

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: 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)		
F 0689 Level of Harm - 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 observation, record review, interview, and facility policy review, the facility failed to provide adequate staff assistance to prevent a fall with injury. Actual Harm occurred on 07/26/25 at 10:20 A.M. when Resident #7, who was dependent on staff for bed mobility, transfers, and toileting, fell during incontinence care when assisted by only one Certified Nursing Assistant (CNA), resulting in an intracerebral contusion (closed head injury) and a dislodged jejunostomy tube (feeding tube). Resident #7 was transferred to the hospital and admitted for additional care and monitoring before returning to the facility on [DATE]. This affected one resident (#7) of three residents reviewed for accidents. The facility census was 67. Findings include: Review of the medical record for Resident #7 revealed an admission date of 04/12/24. Diagnoses included chronic respiratory failure, protein-calorie malnutrition, intercranial hemorrhage, Alzheimer's disease, and gastrostomy. Review of Resident #7's care plan initiated 04/17/24 revealed the resident was at risk for falls related to weakness, impaired cognition, use of assistive devices, medication side effects, impaired mobility, and history of falls. Listed interventions included to anticipate and meet the resident's needs and follow the facility's fall protocol. Continued review of Resident #7's care plan dated 04/17/24 revealed the resident had an activity of living (ADL) self-care performance deficit related to underlying disease and impaired physical mobility. Listed interventions included to transfer Resident #7 using a mechanical (Hoyer) lift and two staff assist and encourage the resident to participate to the fullest extent possible. On 07/30/25, an intervention was added to reflect Resident #7 was totally dependent on two staff for repositioning and turning in bed. Review of Resident #7's physician's orders revealed an order dated 06/21/24 for an air mattress with bolsters to the bed. Review of Resident #7's fall risk assessment dated [DATE] revealed Resident #7 was at low risk for falls. Review of the Minimum Data Set (MDS) quarterly assessment, dated 07/17/25 revealed Resident #7 had severely impaired cognition. The resident was dependent for bed mobility, transfers, toileting hygiene and ambulation. Resident #7 was always incontinent of bowel and bladder. Resident #7 was noted to have a feeding tube and a tracheostomy. Review of the Change in Condition Report dated 07/26/25 at 10:20 A.M. revealed Resident #7 had experienced a fall. At the time of evaluation, Resident #7 had no mental status change, but the resident was noted to have pain. The physician was notified and recommended calling nine-one-one (911) to summon emergency medical services. Review of the Health Status Note dated 07/26/25 at 10:49 A.M. revealed CNA #963 reported to the charge nurse that Resident #7 was on the floor. Upon entering the room, the resident was found lying on her back, face up, with her arms and legs contracted per her baseline. Blood was noted on the floor under resident's head. Resident #7's pupils were equal and reactive. Resident #7's vital signs were taken and at baseline. Facility staff called 911 and Resident #7 was transported to the hospital. Review of the facility fall investigation dated 07/26/25 revealed at 10:20 A.M. Resident #7 had a witnessed fall, sustaining a one-centimeter (1cm) laceration behind her right ear. Resident #7 was sent to the emergency room (ER) for evaluation. Per ER note the resident had no acute fractures or dislocations. The Computed Tomography (CT) scan showed no midline shift or brain herniation. The investigation noted CNA #963 (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 - Actual harm Residents Affected - Few	was changing the resident without a second staff member at bedside when the resident's leg slid, resulting in the resident sliding onto the floor. The resident was sent to ER for evaluation. The resident's J-Tube had become dislodged during the fall and was replaced while in the hospital. Resident #7 remained a two-assist for care with a perimeter air mattress in place. Resident #7 was not on blood thinners. The resident was transported to a local ER for evaluation. Resident #7 returned to the facility on [DATE]. Review of the Hospital Report dated 07/27/25 at 9:30 A.M. revealed Resident #7 was seen by the hospital trauma team upon arrival to the ER. The resident was at baseline, which was nonverbal and contracted. The resident had a small laceration behind her right ear, a dislodged jejunostomy tube, a hematoma of the left thigh, and a right parietal hemorrhagic contusion (bleeding into the brain tissue of the right parietal lobe of the brain) with no loss of consciousness. Interventional Radiology was consulted and replaced Resident #7's jejunostomy tube, and neurosurgery was consulted for monitoring and non-operative management of Resident #7's intracranial contusion, including every