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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and staff interview, the facility failed to maintain a clean kitchen and serve food in a sanitary manner. This affected all residents except one resident (#41) who the facility identified as received nothing by mouth. The facility census was 49. Findings include:Observation and interview on 09/22/25 between 8:16 A.M. and 8:34 A.M. with Dietary Manager (DM) #522 revealed on the back wall where the knives hung were various dried splatters of food-like particles. The mounted, large black fan in this area had a moderate amount of dust-like particles. The back wall behind the rack with the hanging clean utensils was moderately dusty and there was a moderate amount of dust-like particles on the side of the reach in cooler next to it. In the back room of the kitchen, there was a rack of dry foods. On the bottom shelf of this rack, there were two large clear containers of flour and sugar both with blue lids. Both blue lids were dirty with debris and dried stains. Observation of the dish machine revealed a moderate amount of a tannish colored, wet debris/substance on top of the dish machine. DM #522 verified all above findings. Observation and interview on 09/22/25 at 1:13 P.M. revealed DM #522 brought a half of sandwich for Resident #58. DM #522 removed the half sandwich with her ungloved hand, put the mayonnaise on the bread then took the mayonnaise packet and spread the mayonnaise around the bread. DM #522 then handed the half of sandwich to Resident #58. DM #522 stated that she sanitized her hands in the kitchen before she walked to the resident's room. The facility identified Resident #41 received no food from the kitchen. Review of the facility policy titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised November 2022 revealed antimicrobial hand gel is not used in pace of handwashing in foodservice areas. Contact between food and bare (ungloved) hands is prohibited.

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

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review, policy review and staff interview, the facility failed to develop and implement baseline care plans for residents. This affected four (Residents #1, #10, #32, and #57) of 22 residents reviewed for baseline care plans. The facility census was 49. Findings include:1. 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 and diabetes mellitus. Review of Resident #1's electronic medical record and paper chart revealed there was no baseline care plan completed after admission. Interview on 09/24/25 at 10:12 A.M. with Registered Nurse (RN) #569 verified Resident #1 did not have a baseline care plan completed after admission. 2. Review of the medical record for Resident #32 revealed an admission date of 08/07/25 with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus, and heart disease. Review of Resident #32's electronic medical record and paper chart revealed there was no baseline care plan completed after admission. Interview on 09/24/25 at 10:12 A.M. with Registered Nurse (RN) #569 verified Resident #32 did not have a baseline care plan completed after admission. 3. Review of the medical record for Resident #10 revealed an admission date of 09/08/25. Diagnoses included major joint replacement or spinal surgery, obstructive sleep apnea, hypertensive heart disease with heart failure, major depressive disorder, and anxiety disorder. Review of Resident #10's electronic medical record and paper chart revealed there was no baseline care plan completed after admission. Interview on 09/24/25 at 10:12 A.M. with Corporate Minimum Data Set (MDS) Nurse #569 verified there was no baseline care plan completed for Residents #10 within 48 hours of their admission. 4. Review of the medical record for Resident #57 revealed an admission date of 09/18/25. Diagnoses included colon cancer, muscle weakness, severe protein calorie malnutrition, and need for assistance with personal care. Review of Resident #57's electronic medical record and paper chart revealed there was no baseline care plan completed after admission. Interview on 09/24/25 at 10:12 A.M. with Corporate Minimum Data Set (MDS) Nurse #569 verified there was no baseline care plan completed for Residents #57 within 48 hours of their admission. Review of the facility policy titled Care Plans-Baseline dated March 2022 revealed a baseline plan of care would be developed within 48 hours of admission to ensure the resident's immediate health and safety needs were met.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, and record review, the facility failed to ensure the correct servings for the pureed vegetable were provided to the residents who received a pureed diet. This affected four residents (#4, #15, #17, and #37) who the facility identified who received a pureed diet. The facility census was 49. Findings include:Review of the menu for lunch on 09/23/25 revealed for the puree diet the meal included four ounce serving of pureed carrots.Review of the scoop size sheet indicated the #16 scoop which was a blue handled scoop provided two-ounce servings. Observation on 09/23/25 at 11:50 A.M. of lunch meal service revealed Dietary [NAME] (DC) #526 served the pureed carrots using a blue handled scoop (a two-ounce scoop), giving one scoop on each plate. Observation on 09/23/25 at 12:13 P.M. of the last meal cart completed, completing the end of lunch meal service. Interview on 09/23/25 at 12:15 P.M. with DC #526 verified she used the #16 scoop providing one serving each for the pureed carrots. DC #526 verified the #16 scoop provided two-ounce servings and she should have provided four ounce servings for the pureed carrots. Review of the diet type report dated 09/23/25 revealed four residents (#4, #15, #17, and #37) in the facility that received the pureed diet.

