

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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.			
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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.		

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of Quality Assurance (QA) meeting sign-in sheets and staff interview, the facility failed to ensure the Medical Director and the Administrator were active participants and attended QA meetings as required. This had the potential to affect all 91 residents residing in the facility. The facility census was 91. Findings include: Review of the Quality Assurance (QA) committee meeting sign-in sheets revealed the facility Medical Director and the Administrator did not attend the first quarter (03/06/25), second quarter (05/02/25), and third quarter (08/08/25) meetings. Interview with the current Administrator verified the Medical Director and former Administrator did not attend quarterly QA Committee meetings as required in an interview on 04/06/26 at 1:50 P.M.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview and review of the facility policy, the facility failed to maintain documentation in the staff files indicating the staff were provide education related to the COVID-19 vaccination and offered the vaccination. This had the potential to affect all 91 residents residing at the facility. The facility census was 91. Findings include: Record review and interview on 04/06/26 at 8:44 A.M. with Licensed Practical Nurse (LPN) Infection Control Nurse #617 revealed staff were offered the COVID-19 vaccines and education was provided on COVID-19 annually. LPN Infection Control Nurse #617 revealed she would have to find the education provided and the tracking log for the staff COVID-19 vaccines. Interview on 04/06/26 at 11:21 A.M. with Certified Nurse Aide (CNA) #613 revealed she was employed at the facility for four years and did not receive education on COVID-19 over the past year. CNA #613 stated the facility offered the staff an influenza (flu) vaccine, but not the COVID-19 vaccine. Interview on 04/06/26 at 11:22 A.M. with LPN #593 revealed the facility provided education on COVID-19 upon hire but none since. LPN #593 revealed she did not recall being offered the COVID-19 vaccine. Interview on 04/06/26 at 11:23 A.M. with CNA #578 revealed he had been at the facility 13 months and was offered the COVID-19 vaccine when he was hired but not since then. CNA #578 revealed he did not receive any education on COVID-19 since he was hired. Interview on 04/06/26 at 11:25 A.M. with Housekeeper #505 revealed she was not educated on COVID-19 and did not recall being offered the COVID-19 vaccine. Interview on 04/06/26 at 11:26 A.M. with CNA #501 revealed been employed at the facility two years and had never been offered the COVID-19 vaccine. CNA #501 revealed she did receive education on COVID-19 but was not sure when. Interview on 04/06/26 at 1:21 P.M. with LPN Infection Control Nurse #617 confirmed she did not have documentation of anything that showed staff were educated specifically on COVID-19 over the past 12 months. LPN Infection Control Nurse #617 revealed staff knew she had COVID-19 vaccines available if they wanted them, but she never went to each one individual to offer the vaccine, never logged the vaccines staff received, and never kept tract of staff COVID-19 status nor record vaccines. Interview on 04/06/26 at 1:27 P.M. with Human Resource Director (HR) #607 revealed she never tracked COVID-19 vaccines for any staff. Review of the facility policy titled, Covid Vaccination Policy, dated 08/2025, revealed the facility will offer and provide COVID-19 vaccination as recommended should be documented within by the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and other regulatory bodies to minimize the risks of residents and staff acquiring, transmitting, or experiencing complications of COVID-19. Residents and staff will be offered the COVID-19 vaccine as guided by the CDC, state or federal regulations. A consent form will be completed at that time. Prior to offering the COVID-19 immunization to the resident, the residents legal representative or staff, the nursing facility will provide education regarding the benefits and potential side effects of the immunization. The resident or residents legal representative or staff member have the right to refuse the COVID-19 immunization. The refusal and the reason for the refusal should be documented within the staff members personnel file that the staff member was provided education regarding the benefits and potential side effects of the COVID-19 immunization and the staff member either received the COVID-19 immunization or did not receive the COVID-19 immunization.		

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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)		

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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.		

