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	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cityview Healthcare and Rehabilitation	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on closed record review, facility policy review, and interview, the facility failed to report an incident of potential neglect involving Resident #93 to the State Agency as required. This affected one resident (#93) of nine residents reviewed for abuse and neglect. The facility census was 91. Findings include: Review of Resident #93's closed medical record revealed an original admitted [DATE] with diagnoses of schizoaffective disorder, bipolar, dementia, anxiety, antisocial personality disorder, hallucinations and body dysmorphic order, and right leg above the knee amputation. Resident #93 had elected to be a full code (requiring full resuscitation efforts including cardiopulmonary resuscitation in the event of cardiac or respiratory arrest). Resident #93 was transported to a local hospital where he was pronounced deceased on [DATE]. Review of Resident #93's care plan dated [DATE] revealed the resident had a self-care performance deficit for activities of daily living related to diagnoses of dementia, paranoid schizophrenia, and limited mobility. Listed interventions included for the resident to be supervised at all times while shaving. A care plan focus dated [DATE] revealed the resident had a mood problem related to paranoid schizophrenia, dementia with behaviors, history of self-harm, antisocial personality disorder, manic episodes, adjustment disorder, psychotic disorder, major depressive disorder, generalized anxiety disorder, and history of suicidal ideations. Interventions included administering medications as ordered and educating residents, family and caregivers regarding expectation of treatment, concerns with side effects, and potential adverse effects. An additional care plan focus dated [DATE] revealed Resident #93 had an identified traumatic event listed as suicide behavior and self-harm with a single listed trigger of being housed on the secured memory care unit. Listed interventions included allowing the resident to express feelings, develop strategies with the resident and/or family to avoid or decrease trauma triggers, discus coping mechanisms, gain as much additional background from family/friends and other healthcare professions as possible, monitor for anxiety, and refer to psych services as needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition with noted inattention and disorganized thinking. There were no additional behaviors identified. The assessment revealed the resident required (staff) supervision with showers and was independent with personal hygiene. The assessment also noted the resident received anticoagulant and antipsychotic medications. Review of a progress noted dated [DATE] at 5:00 P.M. authored by the DON revealed the note was created on [DATE] at 1:33 P.M. and included on [DATE] at approximately 3:10 P.M., the nurse was notified by the activity assistant that there was an emergency on the second floor. Upon arriving on the floor, Resident #93 was observed seated in a wheelchair with his back towards the door. The resident was pale, clammy cool to touch. There was a large amount of saliva coming from the resident's mouth and large among of blood on the floor. There were copious amounts of blood coming from the resident's groin area. A second nurse assessed the resident for a pulse and could not identify one. The resident was lowered to the floor and CPR was initiated. The second nurse applied pressure to the bleeding leg. EMS arrived and continued to work on the resident. Resident #93 was transported to the hospital. According to EMS, the resident had a pulse before leaving the facility. Review of the facility's investigation dated [DATE] revealed statements were obtained from staff members working that day. All staff interviewed reported no concern or indication that the resident was suicidal. There were no reported behaviors or statements that Resident #93 had wanted to harm himself. The facility completed a root cause analysis which concluded the cause of the incident was the Charge Nurse (LPN #500) provided Resident #93 with a sharp object. Interview on [DATE] at 10:40 A.M. with Licensed Practical Nurse (LPN) #500 revealed she was not assigned to care for Resident #93 on [DATE]. LPN #500 stated at approximately 2:40 P.M., Resident #93 asked her for a pair of scissors to cut his bangs (hair). LPN #500 stated initially she could not find her scissors and went searching for another pair. LPN #500 asked another nurse for a pair of scissors who did not have one. LPN #500 continued to look and found a pair of scissors in her bag and handed them to Resident #93. The scissors were described as safety