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	05/13/2026

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 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 record review, interview, and review of the facility policy and procedure, the facility failed to ensure timely notification of a fall to the resident's responsible party. This affected one resident (#26) of three residents (#22, #23, and #26) reviewed for notification. The facility census was 53. Findings Include: Review of the medical record for Resident #26 revealed an admission date of 06/17/25. Diagnoses included fusion of spine, intellectual disabilities, abnormalities of gait and mobility, and anxiety. Further review of Resident #26's medical record indicated the resident had a guardian.Review of the progress note dated 12/22/25 at 2:34 P.M. revealed the nurse was alerted that Resident #26 had an unwitnessed fall on 12/22/25 in the resident's room during an unassisted transfer. The resident was found in the seated position with her legs crossed in front of her wheelchair. The resident stated she was trying to get out of the wheelchair. Resident #26 had her hand on the floor as if she was pushing her upper body up off of the floor at time of incident. Although the fall was unwitnessed, the resident's nose appeared discolored, anticipatory bruising. Resident denied pain/discomfort at time of incident. Review of the progress note dated 12/24/25 at 12:39 P.M. revealed the nurse updated the residents guardian that the resident had discoloration around the left eye related to the 12/22/25 fall. There was no edema, the resident was at baseline, and the guardian was appreciative of update. The certified nurse practitioner was made aware.Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and required partial and/or moderate assistance with transfers. Interview on 05/06/26 at 12:40 P.M. with Regional Director of Clinical Services (RDCS) #404 verified the guardian for Resident #26 was not notified of the fall on 12/22/25 until 12/24/25. RDCS #404 stated the expectation was if a fall occurred early in the morning, the staff could call next shift if there were no injuries. RDCS #404 stated the notification should be before 48 hours. Review of the facility policy Change in a Resident's Condition or Status, dated December 2025 revealed unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury, including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status; there is a need to change the resident's room assignment; a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital/treatment center. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.This deficiency represents non-compliance investigated under Complaint Number 2703864.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 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, interview, review of shower sheets, review of medical record, grievance log review, and facility policy review, the facility failed to provide residents, who were dependent on staff for activities of livings (ADL's), with timely fingernail care and showers as scheduled and/or per their preference. This affected three residents (#24, #26, #44) out of five residents reviewed for ADL care. The facility identified 31 residents (#1, #3, #7, #8, #9, #10, #13, #16, #17, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #35, #36, #41, #43, #44, #46, #47, #48, #51, #52, and #53) requiring assistance with bathing and/or assistance with fingernails. The facility census was 53. Findings Include:1. Review of medical record for Resident #26 revealed an admission date of 06/17/25 and her diagnoses included intellectual disability, major depression, fusion of spine, and seizure disorder. Review of the Shower/Bath Skin Check and/or Shower/Tub Bath/Bed Bath Sheet forms from 03/01/26 to 05/06/26 revealed Resident #26 had the following showers and/or baths documented: 03/02/26, 03/05/26, 03/09/26, 03/12/26, 03/16/26, 03/20/26, 03/23/26, 03/27/26, 04/10/26, and 04/30/26. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had severe cognitive impairment as she was rarely or never understood. She required partial to moderate assistance with toileting hygiene, lower dressing, personal hygiene, transfers and showers. Review of the care plan dated 06/18/25 revealed Resident #26 required assistance with ADLs due to cognitive impairment, immobility, history of falls, fusion of spine, and seizures. Interventions included to check nails daily for length and cleanliness, provide incontinence care with routine rounds, anticipate needs, and assist with daily hygiene and showering as per facility policy weekly. Review of the undated A and B Hall Shower Schedule revealed Resident #26 was to have a shower twice a week Monday and Thursday on the afternoon/evening shift. On the bottom of the schedule, it stated all shower sheets were to be completed after every shower or refusal by the resident. Certified Nursing Assistants (CNAs) and the nurse were to sign off after every shower or refusal. It also noted that nail care was to be completed as appropriate after every shower. Interview on 05/07/26 at 8:00 A.M. with Regional Director of Clinical Service/Regional Nurse (RN) #404 verified after she brought in the shower sheets for Resident #26 that was all the shower sheets the facility had. Interview on 05/07/26 at 8:27 A.M. with Regional Director of Clinical Service/RN #404 verified per the shower schedule Resident #26 was to have a shower twice a week. She verified there was no shower/bath sheet from 03/28/26 to 04/09/26 (13 days), from 04/11/26 to 04/29/26 (19 days) and from 05/01/26 to 05/06/26 (five days). 2. Review of medical record for Resident #24 revealed an admission date of 10/20/25 and his diagnoses included injury of the cervical spinal cord, diabetes, quadriplegia, and chronic respiratory failure. Review of care plan dated 11/03/25 revealed Resident #24 had ADL self-care performance deficit related to quadriplegia and required staff assistance for the completion of his ADL needs. Interventions included check nail length, trim and clean on bath days and as necessary, and the resident was dependent on staff for all bathing and showering needs. Review of the quarterly MDS dated [DATE] revealed Resident #24 was cognitively intact. He required substantial to maximum assistance with rolling left and right and was dependent on staff for showers, toileting hygiene, and personal hygiene. Review of Shower/Bath Skin Check and/or Shower/Tub Bath/Bed Bath Sheet forms from 03/06/26 to 05/06/26 revealed Resident #24 had the following bed baths: 03/07/26, 03/11/26, 03/14/26, 03/16/26, 03/31/26, 04/01/26, 04/17/26, 04/22/26, 04/27/26, 04/28/26, 04/29/26, and 05/03/26. The last time per the forms it was documented that Resident #24's nails were cleaned or clipped was on 04/22/26.Review of undated Garden Gate Shower Schedule revealed Resident #24 was to have a shower and/or bath twice a week on Tuesday and Friday on the afternoon/evening shift per his room assignment from 03/06/26 to 04/30/26. Review of the undated A and B Hall Shower Schedule revealed Resident #24 was to have a shower and/or bath twice a week (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wednesday and Saturday on the afternoon/evening shift per his room assignment from 04/30/26 to 05/06/26. On the bottom of the schedule, it stated all shower sheets were to be completed after every shower or refusal by the resident. CNAs and the nurse were to sign off after every shower or refusal. It also noted that nail care was to be completed as appropriate after every shower. Interview and observation on 05/05/26 at 9:20 A.M. revealed Resident #24's fingernails on his bilateral hands were approximately one half inch in length (elongated). He revealed he preferred to have a bed bath twice a week. He revealed at times they did not complete his bed bath. He revealed it had been a long time since staff had cut and/or filed his fingernails. He verified his nails were long and that he did not prefer them that long and that he wanted staff to cut them. Interview on 05/05/26 at 9:28 A.M. Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #310 verified Resident #24's nails on his bilateral hands were long. She was aware of Resident #24's request to have them cut and stated she would have someone cut them. Interview and observation on 05/06/26 at 11:05 A.M. revealed Resident #24's fingernails continued to be elongated and not cut/ trimmed and/or filed. Resident #24 revealed staff had not offered to cut his nails and that he still wanted them cut. Interview on 05/06/26 at 11:10 A.M. with ADON/LPN #310 verified Resident #24's nails continued to be long and that staff did not cut them. She stated she would have the nurse cut them today, 05/06/26. Interview on 05/07/26 at 8:00 A.M. with Regional Director of Clinical Service/RN #404 verified after she brought in the shower sheets for Resident #24 that was all the shower sheets the facility had. Interview on 05/07/26 at 8:27 A.M. with Regional Director of Clinical Service/RN #404 verified per the shower schedule Resident #24 was to have a shower and/or bath twice a week. She verified there was no shower/bath sheet from 03/17/26 to 03/30/26 (14 days), and 04/02/26 to 04/16/26 (15 days). 3. Review of medical record for Resident #44 revealed an admission date of 12/31/25 and his diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes, and major depression.Review of care plan dated 01/06/26 revealed Resident #44 had functional ability deficit and required assistance with self-care and mobility related to hemiplegia, and impaired mobility. Interventions included allow time for resident to express feelings of frustration, attempt consistent routines, self-care supervision assistance with personal hygiene and showers, and partial assistance with transfers including tub/shower. Review of the Shower/Bath Skin Check and/or Shower/Tub Bath/Bed Bath Sheet forms from 03/01/26 to 05/06/26 revealed Resident #44 received a shower/bath on 03/04/26, 03/09/26, 03/11/26, 03/14/26, and 03/25/26. There was no documentation his nails were cut on the forms. On 04/29/26 there was a shower form that he had refused as he stated he did not want a shower today. Review of the Resident/Family/Staff Concern Form dated 03/17/26 and completed by Regional Director of Clinical Service/RN #404 revealed Resident #44 would like his fingernails trimmed regularly. The form indicated on 03/26/26 (nine days after the grievance was made) Resident #44 received nail care and was to receive nail care weekly and as needed on shower days and education was provided to staff. Review of quarterly MDS dated [DATE] revealed Resident #44 had intact cognition and had impairment to his upper and lower extremities. He required supervision and set up with personal hygiene and bathing. Review of the undated C Hall Shower Schedule revealed Resident #44 was to have a shower and/or bath twice a week Wednesday and Saturday on dayshift. On the bottom of the schedule, it stated all shower sheets were to be completed after every shower or refusal by the resident. CNAs and the nurse were to sign off after every shower or refusal. It also noted that nail care was to be completed as appropriate after every shower. Interview and observation on 05/06/26 at 11:37 A.M. with Resident #44 revealed his fingernails were slightly elongated. He became upset when asked about staff cutting his fingernails. Resident #44 had aphasia (difficulty speaking) and after series of yes and no questions he revealed staff did not assist with cutting his fingernails and it had been over a month since the last time they cut them. He revealed they were very long, and he had asked staff to cut them, but it had taken them a long time even after he asked. He revealed he preferred a shower twice a week and that staff did not assist with his showers per his preference. He (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified he was unable to trim and/or cut his nails himself as he needed staff assistance. Interview on 05/06/26 at 12:38 P.M. with Regional Director of Clinical Service/RN #404 revealed she had just started at the facility and there were outstanding grievances that were not timely addressed. She revealed she tried to follow up on the grievances and verified they were late. She verified Resident #44 had voiced a concern on 03/17/26 that he would like his fingernails trimmed regularly. She verified his nails were not cut until 03/26/26. Interview on 05/07/26 at 8:00 A.M. with Regional Director of Clinical Service/RN #404 verified after she brought in the shower sheets for Resident #44 that was all the shower sheets the facility had. Interview on 05/07/26 at 8:27 A.M. with Regional Director of Clinical Service/RN #404 verified per the shower schedule Resident #44 was to have a shower and/or bath twice a week. She verified there was no shower/bath sheet from 03/15/26 to 03/24/26 (ten days), from 03/26/26 to 04/28/26 (34 days), and 04/29/26 to 05/06/26 (eight days). Review of facility policy labeled, Fingernails/ Toenails, Care Of dated February 2018 revealed the purpose of the procedure was to clean the nail bed, keep nails trimmed and prevent infection. Nail care included regular cleaning and trimming. Trimmed and smooth nails prevented the resident from accidentally scratching self and injuring his or her skin. Review of facility policy labeled, Activities of Daily Living (ADL), Supporting dated April 2025 revealed residents were provided care, treatment and services as appropriate to maintain or improve their ability to care out ADLs. Appropriate care and services were to be provided for residents who were unable to carry out ADL's independently in accordance with care plan including assistance with hygiene (bathing, dressing, grooming and oral care), mobility, elimination, dining and communication. This deficiency represents non-compliance investigated under Complaint Numbers 2799025, 2703153, and 2703864.