STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366359	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larchwood Care	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 interviews, record reviews, and review of video recordings, the facility failed to monitor for changes in condition by not engaging with Resident #70 during care provided to ensure timely treatment related to a change in the resident's condition. This affected one resident (Resident #70) out of three residents reviewed for change in condition. The facility census was 59.Findings include: Review of the closed medical record for Resident #70 revealed an admission date of [DATE] and a discharge date of [DATE]. Resident #70's diagnoses included but were not limited to cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, respiratory failure, type two diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis, nontraumatic subarachnoid and intracerebral hemorrhage, cognitive communication deficit, tracheostomy, gastrostomy, and obstructive sleep apnea.Review of the care plan dated [DATE] for Resident #70 revealed a care plan that was incomplete, indicating the resident is (SPECIFY) independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs related to (if depended) cognitive deficits, physical Limitations. Interventions included all staff to converse with resident while providing care.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had severely impaired cognition with both short-term and long-term memory problem. Resident #70 was dependent on staff for all activities of daily living. Resident #70 was always incontinent of bladder and bowel.Review of the video recording dated [DATE] at 11:00 P.M. revealed Certified Nursing Assistant (CNA) #262 entered Resident #70's room. The video shows Resident #70 opening her mouth to take a breath and moving her eyes/head. CNA #262 announced turning on light when she entered the room. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided.Review of the video recording dated [DATE] at 11:02 P.M. revealed Resident #70 no longer was opening her mouth to take a breath or moving her head. CNA #262 continued to provide care to Resident #70. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided.Review of the video recording dated [DATE] at 11:04 P.M. revealed Resident #70 was not visibly moving. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided.Review of the video recording dated [DATE] at 11:07 P.M. revealed Resident #70 was not visibly moving. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided.Review of the video recording dated [DATE] at 11:08 P.M. revealed Resident #70 was not visibly moving. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided.Review of the video recording dated [DATE] at 11:09 P.M. revealed Resident #70 was not visibly moving. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided. CNA #262 can be seen moving the resident's head of bed up and lowering bed.Review of the video recording dated [DATE] at 11:10 P.M. revealed Resident #70 was not visibly moving. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided. CNA #262 can be seen adjusting the resident's pillows.Review of the video recording dated [DATE] at 11:11 P.M. to 11:12 P.M. revealed CNA #262 was seen finishing up care and left the room. Resident (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#70 was not visibly moving. At no point CNA #262 attempted to arouse the resident to perform care or communicate what care was being provided. There was no video evidence staff entered the resident's room again until 11:53 P.M.Review of the progress note dated [DATE] at 12:45 A.M. authored by Licensed Practical Nurse (LPN) #160 revealed she was alerted by RN #196 around 11:55 P.M. Resident #70 was unresponsive. Upon assessment Resident #70 had no pulse, no respirations, and no response to verbal or tactile stimuli. Code status verified as full code. Cardiopulmonary Resuscitation (CPR) initiated immediately and 911 called. CPR continued until Emergency Medical Services (EMS) arrived. Upon EMS arrival, cardiac monitor applied with no pulse detected. EMS evaluated resident and pronounced deceased on scene on [DATE] at 12:05 A.M. Interview on [DATE] at 10:32 A.M. with Resident #70's family revealed on [DATE] at 11:02 P.M. while CNA #262 was providing the resident care, Resident #70 took her last breath and her head goes down, and CNA #262 left the room at 11:11 P.M. Resident #70's family revealed at approximately 11:53 P.M. Registered Nurse (RN) #196 entered Resident #70's room looked at her and checked her pulse, she had no pulse, starred at Resident #70 and then left the room. Resident #70's family member reported on [DATE] at approximately 11:55 P.M. everybody rushed into her room, to include two nurses and two other staff. Staff put on automatic external defibrillator (AED) and staff tried for approximately five minutes of cardiopulmonary resuscitation (CPR). Resident #70's family reported they could tell Resident #70 was already gone.Interview on [DATE] at 10:03 A.M. with Certified Nursing Assistant (CNA) #262 confirmed she provided care to Resident #70 and reported she was alive. CNA #262 confirmed when she entered the room she said she was turning on the light but did not have a conversation with Resident #70 while providing care.Interview on [DATE] at 7:15 A.M. with RN #197 revealed he worked on [DATE] when Resident #70 coded. RN #197 revealed when responding to the code Resident #197 had a grayish/blue look to her skin.Interview on [DATE] at 8:06 A.M. with Administrator after showing video recordings sent in by Resident #70's family with consent, confirmed she did not see the resident move in the video footage after 11:04 P.M. on [DATE].Interview on [DATE] at 9:18 A.M. with Respiratory Therapy Director (RT Director) #206 after showing video recordings sent in by Resident #70's family with consent, confirmed Resident #70 had movement of head and eyes, and breathing on the [DATE] 11:00 P.M. video recordings and RT Director #206 confirmed Resident #70's the breathing was not her normal