four hour neurological assessments and repeat imaging tests. Resident #7 returned to the facility on [DATE]. Observation on 09/04/25 at 11:38 A.M. revealed Resident #7 in bed on an air mattress with a touch pad call light beside her. The resident had her eye closed. Interview on 09/04/25 at 12:08 P.M. with Licensed Practical Nurse (LPN) #884 revealed she was Resident #7's nurse at the time of the recent fall. LPN #884 revealed when they were assessing the resident post-fall, they saw her tracheostomy was still in place, but the resident's feeding tube was dislodged. LPN #884 saw a laceration to the resident's head and some blood on the ground near her head. Resident #7 had no other visible bruises or lacerations. LPN #884 reported Resident #7 was nonverbal. The staff did not feel Resident #7 was safe to move, so staff stayed with her and called 911. LPN #884 further stated a CNA had transferred the resident by herself and verified a resident on an air mattress always needed two people to assist. LPN #884 stated the CNA should have known. Interview on 09/04/25 at 1:05 P.M. with the Director of Nursing (DON) verified Resident #7 sustained a fall with injury when CNA #963 was providing care without a second staff member assisting. The DON revealed a resident on an air mattress always required two-person assist with turning and changing. Review of the policy Fall Prevention Program dated 2024 revealed each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document revealed the facility did not implement the policy. This deficiency represents noncompliance investigated under Complaint Number 2584278.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interview, facility Self-Reported Incident (SRI) review, and facility policy review, the facility failed to ensure Resident #67 was not inappropriately restrained during resident care tasks. This affected one resident (#67) of one reviewed for physical restraints. The facility census was 67. Findings include: Review of the medical record for Resident #67 revealed he was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury with loss of consciousness, carrier of carbapenem-resistant <i>Acinetobacter baumannii</i> (a multi-drug resistant organism), and chronic respiratory failure with hypoxia. Review of the care plan initiated 09/17/24 revealed Resident #67's daughter was his guardian. Resident #67 had an electronic monitoring device in use in his room, and required assistance from staff with interventions that included to assist as needed, approach the resident in a calm and gentle state, and ensure a safe environment. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had a short- and long-term memory problem, severely impaired cognition regarding tasks of daily life, impairment to both upper and lower bilateral extremities, and was dependent on staff for activities of daily living (ADLs). Review of the physician orders dated 11/26/24 revealed an order to suction oropharyngeal and tracheal as needed and every shift. Review of the progress note dated 01/31/25 at 11:53 A.M. revealed Resident #67 was combative throughout the shift with care. Review of the progress note revealed tracheostomy care was provided. Review of the progress note dated 02/02/25 at 4:37 P.M. revealed Resident #67 was somewhat combative during tracheostomy care. Review of the progress note dated 02/18/25 at 5:47 P.M. revealed Resident #67 tolerated suctioning and routine respiratory care well but was very combative. Review of the progress note dated 02/21/25 at 9:33 A.M. revealed Resident #67 tracheostomy tube was changed and replaced without any distress. Resident #67 was fighting but Resident #67 daughter held and calmed him down. Review of the progress note dated 02/24/25 at 1:55 P.M. revealed Resident #67 was very combative during suctioning. Review of the progress note dated 02/26/25 at 11:36 A.M. revealed Resident #67 was very combative during tracheostomy care and suctioning, and tracheostomy gauze was unable to be placed. Review of the progress note dated 02/27/25 at 3:49 P.M. revealed Resident #67 was extremely combative with care. Resident #67's daughter was in the room trying to hold him down, but he kept grabbing at the tubing for suction and swinging at Respiratory Therapist (RT). Review of the progress note dated 02/27/25 at 9:00 P.M. revealed Resident #67 had a head-to-toe skin assessment, and a bruise was noted to the back of his left hand related to recent blood draw. Review of the progress note dated 02/28/25 at 2:03 A.M. revealed Resident #67 was combative and a second RT came in to assist with respiratory care. Review of the progress note dated 02/28/25 at 3:56 P.M. revealed Social Service Designee (SSD) #850, the Administrator, and the Director of Nursing (DON) met with Resident #67's daughter related to an incident with a staff member regarding Resident #67 receiving inappropriate care. Review of the progress note revealed the incident was reviewed and Resident #67's daughter was given time to process and vent her frustrations. Review of the SRI #257691 revealed on 02/27/25 at 9:00 P.M., the Administrator received