STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365879	A. Building B. Wing	12/01/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, interview, review of Self-Reported Incident (SRI) investigations, and facility policy review, the facility failed to protect Resident #69 and Resident #12's right to be free from physical abuse by Resident #89. This affected two residents (#12 and #69) of five residents reviewed for physical abuse. The facility census was 88. Actual harm occurred on 09/08/25 when Resident #69 was physically abused by Resident #89 when the resident was struck in the head with a [NAME] requiring transfer to the hospital for evaluation and treatment of a skin tear requiring a thick layer of dermal glue and bruising on the left eye. Additional harm occurred on 09/19/25 when Resident #12 was physically abused by Resident #89 when the resident was struck in the head with a rock which required hospital treatment for a head laceration with staples. Findings include: 1. Review of the medical record for Resident #69 revealed an admission date of 07/31/24 with diagnoses including bipolar disorder severe with psychiatric features, history of traumatic brain injury, restlessness and agitation.Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #69 had severely impaired cognition, and exhibited verbal behavioral symptoms directed at others.Review of a general note dated 09/08/25 at 4:26 P.M. revealed Resident #69 had a physical altercation with Resident #89. The resident indicated Resident #89 hit him (Resident #69) in the face. Resident #69 stayed in the dining area with staff. Vital signs were stable. A skin tear to left chin was noted. The area was cleansed with normal saline solution and a dry dressing applied. The physician was contacted and ordered Resident 69 to be sent to the hospital. Review of a general note dated 09/08/25 at 10:47 P.M. revealed Resident #69 returned to the facility at 9:50 P.M. in stable condition. A thick layer of dermal glue was applied to the resident's left chin, and there was bruising on the left eye. Review of a facility self-reported incident (SRI) and investigation dated 09/08/25 revealed staff witnessed Resident #89 hit Resident #69 while in the dining room. Both residents were separated and head-to-toe assessments completed. Resident #69 had a skin tear on the left chin and was subsequently sent to the hospital for evaluation and treatment. Certified Nursing Assistant (CNA) #212 verified it was Resident #89 who hit Resident #69. There were no details in the witness statements or investigation as to what object was used by Resident #89 to hit Resident #69. Interview on 11/24/25 at 9:53 A.M. with the Director of Nursing (DON) revealed on 09/08/25 Resident #69 was hit by Resident #89 with a [NAME] with a wooden handle and a rubber head. The DON revealed staff believed Resident #89 obtained the [NAME] from a maintenance cart. Review of the closed medical record for Resident #89 revealed an admission date of 05/26/24 and discharge date of 09/19/25. Resident #89 had diagnoses including bipolar disorder and paranoid schizophrenia.Review of the plan of care initiated 05/09/24 revealed Resident #89 had the potential to be physically aggressive related to a diagnosis of mental illness. Interventions included administering medications as ordered (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	after attempting non-medicinal approaches, and if the resident's behavior was a threat to other residents or himself, to immediately call for assistance. On 10/07/24, an additional intervention was added which indicated Resident #89 was counseled regarding conflict management and not to react to peers by becoming aggressive. On 07/01/25, the resident was counseled to seek out staff if he had a conflict with peers. On 08/06/25, another intervention was added to refer Resident #89 to the consulting psychiatrist for a psychiatric evaluation as warranted. Additional review of the plan of care initiated 05/09/24 revealed it was updated on 09/08/25 to note Resident #89 had potential to be physically aggressive related to a diagnosis of mental illness. The care plan revealed the resident hit a peer. An intervention added was for one-on-one counseling regarding conflict management, to walk away and not strike out at others.Review of the behavior note dated 09/08/25 at 12:04 P.M. revealed Resident #89 exhibited behaviors of screaming at and threatening others. Non-pharmacologic interventions of redirection and change of scenery were provided and documented as being effective on this date.Review of a general note dated 09/08/25 at 3:36 P.M. revealed staff notified the nurse of Resident #89 being in a physical altercation with Resident #69. Both residents were separated, and staff assisted Resident #89 out of the dining room to his room. Resident #89 was placed on one-on-one supervision. Psychiatry was contacted and made aware of the incident with no new orders placed. Review of the social services note dated 09/08/25 at 3:43 P.M. revealed the social worker (unnamed) met with Resident #89 about the incident. Resident #89 stated Resident #69 had threatened him, so he took it seriously. Resident #89 was counselled to seek out staff when there was a peer conflict and given further counsel on conflict management, including not to strike out but to walk away.2.Review of the medical record for Resident #12 revealed an admission date of 10/28/20 with diagnoses including schizophrenia, borderline personality disorder, obsessive compulsive disorder, and bipolar disorder.