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	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cityview Healthcare and Rehabilitation	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review, resident interview, staff interview, review of personnel records, review of employee timesheets, and review of the employee handbook, the facility failed to ensure residents were provided with a dignified living environment. This affected one (#17) of two residents reviewed for dignity. The facility census was 91. Findings include:Review of the medical record for Resident #17 revealed an admission date of 04/17/18 and diagnoses including paraplegia, end stage renal disease, accidental discharge from a firearm or gun, aneurysm of a renal artery, anxiety disorder, and major depressive disorder.Review of a Brief Interview for Mental Status (BIMS) evaluation dated 10/22/25 revealed Resident #17's BIMS score of 15 indicating intact cognition.Interview on 03/30/26 at 10:22 A.M. with Resident #17 confirmed he observed a physical altercation between staff members a couple months ago but was unable to remember the exact date. Resident #17 stated he did not want to talk about the fight but stated it could have been avoided.Interview on 04/02/26 at 1:44 P.M. with Certified Nurse Aide (CNA) #501 confirmed there was a physical fight between her and Laundry Aide #619. CNA #501 was not willing to discuss any additional information related to the fight.Interview on 04/02/26 at 1:48 P.M. with the Director of Nursing (DON) confirmed the fight happened on the elevator between CNA #501 and Laundry Aide #619. The DON stated the fight was over a misunderstanding between the two staff members but did not elaborate further on what that meant. The DON stated the fight started as yelling and shoving then became more physical. The DON stated there were no residents on the elevator at the time of the fight. The DON stated it was likely Resident #17 did witness part of the fight as the elevator doors had opened but other staff had intervened to stop the fight. The DON stated both staff members were suspended and it was further handled by the Administrator and Human Resources (HR) Director #607.Interview on 04/02/26 at 1:58 P.M. with Laundry Aide #619 confirmed she was in a physical fight with CNA #501 while on the elevator. Laundry Aide #619 stated they had a verbal altercation prior to the physical fight and CNA #501 was the aggressor. Laundry Aide #619 was unable to recall the exact date of the fight but stated it was a couple of months ago. Laundry Aide #619 stated during the fight the elevator doors opened and additional staff got on to break it up. Laundry Aide #619 stated she was unsure if any residents witnessed the fight when the elevator doors opened. Laundry Aide #619 stated they were both suspended for five days with pay.Interview on 04/02/26 at 2:48 P.M. with the Administrator and HR Director #607 revealed they denied any knowledge of a physical fight or suspension of staff members. They reported both CNA #501 and Laundry Aide #619 were sent home for the day following a verbal altercation as they were both upset. The Administrator and HR Director #607 were not willing to discuss any additional information related to the fight or share any investigative findings.Review of the personnel records for CNA #501 and Laundry Aide #619 revealed no findings related to disciplinary actions related to a physical fight.Review of the employee timesheet for Laundry Aide #619 revealed she worked on 01/14/26 from 7:00 A.M. to 12:15 P.M. Laundry Aide #619 did not return to work until 01/22/26.Review of the employee timesheet for CNA #501 revealed she worked on 01/14/26 from 8:30 A.M. to 12:00 P.M. CNA #501 did not return to work until 01/23/26.Review of the employee handbook dated April 2024 revealed threats or actual physical (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	violence was not permitted in the workplace and staff found to be participating could be terminated.This deficiency represents non-compliance investigated under Complaint Number 2735120 and Complaint Number 2725899.