

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  07/02/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review and review of the facility policy, the facility failed to ensure a clean sanitary environment for Resident's #12, #13, #32, #33, #37, #44, #53, #56, #70, #74, #84, #89 and #92 who resided on the third floor nursing unit and failed to ensure phone calls to the facility were answered timely. This had the potential to affect all residents residing in the facility. The facility census was 93.</p> <p>Findings include:</p> <p>1. Review of Resident #44's medical record revealed an admission date of 07/19/23 and diagnoses included traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, schizophrenia and unspecified dementia with other behavioral disturbance.</p> <p>Review of Resident #44's care plan dated 04/18/25 included Resident #44 had an ADL self-care performance deficit related to diagnoses. Resident #44 would maintain current level of function through the review date of 10/27/25. Interventions included Resident #44 was independent for toileting and Resident #44 required setup assistance with personal hygiene and oral care.</p> <p>Review of Resident #44's Quarterly MDS assessment dated [DATE] revealed Resident #44 was unable to complete the Brief Interview for Mental Status. Resident #44 required setup or clean-up assistance for oral hygiene and supervision or touching assistance for personal hygiene.</p> <p>Observation of the facility work orders open and in progress did not reveal a work order for a dripping ceiling, disconnected sink pipe, sink and counter partially pulled away from wall, paper towel and soap dispenser pulled off wall, no light bulb cover or bathroom door latch needing repaired in Resident #44's room</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365879
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 06/26/25 at 9:38 A.M. of Resident #44's room with Housekeeper #217 revealed Resident #44 resided on the secured third floor nursing unit (Connections Community) and there was a puddle of water on the floor. Closer observation revealed the ceiling was leaking and dripping what appeared to be water onto the floor and the sink drain was not connected to the drain pipe and when the water was turned on for the sink it drained from the sink into the pipe and onto the floor. Housekeeper #217 confirmed both the leaking ceiling and the disconnected pipe under the sink and stated he was usually assigned to clean the third floor nursing unit and for the last two to three months there was always water on the floor in this room. Further observation of Resident #44's room revealed the sink had a square counter surrounding it and both the sink and counter were leaning to the left and partially pulled away from the wall. There was no soap dispenser or paper towel holder on the wall by the sink and a damaged wall with a large area of chipped plaster could be seen where they used to be attached. There was a mirror above the sink and above the mirror two bare light bulbs could be seen and there was no cover on them. A thermostat on the wall did not have a cover. Housekeeper #217 stated the paper towel dispenser and soap dispenser were ripped off the wall two to three months ago by another resident and had not been repaired. Housekeeper #217 stated Resident #44 did not do the damage seen in the room. The door to the bathroom was ajar and Resident #44 asked Housekeeper #217 to shut the door and put the trash can in front of it. Resident #44 stated the door to the bathroom shared with a second resident room would not stay shut and a trash can had to be put in front of it to keep it closed. Resident #44 stated he was sick of this [expletive] and did not like the door to the bathroom continually swinging open.</p> <p>Observation on 06/26/25 at 9:49 A.M. of Resident #44's room with the Director of Nursing (DON) confirmed water was dripping onto the floor from the ceiling, the sink was not connected, the soap dispenser and paper towel holder were ripped off the wall and the wall was damaged with a large area of chipped plaster, the door to the bathroom would not stay shut, there was no thermostat cover and no cover over the light bulbs above the sink. The DON confirmed the sink and counter were partially ripped off the wall and leaning to the left. The DON did not know what the status was of all the broken things in the room.</p> <p>Interview on 06/26/25 at 9:54 A.M. of Environmental and Laundry Supervisor ([NAME]) #218 confirmed another resident with a wardrobe pushed the wardrobe against Resident #44's sink and caused it to be partially pulled away from the wall. [NAME] #218 indicated he did not put a work order in or tell Maintenance Supervisor (MS) #219 about Resident #44's damaged sink. [NAME] #218 stated he was not aware of the other broken and damaged things in Resident #44's room.</p> <p>Interview on 06/26/25 at 12:17 P.M. of MS #219 revealed work orders were placed in the electronic system and staff could always text him, or tell him in person if something needed fixed. MS #219 stated he had two maintenance assistants to help with the work load. MS #219 stated he was not told about the leaking ceiling and sink drain in Resident #44's room, he only found out about it today and a work order was put in today. MS #219 stated Resident #44's sink and counter was on a list to be replaced, and he was working his way down from the fourth floor. MS #219 indicated the paper towel and soap dispensers were replaced a few minutes ago. Observation of Resident #44's room with MS #219 confirmed the leaking ceiling and disconnected sink drain, the bare light bulbs above the sink, the thermostat without a cover, and the door to the bathroom that would not stay closed. MS #219 stated the bathroom door did not have a latch and he would make sure it was fixed, and the thermostat was not connected and he would make sure it was removed.</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 - Many</p>	<p>Observation on 06/26/25 at 1:00 P.M. of the secured third floor nursing unit (Connections Community) with Licensed Practical Nurse (LPN) #204 revealed widespread ceiling tiles stained light and dark brown in Resident's #12, #13, #32, #33, #37, #53, #70, #74, #84, #89 and #92 rooms. Resident #56's room had a broken light cover at the head of the bed.</p> <p>Review of Resident #84's medical record revealed an admission date of 03/31/21 and diagnoses included schizoaffective disorder bipolar type, catatonic disorder due to known physiological condition and major depressive disorder.