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to develop comprehensive care plans to specify resident care needs. This affected five (#9, #20, #44, #64, and #80) of 30 residents reviewed for care plans. The facility census was 91. Findings include: 1. Review of the medical record for Resident #9 revealed an admission date of 01/03/26 and diagnoses including displaced fracture of the surgical neck of the right humerus, type two diabetes mellitus, depression, insomnia, and chronic systolic congestive heart failure. Review of a physician's order dated 01/03/26 revealed Resident #9 had an order for sliding scale insulin coverage for diabetes mellitus. Review of a physician's order dated 01/05/26 revealed Resident #9 had an order for furosemide (diuretic medication) for weight gain and leg swelling. Review of a physician's order dated 02/05/26 revealed Resident #9 had an order for Januvia for diabetes mellitus. Review of a physician's order dated 02/15/26 revealed Resident #9 had an order for metformin for diabetes mellitus. Review of a physician's order dated 02/18/26 revealed Resident #9 had an order for melatonin and Trazodone (atypical antidepressant) at bedtime for insomnia. Review of Resident #9's plan of care revealed no evidence of a comprehensive care plan to address use of diuretic, hypoglycemics, and medications for insomnia. Interview on 04/06/26 at 1:55 P.M. with Regional Minimum Data Set (MDS) Nurse #632 confirmed there was no plan of care developed for Resident #9 for use of diuretics, hypoglycemics, and medications for insomnia. 2. Review of the medical record for Resident #64 revealed an admission date of 01/22/26 and diagnoses including type two diabetes mellitus, borderline personality disorder, schizoaffective disorder bipolar type, and epilepsy. Review of a physician's order dated 02/17/26 revealed Resident #64's had an order for lorazepam for anxiety. Review of a physician's orders dated 03/04/26 revealed Resident #64 had orders for insulin for diabetes mellitus. Review of a physician's order dated 03/05/26 revealed Resident #64 had an order for Farxiga for diabetes mellitus. Review of Resident #64's plan of care revealed no evidence of a comprehensive care plan to address diabetes mellitus and use of medications for anxiety. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/06/26 at 1:55 P.M. with Regional MDS Nurse #632 confirmed there was no plan of care developed for Resident #64 for diabetes mellitus or use of medications for anxiety. 3. Review of the medical record for Resident #80 revealed an admission date of 07/15/25 and diagnoses including bipolar type schizoaffective disorder, post-traumatic stress disorder, generalized anxiety disorder, depression, and insomnia. Review of a physician's order dated 07/15/25 revealed Resident #80 had an order for melatonin at bedtime for insomnia. Review of a physician's order dated 02/05/26 revealed Resident #80 had an order for alprazolam (benzodiazepine) for anxiety. Review of Resident #80's plan of care revealed no evidence a comprehensive care plan to address use of medications for insomnia and anxiety. Interview on 04/06/26 at 1:55 P.M. with Regional MDS Nurse #632 confirmed there was no plan of care developed for Resident #80 for use of medications for insomnia and anxiety. 4. Record review for Resident #20 revealed an admission date of 07/24/19. Diagnoses included dementia, abnormalities of gait and mobility, and unsteadiness on feet. Review of the MDS assessment dated [DATE] revealed Resident #20 was moderately cognitively impaired. Resident #20 had adequate vision and did not wear corrective lenses for vision. Record review on 03/31/26 at 10:00 A.M. revealed Resident #20 did not have a care plan related to corrective lenses. Review of the Eye Care chart note for Resident #20 dated 08/26/25 revealed the resident had decreased vision in the right eye and left eye and it affected both near and far vision. The symptom was constant and the condition was moderate. In addition, the condition was associated with daily activity and chores. Review of the social service note for Resident #20 dated 09/03/25 at 4:05 P.M., completed by Licensed Social Worker (LSW) #589, revealed Resident #20 received prescription eyeglasses on that date. Observation and interview on 03/30/26 at 10:29 A.M. revealed Resident #20 was sitting up in his wheelchair. Resident #20 had on a black pair of glasses that appeared to be old with the left side arm of the glasses taped to the rim of the glasses covering the hinge. Resident #20 revealed the glasses broke a year ago. Interview on 03/31/26 at 2:00 P.M. with Licensed Practical Nurse (LPN) MDS Coordinator #628 confirmed Resident #20 did not have a care plan implemented for his decreased vision or glasses. 5. Record review for Resident #44 revealed an admission date of 09/30/22. Diagnoses included paranoid schizophrenia, hemiplegia affecting the left non-dominant side, schizoaffective disorder, bipolar type, cerebrovascular disease, cognitive communication deficit, and personal history of traumatic brain injury. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE] revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of six indicating the resident was severely cognitively impaired. Resident #44 had no hallucinations or delusions, or behavioral symptoms directed towards others. Review of Resident #44's medication administration record (MAR) for February 2026 revealed and order for the antipsychotic medication Haldol injection solution five (5) milligrams (mg) per milliliter (ml), inject 5 mg intramuscularly one time only for exit seeking behavior. The Haldol was documented on the MAR as administered on 02/20/26 at 12:23 P.M. Record review for Resident #44 revealed Resident #44 did not have a care plan for exit seeking. Review of the progress note dated 02/20/26 at 12:06 P.M., completed by LPN #555, revealed Resident #44 was exit seeking that shift. The resident was standing in front of the elevator with his coat on stating he was leaving to go and see his cousin. The resident was asked by the nurse to move away from the elevator. It was explained to the resident he was not able to leave at that time. Resident #44 stated that he was leaving, and that he was going to punch the nurse in the face. The psychiatric nurse practitioner was contacted and a one-time Haldol order was given. The injection was given and effective. Resident #44 did speak with his cousin who explained to the resident that he could not just leave the facility and that she would be to the facility to visit him. Resident #44 was in his room at that time awake with eyes open with normal rise and fall of chest. Observation on 03/30/26 at 1:01 P.M. revealed Resident #44 was sitting in the hall up in the wheelchair. Resident #44 did not answer when spoken to. Interview on 03/31/26 at 3:23 P.M. with Certified Nurse Aide (CNA) #582 revealed Resident #44 talked about wanting to leave and did at times go to the elevator wanting to leave and exit seeking. Interview and record review on 04/07/26 at 9:05 A.M. with Regional Director of Clinical Services (RDSCS) #631 confirmed prior to 03/30/26, Resident #44 did not have a care plan for exit seeking.		