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of a clinical census, and review of a facility policy, the facility failed to ensure a legal guardian was notified of a change in condition. This affected one (#49) of three residents reviewed for hospitalizations. The facility census was 91. Findings include:Review of the medical record for Resident #49 revealed an admission date of 11/08/23 and diagnoses including dementia, depressive type schizoaffective disorder, impulse disorder, human immunodeficiency virus (HIV), and generalized anxiety disorder.Review of the undated guardianship letter revealed legal guardianship was awarded to Resident #49's sister.Review of a progress note dated 01/07/26 at 9:38 A.M. revealed Resident #49 reported he was short of breath. Vital signs were documented as a blood pressure of 127/65 millimeters of mercury (mmHg), a temperature 99.0 degrees Fahrenheit (F), respirations of 16 breaths per minutes, and an oxygen saturation of 74 percent (%). Licensed Practical Nurse (LPN) #551 notified the physician and received orders to apply two liters of oxygen and call emergency medical services (EMS). LPN #551 documented Resident #49's guardian was notified.Review of a progress note dated 01/07/26 at 3:44 P.M. revealed Resident #49 was admitted to the hospital for acute respiratory hypoxic failure related to possible pneumonia. Registered Nurse (RN) Unit Manager (UM) #598 documented Resident #49's guardian was notified of the admission.Review of a clinical census revealed Resident #49 was hospitalized from [DATE] to 01/22/26.Interview on 04/06/26 at 10:16 A.M. with RN UM #598 revealed she called Resident #49's legal guardian which was identified as his sister around 2:00 P.M. on 01/07/26 to follow up after Resident #49 was transferred to the hospital. RN UM #598 stated the floor nurse did the initial notification of his change in condition and need to go to hospital.Interview on 04/06/26 at 10:42 A.M. with LPN #551 revealed Resident #49 presented with a change in condition on 01/07/26 during her morning medication pass. LPN #551 stated Resident #49 appeared clammy, was having trouble breathing, and had an oxygen saturation of 74%. LPN #551 stated she notified the physician, applied oxygen, and called for EMS to transfer Resident #49 to hospital. LPN #551 stated she notified Resident #49's mother via telephone of the change in condition and transfer to hospital. LPN #551 reported Resident #49's mother was his guardian.Interview on 04/06/26 at 11:16 A.M. with Licensed Social Worker (LSW) #589 confirmed Resident #49's sister was his legal guardian. LSW #589 stated the legal guardian could be hard to get a hold of and the legal guardian gave her approval to contact Resident #49's mother. LSW #589 was unable to provide evidence of this conversation.Review of facility policy titled, Notification of Change in Condition, dated January 2026, revealed the nurse would notify the resident's physician and legal representative when there was a significant change in the resident's physical, mental, or psychosocial status.This deficiency represents non-compliance investigated under Complaint Number 2716185.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, staff interview, and resident interviews, the facility failed to ensure resident rooms and common areas were maintained at comfortable temperatures to promote a safe and comfortable homelike environment. This had the potential to affect 24 (#1, #3, #7, #13, #14, #16, #18, #23, #41, #42, #43, #46, #53, #58, #66, #67, #68, #71, #73, #76, #78, #79, #81, and #83) of 24 residents residing on the Blue Sky Living Unit (400 Hall). The facility census was 91.Findings include:Interview with Resident #1 on 03/20/26 at 9:08 A.M. revealed his room was often too warm.Interview with Resident #53 on 03/20/26 at 9:11 A.M. revealed his room was really warm.Interview with Resident #3 on 03/20/26 at 9:15 A.M. revealed she had to tell staff all the time that her room was too warm.Observation and interview of the 400 Hall on 03/20/26 between 8:45 A.M. and 9:15 A.M. with Licensed Practical Nurse (LPN) #100 revealed Resident #14's room measured 88 degrees Fahrenheit (F), Resident #1's room measured 85.6 degrees F, Resident #88's room measured 86.5 degrees F, Resident #71's room measured 84.6 degrees F, Resident #46's room measured 86.5 degrees F, Resident #78 and #81's room measured 83.5 degrees F, Resident #3's room measured 81.6 degrees F, Resident #4 and #16's room measured 83.5 degrees F, Resident #18 and #53's room measured 83.3 degrees F, the hallway on the 400 Unit measured 82.6 degrees F, and the dining room on the 400 Unit measured 81.9 degrees F. LPN #100 confirmed all of the above temperatures at the times of discovery.This deficiency represents non-compliance investigated under Complaint Number 2688708.

