STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365832	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Manor Health & Reha	2186 Ambleside Rd Cleveland, 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 THIS DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THE ON-SITE INVESTIGATION Based on medical record review, staff interview, resident representative interview, law enforcement interview, review of facility self-reported incidents (SRIs), review of police reports, review of police body camera footage, review of emergency medical services (EMS) run reports, review of hospital records, review of the Facility Assessment, and review of facility policies, the facility failed to ensure Resident #1 was free from physical abuse from Resident #2. This resulted in Immediate Jeopardy and serious life-threatening harm on 03/12/24 at approximately 5:00 A.M. when Resident #1 was found on the floor in a prone position (face down on the stomach) in his room with blood coming out of the left side of his head and face. The resident was transported to the emergency room . Upon further investigation by hospital staff and law enforcement, it was determined Resident #1 was physically assaulted by Resident #2, who had a documented history of violent behaviors and was Resident #1's roommate. Resident #1 sustained numerous blows to the head and abdomen and injuries including scattered abrasions about the head, significant swelling to the left side of the face mostly over the left eyelid with a laceration present in the area, bleeding on the brain, and a fractured sacrum. This affected one resident (#1) reviewed for physical abuse and had the potential to affect 42 additional residents (#3, #4, #5, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #37, #38, #39, #40, #41, #42, #43, #44, #45 and #46) who resided on the secure dementia unit were Resident #2 resided. The facility census was 143. On 04/11/24 at 5:05 P.M., the Administrator and Corporate Registered Nurse (CRN) #116 were notified Immediate Jeopardy began on 03/12/24 at approximately 5:00 P.M. when Resident #1 was found on the floor in the prone position in his room with blood coming out of the left side of his head and face. The injuries were determined to be a result of an incident of physical abuse/assault by Resident #2. The facility did not begin corrective action until 03/18/24 when law enforcement arrived at the facility and informed facility staff Resident #1 alleged the assault by Resident #2, leaving the 43 additional residents residing on the unit at risk for physical abuse from Resident #2 between 03/12/24 and 03/18/24. The Immediate Jeopardy was removed and corrected on 03/21/24 when the facility implemented the following corrective actions: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/12/24 Resident #1 was transferred to the hospital and did not return to the facility. On 03/18/24, Resident #2 was placed on one-to-one supervision until discharged to the hospital. On 03/18/24, the Director of Nursing (DON) notified Resident #2's guardian and physician and orders were received to send the resident to a hospital for a psychological evaluation. Resident #2 was hospitalized from 03/18/24 to 03/21/24. On 03/18/24, the Administrator initiated a facility Self-Reported Incident (SRI) and an investigation for resident-to-resident physical abuse involving Resident #1 and Resident #2 that occurred on 03/12/24. On 03/18/24, the DON/Designee completed interviews with all interviewable residents who could potentially be affected regarding abuse and neglect. There were no negative findings from the resident interviews. On 03/18/24, Assistant Director of Nursing (ADON) #249, Licensed Practical Nurse (LPN) Unit Manager #298, and Registered Nurse (RN) #288 completed skin assessments on all non-interviewable residents to identify any signs or symptoms of abuse. There were no negative findings from the skin assessments. On 03/19/24, the interdisciplinary team (IDT) consisting of the Administrator, ADON #249, Social Service Designee (SSD) #220, RN #257, Regional Director of Clinical Services (RDCS) #350, and LPN Unit Manager #298 reviewed residents with like behaviors, including review of care plans and interventions, and review of all residents and their roommates for compatibility. As a result of the meeting, it was determined Resident #2 was moved to a private room upon readmission to the facility on [DATE]. There were no concerns found with the other residents during the review. On 03/18/24, the Administrator/Designee began education with all staff on abuse, neglect, aggressive behaviors, and violent behaviors. The education was completed face-to-face for facility staff working in the facility and via telephone for staff members not present in the facility. Newly hired staff/agency staff were to be educated upon hire and upon assignment to the facility. All education of current staff members was completed on 03/19/24. On 03/18/24, the DON/designee began audits to include interviews with five staff members three (3) times weekly for four (4) weeks and then monthly for two (2) months to monitor and assess residents for any signs and symptoms of abuse. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. All audits through 04/01/24 revealed no concerns. On 03/18/24, the DON/Designee began audits to include interview with 10 residents who were interviewable and skin assessments on non-interviewable residents 3 times weekly for 4 weeks and then monthly for two months to assess for signs and symptoms of abuse. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. All audits through 04/01/24 revealed no concerns. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/18/24, the DON/Designee began audits to review all residents with aggressive and violent behaviors to ensure appropriate interventions are implemented and/or updated to reflect current resident status. All residents will be audited weekly for 4 weeks and then monthly for 2 months to ensure compliance. All audits through 04/01/24 revealed no concerns. On 03/19/24, the DON/Designee began audits of new admissions and readmissions to the facility to monitor for aggressive and violent behaviors to ensure appropriate interventions are implemented upon admissions. Review of the audits through 04/01/24 revealed no concerns. On 03/21/24 Resident #2 was readmitted to the facility and placed in a private room as an intervention to decrease the risk for resident-to-resident abuse by Resident #2. Review of SRIs on 04/09/24, revealed the facility had submitted no additional allegations of resident-to-resident physical abuse since 03/18/24. Interview with State tested Nurse Aide (STNA) #215, STNA #302, LPN #257, and LPN #298, on 04/15/24 between 8:35 A.M. and 8:55 A.M. revealed all staff members interviewed had been educated regarding abuse, neglect, aggressive behaviors, and violent behaviors. All staff members interviewed confirmed they retained knowledge regarding the content of the education provided. Findings Include: Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included seizures, depression, and post-traumatic stress disorder. Resident #1 shared a room with Resident #2 on admission and remained roommates until Resident #1 was discharged to a local hospital on 03/12/24 and did not return to the facility. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was assessed as cognitively intact and required limited assistance from one staff person for completing his activities of daily living. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, paranoid personality disorder, anxiety disorder, and violent behavior. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #2 was assessed as cognitively intact, had active delusions, and required the assistance of one staff person for completing his activities of daily living. Review of Resident #2's admission paperwork prior to arriving at the facility on 02/18/20 revealed Resident #2 was placed in a psychiatric hospital for physically assaulting another resident and staff person at another nursing facility, causing broken arms in both the staff person and the other resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plan for Resident #2, initiated on 02/18/20 and revised on 05/24/23, revealed a care plan focus that indicated Resident #2 had a mood problem related to paranoid schizophrenia. Resident #2 had the potential to express himself using verbal or physical violence when he was experiencing elevated feelings. Goals for the care plan focus were for Resident #2 to have improved mood through the next review date. Interventions included administering medications as ordered, monitoring/documenting for side effects and effectiveness, assessing/monitoring/recording/reporting to the medical doctor (MD) as needed for risk for harming others, assessing/recording/reporting to the MD as needed acute episodes or significant changes in mood, assessing/record/reporting to the MD as needed mood patterns signs and symptoms of depression, anxiety, mood as per facility behavior monitoring protocols, behavioral health consults/psychiatric consult as needed or per orders, encouraging the resident to express feelings, allowing them time to talk as needed, allowing for Resident #2 to express himself using active listening, maintaining eye contact, speaking in a calm manner, not challenging him while he was in an elevated emotional state, acknowledging and rephrasing what was frustrating Resident #2 so he was aware that he has been heard, and observing for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity. The care plan included no other interventions to specifically address Resident #2's specific behaviors, triggers, or other concerns to prevent violent and aggressive behaviors. Review of the Ohio Department of Health's Enhanced Information Dissemination Collection (EIDC) system revealed Resident #2 was involved in 16 separate incidents resulting in facility SRIs across four different nursing facilities being reported to the State agency since 2014. Notable SRIs which occurred in Resident #2's current facility in the reported SRIs investigations included, on 10/23/23, Resident #2 placed Resident #15 in a choke hold during a physical altercation which resulted in Resident #15 biting Resident #2's finger. Review of an SRI on 12/13/23 revealed Resident #2 and Resident #17 were roommates and Resident #17 was noted with swelling and redness to the right cheek. When a nurse attempted to assess Resident #17, the resident indicated he wanted to be left alone. Resident #2 was interviewed about the incident and stated, I punched him (Resident #17) for no reason. Review of an additional SRI on 02/07/24 revealed Resident #2 struck Resident #449, who at the time were roommates, in the lip causing Resident #449 to have a swollen lip. Review of psychiatrist progress notes from the facility noted the facility's psychiatrist was unwilling to reduce Resident #2's psychiatric medications due to ongoing behaviors. Resident #2 had been most recently seen by facility's psychiatrist for a medication review on 01/17/24 at which time Resident #2 was noted with impaired judgement and incoherent thought process. Resident #2 was documented with medical history of schizophrenia, paranoid personality, violent behavior, anxiety, and schizoaffective disorder. Further review revealed adjustments made since the last visit included an increase in Resident #2's antipsychotic medication Haldol to 300 milligrams every three weeks. Resident #2 was noted to not be a candidate for a dose reduction because of