

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Gardens of McGregor and Amasa Stone		STREET ADDRESS, CITY, STATE, ZIP CODE 14900 Private Dr East Cleveland, OH 44112	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and review of the facility policy, the facility failed to ensure palatable food and drink were served at a safe and appetizing temperature. This affected four residents (#15, #36, #89, and #93) and had the potential to affect 131 residents who received meals from the facility kitchen. The facility identified three residents who did not receive food from the kitchen (Resident #82, #128 and #78). The facility census was 134. Findings include: Interview on 08/11/15 at 11:58 A.M. revealed Resident #15 stated the vegetables were cold and the meat was dry. Interview on 08/11/25 at 10:21 A.M. revealed Resident #36 stated the food was not good and the breakfast was always cold. Interview on 08/11/25 at 1:56 P.M. revealed Resident #89 stated the food was warm, but not hot, and was tasteless. Interview on 08/13/25 at 5:00 P.M. with Resident #93's daughter stated she needed to bring outside food for her father because her father did not like the taste of the facility food. Observation on 08/12/25 at 11:00 A.M. revealed the holding temperatures of the food items on the tray line. The pasta with vegetables and tomato sauce was 199.2 degrees Fahrenheit (F.), the coffee was 143.9 degrees F., and milk was 39.7 degrees F. A test tray was prepared which included the pasta with vegetables, milk, and coffee and the test tray left the kitchen on 08/12/25 at 12:44 P.M. The test tray reached the Two South Unit at 12:44 P.M. Nursing staff started to pass the trays on 08/12/25 at 12:54 P.M. with the last tray passed at 1:17 P.M. Registered Dietitian (RD) #735 used a calibrated facility thermometer to obtain the test tray food temperatures. The test tray temperatures revealed the coffee was 124.3 degrees F., the two percent milk (one pint carton) was 56.8 degrees F., and the pasta with vegetables and tomato sauce was 115.0 degrees F. The mildness was not palatable, and it was warm to the taste. RD #735 verified the pasta with vegetables and tomato sauce was not palatable and did not taste warm. Review of facility policy titled Taste and Temperature Control, revised May 2025, revealed food was maintained at palatable temperatures during service to meet resident expectations. This deficiency represents non-compliance investigated under Complaint Number 1280432.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to store food and beverages in a safe and sanitary manner. This had the potential to affect 41 residents (19 residents who resided on the Two South Unit and 22 residents on the One South Unit) who had the ability to utilize the One and Two South Unit refrigerator/freezers. Findings Include:1. Observation on 08/12/25 at 11:15 A.M. revealed the Two South resident nourishment refrigerator located in the dining area contained a large brown bag of Olive Garden food with no resident name or date on the bag and a half gallon of Minute Maid Fruit Punch was expired as of 06/11/25.Interview at the time of discovery with Registered Dietitian #735 verified the findings in the Two South resident nourishment refrigerator and revealed the dietary staff were to clean out the refrigerators.2. Observation on 08/12/25 at 12:15 P.M. of the One South resident nourishment refrigerator located in the dining room contained a white grocery bag with a pound of bacon with no room number, resident name, or date, and the freezer had a half quart of Butter Pecan ice cream and a half quart of Strawberry ice cream that had no resident name or date received/opened. Interview at the time of discovery with Dietary Services General Manager #662 verified resident food was to be labeled with names and dates and dietary services were to clean out the refrigerators on the units. Dietary Services General Manager #662 verified the findings in the One South resident nourishment refrigerator/freezer.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of facility policy, the facility failed to ensure Resident #45 received appropriate care and services for a non-pressure related wound, including wound treatments as ordered and accurate documentation regarding the completion of the wound treatments. This finding affected one (Resident #45) of six residents reviewed for non-pressure skin conditions. Findings Include: Review of Resident #45's medical record revealed the resident was admitted on [DATE] with diagnoses including cellulitis of the right lower limb, primary osteoarthritis of the knee and essential hypertension. Review of Resident #45's physician orders revealed an order dated 07/29/25 (discontinued 08/07/25) to cleanse the left lateral foot open area with normal saline (NS), pat dry, apply Santyl and calcium alginate to the wound bed and cover with a foam dressing every night shift for wound care; an order dated 08/07/25 (discontinued 08/13/25) to cleanse the left lateral foot open area with NS, pat dry, apply Santyl and calcium alginate to the wound bed and cover with a foam dressing and apply an ace wrap every night shift for wound care; and an order dated 08/13/25 to cleanse the left lateral foot open area with NS, pat dry, apply Santyl and calcium alginate to the wound bed and cover with a foam dressing and apply an ace wrap every evening shift for wound care. Review of Resident #45's skin care plan revealed an intervention dated 07/29/25 for the resident to receive treatments per the physician's order. Review of Resident #45's wound evaluation notes dated 08/07/25 revealed the resident had a diabetic ulcer to her left lateral malleolus measuring 1.2 centimeters (cm) by 2 cm by an undetermined depth with 100 percent (%) slough at the wound base. The note revealed the treatment plan for the wound included the