored by NP #822 revealed the note was recorded as a late entry into the record on 03/23/26. The note did not include any indication that Resident #3 had an accessed implanted venous device.Review of the Skin Observation dated 02/28/26 revealed no evidence the facility had identified Resident #3's had an accessed implanted venous access device.Review of the Skilled Assessment completed by facility nurses on 03/02/26, 03/03/26, and 03/04/26 revealed no indication the facility identified Resident #3 had an accessed implanted venous device. The assessments made no mention of any site care or monitoring provided. Review of the physician orders from 02/20/26 to 03/04/26 revealed no evidence the facility had identified or obtained orders for monitoring or care of Resident #3's implanted venous access device.Review of the facility progress notes revealed there was no note to address Resident #3's condition prior to leaving for an outside oncology appointment on 03/04/26.Review of the infusion center record titled Progress Note dated 03/04/26 at 1:19 P.M. revealed Resident #3 arrived at the cancer center for an appointment. Resident #3 was found to have a Huber needle accessing his implanted venous access device. There was a heavily soiled dressing that was partially intact covering the device. The dressing appeared to be dated 02/11/26. The nurse at the infusion center removed the dressing and was able to get blood return. Resident #3 stated he was not feeling well. Resident #3 reported being uncomfortable, weak, and dizzy. The oncology physician was notified and recommended to send (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Resident #3 to the emergency room.Review of infusion center record titled Progress Note dated 03/04/26 at 1:49 P.M. revealed Resident #3 presented to the infusion center and was lethargic, uncomfortable, and unable to keep his head upright. The nurse noted urine in nephrostomy tubes appeared thick, contained mucous, and was purulent.Review of hospital record titled ED Provider Note dated 03/04/26 at 1:52 P.M. revealed Resident #3 presented to the ED with generalized weakness and abdominal pain which Resident #3 reported started overnight. Resident #3 was positive for tachycardia. Resident #3's nephrostomy tubes were inspected and appeared to be draining appropriately. Resident #3 was further evaluated for sepsis.Review of a facility progress note dated 03/04/26 at 4:00 P.M. revealed Resident #3 had not yet returned from an appointment. The facility nurse contacted the office and was notified Resident #3 had been sent to the emergency room. It was noted Resident #3 was admitted for abdominal wall abscess, sepsis, general abdomen pain, leukocytosis, bladder mass, and elevated serum creatinine.Review of hospital record titled ICU History and Physical dated 03/04/26 at 8:24 P.M. revealed Resident #3's lab work showed leukocytosis and elevated lactate levels. While being worked up for sepsis and being treated for chronic pain Resident #3 became hypotensive requiring ICU admission. It was noted Resident #3 was at cancer center appointment and felt dizzy and weak. Resident #3's port was noted to have been already accessed with a dressing labeled 02/11/26. It was noted the dressing was dirty.Review of hospital record titled Consult - General Surgery dated 03/04/26 revealed there was concern for abscess. Resident #3 had been followed with oncology for management of cancer and was last seen on 01/22/26. Last chemotherapy treatments were from 09/30/25 to 10/30/25. Resident #3's chemotherapy was on hold due to recurrent hospitalizations for infectious causes and acute-on-chronic anemia. Resident #3 was supposed to get chemotherapy today, however, was sent to ED for further evaluation. Evaluation of concern for abscess revealed there was no surgical intervention warranted.Review of hospital lab results dated 03/05/26 revealed blood culture results revealed MRSE and gram-positive cocci (GPC) in clusters. Urine culture results revealed greater than 100,000 of mixed microbiota. A Complete Blood Count (CBC) revealed low hemoglobin level of 5.2 grams per deciliter (g/dL). Resident #3 was given a blood transfusion of two units of packed RBCs on 03/05/26.Review of hospital record titled Infectious Disease Service dated 03/05/26 revealed Resident #3 was admitted to hospital for shock which could be combination of septic and hemorrhagic shock as his hemoglobin level was 5.2. Resident #3 had a left-sided chest wall implanted vascular access device. Blood cultures from the device revealed gram positive cocci (bacteria). Resident #3 was treated with Daptomycin (an intravenous antibiotic) and Zosyn (another intravenous antibiotic). The note also indicated the resident remained on oral Vancomycin (an antibiotic) for recurrent C. Diff.Review of progress note dated 03/12/26 revealed Resident #3 re-admitted to the facility. There was no evidence the facility had identified Resident #3 had an implanted venous access device.Interview on 04/09/26 at 10:53 A.M. with Registered Nurse (RN) #840 from the outside oncology office revealed on 03/04/26, Resident #3 came to office for a chemotherapy treatment. RN #840 stated Resident #3 had been on hold from treatments due to health issues. RN #840 stated when Resident #3 arrived for his appointment he appeared disheveled and unbathed. RN #840 stated their biggest concern was Resident #3's implanted vascular access device had been previously accessed. RN #840 described the device as still having a Huber needle accessing the port in Resident #3's chest. RN #840 stated there was a dressing over the device which was heavily stained and the edges were peeling up. RN #840 stated they were very concerned about infection risk. RN #840 reported Resident #3 was sent to the hospital from the oncology office. RN #840 stated the dressings were typically changed once per week. RN #840 stated Resident #3 had been discharged from the hospital on [DATE] to the facility with the Huber needle still in place. RN #840 stated she would have expected the facility to send Resident #3 back to the hospital to have the needle removed from the resident's implanted vascular access device. Interview on 04/09/26 at 11:08 A.M. with Certified Nursing Assistant (CNA) #808 revealed she regularly cared for Resident #3. CNA #808 was unable to recall if (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Resident #3 had a vascular access port when she provided bathing assistance.Interview on 04/09/26 at 11:18 A.M. with RN #802 revealed she regularly cared for Resident #3. RN #802 stated she was unaware of Resident #3 receiving chemotherapy treatments. RN #802 was unable to recall if Resident #3 had a vascular access port.Follow up email correspondence dated 04/09/26 at 1:06 P.M. from RN #840 revealed a review of Resident #3's hospital medical record was completed and revealed there were no appointments on 02/11/26. RN #840 reported Resident #3 was admitted to the hospital from [DATE] to 02/20/26. RN #840 stated she believed the dressing was actually labeled 02/17/26, however due to legibility and the condition of the dressing it was mistaken for 02/11/26.Interview on 04/09/26 at 1:51 P.M. with the Director of Nursing (DON) revealed the facility did not access implanted venous access devices. The DON confirmed there was no evidence in Resident #3's medical record for monitoring of his implanted venous access device. The DON was unable to provide any evidence the facility had identified the device or monitored the device in any way.Interview on 04/09/26 at 2:49 P.M. with RN #804 revealed she regularly cared for Resident #3. RN #804 stated she had observed Resident #3's implanted venous access device in the past. RN #804 stated she did not have any orders indicating to monitor or address the device. RN #804 stated she could not recall seeing the device accessed.Interview on 04/13/26 at 11:27 A.M. with NP #822 for Physician #820 revealed she was aware Resident #3 had an implanted venous access device. NP #822 stated she had not been notified there were any uses or issues with the device. NP #822 stated she had not visited Resident #3 at the facility and had only seen him in the hospital. NP #822 stated the hospital usually de-accessed the device prior to discharging a patient. NP #822 stated there would be risk for infection if the device was left accessed.Attempted interview on 04/13/26 at 4:24 P.M. with LPN #811 revealed she was a former employee, and the phone number provided was disconnected. LPN #811 had authored progress note on 03/04/26 when Resident #3 was admitted to the hospital.Interview on 04/14/26 at 9:05 A.M. with Physician #820 revealed Resident #3 did have implanted venous access device, however it would not be used by the facility. Physician #820 stated there was a large risk for infection and most nurses were not trained on proper use of the device. Physician #820 stated he was unaware Resident #3's device had remained accessed while at the facility. Physician #820 stated he was not the primary physician for Resident #3 while he was at the hospital. Physician #820 adamantly denied the facility should be handling the device; however, did state the facility could have identified and questioned the dressing date or access of the device. Physician #820 stated it was highly unusual that an implanted venous access device would remain accessed when a patient was discharged to a nursing home; however, he was unable to guarantee this.Review of facility policy Venous Access Site Care dated December 2024 revealed the facility would routinely assess, protect and maintain all venous access sites that were not currently being accessed. The site should be monitored at least once per shift for redness, swelling, pain, drainage, or dislodgement. Implanted ports that were not accessed do not require a dressing once healed.Review of web article titled About Your Implanted Port dated 09/29/25 authored by Memorial [NAME] Cancer Center revealed an implanted port is often called a Mediport or Port-a-Cath. An implanted port is a type of central venous catheter which protects veins from damage from repeated access. The implanted port can be used for blood samples, intravenous medications, intravenous fluids, intravenous blood products such as platelets and plasma, and intravenous contrast. Only trained healthcare providers should access ports. When accessed the port and needle would be covered with a dressing to keep the needle in place.Review of web article titled Blood Transfusions dated 10/30/24 authored by the American Cancer Society revealed blood transfusions may be necessary for some people with cancer related to type of cancer, side effects of cancer treatment, and some people who have had cancer for an extended time can develop anemia of chronic disease. Blood transfusions are given intravenously and can be given using central catheters.This deficiency represents non-compliance investigated under Complaint Number 2796317.