continuing target symptoms and a high risk of relapse if medication was lowered. Review of a nursing progress note dated 03/12/24 at 8:09 A.M. revealed Resident #1 was discovered on the floor of his room at 5:00 A.M. Resident #1 was laying in the prone position with his head turned to the right and blood coming from the left side of his head. Further review of the progress note revealed staff documented prior to a fall Resident #1 was walking around looking for his wheelchair. The progress note indicated Resident #1 was alert and oriented and able to maintain a conversation with the nurse. Resident #1 was transferred to the hospital for evaluation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an EMS run report dated 03/12/24 revealed EMS personnel arrived at the facility at 5:07 A.M. Resident #1 was found lying on the ground in his bedroom with a laceration to the back of the head and his left eye was swollen shut. Nursing staff reported to EMS personnel that they did not know what happened, but assumed Resident #1 fell , but confirmed it was unwitnessed incident. Further review of the EMS run report revealed multiple pools of blood were noted on the doorway of Resident #1's room. As EMS transported Resident #1 to the facility's elevator, Resident #1 told the EMS personnel he did not just fall but was kicked in the face (multiple times) by another resident (#2) who lived in the facility. Review of hospital documentation dated 03/12/24 revealed Resident #1 admitted to the emergency room (ER) with a primary diagnosis of trauma and a left eyelid laceration and intracranial hemorrhage. Resident #1 was brought to the ER as a limited trauma after nursing staff found the resident on the ground, but Resident #1 reported to EMS he was assaulted and kicked multiple times in the head and body. Resident #1 reported to EMS personnel while enroute to the ER that he was assaulted by his roommate and named Resident #2. Resident #1 was alert and oriented to person, place, and time and reported pain throughout his body. Resident #1 was assessed with dried blood on his scalp with scattered abrasions without lacerations identified on his head. Resident #1 had significant swelling to the left side of the face mostly over the left eyelid with an approximate five millimeters long laceration present in the area. The laceration was treated and repaired with sutures. Assessment of Resident #1's abdomen produced some guarding. Review of Resident #1's history revealed the resident had a previous subdural craniotomy (a temporary flap surgically created to the skull) and a flap on the right side of his head where there was no skull. Review of a computed tomography (CT) image of Resident #1's pelvis revealed a nondisplaced acute fracture involving the caudal sacrum. Review of the police body camera footage during an interview with Resident #1 on 03/12/24 at 8:56 A.M., from the ER that Resident #1 was transferred to after the incident, revealed Resident #1 was lying flat on his back with a cervical collar on. Resident #1's face was covered in scratches and bruises with a significant amount of dried blood noted across his face. Photos taken during the interview by the police officer on the body camera footage also noted numerous bruises on Resident #1's abdomen. Resident #1 was noted stating to the officer that he was beat up by his roommate (Resident #2). The body camera footage also noted Resident #1's hospital nurse explained to the officer that Resident #1 suffered bleeding on his brain, a broken sacrum, and was going to be transferred to the hospital trauma intensive care unit (ICU) for further medical care. Review of the police body camera footage dated 03/18/24 at 12:39 P.M. revealed Resident #2 was interviewed regarding the incident by Detective #300 at the nursing facility. Resident #2 stated Resident #1 was reaching for a religious picture that belonged to Resident #2, and he then stuck his foot out to block Resident #1 from touching the religious picture. Resident #2 stated Resident #1 bumped into his foot, Resident #2 took offense to Resident #1 bumping his foot and proceeded to strike Resident #1 with a closed fist. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the police body camera footage dated 03/18/24 at 1:23 P.M. in the ICU of the hospital revealed Resident #1 was interviewed by Detective #300. Resident #1 revealed he was thrown out of his wheelchair during the incident and was stomped multiple times on the ground by Resident #2. As a result of being thrown to the ground, Resident #1 suffered a broken tailbone. Resident #1 was informed that based on Detective #300's investigation, Resident #1 was the victim of felonious assault (defined as causing or attempting to cause serious physical harm to another person, or to their unborn child, with a deadly weapon or dangerous ordnance). Detective #300 further explained that after consultation with the county's prosecutor, the county would like to proceed with criminal charges. Resident #1 stated he would like to press charges for the incident with Resident #2. Detective #300 educated Resident #1 that the case would be brought to the county's grand jury to secure formal indictments against Resident #2. Review of a facility self-reported incident (SRI) dated 03/18/24 revealed Resident #1 was discovered on the floor in his room (on 03/12/24) at 5:00 A.M. Resident #1 was laying on the floor of his room in the prone position with his head turned to the right and bleeding from the left side of his head. The SRI included that while being assessed for injuries, Resident #1 informed his nurses that he fell looking for his wheelchair. After assessment, Resident #1 was transported to a local hospital for evaluation. While being evaluated in the hospital, Resident #1 informed hospital