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F 0600 Level of Harm - Minimal harm or potential for 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** Based on medical record review, review of self-reported incidents and related documents, resident and staff interview, and facility policy review, the facility failed to ensure residents were free from abuse. This affected two (#11 and #64) of six residents reviewed for abuse. The facility census was 91. Findings include: 1. Review of the medical record for Resident #64 revealed an admission date of 08/14/25. Diagnoses include asthma, epilepsy, anemia, bladder dysfunction, psychoactive substance abuse, borderline personality, and schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 was cognitively intact with mild depression and no behaviors. Resident #64 required supervision with ambulating. Review of Resident #64 care plan dated 01/22/26 revealed a plan for mood distress and anxiety related to a history of depressive illness. Interventions include to speaking about feeling and emotions and to attempt alternative therapies such as music. Review of Resident #64's progress note dated 03/22/26 at 12:09 P.M. revealed the resident had an abrasion measuring two centimeters (cm) in length and 0.1 cm in width. Review of the medical record for Resident #80 revealed an admission date of 09/21/25. Diagnoses include psychoactive substance abuse, post-traumatic stress disorder, anxiety, depression, restlessness and agitation, bipolar, and fracture of right tibia, the right shin bone. Review of Resident #80's care plan revealed the resident presented with moderate to intense anger, poor listening skills often becoming angry and defensive and oppositional when suggestions were provided. Interventions included encouraging the resident to express feelings during support groups and to work on improving listening skills. Resident #80 was care planned for verbally aggression related to her mental illness. Interventions included administering medications as ordered and to anticipate and remove triggers that cause signs of agitation. Review of the self-reported incident (SRI), tracking number 272358, revealed Resident #80 went into Resident #64's room and threw an object towards him. Further investigation revealed Resident #80 may have been triggered by an outburst from Resident #64. Further review revealed Resident #80 was placed on a one-on-one supervision level until sent out to emergency room for an evaluation. Upon readmittance, Resident #80 was placed on another floor in a secure unit and followed up with psychiatric services. Review of a witness statement from Certified Nurse Aide (CNA) #539 revealed she entered Resident #64's room and found Resident #80 lying on the floor. CNA #539 interviewed Resident #56, the roommate of Resident #64, who stated he was told by Resident #80 to shush and then took a shaving cream can and threw it at Resident #64. Interview with Resident #80 on 04/02/26 at 3:12 P.M. stated Resident #64 was teasing her and blew smoke into her face. Resident #80 stated she was extremely upset and retrieved a can of shaving (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cream and entered Resident #64's room. Resident #80 got up out of her wheelchair and threw the can of shaving cream at Resident #64's head. Resident #64 pushed her as she walked back to her wheelchair. Resident #80 stated the can missed Resident #64's head. Interview on 04/06/26 at 9:15 A.M. with Resident #64 stated he did not smoke and stated Resident #80 walked into his room uninvited and threw a can of shaving cream at him and caused the injury to his forehead on 03/22/26. Interview on 04/06/26 at 2:18 P.M. with Licensed Practical Nurse (LPN) #610 stated she was the nurse on duty the day prior to the incident involving Resident #64 and Resident #80. LPN #610 stated Resident #80 entered Resident #64's room and told the roommate to be quiet as she walked to the back of the room and threw a can of shaving cream at his head. Resident #64 sustained a small abrasion to his head. Resident #80 had an unsteady gait and fell walking back to her wheelchair. The police came and neither resident would file a complaint. Interview with the Administrator on 04/06/26 at 3:30 P.M. stated through his investigation he could not substantiate resident to resident abuse because Resident #80 did not have logical common sense to think it through. 2. Record review for Resident #11 revealed an admission date of 10/28/20. Diagnosis included schizoaffective disorder, acquired absence of the left foot, weakness, and anxiety disorder. Review of the MDS assessment dated [DATE] revealed Resident #11 was cognitively intact, able to understand others and made self understood. Resident #11 had no behaviors with the exception of wandering, used a wheelchair for mobility, and required supervision or touch assist for chair/bed to chair transfers. Review of the care plan dated 04/29/24 revealed Resident #11 needed to reside in the Connections Community due to aggressive behaviors. The unit was appropriate for the resident safety related to schizophrenia. Review of the Current Condition of Skin dated 11/27/25 at 11:29 A.M., completed by LPN #622, revealed Resident #11 had an alteration in skin integrity which include a scratch to the cheek and reddened area. Review of the progress note for Resident #11 dated 11/27/25 at 1:30 P.M., completed by LPN #622, revealed the nurse was made aware the resident alleged he and a peer had an altercation and a skin alteration was noted. The residents were separated, Resident #11's skin alteration was cleansed, and the physician was notified. Record review of the SRI created 