</p> <p>Review of Resident #84's Annual MDS assessment dated [DATE] revealed Resident #84 had moderate cognitive impairment.</p> <p>Observation on 06/26/25 at 1:00 P.M. of Resident #84's room revealed the bathroom door was open to the shared bathroom with another room and a pungent urine odor was apparent. Resident #84 said the bathroom smelled and to please close the door. Observation of the bathroom revealed it was dirty and had urine stains on the floor and toilet. LPN #204 confirmed the bathroom was dirty, smelled and needed cleaned.</p> <p>2. Review of the local city Division of Fire Incident Report 2025-501332-000 dated 03/03/25 at 3:33 A.M. included a call was received and the arrival time to the facility was 3:37 A.M. On scene at the same time as EMS. There was a delay entering the building due to no one was at the front desk. Post entry, assisted EMS load an elderly male onto a cot and EMS to transport patient to the local hospital. The apparatus clear date and time was 03/03/25 at 3:57 A.M.</p> <p>On 06/30/25 at 5:22 A.M. a phone call was made to the facility. The phone rang 18 times without being answered. After 18 rings the phone rolled over to music for four minutes then back to ringing. The phone rang an additional 8 times and was answered by facility staff.</p> <p>On 07/02/25 at 6:36 A.M. a phone call was placed to the facility. The phone rang 28 times and was not answered by staff. The phone did not roll over to voicemail, but just kept ringing. Unable to talk to staff from facility.</p> <p>Interview on 06/26/25 at 3:32 P.M. of Registered Nurse (RN) #220 revealed she remembered on 03/03/25 Resident #95 called 911 because he did not want to be in the facility. Resident #95 placed himself on the floor after he called 911 because he wanted EMS to take him to the hospital. Resident #95 was on one-to-one observation and the aide who was watching him saw him put himself on the floor. RN #220 did not remember EMS being delayed getting into the facility or have any knowledge this happened.</p> <p>Interview on 07/02/25 at 8:35 A.M. of Nurse #221 revealed she worked night shift and there was no receptionist at the front desk to answer the phone. Nurse #221 revealed the phones rolled over to the second floor and she was not sure if they also rang on the third and fourth floor nursing units. When told the phone rang 28 times on 07/02/25 at 6:36 A.M. without being answered Nurse #221 stated it was busy last night and the nurses and aides could have been busy and unable to answer the phone when it rang. Nurse #221 indicated the residents needed to be monitored and they really needed to have a receptionist on night shift on the first floor to answer the phones and allow visitors into the facility. Nurse #221 stated she was sure she was busy with a dressing change at that time and was unable to answer the phone.</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 - Many</p>	<p>Interview on 07/02/25 at 8:41 A.M. of Registered Nurse (RN) #222 revealed she worked night shift and just left the facility. RN #222 thought the phone rang to all the floors when it rang, but sometimes staff was busy and unable to answer the phone. RN #222 stated last night was a busy night, the residents required close monitoring and the phone could not be answered.</p> <p>Interview on 07/02/25 at 9:06 A.M. of the Director of Nursing (DON) revealed after the receptionist left for the evening around 7:00 P.M. the phones should be forwarded to ring on all three nursing units. The DON stated the phone should be answered within three rings, but on night shift sometimes the staff was busy and unable to answer the phone. The DON indicated if the phone rang 28 times without being answered that was too long and not okay. The DON stated the phones should be answered in case of an emergency.</p> <p>Review of the facility policy titled Housekeeping included the purpose was to establish standards of cleanliness and consistency in the way in which rooms and common areas were cleaned and maintained. The facility would be cleaned on a regular basis according to Federal and State guidelines. The bathroom was to be clean and free of odors. Porcelain sinks were to be free of cracks, chips, stains. Towel, toilet paper and soap dispensers were to be checked daily and refilled, replaced as needed. The resident's room was to be free of odors. If nursing personnel noticed any sanitary violations occurring in resident rooms housekeeping and, or maintenance should be notified promptly.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165460 and OH00163250.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident's #19 and #43 received appropriate incontinence care timely. This affected two residents (Resident's #19 and #43) out of three residents reviewed for incontinence. The facility census was 93.</p> <p>Findings include:</p> <p>1. Review of Resident #43's medical record revealed an admission date of 04/17/12 and a readmission date of 01/06/15. Diagnoses included senile degeneration of the brain, Parkinson's Disease and paranoid schizophrenia.</p> <p>Review of Resident #43's care plan revised 10/07/24 revealed Resident #43 had bladder and bowel incontinence and was at risk for skin breakdown and urinary tract infections. Resident #43 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included staff would provide assistance with toileting and incontinence care as needed.</p> <p>Review of Resident #43's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #43 was unable to complete the Brief Interview for Mental Status. Resident #43 did not reject care during the seven-day assessment look-back period. Resident #43 was dependent for all ADL's (Activity of Daily Living's). Resident #43 was always incontinent of urine and bowel.