breathing. RT Director #206 confirmed there was no movement for Resident #70 in the video recording dated [DATE] at 11:07 P.M.Interview on [DATE] at 11:38 A.M. via phone with RN #196 confirmed on [DATE] he was finishing up his rounds and went he entered Resident #70's room to check on her and she had no pulse, was apneic, and was cold to touch. RN #196 reported he left the room to notify staff and got the crash cart. RN #196 reported 911 was called and they initiated CPR to Resident #70. RN #196 reported EMS arrived, applied their machine, did CPR and then pronounced her dead.Interview on [DATE] at 2:16 P.M. with Director of Nursing (DON) after showing video recordings sent in by Resident #70's family with consent, confirmed Resident #70's breathing didn't appear to be normal on the [DATE] at 11:00 P.M. video. DON confirmed change in breathing from first video to the other videos that followed. DON confirmed she would consider this a change in Resident #70's breathing.Interview on [DATE] at 2:48 P.M. with RT Director #206 after showing video recordings sent in by Resident #70's family with consent, confirmed Resident #70 mouth opening isn't normal breathing, more of an accentuated breathing, did not know what it could be but was showing something abnormal in her breathing. Interview on [DATE] at 7:38 A.M and 7:41 A.M. with RN #202 and Licensed Practical Nurse (LPN) #153, who took care of Resident #70, confirmed Resident #70 normally did not open her mouth to breathe. Interview on [DATE] at 12:07 P.M. with Nurse Practitioner (NP) # 305, after showing the [DATE] video recording at 11:00 P.M., revealed she had not seen Resident #70's breathing like that before. NP #305 confirmed the [DATE] at 11:02 P.M. video recording there was a difference in Resident #70's breathing.Interview on [DATE] at 2:12 P.M. with DON confirmed for Resident #70 it would be difficult to say whether CNA #262 would recognize a difference in Resident #70's breathing pattern.This deficiency represents non-compliance investigated under Complaint Number 2996310.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews. record review, and facility policy, the facility failed to ensure proper wound care assessments, treatment and skin monitoring was in place for Resident #70. This affected one resident (#70) of three reviewed for skin impairments. The facility census was 59.Findings include:Review of the closed medical record for Resident #70 revealed an admission date of 12/19/25 and a discharge date of 04/25/26. Resident #70's diagnoses included but were not limited to cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, respiratory failure, type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis, nontraumatic subarachnoid and intracerebral hemorrhage, cognitive communication deficit, tracheostomy, gastrostomy, and obstructive sleep apnea.Review of hospital after visit summary dated 12/19/26 revealed Resident #70 had a wound pressure injury to coccyx posterior with treatment to include cleanse with wound cleanser, apply calmoseptine and foam dressing. There was no evidence this was ordered upon admission.Review of the admission Nursing assessment dated [DATE] revealed under the skin assessment Resident #70 had a skin tear to coccyx area which measured 3 centimeters (CM) by (X) 2 cm. The assessment did accurately identify the skin impairment as a pressure ulcer.Review of Resident #70's care plan dated 12/19/25 revealed the care plan did not properly identify the resident had a pressure ulcer. The care plan was incomplete indicated (specify) pressure ulcer (specify location) or potential for pressure ulcer development related to mobility. No pressure ulcer noted on admission or type. Interventions included administer medications and treatments as ordered and monitor for effectiveness.Review of the physician orders revealed no wound treatment was ordered until 12/26/26. On 12/26/26, Resident #70 was ordered a treatment to coccyx, cleanse area with normal saline (NS), pat dry, apply triad cream and foam dressing, change daily and as needed (PRN). Review of the Wound Physician Note dated 12/26/26 revealed Resident #70 had a stage two pressure injury to the coccyx with measurements of 1.0 cm x 0.5 cm x 0.1 cm. The wound had moderate serous drainage, with no signs of infection noted. Treatment included hydrocolloid paste (triad) apply once daily and as needed (PRN). Apply foam with border once daily and PRN. Review of the facility weekly skin observations revealed the first skin observation was completed on 12/28/25. Additional weekly skin observations were completed 01/22/26 and 02/03/26.Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/26/26 revealed Resident #70 had severely impaired cognition with both short-term and long-term memory problem. Resident #70 was dependent for all activities of daily living. Resident #70 was always incontinent of bladder and bowel.Interview on 04/29/26 at 1:33 P.M. with MDS Coordinator Registered Nurse (MDS RN) #170 confirmed Resident #70's care plan was not comprehensive and individualized. MDS RN #170 reported she doesn't know what happened and it must have been an oversight. Interview on 05/04/26 at 11:11 A.M. with Wound Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #105 confirmed the weekly skin observations were not completed timely and weekly. Wound LPN/ADON #105 confirmed on 12/19/25 the Nursing admission Assessment did not accurately reflect the resident's pressure ulcer. Wound LPN/ADON #105 confirmed Resident #70 admitted to facility with pressure injury to coccyx. Wound LPN/ADON #105 confirmed wound treatment for Resident #70 was started on 12/26/26, seven days after admission. Review of facility policy, Pressure Injury Prevention and Management, revised 01/01/2026, revealed the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Further states, Licensed nurses will conduct a full body skin assessment on all resident upon admission/re-admission, weekly and after any newly identified pressure injury. This deficiency represents non-compliance investigated under Complaint Number 299631.