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 12/06/2024
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm 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 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, review of facility self-reported incidents (SRIs), policy review, and review of facility corrective action, the facility failed to ensure residents were free from resident-to-resident physical abuse. This affected five (#2, #20, #21, #22, and #23) of five residents reviewed for abuse. The facility census as 98. Findings Include: 1. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, dementia, and dysphagia. Review of the most recent comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was severely cognitively impaired and required extensive assistant for completing his activities of daily living (ADLs). 2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, dementia, and type two diabetes. Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed Resident #20 was severely cognitively impaired and required extensive assistance of one staff person for completing his ADLs. 3. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence, dementia, and gout. Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was severely cognitively impaired and required extensive assistance of one staff person for completing his ADLs. 4. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, cocaine abuse, and brief psychotic disorder. (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

Printed: 03/01/2025
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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365879	A. Building B. Wing	12/06/2024

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Cityview Healthcare and Rehabilitation	6606 Carnegie Ave Cleveland, OH 44103

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact and required the supervision of one staff person for completing his ADLs. 5. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, bipolar two disorder, and psychotic disorder. Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact and required the supervision of one staff person for completing her ADLs. Review of the SRI dated 11/15/24 and timed 11:41 A.M. revealed staff reported to the Administrator that Resident #2 kicked Resident #23 in the leg. The staff intervened and separated both residents. A nurse assessed Resident #23 with no injuries noted and the facility initiated every 15-minute checks for Resident #2 and Resident #23. There were no further incidents between Residents #2 and Resident #23. Review of the SRI dated 11/17/24 and timed 4:59 P.M. revealed staff reported to the Administrator that Resident #2 hit Resident #21 in the face because, according to Resident #2, Resident #21 had Resident #2's television remote in the drawer. Upon the approval of Resident #21 and his responsible party, Resident #21 was moved to a room down the hall away from Resident #2 to prevent any further incidents. Both residents were assessed after the incident with no negative findings. Review of the SRI dated 11/17/24 and timed 6:37 P.M. revealed facility staff informed the Administrator that Resident #2 hit Resident #20 in the head and made him fall to the floor. Staff immediately separated the residents and assisted Resident #20 up from the floor. Resident #20 was immediately assessed with no injuries noted. Resident #2 was immediately transferred to the secured behavior unit to increase behavior monitoring. Review of the SRI dated 11/18/24 and timed 1:23 P.M. revealed staff notified the Administrator that Resident #22 scratched Resident #2 in the face because Resident #2 was attempting to punch Resident #22. Resident #22 stated he scratched Resident #2 in the face while trying not to get hit and intended no harm from incident and simply was trying to engage in self defense. A nurse on the floor assessed Resident #2 and noted superficial scratches to the face. Resident #22 did not sustain any injuries as a result of the incident. Resident #2's primary care physician was contacted and ordered for Resident #2 to be sent to a local psychiatric hospital for evaluation. Interview with the Administrator on 12/06/24 at 1:11 P.M. verified Resident #2 kicked Resident #23 in the leg on 11/15/24, verified Resident #2 hit Resident #21 in the face on 11/17/24, verified Resident #2 hit Resident #20 in the head causing the resident to fall on 11/17/24, and verified Resident #22 scratched Resident #2's face while Resident #2 was attempting to hit Resident #22. The Administrator confirmed none of the residents involved in the incidents was significantly hurt and immediate interventions were implemented. Review of the policy titled, Abuse , Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/01/22, revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. As a result of the incident, the facility took the following actions to correct the deficient practice by 11/20/24: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/24 at 11:41 A.M. the facility initiated every 15-minute checks on both of the involved of the residents (#2 and #23). In addition, Resident #2's primary physician ordered a one time dose of the antipsychotic Haldol two (2) milligrams (mg) to be administered to control Resident #2's behaviors. The medication was noted to be successful in controlling Resident #2's behaviors. On 11/17/24 at 4:59 P.M. the facility asked, and Resident #21 agreed, to move his room down the hallway away from Resident #2 to avoid further confrontations. There were no additional incidents between Resident #2 and Resident #21. On 11/17/24 at 6:37 P.M. Resident #2 was moved to the facility's secure behavioral unit designed for close monitoring of aggressive behaviors. On 11/18/24 at 1:23 P.M. Resident #2's physician was contacted and ordered for Resident #2 to be sent to a local hospital for psychiatric evaluation and subsequent admission for inpatient psychiatric services. Resident #2 returned to the facility on [DATE] with multiple new medications and treatment orders. There have been no further incidents with Resident #2 since returning to the facility from the hospital. Resident #2, Resident #20, Resident #21, Resident #22, and Resident #23's responsible parties and guardians, as well as appropriate medical practitioners, were notified of each related incident involving the residents on 11/15/24, 11/17/24, and 11/18/24. Questionnaires of all residents residing in the facility were completed regarding feelings of safety and any concerns related to abuse, neglect, and misappropriation by 11/20/24. There were no negative findings discovered from resident questionnaires. An all staff in-service was completed on 11/17/24 regarding the facility's abuse, neglect, and misappropriation policy and procedure. All staff who were unable to complete the in-service when it was scheduled were educated prior to working their next shift at the facility. All facility staff completed the in-service by 11/20/24. The facility created an SRI/Risk Investigation tool to use for all future SRIs. The tool required the facility to complete a root cause analysis on each incident and report such findings to the Quality Assurance and Performance Improvement (QAPI) committee to identify trends and deficiencies. The tool was put in place by 11/20/24 and was currently in use by the facility for its ongoing SRIs. This deficiency represents non-compliance investigated under Master Complaint Number OH00160296.