</p> <p>Observation on 07/01/25 at 7:43 A.M. of Certified Nursing Assistant's (CNA)'s #223 and #224 revealed they were preparing to provide Resident #43's incontinence care. Observation revealed Resident #43 was wearing two incontinence briefs. The two briefs were soaked with dark yellow urine and a moderate amount of somewhat hard brown feces could be seen. CNA #223 stated it looked like Resident #43 had not been changed in awhile. CNA #224 did not have all the supplies she needed and left the room to gather the supplies leaving Resident #43 uncovered from the waist down while she was gone. CNA #223 did not pull the covers over Resident #43 while she waited for CNA #224 to return. CNA #223 stated Resident #43 should not be wearing two incontinence briefs and she never used two incontinence briefs when she was providing care. After a few minutes CNA #224 returned to the room and CNA's #223 and #224 continued Resident #43's incontinence care. Resident #43 cried out in pain when her buttocks were wiped and some redness could be seen on the bilateral inner buttocks. Assistant Director of Nursing (ADON) #225 entered the room and CNA #223 told her Resident #43 was having some pain and her feces were somewhat hard and ADON #225 stated she would check for the last bowel movement and if Resident #43 had anything ordered for constipation. After providing incontinence care CNA #224 placed Resident #43's soiled incontinence briefs in a plastic bag. Using the soiled gloves she used for incontinence care, CNA #224 picked up the clean incontinence brief and placed the clean brief on Resident #43. CNA #224 did not change her soiled gloves or use hand hygiene and covered Resident #43 with a sheet and blanket. CNA #224 confirmed she did not change her soiled gloves before putting a clean incontinence brief on Resident #43 and covering her with a sheet and blanket.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Incontinence Care updated 01/06/25 included the purpose was to maintain skin integrity, prevent skin breakdown, control odor and provide comfort and self-esteem for the residents. The policy was to be used on residents were were incontinent of bowel and bladder. When providing incontinence care cleanse the area with perineal wash or a mild cleanser, pat dry, remove gloves, perform hand hygiene, don gloves. Provide absorbent under pad and briefs as needed. Remove gloves and perform hand hygiene, then don gloves. Change linens and clothing as needed.</p> <p>2. Review of Resident #19's medical record revealed an admission date of 07/20/09 and diagnoses included unspecified dementia, anxiety disorder and adult failure to thrive.</p> <p>Review of Resident #19's care plan revised 10/15/24 revealed Resident #19 had bowel and bladder incontinence related to impaired mobility and diagnoses. Resident #19 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to change disposable briefs as required and needed.</p> <p>Review of Resident #19's Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status was not conducted due to Resident #19 was rarely or never understood. Resident #19 was dependent for ADL's and was frequently incontinent of urine and always incontinent of bowel.</p> <p>Observation on 07/01/25 at 7:55 A.M. of CNA's #223 and #226 revealed they were preparing to provide incontinence care for Resident #19. Observation revealed Resident #19's incontinence brief had a large amount of dark yellow urine that appeared to have been there awhile. CNA #223 stated Resident #19 did not look like she had her incontinence brief changed for awhile and pointed to a folded blanket under Resident #19's buttocks. The blanket had dried urine on it. Further observation revealed Resident #19 had a folded blanket under her buttocks and also a reusable chux pad. CNA #223 stated Resident #19 should not have a folded blanket and a reusable chux underneath her and it looked like it was put there for added protection for urine incontinence. CNA #226 left the room to get supplies and Resident #19 was left uncovered from the waist down while she was gone. CNA #223 did not cover Resident #19 while she waited for CNA #226 to return.</p> <p>Review of the facility policy titled Incontinence Care updated 01/06/25 included the purpose was to maintain skin integrity, prevent skin breakdown, control odor and provide comfort and self-esteem for the residents. The policy was to be used on residents were were incontinent of bowel and bladder. When providing incontinence care cleanse the area with perineal wash or a mild cleanser, pat dry, remove gloves, perform hand hygiene, don gloves. Provide absorbent under pad and briefs as needed. Remove gloves and perform hand hygiene, then don gloves. Change linens and clothing as needed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165460.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, review of the facility Activity Calendar and review of facility policy the facility failed to ensure residents were provided activities as scheduled and failed to ensure Resident's #11, #33, #47 #67, and #82's care planned interventions were implemented for activities and activities were offered per their preferences. This had the potential to affect all the residents in the facility. The facility census was 93.</p> <p>Findings include:</p> <p>Review of Resident #67's medical record revealed an admission date of 04/05/25 and a readmission date of 06/19/25. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left dominant side, type two diabetes mellitus and schizoaffective disorder. Resident #67 resided on the second floor nursing unit.</p> <p>Review of Resident #67's electronic record from 06/01/25 through 06/26/25 did not reveal evidence Resident #67 had one-to-one activity participation or self-directed activity participation.</p> <p>Review of Resident #67's admission Minimum Data Set assessment dated [DATE] revealed Resident #67 was cognitively intact. Over the past two weeks Resident #67 stated he felt down, depressed or hopeless on two to six days. Resident #67 did not reject care during the seven-day assessment look-back period. Resident #67 stated it was very important to listen to music he liked, to do his favorite activities, to go outside when the weather was good. Resident #67 stated it was somewhat important to do things with groups of people and to be around animals such as pets. Resident #67 used a wheelchair and was dependent for chair-to-bed-to-chair transfer.</p> <p>Review of Resident #67's care plan dated 06/26/25 revealed long term stay in the facility was in the best interests of Resident #67. Discharge to the community would not be pursued at this time due to care needs. Interventions included staff would encourage, assist Resident #67 to interact with other residents, attend activities and understand where the bathrooms, dining room, activity areas etcetera were located.</p> <p>Review of Resident #67's progress notes dated 06/19/25 through 07/01/25 did not reveal evidence Resident #67 attended activities or was encouraged to attend activities.