

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER University Manor Health & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>34297</p> <p>Based on observation, record review and interview, the facility did not maintain an ambient temperature in resident rooms and common areas. This finding had the potential to affect all 42 residents residing on the second floor and all 25 residents residing on the third floor. The facility census was 143.</p> <p>Findings include:</p> <p>Interview on 01/22/25 at 4:11 P.M. with Security #801 stated he felt it was cold in the facility the last two days.</p> <p>Interview on 01/22/25 at 4:15 P.M. with the Administrator indicated the problems with the heat started with the boiler system in the basement. The Administrator indicated she was aware the temperatures were off.</p> <p>Interview on 01/22/25 at 4:16 P.M. with the Director of Nursing (DON) indicated it was cold in the facility on 01/21/25. The DON stated the facility put heaters at the end of the halls.</p> <p>Interview on 01/22/25 at 4:23 P.M. with Resident #38 indicated it was cold in the facility on 01/21/25 and 01/22/25.</p> <p>Interview on 01/22/25 at 4:25 P.M. with Resident #110 revealed the facility had been cold. Observation of the resident at the time of the interview revealed she was in the first-floor smoking lounge with a coat and hat on at the time of the observation. Staff were observed sitting in a chair outside of the smoking lounge.</p> <p>Telephone interview on 01/22/25 at 4:27 P.M. with Heating Services #802 indicated their company was in the facility on 01/08/25 because the basement flooded with sewage. Heating Services #802 stated their company cleaned the burners, repaired two circuit boards, four flame sensors, four pilot assemblies and two gas valves. He stated the compression tank was repaired and the pressure regular valve (auto fill valve) was repaired. He stated he was obtained temperatures on 01/21/25 the temperature on the second floor was 68 degrees Fahrenheit.</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 - Some</p>	<p>Observation on 01/22/25 at 4:42 P.M. with Mobile Administrator #803 who used a temperature gun and obtained a temperature near the first-floor smoke room revealed the temperature was 61 degrees Fahrenheit (first floor).</p> <p>Observation on 01/22/25 at 4:45 P.M. with Mobile Administrator #803 who used a temperature gun and obtained a temperature of Residents #25 and #26's resident room revealed the temperature was 67 degrees Fahrenheit (second floor).</p> <p>Observation on 01/22/25 at 4:45 P.M. with Mobile Administrator #803 who used a temperature gun and obtained a temperature of Resident #38's resident room revealed the temperature was 64 degrees Fahrenheit (second floor).</p> <p>Observation on 01/22/25 at 4:47 P.M. with Mobile Administrator #803 who used a temperature gun and obtained a temperature of Residents #12 and #13's resident room revealed the temperature was 66 degrees Fahrenheit (second floor).</p> <p>Interview on 01/22/25 at 5:07 P.M. with Receptionist #804 indicated the first floor was administration offices except for the smoking room.</p> <p>Interview on 01/22/25 at 5:08 P.M. with Registered Nurse (RN) Assistant Director of Nursing (ADON) #805 indicated it had been cold in the facility for the last twenty-four to forty-eight hours.</p> <p>Observations on 01/22/25 at 5:10 P.M. revealed three mobile air and power rental units on the 2nd floor (one on the end of each hall plus one in the common lounge).</p> <p>Interview on 01/22/25 at 5:12 P.M. with LPN #807 indicated she had worked most days from 01/19/25 to 01/22/25 and the facility started getting cold 01/20/25 or 01/21/25.</p> <p>Observations on 01/22/25 at 5:15 P.M. revealed three mobile air and power rental units on the third floor (one on the end of each hall plus one in the common lounge).</p> <p>Interview on 01/22/25 at 5:26 P.M. with Mobile Administrator #803 confirmed the second floor did not meet the required ambient temperatures within the range of 71 to 81 degrees Fahrenheit. Mobile Administrator #803 indicated he would move one of the mobile heaters from the third floor to the second floor to increase the ambient temperature of the second floor.