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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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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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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 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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure a resident's choice for bathing method and frequency was honored. This affected one (#89) of four residents reviewed for bathing preferences/schedule. The facility census was 91. Findings include: Record review for Resident #89 revealed an admission date of 06/06/18. Diagnosis included spastic diplegic, cerebral palsy, polyneuropathy, spina bifida, and muscle weakness. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #87 revealed it was very important to the resident to choose between a tub bath, bed bath, or sponge bath. Review of the quarterly MDS assessment dated [DATE] revealed Resident #89 was cognitively intact. Resident #89 had impairment on both sides of the upper and lower extremities. Resident #89 used a wheelchair for mobility, was dependent for showers/bathing, personal hygiene, and chair/bed to chair transfers. Review of the care plan dated 12/22/25 revealed Resident #89 had an activity of daily living (ADL) self-care performance deficit related to a decline in functional mobility. Interventions included for bathing to avoid scrubbing and pat dry sensitive skin and to check nail length and trim and clean on bath day and as necessary. Staff were to report any changes to the nurse and the resident was transferred with mechanical (Hoyer) lift. Review of the shower schedule revealed Resident #89 was to receive two showers per week with scheduled days on Mondays and Thursdays. Observation and interview on 03/30/26 at 10:38 A.M. with Resident #89 revealed his fingernails were long, uneven, and embedded with a dark substance. Resident #89 stated he would like his fingernails cleaned and trimmed but staff would not do it. Resident #89 stated he could never get a shower, had not been showered in two weeks, before that was two months. Resident #89 stated the facility gave him a bed bath and he wanted a shower. Resident #89 stated the staff have to lift him for the shower chair and the staff is almost all women and they do not want to do it. Observation and interview on 04/01/26 at 3:31 P.M. with Certified Nurse Aide (CNA) #584 verified Resident #89's fingernails were long, uneven, and embedded with a dark substance. CNA #584 revealed Resident #89 received showers and bed baths. If they run out of Hoyer lift pads, the resident had to receive a bed bath. CNA #584 stated, Resident #89 was a two person assist for transfers and it was hard getting him up and down. CNA #584 stated the staff would have to get him out of the wheelchair, in a shower chair, back in the wheelchair, then to bed, and that was a lot of lifting so sometimes the staff just give a bed bath instead of a shower. CNA #584 revealed Resident #89 never refused staff to trim or clean his fingernails but sometimes there was not enough time for staff to clean the fingernails. Interview on 04/02/26 at 9:26 A.M. with Activities Director #561 confirmed she completed the likes and dislikes form with Resident #89. Activities Director #561 confirmed Resident #89 revealed he preferred showers during the interview. Record review and interview on 04/02/26 at 11:26 A.M. of Resident #89's Bath and Skin Report Sheets for March 2026, with Regional Chief Clinical Nursing Operator (RCCNO) #701, revealed the forms were filled in with Resident #89's name and date to receive the scheduled bath/shower on 03/02/26, 03/05/26, 03/09/26, 03/12/26, 03/19/26, 03/23/26, and 03/26/26. RCCNO #701 confirmed the section of the form revealing the shower/bath was completed was not filled in or documented as completed. Review of the electronic medical record for Resident #89 with RCCNO #701 revealed Resident #89 received four bed baths (03/09/26, 03/23/26, 03/26/26, and 03/30/26) for the month of March 2026. RCCNO #701 confirmed there were no showers documented as received for the month of March 2026 and confirmed residents have the right to choose between a bath, bed bath, or shower. Interview on 04/02/2026 at 11:40 A.M. with the Director of Nursing (DON) revealed residents should receive two showers/baths a week and as needed. Review of the shower schedule in the electronic medical record for Resident #89 revealed the resident preferred showers on Monday and Thursday from 3:00 P.M. to 11:00 P.M., and staff were to (continued on next page)		

Department of Health & Human Services
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offer to shave the resident and clean and trim nails on shower days. Review of the facility policy titled, Bathing Choice Policy, dated 06/2025, revealed the policy was to establish frequency of bathing by resident choice. Residents are interviewed during the admission process regarding the frequency they want the bath or shower. Changes will be implemented if indicated by the residents choice.		