</p> <p>Observation on 06/26/25 at 12:35 P.M. of Resident #67 revealed he was sitting in a motorized wheelchair in the common area of the main entrance to the facility. Resident #67 waved the surveyor over and stated he felt cooped up in the facility. Resident #67 stated there were no activities provided, they never take us on trips and the residents needed something to do.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 06/26/25 at 12:58 P.M. of Licensed Practical Nurse (LPN) #204 and Certified Nursing Assistant (CNA) #203 revealed they were standing near the third floor nurses station. LPN #204 indicated the third floor nursing unit was a secured unit and residents with behavioral and mental health issues resided on it. CNA #203 stated the residents got into fights and broke things because they had no activities to occupy them. LPN #204 and CNA #203 stated emphatically that they had not seen an activity person today, the activity schedule looked good, but there had not been any activities provided so far today from 7:00 A.M. until 12:58 P.M. CNA #203 stated it was worse on the second floor nursing unit, and the second floor did not do any activities at all. Again CNA #203 stated the schedule looks good but there are no activities.</p> <p>Review of the Second Floor Activities Calendar revealed on 06/26/25 at 1:00 P.M. the scheduled activity was Manicures and Cards.</p> <p>Review of the Connections Community Activities (third floor secured nursing unit) revealed on 06/26/25 at 1:00 P.M. the activity scheduled was Discussion (Responsibly).</p> <p>Review of the Blue Sky Community (fourth floor secured memory unit) Activity Calendar revealed on 06/26/25 at 1:00 P.M. Manicures and Cards was the activity scheduled.</p> <p>Observation on 06/26/25 at 1:11 P.M. of the third floor secured nursing unit did not reveal any activity was provided including Discussion (Responsibly). There was no observation of activity staff. LPN #204 stated no activity person showed up.</p> <p>Observation on 06/26/25 at 1:20 P.M. of the second floor did not reveal any activities were provided including Manicures and Cards. Registered Nurse (RN) #205 stated there were no activities right now but the residents had church this morning from about 10:15 A.M. until 11:45 A.M. RN #205 stated there were no activities now because the activities staff were responsible to take the residents out for their smoke break at 1:30 P.M.</p> <p>Observation on 06/26/25 at 1:25 P.M. of the fourth floor secured nursing unit (Blue Sky Community) including the common area did not reveal any activities including Manicures and Cards were provided.</p> <p>Interview on 06/26/25 at 1:26 P.M. of RN #206 revealed she was sitting at the fourth floor nurses station. RN #206 confirmed there were no activities being provided now or at 1:00 P.M. RN #206 stated if activities were provided they would be held in the common area of the fourth floor.</p> <p>Review of the fourth floor Blue Sky Community Activities Calendar revealed on 06/26/25 at 2:00 P.M. a Hydration Cart was the activity scheduled. On 06/26/25 at 3:00 P.M. Bingo was the activity scheduled.</p> <p>Observation on 06/26/25 at 2:42 P.M. of the fourth floor nursing unit (Blue Sky) did not reveal evidence of a Hydration Cart or Bingo being provided for the residents.</p> <p>Review of the Connections Community Activities (third floor secured behavioral unit) revealed on 06/26/25 at 3:00 P.M. Board Games was the activity scheduled.</p> <p>Review of the Second Floor Activities Calendar revealed on 06/26/25 at 2:00 P.M. the activity scheduled was Hydration Cart. on 06/26/25 at 3:00 P.M. the activity scheduled was Game Room.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 06/26/25 at 2:45 P.M. of the second floor nursing unit revealed no evidence activities were provided including a Hydration Cart.</p> <p>Observation on 06/26/25 at 3:18 P.M. of the fourth floor secured memory unit (Blue Sky Community) including the common area did not reveal evidence activities were provided for the residents including Bingo.</p> <p>Observation on 06/26/25 at 3:20 P.M. of the second floor nursing unit did not reveal any activities were being provided to the residents including Game Room.</p> <p>Observation on 06/26/25 at 3:22 P.M. of the third floor secured nursing unit (Connections Community) did not reveal activities were offered to the residents including Board Games.</p> <p>Interview on 06/26/25 at 3:22 P.M. of LPN #204 confirmed there were no activities currently being provided to the residents on the third floor secured nursing unit.</p> <p>Interview on 06/26/25 at 3:40 P.M. of Activity Director (AD) #207 revealed he had four Activity Assistant's (AA)'s #208, #209, #210 and #211. AD #207 stated AA #209 called off today, and AA #210 and AA #211 had a scheduled day off. AD #207 stated AA #208 worked today. AD #207 confirmed activities were not provided as scheduled due to three Activity Aides were off today. AD #207 stated each nursing unit had an Activity Aide and activity schedules were different for each nursing unit. AD #207 stated church services was offered this morning from 10:15 A.M. until 11:45 A.M. and many residents enjoyed going to the church service. AD #207 first stated the fourth floor nursing unit had Bingo at 2:15 P.M. or 2:30 P.M. and when told Bingo was not observed on the fourth floor at those times AD #207 stated Bingo was not provided because he had to attend resident care conferences from about 1:45 P.M. until 2:45 P.M. AD #207 confirmed the activity staff supervised smoke breaks at 9:30 A.M., 1:30 P.M. and 4:30 P.M. AD #207 stated the only activity provided on the third floor secured nursing unit (Connections Community) today was a movie at around 1:10 P.M. AD #207 stated he started the movie so residents could watch it while they ate their lunch meal. AD #207 stated he placed cards and puzzles at the far end of the counter of the second floor nurses station and there were also cards located on an activity cart that stayed on the second floor in the common area. AD #207 stated he made an announcement to the residents to let them know where the cards and puzzles were.