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy the facility failed to ensure resident weights were completed per orders and ordered notification occurred. This affected two residents (#4, and #23) of three residents reviewed for daily weights. The facility also failed to ensure medications were administered per physician orders. This affected one resident (#33) of four reviewed for medication administration. The facility census was 53.Findings include: 1.Review of resident #33's medical records revealed an admission date of 11/17/25. Diagnoses included high blood pressure and chronic obstructive pulmonary disease. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had intact cognition. Resident #33 required supervision with bathing. Review of care plan dated 03/23/26 revealed Resident #33 was at risk for decreased cardiac output. Interventions included administer medications as ordered and report any abnormal findings to the provider. Review of current physician orders for May 2026 revealed Resident #33 was ordered Digoxin (medication to treat heart failure and abnormal heart rhythms) 125 micrograms (mcg) one time a time. Review of Medication Administration Record (MAR) for May 2026 revealed Resident #33 had documented refusals daily with the exception of 05/04/26. Review of Resident #33's medical records did not include physician notification of his Digoxin refusal. Observation of medication administration on 05/06/26 at 7:40 A.M. for Resident #33 with Licensed Practical Nurse (LPN) #324 revealed LPN #324 had stated to Resident #33 you're not gonna take your digoxin right?, and Resident #33 had responded no. Interview with Resident #33 at time of observation revealed he had not taken his digoxin due to it had made his heart rate too low and he felt funny. Interview with LPN #324 after medication administration revealed she knew what Resident #33 would take and what he would refuse. LPN #324 was asked if she had notified the physician of Resident #33's refusals and LPN #324 stated not every time. Interview on 05/11/26 at 1:56 P.M. with Regional Director of Clinical Services (RDCS) #404 confirmed physicians were to be notified of resident medication refusals. 2. Review of medical record for Resident #23 revealed an admission date of 10/17/25 and his diagnoses included hypertensive heart disease with heart failure, and hemiplegia and hemiparesis following cerebral infarction affecting left non- dominant side. Review of a care plan dated 03/03/26 revealed Resident #23 had a nutritional problem and had the potential for weight changes related to diuretic, edema, and significant weight fluctuations. Interventions included administer medications as ordered, weigh at same time each day and record per policy. Review of April 2026 Treatment Administration Record (TAR) revealed the nurse documented an (NA) by the order for the daily weight on the following dates: 04/02/26, 04/09/26, 04/15/26, 04/16/26, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/21/26, 04/22/26, 04/23/26, 04/25/26, 04/26/26, 04/29/26, and 04/30/26. The TAR was blank on 04/24/26. There was a weight recorded on 04/01/26, 04/03/26, 04/04/26, 04/06/26, 04/10/26, and 04/11/26 and the other days he had refused the weight. Review of weight record from 04/01/26 to 05/05/26 revealed the following weights were documented for Resident #23: 04/01/26 of 450 pounds, 04/03/26 of 450 pounds, 04/04/26 of 450.2 pounds, 04/06/26 of 450.2 pounds, 04/10/26 of 454 pounds and 04/11/26 of 454 pounds. There were no other weights documented. Review of May 2026 TAR revealed the nurse documented an (NA) by the order for the daily weight on the following dates: 05/01/26, 05/04/26, 05/05/26, and 05/06/26. He had refused the weight on 05/02/26 and 05/03/25. Review of May 2026 physician orders revealed Resident #23 had an order dated 12/20/25 for a weight every morning at 6:00 A.M. after he voided and to notify the physician if he had a weight gain of three pounds in 24 hours and/ or weight gain of five pounds in seven days. Interview on 05/07/26 at 12:12 P.M. with Regional Director of Clinical Service/ Registered Nurse (RN) #404 verified Resident #23 had an order for a daily weight dated 12/20/25 and the nurse had documented a NA on the following days: 04/02/26, 04/09/26, 04/15/26, 04/16/26, 04/21/26, 04/22/26, 04/23/26, 04/25/26, 04/26/26, 04/29/26, 04/30/26, 05/01/26, 05/04/26, 05/05/26, and 05/06/26. She verified the nurses had documented NA for the daily weight but was unsure what it meant but the nurse should have documented the weight and/ or if he had refused as he was in the facility during the days that were documented. She verified there was not any documentation that the physician was aware Resident #23 had refused his daily weight and/ or his daily weight was not being completed. 3. Review of medical record for Resident #4 revealed an admission date of 08/28/25 and diagnoses included chronic kidney disease, diabetes, Hypertension (HTN), heart failure, and dependence of renal hemodialysis (a life-saving medical procedure that filters waste, toxins, and excess fluids from the blood when kidneys have failed, acting as an artificial kidney). Review of undated Hemodialysis Communication forms for Resident #4 from 01/01/26 to 05/06/26 revealed there were no communication forms the facility had sent dialysis and/ or that dialysis had sent back to the facility for each scheduled dialysis including any weight documented. Review of April 2026 TAR for Resident #4 revealed he had an order dated 12/30/25 for a weight every morning at 6:00 A.M. after he voided and to notify the physician if he had a weight gain of three pounds in 24 hours and/ or weight gain of five pounds in seven days. The nurse documented with an X and no weight recorded on all the days except 04/24/26 which was blank. Review of weight record from 04/01/26 to 05/05/26 revealed the following daily weights were not obtained: 04/02/26, 04/04/26, 04/05/26, 04/07/26, 04/09/26, 04/10/26, 04/11/26, 04/12/26, 04/14/26, 04/16/26, 04/18/26, 04/19/26, 04/21/26, 04/23/26, 04/24/26, 04/25/26, 04/26/27, 04/28/26, 04/30/26, and 05/02/26. The weight record indicated on 05/01/26 his weight was 217.8 pounds and on 05/03/26 his weight was 227.7 pounds (9.9-pound increase) and there was no documentation the physician was notified in his medical record. Review of care plan last revised 04/21/26 revealed Resident #4 had a nutritional problem related to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heart failure, HTN, chronic kidney disease, and the potential for unavoidable weight loss. Interventions included administer medications as ordered, weigh at same time of day and record per policy. Review of May 2026 physician orders revealed Resident #4 had an order dated 12/30/25 for a weight every morning at 6:00 A.M. after he voided and to notify the physician if he had a weight gain of three pounds in 24 hours and/ or weight gain of five pounds in seven days. Interview on 05/07/26 at 12:12 P.M. with Regional Director of Clinical Service/ Registered Nurse (RN) #404 verified Resident #4 was to have a daily weight and the weight was not obtained on the following days: 04/02/26, 04/04/26, 04/05/26, 04/07/26, 04/09/26, 04/10/26, 04/11/26, 04/12/26, 04/14/26, 04/16/26, 04/18/26, 04/19/26, 04/21/26, 04/23/26, 04/24/26, 04/25/26, 04/26/27, 04/28/26, 04/30/26, and 05/02/26. She also verified the weight record indicated on 05/01/26 Resident #4's weight was 217.8 pounds and on 05/03/26 his weight was 227.7 pounds (9.9-pound increase) and there was no documentation the physician was notified of the weight increase in his medical record. She verified the nurses documented with an X and no weight recorded on all the days except 04/24/26 which was blank. She revealed the nurses should have documented a weight or a reason why it was not completed. Review of facility policy labeled, Weight Assessment and Intervention dated March 2022 revealed resident weights were monitored for undesirable or intended weight loss or gain. Residents were weighed upon admission and at intervals established by the interdisciplinary team. Weights were recorded in each unit's weight record and resident's medical record. There was nothing in the policy regarding ensuring daily weight parameters were followed including notification to the physician. This deficiency represents non-compliance investigated under Complaint Number 2799025.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy and procedure, the facility failed to ensure physician orders were in place and a care plan was developed in a timely manner for nephrostomy care. This affected one resident (#46) of three residents (#22, #26, and #46) reviewed for appointments. The facility census was 53. Findings include: Review of the medical record for Resident #46 revealed an admission date of 01/21/26. Diagnoses included bladder cancer, chronic kidney disease, and artificial openings of the urinary tract. Review of the hospital after visit summary dated 01/07/26 through 01/21/26 revealed nephrostomy tube placement or exchange discharge instructions that included instructions for dressing changes, daily care, and tube flushing instructions. The after visit summary also indicated to schedule an appointment with urology as soon as possible for a visit. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed the resident had intact cognition, had an indwelling catheter for bladder, and was dependent on staff for toileting hygiene.Review of the physician orders for March 2026 for Resident #46 revealed orders dated 01/21/26 to schedule a urology appointment as soon as possible two times a day and discontinue when completed; an order dated 03/04/26 for the left nephrostomy with instructions to cleanse site with normal saline (NS), pat dry, apply split gauze daily and as needed (PRN) every night shift; an order dated 03/04/26 for the right nephrostomy with instructions to cleanse site with NS, pat dry, apply split gauze daily and PRN every night shift; and also orders dated 03/04/26 to monitor the nephrostomy tube sites for redness, drainage, or any signs/symptoms of infection every shift and PRN, and to notify the physician of any abnormal findings every shift.Review of the treatment administration records (TARS) dated January 2026, February 2026, and March 2026 revealed treatment orders for Resident #46's nephrostomy tubes were initiated on 03/04/26, indicating there was no documented evidence of treatments or monitoring to the left and right nephrostomy tubes from 01/21/26 through 03/03/26. Also noted on the TARS revealed an order to schedule urology appointment ASAP two times a day with instructions to discontinue when completed, was being signed off during this time frame. Review of the plan of care (POC), initiated 03/04/26, revealed Resident #46 had an alteration in elimination related to need for right and left nephrostomy and the resident was at risk for potential complications, altered body image, fluid imbalance, skin breakdown and pain with interventions to document output, empty ostomy bag as needed, keep nephrostomy tube free from obstructions and kinks, and maintain drainage below the bladder level. The POC dated 03/04/26 also revealed Resident #46 was to have enhanced barrier precautions (EBP) due to the right and left nephrostomy tubes with interventions to use gown and gloves during high contact care, and to see the catheter POC. There was no documented evidence of a catheter POC or any POC related to the treatments or monitoring of the nephrostomy tubes prior to 03/04/26. Interview on 05/06/26 at 4:44 P.M. with Regional Director of Clinical Services (RDCS #404) and Director of Nursing (DON) verified there were no physician orders for the care of the nephrostomy tubes until 03/04/26 and that the care plan for the nephrostomy tube was also initiated on 03/04/26. Both the DON and RDCS #404 stated there were no issues or concerns that resulted in the untimely physician orders or care plan. Both DON and RDCS #404 stated they were not able to locate any documentation or information whether the appointment for the urology dated 01/21/26 was scheduled or attempted to be scheduled. Both DON and RDCS #404 stated usually when the appointment was scheduled the date/time and location of the appointment was placed in the orders. The DON stated Resident #46 went to a urology appointment on 04/15/26. This deficiency represents non-compliance investigated under Complaint Number 2799025.