scissors with a rounded blunted end. LPN #500 provided the scissors to Resident #93 due to her belief the resident was fairly independent with his activities of daily living and had no aggressive behaviors. LPN #500 verified she never looked at the resident's Kardex or care plan prior to giving the resident her scissors. In addition, the resident was not provided any level of supervision while having the scissors. Interview on [DATE] at 12:10 P.M. with the Administrator confirmed the incident with Resident #93's self-harm and suicide was not reported to the State Agency. The Administrator stated the incident was an accident and was not reportable. The Administrator did confirm, following the incident, he completed an investigation but stated he did not believe he needed to report the incident to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated ,d+[DATE] revealed it was the facility's policy to investigate all alleged violations involving abuse, neglect, and misappropriation of resident property, including injuries of unknown source. The policy defined an alleged violation as a situation or occurrence that was observed or reported but had not yet been investigated and, if verified, could be noncompliance with federal requirements. The policy defined an injury of unknown source as an injury which occurs when the source of the injury was not observed by any person, the source of the injury could not be explained by the resident, and the injury was suspicious because of the extent or location of the injury. The policy defined neglect as the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. This deficiency represents an incidental finding of non-compliance identified during the complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, closed medical record review, review of an Emergency Medical Service (EMS) report, review of medical examiner records, facility policy review and interviews with facility staff, Medical Director, Certified Nurse Practitioners (CNP) #332 and #334, the facility failed develop and implement comprehensive, individualized and effective interventions/treatment and services to meet the behavioral health care needs of Resident #93 and to assist the resident to attain/maintain his highest practicable mental and psychosocial well-being. This resulted in Immediate Jeopardy and actual harm/death on [DATE] when Resident #93, who had diagnoses including schizoaffective disorder, bipolar, dementia, anxiety, antisocial personality, hallucinations, body dysmorphic disorder and history of suicide attempt was found unresponsive in a communal shower room as a result of a self-inflicted injury with scissors provided to the resident by Licensed Practical Nurse (LPN) #500. Cardiopulmonary resuscitation efforts were initiated, and the resident was transported to the hospital where he was pronounced deceased . The resident's manner of death was listed as suicide. On [DATE] at 4:00 P.M. the Administrator, Director of Nursing (DON), and Regional Clinical Support Nurse #244 were notified Immediate Jeopardy began on [DATE] at approximately 2:40 P.M. when LPN #500 provided Resident #93, who had a significant psychiatric history, with a pair of scissors to cut his hair/bangs. On [DATE] at approximately 3:10 P.M., Certified Nursing Assistant (CNA) #214 found Resident #93 in the communal shower room slumped over in his wheelchair with shallow breathing. There was a large amount of blood on the floor and copious amounts of blood coming from the resident's leg and groin area. CNA #214 summoned assistance from nearby nurses who responded. Resuscitation efforts were initiated, EMS arrived and transported Resident #93 to a local hospital where he was pronounced deceased . The resident's manner of death was listed as suicide. The Immediate Jeopardy was removed on [DATE] and the deficiency corrected on [DATE] after the facility implemented the following corrective actions: On [DATE] at 3:10 P.M. Resident #93 was noted with acute blood loss, Emergency Medical Services (EMS) was notified, and Resident #93 was transported to a local emergency room (ER) by local EMS providers. On [DATE], at 3:55 P.M., LPN #500 was immediately provided 1:1 verbal education by the DON on not providing sharp objects to residents. On [DATE] at 3:55 P.M., LPN #500, was suspended by the Administrator following the incident, pending a thorough investigation. LPN #500 was permitted to return to work beginning on [DATE]. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the Director of Nursing (DON), ADON #270, Unit Manager #267, Housekeeping Supervisor #283, Human Resource Manager #262, Licensed Social Worker (LSW) #246, Central Supply #317 and Admissions Director #216 completed a whole house sweep for sharp objects at 4:00 P.M. with no sharp objects noted. On [DATE] by 4:30 P.M., all residents were assessed, and medical records were reviewed (including psychiatric/provider notes) to identify those residents who had self-harm and/or suicidal ideation history. In addition, those who could be, were interviewed, related to suicidal ideation/self-harm. Eleven residents (#100, #15, #16, #28, #33, #38, #40, #101, #57, #61, and #102) were identified as at risk for self-harming behaviors. Care plans and associated Kardex's were reviewed by Regional Clinical Support Nurse #244. On [DATE] by 5:00 P.M. all staff were interviewed regarding any knowledge of residents exhibiting any signs, symptoms, or behaviors which could be indicative of suicidal ideations. This was completed by the Administrator. On [DATE] by 5:00 P.M. Regional Clinical Support Nurse #244 educated all facility interdisciplinary team members (IDT) on updating care plans for resident(s) who have suicide ideations/self-harm and pulling them to the Kardex. On [DATE] by 5:00 P.M. all staff were educated by the DON/Designee on reviewing residents' Kardex, ensuring residents were free and safe from self-harm, and assisting and providing supervision to residents as deemed necessary. On [DATE] by 5:30 P.M. the Administrator completed a quality assessment and performance improvement (QAPI) and a root cause analysis with the Medical Director, DON, ADON #270, Regional Clinical Support Nurse #244, Medical Records #317, Human Resources Manager #262 and LSW# 246. The facility root cause analysis identified the nurse (LPN #500) gave Resident #93 a sharp object and should not have. The facility corrective action plan involved mitigating the risk and availability of sharp objects and identifying those residents at risk for self-harm or suicidal ideations. On [DATE] the DON/Designee began random, ongoing resident audits on care plans for residents with a history of suicidal ideations and/or self-harm. The ongoing audits were completed four times weekly for a total of six weeks, completed on [DATE]. On [DATE] the DON/Designee began random, ongoing audits of staff competencies regarding staff utilization of the resident Kardex's. The audit reviewed five random staff members four times weekly for a total of four weeks. On [DATE], at 9:30 A.M. the Administrator held a QAPI meeting with the DON, ADON, Medical Director, Activities Director #201, Medical Records Coordinator #317, Human Resource Manager #262, Regional Clinical Support Nurse #244 and LSW# 246 to discuss the findings of the facility audits as of this time. Findings include: (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the closed medical record for Resident #93's revealed an original admitted [DATE] with diagnosis of schizoaffective disorder, bipolar, dementia, anxiety, antisocial personality disorder, hallucinations and body dysmorphic order, and right leg above the knee amputation. Advance directives revealed the resident was a full code. Resident #93 was transported to a local hospital where he was pronounced deceased on [DATE]. Review of Resident #93's care plan dated [DATE] revealed the resident had a self-care performance deficit for activities of daily living related to diagnoses of dementia, paranoid schizophrenia, and limited mobility. Listed interventions included for the resident to be supervised at all times while shaving. A care plan focus dated [DATE] revealed the resident had a mood problem related to paranoid schizophrenia, dementia with behaviors, history of self-harm, antisocial personality disorder, manic episodes, adjustment disorder, psychotic disorder, major depressive disorder, generalized anxiety disorder, and history of suicidal ideations. Interventions included administering medications as ordered and educating residents, family and caregivers regarding expectation of treatment, concerns with side effects, and potential adverse effects. An additional care plan focus dated [DATE] revealed Resident #93 had an identified traumatic event listed as suicide behavior and self-harm with a single listed trigger of being housed on the secured memory care unit. Listed interventions included allowing the resident to express feelings, develop strategies with the resident and/or family to avoid or decrease trauma triggers, discus coping mechanisms, gain as much additional background from family/friends and other healthcare professions as possible, monitor for anxiety, and refer to psych services as needed. Review of Resident #93's primary care progress note dated [DATE] revealed the resident was seen by CNP #334 and was coherent and cooperative upon assessment. Resident #93 was noted to have significant mental illness and had noted delusions and a flat effect. The resident was noted to be unkept and was not well-groomed. Review of Resident #93's psychiatric progress note dated [DATE] revealed