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	366058	A. Building B. Wing	09/29/2025

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on observation, interview and record review, the facility failed to effectively implement the facility smoking policy. This affected one (Resident #12) of two residents reviewed for smoking. The facility identified 16 residents who smoke. The facility census was 49. Findings include:Observation on 09/22/25 at 10:38 A.M. with Certified Nursing Assistant (CNA) #504 verified Resident #12 had her cigarettes on her night table. CNA #504 stated Resident #12 was an independent smoker and could have them in her possession. Interview on 09/22/25 at 11:38 A.M. with the Administrator revealed the smoking policy stated the independent smokers must keep their smoking materials locked up. Interview on 09/24/25 at 1:56 P.M. with the Director of Nursing (DON) revealed the wrong smoking policy was presented to the State Survey Agency and provided a second policy and stated the corporate lawyer was working on a new policy. Review of the first facility policy dated 10/28/21 titled Smoking revealed independent smokers must keep their smoking materials in the red lock boxes provided and kept in the cabinet in the lobby. Review of the second smoking policy presented dated 2001 titled Smoking Policy-Residents, revealed the residents will be evaluated upon admission and independent smokers are permitted to smoking materials in their possession. This deficiency represents non-compliance investigated under Complaint Number 2591659.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) included the resident's mental health diagnosis. This affected one (Resident #46) of two residents reviewed for PASARR. The facility census was 49. Findings include:Record review revealed Resident #46 was admitted on [DATE] to the facility with diagnoses including schizophrenia disorder, panic disorder, and psychosis not due to a substance or known physiological condition. Review of Resident #46's PASARR assessment dated [DATE] revealed the PASARR did not address Resident 46's diagnosis of schizoaffective disorder. Interview with Social Service Designee (SSD) #538 on 09/23/25 at 10:29 A.M. verified Resident 46's PASARR did not address her diagnoses of schizoaffective disorder. SSD #538 stated when she arrived she filled out the PASARR. She stated she did not include a schizophrenia diagnosis because there was no proof that Resident #46 had schizophrenia. SSD #538 stated that psychiatric services saw her just recently and verified the diagnosis. She asked the psychiatrist to come see her and wait for the assessment to come in. She will complete a significant change assessment if there is actual documentation to verify the diagnosis. Interview on 09/23/25 at 2:08 P.M. with Corporate Nurse #569 revealed Resident #46 had a diagnosis of schizophrenia prior to admission and the reason why she was on an antipsychotic medication. Resident #46's PASARR should have included the diagnosis of schizophrenia.

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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. 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 (continued on next page)