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	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 interview, observation, review of medical records and review of facility policy, the facility failed to ensure ongoing communication and collaboration between the facility and the outside dialysis center. This affected two residents (#4 and #32) out of two residents that received dialysis services. The facility census was 53.Findings include: 1. Review of medical record for Resident #4 revealed an admission date of 08/28/25 and diagnoses included chronic kidney disease, diabetes, hypertension (HTN), heart failure, and dependence of renal hemodialysis (a life-saving medical procedure that filters waste, toxins, and excess fluids from the blood when kidneys have failed, acting as an artificial kidney). Review of undated Hemodialysis Communication forms for Resident #4 from 01/01/26 to 05/06/26 revealed there were no communication forms the facility had sent dialysis and/ or that dialysis had sent back to the facility for each scheduled dialysis. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had intact cognition and received dialysis. Review of care plan dated 03/06/26 revealed Resident #4 had end stage renal disease and was on dialysis. Interventions included to administer medications as ordered, complete skin check every seven to ten days and as needed, dialysis three times a week at an outside dialysis center on Mondays, Wednesdays, and Friday, and dietary consult as needed. There was nothing in the care plan regarding ensuring the hemodialysis communication forms were sent to the dialysis center and returned from the dialysis after each scheduled dialysis. Review of May 2026 Physician Orders revealed Resident #4 had an order for hemodialysis at outside dialysis center every Monday, Wednesday, and Friday and the facility was to complete pre-dialysis and post- dialysis assessments one time a day every Monday, Wednesday and Friday. He also had an order to check his dialysis catheter to his right upper chest for bleeding and signs or symptoms of infections every shift. Interview and observation on 05/05/26 at 8:49 A.M. with Resident #4 revealed he went every Monday, Wednesday and Friday to an outside dialysis center for dialysis. He had a dialysis catheter to his right upper chest with dressing dated 05/04/26. He revealed he was unsure if any communication forms were sent from the facility to dialysis and/ or if the dialysis center sent back any forms as he had not seen any. Observation on 05/06/26 at 7:32 A.M. revealed Resident #4 was out of the facility at dialysis. 2. Review of medical record for Resident #32 revealed an admission date of 01/28/26 and his diagnoses included malignant neoplasm to the bone, heart failure, anemia, end stage renal disease, and dependance on renal hemodialysis.Review of undated Hemodialysis Communication forms for Resident #32 from 01/28/26 to 05/06/26 revealed there were no communication forms the facility had sent dialysis and/ or that dialysis had sent back to the facility for each scheduled dialysis. Review of care plan dated 01/30/26 revealed Resident #32 was at risk for complications related to dialysis needs. Interventions included to administer medications as ordered, hemodialysis as ordered, observe dialysis site for signs of infection, and obtain labs as ordered. There was nothing in the care plan regarding ensuring the hemodialysis communication form was sent to the dialysis center and returned from the dialysis after each scheduled dialysis. Review of Medicare Five-Day MDS assessment dated [DATE] revealed Resident #32 had intact cognition and received dialysis. Review of May 2026 Physician Orders revealed Resident #32 had an order for dialysis every Monday, Wednesday and Friday and an order to monitor the right Internal Jugular (IJ) catheter (a central venous line inserted into the neck's internal jugular vein, typically used for rapid fluid/medication delivery, hemodynamic monitoring, or dialysis). There was no order for pre-dialysis and post- dialysis assessments to be completed. Interview and observation on 05/06/26 at 1:51 P.M. with Resident #32 revealed he had just returned from dialysis, and he was unsure if the facility sent a communication form to dialysis and/or if the dialysis center sent a communication form back after his dialysis sessions. Interview on 05/05/26 at 12:44 P.M. with Licensed Practical Nurse (LPN) #327 revealed the facility nurse was supposed to send dialysis communication forms with any resident that received (continued on next page)

