

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/31/2025
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)		
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #96's resident fund account was dispersed timely following the resident's discharge from the facility. This affected one resident (Resident #96) of five residents reviewed for funds. The facility census was 88. Findings include: Review of Resident #96's medical record revealed the resident was readmitted on [DATE] and discharged on 06/06/25 with diagnoses including unspecified dementia, paranoid schizophrenia and major depressive disorder. Review of resident fund accounts revealed \$767.94 (seven hundred sixty-seven dollars and ninety-four cents) was dispersed on 07/29/25 from Resident #96's resident fund account following the resident's discharge from the facility on 06/06/25. Interview on 07/30/25 at 12:18 P.M. with Regional Director of Operations #920 confirmed Resident #96's resident fund account monies were not dispersed within thirty days as required.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on record review, interview and observation, the facility failed to ensure staff followed infection control standards to prevent cross contamination during tracheostomy (a tube in the opening of the trachea for breathing) care. This affected one (Resident #76) of one resident reviewed for tracheostomy care. The facility census was 88. Findings include: Review of the medical record for Resident #76 revealed an admission date of 07/31/20 with diagnoses including brain damage, tracheostomy status and chronic respiratory failure. Review of the physician's orders for Resident #76 for July 2025 revealed staff were to change her inner cannula every day and as needed dated 02/28/25 and to change the tracheostomy ties every night shift and as needed dated 06/29/22. An observation was conducted on 07/29/25 at 12:12 P.M. of tracheostomy care to Resident #76 by Registered Nurse (RN) #868 with Assistant Director of Nursing/Licensed Practical Nurse (LPN) #805 present during the observation. RN #868 washed her hands, put on a surgical mask, gown and gloves. Resident #76's tray table was covered with a barrier and supplies were in packages and placed on the table. RN #868 placed a barrier on Resident #76's chest, loosened Resident #76's oxygen mask ties and positioned her for tracheostomy care. RN #868 removed her gloves and washed her hands. She then placed on sterile gloves and began to remove Resident #76's tracheostomy ties and cleaned on both sides of the residents neck. She dried the areas and placed new tracheostomy ties on the resident. RN #868 then removed the split tracheostomy gauze sponge and inner cannula and placed them on the barrier on Resident #76's chest. Next, without removing the soiled gloves nor washing her hands and applying clean gloves, she went to the tray table, removed a new sterile cannula from the package and inserted it into Resident #76's outer cannula. RN #868 opened a new split tracheostomy sponge and placed it around her tracheostomy. She reapplied Resident #76's oxygen mask all while wearing the same soiled gloves worn during the treatment. Interview on 07/29/25 at 12:30 P.M. with RN #868 verified she did not follow proper steps during tracheostomy care. She verified her gloves were not sterile during insertion of the new inner cannula causing cross contamination between clean and dirty areas. Interview on 07/29/25 at 12:31 P.M. with LPN #805 also verified RN #868 did not follow the facility's policy and procedure as well as not maintaining infection control practices to prevent cross contamination. Review of the facility policy titled, Trach Care Policy, revised January 2021, revealed changing the inner cannula, trach dressing and collar should be under sterile technique. The nursing staff were to use non-sterile gloved hands, remove oxygen source, remove site dressing, assess, replace the oxygen source and remove gloves. Staff were to put on sterile gloves and remove the inner cannula with their non-dominant hand. With their dominant hand, nursing staff were to gently insert the clean (new) inner cannula into the outer cannula and replace oxygen. After replacing the inner cannula, staff were to clean under the ties and apply the new dressing and ties.		