STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365661	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Rehabilitation and Healthcare Center, The	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, Self-Reported Incident review, review of witness statements, review of police incident report, review of Resident Funds Management Service statement landscape and withdrawal record, review of cashed checks, review of emails, personnel record review, disciplinary action review, policy review and interview, the facility failed to protect residents right to be free from misappropriation of resident property and/or exploitation. This affected 13 residents (#6, #8, #9, #12, #32, #43, #57, #67, #83, #87, #97, #105, and #107) of 66 residents who had a resident funds account during January 2025 and September 2025. The census was 102.Findings Include:Review of the Self-Reported Incident (SRI) dated 09/02/25 revealed an allegation of misappropriation when staff notified the Administrator of suspected misappropriation of resident funds. On 09/02/25, it was identified Business Office Manager (BOM) #120 allegedly purchased items for Resident #97 that were not authorized by the resident ' s emergency contacts and that were also unable to be found in the resident ' s possession. Staff alleged that communication regarding the authorization of purchases had occurred; the family denied this. After thorough investigation, the facility concluded that misappropriation had occurred. The family had claimed that items purchased on the resident ' s behalf were not authorized. The alleged perpetrator [BOM #120] had claimed no wrongdoing but did acknowledge purchasing items in question. The families of all affected residents had been notified; the facility would reconcile. Review of the SRI addendum dated 09/09/25 revealed additional findings which included: Resident #107 reimbursed $825.65; Resident #6 reimbursed $1,464.71; Resident #12 reimbursed $3,323.65; Resident #43 reimbursed $61.59; Resident #57 reimbursed $66.24; Resident #32 reimbursed $280.79; Resident #67 reimbursed $597.26 and $2,359.09; Resident #9 reimbursed $1,624.93; Resident #97 reimbursed $6,235.96; Resident #8 reimbursed $33.31; Resident #87 reimbursed $684.79; Resident #83 reimbursed $2,096.34; and Resident #105 reimbursed $326.73.Review of the interview record (witness statement) authored by Regional Business Office Manager (RBOM) #123 as the interviewee and Regional Director of Operations (RDO #124) as the interviewer dated 09/02/25 revealed, how did you find the checks written in [BOM #120 ' s] name? I was in the business office to support while the BOM was off and she had old receipts in the office file fold and noticed one had her name on it. So then I went to the check registry in RFMS [resident funds management system] and reviewed all past transactions and noticed she had been writing checks for large sums of money to herself. I then printed all the checks and notified [the Administrator] and RDO #124 at which time we all started looking for all receipts for every check written and began to verify if all items were in the building. A spreadsheet was compiled of all checks written including checks, missing receipts, cross refencing questionable items, double purchases and BIMS [brief interview for mental status] scores. What is the process for writing checks? Division of duties, receptionist passes out cash and has residents sign, Assistant BOM enters receipts and BOM prints checks. As the Regional BOM, did you find that the policy was not followed in this instance? Yes, correct.Review of the interview record (witness statement) authored by Assistant Business Office Manager (ABOM) #122 as the interviewee and the Administrator as the interviewer dated 09/02/25 revealed, .I don ' t know how items are decided upon for R [residents]. When R packages arrive, they are in [BOM #120 ' s] name and she opens them and tells me where they go. I have never opened a package without being asked that was addressed to [BOM #120] or opened a package unwitnessed. Sometimes I think the dollar amount of items purchased are excessive. I have never observed any jewelry. I questioned [BOM #120] and [Receptionist #128] on the cost of the items (fans specifically - [NAME] fans). I did not mention my thoughts to [previous Administrator] .Review of the interview record (witness statement) authored by Receptionist #128 as the interviewee and RDO #124 as the interviewer dated 09/02/25 revealed, Have lots of boxes come to the office in [BOM #120 ' s] name? We used to get a lot but not as many now. Did you open the boxes? Only the ones she told me to open. When she has you open them, what is the process? I label the items and take them to resident rooms .Review of the interview record (witness statement) authored by former Activities Director #127 as the interviewee and the Administrator as the interviewer dated 09/02/25 revealed, .Why did activities stop buying items for residents? I told [the former Administrator] I was done because there were too many hands in the pot. I felt like [BOM #120] was buying [NAME] and inappropriate items for residents. What kind of items? Play Station 5, gold watch, expensive items that these residents don ' t use. Did you report this? Yes, I reported it to [former Administrator]. Also, the resident did not want the Play Station 5 so [BOM #120] wanted to donate it