</p> <p>Review of the Floor Plan Master Audit Sheet dated 01/21/25 at 11:00 A.M. of the second and third floor temperatures revealed the facility Residents #3 and #4's room temperature was 65 degrees Fahrenheit; Residents #8 and #9's room was 69 degrees Fahrenheit; Resident #20's room temperature was 66 degrees Fahrenheit; Residents #27 and #28's room temperature was 68 degrees Fahrenheit; Resident #33's room temperature was 67 degrees Fahrenheit; Resident #43's room temperature was 67 degrees Fahrenheit; Resident #47's room temperature was 68 degrees Fahrenheit; Resident #57's room temperature was 69 degrees Fahrenheit; Resident #66's room temperature was 69 degrees Fahrenheit; and Resident #69's room was 68 degrees Fahrenheit.</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 - Some</p>	<p>Review of the Floor Plan Master Audit Sheet dated 01/21/25 at 3:30 P.M. of the second and third floors revealed Residents #3 and #4's room temperature was 64 degrees Fahrenheit; Residents #8 and #9's room temperature was 64 degrees Fahrenheit; Resident #14's room temperature was 65 degrees Fahrenheit; Residents #18 and #19's room temperature was 64 degrees Fahrenheit; Residents #23 and #24's room temperature was 64 degrees Fahrenheit; Residents #31 and #32's room temperature was 67 degrees Fahrenheit; Resident #38's room temperature was 68 degrees Fahrenheit; Resident #43 and #44's room temperature was 65 degrees Fahrenheit; Resident #46's room temperature was 68 degrees Fahrenheit; Resident #50's room temperature was 69 degrees Fahrenheit; Resident #61's room temperature was 69 degrees Fahrenheit; Resident #65's room temperature was 68 degrees Fahrenheit; Resident #68's room was 69 degrees Fahrenheit; and Resident #70's room temperature was 66 degrees Fahrenheit.</p> <p>Review of the Floor Plan Master Audit Sheet dated 01/21/25 at 9:15 P.M. of the second and third floors revealed Residents #1 and #2's room temperature was 65 degrees Fahrenheit; Residents #6 and #7's room temperature was 66 degrees Fahrenheit; Residents #12 and #13's resident room was 64 degrees Fahrenheit; Residents #15 and #16's room temperature was 64 degrees Fahrenheit; Resident #17's room temperature was 65 degrees Fahrenheit; Resident #20's resident room temperature was 64 degrees Fahrenheit; Residents #23 and #24's room temperature was 63 degrees Fahrenheit; Residents #29 and #30's room temperature was 66 degrees Fahrenheit; Residents #34 and #35's room temperature was 67 degrees Fahrenheit; Resident #38's room temperature was 64 degrees Fahrenheit; Resident #43's room temperature was 64 degrees Fahrenheit; Residents #35's room temperature was 67 degrees Fahrenheit; Resident #47's room temperature was 68 degrees Fahrenheit; Resident #52's room temperature was 68 degrees Fahrenheit; Resident #53's room temperature was 67 degrees Fahrenheit; Resident #55's room temperature was 68 degrees Fahrenheit; Resident #59's room temperature was 65 degrees Fahrenheit; Resident #61's room temperature was 67 degrees Fahrenheit; Resident #63's room temperature was 65 degrees Fahrenheit; Resident #65's room temperature was 65 degrees Fahrenheit; Resident #68's room temperature was 66 degrees Fahrenheit; and Resident #69's room temperature was 63 degrees Fahrenheit.</p> <p>Review of the Floor Plan Master Audit Sheet dated 01/22/25 at 7:15 A.M. of the second and third floors revealed Residents #1 and #2's room temperature was 64 degrees Fahrenheit; Residents #3 and #4's room temperature was 66 degrees Fahrenheit; Residents #10 and #11's room temperature was 63 degrees Fahrenheit; Residents #12 and #13's room temperature was 67 degrees Fahrenheit; Residents #18 and #19's room temperature was 68 degrees Fahrenheit; Residents #23 and #24's room temperature was 64 degrees Fahrenheit; Residents #27 and #28's room temperature was 69 degrees Fahrenheit; Residents #31 and #32's room temperature was 67 degrees Fahrenheit; Residents #34 and #35's room temperature was 66 degrees Fahrenheit; Residents #39 and #40's room temperature was 68 degrees Fahrenheit; Residents #44 and #45's room temperature was 68 degrees Fahrenheit; Resident #47's room temperature was 66 degrees Fahrenheit; Resident #50's room temperature was 63 degrees Fahrenheit; Resident #55's room temperature was 62 degrees Fahrenheit; Resident #58's room temperature was 62 degrees Fahrenheit; Resident #62's room temperature was 62 degrees Fahrenheit; Resident #67's room temperature was 64 degrees Fahrenheit; and Resident #69's room temperature was 64 degrees Fahrenheit.