

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cityview Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6606 Carnegie Ave Cleveland, OH 44103	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, medical record review, facility policy review and interviews, the facility failed to ensure a safe environment free from a potential accident hazard when smoking materials were not secured to prevent unsafe smoking in resident rooms. This resulted in Immediate Jeopardy and the potential for serious harm, injury and/or death on [DATE] at 1:03 P.M. when Resident #38, who was assessed to require staff supervision and the use of a smoking apron (device worn to protect from burns caused by hot ashes or lit cigarettes) was observed alone in his room with a strong cigarette odor and visible cigarette smoke in the air. Certified Nursing Assistant (CNA) #300 verified the odor and presence of smoke in Resident #38's room and further stated Resident #37, who was Resident #38's roommate and away from the facility at the time of the observation, had been seen previously smoking in the room. Additionally, Resident #37 and Resident #38's bathroom had cigarette ashes on the floor, burn marks on the toilet seat and toilet paper holder and two cigarette butts were found in the plastic trash can located next to Resident #38's bed. Resident #37 and Resident #38 resided in a room located across the hall from Resident #32, who was identified to utilize oxygen. This affected two residents (#37 and #38) of seven residents reviewed for smoking with the potential to affect all residents residing in the facility. The facility census was 101.</p> <p>On [DATE] at 1:08 P.M., the Administrator, Regional Registered Nurse (RRN) #333 and Regional Director of Operations (RDO) #334 were notified Immediate Jeopardy began on [DATE] at 1:03 P.M. when a strong cigarette odor and visible smoke was observed in Resident #37 and Resident #38's room. Additionally, there were cigarette ashes on the bathroom floor, burn marks on the toilet seat and toilet paper holder and two cigarette butts located in the plastic trash can next to Resident #38's bed. While Resident #37 was away from the facility at the time of the observation, Resident #38 was in the room and identified to be a smoker who required supervision and the use of a smoking apron while smoking.</p> <p>The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions:</p> <p>On [DATE] at 3:00 P.M., the Interdisciplinary Team (IDT), including Housekeeping Manager (HM) #283, Medical Records Coordinator (MRC) #322, Activities Director (AD) #202, Maintenance Director (MD) #271, the Administrator, Human Resources (HR) #262, Scheduler #261, Licensed Social Worker (LSW) #301, Social Services Designee (SSD) #260, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #273, Unit Manager Registered Nurse (UM/RN) #256 and UM/RN #302, conducted room sweeps on all resident rooms for the presence of smoking materials.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 3:15 P.M., UM/RN #302 searched Resident #37's room and any smoking materials identified were secured.</p> <p>On [DATE] at 3:15 P.M., the DON searched Resident #38's room and person and any smoking material identified were secured.</p> <p>On [DATE] at 3:25 P.M., the DON assessed Resident #32, Resident #37 and Resident #38 for injuries, with no adverse effects noted.</p> <p>On [DATE], at 5:00 P.M., the Administrator re-educated all staff on the facility smoking policy and procedure related to supervision of residents who smoke. The education was provided electronically via On-Shift software messaging and texting to staff. The education was completed by all staff by 6:00 P.M.</p> <p>On [DATE], at 5:00 P.M., LSW #301 re-educated all 64 residents who smoke (#2, #3, #4, #5, #6, #8, #10, #12, #15, #18, #19, #20, #21, #22, #24, #26, #27, #28, #29, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #47, #48, #51, #52, #60, #61, #62, #63, #64, #65, #67, #70, #71, #72, #73, #74, #77, #79, #80, #81, #82, #83, #84, #86, #88, #90, #91, #92, #93, #96, #97, #98, #99, #100 and #101) on the smoking policy, which included residents smoking only in designated areas, securing smoking materials and other applicable policies. Failure to follow the facility smoking policy would result in a discharge notice.</p> <p>On [DATE] at approximately 5:00 P.M., a root cause analysis was performed by the Administrator, the DON, ADON #273, HM #283, MRC #322, AD #202, MD #271, HR #262, Scheduler #261, LSW #301 and SSD #260. It was determined residents who had left the facility for appointments or other leave of absences (LOA) may have purchased and brought back smoking materials without staff knowledge and policies and procedures for securing smoking materials had not been adhered to.