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	366058	A. Building B. Wing	09/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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	366058	A. Building B. Wing	09/29/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, the facility failed to ensure there were smoking assessments of the resident's capabilities and deficits to determine whether or not supervision is required. This affected two (#15 and #46) of three residents reviewed for smoking. The facility census was 49. Findings include: 1. Review of the medical record for Resident #15 revealed an admission date of 10/03/24. Diagnoses included major depressive disorder, psychoactive substance abuse, throat cancer, and nicotine dependence. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition and used tobacco. Review of the care plan dated 05/06/25 revealed Resident #15 was at risk for injury related to smoking. Interventions included the resident was an independent smoker. There was no smoking assessment for Resident #15 in the medical record from 10/03/24 to 09/23/24. Observation on 09/22/25 at 11:31 A.M. revealed Resident #15 was outside in the courtyard smoking a cigarette. Interview on 09/24/25 at 3:40 P.M. with Director of Nursing (DON) verified Resident #15 was a smoker and there was no smoking assessment for Resident #15. 2. Record review revealed Resident #46 was admitted on [DATE]. Diagnoses included schizophrenia disorder, panic disorder, and psychosis not due to a substance or known physiological condition. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 was cognitively intact and required moderate assistance for activities of daily living. The MDS assessment did not indicate that Resident #46 used tobacco. There was no smoking assessment for Resident #46 in the medical record from 07/30/25 to 09/22/25. Observation on 09/22/25 at 10:38 A.M. with Certified Nursing Assistant (CNA) #504 verified Resident #12 had her cigarettes on her night table. CNA #504 stated Resident #12 was an independent smoker and could have them in her possession. Interview on 09/23/25 at 2:12 P.M. with Corporate MDS Nurse #569 verified the MDS assessment not indicate Resident #46 used tobacco and a smoking assessment was not completed. Review of the facility policy titled Smoking Policy-Residents dated 2001 revealed that residents will be evaluated upon admission.

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	366058	A. Building B. Wing	09/29/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, policy review, and staff interview, the facility failed to ensure pharmacy medication regimen reviews were adequately addressed and followed through in a timely manner. This affected two residents (#13 and #45) of five residents reviewed for unnecessary medications. The facility census was 49. Findings include: Review of the medical record for Resident #45 revealed an admission date of 07/09/25. Diagnoses included acute respiratory failure with hypoxia, pneumonia, non-pressure chronic ulcer of left heel and mid-foot with fat layer exposed, obesity, mild protein calorie malnutrition, and depression. Review of the Consultant Pharmacist Medication Regimen Review (MRR) dated 07/24/25 for a physician recommendation, revealed polypharmacy has been associated with an increased risk of hospital admissions. It has been associated with decreased physical and cognitive capability. High medication burden often increased the potential for drug interactions and prescribing cascades as well. The goal is to reduce medication burden, adverse effects, improved quality of life, and reduce nursing time on med pass to focus on patient care. Recommendations included to please check any medications that can be trial discontinued: Mucinex (expectorant and nasal decongestion) 600 milligrams (mg) two times a day; Aspirin (ASA) 81 mg once a day (will interfere with wound healing)-not recommended for primary prevention; Vitamin D 1,000 units and obtain level on next lab day; Multivitamin (MVI) once a day; Vitamin B-12 1,000 microgram (mcg) once a day and obtain level on next lab day; Please check any medications that can be trialed to as needed (PRN) to assess need for scheduled dosing; Ipratropium-Albuterol once a day (started after pneumonia?); and Meloxicam 15 mg once a day-NSAIDs (non-steroidal anti-inflammatory drug) high in elderly due to bleeding risks. On the Consultant Pharmacist MRR, the box next to disagree noted to provide a brief clinical rationale note. The box was next to disagree was marked. Handwritten on the response line below was, Reviewed and all medications require continuation. The form was signed by the nurse practitioner and dated 08/06/25. Resident #45's medical record revealed no other notes or progress notes indicating a clinical rationale note. There was no physician order for Vitamin D or Vitamin B-12 laboratory value on the next lab draw. Interview on 09/24/25 at 12:27 P.M. with the Administrator verified the nurse practitioner did not write any more details on the clinical rationale to continue all the medications and there were no physician orders for a Vitamin D and B-12 laboratory value on the next lab draw for the Consultant Pharmacist MRR for 07/24/25. The Administrator stated they talked with the nurse practitioner today and she ordered labs to be drawn for Vitamin D and Vitamin B-12 levels. 2. Review of the medical record for Resident #13 revealed an admission date of 04/09/21 with diagnoses including diabetes mellitus, hypertension and dementia. Review of the Consultant Pharmacist Medical Regimen Review (MRR) dated 01/24/25 revealed Resident #13 had an order for acetaminophen (treats mild pain). The pharmacist recommended to add to the order to not exceed three grams in a 24-hour period of all sources of acetaminophen. The physician agreed and stated to please write the order on 02/10/25. (continued on next page)