</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 - Some</p>	<p>Review of the Floor Plan Master Audit Sheet dated 01/22/25 at 2:15 P.M. of the second and third floors revealed Residents #1 and #2's room temperature was 68 degrees Fahrenheit; Resident #5's room temperature was 65 degrees Fahrenheit; Residents #6 and #7's room temperature was 68 degrees Fahrenheit; Residents #8 and #9's room temperature was 66 degrees Fahrenheit; Residents #10 and #11's room temperature was 68 degrees Fahrenheit; Residents #12 and #3's room temperature was 65 degrees Fahrenheit; Resident #14's room temperature was 67 degrees Fahrenheit; Residents #15 and #16's room temperature was 65 degrees Fahrenheit; Resident #17's room temperature was 67 degrees Fahrenheit; Residents #23 and #24's room temperature was 65 degrees Fahrenheit; Residents #25 and #26's room temperature was 65 degrees Fahrenheit; Residents #27 and #28's room temperature was 64 degrees Fahrenheit; Residents #31 and #32's room temperature was 65 degrees Fahrenheit; Resident #33's room temperature was 62 degrees Fahrenheit; Residents #34 and #35's room temperature was 62 degrees Fahrenheit; Residents #36 and #37's room temperature was 62 degrees Fahrenheit; Residents #38's room temperature was 62 degrees Fahrenheit; Residents #39 and #40's room temperature was 62 degrees Fahrenheit; Resident #43 and #44's room temperature was 60 degrees Fahrenheit; Resident #50's resident room temperature was 68 degrees Fahrenheit; Resident #51's room temperature was 68 degrees Fahrenheit; Resident #53's room temperature was 67 degrees Fahrenheit, Resident #54's room temperature was 68 degrees Fahrenheit; Resident #56's room temperature was 68 degrees Fahrenheit; Resident #57's room temperature was 68 degrees Fahrenheit; Resident #58's room temperature was 66 degrees Fahrenheit; Resident #62's resident room temperature was 67 degrees Fahrenheit; Resident #63's room temperature was 68 degrees Fahrenheit; Resident #65's room temperature was 66 degrees Fahrenheit; Resident #67's room temperature was 68 degrees Fahrenheit; Resident #69's room temperature was 67 degrees Fahrenheit; and Resident #70's room temperature was 64 degrees Fahrenheit.</p> <p>Review of the undated facility Extreme Weather Heat or Cold policy revealed to monitor and obtain updates on weather conditions; contact the utility company for restoration of power and/or vendors for needed equipment such as heaters and coolers; monitor the situation in coordination with local response authorities; communicate with local emergency management and state survey agency regarding nursing home situation status, critical issues and resource requests; inform staff, residents and families/representatives of the situation and provides updates as needed, assess residents frequently for changes in condition; identify residents who may require a transfer; ensure continuation of resident care and essential services; distribute appropriate comfort equipment throughout the nursing home such as fans or blankets as needed, complete repairs and restoration activities.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161830.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review and interview, the facility failed to ensure Resident #74 was free from physical abuse. This finding affected one (Resident #74) of four residents reviewed for abuse.</p> <p>Findings Include:</p> <p>Review of Resident #701's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including schizoaffective disorder, diabetes and vascular dementia.</p> <p>Review of Resident #701's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.