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Cityview Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6606 Carnegie Ave Cleveland, OH 44103	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 06/26/25 at 3:50 P.M. with AD #207 of the second floor nursing unit revealed there were no cards or games located on the nurses station counter at the far end. AD #207 stated the residents probably took them to their rooms. Observation of the third floor nursing unit revealed there were papers for word search, coloring etcetera contained in plastic covers and thumb tacked to a bulletin board. There was no observation of pencils or crayons. Further observation with AD #207 of the third floor nursing unit revealed a locked room with a broken video game, a broken air hockey table and a broken table soccer game. There was a basketball game in the common area which was available for resident use. AD #207 stated the games had been broken anywhere from two weeks to a month. Observation of the fourth floor nursing unit (Blue Sky) revealed a couple board games on a ledge in the common area along with some coloring items, a baby doll and a therapeutic stuffed doggie. AD #207 stated there had been no outside trips planned for the residents since about 10/2024 because the bus driver quit and the bus was given to a sister facility. AD #207 stated the only transportation the facility had now was a van which was acquired about three months ago and only had the capacity to hold one wheelchair, two walkers and one aide and the van was mostly used for resident appointments. A van driver was hired about a month ago. AD #207 stated residents asked to go on trips all the time. The residents want to go to the zoo on Mondays because it is free, and want to go to parks, to see Christmas lights, to see the air show but were unable to because the facility did not have a bus big enough to accommodate the residents. AD #207 stated the residents missed their trips and when they returned from the trips they had a better, different mind set, and it was a positive experience for them. AD #207 stated he was going to contact the sister facility to see if they could loan the facility the bus for some trips. AD #207 stated when a resident attended activities it was documented in their electronic record. AD #207 confirmed the activity calendars for the second, third (Connections Community) and fourth floor (Blue Sky) nursing units had zoo trips planned for 10:00 A.M. on 06/09/25, 06/16/25, and 06/30/25 and those trips did not happen.</p> <p>Interview on 06/30/25 at 12:45 P.M. with Resident's #5 and #60 revealed they resided on the third floor secured nursing unit (Connections Community). Resident #5 stated the residents stayed in the facility and did not go anywhere. Resident #5 stated I wish we could go somewhere. Resident #5 stated the residents were taken outside about a month ago, but the facility did not offer outside too much. Resident #60 stated we used to go places and I want to go places. Resident #60 stated she was not taken outside the facility to the grassy area, and would like to do that.</p> <p>Review of Resident #82's medical record revealed an admission date of 09/13/12 and diagnoses included other specified injuries of the left wrist, hand, and fingers, spastic hemiplegia affecting the left non-dominant side, and and generalized anxiety disorder.</p> <p>Review of Resident #82's care plan revised 04/14/21 included Resident #82 was self-directed with leisure pursuits. Resident #82 would try to maintain current level of leisure. Interventions included to encourage participation in group activities of interest, leave of absence with supervision only; offer assistance to and from group activities if needed, preferred activities were cards, games, music, outdoors, outings (parks, picnics, movies), arts and crafts, cooking, religious services, sports, educational, provide Resident #82 with an activities calendar and notify him of any changes to the calendar or activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident #82's Annual MDS assessment dated [DATE] revealed Resident #82 was cognitively intact. Resident #82 did not reject care during the seven-day assessment look-back period. It was very important to Resident #82 to go outside to get fresh air when the weather was good and very important to do his favorite activities. It was very important to be around animals such as pets. Resident #82 used a wheelchair and required partial to moderate assistance for chair-to-bed-to-chair transfers. Resident #82 required substantial to maximal assistance for upper and lower body dressing.</p> <p>Review of Resident #82's electronic record dated 06/01/25 through 06/26/25 revealed there was no evidence Resident #82 participated in one-to-one activities for things like pet visits therapy, and going outside. Group participation activities revealed on 06/04/25 and 06/22/25 Resident #82 played Bingo, on 06/18/25, 06/21/25, 06/22/25 and 06/25/25 he attended coffee, social interaction and news. Resident #82's self-directed activity participation revealed on 06/04/25 he had coffee, social interaction and news. On 06/08/25 music, dancing, and entertainment was documented. On 06/13/25 he was outside in the courtyard. On 06/21/25 at 10:05 A. M. he did exercise and strength. There were no additional activities documented including trips outside the facility .</p> <p>Interview on 06/30/25 at 12:58 P.M. of Resident #82 revealed he was the Resident Council President. Resident #82 stated the residents could go in the back of the facility by the grass, but did not leave the facility because the facility did not have a bus to take us anywhere. Resident #82 stated the residents were taken outside for Veterans Day last November and if there was enough staff they would be given ice cream outside, but he could not remember the last time this happened. Resident #82 indicated the second floor residents were taken out more often than the residents who resided on the third and fourth floor nursing units. Resident #82 stated residents want to leave the facility and go on trips, and told him they were upset because they wanted to go places like the store and the zoo. A sister facility had the bus that used to be at the facility and used for outings, and when it was taken to the sister facility there were no more outings. Resident #82 stated he was told by staff that we are the projects and can't get the bus.</p> <p>Review of the Second Floor Activities Calendar revealed on 06/30/25 at 1:00 P.M. the scheduled activity was Cornhole.</p> <p>Observation on 06/30/25 at 1:16 P.M. of the second floor nursing unit did not reveal Cornhole was provided as scheduled. RN #212 confirmed there was no Cornhole and stated the activities staff rotated floors on days Cornhole was offered, and she thought Cornhole was being offered on the third floor secured nursing unit.</p> <p>Review of the Connections Community Activities (third floor) Calendar revealed on 06/30/25 at 1:00 P.M. Discussion (Love) was scheduled as an activity.