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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 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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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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, staff interview, review of a self-reported incident, and review of a facility policy, the facility failed to ensure an allegation of abuse was timely reported to the state survey agency. This affected one (Resident #11) of six residents reviewed for abuse. The facility census was 91. Findings include: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.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 progress note for Resident #11 dated 11/27/25 at 1:30 P.M., completed by Licensed Practical Nurse (LPN) #622 revealed the nurse made aware that the resident alleged he and a peer had an altercation with a skin alteration noted. The residents were separated, the skin alteration was cleansed, and the physician was notified.Record review of a self-reported incident (SRI) for an allegation of physical abuse, created 11/28/25 at 11:21 A.M. with a date of discovery of 11/27/25, 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 facility unsubstantiated the allegation indicating evidence of abuse, neglect, or misappropriation did not occur.Interview on 04/02/26 at 4:13 P.M. with the Administrator verified the abuse allegation occurred on 11/27/25 at 1:30 P.M. and was reported on 11/28/25 at 11:21 A.M. The Administrator revealed no one was available to complete the SRI until he returned from his holiday trip. The Administrator revealed he did not remember when the facility staff notified him and revealed he did not know how long he had to report abuse.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. If any form of abuse was alleged or serious bodily injury was identified, the Administrator or his/her designee will notify the Ohio Department of Health immediately but no later than two hours after the allegation was made.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare and Medicaid Services (CMS) within 14 days of completion, as required. This affected one (#84) three residents reviewed for MDS assessment submissions. The facility census was 91. Findings include: Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, generalized anxiety disorder, and vitamin D deficiency. Review of the Minimum Data Set (MDS) assessment schedule for Resident #84 on 03/31/26 revealed a quarterly MDS assessment was completed on 10/10/25, and a subsequent quarterly MDS assessment was completed on 01/10/26. Further review revealed the 01/10/26 assessment was listed as exported, indicating it had not been successfully transmitted and accepted by the Centers for Medicare and Medicaid Services (CMS) within the required 14-day timeframe following completion. Interview with MDS Nurse #628 on 03/31/26 at 3:22 P.M. confirmed the quarterly MDS assessment dated [DATE] for Resident #84 was not transmitted to CMS within 14 days of completion, as required.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure one (#44) of four residents reviewed for activities of daily living (ADLs) was properly assessed and provided services to address a decline in ADLs self-care. The facility census was 91. Findings include: Record review for Resident #44 revealed an admission date of 09/30/22. Diagnoses included paranoid schizophrenia, hemiplegia affecting the left nondominant side, osteonecrosis of the right femur, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, muscle weakness, extrapyramidal and movement disorder, retention of urine, vertigo, and personal history of a traumatic brain injury. Review of the facility census revealed Resident #44 was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 10/29/24. Resident #44 was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 07/16/25. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was moderately cognitively impaired, was always continent of bowel and bladder, did not use a wheelchair, was independent for chair/bed to chair transfer, was independent walking 10 feet, required supervision or touch assist for walking 150 feet, and also required supervision or touch assistance with a shower/bath. Review of the MDS assessment dated [DATE] revealed Resident #44 was severely cognitively impaired. Resident #44 was occasionally incontinent of bladder, required supervision or touch assistance for chair/bed to chair transfer and to walk 10 feet. Resident #44 did not use a wheelchair and required supervision or touch assistance for a shower/bath. Review of the care plan updated 02/13/26 revealed Resident #44 had an activities of daily living (ADL) self-care performance deficit related to paranoid schizophrenia, muscle weakness, cognitive communication deficit, and hemiplegia. Interventions included to provide a sponge bath when a full bath could not be tolerated, transfers with no physical assist needed from staff, and monitor, document, and report as needed and changes, any potential for improvement, reason for self-care deficit, expected course, and decline in function. Observation on 03/30/26 at 1:01 P.M. revealed Resident #44 was sitting in the hall up in the wheelchair. Resident #44 did not answer when spoken to. Interview on 03/31/26 at 4:40 P.M. with Licensed Practical Nurse (LPN) #595 revealed when Resident #44 was out of bed he required a wheelchair for mobility. Resident #44 could transfer himself to the wheelchair, but he did not walk at all. LPN #595 confirmed Resident #44 was incontinent of bladder. Interview on 03/31/26 at 4:42 P.M. with Certified Nurse Aide (CNA) #616 revealed Resident #44 was incontinent of urine all the time. Interview on 04/01/26 at 9:53 A.M. with Certified Occupational Therapy Assistant (COTA) #519 revealed the nursing department did referrals for therapy to pick up residents for a decline. Therapy would evaluate the resident to determine the need. Interview on 04/01/26 at 10:06 A.M. with Occupational Therapist (OT) #700 revealed on 11/17/25 occupational therapy picked up Resident #44 for a wheelchair evaluation for a custom wheelchair. The new wheelchair arrived 12/16/25 and Resident #44 was seen again on that day to make sure the new custom wheelchair fit appropriately. Prior to that, Resident #44 was picked up by therapy from 10/14/25 through 11/04/25 related to a fall he had from his old wheelchair. Therapy completed safety awareness and transfers to the wheelchair at that time because he fell due to not locking the wheelchair break. OT #700 revealed on 11/17/25 there was no referral given to therapy for a decline in ADLs including ambulation and stated it was just an evaluation for his wheelchair fitting only. OT #700 confirmed she reviewed all the therapy discipline notes and confirmed Resident #44 was not referred to therapy since 11/17/25. OT #700 revealed a therapist would attend morning meetings and if a resident decline was discussed, the therapist would put the resident on her schedule for an evaluation. OT #700 confirmed there were no further referrals for Resident #44 after 11/17/25 except for wheelchair fitting. Interview on 04/01/26 at 10:21 A.M. with LPN #355 revealed Resident #44 had been using a wheelchair and revealed she (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not remember for how long but prior to that, he use to walk. LPN #355 revealed Resident #44 was unable to walk anymore and had not for a long time. CNA #503 was present and revealed Resident #44 also now wore a brief and revealed when Resident #44 transferred downstairs to live he was continent and could walk, he came back upstairs in a wheelchair and was incontinent. CNA #503 stated the staff noticed the difference and Resident #44 needed more help now with showers and before he did himself. Interview and observation on 04/01/26 at 10:40 A.M. revealed Resident #44 self-transferred from his bed to a wheelchair. Resident #44 did not lock the wheelchair brakes and the wheelchair rolled backwards as he went to pivot to the chair. The chair was stopped by the partially opened corner of the door. Resident #44 revealed he used a wheelchair all the time and he use to walk but he could not much anymore. Interview and record review on 04/01/26 at 10:46 A.M. with LPN MDS Coordinator #628 of Resident #44's MDS assessments dated 11/13/25 and 02/13/26 was compared for a decline in ADLs. LPN MDS Coordinator revealed Resident #44 had been in a wheelchair for a long time and revealed Corporate MDS Coordinator #630, who worked from home, assisted in completing resident MDS assessments. LPN MDS Coordinator #628 revealed if the resident triggered for a decline from one MDS assessment to the next, they would re-interview the resident and notify therapy. LPN MDS Coordinator confirmed Resident #44 had a decline in cognition, transfers, ambulation, and continence documented on the quarterly MDS assessments from 11/13/25 to 02/13/26. Interview on 04/01/26 at 2:36 P.M. with the Director of Nursing (DON) revealed Resident #44 started to use the wheelchair for mobility last year when he had a fall. The DON revealed compared to last year, Resident #44 needed more assistance and revealed therapy should have screened him when the decline occurred and stated, When we asked (therapy) for the wheelchair evaluation, they should have looked at him for the decline because he was walking and now needed a wheelchair. Interview on 04/01/26 3:28 P.M. with CNA #584 revealed when Resident #44 was originally on the third floor, he was walking and doing everything himself. He graduated to the second floor and came back in a wheelchair that he had been in since. CNA #584 stated the staff had to help Resident #44 with his ADLs now. Review of the facility policy titled, Activities of Daily Living Policy, dated 05/2025, revealed the facility activity of daily living (ADL) goal was that a resident's abilities in ADLs do not diminish unless circumstances of the individual's clinical condition demonstrate that decline was unavoidable. This includes the resident's ability to bath, dress, groom, transfer, ambulate, toilet, and eat.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of shower schedules, the facility failed to ensure adequate fingernail care was completed for dependent residents. This affected one (#89) of four residents reviewed for bathing/showers. The facility census was 91. Findings include: Record review for Resident #89 revealed an admission date of 06/06/18. Diagnoses included spastic diplegic, cerebral palsy, polyneuropathy, spina bifida, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 was cognitively intact. Resident #89 had impairment on both sides of the upper and lower extremities. Resident #89 used a wheelchair for mobility, was dependent for showers/bathing, personal hygiene, and chair/bed to chair transfers. Review of the care plan dated 12/22/25 revealed Resident #89 had an activity of daily living (ADL) self-care performance deficit related to a decline in functional mobility. Interventions included for bathing to avoid scrubbing and pat dry sensitive skin and