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	366058	A. Building B. Wing	05/13/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis to the dialysis center. When asked if this was being completed, she revealed that she thought it was but that the facility did not get the forms back from dialysis, but that she was unsure. Interview on 05/06/26 at 8:11 A.M. with Regional Director of Clinical Service/ Registered Nurse (RN) #404 revealed a hemodialysis communication form was to be sent by the facility nurse to the outside dialysis center for each scheduled dialysis day and then the dialysis center was to send back the hemodialysis communication form after the dialysis was complete to collaborate necessary services. She verified for Resident #4 there were no communication forms from 01/01/26 to 05/06/26 and for Resident #32 from 01/28/26 to 05/06/26. She also verified there was no order and/or documentation pre-dialysis and post- dialysis assessments were completed for Resident #32Interview on 05/06/26 at 8:22 A.M. with Dialysis RN #405 and Dialysis RN #406 from the outside dialysis center revealed they provide dialysis services for Resident #4 and Resident #32 every Monday, Wednesday and Friday. They verified the facility does not send communication forms and they do not send back any communication forms. Dialysis RN #405 revealed she thought Resident #4 and Resident #32 were coming from an assisted living facility, not a nursing home, and that was why a communication form was not sent. Dialysis RN #405 verified it would be beneficial to have a communication form especially to communicate any changes and/or issues. They verified both Resident #4 and Resident #32 were currently at dialysis, and they did not receive communication this morning, 05/06/26 from the facility. Review of undated Hemodialysis Communication form that included the following information was to be sent to the dialysis center from the facility nurse for each scheduled dialysis day: vital signs, type of vascular access, dressing if it was dry and intact, if the caps to the vascular access were intact, any acute problems since last dialysis treatment, if there was any physician order changes, if there was any nutritional concerns, if any social changes, if any lab tests completed since last dialysis treatment, and if there any additional concerns and/ or questions. The form had a section on the bottom that the dialysis center was to send back to the facility nurse after the resident received his dialysis that included pre and post dialysis temperature, blood pressure, weight, if the dressing as dry and intact, if the caps to the vascular access were intact, if there was any post bleeding after the dialysis treatment, medications provided during the treatment, any issues during the dialysis treatment and if there was any physician order changes. Review of Dialysis Agreement dated 08/06/19 revealed the facility signed an agreement with an outside dialysis center to provide dialysis services. The agreement revealed the nursing facility should offer assistance and provide the dialysis center with any information which was necessary to the dialysis center in the provision of dialysis services. Review of undated facility policy, Dialysis Care revealed the policy was to ensure residents received dialysis treatment in a safe, well assessed, and that the facility collaborated care with the dialysis center. The policy revealed the facility shall use a form to communicate between the dialysis center each visit. The facility nurse would complete an assessment of the resident prior to leaving the facility and upon return to the facility each dialysis visit. The policy revealed upon return from dialysis the nurse would review the communication form sent from the dialysis center. If the dialysis center failed or refused to provide communication then the nurse was to document on the form. This deficiency represents non-compliance investigated under Complaint Number 2799025.

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	366058	A. Building B. Wing	05/13/2026

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review the facility failed to ensure the physician had signed off orders in a timely manner. This affected one resident (#47) of three reviewed for timely physician orders. The facility census was 53.Findings include: Review of Resident #47's medical records revealed an admission date of 01/30/26. Diagnoses included right knee fracture, right knee replacement and aftercare following surgery.Review of physician order revealed orders were received on 01/30/26, however Medical Director (MD) #408 had not acknowledge Resident #47's orders until 04/08/26.Interview on 05/07/26 at 7:49 A.M. with MD #408 revealed he had seen new admission residents usually within 48 hours of admission and stated he had been at the facility at least once a week. MD #408 stated he had signed his orders manually when he was at the facility and stated he did not have electronic access at the current time.Interview on 05/07/26 at 9:56 A.M. with the [NAME] President of Operations (VPO) #603 and the Director of Nursing (DON) revealed MD #408 had electronic access, however the IT (information technology) department was working to have the access on his cell phone. DON stated she had been working with MD #408 to get the orders signed and into the electronic records. DON stated MD #408 was present at the facility on 04/08/26 and she and MD #408 had worked on signing the orders. Interview on 05/07/26 at 3:19 P.M. with Regional Director of Clinical Services (RDCS) #404 confirmed Resident #47's admission date of 01/30/26 and MD #408 had acknowledge Resident #47's orders on 04/08/26. RDCS #404 further confirmed physician orders should have been signed in a more timely manner. This deficiency represents non-compliance investigated under Complaint Number 3001090.