</p> <p>On [DATE] by 5:00 P.M., the IDT, including RRN #333, the DON, ADON #273, UM/RN #302 and UM/RN #256 completed an audit of the smoking assessments for all 64 residents who smoke to ensure accuracy and updated care plans as needed.</p> <p>On [DATE] by 5:00 P.M., the DON, ADON #273, UM/RN #256 and UM/RN #302 completed a skin assessment on all residents who smoke.</p> <p>On [DATE] at 5:00 P.M., the Administrator provided all staff two questionnaires to ensure education from [DATE] was effective.</p> <p>On [DATE] at 7:00 P.M., the Administrator updated the procedure for securing smoking materials when a resident leaves and returns to the facility, to include signing out smoking materials and signing them back in. The Administrator educated all staff and residents on the procedure. Staff would contact the Administrator or designee if smoking materials were not returned.</p> <p>Beginning on [DATE], the Administrator or designee would audit smoking material sign out/sign in sheets one time daily to ensure smoking materials were returned.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Beginning on [DATE], the Administrator or designee would complete room audits on all residents who smoke, and throughout the facility, two times per day for eight weeks to ensure residents have no smoking materials in their rooms and were adhering to the facility's smoking policy.</p> <p>On [DATE], an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held to review the root cause analysis and corrective action plan. Those in attendance included the Administrator, the DON and Medical Director (MD) #355.</p> <p>Review of five (#6, #15, #71, #80 and #98) additional open resident records revealed no concerns.</p> <p>Interviews on [DATE] from 7:37 A.M. through 2:09 P.M. with Dietary Aide (DA) #226, DA #285, CNA #203, CNA #211, CNA #328, CNA #329, CNA #357, Licensed Practical Nurse (LPN) #241, LPN #257, LPN #318, Activities Assistant (AA) #236, Housekeeping #321 and Receptionist #279 confirmed the facility provided education on the smoking policies and procedures, including signing smoking materials in and out.</p> <p>Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of Resident #37's medical record revealed an admitted [DATE] with diagnoses including nicotine dependence, end stage renal disease and muscle weakness.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #37 had impaired cognition.</p> <p>Review of the care plan dated [DATE] revealed Resident #37 was a smoker. Interventions included assess resident for smoking safety, educate resident on where smoking may occur, not giving or trading cigarettes with other residents, encourage safe smoking practices at all times, explain the consequences for smoking including removal of all smoking materials and only being allowed to smoke when supervised, provide a copy of the facility safe-smoking policy and explain so resident is aware of all obligations and consequences of violating the rules, smoking may not occur in residents rooms, bathrooms, hallways or other non-designated areas.</p> <p>Review of the Smoking Assessment, dated [DATE], revealed Resident #37 was assessed by the facility to require supervision while smoking.</p> <p>Review of a Last Chance Agreement, dated [DATE], revealed Resident #37 had agreed to not smoke without proper supervision.</p> <p>Review of Resident #38's medical record revealed an admitted [DATE] with diagnoses including nicotine dependence, bilateral amputations, muscles weakness and muscle weakness.</p> <p>Review of the MDS assessment, dated [DATE], revealed Resident #38 had intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the care plan dated [DATE] revealed Resident #38 was a smoker. Interventions included monitor for compliance with smoking policy, smoking apron and supervision while smoking.</p> <p>Review of the Smoking Assessment, dated [DATE], revealed Resident #38 was assessed by the facility to require a smoking apron and supervision while smoking.</p> <p>Observation on [DATE] at 1:03 P.M. revealed a strong odor of cigarette smoke outside of Resident #37 and Resident #38's room. Further observation of the residents' room confirmed the presence of cigarette smoke odor and further revealed visible smoke in the air. Concurrent interview with Certified Nursing Assistant (CNA) #300 verified the odor and presence of smoke in the residents' room. CNA #300 stated Resident #37 had previously been observed smoking in the room (date(s) not provided). At the time of the observation, Resident #37 had been out of the facility for approximately one and one-half hours. Resident #38, who also smoked, was lying in bed with a blanket pulled up over his head. An attempted interview with Resident #38 at the time of the observation revealed the resident denied smoking in the room.