STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Plaza	12504 Cedar Road Cleveland Heights, OH 44106

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 - Immediate jeopardy to resident health or safety 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** 37095 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, resident and staff interview, review of a police report and review of facility policy, the facility failed to provide a safe environment free from a potential accident hazard when State tested Nursing Assistant (STNA) #563 was found to have an unsecured loaded firearm in the facility. This resulted in Immediate Jeopardy and potential for serious life-threatening harm when STNA #563 left a loaded firearm, with additional rounds of ammunition, wrapped in a fleece vest and in a clear plastic bag, unsecured on a cart on the 3 North Hallway where residents resided and had access to the bag. Resident #64 subsequently took the bag containing the loaded firearm to her room, without staff knowledge, found the firearm, and placed it under the mattress of her bed. This affected one (#64) resident and had the potential to affect all 108 residents residing in the facility. The facility census was 108. On 05/13/24 at 2:25 P.M., the Director of Nursing (DON) and Regional Registered Nurse (RRN) #707 were notified Immediate Jeopardy began on 05/03/24 at approximately 1:00 P.M. when STNA #563 notified Unit Manager (UM) #628 his coat and loaded firearm were missing from the 3 North Hallway. STNA #563 left the loaded firearm, unsecured, in a plastic bag on a cart in the hallway and discovered it was missing at approximately 1:00 P.M. Resident #64 saw the unattended bag on the cart, believed it was hers, and took the bag to her room. Resident #64 found the loaded firearm and placed it under her mattress. The facility was unable to locate the firearm during searches of the facility. On 05/03/24 at approximately 3:33 P.M., Resident #64 told STNA #592 she found the firearm and the local police department, who had been contacted regarding the incident by the facility, took possession of the weapon and additional rounds of ammunition. The Immediate Jeopardy was removed on 05/04/24 and the deficiency continued at a Severity Level II (no harm with the potential for more than minimal harm that is not immediate jeopardy) until the deficiency was corrected on 05/06/24, when the facility implemented the following corrective actions: On 05/03/2024 at approximately 1:00 P.M., STNA #563 informed Unit Manager (UM) #628 his coat and firearm were missing from the 3 North Hallway. UM #628 immediately notified the DON of the missing firearm. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365033	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Plaza	12504 Cedar Road Cleveland Heights, OH 44106