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	05/13/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, narcotic sheet review, and facility policy review, the facility failed to ensure controlled substances were accurately accounted for, recorded in the residents' medical records, and narcotic sheets were legible. This affected five residents (#28, #33, #34, #40, and #51) of six residents reviewed for controlled substances. The facility census was 53.Findings include: 1. Review of Resident #28's medical record revealed an admission date of 02/19/26. Diagnoses included bone cancer, right femur fracture, schizoaffective disorder, and need for personal care assistance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition. Resident #28 required moderate assistance with bathing and toileting.Review of the care plan dated 03/23/26 revealed Resident #28 was at risk for adverse reactions related to psychotropic medications. Interventions included to administer medications as ordered. The care plan noted Resident #28 was at risk for pain related to diagnoses of bone cancer. Interventions included to administer medications as ordered.Review of Resident #28's active physician orders revealed an order for Oxycodone (narcotic pain reliever) 5 milligrams (mg), give one half tablet (2.5 mg) every eight hours as needed for pain.Review of Resident #28's narcotic sheet from 03/16/26 to 03/31/26 revealed Oxycodone had been signed out on 03/16/26, 03/18/26, 03/19/26, 03/25/26 and 03/31/26.Review of Medication Administration Record (MAR) for March 2026 revealed Resident #28's Oxycodone had been recorded as administered on 03/16/26 and 03/18/26. No other administration had been documented in Resident #28's medical record. 2. Review of Resident #33's medical records revealed an admission date of 11/17/25. Diagnoses included opioid dependence in remission, mood disorder, and depression.Review of the MDS assessment dated [DATE] revealed Resident #33 had intact cognition. Resident #33 required supervision with bathing and was continent of bowel and bladder.Review of the care plan dated 03/23/26 revealed Resident #33 had a history of substance abuse. Interventions included to observe for signs and symptoms of substance abuse and signs of withdrawal. The care plan noted Resident #33 was at risk for pain. Interventions included to administer medications as ordered.Review of Resident #33's active physician orders revealed an order dated 12/27/25 for Oxycodone 5 mg one tablet every four hours as needed for pain and Oxycodone 5 mg two tablets (total of 10 mg) every four hours as needed for pain, and an order dated 03/17/26 for Tramadol (narcotic pain medication) 50 mg by mouth as needed for chronic pain (no frequency was specified on the order). Review of narcotic sheet for Resident #33 from 03/04/26 to 03/28/26 revealed Oxycodone 5 mg was signed for twice on 03/22/26 at 6:00 P.M., twice on 03/24/26 at 3:30 P.M., twice on 03/26/26 at 9:22 A.M., and twice on 03/27/26 at 6:38 A.M. Review of Resident #33's MAR for March 2026 revealed Oxycodone administration times had not correlated with Resident #33's narcotic sheets times and there had been missing documentation on the evenings of 03/22/26, 03/26/26, 03/30/26 and 03/31/26.Review of Resident #33's narcotic sheet for Tramadol from 03/17/26 to 3/22/26, revealed medication was signed for on 03/20/26 at 9:00 P.M. and 03/22/26 at 9:00 P.M.Review of Resident #33's MAR revealed no documentation of Tramadol on 03/20/26 at 9:00 P.M. or 03/22/26 at 9:00 P.M.3. Review of Resident #34's medical records revealed an admission date of 03/20/26. Diagnoses included low back pain, stroke with right-sided weakness, and bipolar disorder.Review of the care plan dated 03/21/26 revealed Resident #34 was at risk for pain related to stroke. Interventions included to administer medications as ordered.Review of MDS assessment dated [DATE] revealed Resident #34 had intact cognition. Resident #34 required moderate assistance with bathing and supervision with toileting.Review of physician orders for March-April 2026 revealed Resident #34 was ordered Oxycodone 10 mg once daily at 12:00 P.M.Review of Resident #34's Oxycodone narcotic sheet from 03/26/26 to 03/31/26 revealed an illegible date and signature of Oxycodone being administered at 12:00 A.M. and a date that appears to (continued on next page)

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	366058	A. Building B. Wing	05/13/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be 03/17/26 at 2:00 P.M. Further review of narcotic sheet revealed no nursing staff signature or date recorded on the sheet to indicate when the medication was received and the staff who received the medication. 4. Review of Resident #40's medical records revealed an admission date of 09/25/24. Diagnoses included polyneuropathy and stroke with left-sided weakness.Review of the care plan dated 03/23/26 revealed Resident #40 was at risk for pain related to neuropathy. Interventions included to administer medications as ordered.Review of the MDS assessment dated [DATE] revealed Resident #40 had intact cognition. Resident #40 required supervision with toileting and bathing.Review of physician orders from 01/12/26 03/18/26 revealed Resident #40 was ordered Lyrica 50 mg three times a day at 9:00 A.M., 1:00 P.M. and 9:00 P.M. Physician orders from 03/18/26 to current revealed Resident #40 was ordered Lyrica 50 mg two times a day at 9:00 A.M. and 9:00 P.M.Review of Resident #40's Lyrica narcotic sheet for three times a day revealed a dose signed out on 03/25/26 at 9:13 (not documented with A.M. or P.M.), one dose on 03/26/26 at 9:15 P.M., one dose on 03/27/26 at 9:00 A.M., one dose on 03/28/26 at 9:00 A.M., two doses on 03/29/26 at 9:00 A.M. and 9:00 P.M., one dose on 03/30/26 at 9:00 P.M., and one dose on 03/31/26 at 8:06 A.M. The narcotic sheet had indicated signed out doses were from physician orders of Lyrica three times a day.Review of Resident #40's MAR from 03/01/26-03/18/26, for Resident #40 revealed doses of Lyrica had been documented with the exception of no documentation on 03/13/26 at 9:00 P.M.Review of MAR from 03/18/26-03/31/26 for Resident #40 revealed doses of Lyrica had been documented with the exception of no documentation on 03/30/26 at 9:00 P.M.5. Review of Resident #51's medical records revealed an admission date of 03/19/26. Diagnoses included chronic obstructive pulmonary disease, muscle weakness and congestive heart failure.Review of the care plan dated 03/24/26 revealed Resident #51 was at risk for pain. Interventions included to administer medications as ordered.Review of the MDS assessment dated [DATE] revealed Resident #51 had intact cognition. Resident #51 was dependent with toileting and bathing.Review of physician orders from March-April 2026 revealed Resident #51 was ordered Morphine (narcotic pain medication) 30 mg two times a day at 9:00 A.M. and 9:00 P.M.Review of Resident #51's narcotic sheet from 03/24/26-03/31/26 revealed three doses signed out on 03/30/26 at 8:31 A.M., a second with no time documented, and a third dose at 8:00 P.M. The narcotic sheet's last entry had an illegible date, time, and signature. Further review of narcotic sheet revealed no nursing staff signature or date recorded on the sheet to indicate when the medication was received and the staff who received the medication. Interview on 05/11/26 at 1:56 P.M. with Regional Director of Clinical Services (RDCS) #404 confirmed the various narcotic discrepancies for Residents #28, #33, #34, #40, and #51 and stated nursing staff had been educated on proper narcotic documentation and ensuring narcotics are accounted for at the end of each shift. Review of facility policy titled Controlled Substances revised 11/2022 revealed controlled substances are counted upon delivery and the nurse receiving the medication along with the person delivering the medication must count the controlled substances together and both individuals sign the controlled substance report. Review of facility policy titled Charting and Documentation revised 07/2017 revealed medication administration was to be documented in the residents medical records.This deficiency represents non-compliance investigated under Complaint Number 3001090.

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	366058	A. Building B. Wing	05/13/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure as-needed (PRN) medications had a designated stop date of usage. This affected one Resident (#30) of three reviewed for as needed medications. The facility census was 53.Findings include: Review of Resident 30's medical records revealed an admission date of 03/02/26. Diagnoses included obsessive-compulsive disorder, schizoaffective disorder and depression.Review of care plan dated 03/03/26 revealed Resident #30 revealed Resident #30 was at risk for behavior/mood changes. Interventions included administer medications as ordered and attempt non-pharmacological interventions to improve sleep.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had intact cognition.Review of Resident #30's physician orders revealed the resident had an order dated 0302/26 for Hydroxyzine (an antihistamine medication used to help control anxiety) 50 milligrams (mg) every eight hours as needed for anxiety. Physician orders did not include a stop date for medication. Review of Medication Administration Record (MAR) for May 2026 revealed Resident #30 had received Hydroxyzine on 05/0526, 05/07/26, 05/08/26, 05/09/26, 05/10/26 and 05/11/26.Telephone interview on 05/12/26 at 12:47 P.M. with Regional Director of Clinical Services (RDCS) #404 confirmed as-needed medications were to have stop dates in place. Review of facility policy titled Psychotropic Medication Use revised February 2025 revealed as needed (PRN) medications are limited to 14 days and if the physician believes it is appropriate to extend the PRN order beyond 14 days they are to document the rationale for extending the use and include the duration for the PRN order.This deficiency represents non-compliance investigated under Complaint Number 2799025.