</p> <p>At the time of the observation, UM/RN #302 entered the room and opened Resident #37 and Resident #38's bathroom door and revealed cigarette ashes on the floor and burn marks on the toilet seat and toilet paper holder. LSW #301 was also present and discovered two cigarette butts in the plastic trash can, which had some paper waste, located next to Resident #38's bed.</p> <p>An interview with UM/RN #302 at the time of the observation verified the findings and further confirmed Resident #38 was to be supervised by staff while smoking and required a smoking apron to prevent burns.</p> <p>A continuous observation at this time revealed Resident #32 resided in the room across the hall from Resident #37 and Resident #38 and had a sign posted outside of the room indicating the resident had oxygen in use. Interview with LSW #301 and UM/RN #302 verified Resident #32 was on oxygen and smoking was not permitted in the area.</p> <p>An interview on [DATE] at 3:48 P.M. with the Administrator revealed staff and residents had been educated on the facility process for signing out smoking materials and signing them back in upon re-entry to the facility. No additional information was provided to determine or support the facility had effective systems in place to ensure smoking materials were actually being signed out and then back in or to prevent residents from engaging in unsafe smoking practices and smoking in their rooms.</p> <p>Review of the facility policy titled Resident Smoking, revised [DATE], revealed smoking was only permitted in designated smoking areas, all resident smoking materials were to be kept locked at all times and non-compliance with the smoking policy could result in a thirty-day discharge notice.</p> <p>This was an incidental finding discovered during the complaint investigation.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>42733</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, resident and staff interview and review of Resident Council meeting minutes, the facility failed to ensure meals were served at an appropriate temperature and were palatable. This had the potential to affect all residents, except Resident #50 was what identified by the facility as receiving no food from the kitchen. The facility census was 101.</p> <p>Findings include:</p> <p>Observation on 11/12/24 at 12:35 P.M. of the lunch meal service with Licensed Practical Nurse (LPN) #241 revealed a lunch tray that contained of a plate of a red watery substance, a mixture of meat and beans and a bag of chips. LPN #241 stated she was unsure what the meal was and stated this is the slop they are often served. Further observation revealed a container of ice cream on the tray. LPN #241 removed the lid from the ice cream and revealed the ice cream was melted. LPN #241 verified the ice cream was melted and stated the residents often complained about the food and the small portions they received. Concurrent interview with Resident #71 and Resident #73 revealed the food was awful and the portions were not usually enough.</p> <p>Interview on 11/13/24 at 11:37 A.M. with Regional Dietary Manager (RDM) #336 revealed she observed the lunch meal served on 11/12/24 and stated she spoke with the Administrator about placing an order for bowls to serve those type of meals in to make them more appealing.</p> <p>Observation of a meal test tray on 11/14/24 revealed the test tray left the kitchen on a meal cart at 9:22 A.M. and the test tray was received at 9:43 A.M. Further observation, with Assistant Director of Nursing (ADON) #273, revealed the meal consisted of scrambled eggs, bacon, toast and grits. The food temperature was cold and lacked flavor. Concurrent interview with ADON #273 verified the findings.</p> <p>Review of Resident Council meeting minutes revealed food concerns were voiced in August 2024 related to meat being too hard and in September 2024 concerns were voiced related to food not being done.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158177.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>42733</p> <p>Based on observation and staff interview, the facility failed to ensure resident call lights were in working order and able to be reached by residents. This affected 14 residents (#41, #42, #43, #44, #63, #64, #80, #81, #83, #84, #89, #90, #91 and #92) of 14 residents observed for call lights. The facility census was 101.