11/28/25 at 11:21 A.M., completed by the Administrator revealed Resident #102 went to Resident #11's room and blocked him in. Resident #11 requested Resident #102 to move out of the way and Resident #102 refused. Resident #102 hit Resident #11 in the face. The allegation was unsubstantiated by the facility as evidence indicated abuse, neglect, or misappropriation did not occur. Interview on 04/02/26 at 2:07 P.M. with LPN #355 revealed Resident #11 was alert and oriented to person, place, and time. LPN #355 stated Resident #11 would know the difference between right and wrong, he apologized after he did something wrong, and Resident #11 had not hit staff or other (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. Interview on 04/06/2026 at 4:13 P.M. with Resident #11 revealed he did not recall an altercation with another resident. Multiple observations throughout the day revealed Resident #11 participated in multiple activities, socialized with other residents and did not become aggressive. Record review for Resident #102 revealed an admission date of 03/19/20 and a discharge date of 12/08/25. Diagnoses included schizoaffective disorder and major depressive disorder. Review of the MDS dated [DATE] revealed Resident #102 was cognitively intact, was able to make self understood and was able to understand others. Resident #102 had no hallucinations or delusions and physical behavior symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred one to three days of the seven day look back period. Review of the care plan dated 06/16/25 revealed Resident #102 needed to reside in the Connections Community due to behavior or behaviors of destructive to property safety for self and others related to schizoaffective disorder. Interventions included to encourage daily routine to stay as independent as possible, and encourage outlets of behaviors such as journaling, talking, and group meetings. Review of the care plan dated 07/14/25 revealed Resident #102 had a behavior problem related to aggression, refusing medications, destruction to property, pouring urine on himself, and drinking urine. Resident #102 was also sexually inappropriate. Interventions included to administer medications as ordered. Review of the psychiatric note for Resident #102 dated 10/28/25, completed by Certified Nurse Practitioner (CNP) #630 revealed during the assessment, the resident was observed seated in his room, alert, cooperative, and engaged but distractable. Resident #102 stated his mood was pretty good and had a soft voice. He denied depression and anxiety and denied any auditory hallucinations or experiencing commands. Resident #102 questioned when he will be able to go back down to the second floor and the nurse and staff confirmed the resident had a decrease in behaviors and aggression. Resident #102 was taking medications as prescribed and there had been no recent acute issues or hospitalizations reported. Review of the progress note dated 11/23/25 at 3:53 P.M., completed by LPN #558, revealed Resident #102 had a leave of absence (LOA) with family at 1:00 P.M. and the resident left in stable condition with medications and the physician and family were notified. Review of the progress notes for Resident #102 dated 11/24/25 at 1:17 P.M. and on 11/25/25 at 9:04 A.M. revealed Resident #102 was on a LOA. Interview on 04/02/26 at 2:08 P.M. with LPN #355 revealed Resident #102 was alert and oriented to person, place, and sometimes to time. LPN #355 revealed Resident #102 absolutely knew the difference between right and wrong, he was not normally aggressive, and revealed she did not recall him hitting other residents in the past. Interview on 04/02/26 at 2:16 P.M. with LPN #622 revealed she witnessed the altercation between Resident #11 and #102 on 11/27/25. LPN #622 stated she saw the altercation down the hall; Resident #11 was going back to his room after lunch. Resident #11 was on the outside getting ready to go in his room and Resident #102 was blocking his door. Resident #11 asked him to move and Resident #102 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not say anything, just punched Resident #11 in the face then we separated him. LPN #622 stated staff put Resident #102 on a one-on-one observation and Resident #11 in his room. Resident #11 did not instigate anything and Resident #102 was being aggressive that day all day cussing at staff and residents, yelling, and he was refusing medication and was irritable. LPN #622 reiterated Resident #102 was also aggressive that morning and revealed he went to his sister's for a few days prior to the altercation and his sister said when he came back that he was not taking his medication during the leave of absence. LPN #622 revealed when he returned he also refused medications. LPN #622 confirmed no new interventions were put into place for Resident #102 even though it was reported he refused medications including antipsychotic medications for several days and had increased symptoms of aggression for several hours prior to him hitting another resident. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 05/2025, revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish. Willful meant the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Prevention included completing ongoing assessments and care planning for appropriate interventions and monitoring of residents with behaviors including but not limited to verbally aggressive behaviors, physically aggressive, and wandering into other residents rooms.