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/03/24 at approximately 1:05 P.M., the DON notified the Administrator of the missing firearm. On 05/03/24 at approximately 1:07 P.M., the Administrator notified the local police department (LPD) of the missing firearm. On 05/03/24 at approximately 1:10 P.M., the DON assigned managers to search the first, second, and third floors of the facility for the missing firearm. On 05/03/24 at approximately 1:40 P.M., the Local Police Department (LPD) arrived at the facility. The Administrator and UM #628, along with the responding officer, reviewed camera surveillance to determine if the missing firearm could be seen being removed from the last known location. The cameras did not assist in identifying who may have removed the bag carrying the missing firearm. On 05/03/24 at approximately 2:00 P.M., the DON and Administrator assigned new areas for managers to search for the missing firearm, including dietary, the basement, and the exterior of the facility. On 05/03/24 at approximately 2:15 P.M., the DON and Maintenance Supervisor (MS) #618 searched the garbage for the missing firearm. On 05/03/24 at approximately 2:20 P.M., a second officer from the LPD arrived and obtained a statement from STNA #563 regarding the missing firearm. On 05/03/24 at 3:33 P.M., STNA #592 located the missing firearm in Resident #64's room. The LPD took immediate possession of the firearm. On 05/03/24, STNA #563 was suspended pending the investigation into the firearm he brought into the facility. On 05/03/24, at approximately 4:00 P.M., an Ad Hoc QAPI was held with the Administrator, DON, Business Office Manager (BOM) #537, Cook #639, Receptionists #535 and #583, Corporate Admission (CA) #701, Dietary Tech (DT) #702, Assistant Business Office Manager (ABOM) #565 and Admissions Director (AD) #703 to review the facility policy on Firearms and Other Weapons. The facility prohibits employees, residents, visitors, vendors, or others from possessing firearms or other weapons while in/on facility premises. On 05/03/24, the DON notified Medical Director (MD) #704 of the incident involving the firearm. On 05/03/24, Chief Clinical Officer (CCO) #705 re-educated the DON on the facility's policy on firearms and other weapons. On 05/03/24, the DON and CCO #705 educated all staff, including five activities staff, two admissions staff, two business office staff, one central supply staff, 25 dietary staff, seven hospitality aides, 12 housekeepers, two laundry staff, 27 Licensed Practical Nurses (LPN), one maintenance staff, three medication technicians, three social workers, two therapists, three receptionists, 10 Registered Nurses (RN) and 37 STNAs related to the facility firearm policy. Education was provided in person for staff at the facility and over the phone for those off duty. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cedarwood Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 12504 Cedar Road Cleveland Heights, OH 44106	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/03/24, UM #628 completed a skin assessment for Resident #64. No new areas of concern were identified. On 05/03/24, the DON or designee completed an assessment of all residents. Residents were safe and at baseline. No psychosocial concerns were identified. On 05/03/24, the Administrator placed new, more prominent signage at the entrances prohibiting firearms in the facility. On 05/03/24, Maintenance Staff (MS) #618 changed door codes due to the suspension of STNA #563. Beginning 05/04/24, the DON or designee implemented a system to audit five random staff four times weekly for four weeks then three random staff weekly for eight weeks to ensure knowledge of the facility's firearms policy. Findings would be reviewed in weekly QAPI meetings to ensure compliance with the policy. On 05/06/24 at approximately 11:00 A.M., Regional Director of Operations (RDO) #706 notified STNA #563 of termination of employment due to not following the facility policy on firearms. Interviews on 05/13/24 from 2:37 P.M. through 05/14/24 at 8:58 A.M. of Resident #64, #18, and #42 revealed each denied any knowledge of firearms or other weapons in the facility, outside of the incident involving STNA #563's firearm. Interviews on 05/13/24 from 3:06 P.M. through 05/14/24 at 9:49 A.M. of STNAs #542, #543, and #644 and LPN #628 revealed each were able to articulate the facility policy related to firearms and other weapons. Each denied knowledge of any weapons in the facility, outside of the incident on 05/03/24. Observation on 05/14/24 at 8:58 A.M. verified prominent signage prohibiting firearms in the facility were placed at the entrances. Review of staff education sign-in sheets verified all staff were educated on the facility's firearms and other weapons policy on 05/03/24. Findings include: Review of Resident #64's medical record revealed an admitted [DATE]. Resident #64 had diagnoses including depression, anemia and uncomplicated alcohol dependence. Review of the Minimum Data Set (MDS) assessment, dated 04/11/24, revealed Resident #64 had mild or no cognitive impairment and daily occurrences of feeling down or depressed. Review of a psychiatry note, dated 05/09/24, revealed Resident #64 was alert and oriented to person and place, but had poor memory, insight, and judgement. Review of a social worker progress note, dated 04/10/24, revealed Resident #64 had periods of forgetfulness. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON on 05/13/24 at 9:52 A.M. revealed STNA #563 brought a gun to the facility on [DATE]. The gun was located in a bag, which was taken mistakenly by Resident #64 who thought the bag was hers. Resident #64 subsequently found the gun and gave it to STNA #592, and the police took immediate possession of the firearm. During the interview, the DON revealed guns were not permitted in the facility. Interview with STNA #563 on 05/13/24 at 12:01 P.M. verified he brought a loaded nine-millimeter [NAME] pistol to work at 11:00 P.M. on 05/02/24. The STNA indicated he had the gun for personal protection due to working nights and taking the bus (to and from work). STNA #563 stated he stored the firearm with his personal belongings in a bag at his workstation on the third floor. STNA #563 stated he last saw the bag at 12:40 P.M. on 05/03/24 after coming back from lunch. At approximately 1:00 P.M., STNA #563 noticed the bag was missing and he was unable to locate it. STNA #563 stated he notified an unknown nurse of his missing belongings, including the gun. STNA #563 stated he was removed from the search then told to leave the building after giving a statement to the police. STNA #563 stated it was common for him to bring the pistol wherever he went, though he stated he never took it out of the bag while at the facility. STNA #563 confirmed the facility terminated him following the incident. Interview with Resident #64 on 05/13/24 at 2:37 P.M. confirmed she found a bag at the aide's workstation (a desk and chair in the hallway) on 05/03/24 at approximately 1:00 P.M., and believed it was hers. Resident #64 brought the bag into her room and found a jacket with a pistol in the pocket. She stated she then hid the gun under the mattress of her bed until she found STNA #592 and told her about it. STNA #592 told Resident #64 the facility had been looking for the gun. The police were brought to her room and removed the firearm. Interview with UM #628 on 05/13/24 at 3:06 P.M. revealed STNA #563 informed her his coat was missing on 05/03/24 and staff began looking for it. When they could not find the coat, STNA #563 came to UM #628's office, shut the door, and said his gun was with the coat. UM #628 notified the DON. The managers broke into pairs and began searching the building for the firearm. Resident #64 told an aide the gun was in her room roughly two hours after the event began. Interview with STNA #592 on 05/14/24 at 3:11 P.M. revealed she worked second shift (3:00 P.M. to 11:00 P.M.) on 05/03/24. Shortly after she entered the building, Resident #64 informed her she took a bag to her room thinking it had her own belongings in it and found a gun inside. STNA #592 notified the police, who took control of the weapon. Record review of STNA #563's personnel file revealed he was hired 03/18/24 and his orientation paperwork included acknowledgement of receipt of various policies, including deadly weapons. Further review revealed STNA #563 had no disciplinary action until his suspension on 05/03/24 and subsequent termination on 05/06/24 for violating the facility's firearms and other weapons policy. (continued on next page)

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the local police report, identified as Incident Number 24-01711 and dated 05/03/24, revealed police responded to the facility on [DATE] at 2:00 P.M. for a report of a missing firearm. STNA #563 reported his [NAME] pistol was concealed inside a fleece vest pocket along with two additional magazines, which was stored inside a clear garbage bag and left on a nursing cart outside of room [ROOM NUMBER]. STNA #563 told the police he brought his gun to work because he worked nights and had to ride the bus. Staff located the weapon at 3:45 P.M. under a mattress in room [ROOM NUMBER]. The gun was found with a bullet in the chamber, an inserted magazine containing nine bullets, and with two extra magazines of ten bullets each. Police interview with Resident #64 revealed she initially believed the bag was hers and took it into her room, where she found the gun. She did not feel comfortable turning it over to any staff member except STNA #592 and so waited until this staff began her shift to report it. The police took custody of the firearm. Review of the facility policy titled Firearms and Other Weapons, dated April 2007, revealed the facility prohibited any individual from possessing firearms or other weapons on the premises. Individuals bringing a weapon into the facility must leave it with the administrative office or a security officer before entering resident care areas. Violations of the policy could result in various steps including immediate termination of employment.