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	366058	A. Building B. Wing	09/29/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for Resident #13 revealed he had an order for acetaminophen 325 milligrams (mg) give two tablets by mouth every four hours as needed for pain dated 02/04/24. There were no physician orders on 02/10/25 or thereafter to not exceed three grams in a 24-hour period for all sources of acetaminophen. Interview on 09/24/25 at 3:22 P.M. with the Director of Nursing (DON) verified the facility had not followed the recommendation from the pharmacist after the physician had agreed and provided an order for the acetaminophen to be changed with the clarification not to exceed three grams in a 24-hour period. Review of the facility policy titled Medication Regimen Review, revised February 2025 revealed under physician response noted upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them.

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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. Based on record review, facility policy review, and staff interview, the facility failed to ensure the residents were being monitoring for side effects while taking antidepressant medications. This affected one (#45) of five residents reviewed for unnecessary medications. The facility census was 49. Findings include:Review of the medical record for Resident #45 revealed an admission date of 07/09/25. Diagnoses included depression. Review of the care plan dated 07/28/25 revealed Resident #45 used antidepressant medication related to depression. Interventions included administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Review of the physician orders for September 2025 revealed active orders for Duloxetine HCl 60 milligram (mg) capsule delayed release particles. Give one capsule by mouth one time a day for depression. There was also an active order for Bupropion HCl ER (XL) oral tablet extended release 24-hour 300 mg. Give one tablet by mouth one time a day for depression. Resident #45's medical record did not have documentation for monitoring for side effects for the use of antidepressant medications. Interview on 09/24/25 at 3:24 P.M. with Director of Nursing (DON) verified there was no documentation in Resident #45's medical records for monitoring the side effects of antidepressants. The DON stated there will be a physician order for monitoring side effects. Review of the facility policy titled Psychotropic Medication Use, revised February 2025 revealed medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: anti-psychotics; anti-depressants; anti-anxiety medications; and hypnotics/sedatives.

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	366058	A. Building B. Wing	09/29/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interview, the facility failed to ensure effective collaboration of care for a hospice resident. This affected one (Resident #1) of one resident reviewed for hospice services. 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 and diabetes mellitus. Review of the hospice contract with the facility dated 06/17/25 revealed documentation would be provided to the facility including copies of clinical notes after each visit. Review of the hospice binder for Resident #1 revealed two hospice interdisciplinary group reports as well as plan of care dated 08/20/25 and 09/03/25. There was no documentation related to nurse or aide visits from 08/11/25 to 09/23/25 when Resident #1 was admitted to hospice services. 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 all documentation for Resident #1 would be in his own personal binder at the nurse's station. She verified the documentation for Resident #1 would include his plan of care, physician's orders, any visits by their staff and the certificate of need. Interview on 09/24/25 at 3:00 P.M. with Registered Nurse (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. Review of the facility policy titled, Hospice Program, dated July 2017, revealed it was the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, resident and staff interview, and record review, the facility failed to ensure a clean and sanitary environment and the walls received timely repairs. This affected two (#42, and #45) of 28 residents reviewed for physical environment. The facility census was 49. Findings include: 1.Observation on 09/22/25 at 10:31 A.M. revealed there were dirty linens with feces on them in the corner of the closet in Resident #42's room. At this time, Assistant Director of Nursing (ADON) #539 verified the observation. Review of the facility's undated policy titled Laundry and Bedding, Soiled revealed contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used). Leak-resistant containers or bags are used for linens or textiles contaminated with blood or body substances. 2. Observation on 09/22/25 at 2:45 P.M. of Resident #45's room revealed two very large holes in the wall behind the resident's bed. The resident's bed was moved away from the wall. Resident #45 stated it had been that way for about three weeks and was told by maintenance that they would take care of it when they redo the rooms. Observation and interview on 09/22/25 at 2:52 P.M. with the Administrator verified the holes in Resident #45's wall and stated she was not aware of the two large holes prior. This deficiency represents non-compliance investigated under Complaint Number 2591659.