

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Heights Rehabilitation and Healthcare Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 E Royalton Rd Broadview Heights, OH 44147	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure comfortable room temperatures for Resident #20 and Resident #113. This finding affected two residents (Residents #20 and #113) of 115 residents who reside in the facility.</p> <p>Findings include:</p> <p>1. Review of Resident #113's medical's medical record revealed the resident was admitted on [DATE] with diagnoses including cerebral infarction, acute respiratory failure with hypoxia, and tracheostomy status.</p> <p>Review of Resident #113's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.</p> <p>Review of Resident #113's medical record revealed the resident's temperature on 06/20/25 at 11:36 A.M. was 98.0 degrees Fahrenheit; on 06/21/25 at 9:16 A.M. was 98.4 degrees Fahrenheit; on 06/22/25 at 9:25 A.M. was 98.9 degrees Fahrenheit; on 06/23/25 at 9:10 P.M. was 97.7 degrees Fahrenheit; and on 06/24/25 at 5:14 A.M. was 98.6 degrees Fahrenheit.</p> <p>Review of Resident #113's medical record revealed the resident's oxygen levels via a tracheostomy on 06/21/25 at 9:16 A.M. was at 97%; on 06/22/25 at 8:31 A.M. was at 95%; on 06/23/25 at 1:50 P.M. was 92%; on 06/24/25 at 2:13 A.M. was 93% and on 06/24/25 at 5:14 A.M. was 85%.</p> <p>Review of Resident #113's progress note dated 06/24/25 at 5:52 A.M. revealed the resident was sent to the hospital due to a respiratory rate of greater than 40, labored breathing and a pulse oximetry of 85%.</p> <p>Review of Resident #113's progress note dated 06/24/25 at 12:23 P.M. revealed the resident was admitted to the hospital with bilateral pneumonia.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/24/25 at 9:19 A.M. with Maintenance Assistant #814 and Maintenance Director #816 of Resident #113's room revealed the door was closed, the air conditioning unit was turned off with two wet blankets underneath the air conditioning unit and two wet blankets were noted in a corner of the resident's room. A fan was observed in the resident's room. The air conditioning unit was turned back on in the automatic setting at the time of the observation and little air was noted from the unit. Observations revealed the front of the air conditioning unit was removed and lying beside the wall.</p> <p>A second observation on 06/24/25 at 9:37 A.M. with Maintenance Director #816 of Resident #113's room revealed the air conditioning unit was blowing slight air into the resident's room.</p> <p>Interview on 06/24/25 at 9:37 A.M. with Maintenance Director #816 revealed the facility was not aware of Resident #113's air conditioning unit not functioning appropriately. Maintenance Director #816 revealed the air conditioning unit was leaking due to condensation or sweating. Maintenance Director #816 did not know why the front of the air conditioning unit was removed and lying beside the wall.</p> <p>Interview on 06/24/25 at 9:38 A.M. with Registered Nurse (RN) #815 revealed she had worked on 06/23/25 and Resident #113's room was hot. RN #815 confirmed the resident was sweating but she did not know the temperature in the resident's room. RN #815 also confirmed she had previously reported the leaking air conditioner to the maintenance department and the maintenance staff had placed blankets underneath the air conditioning unit.</p> <p>Interview on 06/25/25 at 7:46 A.M. with Licensed Social Worker (LSW) #818 indicated Resident #113's family had come in at some point over the weekend (06/21/25 or 06/22/25) and reported environmental concerns including the hot temperature of the resident's room.</p> <p>Review of the temperature Logbook Documentation forms revealed Resident #113's room temperature was last obtained on 06/20/25 with a result of 72 degrees Fahrenheit (F).</p> <p>Review of the Resident/Family Concern/Grievance Form dated 06/23/25 revealed Resident #113's family had reported environmental concerns related to the room and the facility provided a fan for the room (and a portable air conditioner on 06/24/25).</p> <p>2. Review of Resident #20's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure, tracheostomy status and neuromuscular dysfunction of the bladder.</p> <p>Review of Resident #20's MDS 3.0 assessment dated [DATE] revealed the resident had a memory problem.