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	366058	A. Building B. Wing	05/13/2026

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review and review of facility policy, the facility failed to ensure a urine culture and sensitivity (a laboratory diagnostic procedure that detects and identifies microorganisms (bacteria or yeast) in a urine sample to diagnose a Urinary Tract Infection (UTI)) was obtained per the nurse practitioner's (NP) recommendation. This affected one Resident (#46) out of three residents reviewed for laboratory services. The facility census was 53. Findings include: Review of the medical record for Resident #46 revealed an admission date of 01/21/26 and diagnoses included heart failure, diabetes, acute cystitis (inflammation of the bladder usually caused by infection) with hematuria (blood in urine), acute kidney failure, and malignant neoplasm of the bladder. Review of nursing note dated 03/02/26 at 4:44 A.M. and completed by Licensed Practical Nurse (LPN) #320 revealed Resident #46 expressed concern about blood-tinged urine in her nephrostomy bag with no clots. Resident #46 had denied pain. The note revealed the nurse practitioner (NP) was notified and instructed to obtain a urine sample for a urine culture and sensitivity. Review of the care plan dated 03/04/26 revealed Resident #46 had an alteration in elimination related to need for right and left nephrostomy tubes and was at risk for potential complications. Intervention included document urinary output, empty ostomy bag every shift and as needed, keep nephrostomy tubes free from obstruction and kinks, and maintain the drainage bag below bladder level. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #46 had impaired cognition. She had an indwelling catheter and there was no documentation she had an ostomy (surgically created opening (stoma) in the body to discharge waste). Review of care plan dated 04/15/26 revealed Resident #46 was at risk for complications related to an actual acute infection: urinary tract infection. Interventions included administer medications as ordered, observe and document for signs of infection, observe and report to physician any signs of urinary tract infection, and obtain labs and diagnostic testing as ordered.Review of all laboratory reports, including urinalysis and urine culture and sensitivity, for Resident #46 dated from 01/01/26 to 05/05/26 revealed she had only one urine completed that was collected on 04/20/26 and reported on 04/25/25 that indicated Resident #46's culture contained over 100,000 colony-forming unit (CFU) per milliliter (ML) pseudomonas aeruginosa carbapenem resistant (CRPA) (a bacteria that developed multi- drug resistance) and 16,000 to 20,000 CFU per ml of klebsiella pneumonia (a type of bacteria). There was no urine culture obtained on 03/02/26. Review of Physician Order Recap Report from 01/01/26 to 05/5/26 for Resident #46 revealed she had the following orders: left and right nephrostomy (a thin, flexible tube (catheter) through the skin of the back directly into the kidney) cleanse site with normal saline, pat dry, apply split gauze daily as needed dated 03/04/26, monitor the nephrotomy tube sites for redness, drainage, or any signs of infection dated 03/04/26, and an order to document the output of the nephrostomy every shift dated 03/04/26. There was no order for a urine sample to be obtained for a urine culture and sensitivity dated 03/02/26. Interview and observation on 05/05/26 at 9:34 A.M. with Resident #46 revealed she had an ostomy and two bilateral nephrostomy tubes in her back (one on each side). She revealed she recently had seen a urologist who capped the nephrostomy tubes and currently only had the ostomy. She revealed she did remember a time there was blood in her ostomy a while back but could not recall many details. She revealed recently she had not noticed any blood, denied any pain or any other sign and symptoms. Observation of Certified Nursing Assistant (CNA) #346 on 05/05/26 at 9:37 A.M. revealed CNA #346 emptied her ostomy per Resident #36's request and it contained 125 milliliters (ml) of medium yellow urine with no blood. Interview on 05/06/26 at 2:49 P.M. with Regional Director of Clinical Service/Registered Nurse (RN) #404 verified the nursing note dated 03/02/26 at 4:44 A.M. and completed by LPN #320 revealed Resident #46 expressed concern about blood-tinged urine in her nephrostomy bag and that the NP was notified and instructed to obtain a urine sample for a urine (continued on next page)

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	366058	A. Building B. Wing	05/13/2026

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

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	culture and sensitivity. She verified the urine sample was not collected per the nurse practitioner's recommendation and stated, she was not sure why. She verified it was possible the nurse did not put in the order as it was not on the recap order listing. She verified there was no documentation in her medical record that revealed the urine culture should not have been completed on 03/02/26. She verified the only urine results she had from 01/01/26 to 05/05/26 was from 04/20/26. Review of facility policy labeled, Lab and Diagnostic Test Results- Clinical Protocol last revised November 2018 revealed the physician would identify and order diagnostic and lab testing based on the resident's diagnostic monitoring needs. The staff would process test requisitions and arrange for tests. This deficiency represents non-compliance investigated under Complaint Number 2799025.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, interview, and review of the facility policy and procedure, the facility failed to ensure room changes were documented in the resident's medical record. This affected two residents (#22 and #23) of three residents reviewed for room changes. The facility census was 52. Findings include:1. Review of the medical records for Resident #22 revealed an admission date of 09/18/25. Diagnoses included Alzheimer's disease with late onset, dementia, muscle weakness, and residual schizophrenia. Review of the medical record for Resident #22 revealed no documented room changes. Further review of Resident #22's medical record reviewed a room change form uploaded under the miscellaneous tab of the electronic medical record dated 03/05/26 indicating Resident #22 was moving rooms due the roommate needed to be in a room by himself for safety and wellness precautions. The form also indicated Resident #22's guardian was notified and was in agreeance with the move. 2. Review of the medical record for Resident #23 revealed an admission date of 11/18/15. Diagnoses included hemiplegia and hemiparesis following a stroke affecting left non-dominant side and major depressive disorder.Review of the medical record for Resident #23 revealed no documentation of a room change. Review of the list provided by the facility of residents that had a room change dated 03/05/26 through 05/05/26 revealed Resident #23 had a room change on 03/06/26. Resident #22 was not included on this list. Interview on 05/05/27 at 4:46 P.M. with Resident #23 revealed was notified at the last minute by Social Services Director (SSD) #383 that he was being moved to another room. Resident #23 stated he did not receive or sign any form related to a room change. Interview on 05/06/26 at 2:05 P.M. with SSD #383 stated she was responsible for room changes. SSD #383 stated she would go talk to the resident to let the know of the room change and the reason for the room change. SSD #383 stated she would have the resident sign the room change form and then she would upload the form to the electronic medical record. SSD #383 stated she would then write a progress note regarding the room change. SSD #383 verified she did not document the room changes for Residents #22 and #23 in their medical records. Review of the facility policy titled Room Change/Roommate Assignment, dated November 2025 revealed documentation of a room change is recorded in the resident's medical record.This deficiency represents non-compliance investigated under Complaint Number 2799025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, record review, review of the facility infection control tracking and trending, review of Center of Disease Control and Prevention (CDC) guidelines, QSO-24-08-NH memorandum review and review of facility policy the facility failed to ensure enhanced barrier precautions (EBP) (an infection control intervention in nursing homes designed to reduce the spread of multi-drug resistant organisms (MDROs) were utilized during high contact resident care) and did not ensure transmission-based precautions were utilized as ordered. This affected one resident (Resident #4) of two residents observed for EBP and affected one Resident (#24) of two residents observed for transmission-based precautions. The facility also failed to ensure a comprehensive infection control program was in place to timely identify infections and monitor the effectiveness of interventions. This had the potential to affect all residents in the facility. The facility census was 53. Findings included: 1. Review of Infection Control Preventionist from 10/01/25 to 05/05/26 revealed the facility identified Director of Clinical/ RN #410 was the designated the infection preventionist (IP) from October 2025 to March 2026 and the Director of Nursing (DON) was designated from March 2026 to the present, 05/05/26. Review of Antibiotic Infection Summary Logs dated from October 2025 to February 2026 revealed there was no infection control logs to track and trend infections throughout the facility, determine if interventions were appropriate and to timely identify potential outbreaks in the facility.2.Review of medical record for Resident #24 revealed an admission date of 10/20/25 and his diagnoses included diabetes, quadriplegia, chronic respiratory failure, and morbid obesity. There was nothing in his medical record regarding his CRE in his sputum and/ or Candida Auris except a physician order that he was to be on contact isolation. Review of discharge orders from previous facility dated 10/20/25 revealed Resident #24 had an order dated 10/08/26 for droplet precautions due to CRE in the sputum and an order dated 10/11/25 for contact isolation due to Candida Auris. Review of May 2026 Physician Orders revealed Resident #24 had an order dated 10/23/25 for contact precautions secondary to Candida Auris and known history of CRE in the sputum. Review of care plan dated 11/03/25 revealed Resident #24 had activities of daily living (ADL) self-care performance deficit related to quadriplegia and required staff assistance for ADL completion. Interventions included Resident #24 required staff assistance with bathing, bed mobility, dressing, personal hygiene, and toileting. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #24 had intact cognition and was dependent on staff for ADLs included toileting hygiene, transfers, showers, dressing, and personal hygiene. He required substantial to maximum assistance with rolling left and right in bed. Review of care plan dated 03/03/26 revealed Resident #24 required EBP due to wound to right great toe. Interventions included EBP (gown and gloves) during high contact resident care. There was nothing in the care plan regarding respiratory isolation due to CRE in sputum and/ or contact isolation due to Candida Auris. Interview and observation on 05/05/26 at 9:20 A.M. with Resident #24 revealed he had on the outside of his door signage that indicated he was on EBP and not contact isolation. He revealed at the previous facility where he resided, he was diagnosed with CRE and Candida Auris. He revealed he was told that he would have to always remain in isolation as he would always carry these infections as there was not an antibiotic that could treat them. He revealed he was concerned as the staff did not wear personal protective equipment (ppe) when providing care including cleaning his room as well as he had a room with a roommate and did not want to spread his infection. He revealed he had attempted to tell the facility but that the facility did not listen to him. Interview on 05/05/26 at 3:26 P.M. and 3:55 P.M. with DON revealed Resident #24 had an order for contact precautions due to Candida Auris and known history of CRE in sputum dated 10/23/25. She verified the signage outside his door only indicated he was on EBP not contact precautions. She verified the discharge orders when Resident #24 was admitted to the facility included: an order dated 10/08/25 for droplet precautions due to CRE in the sputum and an order dated 10/11/25 for contact (continued on next page)

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	366058	A. Building B. Wing	05/13/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	isolation due to Candida Auris. She verified she had no documentation including infection control notes that the physician was notified regarding Resident #24's infections and interventions to be implemented including isolation. Interview on 05/05/26 at 4:06 P.M. with Regional Director of Clinical Services/ Registered Nurse (RN) #404 and DON verified there was no Antibiotic (ATB)/ Infection Control logs completed from October 2025 to February 2026. They revealed the infection control program at the facility when they both started March 2026 was not done. They revealed they looked back as Resident #24 did have an order for contact and respiratory isolation on his admission orders and that on 10/23/25 he had a physician order for contact precautions secondary to Candida Auris and known history of CRE in the sputum but that there was no signage on his room indicating he was on contact isolation. They revealed they would have to investigate into the situation to determine what isolation Resident #24 was to be on, and if Resident #24 should have a roommate. Interview on 05/07/26 at 7:52 A.M. with Primary Care Physician (PCP)/ Medical Director #408 revealed when he was asked regarding Resident #24's Candida Auris and CRE stated he was not aware of Resident #24 and did not believe he was his physician but if he was he was not aware of his Candida Auris and/ or CRE. He revealed he did not know if Resident #24 should be in isolation or not and what interventions the facility should be taking.Interview on 05/07/26 at 8:59 A.M. with Director of Clinical/ RN #410 verified she was designated as the IP from October 2025 to 03/03/26 when she switched roles to the corporate director of education. She verified she was unable to locate any of the antibiotic infection control logs. She revealed she was not aware Resident #24 had CRE, Candida Auris and/ or any other infection when he was admitted . She revealed she was not aware he had an order for contact isolation as nobody had said anything. She revealed if she was aware she would have investigated it, placed him on isolation and he should have been in a private room. Interview on 05/07/26 at 10:22 A.M. with the DON verified PCP/ Medical Director #408 was assigned as Resident #24's PCP. Interview on 05/07/.26 at 1:56 P.M. with Housekeeping #397 revealed she had worked at the facility approximately one year and cleaned Resident #24's room frequently. She revealed she went by the signage outside the room as to what ppe she wore and Resident #24 always had signage for EBP not contact isolation. She revealed she was trained the EBP signage was for the certified nursing assistant (CNAs) when they provided care and that she did not wear any ppe except for gloves. She revealed she was not aware of any infection Resident #24 had, any extra precautions to take including cleaning guidelines and/ or what CRE or Candida Auris was. 3. Review of medical record for Resident #4 revealed an admission date of 08/28/25 and his diagnoses included diabetes with diabetic neuropathy, diabetic foot ulcer, acquired absence of left leg below knee, and dependance of renal dialysis.Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had intact cognition. He had a diabetic foot ulcer and received dialysis. Review of care plan dated 03/30/26 revealed Resident #4 required enhanced barrier precautions (EBP) due to central line (a soft, flexible tube inserted into a large vein to provide immediate, high-volume blood access for hemodialysis). It to his right chest for dialysis and wounds. Intervention included EBP including gown and gloves during high contact resident care. Review of May 2025 Physician Orders revealed Resident #4 had and an order dated 10/28/25 to check his central line dialysis catheter site to his right upper chest for bleeding and/ or signs of infections, an order dated 10/28/25 for EBP due to wounds and dialysis catheter and an order dated 04/21/26 to cleanse his right medial foot with 0.25 percent Dakins (an antiseptic solution), pat dry, apply gentamicin (ATB) ointment to wound bed, cover with calcium alginate (a highly absorbent wound dressing), top with abdominal pad (ABD), wrap with kerlix and an ace wrap twice a day. Interview and observation on 05/05/26 at 8:49 A.M. with Resident #4 revealed he had a dialysis catheter to his right chest and dressing to his right foot. There was signage outside his room indicating he was on EBP and a yellow bag on the back of the door to his room that contained personal protective equipment (ppe) including gowns, and gloves. Observation on 05/05/26 at 8:51 A.M. revealed Wound Nurse Practitioner (WNP) #600 and Assistant Director of Nursing (ADON)/ Licensed Practical Nurse (LPN) #310 knocked on Resident #4's door and asked Resident #4 (continued on next page)