to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Review of the shower schedule revealed Resident #89 was to receive two showers/baths per week. Observation and interview on 03/30/26 at 10:38 A.M. with Resident #89 revealed his fingernails were long, uneven, and embedded with a dark substance. Resident #89 stated he would like his fingernails cleaned and trimmed but staff would not do it. Observation on 04/01/26 at 3:31 P.M. with Certified Nurse Aide (CNA) #584 verified Resident #89's fingernails were long, uneven, and embedded with a dark substance. CNA #584 revealed Resident #89 never refused staff to trim or clean his fingernails but sometimes there was not enough time for staff to clean the fingernails. Interview on 04/02/26 at 11:40 A.M. with the Director of Nursing (DON) revealed residents should receive two showers/baths a week and as needed. Review of Resident #89's shower schedule in the electronic medical record with the DON revealed Resident #89 preferred showers on Monday and Thursday between 3:00 P.M. to 11:00 P.M., and staff were to offer to shave the resident and clean and trim nails on shower days.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and medical record review, the facility failed to ensure one (#20) resident received assistance with his glasses to ensure consistency with utilizing the prescribed glasses. This affected one (#20) of three residents reviewed for ancillary services. The facility census was 91. Findings include: Record review for Resident #20 revealed an admission date of 07/24/19. Diagnoses included dementia, abnormalities of gait and mobility, and unsteadiness on feet. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was moderately cognitively impaired. Resident #20 used a wheelchair for mobility, required supervision or touch assistance to ambulate 150 wheelchair mobility, had clear speech, was usually understood and understands others, had adequate vision and did not wear corrective lenses for vision. Record review on 03/31/26 at 10:00 A.M. revealed there was no care plan for Resident #20 related to corrective lenses. Review of the eye care chart note for Resident #20 dated 08/26/25 revealed the resident had decreased vision in the right eye and left eye affecting both near and far vision. The symptom was constant and the condition was moderate. In addition, the condition was associated with daily activity and chores. It was noted there were n bifocal material glasses with parallel, blue fade. Review of the social service note for Resident #20 dated 09/03/25 at 4:05 P.M., completed by Licensed Social Worker (LSW) #589, revealed Resident #20 received prescription eyeglasses on that date. Observation and interview on 03/30/26 at 10:29 A.M. revealed Resident #20 was sitting up in his wheelchair. Resident #20 had on a black pair of glasses that appeared to be old with the left side arm of the glasses taped to the rim of the glasses covering the hinge. Resident #20 revealed the glasses broke a year ago and he has not seen the eye doctor yet to get new ones. Interview on 03/31/26 at 1:02 P.M. with Registered Nurse (RN) Unit Manager (UM) #598 confirmed Resident #20 wore eyeglasses and revealed he had a black pair with tape holding the arm piece on. RN UM #598 revealed she did not know he received a new pair of prescription eyeglasses. RN UM #598 confirmed after searching Resident #20's room, she was unable to find his prescription glasses. Interview on 03/31/26 at 1:06 P.M. with Resident #20 revealed he was unsure where his new glasses where and confirmed he needed them but felt he must have left them at home. Interview on 03/31/26 at 1:11 P.M. with Licensed Practical Nurse (LPN) #551 revealed she started working at the facility in December 2025. LPN #551 revealed she had only ever seen Resident #20 with black glasses with tape since she started working at the facility and revealed she did not know he had prescription glasses. Interview on 03/31/26 at 1:27 P.M. with LSW #589 confirmed she gave Resident #20 his new glasses on 09/03/25 and revealed she did not know the new glasses were missing and staff did not report it to her. Interview on 03/31/26 at 3:26 P.M. with Certified Nurse Aide (CNA) #582 revealed she did not know what happened to Resident #20's new glasses and confirmed she only saw him wear black ones with the tape and did not know he had new ones. Interview on 04/06/26 at 10:49 A.M. with LSW #589 revealed she and the staff looked all over and could not find Resident #20's new prescription glasses. LSW #589 revealed she did not know where he got the broken black glasses stating, We have no idea.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure orders for urostomy care were obtained and completed. This affected one (#25) of one resident reviewed for urostomy care. The census was 91. Findings include: Record review for Resident #25 revealed an admission date of 03/19/26. Diagnoses included chronic kidney disease, borderline personality, post-traumatic stress disorder, heart failure, and suicidal ideation. Review of the baseline admission assessment and baseline care plan dated 03/19/26 revealed Resident #25 was cognitively intact and used a device for ambulation. Resident #25 had a urostomy (an artificial opening which allows urine to leave the body through a stoma (opening) in the abdomen) was in normal limits. The assessment did not identify a care plan and or interventions for the urostomy. Review of Resident #25's physician orders revealed an order dated 03/19/26 with a start date of 04/01/26 to change the urostomy bag every three days