STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366377	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tranquility of Richmond Heights	562 Richmond Road Richmond Heights, OH 44143

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the police report, interview and facility policy review, the facility failed to appropriately discharge Resident #55. This affected one (Resident #55) out of three residents discharged from the facility. The facility census was 54 residents.Findings include: A review of Resident #55's clinical record revealed an admission date of 06/23/25 with diagnoses including cellulitis of the left lower limb, cerebral palsy, high blood pressure, major depression and genetic intellectual disability. Resident #55 was discharged from the facility on 07/07/25. A review of Resident #55's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #55 was moderately cognitively impaired and needed assistance with bathing, dressing and personal care. Resident #55's plan of care initiated on 06/23/25 indicated a self-care deficit related to intellectual disability. Interventions on the care plan included encourage Resident #55 to participate in planning day-to-day care, evaluate Resident #55's ability to perform activities of daily living (ADL), maintain a consistent schedule with a daily routine, minimize environmental stimuli, provide assistance with ADL as needed. Resident #55's plan of care initiated on 07/02/25 indicated Resident #55 had impaired cognitive impairment with functional/dementia or impaired thought processes related to difficulty making decisions and impaired decision making. Interventions on the plan of care included for staff to communicate with Resident #55, family, caregivers regarding Resident #55's capabilities and needs, discuss concerns about confusion, disease process, nursing home placement with Resident #55, family and caregivers, engage Resident #55 in simple structured activities that avoid overdemanding tasks according t A review of Resident #55's form titled Notice of Medicare Non-Coverage dated 07/07/25 indicated Resident #55 was notified his last day for payment of skilled services was 07/05/25 and the instructions for the right to appeal the decision were included on the form. The form was signed by Resident #55 on 07/03/25. A review of Resident #55's physician orders dated 06/23/25 to 07/07/25 revealed no order to discharge Resident #55 from the facility. A review of the police report dated 07/07/25 revealed the police received a call at 6:24 P.M. that a male needed transported from an independent living facility to the hospital for a health evaluation. The police report revealed Resident #55 left the independent nursing facility at 6:41 P.M. and was transported to the hospital. An interview on 07/10/25 at 8:49 A.M. with Social Services Designee (SSD) #62 revealed she had attempted to obtain the Power of Attorney (POA) paperwork to prove Resident #55's POA was legally appointed as his POA. SSD #62 contacted the POA listed on Resident #55's hospital discharge papers and requested the paperwork to prove he was Resident #55's POA. SSD #62 stated she never received the paperwork. SSD #62 revealed on 07/07/25 Certified Nurse Practitioner (CNP) #65 talked to the Assistant Director of Nursing (ADON) from the independent living facility and was informed Resident #55 was denied admission to the independent living facility. SSD #62 stated she and admission Coordinator (AC) #63 traveled to the independent nursing facility on 07/07/25 at 11:00 A.M. and met with the Independent Living Marketing Director and spoke to the Independent Living Administrator ([NAME]) #66 via speaker phone. The [NAME] #66 informed them that the independent living facility was unable to meet Resident #55's needs and woul A voice message was left on Resident #55's POA's phone on 07/07/25 at 9:30 A.M. and a return phone call on 07/10/25 at 12:00 P.M. revealed he was aware the facility has discharged Resident #55 to the independent nursing facility. Resident #55's POA stated he disagreed with the decision to discharge Resident #55 to the independent nursing facility and was working on finding Resident #55 alternate placement in a long term care facility. An interview with Independent Living Employee ([NAME]) #60 on 07/10/25 at 9:34 A.M. revealed Resident #55 had resided in the independent living facility prior to his hospitalization in June 2025 for wound care. When Resident #55 was sent to the hospital Resident #55's POA was notified he would need a higher level of care and could not return to the independent facility. The POA informed the independent living facility he was investigating placement for Resident #55 in a long-term care facility. [NAME] #60 stated the independent living facility Director of Nursing (DON) #61 received a call from the Administrator of the skilled nursing facility where Resident #55 was provided skilled wound care informing them, he would be returning to the independent living facility. DON #61 informed the Administrator #64 from the skilled nursing facility that they were unable to meet Resident #55's needs because he needed a higher level of care. [NAME] #60 stated SSD #62 and AC #63 from the skilled nursing facility met with the M An interview with Administrator #64 on 07/10/25 at 10:51 A.M. revealed Resident #55 was admitted to the skilled nursing facility for wound care following hospitalization. Administrator #64 stated that when Resident