the resident was seen by psych CNP #332. The note indicated the resident had a history of 18 prior psychiatric hospitalization s, had chronic passive suicidal ideations, and one prior suicide attempt (date unknown) by throwing himself in front of a semi-truck. The note referenced in the review of systems, Resident #93 was positive for anxiety, had delusions that were evident, and had passive suicidal ideations. Resident #93's general appearance was described as evasive/distant. His mood was recorded as uncomfortable but ok and his affect blunted/flat. Resident #93 was noted to have poor concentration, disorganized thought processes, and delusional thought content. The resident was recorded as having grossly impaired insight and judgement and had self-defeating/endangering behavior without regard to the consequences. The note referenced Resident #93 had no current suicide ideation, intent, or current plan but had a history of chronic, passive suicidal ideations. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition with noted inattention and disorganized thinking. There were no additional behaviors identified. The assessment revealed the resident required (staff) supervision with showers and was independent with personal hygiene. The assessment also noted the resident received anticoagulant and antipsychotic medications. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the physician's orders for [DATE] revealed the resident had an order dated [DATE] for Lithium (an anti-manic, mood stabilizing medication) 600 milligrams (mg) by mouth twice daily, an order dated [DATE] for Eliquis 5mg by mouth twice daily, an order dated [DATE] for Olanzapine (an antipsychotic medication) 10 milligram (mg) daily in the morning, and an order dated [DATE] for Olanzapine 12.5 mg daily at bedtime. Review of an Emergency Medical System (EMS) patient care report dated [DATE] revealed a call was received/created at 3:17 P.M., dispatched at 3:25 P.M., arrived on the scene at 3:31 P.M., and EMS arrived at the patient (Resident #93) at 3:36 P.M. The incident summary indicated upon arrival, Resident #93 was located on the floor of his room. There was a copious amount (estimated between three and four liters) of blood on the floor which had already begun to coagulate (clot). The resident was pale, unresponsive, and breathing shallow. Nursing home staff reported they had done chest compressions but had detected a weak carotid pulse. The patient was noted to have a significant stab-like wound to his medial thigh on his left leg. The wound was wrapped (to control the bleeding) by the fire department. The nursing home staff reported they had no idea what happened but advised he had asked for a pair of scissors earlier for an unknown reason. The nursing home staff had come to check on him after not seeing him for some time and found him on his bathroom floor with blood everywhere and not responding. The nursing home staff's suspicion was that the resident self-inflicted the wound on his leg and went an unknown amount of time before being discovered in the bathroom. The local fire department and EMS providers noted they did not notice or locate any scissors present on the scene but noted their primary focus was on the condition of the patient. The report indicated the amount of blood lost was immediately noted as life-threatening and indicated that cardiac arrest from exsanguination was likely-to-imminent. What vitals could be obtained on the scene indicated the resident had a slow, weak pulse, poor respiratory effort, and non-discernable blood pressure. EMS did apply a tourniquet to the extremity as the amount of blood lost was indicative of an arterial wound. Once in the ambulance the initial assessment indicated that the patient no longer had a palpable pulse. CPR was initiated and his heart rhythm monitor indicated a slow rhythm. Resuscitation was attempted while enroute to the hospital. No pulse was ever recovered, and the resident was left in the care of emergency room (ER) staff who promptly terminated further efforts. Resident #93 was pronounced deceased at the local hospital. Review of a progress noted dated [DATE] at 5:00 P.M. authored by the DON revealed the note was created on [DATE] at 1:33 P.M. and included on [DATE] at approximately 3:10 P.M., the nurse was notified by the activity assistant that there was an emergency on the second floor. Upon arriving on the floor, Resident #93 was observed seated in a wheelchair with his back towards the door. The resident was pale, clammy cool to touch. There was a large amount of saliva coming from the resident's mouth and large among of blood on the floor. There were copious amounts of blood coming from the resident's groin area. A second nurse assessed the resident for a pulse and could not identify one. The resident was lowered to the floor and CPR was initiated. The second nurse applied pressure to the bleeding leg. EMS arrived and continued to work on the resident. Resident #93 was transported to the hospital. According to EMS, the resident had a pulse before leaving the facility. Review of local medical examiner office records revealed Resident #93's body was received at the local medical examiner's office on [DATE]. Resident #93's cause of death was recorded as sharp force trauma of the left leg with vascular and soft tissue injuries, complicated by Eliquis. The manner of death was suicide. The place of death was recorded as a local hospital. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's investigation dated [DATE] revealed statements were obtained from staff members working that day. All staff interviewed reported no concern or indication that the resident was suicidal. There were no reported behaviors or statements that Resident #93 had wanted to harm himself. The facility completed a root cause analysis which concluded the cause of the incident was the Charge Nurse (LPN #500) provided Resident #93 with a sharp object. Interview on [DATE] at 10:40 A.M. with Licensed Practical Nurse (LPN) #500 revealed she was not assigned to care for Resident #93 on [DATE]. LPN #500 stated at approximately 2:40 P.M., Resident #93 asked her for a pair of scissors to cut his bangs (hair). LPN #500 stated initially she could not find her scissors and went searching for another pair. LPN #500 asked another nurse for a pair of scissors who did not have one. LPN #500 continued to look and found a pair of scissors in her bag and handed them to Resident #93. The scissors were described as safety scissors with a rounded blunted end. LPN #500 provided the scissors to Resident #93 due to her belief the resident was fairly independent with his activities of daily living and had no aggressive behaviors. LPN #500 verified she never looked at the resident's Kardex or care plan prior to giving the resident her scissors. In addition, the resident was not provided any level of supervision while having the scissors. Interview on [DATE] at 11:40 A.M. with psychiatric CNP #332 revealed Resident #93 had a very flat affect with baseline depression. The CNP stated it was her belief the resident had no recent changes in his medication regimen and no change in behavior indicating he had wanted to self-harm. CNP #332 denied knowledge of the resident having any type of current delusions or self-injury but documented them to remind herself that residents do have these behaviors. Interview on [DATE] at 11:13 A.M. with LPN #281 revealed she was assigned to care for Resident #93 the day of the incident (on [DATE]). The LPN revealed CNA #214 approached the shower and noticed blood on the floor. CNA #214 immediately went to get the nurses. Upon entering the shower room, the resident was slumped over in his wheelchair and was moaning. LPN #281 stated they lowered the resident to the floor and started CPR. LPN #281stated she was not sure if the resident(s) were allowed to have sharp objects on the unsecured unit since it was a more liberal environment than the secured unit. LPN #281 stated following the incident with Resident #93 on [DATE], rooms were searched for sharp objects and education was provided for staff. Interview on [DATE] at 1:38 P.M. with CNA #214 revealed she worked second shift and was assigned to care for Resident #93 on [DATE]. CNA #214 stated she was doing a walk-through to see what residents were in their rooms, and noticed Resident #93 was not in his room. Resident #93's roommate told her someone was in the shower room bleeding. CNA #214 proceeded to the shower room, opened the door, and from the back saw Resident #93 slumped over in his wheelchair with blood on the floor and called for help. CNA #214 walked in front of the resident and called his name. Resident #93 was breathing, and he opened his eyes. CNA #214 summoned help from the nursing staff. Interview on [DATE] at 10:37 A.M. with Resident #50, who had been Resident #93's roommate, revealed (on [DATE]) he had opened the shower room door and saw Resident #93 seated back in his wheelchair with blood on the floor. He stated he quickly closed the door and went to his room and looked out the window and saw an ambulance. Resident #50 stated he was afraid to tell staff because he did not want to get blamed. Resident #50 stated he liked to shave his own face and body, he would get a razor from the supply area and shave in the shower or at the sink in the room which staff allowed. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 11:47 A.M. with LPN #330 revealed CNA #214 came out of the shower room and yelled that a resident was bleeding. LPN #330 and another nurse went into the shower room, observed the resident (#93) was unresponsive, and called a code. LPN #330 stated the nurse had a hard time finding the resident's pulse. EMS was called, arrived on scene, and continued resuscitative efforts. Resident #93 had a pulse when he left the unit. She stated it was very chaotic, and LPN #500 was crying. LPN #330 did not observe anyone else in the shower room upon entering the room. The LPN stated it was common that Resident #93 would occasionally ask for a razor to shave and scissors to cut his bangs. She stated it was unfortunate that the nurse given him the scissors. Record review revealed no safety assessment or care plan interventions were in place related to the resident's independent use of razors and/or scissors. Interview on [DATE] at 1:51 P.M. with Registered Nurse (RN) #276 revealed Resident #93 had periods of depression but stated not to the point of any concerns. RN #276 was aware of Resident #93's extensive psychiatric history. The RN revealed the resident had a right above-the-knee amputation and always wanted his legs to match. Prior to coming to the facility, he had jumped out of a moving car so his legs would match. RN #276 stated at the time of the incident on [DATE], there was a whole lot of blood on the floor, and she had applied pressure to the resident's leg. Resident #93 did not respond initially, but made an occasional grunting sound as the staff and EMS were providing resuscitative efforts. RN #276 stated EMS reported Resident #93 had a faint pulse at the time he left the unit. Interview on [DATE] at 2:38 P.M. with Resident #93's primary care CNP #334 revealed she saw the resident for a left lower extremity vascular issue that severely damaged circulation to his leg. The resident had lymphedema in the left leg, saw an outside vascular medicine provider, but would refuse therapy to treat the leg. CNP #334 reported Resident #93 was moody, quiet, had poor eye contact and could be very manipulative when he wanted something. CNP #334 stated she would not expect staff to provide sharp objects to residents. Interview on [DATE] at 3:53 P.M. with Medical Director (MD) #610 revealed Resident #93 was schizophrenic and was visited monthly. MD #610 revealed the resident had been at the facility for many years and was believed to be stable. MD #600 recalled the resident was withdrawn and did not communicate much information, which was a classic sign of schizophrenia. MD #600 was surprised about the incident (on [DATE]) and was unaware that a nurse provided Resident #93 with a pair of scissors. Interview on [DATE] at 3:33 P.M. with LPN #296 revealed a CNA called her into the shower room (on [DATE]) and Resident #93 was observed sitting in his wheelchair with his clothes on. On the floor around the resident was a large puddle of blood. LPN #296 called 911 to summon EMS. Resident #93 was unresponsive and at first staff could not locate a pulse, eventually locating a weak pulse. LPN #296 stated EMS arrived promptly. LPN #296 was surprised that LPN #500 had provided scissors to Resident #93. LPN #296 stated the resident could not handle shaving and would cut himself. Additionally, she noted Resident #93 would occasionally exhibit delusions and talk to walls. Interview on [DATE] at 9:30 A.M. with Regional Clinical Support Nurse #244 revealed the facility had no policy addressing suicidal behavior, residents at risk for self-harm, or sharp object safety. Telephone interview on [DATE] at 11:30 A.M. with the DON revealed on [DATE] she located the scissors involved in Resident #93's incident after the resident had left the facility. The DON reported the scissors were disposed of in the facility's sharps container. (continued on next page)

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	365879	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cityview Healthcare and Rehabilitation	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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated ,d+[DATE] revealed it was the facility's policy to investigate all alleged violations involving abuse, neglect, and misappropriation of resident property, including injuries of unknown source. The policy defined an alleged violation as a situation or occurrence that was observed or reported but had not yet been investigated and, if verified, could be noncompliance with federal requirements. The policy defined an injury of unknown source as an injury which occurs when the source of the injury was not observed by any person, the source of the injury could not be explained by the resident, and the injury was suspicious because of the extent or location of the injury. The policy defined neglect as the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. This deficiency represents an incidental finding of non-compliance identified during the complaint investigation.