</p> <p>Interview on 06/24/25 at 11:07 A.M. with Resident #20's daughter revealed the resident's air conditioning unit was not working appropriately and it was hot in the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/24/25 at 11:15 A.M. with Maintenance Assistant #814 of Resident #20's resident room revealed the ambient temperature using a hydrometer was 81.4 degrees Fahrenheit. Observation of the air conditioning unit with Maintenance Assistant #814 of the air conditioning unit revealed the unit was set to automatic and felt cold when touched but was only slightly blowing cold air into the room. Two fans were noted in the resident's room.</p> <p>Observation and subsequent interview on 06/24/25 at 12:07 P.M. with the Administrator of Resident #20's room revealed the air conditioning unit was set at the automatic setting and was slightly blowing cold air into the resident's room. The Administrator revealed he would talk to the maintenance department about the air conditioning unit. A blanket was noted underneath the air conditioning unit.</p> <p>Review of the Facility Temperature Policy dated 09/2021 revealed the purpose of the policy was to provide a comfortable and safe temperature for the residents in the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00166906 and OH00164339.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure visibly soiled bedding was changed in a timely manner affecting Resident #76. The facility also failed to ensure the south wing shower room wall was maintained in good repair. This had the potential to affect 35 residents (#5, #9, #21, #24, #27, #30, #31, #37, #38, #41, #44, #48, #49, #52, #56, #65, #66, #68, 69, #71, #72, #74, #82, #84, #92, #95, #97, #99, #100, #101, #102, #104, #108, 109, and #114) of 38 residents that use the south wing shower room. The facility census was 115.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #76 revealed an initial admission date of 12/03/24. Diagnoses included quadriplegia, tracheostomy status, dependence on respirator (ventilator), gastrostomy (feeding tube).</p> <p>Review of the comprehensive minimum data set (MDS) assessment dated [DATE] revealed Resident #76 had intact cognition and was dependent on staff for all activities of daily living (ADLs).</p> <p>Observation on 06/24/25 at 11:32 A.M. of Resident #76's bedding revealed a dried, brownish stain approximately 2 &frac12; inches on his sheet near where his right wrist was laying but did not observe any open areas. Interview at this time with Resident #76 revealed he wasn't sure what the stain was.</p> <p>Observation on 06/24/25 at 11:38 A.M. with Registered Nurse (RN) #815 of Resident #76's bedding verified the dried brown stain and stated she believed it was blood that came from a small scabbed over area on top of the right arm near the wrist area. RN #815 stated it was warm in the room so it could have dried fast but will make sure when the aides come into his room for care that they change his sheets.</p> <p>Interview on 06/25/25 at 10:47 A.M. with the Director of Nursing (DON) stated she thinks the blood was from the blood draw and provided lab results report for Resident #76. Review of the lab results revealed a collection date of 06/23/25 at 6:35 A.M. DON verified the lab draw was from the day before the observation of the dried, brown stain on 06/24/25. DON stated she was just trying to figure where the blood could have possibly come from. DON stated linens should be changed when visibly soiled.</p> <p>2. Observation on 06/24/25 at 1:47 P.M. of the south wing shower room with Certified Nursing Assistant (CNA) #808 revealed the lower part of the wall between the shower and the bathroom and under the hand sanitizer was a hole with broken tiles, basketball sized, broken inward. Interview at this time with CNA #808 verified the observation and stated he was not sure how long the wall had been that way and was his first time seeing it.</p> <p>Review of the list provided by the facility indicated 35 residents (#5, #9, #21, #24, #27, #30, #31, #37, #38, #41, #44, #48, #49, #52, #56, #65, #66, #68, 69, #71, #72, #74, #82, #84, #92, #95, #97, #99, #100, #101, #102, #104, #108, 109, and #114) of 38 residents used the south wing shower room.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00165647.</p>		