

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Larchwood Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4110 Rocky River Drive Cleveland, OH 44135	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Larchwood Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4110 Rocky River Drive Cleveland, OH 44135	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure a resident's request for assistance was responded to in a timely manner. This affected one resident (#5) of one reviewed for timely care and assistance. The facility census was 67. Findings include: Review of the medical record for Resident #5 revealed she was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and attention to tracheostomy (a surgically-created artificial airway). Review of the care plan dated 06/27/25 revealed Resident #5 had an ADL self-care performance deficit related disease process and generalized weakness with interventions that included assistance with ADLs and dressing. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14 that indicated she was alert and oriented to person, place, and time. Resident #5 had impairments to both lower extremities and was dependent on staff for activities of daily living (ADLs). Observation and interview on 09/02/25 at 3:02 P.M. revealed Resident #5 was lying in bed with her call light activated. Resident #5 had a white washcloth covering her upper chest and cleavage area and a white sheet covering her stomach and lower extremities. Resident #5 appeared visibly upset and stated she had been waiting for 2 hours for someone to assist her with getting dressed. Resident #5 revealed she received a bed bath and was awaiting assistance with her dressing change so she could finish getting dressed. At the time of Resident #5's interview, Certified Nurse Assistant (CNA) #837 entered the room and informed Resident #5 that Licensed Practical Nurse (LPN) #883 told her to let Resident #5 know she would be in soon. CNA #837 revealed LPN #883 was passing medications to other residents and she did not know how much longer she would be waiting. CNA #837 apologized to Resident #5 for the long wait and stated, I know you're waiting to get dressed and don't want to put the shirt on due to the dressing change. Observation and interview on 09/02/25 at 3:14 P.M. revealed LPN #883 passing medications. LPN #883, upon seeing the state surveyor approaching, stated I'm already aware that Resident #5 is waiting for her tube feed tube to be replaced and dressing change. She doesn't like getting dressed until after her dressing change so that she doesn't have to keep getting dressed and undressed. Resident #5 will have to wait until I finish passing medications. She has only been waiting 40 minutes, and I still have 3 residents to go. I will get to her when I am done with the medication pass. Her tube came out during her bed bath, and she doesn't want to get dressed until the tube is replaced. LPN #883 confirmed and verified Resident #5 needed assistance and she had been waiting at least 40 minutes. Observation and interview on 09/03/25 at 7:45 A.M. revealed Resident #5's call light was activated. Registered Nurse (RN) #845 was observed near Resident #5 room with the medication cart. RN #845 began to push the medication cart in the opposite direction of Resident #5 room to continue medication pass and did not answer the call light. The state surveyor entered Resident #5's room and Resident #5 stated she wanted something to drink. Upon state surveyor exiting Resident #5 room, RN #845 asked state surveyor What does she want?! I'll go in there in a minute. RN #845 confirmed and verified she did not answer Resident #5 call light, and all staff were responsible to answer call lights once activated. Interview on 09/03/25 at 3:45 P.M. with the Director of Nursing (DON) revealed all facility staff were to answer call lights and assist residents as needed. DON revealed Resident #5's bed bath and dressing change should have been scheduled concurrently to ensure Resident #5's preference in wanting to be dressed and not waiting long period of times in between bed bath and dressing change were honored. The DON revealed there were 5 CNA's, 3 nurses, and a unit manager on the unit that could have assisted Resident #5 to ensure timely care and assistance was provided. Review of the facility document titled Call Lights: Accessibility and Timely Response undated, revealed the facility had a policy in place that indicated all staff members were responsible for responding to call lights if they see or hear an activated call light. Review of the document revealed the facility did not implement the policy. This deficiency represents noncompliance investigated under Complaint Number 2584278.</p>		