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (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 0740 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 observation, medical record review, nursing staff schedule review, disciplinary action review, policy review and interview, the facility failed to implement a person-center care plan to support the behavioral health care needs of Resident #1. This affected one (Resident #1) of three residents reviewed for behavioral health. The census was 102.Findings include: Review of the medical record for Resident #1 revealed an admission date of 04/22/25 with diagnoses which included borderline personality disorder, post-traumatic stress disorder, generalized anxiety disorder, hereditary and idiopathic neuropathy, severe morbid obesity due to excess calories, arthritis, pain in left hip and fibromyalgia. Review of the potential for pain care plan revised on 04/26/25 revealed Resident #1 had potential for pain related to fibromyalgia, neuropathy, osteoarthritis and left hip pain with interventions which included: administer medications per physician orders, notify physician or nurse practitioner if current pain medication was ineffective, and encourage resident to request pain medication before the pain became too intense.Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #1 was cognitively intact, had verbal behaviors one to three days during the assessment, had other behavioral symptoms four to six days during the assessment, used a wheelchair for mobility, was independent with bed mobility and transferring from the bed to chair. Review of the behavior care plan revised on 08/07/25 revealed Resident #1 had behaviors resistant to care which included she did not want to be disturbed while sleeping and demanded her medications be administered at midnight with interventions which included: administer medications per physician order, attempt to redirect resident when exhibiting behaviors; reapproach when resident has deescalated, encourage the resident to ask for staff assistance when feeling frustrated with others and two care providers at all times.Review of the aggressive behaviors care plan revised on 08/28/25 revealed Resident #1 had aggressive behaviors related to being verbally aggressive towards staff, utilizing inappropriate language towards staff, swearing and yelling at staff, and being physically aggressive toward staff/alternate residents with interventions which included administer medications per physician orders and allow resident to verbalize frustrations, and provide emotional support and reassurance. Review of the psychiatric/mood care plan revised on 09/03/25 revealed Resident #1 had an impaired psychiatric/mood status related to depression, anxiety, bipolar and post-traumatic stress disorder (PTSD). PTSD triggers included: staff waking her up and any physical touch of her person or belongings. Interventions included: administer medications and treatments as indicated by physician orders, encourage participation from the resident to make her own decisions, provide a calm environment when the patient was emotional or frustrated and allow time to voice feelings and staff to knock on door and announce their presence if needing to wake resident. Review of the September 2025 physician orders revealed Resident #1 was ordered the following medications: Diclofenac sodium tablet delayed release 75 mg with instructions to give one tablet by mouth at bedtime for inflammation/left hip pain at 12:00 A.M., Naproxen oral tablet 500 mg with instructions to give one tablet by mouth at bedtime related to fibromyalgia at 12:00 A.M., Hydroxyzine pamoate (an antihistamine used to treat anxiety) capsule 50 mg with instructions to give one capsule by mouth three times a day related to generalized anxiety disorder from 7:00 A.M. to 11:00 A.M., 4:00 P.M. to 6:00 P.M. and 7:00 P.M. to 11:00 P.M., Acetaminophen oral tablet 500 mg with instructions to give two tablets by mouth every six hours as needed by mild/moderate pain, Diclofenac Sodium external gel 1% with instructions to apply to lower back topically every 12 hours as needed for pain, Ibuprofen tablet 800 mg with instructions to give one tablet by mouth every eight hours as needed for pain, and Tramadol HCl tablet 50 mg with instructions to give one tablet by mouth as needed for mild/moderate pain (pain on scale six to eight [out of 10]).Review of the nurses note dated 09/09/25 timed 4:34 A.M. authored by Registered Nurse (RN) #126 revealed Resident #1 was scheduled for routine medication at 12:00 A.M. The resident requested medication at 4:00 A.M. while this nurse was on lunch break. Upon return at 4:30 A.M., this nurse was in a room when she overheard resident at the nurses' station upset and hostile talking about this nurse to an aide, making derogatory remarks yelling, that [expletive] ain't nowhere but in that room. She also stated that [expletive] been on break all shift, I'll drag her [expletive] all over the internet. I already have footage of her being a [expletive] nurse. The resident appeared agitated and uncooperative. For staff safety, medications were not administered at this time. The behavior was reported to management for awareness, further direction, and follow up. There was no evidence that RN #126 attempted any interventions or asked another nurse in the facility to attempt to administer Resident #1's medication and