

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 08/12/2025
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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility did not ensure an individualized care plan was developed for Resident #1 to address the diagnosis of post-traumatic stress disorder (PTSD) to identify triggers and interventions to minimize risk of re-traumatization. This affected one resident (#1) of three residents reviewed for care planning. The facility identified one resident (Resident #1) as having PTSD. The facility census was 108. Findings include: Review of the medical record for Resident #1 revealed an admission date of 04/22/25. Diagnoses included generalized anxiety, borderline personality disorder, major depressive disorder, and PTSD. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 07/29/25, revealed Resident #1 was cognitively intact, exhibited other behavioral symptoms not directed toward others four to six days of the assessment reference period, was independent for transfers and was able to independently maneuver her motorized wheelchair 50 and 150 feet. Walking hadn ' t been attempted during the assessment reference period. Review of PTSD Checklist for DSM-5, dated 04/23/25, revealed Resident #1 was quite a bit bothered when something reminded the resident of the stressful experience, and the resident was moderately bothered when the resident had strong physical reactions when something reminded her of the stressful experience, such as heart pounding, trouble breathing, or sweating. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #1 or the potential triggers which may cause re-traumatization. Review of the plan of care, dated 04/23/25, for Resident #1 revealed the resident had impaired psychiatric/mood status related to depression, anxiety, bipolar, and PTSD. Further review of the care plan revealed the cause of the PTSD or the triggers which may cause re-traumatization hadn ' t been identified on the care plan therefore no interventions were developed to mitigate risk of re-traumatization. An interview with Resident #1 on 08/07/25 at 9:43 A.M. revealed the resident voiced she had PTSD and wanted people to stay out of her personal space. Resident #1 stated when people get too close to her, it triggers her. An interview on 08/12/25 at 12:45 P.M. with Licensed Practical Nurse #405, who had picked up a shift and was working on a unit she normally didn ' t work, revealed she had been unaware if she got too close to Resident #1, the resident would get anxious, until the earlier in the shift when LPN #405 had gotten too close to the resident, the resident told her she was getting too close to her. An interview with the Administrator on 08/12/25 at 1:59 P.M. stated the facility didn ' t have a PTSD policy. An interview on 08/12/25 at 2:55 P.M. with Certified Nursing Assistant #425 revealed she was unaware getting too close to Resident #1 bothered her until Resident #1 told her she didn ' t like people getting too close to her. An interview on 08/12/25 at 3:03 P.M. with Social Services Director (SSD) #360 revealed when a resident was admitted with a diagnosis of PTSD, she would complete the PTSD Checklist for DSM-5. She stated she would talk about triggers for PTSD when she was completing the assessment or during the 72 hour meeting they held with residents. She indicated if a resident with PTSD voiced any triggers, she would relay those triggers to staff through verbal communications. SSD #360 indicated the first thing Resident #1 mentioned about her trigger for her PTSD was people getting too close to her. SSD #360 stated she was unsure when the resident had told her about this trigger for her PTSD. She confirmed the medical record hadn ' t identified the cause of Resident #1 ' s PTSD or the triggers related to her PTSD, and staff should be aware of triggers for a resident's PTSD. SSD #360 verified no care plan had been developed and implemented to address triggers or interventions related to Resident #1's PTSD.</p>		