staff that he was assaulted by Resident #2. The facility was contacted related to the situation and then began an investigation into the incident. Interview on 04/09/24 at 2:47 P.M. with Resident #1's guardian revealed Resident #1 was nothing like he used to be before the incident on 03/12/24 and has periods of impaired cognition. Interview on 04/09/24 at 5:30 P.M. with the Administrator and DON verified Resident #2's history of physically aggressive behaviors toward other residents, and confirmed the facility did not develop individualized interventions to prevent Resident #2 from physically abusing other residents, including Resident #1. Interview with Detective #300 on 04/11/24 at 9:33 A.M. verified local law enforcement were moving ahead with charges of felonious assault against Resident #2 related to the incident with Resident #1 on 03/12/24. Detective #300 also commented the facility was visited often by law enforcement for incidents of resident-to-resident abuse and other similar incidents. Interview with STNA #215 on 04/15/24 at 8:44 A.M. revealed he was the staff person who found Resident #1 after the incident on 03/12/24. STNA #215 revealed Resident #1 was sitting on his knees on the floor with a large amount of blood coming from the left side of his head. STNA #215 noted Resident #2 was in the room lying awake in his bed and did not speak to STNA #215. Interview with STNA #302 on 04/15/24 at 8:50 A.M. revealed Resident #2 had numerous instances of violent behavior toward staff and others. STNA #302 further noted Resident #2's behaviors were often exacerbated when he had a roommate. Interview with LPN #257 on 04/15/24 at 8:55 A.M. revealed Resident #2's behaviors were often more extreme during the evening and late-night hours. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Psychologist #900 on 04/15/24 at 2:35 P.M. revealed Resident #2 was very territorial in his behaviors, and if Resident #2's personal space and routine were changed/violated, he would very likely retaliate against others. Interview with Resident #2's guardian on 04/15/24 at 1:05 P.M. revealed Resident #2 had a long history of violent behaviors at numerous nursing homes and estimated Resident #2 was placed at over a half dozen nursing homes in the state over the last seven to ten years. Review of the Facility assessment dated [DATE], under the subsection of Mental health and behavior, revealed the facility would manage the medical conditions and medication-related issues causing psychiatric symptoms and behaviors, and identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder, and other psychiatric diagnoses. Review of the policy titled, Secured Resident Unit Policy, dated 05/12/22, revealed the facility's secured unit was meant to improve quality of life via enhanced safety and maintenance or improvements in the level of functioning. Review of the policy titled, Abuse, Neglect, and Exploitation, dated 08/30/23 revealed the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Further review of the police revealed, in order to prevent and identify abuse, the facility will assessment, care plan, and monitors residents with needs and behaviors which might lead to conflict or neglect. This deficiency is based on incidental findings discovered during the course of the complaint investigation.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 38091 Based on review of personnel files and staff interview, the facility failed to ensure state tested nurse aides (STNAs) were given yearly performance evaluations as required. This affected two (#291 and #296) of two STNA's personnel files reviewed who were employed for more than one year at the facility. This had the potential to affect all 143 residents residing in the facility. The facility census was 143. Findings Include: 1. Review of the personnel record for STNA #291 revealed a hire date of 12/23/22. There was no evidence of a yearly performance evaluation completed for STNA #291 for the last year. 2. Review of the personnel record for STNA #296 revealed a hire date of 01/13/22. There was no evidence of a yearly performance evaluation completed for STNA #296 for the last year. Interview with Human Resources Director (HRD) #350 on 04/16/24 at 11:30 A.M. verified no yearly performance reviews were completed as required for STNA #291 and STNA #296. This deficiency is based on incidental findings discovered during the course of the complaint investigation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, staff interview, review of facility self-reported incidents (SRIs), review of the Facility Assessment, and policy review, the facility failed to ensure adequate behavioral health services and person-centered care planning were in place to address the individualized needs of residents with history of mental disorders and history of violent behaviors against other residents. This affected one (#2) of three residents reviewed for behaviors. The facility census was 143. Findings Include: Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, paranoid personality disorder, anxiety disorder, and violent behavior. Review of Resident #2's admission paperwork prior to arriving at the facility on 02/18/20 revealed Resident #2 was placed in a psychiatric hospital for physically assaulting another resident and staff person at another nursing facility causing broken arms in both the staff person and the other resident. Review of the most recently completed Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was assessed as cognitively intact, had active delusions, and required the assistance of one staff person for completing his activities of daily living. Review of the Ohio Department of Health's Enhanced Information Dissemination Collection (EIDC) system revealed Resident #2 was involved in 16 