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, review of the Resident Council meeting minutes, and review of a facility policy and procedure, the facility failed to ensure residents received large portions according to their diet orders. This had the potential to affect 34 (#4, #5, #7, #11, #14, #15, #17, #19, #20, #28, #36, #38, #39, #40, #44, #47, #48, #49, #52, #54, #55, #57, #62, #63, #64, #70, #76, #77, #82, #85, #86, #87, #88, and #90) of 91 residents who received large portions. The facility census was 91. Findings include:Review of the Resident Council meeting minutes dated 12/05/25 revealed resident complaints regarding the food included not getting what they were supposed to get. On 01/05/26 there were complaints of not having enough food on the plate and making sure there were enough portions and the menus matching. On 02/05/26 there were complaints for not receiving enough food and on 03/05/26 there were complaints of not having enough food and making sure there were enough food portions. Observation on 04/02/26 at 1:21 P.M. of the lunch tray line meal service revealed Dietary Manager (DM) #611 was serving the meal. The meal menu was noted to included sausage, baked beans, California blend vegetables, ground sausage, pureed sausage, pureed baked beans, pureed vegetable, green beans, rice, and hamburger for the renal and cardiac diets. Further observation revealed DM #611 served two servings of the main entree (sausage on bun or hamburger) and one four ounce serving each of the baked beans and California blend vegetables or rice and green beans for large portion diets as indicated per therapeutic diet or preference.Observation on 04/02/26 between 12:02 P.M. 12:27 P.M. of dining on the second floor revealed Resident #62 received one hamburger on a bun and a four ounce serving each of rice and green beans. Observation of Resident #62's diet order on his meal ticket revealed the resident was on a large portion renal diet. Observation of Resident #17's lunch tray revealed one sausage on a bun and four ounce serving each of baked beans and California blend vegetables. Observation of Resident #17's meal ticket revealed the resident was on a large portion, regular diet. Interview on 04/02/26 between 12:02 P.M. and 12:27 P.M. with Regional Dietary Manager (RDM) #650 verified Resident #17 and Resident #62 did not receive large portions for their lunch meal. Review of the undated facility policy titled, Large, Small, Double Portions, revealed a large portion was a modest increase above the standard portion 1.5 intended to meet higher caloric or appetite needs while maintaining balance. The definition of a large portion an approved increase above the standard portion that equals 1.5 portion. Large portion should be measured consistently using pre-determined guidelines (e.g. 1.5 scoop instead of one scoop). Interview on 04/02/26 at approximately 2:25 P.M. with DM #611 and RDM #650 verified the facility policy indicated residents were to receive 1.5 portions for large portions. DM #611 stated she thought it meant double entree and verified she gave one four ounce serving of the vegetables (California blend or green beans) and the rice or baked beans. Interview on 04/02/26 at 3:34 P.M. with Activity Director (AD) #561 stated she started in December 2025 and verified during Resident Council, residents consistently complained of not receiving enough food. Review of the diet order report dated 04/01/26 revealed 34 residents (#4, #5, #7, #11, #14, #15, #17, #19, #20, #28, #36, #38, #39, #40, #44, #47, #48, #49, #52, #54, #55, #57, #62, #63, #64, #70, #76, #77, #82, #85, #86, #87, #88, and #90) received large portions at meals.This deficiency represents non-compliance investigated under Complaint Number 2735120 and Complaint Number 2688708.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the facility policy and procedure, the facility failed to ensure food was stored in a manner to prevent spoilage and failed to maintain a clean and sanitary kitchen and cooking equipment. This had the potential to affect all 91 residents residing in the facility. The facility census was 91. Findings include:1. Observation during the tour of the kitchen on 03/30/26 from 7:54 A.M. to 8:15 A.M. revealed a moderate amount of dried white splatter on the backside of the stove. Observed on the tray that sat between the stove top and oven had various food items such as corn on it and once the tray was removed revealed dried brown stains. Observed on the silver plate portion of the wall to the right of the three compartment sink had a moderate amount of various, dried food splatter. Interview on 03/30/26 at approximately 8:10 A.M. with Dietary Manager (DM) #611 verified the above findings. 2. Observation on 04/02/26 at 9:56 A.M. of the nursing unit refrigerator on the third floor revealed a moderated amount of dried brown splatter throughout and on the inside door shelves. Observation of the freezer revealed various stains and food debris. Interview at this time with Licensed Social Worker (LSW) #589 verified the findings and stated night shift staff were responsible to clean the refrigerator. 3. Observation on 04/02/26 at 10:45 A.M. of the fourth floor nursing unit refrigerator revealed a tray of five peanut butter and jelly sandwiches, a small dessert dish with fruit cover with a plastic lid, and a pitcher of orange juice that was half full all with no labels or dates. In the freezer were two pitchers of frozen water also with no label or date. Interview at that time with Licensed Practical Nurse (LPN) #622 verified the findings. Review of the facility policy titled, Sanitation, dated 08/01/23, revealed the food service area shall be maintained in a clean and sanitary manner. All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. This deficiency represents non-compliance investigated under Complaint Number 2688708.