</p> <p>Observation on 06/30/25 at 1:18 P.M. of the secured third floor nursing unit (Connections Community) did not reveal Cornhole was provided as an activity. Further observation did not reveal Discussion (Love) was conducted.</p> <p>Review of the Blue Sky Community (fourth floor) Activity Calendar revealed on 06/30/25 at 1:00 P.M. the scheduled activity was Cornhole.</p> <p>Observation on 06/30/25 at 1:21 P.M. of the secured fourth floor nursing unit (Blue Sky) did not reveal Cornhole was offered as an activity.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 06/30/25 at 1:30 P.M. of AA #208 confirmed Cornhole was not provided as scheduled on the second and fourth floor nursing unit, and Discussion (Love) or Cornhole was not provided on the third floor nursing unit. AA #208 stated AD #207 and AA #209 were both not working today. AA #208 stated AA #211 was only working until 3:00 P.M. and the activities had to be pushed back. AA #208 stated the resident birthday party scheduled for 3:00 P.M. had to be done now because AA #211 was leaving at 3:00 P.M. AA #208 indicated activities were documented in resident's electronic record, but often the Activity Aides were not able to log into the system to log the activities residents attended. AA #208 tried to log into the electronic record system and showed the surveyor how the system froze and would not let her into the electronic system to record activities. When this happened AA #208 stated the Activity Aides wrote resident names and the activities they attended on a piece of paper and this was given to AD #207 and he documented the activities. AA #208 stated there were no sign in sheets or resident names written down to document when residents attended activities. AA #208 indicated we just know what residents attended. AA #208 revealed the facility had a shaded, grassy area with picnic tables where residents could be taken if the weather permitted, and this would be documented in their electronic record. AA #208 showed the surveyor the outside area which had picnic tables positioned under trees and the surrounding area was grassy. There were no residents in the grassy, shaded area.</p> <p>Interview on 06/30/25 at 2:18 P.M. of Unit Manager (UM) #213 revealed the third floor nursing unit (Connections Community) residents could be taken outside with supervision.</p> <p>Interview on 06/30/25 at 2:33 P.M. of Resident #67 revealed the facility had no activities provided to the residents on a regular basis. Resident #67 stated it was boring here and they only had parties sometimes. When asked if the residents were taken to the grassy, shaded outside area with picnic tables Resident #67 stated [expletive] no, they only keep us on the pavement by the smoking area.</p> <p>Interview on 06/30/25 at 3:44 P.M. with AA #210 revealed she usually provided activities on the second floor nursing unit. Today she was going to play Name That Tune in the morning but she could not get the radio to work. AA #210 confirmed Name That Tune was not a scheduled activity and the scheduled activities of a Zoo Trip at 10:00 A.M., Cornhole at 1:00 P.M., Hydration Cart at 2:00 P.M. were not offered. AA #210 stated the Monthly Resident Birthday Party scheduled for 3:00 P.M. had to be moved up because AA #211 was leaving at 3:00 P.M. AA #210 stated she did not document resident activities because she did not have access to the electronic system, did not have a log in, and a coworker charted for her. AA #210 stated she worked on 06/15/25, it was Fathers Day and the facility cooked hot dogs inside, not outside for the residents. AA #210 indicated that she felt like the residents would like to go outside more, but that did not happen very much due to staffing.</p> <p>Review of Resident #11's medical record revealed an admission date of 10/14/16 and a readmission date of 11/29/24. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus and bipolar disorder.</p> <p>Review of Resident #11's care plan dated 10/18/24 included long term stay in the facility was in the best interests of Resident #11 and discharge to the community would not be pursued. Resident #11 would be long term care with staff attempting to anticipate and meet his needs. Interventions included staff would encourage and assist resident to interact with other residents, attend activities and understand where bathrooms and activity areas were located.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident #11's Quarterly MDS assessment dated [DATE] revealed Resident #11 was cognitively intact. Resident #11 did not reject care during the seven-day assessment look-back period. Resident #11 used a wheelchair and required supervision or touching assistance for upper and lower dressing and chair-to-bed-to-chair-transfer.</p> <p>Review of Resident #11's progress notes dated 06/02/25 through 06/30/25 did not reveal evidence Resident #11 was encouraged to attend activities or that he refused to attend activities.</p> <p>Review of Resident #11's medical record including activity charting dated 06/01/25 through 06/30/25 revealed there was no evidence Resident #11 attended one-to-one activities. On 06/03/25 Resident #11 attended a group activity and played Bingo. On 06/03/25 Resident #11 had a self-directed activity for coffee, social interaction and news. There was no further evidence of activities.</p> <p>Interview on 06/30/25 at 4:14 A.M. with Resident #11 revealed he resided on the second floor nursing unit and the facility did not have enough activities. Resident #11 revealed they only do one percent of the activities scheduled on the calendar and no one watches over them. Resident #11 revealed there was a resident birthday party today and he was not asked to attend, and he was not asked to attend any activities. Resident #11 revealed trips such as zoo trips were posted on the activity calendar but they did not happen. Resident #11 revealed he would like to go on outside trips, the facility used to take them on trips, and it was very upsetting to him and boring at the facility. He would like to go to the zoo, picnics and to the beach. Resident #11 revealed he had not been taken outside by the activity staff other than for smoke breaks.</p> <p>Review of Resident #47's medical record revealed an admission date of 11/21/22 and diagnoses included unspecified dementia, moderate with psychotic disturbance, schizoaffective disorder bipolar type and chronic kidney disease.