and as needed. There was an order dated 04/01/26 with a start date of 04/01/26 to provide urostomy care every shift and as needed. Review of the treatment administration record for March 2026 revealed no treatments or documentation to change the urostomy bag or provide urostomy care every shift for Resident #25. Interview on 04/01/26 at 2:54 P.M. with Licensed Practical Nurse (LPN) #355 stated Resident #25 had her urostomy changed every three days in the evening. LPN #355 reviewed Resident #355's orders for urostomy and was unable to find the orders for the evening. LPN #355 stated she did not know why the orders were not available. Interview on 04/01/26 at 2:57 P.M. with Resident #25 stated the nurses are supposed to change her urostomy bag every three days. Interview on 04/06/25 at 3:26 P.M. with Registered Nurse (RN) #598 stated the admission hospital orders did not have any urostomy order listed. The orders never got entered in the computer. RN #598 verified there was no ostomy care listed in the baseline care plan. Review of the facility policy titled, Ostomy Care, dated October 2025, revealed to obtain a physician's order for the procedure and it was recommended for routine and as necessary orders to change ostomy appliance.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a dialysis agreement, the facility failed to ensure ongoing assessments of a resident's condition and monitoring for complications before and after dialysis treatments were consistently completed. This affected one (#6) of one resident reviewed for dialysis. The facility census was 91. Findings include: Review of the medical record for Resident #6 revealed an admission date of 02/18/26. Diagnoses included end stage renal disease, dependence on renal dialysis, anemia in chronic kidney disease, morbid (severe) obesity due to excess calories, schizoaffective disorder, bipolar type, anxiety disorder, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had intact cognition, required supervision or touch assistance with eating, and was dependent on staff for bed mobility and transfers. The assessment also indicated the resident received dialysis. Review of the physician orders for March 2026 revealed active orders for dialysis days on Monday, Wednesday, and Friday. Review of Resident #6's medical record, including the paper and electronic records, revealed only three pre- and post-dialysis forms dated 03/04/26, 03/18/26, and 03/13/26. Interview on 04/02/26 at 9:31 A.M. with Nurse Unit Manager (NUM) #626 stated the facility send their pre- and post-dialysis assessments but the dialysis center does not send anything back to them. NUM #626 stated sometimes they do not send the form they send back to them. NUM #626 stated the dialysis center completes their own assessment of Resident #6 before and after dialysis. NUM #626 verified there were only three forms in Resident #6's medical record to show ongoing assessments of the resident's condition and monitoring for complications before and after dialysis treatments because that was what was sent back from the dialysis center. Interview on 04/07/26 at 12:19 P.M. with the Director of Nursing (DON) stated she talked with the dialysis center and moving forward they will be sending a folder with the facility form for dialysis to keep and dialysis will send back a form with their information such as medications given there, weights, etc. Review of the undated dialysis agreement between facility and the dialysis center revealed the dialysis center agreed to cooperate facilitating and communicating information to the nursing facility which was useful or necessary for the care of a dialysis resident. If, based on a nursing judgement, there was a change in a dialysis resident's condition, the dialysis center will notify the nursing facility when the resident returns to the nursing facility.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, medical record review, and review of the facility policy, the facility failed to ensure staff maintained proper infection control practice when providing care for residents in enhanced barrier precautions (EBP). This affected two (#5 and #33) of eight residents observed for EBP. The facility census was 91. Findings include: 1. Record review for Resident #5 revealed an admission date of 10/31/24. Diagnoses included obstructive and reflux uropathy, retention of urine, and chronic viral hepatitis C. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. Resident #5 had an indwelling catheter and was dependent for personal hygiene. Review of the care plan dated 09/08/25 revealed Resident #5 required enhanced barrier precautions (EBP) related to the suprapubic catheter. Interventions included the use of appropriate EBP when performing resident care tasks including dressing, bathing, showering, transferring, personal hygiene, changing linens, changing briefs or assisting with toileting; device care or use including central line, urinary catheter, feeding tube, tracheotomy, ventilator, and wound care including any skin opening requiring a dressing. Review of the physician order dated 03/31/26 for Resident #5 revealed, for the resident's suprapubic catheter site, staff were to cleanse with normal saline and cover with four by four (4 x 4) split gauze every day and as needed. Review of the physician order dated 03/19/26 for Resident #5 revealed the resident was in EBP related to suprapubic catheter every shift. Observation on 04/01/26 at 3:44 P.M. of Certified Nurse Aide (CNA) #616 revealed the staff member emptied the urine drainage bag for Resident #5 while the