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	04/07/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and resident and staff interview, the facility failed to maintain a clean and sanitary environment. This had the potential to affect all 91 residents residing in the facility. The facility census was 91.Findings include:1. Observation during an environmental tour conducted with Assistant Director of Nursing (ADON) #617 on 04/02/26 between 9:00 A.M. and 10:00 A.M. revealed the room occupied by Resident #11 and Resident #86 had a hole in the bathroom ceiling. The soap dispenser in the room occupied by Resident #52 and Resident #74 was detached from the wall and observed lying on top of the closet door, leaving multiple holes in the wall. The wedge pillow utilized by Resident #89 was heavily soiled with visible dirt and debris. The rooms occupied by Resident #46 and Resident #68 had multiple large cracks across several floor tiles. The rooms occupied by Resident #11, Resident #46, Resident #68, and Resident #86 had an unidentified substance on the floor, resulting in a sticky surface. The room occupied by Resident #71 had a hole in the wall with a cable cord fed through the opening. The rooms occupied by Resident #10, Resident #13, Resident #24, Resident #70, Resident #73, Resident #88, and Resident #99 had privacy curtains with varying degrees of staining. There was a water leak observed under the vanity sink in the room occupied by Resident #62, resulting in brown staining on the wall. The pillow utilized by Resident #27 lacked a pillowcase and was torn, worn, and discolored. The rooms occupied by Resident #67 and Resident #79 had multiple missing window blinds. Continued observation on 04/02/26 between 9:00 A.M. and 10:00 A.M., with ADON #617, revealed the rooms occupied by Resident #5, Resident #8, Resident #19, Resident #25, Resident #34, Resident #43, Resident #48, Resident #51, Resident #58, Resident #74, Resident #77, Resident #82, and Resident #84 had multiple water-stained ceiling tiles. The tile surrounding the drain in the second-floor shower room was cracked. The Connections Unit dining area had missing covers on overhead lights. The hallway of the Connections Unit had a missing ceiling tile with exposed wiring. The armrests of the wheelchair utilized by Resident #20 were torn, with exposed padding. The room occupied by Resident #38 had a missing ceiling tile, exposing a water pipe. The recliner chair utilized by Resident #16 and Resident #41 had visible food debris and dirt accumulation. The chair in the room occupied by Resident #34 had torn and tattered upholstery. The vanity base in the room occupied by Resident #35 and Resident #49 was cracked, with pieces observed on the floor. The fall mat utilized by Resident #34 was torn, worn, and contained visible debris. Multiple electrical outlet covers in the room occupied by Resident #111 were missing, exposing wall openings. Resident #7 had a personal miniature (mini) refrigerator in the room with gnats observed flying around it. Upon opening the refrigerator, leftover fast food items were observed inside. The Blue Sky Unit hallway had multiple water-stained ceiling tiles. A window in the Blue Sky Unit dining room had a large crack. The floors in the Blue Sky Unit dining room had significant staining, dirt accumulation, and multiple cracks. The 200 Hall dining area had rusted air vents and the cover to the baseboard heating and cooling unit was detached. ADON #617 verified all of the above findings at the time of the observation during the environmental tour on 04/02/26 between 9:00 A.M. and 10:00 A.M. 2. Observation on 03/30/26 at 8:21 A.M. the dining room on the second floor revealed the floor appeared dirty in various areas, there was a small hole in wall on the left, and observed under the radiator along wall was dirty with various crumbs underneath. Interview on 03/30/26 at 8:48 A.M. with Housekeeping Supervisor #629 verified the above findings. (continued on next page)

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	04/07/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observation and interview on 03/30/26 at 10:22 A.M. of Resident #17's radiator vent in his room along wall under the window revealed it was heavily dusty. Resident #17 stated it had been that way for a while. Observation on 04/01/26 at 12:51 P.M. with Housekeeper #574 of Resident #17's radiator vent verified the above finding. Housekeeper #574 stated it was their responsibility to clean but the duster they had did not clean the vents well. This deficiency represents non-compliance investigated under Complaint Number 2688708.