

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 09/17/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, closed record review, review of emergency services report, review of hospital records, facility policy review and interview, the facility failed to maintain a safe environment to prevent Resident #51 from accessing a locked soiled utility room and falling from the third-floor secured unit to the facility basement via a laundry chute. This resulted in Immediate Jeopardy and Actual Harm on 08/07/25 at approximately 1:30 P. M. when Resident #51 was observed in the laundry chute room, inside a laundry bin, behind a locked door in the facility's basement. Maintenance Director (MD) #400 reported he had been in the facility basement outside of the laundry chute room when he heard a loud thud sound from inside the room. Upon opening the locked door of the laundry chute room, MD #400 observed Resident #51 inside a laundry bin, and confirmed the only points of entry into the room were the laundry chute and the locked door he had opened. MD #400 recalled Resident #51 had bleeding around his mouth and eye and a large bump on the back of his right hand. MD #400 reported Former Administrator #500 was present in the facility's basement with another unknown resident at the time of the incident and was informed Resident #51 was in the laundry bin. Former Administrator #500 proceeded to escort Resident #51 out of the laundry chute room and back to his room on the third floor prior to the resident being comprehensively assessed for injury. Resident #51 was transported to the hospital by Emergency Medical Services (EMS) at approximately 2:55 P.M. Upon arrival to the hospital, Resident #51 was found to have a C6 compression fracture (a collapse of one of the cervical vertebra in the neck) of unknown chronicity, an acute T4 anterior fracture (a break of the fourth thoracic vertebra in the mid-back), and multiple left-sided rib fractures of the second through seventh ribs. Resident #51 was hospitalized from [DATE] until 09/03/25 at which time he was transferred to a local long term acute care hospital (LTACH) for ongoing care and treatment. Resident #51 did not return to the facility. This affected one resident (#51) of three residents reviewed for accidents. The facility census was 88. On 09/08/25 at 3:04 P.M., the Administrator, Director of Nursing (DON), and Regional Clinical Support Registered Nurse (RCSRN) #401 were notified Immediate Jeopardy began on 08/07/25 at approximately 1:30 P.M. when Resident #51 was able to gain access to the secured soiled utility room (in which the laundry chute access was contained in) on the third floor and was subsequently observed inside a laundry bin in the laundry chute room of the facility's basement. Resident #51 was transported to a local hospital where he was admitted for multiple traumatic injuries. In addition, the facility failed to ensure an accurate and timely investigation and documentation regarding the circumstances of the incident were completed at the time of the incident. Immediate Jeopardy was removed on 08/08/25 when the facility implemented the following corrective actions: On 08/07/25 at approximately 1:30 P.M., Former Administrator #500 was informed by Maintenance Director (MD) #400 that Resident #51 was in the basement laundry chute room. On 08/07/25 at approximately 1:45 P.M. Former Administrator #500 instructed Licensed Practical Nurses (LPN) #283, #291, #303, and #342 to conduct head counts of their units to ensure all residents were accounted for and had not wandered off their units. On 08/07/25 at approximately 2:00 P.M., Former Administrator #500 checked the soiled utility room containing the laundry chute on the 200 unit to determine if the door was locking properly. On 08/07/25 at 2:11 P.M., the DON called EMS to transport Resident #51 to a local hospital. On 08/07/25 at approximately 2:15 P.M., Former Administrator #500 checked the soiled utility room containing the laundry chute on the 400 unit to determine if the door was locking properly. On 08/07/25 at approximately 2:30 P.M., Former Administrator #500 checked the soiled utility room containing the laundry chute on the 300 unit to determine if the door was locking properly. On 08/07/25 at approximately 3:00 P.M., Former Administrator #500 coordinated an ad hoc Quality Assurance (QA) meeting to discuss the incident with Resident #51. In attendance at the meeting included Former Administrator #500, the DON, Assistant Director of Nursing (ADON) #279, and RCSRN #401. Regional Director of Operations (RDO) #510 and Medical Director #650 attended via phone. A root cause analysis was performed, and the team discussed a plan to prevent the incident of a resident wandering into secured places and/or off the unit. The QA team decided to re-educate staff on the importance of ensuring the utility room doors were latched and always locked, after each entry and exit, as well as installing an extra lock on each (laundry) chute access on each unit. Additional staff training would include ensuring residents on secured units were always supervised and present on their units, ensuring maintenance work orders and all work orders would be placed into TELS (an electronic method for placing, tracking, and communicating work orders that are needed) and emergency orders would</p>		