STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365711	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chardon Center	620 Water Street Chardon, OH 44024

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51521 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure staff knocked on Resident #21's room door and/or asked permission to enter the resident's room prior to entering. This affected one resident (#21) of one resident reviewed for privacy. The facility census was 85. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including epilepsy, respiratory failure, chronic obstructive pulmonary disease, Type 2 diabetes mellitus with diabetic chronic kidney disease, unspecified dementia, psychotic disturbance, mood disturbance, anxiety, depression, and personal history of cerebral infarction without residual deficits. Observation on 04/16/25 at 8:27 A.M. revealed Certified Nurse Aide (CNA) #500 walked into Resident #21's without knocking on the door or asking permission to enter the room. Interview with Resident #21 on 04/15/25 at 9:03 A.M. revealed staff does not respect his privacy. They just walk into the room without knocking or asking permission. Interview with CNA # 500 on 04/16/25 at 8:43 A.M. verified CNA #500 did not knock or ask permission before entering Resident #21's room. Review of the undated policy titled Resident Rights revealed residents' private space and property shall be respected at all times, and staff will knock before entering resident room and wait for an answer and/or request permission before entering residents' rooms.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview and facility policy review, the facility failed to ensure Residents #67, #189 and #196 were provided with showers as scheduled. This finding affected three residents (#67, #189 and #196) of five residents reviewed for showers. The facility census was 85. Findings include: 1. Review of the medical record revealed Resident #189 was admitted on [DATE] with diagnoses including encounter for orthopedic aftercare following a surgical amputation, diabetes, and generalized weakness. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #189 exhibited moderate cognitive impairment and was dependent on staff for showers/bathing. Review of the activities of daily living (ADL) care plans revealed an intervention dated 03/25/25 for shower/bathing, and Resident #189 was totally dependent on staff. Review of the shower schedules revealed Resident #189 was scheduled for showers Sunday and Thursday during the nightshift. Review of the Documentation Survey Report form dated 03/21/25 to 04/14/25 revealed Resident #189 received a shower/bath on 03/27/25, 03/30/25, 04/07/25 and 04/13/25. Interview on 04/14/25 at 10:37 A.M. with Resident #189 revealed he had only received two bed baths and one shower since admission. Interview on 04/15/25 at 12:12 P.M. with the Director of Nursing (DON) confirmed Resident #189 should have had at least six showers/baths since 03/21/25 and was only provided four showers/bathes since admission. 2. Review of the medical record revealed Resident #196 was admitted on [DATE] with diagnoses including myelodysplastic syndrome and unspecified cirrhosis of the liver. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #196 had intact cognition and was dependent on staff for showers/bathing. Review of the ADL care plans revealed an intervention dated 03/25/25 for shower/bathing, and Resident #196 was totally dependent on staff. Review of the shower schedules revealed Resident #196 was scheduled for showers Tuesday and Saturday on nightshift. Interview on 04/14/25 at 10:40 A.M. with Resident #196 revealed she had not received a shower/bath since admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Documentation Survey Report form from 03/21/25 to 04/14/25 revealed Resident #196 refused a shower/bath on 04/05/25 and received a shower/bath on 04/09/25. Interview on 04/15/25 at 12:12 P.M. with the DON confirmed Resident #196 should have had at least six showers/baths since 03/21/25, and the resident refused one shower/bath and received only one shower/bath. 51521 3. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including muscle weakness, unspecified lack of coordination, and abnormal posture. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #67 had intact cognition, required substantial/maximal assistance for shower/bathing, was dependent for mobility and transfers with the assistance of two or more staff for showers and all transfers by Hoyer (mechanical) lift. Review of the shower scheduled revealed Resident #67 was to receive showers every Sunday and Thursday. Review of the plan of care dated 02/14/25, revealed Resident #67 required assistance for ADL self-care. Interventions included bed mobility, transfer with Hoyer lift, bathing, toileting and hygiene required the assistance of two staff. Review of the Documentation Survey Report Form dated 03/01/25 through 03/31/25 revealed Resident #67 received showers on 03/13/25, 03/27/25, and 03/30/25. Interview on 04/16/25 at 9:38 A.M. with Resident #67 revealed that she would like to have her showers as scheduled and would like more showers than her scheduled two days. Resident #67 revealed issues with staff having time to Hoyer her to be showered. Interview with Executive Director on 04/17/25 at 8:42 A.M. verified the skin assessment/shower sheets revealed that Resident # 67 only received three showers in March on 03/13/25, 03/27/25, and 03/30/25. Review of the undated Routine Resident Care policy revealed routine resident care was defined as care that was not necessarily medically or clinically based but necessary for quality of life promoting dignity and independence as appropriate including routine care by a nursing assistant. The routine care by a nursing assistant includes but not limited to bathing, dressing, eating, hydration and toileting.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on record review, observations, interviews and review of the facility policy, the facility failed to ensure oxygen tubing was changed and dated and oxygen was set to the ordered liter flow per minute. This affected five residents (#1, #5, #8, #61, and #65) out of eight residents reviewed for oxygen. The facility census was 85. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included epilepsy, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), chronic diastolic congestive heart failure and atrial fibrillation. Review of Resident #1's Minimal Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. He required setup or clean up assistance with eating and dressing. He was independent with bed mobility, and required supervision or touching assistance with showers, toileting, and personal hygiene. Review of the Care Plan dated 04/09/25 revealed Resident #1 had COPD and chronic respiratory failure. Goals and interventions included Resident #1 would have a reduction in complications related to COPD, staff were to administer medications per order, observe for side effects and effectiveness, and report any abnormal findings to the physician. Staff were to monitor vital signs, observe for signs and symptoms of COPD, increased shortness of breath, coughing with or without mucus, wheezing, tightness in the chest, and anxiety. Oxygen therapy as ordered, and changing tubing per facility policy. Review of Resident #1's Physician orders dated April 2025 revealed an order for oxygen at three liters per minute (lpm) via nasal cannula (NC) continuous every shift. Change oxygen tubing and humidifier every seven days and as needed on Wednesday on night shift. Observation on 04/14/25 at 10:08 A.M. of Resident #1's oxygen revealed it was set at four lpm. Interview on 04/14/25 at 10:10 A.M. with Licensed Practical Nurse (LPN) #585 revealed they verified Resident #1 was to be on three lpm of oxygen, and the resident was on four lpm of oxygen. 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included systolic congestive heart failure, venous insufficiency, chronic atrial fibrillation, and COPD. Review of Resident #5's quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. He required setup or clean up assistance with eating, supervision or touching assistance with bed mobility, partial to moderate assistance for oral hygiene, showers, dressing, and personal hygiene. He required substantial to maximal assistance for toileting. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's care plan dated 02/24/25 revealed the resident had COPD with potential for shortness of breath while lying flat. Interventions and goals included staff administering medications per medical providers order, observing for side effects and effectiveness, reporting abnormal findings to the medical provider, resident and resident representative. Provide oxygen therapy as ordered, change tubing per facility policy and provide bilevel positive airway pressure (BiPAP)/continuous positive airway pressure (CPAP) as ordered. Review of Resident #5's physician orders dated April 2025, revealed the resident was to wear a BiPAP with settings of 16/10 with an oxygen bleed of two lpm at bedtime. Observation made on 04/14/25 at 10:18 A.M. revealed the oxygen tubing from the oxygen concentrator to the BiPAP machine was last changed and dated 04/03/25. Interview on 04/14/25 at 10:20 A.M. with LPN #585 revealed she verified the oxygen tubing had not been changed since 04/03/25, and the tubing was to be changed weekly. 3. Review of Resident #8's medical record revealed an admitted [DATE]. Diagnoses included chronic respiratory failure with hypoxia, COPD, and congestive heart failure (CHF). Review of Resident #8's Medicare 5-day admission MDS assessment dated [DATE] revealed the resident had intact cognition. She required setup to clean up assistance with eating, partial to moderate assistance for oral hygiene, and bed mobility. She required substantial to maximal assistance for showers, dressing, and personal hygiene. Review of Resident #8's care plan dated 02/09/25 revealed the resident had oxygen therapy related to diagnosis of COPD and CHF. Interventions and goals included the resident would not have signs or symptoms of poor oxygen absorption, staff would encourage or assist with ambulation as indicated, staff to give medications as ordered by the physician, monitor and document side effects and effectiveness, staff to monitor for signs and symptoms of respiratory distress and report to the physician as needed. Resident #8 to have oxygen at four lpm via nasal cannula. Review of Resident #8's physician orders dated April 2025 revealed the resident was prescribed oxygen at four lpm via nasal cannula continuously every shift. Change oxygen tubing and humidification every seven days and as needed, every night shift on Wednesday and as needed. Observation on 04/14/25 at 9:38 A.M. of Resident #8's oxygen tubing revealed it was undated as to when it was changed last. The humidification bottle was undated and empty, and the oxygen concentrator was set to 4.5 lpm. Interview on 04/14/25 at 9:40 A.M. with Resident #8 revealed staff had not changed the oxygen tubing in over a week. Resident #8 stated her oxygen was to be at four lpm. Interview on 04/14/25 at 9:41 A.M. with LPN #585 verified Resident #8's oxygen tubing was not dated, the humidification bottle was empty and undated, and the concentrator was set to 4.5 lpm and not 4 lpm per the resident's physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included COPD, nonspecific abnormal findings of lung field, personal history of other malignant neoplasm of bronchus and lung. Review of Resident #61's quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition. She required setup or clean up assistance for eating and oral hygiene. She required substantial to maximal assistance for bed mobility and was dependent on staff for toileting hygiene, showers, dressing and personal hygiene. Review of Resident #61's care plan dated 04/02/25 revealed the resident had COPD with potential for shortness of breath while lying flat. Interventions and goals included staff administering medications per physician orders, oxygen therapy as ordered, and changing tubing per facility policy. Review of Resident #61's physician orders dated April 2025 revealed oxygen at two lpm via nasal cannula, change oxygen tubing and humidifier every seven days and as needed every night shift on Wednesday. Observation on 04/14/25 at 10:12 A.M. of Resident #61's oxygen tubing revealed it was undated, and oxygen was set at three lpm. Interview on 04/14/25 at 10:13 A.M. with LPN #585 verified Resident #61's oxygen tubing was undated, and the oxygen was set at three lpm and not at two lpm per the physician orders. 5. Review of the medical record for Resident #65 revealed an admitted [DATE]. Diagnoses included CHF, emphysema, atrial fibrillation, hypertension, and heart failure. Review of Resident #65's annual MDS assessment dated [DATE] revealed she had intact cognition. She required setup or clean up assistance for eating and oral hygiene and substantial to maximal assistance for showers, dressing, and personal hygiene. She was independent with bed mobility. Review of Resident #65's care plan dated 02/24/25 revealed she had COPD with potential of shortness of breath while lying flat, staff were to apply oxygen therapy as ordered and change tubing per facility policy. Review of Resident #65's physician's orders dated April 2025 revealed the resident was prescribed oxygen at two lpm via nasal cannula continuous every shift, change oxygen tubing and humidifier every seven days on Wednesday and as needed. Observation on 04/14/25 at 9:58 A.M. of Resident #65's oxygen revealed the oxygen tubing had not been changed since 04/03/25 and was set at 3.5 lpm. