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	06/15/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review, and policy review, the facility failed to ensure Resident #100 received all personal belongings upon discharge. This affected one resident (Resident #100) of three residents reviewed for discharge. Findings include:Review of the closed medical record for Resident #100 revealed an admission date of 09/08/23 and a discharge date of 02/24/26. Resident #100 diagnoses included diabetes, hypertension, bipolar disorder, anxiety and above the right knee amputation. Review of Resident #100 ?s admission Agreement dated 05/16/25 revealed the facility would take reasonable precautions to safeguard resident belongings, but was not liable for loss or theft unless due to facility negligence. Residents were encouraged to keep valuables secured or offsite. Review of the quarterly Minimum Data Set 3.0 dated 12/03/25 revealed Resident #100 was cognitively intact. Review of a late entry progress note dated 02/24/26 and timed at 8:15 P.M. and authored by Assistant Director of Nursing (DON) #600 revealed Resident #100 was being discharged to another long-term care facility with most of her personal belongings. The rest of her belongings would be delivered to resident. Interview on 06/15/26 at 11:17 A.M. revealed Resident #100 believed her mini-van was still at the facility parking lot and she never received the rest of her belongings. Resident #100 revealed in calling the facility, she was not able to get through to anyone to discuss retrieval of her belongings. Resident #100 revealed she still resided at the long-term care facility she was discharged to. Phone interview on 06/15/26 at 12:18 P.M. with former Licensed Social Worker (LSW) #200 revealed about half Resident 100's belongings were sent with her upon her discharge. He stated the other half were put in storage at the facility. He stated a driver from their sister facility said he would make a second trip to take the rest of her items to her. LSW #100 said he followed up with the sister facility however he never heard back from them. LSW #200 also stated Resident #100 had a mini-van parked at the facility but stated it was broken down. LSW #200 stated the former Administrator stated Resident #100 would have to make arrangements herself for it to be moved. LSW #200 stated he believed the facility dropped the ball on sending the remaining personal items. He stated he received an email approximately three weeks after discharge from Resident #200 stating she was trying to get a hold of someone from the facility about her belongings. He stated he forwarded the email to the former Administrator but was not aware of the results. LSW #200's last day was in March 2026.Interview on 06/15/26 at 12:52 P.M. with Director of Nursing (DON) and Administrator revealed Resident's 100's personal belongings were still at the facility and previously had a car at the facility. DON described the car as having no windows, only two tires and no alternator. DON revealed she remained in contact with Resident #100 but did not discuss her personal property at all.Interview on 06/15/26 at 1:29 P.M. with Administrator revealed they would offer to transport Resident #100's items to her since staff may have said they would transport belongings but normally they would not. Administrator revealed their policy was any items a resident left behind would be donated or disposed of after 30 days. Administrator revealed it was not reasonable to wait almost four months to send her belongings to her. Interview on 06/15/26 at 1:39 P.M. with Ombudsman revealed Resident #100 contacted her in May 2026 with concerns she did not receive her belongings or car.Interview on 06/15/26 at 2:23 P.M. with Administrator revealed he learned the sister (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's transport van had been broken down until about a month ago. Administrator confirmed there was no evidence arrangements were made for Resident #100 to receive her car.Phone interview on 06/15/26 at 3:31 P.M. with former Administrator #400 revealed he never had a personal conversation with Resident #100 about her belongings. He stated they were trying to look at options stating their bus was not great, the sister facility's bus was down recently and repaired about a month ago. He also stated they looked at renting a moving van but could not state why that option did not work out. Former Administrator #400 stated Resident #100 never reached out to him after discharge. Former Administrator #400 acknowledged receiving the email from LSW #200 but could not recall if he responded.Review of the facility policies titled Parking Lot and Facility Storage Policy, not dated, revealed two policies on the same form. Resident Personal Property Storage revealed upon discharge, transfer, death or abandonment of personal belongings, the facility would inventory and securely store resident property for a minimum of 30 days. Reasonable efforts would be made to notify the resident. After 30 days, if the property was unclaimed and all reasonable notification attempts have been documented, the facility may dispose of, donate, or otherwise manage the property in accordance with applicable laws and facility procedures. Parking Lot Liability Notice stated the facility provided parking for the convenience of residents, visitors and staff. They were not responsible for any loss, theft or damage to vehicles or personal property left in vehicles while parked on the premises. All vehicles were parked at the owner's sole risk. By using the parking facilities, you acknowledge and accept these terms. The policy did not require a signature.This deficiency represents non-compliance investigated under Complaint Number 3010602.