resident was lying in bed. The suprapubic catheter was intact. An EBP sign was posted on the wall above Resident #5's bed and included instructions that everyone must wear gloves and a gown for care areas which included device use; a urinary catheter. Observation revealed CNA #616 never donned an isolation gown. CNA #616 emptied Resident #5's urine drainage bag into a urinal then poured the urine from the urinal into the toilet. CNA #616 verified there was 200 cubic centimeters (cc) of cloudy urine. CNA #616 verified the EBP sign above the bed and confirmed she did not wear an isolation gown while draining the urine from the catheter bag and revealed she was not sure if she should. Observation on 04/01/26 at 4:04 P.M. of Licensed Practical Nurse (LPN) #596 providing suprapubic catheter site care for Resident #5. Resident #5 had a small amount of pink brownish drainage at the insertion site. LPN #596 provided the care and treatment to the suprapubic catheter site without donning an isolation gown. LPN #596 confirmed she never donned an isolation gown while providing care and treatment to Resident #5's suprapubic catheter site. 2. Record review for Resident #33 revealed an admission date of 09/12/24. Diagnoses included hypertensive heart disease with heart failure, systemic lupus erythematosus, and neuroleptic induced parkinsonism. Review of the quarterly MDS assessment dated [DATE] revealed Resident #33 was mildly cognitively impaired. Resident #33 was frequently incontinent bowel and bladder and was dependent for personal hygiene. Resident #33 had medically complex conditions. Review of the care plan dated 03/25/25 revealed Resident #33 required EBP related to a history of multi-drug-resistant organisms (MDRO). Interventions included the use of appropriate EBP when performing resident care tasks including, dressing, bathing, showering, transferring, personal hygiene, changing linens, toileting, and peri-care. Review of the physician orders for Resident #33 dated 06/09/25 revealed an order for EBP related to a history of MDRO. Observation on 04/06/26 at 11:28 A.M. revealed CNA #578 was performing incontinence care for Resident #33 while the resident was lying in bed. Above the bed was a sign for EBP and included instructions revealing everyone must clean their hands before entering and when leaving the room and wear gloves and gown for high contact care activities including changing a brief and providing hygiene. Observation revealed CNA #578 did not wash his hands before entering the room nor donned an isolation gown prior to incontinence care. CNA #578 confirmed he did not wear an isolation gown while providing incontinence care for Resident #33 and revealed it was because Resident #33 did not (continued on next page)		

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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 04/07/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have a wound. Interview on 04/06/26 at 11:49 A.M. with LPN #550 confirmed she was Resident #33's primary nurse. LPN #550 revealed Resident #33 was not on EBP and did not know when she had an EBP sign. LPN #550 reviewed the physician orders for Resident #33 then confirmed Resident #33 was on EBP related to a history of MRDO. Interview on 04/06/26 at 11:55 A.M. with the Director of Nursing (DON) verified Resident #33 was on EBP related to the history of MRDO. Review of the facility policy titled, Enhanced Barrier Precautions, updated 04/2024, revealed colonization was when a germ was found on or in the body but is not causing infection. MDRO was a bacteria or fungi resistant to multiple antimicrobials. Recent Centers for Disease Control and Prevention (CDC) studies have shown many nursing home residents are unknowingly colonized with MDRO, especially residents with risk factors like indwelling medical devices or wounds. Residents who have an MDRO can develop serious infections, remain colonized for a long time, and spread MDROs to others. Healthcare personnel in long term care can unknowingly spread MDROs through contaminated hands and clothing. The CDC has determined by using EBP, long term care facilities can reduce the spread of MDROs without isolating residents for long periods of time. EBP was used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high contact resident care activities that provide opportunity for transfer of MDROs to staffs hands and clothing. EBP are indicated for residents with any of the following to include infection or colonization with a CDC targeted MDRO, and wounds or an indwelling medical device. An EBP sign will be placed to identify the PPE required during high contact care activities.		

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and review of the facility assessment, the facility failed to develop and implement a facility assessment that addressed all necessary components. This had the potential to affect all 91 residents. The facility census was 91. Findings include: Review of the facility assessment dated [DATE] revealed, in creating the assessment, there was no evidence the facility solicited input from residents or their representatives. The assessment did not address staffing needs for each shift including nights and weekends or contingency planning for events that do not require activation of the facility's emergency plan. Interview on 04/06/26 at 9:54 A.M. with the Administrator and Regional Director of Operations (RDO) #631 confirmed the facility assessment did not address input from residents and representatives, nights and weekend staffing needs, and contingency planning.		