a report of abuse occurring on the night shift during shift change and that resulted in Resident #67 being immediately assessed. Continued review of the SRI revealed a head-to-toe assessment was completed resulting in a bruise noted to the back of Resident #67 left hand that was ruled out as being caused by a recent blood draw. Resident #67 had no signs of pain and/or discomfort to her hand. Resident #67's daughter was at the bedside during the incident. Review of the SRI revealed RT #500 was placed on suspension pending investigation, abuse educations in-services were initiated for all staff, and additional head-to-toe assessments were completed for additional residents. Review of the SRI revealed Resident #67's daughter was contacted and stated she was at the bedside at the time RT #500 entered the room (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without knocking or identifying herself before providing care. Resident #67 became combative by swinging his arms towards RT #500, when RT #500 abruptly used her knee to hold down Resident #67 hand. Resident #67's daughter revealed she offered to assist RT #500 during tracheostomy care and RT #500 knee was immediately removed and care was provided. Review of the witness statement written by RT #854 dated 02/27/25 revealed during report RT #500 stated Resident #67 was combative during tracheostomy care and she had to place her knee on his arm to restrain it, and while suctioning, Resident #67 grabbed the suction catheter. RT #500 then stated she had to bend Resident #67 finger back to get him to release it. RT #500 then stated Resident #67 daughter was at the bedside and asked RT #500 please don't bend my father's finger back and to not place her knee on her father's arm. RT #500 reported Resident #67's daughter was willing to assist RT #500 in holding Resident #67's arm. RT #500 then told Resident #67's daughter that she had a job to do and she wasn't going to get hit. Review of the witness statement written by RT #856 dated 02/27/25 revealed during 7:00 P.M. report, RT #500 stated she was at Resident #67's bedside to suction him and Resident #67's daughter was also in the room. RT #500 stated Resident #67 became combative and she placed her knee on his arm to hold it down when Resident #67's daughter told her not to do that and offered to help her hold him down. RT #500 then told Resident #67 daughter she was not going to get hit and she was doing her job. R T #500 then stated Resident #67 daughter was not holding Resident #67 arm and he grabbed the suction catheter when RT #500 bent Resident #67's finger back to get him to release his grip. Resident #67's daughter told RT #500 to not bend Resident #67's finger back, when RT #500 stated she was doing her job, Resident #67 was always like that, and she would do what she had to do. Review of the witness statement written by SSD #850 dated 02/27/25 revealed SSD #850 was notified by RT #854 and RT #856 that during the night shift report, RT #500 revealed she held down Resident #67 and pulled his finger back while suctioning him. SSD #850 immediately alerted the Administrator, the Director of Nursing (DON) and the Assistant DON #894. SSD #850, who previously worked as a Registered Nurse (RN), assessed and interviewed Resident #67 and multiple additional residents with no issues noted to any body part. Review of the personnel file for RT #500 revealed a notice and termination given on 02/28/25 for being discharged for unsafe work conduct, procedures, habits, practices and/or methods. Review of RT #500 Department of Unemployment Insurance Operations document titled Request to Employer for Separation Information revealed RT #500 was discharged from work for an allegation of abuse by physically restraining patient on 02/27/25 due to zero tolerance of abuse or physical restraints. Interview on 09/03/25 at 4:27 P.M. with the Administrator revealed RT #500 held Resident #67 down with her knee while performing care due to him being combative. The Administrator revealed all abuse policies and protocols were initiated immediately with RT #500 being suspended pending investigation, staff educated, and like-residents interviewed and assessed. The Administrator revealed Resident #67 daughter was upset, crying, and in a state of disbelief. The Administrator revealed RT #500 was subsequently terminated as a result of the incident. Review of the facility document titled Restraint Free Environment, undated, revealed the facility had a policy in place that each resident shall attain and maintain a practical well-being in an environment that prohibits the use of physical restraints for discipline or convenience such as holding down a resident in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing care.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident record review, staff interview, and family interview, the facility failed to ensure mouth care was provided for a dependent resident. This affected one resident (#21) of one reviewed for mouth care. The facility census was 67. Findings include: Review of the medical record for Resident #21 revealed he was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, chronic respiratory failure with hypoxia, and cerebral infarction. Review of the medical record revealed Resident #21 had a guardian in place. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had a short- and long-term memory problem, severely impaired regarding tasks of daily life, impaired on both side upper and lower extremities, and was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 08/06/25 revealed Resident #21 had an electronic monitoring device in use in his room and required assistance from staff for ADLs. Interventions included encouraging ongoing family support and providing assistance with ADLs. Observation on 09/02/25 at 8:53 A.M. Resident #21 laying in bed with dry, cracked, and peeling lips. Interview on 09/02/25 at 10:22 A.M. with Resident #21's guardian revealed Resident #21's lips were always dry, and she had to constantly tell facility staff to keep his lips moisturized. Resident #21's guardian revealed dry, cracked, and peeling lips would hurt if it built up. Observation on 09/02/25 at 3:08 P.M. revealed Resident #21 was in his room, up in a chair, and his lips appeared dry, cracked, and peeling. Interview on 09/02/25 at 3:12 P.M. with Certified Nurse Assistant (CNA) #837 revealed Resident #21 was assigned to another staff member and was not aware of the last time he received mouth care. CNA #837 revealed Resident #21 moved his head from side to side but that did not interfere with providing mouth care. CNA #837 confirmed and verified Resident #21's dry, cracked, and peeling lips.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, staff interviews, family interview, and facility policy review, the facility failed to ensure orders for splints were obtained per guardian preference for Resident #21, who was known to have bilateral upper extremity contractures. This affected one resident (#21) of one reviewed for positioning and mobility. The facility census was 67. Findings include: Review of the medical record for Resident #21 revealed he was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, chronic respiratory failure with hypoxia, and cerebral infarction. Review of the medical record revealed Resident #21 had a guardian in place. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had a short- and long-term memory problem, severely impaired regarding tasks of daily life, impaired on both side upper and lower extremities, and was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 08/06/25 revealed Resident #21 had an electronic monitoring device in use in his room, had the potential for pain related to contractures with interventions that included, but not limited to, required assistance from staff for ADLs and encourage ongoing family support. Review of the physician orders revealed an order initiated on 12/23/23 and discontinued on 05/08/24 for Resident #21 to wear bilateral dorsiflexion assist splints up to 6 hours as tolerated and remove for hygiene. Review of the physician orders revealed an order initiated on 09/18/24 and discontinued on 01/06/25 for Resident #21 to admit to restorative services for splinting bilateral hands, Pressure Relief Ankle Foot Orthosis (PRAFO) boots (used to relieve pressure on the heel and aid in positioning) and bilateral and range of motion (ROM). Resident #21 had an additional order initiated on 01/09/25 for a referral to restorative services for ROM and splinting which was discontinued on 02/27/25. Review of Resident #21's current physician orders revealed no active orders for splints. Review of the assessment titled Skilled Note dated 09/01/25 and 09/02/25 revealed Resident #21 required bilateral upper extremity splinting. Observation on 09/02/25 at 8:53 A.M. revealed Resident #21 lying in bed with both hands contracted. Resident #21 had a white cloth rolled up in the palm of his left hand. Observation revealed, on the wall adjacent to the foot of the bed, a sign that read Resting hand roll splint on bilateral hands for 6 hours per day, fit 2 fingers between strap and arm/hand, skin check and hand hygiene before donning and after doffing, and left upper extremity in neutral and keep in sight (not under blankets) while wearing splint. Interview on 09/02/25 at 8:55 A.M. with Licensed Practical Nurse (LPN) #873 revealed the therapy department was responsible for maintaining ROM and splinting for Resident #21. LPN #873 revealed the therapy department placed splints on residents and was not sure why Resident #21 had one towel in his left hand. LPN #873 revealed staff were to follow instructions based on the sign on his wall. LPN #873 confirmed and verified Resident #21 was lying in bed without splints in place. Interview and observation on 09/02/25 at 9:05 A.M. with Therapy Director (TD) #890 revealed a white cloth/towel rolled up in Resident #21's left hand. TD #890 revealed the cloth/towel was possibly placed in Resident #21 hand due to staff cleaning him up and soaking up moisture in his hand. Follow-up interview on 09/02/25 at 9:28 A.M. with TD #890 revealed the signs posted in Resident #21 room were signs provided by Resident #21's