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	366058	A. Building B. Wing	05/13/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	if they could complete his dressing change to his right foot. Observation revealed both staff completed hand hygiene and applied gloves but no gown. WNP #600 unwrapped the kling dressing to his right foot and removed the dressing. She proceeded to provide hand hygiene, cleanse the wound with 0.25 percent Dakins, and measured the wound that measured 4.5 centimeters (cm) in length, five cm in width and 0.2 cm in depth. Then she performed hand hygiene. applied gentamycin, calcium alginate, covered with an ABD pad, wrapped with kling and ace wrap. WNP #600 doffed the gloves, performed hand hygiene and exited the room. Interview on 05/05/26 at 9:01 A.M. with WNP #600 and ADON/LPN #310 verified on the outside of the door indicated Resident #4 was on EBP and that he had a wound as well as a dialysis central line catheter to his right chest. WNP #600 verified that she did not apply a gown during Resident #4's dressing change. WNP #600 revealed she was unsure of what the facility's policies were and that at some facilities she wore EBP including a gown and at other facilities she did not as she went by if the facility told her if she needed to or not. She revealed the facility had not told her she needed to wear EBP and that was why she did not wear a gown during Resident #4's dressing change. ADON/LPN #310 revealed she was new at the facility and was unsure as well of the facility policy and would have to ask the DON. Interview on 05/05/26 at 11:27 A.M. with DON verified Resident #4 had had order for EBP and during high contact care including dressing changes with a gown and gloves were to be worn. Review of Facility assessment dated [DATE] revealed Director of Clinical/ RN #410 was the designated as the IP. There was no other update to the facility assessment listing another IP.Review of facility policy labeled, Isolation- Categories of Transmission-Based Precautions dated September 2022 revealed transmission-based precautions were initiated when a resident developed signs and symptoms of transmissible infection, arrives with symptoms of an infection, or had a laboratory confirmed infection and is at risk of transmitting the infection to other residents. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it spread from person to person. The three types of transmission-based precautions were contact, droplet and airborne. When a resident was placed on transmission-based precautions, appropriate notification was placed on the room entrance door and on the front of the chart so that personnel and visitors were aware of the need for and the type of precaution.Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions were indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24.Review of undated CDC handout labeled, CRE Carbapenem- Resistant Enterobacterales An Urgent Public Threat revealed CRE infections do not respond to common antibiotics and the invasive infections were associated with high mortality rate. Some CRE were resistant to all available antibiotics. CRE spreads through direct and indirect contact with patients infected or colonized with CRE or a contaminated environment. Some environmental sources such as sink drains and toilets can be reservoirs contributing to CRE transmission. CRE primarily colonizes in the digestive tract, but a resident can be colonized with CRE for months and years. The handout revealed many residents could be colonized and the colonized residents could be the source of spread of CRE to other residents. Residents that were colonized could go undetected and contribute to the silent spread of CRE. The handout recommended the facility timely and accurately identify residents with CRE including ensure they followed recommendations for CRE colonization screening, and work with the health department to understand CRE epidemiology, protect residents by wearing a gown and gloves for resident care, ensure high-touch surfaces were cleaned frequently, dedicated non-critical medical equipment such as blood pressure cuff, ensure shared medical equipment was cleaned and disinfected such as portable x-ray machine, clean and disinfect countertops, handles, faucets and sinks at least daily, keep resident care items at least three feet away from sinks, toilets and hoppers, and do not discard (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	patient waste in sinks. Review of CDC guidelines for Carbapenem- Resistant Enterobacterales (CRE) Infection Control dated 12/17/25 revealed healthcare providers should follow these recommendations to reduce the risk of CRE infections in their facility. CRE infections were difficult to treat and can cause outbreaks and threats to resident safety. Infection control measures included EBP or isolation and contact precautions in nursing homes depending on the situation. Review of facility policy labeled, Enhanced Barrier Precautions dated December 2024 revealed EBP was to be utilized to prevent the spread of multi-drug-resistant organism to residents. EBP targeted gown and glove use in addition to standard precautions during high contact care activities when contact precautions do not otherwise apply. Gloves and gown were to be applied prior to performing high contact resident care activity. Examples of high contact resident care activities requiring the use of gown and gloves for EBP included dressing, bathing, device care or use, and/ or wound care. This deficiency represents non-compliance investigated under Complaint Number 2799025.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. Based on interview, record review and review of facility policy, the facility failed to ensure an effective antibiotic stewardship program was in place that monitored antibiotic use including reducing the risk of adverse effects of the development of multidrug-resistant organisms (MRDO) from unnecessary or inappropriate antibiotic use and tracking of infections. This had the potential to affect all 53 residents residing at the facility. The facility census was 53. Findings include: Review of Infection Control Preventionist from 10/01/25 to 05/05/26 revealed the facility identified Director of Clinical/Registered Nurse (RN) #410 was the designated the infection preventionist (IP) from October 2025 to March 2026 and the Director of Nursing (DON) was designated from March 2026 to the present, 05/05/26. Review of Antibiotic Infection Summary Logs dated from October 2025 to February 2026 revealed there were no infection control logs. Interview on 05/05/26 at 4:06 P.M. with Regional Director of Clinical Services/ Registered Nurse (RN) #404 and DON verified there were no ATB/ Infection Control logs completed from October 2025 to February 2026. They revealed the infection control program at the facility when they both started March 2026 was not done as they stated, it was a mess. They verified without the antibiotic (ATB) logs, she was unable to determine which residents were on ATBs, had infections, and/or if there were any trends and/or patterns of infections from 10/01/25 to 05/05/26. They verified they had no evidence ATB use was documented to ensure the ATB met criteria for use and was appropriate for the resident. Interview on 05/07/26 at 8:59 A.M. with Director of Clinical/RN #410 verified she was designated as the IP from October 2025 to 03/03/26 when she switched roles to the Corporate Director of Education. She revealed there were antibiotic logs and she was not aware the logs were not able to be located. She revealed, I have had the most incompetent people around me, you do not understand they box things up and that is why cannot find anything as so many different administrators and DONs they just move things. She verified she was unable to locate any of the antibiotic infection control logs. Review of facility policy labeled, Antibiotic Stewardship dated December 2016 revealed antibiotics would be prescribed and administered to residents under the guidance of the facilities antibiotic stewardship program. If an antibiotic was indicated prescribers would complete antibiotic orders including the following drug name, dose frequency, duration of treatment, route of administration and indications for use. There was nothing in the policy regarding the facility tracking the ATB use including the tracking of infections to determine if there were trends and patterns including MRDO infections. This deficiency represents non-compliance investigated under Complaint Number 2799025.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interview, and review of facility policy and procedure, the facility failed to ensure a homelike environment. This had the potential to affect all residents residing in the facility. The facility census was 53. Findings include: Observation on 05/05/26 at 9:12 A.M. revealed a trail of bowel movement on the floor going into the shower room across from Residents #30 and #31's room toward the toilet and observed a soiled brief sitting on top of the trash can in the shower room. Observation of the shower room revealed the room was cluttered with a Hoyer lift and other equipment. Interview on 05/05/26 at 9:16 A.M. with Certified Nurse Aide (CNA) #334 verified the above findings and stated the bowel movement just happened as it appeared fresh. CNA #334 verified the shower room was cluttered but stated it was normally not like that.Observations during an environmental tour on 05/05/26 between 10:04 A.M. and 10:30 A.M. with Director of Maintenance (DOM) #401 revealed no baseboards on the wall near the nursing station and Director of Nursing (DON) office. DOM #401 stated he was literally in the process of placing the baseboard on the walls. DOM #401 stated he started yesterday and planed to do more today. DOM #401 stated he started working at the facility in January 2026 and they had a company doing it, but they left the job and he did not know why. Continued observation of the end of the handrail by Residents #24 and #25's room was covered with old, tattered, gray tape and the screws were missing, causing the handrail to be loose. DOM #401 verified the observation and stated he just got a work order about the loose handrail. Observation in Residents #24 and #25's room revealed above Resident #24's bed where the privacy curtain track was screwed/bolted to the ceiling, the ceiling around the bolt had a medium sized brown stain with a slight bulge. DOM #401 verified the observation and stated it was from an old roof leak. DOM #401 stated the roof was patched and the area of the ceiling was dry and secure it was just aesthetics. Observation in Residents #22 and #23 revealed the window blinds were in disrepair, missing a blind slat in the middle of the blinds. DOM #401 verified and stated he will replace the blinds. Observation in the shower room across from Residents #30 and #31's room revealed it had been clean and cleared of the clutter, but the water temperature was tested and resulted at 101 degrees Fahrenheit. DOM #401 verified the observation and stated he thought a sink was running and needed to check. DOM #401 stated the showers in morning drained the tank fast, and it was in the process of replenishing. DOM #401 stated to give it a few and then recheck the water temperature. Continued observation revealed missing baseboards in this area along the hall by the therapy room into the vending area. Observed a pile of baseboards piled in hall near the therapy room. DOM #401 verified the observations and stated the baseboards came in last week from a sister facility and he didn't have a place to store them. Observation in the vending area near the entrance where the scale were two open, square-shaped holes under the alarmed keypad. DOM #401 verified the observation and stated he was checking for a sensor for the keypad and made those holes about two weeks ago. DOM #401 stated he just needed to patch them. Observation at 10:30 A.M. of the re-attempted water temperature for the shower room across from Residents #30 and #31's room revealed a temperature of 103 degrees Fahrenheit. Interview on 05/05/26 at 10:38 A.M. with Resident #31 revealed he did not use that shower room across from his room due to the water was cold and that it was always nasty. Resident #31 stated they never clean that shower room that was why he used the other shower room. Interview on 05/05/26 at 10:41 A.M. with Residents #33 and #44 both stated the shower room across from Resident #31's room was not clean at all times. Resident #44 stated the water sucked and was usually cold. Resident #33 stated he used the other shower room because of the concerns with the shower room across from Resident #31's room. Resident #33 stated he had concerns with the bathroom in his room and stated go take a look at it. Observation on 05/05/26 at 10:46 A.M. of Resident #33's bathroom with DOM #401 revealed the toilet paper holder was in disrepair, the wall needed painting behind the paper towel holder, there were two small, patched holes on wall near the (continued on next page)

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	05/13/2026

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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	sink. DOM #401 confirmed the findings at the time of observation. Review of the facility policy titled Homelike Environment, dated February 2021 revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included a clean, sanitary and orderly environment.This deficiency represents non-compliance investigated under Complaint Numbers 3001090 and 2799025.