</p> <p>Review of Resident #701's progress note dated 01/04/25 at 9:30 A.M. (recorded as a late entry on 01/05/25 at 2:45 A.M.) authored by Licensed Practical Nurse (LPN) #814 revealed the writer was informed of resident involvement in a physical altercation with Resident #74. The resident was removed from the room and placed in staff view. An assessment was completed with no injuries noted to Resident #701. Upon an interview of Resident #701, she stated she informed Resident #141 of Resident #74 taking her belongings. The two then went to Resident #74's room to confront him and started a physical altercation with the resident. No new orders were obtained, and the emergency contacts were notified.</p> <p>Review of Resident #701's progress note dated 01/04/25 at 9:30 P.M. (recorded as a late entry on 01/05/25 at 3:04 A.M.) authored by LPN #814 revealed the writer was informed of resident involvement in a physical altercation with Resident #74. The resident was removed from the room and placed in staff view. An assessment was completed with no injuries noted to Resident #701. Upon interview of Resident #701, she stated she informed Resident #141 of Resident #701 taking her belongings. The two then went to Resident #74's room to confront him and started a physical altercation with the resident. No new orders were obtained, and the emergency contacts were notified.</p> <p>Review of Resident #701's progress note dated 01/05/25 at 4:05 A.M. authored by LPN #815 indicated Resident #701 along with another resident (Resident #141) initiated a physical altercation with a third resident (Resident #74). Resident #701 did not sustain any injuries from the altercation and an attempt was made to contact the next of kin.</p> <p>Review of Resident #701's progress note dated 01/06/25 at 11:31 A.M. authored by Social Services (SS) #816 revealed the resident had a history of making false allegations. In particular, she targeted another male resident (Resident #74) and accused him of entering her room and taking some money. She was unsure how much. Staff monitors this resident and her room closely. No one was observed entering her room and staff also stated that she had no money. The resident was very delusional, paranoid and psychotic. Will continue to monitor.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #701's progress note dated 01/06/25 at 5:40 P.M. authored by LPN #817 indicated staff had been observing the resident on the unit. Resident #701 went into Resident #74's room yelling and screaming at him. The unit manager and staff followed the resident. Resident #701 went into Resident #74's room with an ink pen and stabbed him in the left and right arm. Both residents were immediately separated, and the family were made aware of the event. The resident continued to use inappropriate words threatening to kill Resident #74. The resident was sent to the emergency room . Resident #701 did not return to the facility.</p> <p>Review of Resident #141's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] to home with diagnoses including diabetes, essential hypertension and cellulitis of the lower right limb.</p> <p>Review of Resident #141's Admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of Resident #74's medical record revealed the resident was admitted on [DATE] with diagnoses including schizophrenia, difficulty in walking and muscle weakness.</p> <p>Review of Resident #74's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of Resident #74's Physical Abuse Self-Reported Incident (SRI) Form Tracking #255777 dated 01/05/25 revealed on 01/04/25 at approximately 10:00 P.M., Resident #141 and Resident #701 entered Resident #74's room accusing him of stealing from Resident #701. The confrontation resulted in both Resident #141 and Resident #701 striking Resident #74. Staff immediately separated the residents. Resident #141 had been referred for further psychiatric evaluation and would remain on one to one until further notice while in the facility. The unit nurse completed skin and pain assessments on all residents. Resident #74 was noted to have sustained multiple scratches, red eyes, and a bloody mouth. Resident #74 was refusing further medication evaluation and treatment and would continue to be monitored for any change in condition. Resident #74 would be moved to another floor to ensure continued safety. The SRI conclusion revealed the allegation was unsubstantiated as the evidence was inconclusive. Abuse, neglect or misappropriation was suspected.</p> <p>Review of Resident #74's Observation Detail List Report form (skin assessment) dated 1/04/25 at 11:38 P.M. revealed two 15 cm (centimeter) scratches on the left side of the back with several small scratches on the face and blood shot red eyes.</p> <p>Review of Resident #74's Physical Abuse SRI Form Tracking Number #255828 dated 01/06/25 revealed a resident-to-resident altercation took place. On 01/06/25 at approximately 5:30 P.M., Resident #701 entered Resident #74's room without permission and accused him of taking her belongings. As Resident #701 approached Resident #74, she began poking him in both the right and left arm with a pen which resulted in a break of the resident's skin. Resident #701 was pink slipped to the hospital for a psychiatric evaluation and Resident #74 was sent to the hospital for further medical evaluation and treatment. The resident returned the same day after evaluation and a tetanus shot. The conclusion revealed the allegation was substantiated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #74's hospital After Visit Summary form dated 01/06/25 revealed the resident had a left penetrating forearm wound and a superficial injury of the right forearm. The medications administered included a tetanus booster vaccine.</p> <p>Review of Resident #74's Observation Detail List Report form (skin assessment) dated 01/07/25 at 3:17 P.M. revealed the resident had scratches on his back and bilateral arms.</p> <p>Interview on 01/30/25 at 11:51 A.M. with Security Director #810 indicated he was called up to the floor on 01/06/25 when Resident #701 had accused Resident #74 of stealing something and she stabbed him with a fork.</p> <p>Interview on 01/30/25 at 11:59 A.M. with Resident #74 revealed Resident #701 came in his room and hit him with a pen in his arms. He stated he had one drop of blood in his left arm, and he went to the hospital. He did not report any other concerns.</p> <p>Interview on 01/30/25 at 1:36 P.M. with Registered Nurse (RN) Unit Manager (UM) #818 indicated she was coming down the hall and heard a resident say no to Resident #701. She stated she walked into Resident #74's room and observed Resident #701 stab him with a pen.</p> <p>Telephone interview on 01/30/25 at 1:42 P.M. with LPN #814 with RN UM #818 in attendance revealed Resident #701 had jumped onto Resident #74's back while Resident #141 was in front of the resident during the altercation which occurred on 01/04/25. She stated the residents were separated. LPN #814 stated she did not know why she documented the same altercation between Residents #74, #141 and #701 on 01/04/25 at 9:30 A.M. and 9:30 P.M. but confirmed the actual events occurred on 01/04/25 at 9:30 P.M.</p> <p>Telephone interview on 01/31/25 at 1:51 P.M. with LPN #817 with RN UM #818 in attendance revealed on 01/06/25 at 5:11 P.M., Resident #74 walked down to his room and stayed there. LPN #817 stated she heard shouting and RN UM #818 as well as the CNA were in the resident's room. She confirmed that Resident #701 had stabbed Resident #74 in the right and left arm with a pen and Resident #701 was walked back to the common area to be monitored. Resident #74 was sent to the hospital.</p> <p>Interview on 01/30/25 at 2:03 P.M. with SS #816 indicated Resident #701 had a large psychiatric history and targeted males. He also stated on the 01/04/25 incident involving Residents #74, #141 and #701, Resident #74 was the aggressor when Residents #141 and #701 went into the resident's room.</p> <p>Interview on 01/30/25 at 2:09 P.M. with the Administrator and SS #816 indicated the facility investigated the allegation of abuse on 01/04/25 between Residents #701, #141 and #74 and Resident #701 definitely did not jump on Resident #74's back at any point. The Administrator stated they felt the allegation was unsubstantiated because Residents #701 and #141 went into Resident #74's room but Resident #74 was the person who started the altercation with the other two residents. The Administrator confirmed the second abuse allegation on 01/06/25 between Residents #74 and #701 was substantiated.</p> <p>A second telephone interview on 01/30/25 at 2:14 P.M. with LPN #814 with the Administrator and SS #816 in attendance revealed she had heard that Resident #701 jumped on Resident #74's back but she had not witnessed the event.