</p> <p>Review of Resident #47's care plan dated 02/03/23 included Resident #47 needed to reside in the secured Blue Sky Living Community (fourth floor) to meet the physical, mental, spiritual and emotional well-being and safety needs of the resident. Resident #47 would reside safely in the Blue Sky Living Community daily. Interventions included to encourage activities.</p> <p>Review of Resident #47's Quarterly MDS assessment dated [DATE] included Resident #47 was cognitively intact. Resident #47 did not reject care during the seven-day assessment look-back period. Resident #47 used a wheelchair and required supervision or touching assistance for upper and lower body dressing and chair-to-bed-to-chair transfers.</p> <p>Review of Resident #47's medical record activity charting dated 06/01/25 through 06/30/25 did not reveal evidence Resident #47 attended one-to-one activities. On 06/09/25 and 06/19/25 Resident #47 attended a group activity for coffee, social interaction and news. There was no further evidence Resident #47 attended activities.</p> <p>Interview on 06/30/25 at 4:30 P.M. with Resident #47 revealed she resided on the fourth floor memory unit (Blue Sky) and all they have is coffee. Resident #47 revealed she was taken outside one time to the smoking area, but there was no one to talk to. Resident #47 revealed there were no zoo trips because the facility did not have a bus and she wished there were outings. Resident #47 revealed she was not invited to the cook out and it was very upsetting not to have outside time and outings.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 06/30/25 at 4:33 P.M. with Certified Nursing Assistant (CNA) #214 revealed there were no activities scheduled on the second shift and sometimes residents say they were bored and act out. If activities were scheduled it would give the residents something to do other than argue and act out. CNA #214 indicated she only saw the activity staff giving residents coffee, CNA #214 made a face, rolled her eyes, and stated I can think of plenty of activities for the residents.</p> <p>Review of Resident #33's medical record revealed an admission date of 04/04/25 and diagnoses included paraplegia, attention-deficit hyperactivity disorder and bipolar disorder.</p> <p>Review of Resident #33's care plan dated 04/07/25 included Resident #33 triggered a level II referral to ODMH (Ohio Department of Mental Health) for PASSRR due to diagnoses of bipolar, anxiety and ADHD. Resident #33's needs per ODMH recommendations. Interventions included socialization and recreation activities to decrease isolation, improve mood and increase peer interaction.</p> <p>Review of Resident #33's admission MDS assessment dated [DATE] included Resident #33 was cognitively intact. Resident #33 stated he sometimes felt lonely or isolated from those around him. Resident #33 did not reject care during the seven-day assessment look-back period. Resident #33 responded it was very important for him to go outside to get fresh air when the weather was good, to do his favorite activities. Resident #33 responded it was somewhat important to do things with groups of people. Resident #33 used a wheelchair and required partial to moderate assistance for upper and lower body dressing and chair-to-bed-to-chair transfer.</p> <p>Review of Resident #33's progress notes dated 06/02/25 through 06/30/25 did not reveal evidence Resident #33 refused to attend activities or was encourage to attend activities.</p> <p>Review of Resident #33's medical record including activity charting dated 06/01/25 through 06/30/25 did not reveal evidence Resident #33 attended one-to-one activities. There was no evidence Resident #33 attended group activities. There was no evidence Resident #33 attended self-directed activities.</p> <p>Interview on 06/30/25 at 4:39 P.M. with Resident #33 revealed he resided on the secured third floor nursing unit (Connections Community). Resident #33 stated the activities were Bingo two times a week, no other activities were offered, and he wished there was more of a variety of activities. Resident #33 indicated the activity staff always offered excuses why there were no activities planned. If something gets lost then we are never able to play games, the video game, table soccer and air hockey games were broken and there was no paddle or ping pong balls for ping pong. Resident #33 stated there were no activities on the weekends, the activity staff brought coffee around about four times a week, he was not asked to attend any activities, and he was very upset there were no outside trips. Resident #33 revealed it does not even cross their minds to take us outside. Resident #33 stated they do not even get the papers with things like word search, crossword puzzles or coloring, there were no pencils, and no board games either. In the month and a half since Resident #33 lived in facility there was only two times where a movie and popcorn were offered.</p> <p>Interview on 06/30/25 at 4:54 P.M. with Resident #57 revealed the facility did not have much activities. Resident #57 stated sometimes he snagged a coffee.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 06/30/25 at 5:16 P.M. of Regional Director of Operations (RDO) #201 revealed the facility bus was always shared with the sister facility and when the facility needed the bus they made arrangements with the sister facility. RDO #201 stated she was not aware the residents had not gone on any bus trips since last year, and the bus was shared with a sister facility and should be used for trips. RDO #201 indicated she did not know how long the facility did not have a driver, but AD #207 had a license and could drive the bus.</p> <p>Observation on 07/01/25 at 10:12 A.M. of the third floor secured nursing unit (Connections Community) with UM #213 revealed behind the nurses station, activity papers for word search, coloring etcetera were observed hanging on a bulletin and contained in plastic sleeves. There were no pencils, colored pencils, crayons, or pens observed. UM #213 confirmed this and stated if the residents ask for the activity papers the nurses could go to the second floor activity room for the pens, crayons, pencils. Residents on the third floor had to be monitored when they were given pens, pencils, and crayons to make sure they were used appropriately.</p> <p>Observation on 07/01/25 at 10:12 A.M. with UM #213 of the second floor activity room revealed no activity staff were present in the room and no pencils, pens, crayons could be found. UM #213 revealed she could not find pens, pencils or crayons but the activity staff knew where they were. UM #213 stated the activity room was locked when the staff left for the day, but nurses from the nursing units had keys and could access the room.