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition and no behaviors. Review of the head-to-toe assessment dated [DATE] at 10:32 A.M. revealed Resident #12 had a laceration to the back of the head.Review of the health status note dated 09/19/25 at 10:01 P.M. revealed Resident #12 returned from the hospital at 4:00 P.M. with a laceration to the crown of the head which was closed with two staples and left open to air. A Computerized Tomography (CT) scan without contrast resulted in no (additional) anomalies. Review of an SRI dated 09/19/25 revealed Resident #89 struck Resident #12 in the back of the head while in the hallway. The residents had argued over a notebook which was subsequently found in Resident #89's room. Resident #12 was sent to the hospital due to being hit on the head. Staff witnesses confirmed the incident had occurred. Housekeeper #214 saw both residents arguing which resulted in Resident #89 hitting Resident #12. There was no mention of any additional details. CNA #215 noted in her witness statement of Resident #89 being very aggressive that morning.Review of a note contained in Resident #89's medical record revealed a general note dated 09/19/25 at 9:30 A.M. which indicated staff informed the Assistant Director of Nursing (ADON) #209 of a physical altercation between Resident #89 and Resident #12. Resident #12 reported it was about a composition notebook so Resident #89 struck him on the head. The back of Resident #12's head was cleansed, and pressure applied, followed by a clean dry dressing. The physician when notified ordered to send Resident #12 to the hospital for evaluation and treatment. The psychiatric nurse when notified ordered for Resident #89 to be pink slipped (an emergency mental health hold) to the hospital. Emergency services were contacted. The police picked up Resident #89 who was transported to the hospital, and his responsible party was notifiedInterview on 11/20/25 at 9:15 A.M. with Resident #12 confirmed he was knocked in the head with rock by Resident #89. When asked about the incident and the pain it caused, the resident would only state being fine now and safe. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	He voiced being glad that Resident #89 was no longer there. Interview on 11/20/25 at 12:49 P.M. with the Director of Nursing (DON) revealed Resident #89 had delusions which caused him to feel he had to protect himself. The DON revealed the resident had been placed on one-to-one supervision (from 09/08/25 to 09/16/25 following the incident with Resident #69) and had come to the facility with physical aggression problems. Following the second incident of physical abuse on 09/19/25 Resident #89 was pink slipped to the hospital and did not return to the facility. The deficient practice was corrected on 09/19/25 when the facility implemented the following corrective actions: -On 09/08/25 the DON/designee completed a full body assessment on Resident #69 and all like facility residents. -On 09/08/25 the DON/designee completed resident interviews for safety and/or abuse.-On 09/08/25 the DON/designee completed a whole house audit of residents' rooms for potentially harmful objects.-On 09/08/25 the DON/designee audited five resident rooms daily, five days a week, for four weeks for potentially harmful objects.-On 09/08/25 the DON/designee completed education for all staff on abuse, resident rights, and triggers for aggression in older adults.-On 09/08/25 the Regional Director of Operations (RDO) #217 instructed Maintenance Director (MD) #218 to prohibit all maintenance carts from going onto any resident floors. -On 09/08/25 MD #218 made maintenance staff aware moving forward of maintenance carts being prohibited onto any resident floors. -On 09/08/25 MD #218 audited maintenance cart locations five days weekly for four weeks to ensure all maintenance carts were in designated areas.-From 09/08/25 to 09/16/25 Resident #89 received staff one-to-one supervision. -Following the incident on 09/19/25 Resident #89 was again placed on one-on-one supervision immediately until the psychiatric nurse practitioner had the resident sent out to the hospital. The facility also conducted an investigation with staff statements obtained. Resident skin assessments were completed for all residents with cognitive impairment. -Resident #12 was assessed and transferred to the hospital for treatment and then returned to the facility. -On 09/19/25 all staff were educated on abuse, de-escalation, and handling aggressive behaviors. -On 09/19/25, Resident #89 received an immediate discharge after being pink slipped by psychiatry.This deficiency represents non-compliance investigated under Complaint Number 2622325.