</p> <p>Findings include:</p> <p>Interview on 11/12/24 at 11:46 A.M. with Activities Aide (AA) #236 revealed she had observed short call light cords in some resident rooms. AA #236 stated she was unsure why the call light cords were shorter than others. Observation with AA #236 revealed call light cords, approximately two to three inches in length, were in Resident #89, Resident #90, Resident #91 and Resident #92's rooms. AA #236 verified the call light cords were not long enough to reach the residents if they were in bed. Continued observations with AA #236 revealed call lights were not functioning in Resident #80, Resident #81, Resident #83, Resident #84, Resident #89, Resident #90, Resident #91 and Resident #92's rooms and there was no evidence an alternative call light system had been implemented. AA #236 stated the call lights had not been functioning for quite a few weeks.</p> <p>Interview on 11/12/24 at 12:26 P.M. with Certified Nursing Assistant (CNA) #203 revealed she was aware of several non-functioning resident calls lights. Concurrent observation with CNA #203 verified Resident #41, Resident #42, Resident #43, Resident #44, Resident #63 and Resident #64 did not have a functioning call light and there was no evidence an alternative call light system had been implemented.</p> <p>Interview on 11/14/24 at 2:09 P.M. with Maintenance Director (MD) #271 revealed he became aware approximately two to three weeks prior that the call light system was no functioning properly. MD #271 stated he received an estimate for replacement of the system on 11/07/24 and further stated he received parts to begin repairs on 11/14/24. MD #271 stated he was unsure why some of the resident rooms had short call light cords and confirmed residents would not be able to reach the call lights if they were in bed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158177.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>42733</p> <p>Based on resident interview, observation and staff interview, the facility failed to ensure a clean and sanitary environment. This affected two residents (#39 and #46) of three residents reviewed for environment. The facility census was 101.</p> <p>Findings include:</p> <p>1. Interview on 11/12/24 at 8:59 A.M. with Resident #39 revealed there was water coming into his room from the ceiling and wall. The resident stated the leak had been going on for a few weeks. Resident #39 stated he he informed the Administrator and maintenance of the situation; however, it had not been fixed. Resident #39 stated staff placed towels and sheets down to soak up the water. Concurrent observation revealed a large puddle of water, with multiple sheets placed on the floor near the baseboard, in Resident #39's room. Additionally, Resident #39's sheets were odorous and had several brown and black stains. Resident #39 stated he could not recall the last time the sheets were changed.</p> <p>During the observation of Resident #39's room, Housekeeper (HSK) #321 entered and stated she had seen the water in the room for several weeks and was unaware of what was being done to fix the leak. HSK #321 stated Certified Nursing Assistants (CNA) were responsible for changing bed linens.</p> <p>Continuous observation with CNA #216 confirmed Resident #39's linens were odorous and had brown and black stains. CNA #216 stated he would change the sheets.</p> <p>Observation on 11/13/24 at 10:48 A.M. revealed Resident #39's room had wet towels and sheets on the floor and the bed sheets continued to have an odor and brown and black stains.</p> <p>Interview on 11/13/24 at 11:00 A.M. with CNA #254 verified Resident #39's bed linens were soiled and further stated they should have been changed following the previous observation of them being soiled.</p> <p>Interview on 11/14/24 at 2:09 P.M. with Maintenance Director (MD) #271 revealed he had been attempting to find the leak in Resident #39's room for about two to three weeks and just identified the source today.</p> <p>2. Observation on 11/12/24 at 12:15 P.M. revealed a strong, pungent odor of stool and urine outside of Resident #46's room. Further observation revealed Resident #46's toilet had a large amount of stool and dark colored urine inside the toilet and dried stool inside the toilet bowl and on the toilet seat.</p> <p>Coinciding interview with CNA #203 verified the findings and further stated she did not want to flush the toilet because she was unsure if the toilet would overflow. CNA #203 stated she would inform the nurse to call maintenance.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158177.</p>		