importance of adhering to prescribed treatments and dressing changes to prevent infection. Review of Resident #45's Treatment Administration Record (TAR) from 08/01/25 to 08/14/25 revealed Licensed Practical Nurse (LPN) #542 provided wound care on 08/03/25, 08/07/25, 08/08/25 and 08/11/25. Interview on 08/11/25 at 10:37 A.M. with Resident #45 revealed she was not getting wound care as ordered. Resident #45 said she received wound care on 08/07/25 by Registered Nurse (RN) #626 and Wound Nurse Practitioner #740 and told them she was not receiving wound care daily. She was told by RN #626 that she would look into the issue. Resident #45 said she did not receive wound care again until 08/10/25 when she asked the day shift nurse to change her bandage because it was hurting. Interview on 8/12/25 at 4:20 P.M. with Resident #45 and RN #626 revealed RN #626 confirmed the conversation with Resident #45 from 08/07/25 about wound care not being completed daily. Resident #45 also revealed that it was one nurse that was not completing the wound care. RN #626 confirmed she had spoken with the nurse about falsifying records and they were given a verbal warning. Resident #45 stated she had not received wound care since 08/10/25. Interview on 08/12/25 at 4:40 P.M. with RN #626 revealed the nurse not providing the wound care was identified as LPN #542. Observation on 8/12/25 at 4:23 P.M. of RN #626 providing wound care to Resident #45 revealed RN #626 removed the residents wound dressing and there was no date documented on the dressing. Interview on 08/14/25 at 10:22 A.M. with LPN #542 revealed on 08/11/25 he documented that he provided wound care for Resident #45, but he got distracted and never provided the wound care. He said the facility had called him and educated him on documenting after you provide care. Interview on 08/12/25 at 2:16 P.M. with RN #626 revealed she spoke with LPN #542 about the documentation issues on 08/07/25. She stated she had talked to him prior about correct documentation in addition to the conversation on 08/07/25. RN #626 confirmed that the TAR did not accurately reflect the wound care provided. Review of the facility policy titled Skin Alteration, Pressure Prevention and Risk Identification, dated January 2024, revealed a care plan would be developed and updated as needed and interventions would be implemented as indicated by the physician/nurse practitioner and as determined by the interdisciplinary team. This deficiency represents non-compliance investigated under Complaint Number 1280432.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure medications were administered as ordered and best practice guidelines. This finding affected two (Residents #34 and #142) of five residents observed for medication administration. A total of 35 medications were administered with three errors for a medication error rate of 8.57%. Findings include: 1. Review of Resident #34's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes and muscle weakness. Review of Resident #34's physician orders revealed an order dated 08/08/25 to use 5 milliliters (ml) of heparin and flush the peripherally inserted central catheter (PICC) line intravenously (IV) every 12 hours; an order dated 08/08/25 for vancomycin 1500 mg (milligrams)/300 ml with instructions to administer 500 ml IV one time a day for infection until 09/01/25; and an order dated 08/08/25 to use sodium chloride solution (normal saline or NS) 10 ml IV every 12 hours for a flush. Observation on 08/12/25 at 8:24 A.M. revealed Licensed Practical Nurse (LPN) #650 administered Resident #34's oral medications. The nurse then washed her hands, put on gloves and flushed Resident #34's right arm PICC line with heparin solution, wiped the PICC hub and flushed with 10 ml of NS and then administered the IV vancomycin antibiotic via an administration pump. Interview on 08/12/25 at 8:35 A.M. with LPN #650 revealed she was not aware that she was required to flush Resident #34's PICC line with the NS syringe, administer the IV antibiotic, flush the PICC a second time with NS and then use the heparin to maintain patency of the resident's PICC line. Interview on 08/12/25 at 9:40 A.M. with the Director of Nursing (DON) confirmed LPN #650 should have used best practice guidelines when administering Resident #34's IV antibiotic which included the SASH method (saline flush, administer medications, saline flush, heparin flush). Review of the Flushing Considerations and Technique policy dated 2011 revealed for catheters requiring heparin use the S-A-S-H method which included to flush with saline prior to each use, administer the prescribed drug or infusion therapy, flush immediately afterward with saline and final flush with heparin to maintain patency during the time that the device was not in use. 2. Review of Resident #142's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, major depressive disorder and generalized anxiety disorder. Review of Resident #142's physician orders revealed an order dated 03/18/20 for cetirizine give 5 mg by mouth one time a day for allergies; and an order dated 12/15/22 for vitamin D3 50 MCG (micrograms) with instructions to administer one tablet by mouth one time a day for a supplement. Observation on 08/11/25 at 8:43 A.M. revealed LPN #668 administered eight medications to Resident #142 including cetirizine 10 mg and vitamin D3 25 mcg (1000 IU). Interview on 08/11/25 at 11:38 A.M. with LPN #668 confirmed she gave the wrong dose of cetirizine and vitamin D3 to Resident #142. Review of the undated Medication Administration policy revealed the purpose was to ensure safe, accurate and timely administration of medications to residents in accordance with federal and state regulations, professional standards of practice, and facility procedures. This deficiency represents non-compliance investigated under Complaint Number 1280432.		