separate incidents resulting in facility SRIs across four different nursing facilities being reported to the State agency since 2014. Notable SRIs which occurred in Resident #2's current facility in the reported SRIs investigations included, on 10/23/23, Resident #2 placed Resident #15 in a choke hold during a physical altercation which resulted in Resident #15 biting Resident #2's finger. Review of an SRI on 12/13/23 revealed Resident #2 and Resident #17 were roommates and Resident #17 was noted with swelling and redness to the right cheek. When a nurse attempted to assess Resident #17, the resident indicated he wanted to be left alone. Resident #2 was interviewed about the incident and stated, I punched him (Resident #17) for no reason. Review of an additional SRI on 02/07/24 revealed Resident #2 struck Resident #449, who at the time were roommates, in the lip causing Resident #449 to have a swollen lip. Review of psychiatrist progress notes from the facility noted the facility's psychiatrist was unwilling to reduce Resident #2's psychiatric medications due to ongoing behaviors. Resident #2 had been most recently seen by facility's psychiatrist for a medication review on 01/17/24 at which time Resident #2 was noted with impaired judgement and incoherent thought process. Resident #2 was documented with medical history of schizophrenia, paranoid personality, violent behavior, anxiety, and schizoaffective disorder. Further review revealed adjustments made since the last visit included an increase in Resident #2's antipsychotic medication Haldol to 300 milligrams every three weeks. Resident #2 was noted to not be a candidate for a dose reduction because of continuing target symptoms and a high risk of relapse if medication was lowered. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an SRI dated 03/18/24 revealed another resident (#1) was discovered on the floor in his room (on 03/12/24) at 5:00 A.M. Resident #1 was laying on the floor of his room in the prone position with his head turned to the right and bleeding from the left side of his head. The SRI included that while being assessed for injuries, Resident #1 informed his nurses that he fell looking for his wheelchair. After assessment, Resident #1 was transported to a local hospital for evaluation. While being evaluated in the hospital, Resident #1 informed hospital staff that he was assaulted by Resident #2. The facility was contacted related to the situation and then began an investigation into the incident. Review of the care plan for Resident #2, initiated on 02/18/20 and revised on 05/24/23, revealed a care plan focus that indicated Resident #2 had a mood problem related to paranoid schizophrenia. Resident #2 had the potential to express himself using verbal or physical violence when he was experiencing elevated feelings. Goals for the care plan focus were for Resident #2 to have improved mood through the next review date. Interventions included administering medications as ordered, monitoring/documenting for side effects and effectiveness, assessing/monitoring/recording/reporting to the medical doctor (MD) as needed for risk for harming others, assessing/recording/reporting to the MD as needed acute episodes or significant changes in mood, assessing/record/reporting to the MD as needed mood patterns signs and symptoms of depression, anxiety, mood as per facility behavior monitoring protocols, behavioral health consults/psychiatric consult as needed or per orders, encouraging the resident to express feelings, allowing them time to talk as needed, allowing for Resident #2 to express himself using active listening, maintaining eye contact, speaking in a calm manner, not challenging him while he was in an elevated emotional state, acknowledging and rephrasing what was frustrating Resident #2 so he was aware that he has been heard, and observing for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity. The care plan included no other interventions to specifically address Resident #2's specific behaviors, triggers, or other concerns to prevent violent and aggressive behaviors. Interview with the Administrator and Director of Nursing (DON) on 04/09/24 at 5:30 P.M. verified there were no specific care plan or other behavioral health interventions put in place to address Resident #2's history of violent behaviors. Interviews on 04/15/24 between 8:00 A.M. and 9:00 A.M with State tested Nurse Aide (STNA) #215 and STNA #302 and Licensed Practical Nurse (LPN) #257 verified they taken care of Resident #2 on numerous occasions and stated the resident had violent and aggressive behaviors most often towards other residents. All staff interviewed were not aware of any resident specific interventions to address Resident #2's behaviors. Review of the Facility assessment dated [DATE], under the subsection of Mental health and behavior, revealed the facility would manage the medical conditions and medication-related issues causing psychiatric symptoms and behaviors, and identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder, and other psychiatric diagnoses. Review of the facility policy titled, Behavior Management Program, dated 10/31/23, revealed the goal of the facility was to improve management of behaviors and move closer to the goal of ending any inappropriate or unnecessary use of antipsychotic medications. The facility will assess and track behaviors that negatively impacts each resident in regards to their quality of life. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365832	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Manor Health & Reha	2186 Ambleside Rd Cleveland, 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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non compliance investigated under Master Complaint Number OH00152988.