guardian. TD #890 revealed the signs were not provided by the facility and not followed by facility staff. TD #890 confirmed and verified Resident #21 had bilateral contractures in his hands, the resident's guardian had preferences for splints to be applied per the sign on the wall, and that Resident #21 previously had orders for splints. Interview on 09/02/25 at 10:22 A.M. with Resident #21's guardian revealed there was a camera in the room that she utilized for monitoring to ensure Resident #21 received adequate care. Resident #21's guardian revealed Resident #21 had contractures in both his left and right hands and splints were supposed to be in place. Resident #21's guardian stated Regardless of Resident #21's current state, mentally and physically, he should still be properly cared for. Resident #21's guardian revealed every time she (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visited or checked the camera's; the bilateral hand splints were not in place as she wished and preferred, to prevent Resident #21 hands from contracting further. Interview on 09/02/25 at 3:12 P.M. with Certified Nurse Assistant (CNA) #837 revealed Resident #21 was not alert and oriented and was dependent on staff for all his care. CNA #837 revealed Resident #21 was contracted in both hands and the therapy department was responsible for putting splints in place. CNA #837 revealed she was aware of Resident #21's guardian request for splints via the sign on the wall, but she had never seen the splints in place. CNA #837 revealed the cloth in Resident #21 hand was not for moisture because if that were the case, both hands would have the cloths in place. CNA #837 confirmed and verified Resident #21's bilateral contractures of the hand, sign requesting splints, and splints not in place. Follow-up interview on 09/02/25 at 4:08 P.M. with TD #890 revealed the facility followed physician orders when it came to residents requiring splints. TD #890 revealed Resident #21 was not currently wearing any splints and he was not sure why. TD #890 revealed the sign on wall were Resident #21 guardian's preference. TD #890 revealed there were no current orders in place. TD #890 also revealed Resident #21's guardian could visit the facility and put the splints on Resident #21, but the facility would remove them and not put them back on. TD #890 revealed the facility purchased the splints and kept them in a bin in resident rooms and whether it was a preference or not, the facility removed them if there weren't any orders in place. Interview on 09/03/25 at 3:45 P.M. with the Director of Nursing (DON) confirmed and verified Resident #21 did not have an order for splints and staff were not putting splints on per guardian's request. Review of the facility document titled Care Planning-Resident Participation undated, revealed the facility had a policy in place that the facility would encourage and assist the resident and/or resident representative to participate in choosing care and treatment options including initial decisions about treatment, decisions about changes and the right to refuse treatment. Review of the document revealed the facility did not implement the policy.		

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

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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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure medications were not left unattended during medication administration. This affected one resident (#12) of three residents reviewed for safe storage of medications. The facility census was 67. Findings include: Review of the medical record for Resident #12 revealed she was admitted on [DATE] and had diagnoses including diabetes, mild cognitive impairment, and major depressive disorder. Review of Resident #12's self-medication administration assessment dated [DATE] revealed the resident did not wish to self-administer medications. Resident #12 was identified on the assessment to not be a candidate for self-administration of medications. Review of Resident #12's physician's orders revealed the resident had no physician order to self-administer medications. Observation of Resident #12 on 09/02/25 at 9:36 A.M. revealed she had several unknown pills mixed in with applesauce in a medication cup on her bedside table. No staff was in the room or observing from the doorway. Resident #12 had a tracheostomy and ventilator and could not be understood, but appeared to shake her head 'no' when asked if she had concerns. Interview with Registered Nurse (RN) #848 on 09/02/25 at 9:39 A.M. revealed Resident #12 took a long time to swallow her medications. During the medication administration for Resident #12, RN #848 stated she got distracted with another resident and left the remainder of medications at Resident #12's bedside. RN #848 confirmed the medications were still at the bedside and that Resident #12 had no order for self-administration of medications. Review of the policy Medication Administration dated 03/01/25 revealed part of the medication administration process was to observe resident consumption of medications.		