STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366058	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristos Nursing and Rehabilitation	4650 Rocky River Dr Cleveland, OH 44135

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, policy review, and interviews with staff and hospice provider, the facility failed to ensure the residents were timely assessed when new wounds were identified and failed to ensure the wounds were documented accurately in the facility's records. This affected one (Resident #1) of two residents reviewed for pressure ulcers. The facility census was 49. Findings include:Review of the medical record for Resident #1 revealed an admission date of 02/28/25 with diagnoses including adult failure to thrive, chronic kidney disease, diabetes mellitus, contracture to bilateral knees and hips. Review of Resident #1's nursing evaluations revealed Resident #1 had a weekly skin evaluation on 07/31/25 and had no skin breakdown. There was no skin evaluation from 08/01/25 to 08/22/25. The next weekly skin evaluation was on 08/24/25. Review of the nursing progress notes for Resident #1 for 07/31/25 through 08/19/25 revealed there was no documentation as to skin breakdown to his bilateral heels or ankles. Review of the shower sheets for Resident #1 revealed Resident #1's skin was intact on 08/04/25 and 08/11/25. On 08/18/25, it stated skin was not intact but there was no documentation as to where the new skin impairment was located. There was no documentation in the progress notes or a wound assessment on 08/18/25. Review of the internal incident report (not available in Resident #1's medical record) dated 08/18/25 at 4:09 A.M. revealed Licensed Practical Nurse (LPN) #547 (agency nurse) had noted open wounds to bilateral lower ankles. She stated the left ankle wound was three centimeters by three centimeters in size and was a stage II (partial thickness skin loss involving the epidermis and or dermis layers) or III (full thickness skin loss that extends into the subcutaneous tissue but does not involve muscle, tendon or bone) pressure ulcer. The right ankle wound was four centimeters by five centimeters and was a stage II or III pressure ulcer. LPN #547 stated she updated the hospice nurse on duty and applied protective dressings to both of the wounds. Review of the hospice binder revealed a physician's order was dated 08/18/25 at 4:35 P.M. to cleanse the bilateral inner heels with normal saline, pat dry, and apply calcium alginate and foam daily and as needed. There was no skin assessment noted as to why there was a new physician's order for the bilateral inner heels or a hospice nurse progress note on 08/18/25 and 08/19/25. Review of the wound evaluation dated 08/20/25 revealed Resident #1 had a left medial heel and right medial ankle stage III pressure ulcers that were new and had been acquired at the facility. Review of the Matrix for Providers document provided by the facility on 09/22/25 revealed Resident #1 had no in-house acquired pressure ulcers. Interview on 09/23/25 at 3:30 P.M. with Registered Nurse (RN) #549 revealed Resident #1's in-house acquired pressure ulcers to his bilateral ankles were initially observed and assessed on 08/20/25. Interview on 09/24/25 at 1:04 P.M. with the Administrator verified the facility was aware on 09/08/25 of weekly skin assessments not being performed for residents. She also verified the Matrix for Providers was incorrect as Resident #1's two stage III in-house pressure ulcers were not documented. The Administrator stated the facility was confused if Resident #1's pressure ulcers to his bilateral heels were in-house or community acquired and that was why they were not listed on the matrix. Interview on 09/24/25 at 2:09 P.M. with Hospice Nurse #572 verified hospice staff came to the facility twice weekly. She stated hospice was updated on 08/18/25 at 4:00 A.M. by the facility nurse stating that Resident #1 had new wounds to his bilateral inner ankles. Hospice Nurse #572 stated she told the nurse she would look at the wounds when she came to the facility later that day. Hospice Nurse #572 stated she went to the facility that afternoon and assessed Resident #1, provided new treatment orders and placed the skin assessments in Resident #1's hospice binder. Hospice Nurse #572 verified she had no written wound assessments for the right and left ankles. Interview on 09/24/25 at 3:00 P.M. with RN #569 verified there was no documentation in Resident #1's medical record, including his hospice binder, related to hospice nurse and aide visits since his admission to hospice on 08/11/25. Interview on 09/25/25 at 10:45 A.M. with the [NAME] Present of Operations #568 revealed the facility had an internal incident report dated 08/18/25 at 4:09 A.M. by LPN #547, which was the initial documentation of the two pressure areas to Resident #1's bilateral ankles. She verified the incident report was not part of the medical record and verified there were no initial wound assessments of the bilateral ankles until two days later on 08/20/25 in Resident #1's medical record. Review of the facility policy titled Wound Care dated October 2010 revealed staff should document any change in the resident's condition and all assessment data obtained when inspecting a wound. This deficiency represents non-compliance investigated under Complaint Number 2591659.