

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2024
NAME OF PROVIDER OR SUPPLIER Candlewood Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 Belmore Ave East Cleveland, OH 44112	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to ensure a staff-to-resident physical abuse allegation involving Resident #2 was reported to the Administrator. This affected one resident (#2) of five residents reviewed for abuse. The census was 99.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side, vascular dementia with mood disturbance, diabetes, gastrostomy, chronic heart failure, anxiety disorder, depression, psychosis and suicidal ideations.</p> <p>Review of the general note dated 04/15/24 revealed Resident #2 was alert and oriented times two and pleasant. He was able to make his needs known to staff. He utilized a Hoyer (mechanical lift) for transfers and two-person maximum assistance with all other activities of daily living. He was incontinent of bowel and bladder. He was NPO (nothing by mouth) and was tolerating continuous tube feedings.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #2 was cognitively intact, had hallucinations and delusions, was dependent on staff for oral and personal hygiene, toileting, bathing, upper and lower body dressing, and bed mobility.</p> <p>Observation on 06/17/24 at 9:15 A.M. revealed Resident #2 was lying in bed, in a hospital gown, on his back, asleep, with a feeding tube. Interview, during the observation, with Resident #2 revealed he had a complaint that one of the workers bent his right arm back and cut his fingernails when he told her not to do it. The incident occurred approximately four months ago, and he told a nurse or someone about it but he couldn't remember the name of the person he reported the incident to. Resident #2 stated my arm hurts as he held up and bent his right arm at the elbow.</p> <p>Interview on 06/17/24 at 10:00 A.M. with State-tested Nurse Aide (STNA) #4 revealed Resident #2 did make an allegation of abuse towards STNA #3 saying, she abused him by pulling his arm, and he asked STNA #3 to stop but she didn't. The incident occurred approximately a couple of weeks ago/a month ago. STNA #4 notified former Registered Nurse (RN) #7 of the allegation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/17/24 at 10:28 A.M. with the Administrator and the Director of Nursing (DON) revealed RN #7 hadn't worked at the facility since 02/10/24. The Administrator and the DON were unaware of Resident #2's physical abuse allegation towards STNA #3.</p> <p>Interview on 06/17/24 with Resident #2's Power of Attorney (POA) revealed STNA #3 was rough with Resident #2 and would hold him down and talk smack to him. Resident #2's POA reported the incident to the Scheduler and Case Manager; however, Resident #2's POA was unable to remember the staff names.</p> <p>Interview on 06/17/24 wat 11:25 A.M. with Regional Clinical Support Nurse (RCSN) #9 with the Administrator and DON present, revealed former Administrator/Regional Administrator #10 was also unaware of a physical abuse allegation involving Resident #2 and STNA #3. RCSN #9, the Administrator and the DON all verified it was the expectation and facility policy for the Administrator to be immediately notified a resident abuse allegation.</p> <p>Review of the facility's Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property policy dated October 2022 revealed staff should report all incidents/allegations immediately to the Administrator or designee. If a staff member is accused or suspected, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. All incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property and all injuries of Unknown Source must be reported immediately to the Administrator or designee. The Administrator/designee should be notified by informing him/her in person, calling via telephone, or sending an email or text message.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154585 and Complaint Number OH00154530.</p>		