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, interview, and facility policy review, the facility failed to document concerns regarding Resident #37's care in the facility. This affected one (Resident #37) out of three residents reviewed with concerns. The facility census was 54.Findings include: A review of Resident #37's clinical record revealed an admission date 06/18/25 with diagnoses including fractured pelvis and left arm, anemia, anxiety, dementia, depression, neuromuscular dysfunction of the bladder and schizophrenia. Resident #37's physician order dated 06/30/24 revealed an appointment was scheduled with the orthopedic physician for after-care of bone fractures. Resident #37's progress note dated 06/30/25 indicated Resident #37 was transported to an appointment at 12:24 P.M. and returned to the facility following an orthopedic appointment at 3:27 P.M. A review of Resident #37's discharge information from the hospital dated 06/18/25 indicated a follow-up appointment was scheduled on 06/30/25 at 12:30 P.M. with the orthopedic physician's office for X-rays. An interview with Resident #37's niece on 07/10/25 at 9:45 A.M. revealed she was Resident #37's guardian and was not notified that Resident #37 had an appointment scheduled for a follow-up visit with the orthopedic physician on 06/30/25. Resident #37's niece stated she found out that Resident #37 had been transported to an appointment and was not in the facility when another family member went to visit Resident #37. Resident #37's niece stated she voiced her concerns to the Administrator but had no follow-up to her concerns. An interview with the Administrator on 07/10/25 at 11:06 A.M. revealed Resident #37's niece constantly complained about her aunt's care in the facility. The Administrator stated Resident #37's niece had talked to the Director of Nursing (DON) #67 and had screamed at DON #67 and stated she was furious the facility had not notified her of Resident #37's appointment on 06/30/25. The Administrator stated Resident #37's niece was Resident #37's guardian and would have been notified of the follow-up appointment with the orthopedic physician scheduled on 06/30/25 upon the discharge from the hospital. The discharge paperwork was given to Resident #37's niece when discharged from the hospital and the information was entered into the electronic system (MyChart) for patients to review their care while in the hospital. The Administrator stated the DON tried to explain the notification of family/responsible party policy and Resident #37's niece just kept yelling at the DON, and Administrator had to end the conversat A review of Resident #37's clinical record revealed no documentation that Resident #37's niece was upset the facility had failed to notify her of the appointment scheduled with the orthopedic physician. A review of the Concern Log dated 05/2025 to 07/2025 revealed no concerns were documented regarding Resident #37's niece's concern with notification of appointments or any other concerns during Resident #37's stay in the facility. An interview with the Administrator and DON #67 on 07/14/25 at 2:47 P.M. verified the above information and had failed to document Resident #37's niece's concerns in Resident #37's medical record. A review of the facility policy titled Charting and Documentation (undated) indicated the policy was that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The Policy Interpretation and Implementation included:Documentation in the medical record may be electronic, manual or a combination.The following information is to be documented in the resident medical record:Objective observations;Medications administered;Treatments or services performed;Changes in the resident's condition;Events, incidents or accidents involving the resident; andProgress toward or changes in the care plan goals and objectives.Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the resident's medical chart as permitted by facility policy.Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the director of nursing services, nurse supervisor/charge nurse or to the business office. This deficiency represents non-compliance investigated under Master Complaint Number 2568840.