</p> <p>Interview on 07/01/25 at 10:43 A.M. of AD #207 revealed he did not document resident activities and the Activity Assistants were responsible to use his office laptop computer to document resident activities. AD #207 indicated Activity Assistant's #208, #209, #210 and #211 did not have access to the electronic system to document activities at the nurses station but he was looking into it. AD #207 stated the fourth floor Blue Sky Community was more dementia, hospice and long term care and the activity staff try to have activities to brighten their day. Last week therapy dogs were brought to facility, but AD #207 confirmed it was not documented on the activity calendar or in resident electronic records. It was important for third floor residents to stay active and there were numerous games kept on the floor and a basketball hoop game. Paddles and ping pong balls were kept behind the desk of the second floor nursing unit and he was planning to talk to the management staff about fixing the third floor video game, air hockey and table soccer games. AD #207 stated he sent an email to the management staff about fixing the games and he would provide it to the surveyor, but no email was provided. AD #207 stated the outside, shaded grassy area was difficult for residents in wheelchairs because the ground sloped down, and they were not taken there often.</p> <p>Observation on 07/01/25 at 11:27 A.M. of the second floor nursing unit with AD #207 and Licensed Practical Nurse (LPN) #215 revealed there was a ping pong table in the common area, but no paddles or ping pong balls could be found. AD #207 and LPN #215 searched the common area and the nurses station and surrounding areas and could not find ping pong paddles or ping pong balls.</p> <p>Interview on 07/02/25 at 8:05 A.M. of RDO #201 revealed she had no knowledge of AD #207 requesting video game, air hockey and table soccer game to be fixed. RDO #201 stated on 06/26/25 he talked to her about getting them fixed and she was under the impression the games were recently broken.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review and review of facility policy the facility failed to ensure Resident #19's physician orders and care planned interventions for enhanced barrier precautions were followed. This affected one resident (Resident #19) of two residents observed for enhanced barrier precautions. The facility census was 93.</p> <p>Findings include:</p> <p>Review of Resident #19's medical record revealed an admission date of 07/20/09 and diagnoses included unspecified dementia, anxiety disorder and adult failure to thrive.</p> <p>Review of Resident #19's physician orders revealed Enhanced Barrier Precautions related to feeding tube, every shift.</p> <p>Review of Resident #19's care plan revised 10/15/24 revealed Resident #19 required Enhanced Barrier Precautions related to feeding tube. To reduce the potential of spreading multi-drug resistant organisms daily. Interventions included use of appropriate Enhanced Barrier Precautions when performing the following including personal hygiene, toileting and peri care.</p> <p>Review of Resident #19's Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status was not conducted due to Resident #19 was rarely or never understood. Resident #19 was dependent for ADL's and was frequently incontinent of urine and always incontinent of bowel. Resident #19 had a PEG (percutaneous endoscopic gastrostomy) feeding tube and received 51 percent or more of total calories through tube feeding.</p> <p>Observation on 07/01/25 at 7:55 A.M. of Resident #19's room revealed isolation gowns were hanging on the door leading into the room from the hall. An Enhanced Barrier Precautions sign was hung on the wall above Resident #19's bed. The sign included everyone must clean their hands, including before entering and when leaving room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube, tracheostomy, and wound care.</p> <p>Observation on 07/01/25 at 7:55 A.M. of Certified Nursing Assistant's (CNA)'s #223 and #226 revealed they were preparing to provide incontinence care for Resident #19. CNA's #223 and #226 did not don an isolation gown before entering Resident #19's room to provide care. Licensed Practical Nurse (LPN) #227 entered Resident #19's room, did not don an isolation gown and disconnected the tube feeding from Resident #19's PEG tube. LPN #227's clothes brushed against Resident #19, her bed, and the bed linens while she disconnected the tube. Without donning isolation gowns CNA's #223 and #226 provided incontinence care for Resident #19. While they were providing care CNA's #223 and #226 clothes brushed against Resident #19, her bed and the bed linens. When Resident #19's incontinence care was completed LPN #227 reentered her room without donning an isolation gown and reconnected the tube feeding and turned the tube feeding pump on. CNA's #223 and #226 confirmed they did not wear an isolation gown during Resident #19's incontinence care. LPN #227 confirmed she did not wear an isolation gown when she disconnected and reconnected Resident #19's tube feeding. LPN #227 stated she did not realize she had to wear a gown when hooking up and unhooking the tube feeding.</p> <p>(continued on next page)</p>		

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  07/02/2025
NAME OF PROVIDER OR SUPPLIER  Cityview Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6606 Carnegie Ave Cleveland, OH 44103	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/01/25 at 9:00 A.M. of Regional Director of Operations (RDO) #201 revealed she was so disappointed to hear the aides and nurses did not don appropriate PPE (Personal Protective Equipment) when providing Resident #19's incontinence care and tube feeding care. RDO #201 revealed they have provided so much staff education on Enhanced Barrier Precautions.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions Policy updated 01/2025 included EBP was used in conjunction with standard precautions and expands the use of PPE to donning gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP was indicated for residents including indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. Indwelling medical devices included feeding tubes. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube, tracheostomy, and wound care.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165460.</p>