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Telephone interview on 01/30/25 at 2:15 P.M. with Certified Nursing Assistant (CNA) #819 revealed he was coming up the stairs and had observed Resident #74 fending off Resident #141 and Resident #701. He stated Resident #141 was in front of Resident #74 and Resident #701 was behind the resident scratching at the resident's back. CNA #819 indicated Resident #74 was bleeding from his face with blood on the wall and on the floor and blood appeared on his face near his mouth and right eye. CNA #819 revealed both Residents #141 and #701 were attacking Resident #74 when he entered the room.</p> <p>Review of the Ohio Resident Abuse Policy revised 07/11/24 revealed the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone.</p> <p>The deficient practice was corrected on 01/24/25 when the facility implemented the following corrective actions:</p> <p>Resident #74 was sent to the hospital for evaluation on 01/06/25 and received a tetanus vaccine. The resident returned to the facility and was moved to a different floor.</p> <p>Resident #701 was sent to the hospital for a psychiatric evaluation and did not return to the facility.</p> <p>Resident #141 was put on a one-to-one supervision from 01/04/25 until discharge to home on 01/30/25.</p> <p>From 01/06/25 to current, SS #816 began behavior huddles with the nursing staff including the nurse and CNA for all residents with any type of report behaviors. The huddles discuss a plan of action to make sure resident behaviors do not escalate and de-escalation techniques to ensure the plan succeeds.</p> <p>The Abuse, Neglect and Misappropriation policy was reviewed by the Administrator on 01/07/25.</p> <p>On 01/07/25 through 01/09/25, Mobile Administrator #803 educated 11 staff members on abuse and behavior management with quizzes following the education including LPNs #806, #807, #814, #884, #964; CNAs #702, #863, #875; Security #846; Environmental Services #843, #848, #874, #970; and Maintenance #878, #919.</p> <p>On 01/08/25, the Administrator conducted an inservice on Abuse Education and Resident to Resident Altercations. The Inservice Sign-Off Sheet revealed LPNs #708, #814, #820, #825, #891, #895, #917, #964, #968; CNAs #827, #833, #838, #839, #841, #844, #847, #853, #863, #864, #872, #875, #883, #902, #908, #931, #933, #940, #946, #956, #962; Food #821, #876, #885, #958, #971, #974; Environmental Staff Members #843, #879, #924, #959, #970; Security Staff Members #845, #846, #871, #912; RN UM #813; SS #869; Maintenance #919; Administration Staff Members #920, #941; SS #816; RN Assistant Director of Nursing (ADON) #805; Clinical Support #942; Receptionist #954; and RN MDS #963 received the inservice.</p> <p>On 01/08/25, the Administrator emailed education to all staff members regarding abuse, neglect and behavior management. The Administrator revealed this was for all staff members, including those who did not make it to the education sessions in person.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER University Manor Health & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/10/25, a Quality Assurance and Performance Improvement (QAPI) meeting was held with RN MDS #963; Administration #941 (admissions); Environmental Services Director #959; Clinical Support #942 (central supply and medial records); RN ADON #805; the Director of Nursing (DON); SS #816; and the Administrator on abuse, neglect and behavior management.</p> <p>On 01/16/25, Mobile Administrator #803 educated 13 staff members on abuse and behavior management with quizzes following the education including RN MDS #965; CNAs #828, #832, #833, #840, #875, #904, #906, #933, #940; Food #957; Administration #920; Social Services Designee #869 (prior); and Environment #843, #959.</p> <p>On 01/24/25, Mobile Administrator #803 and the DON educated 15 staff members on abuse and behavior management with quizzes following the education including Security #892; CNAs #706, #707, #808, #841, #857, #952; Life Enrichment #850; RN UMs #813, #818; Administration #941; RN MDS #963; Office Support #954; LPN #820; and Clinical Support #942.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161562.</p>		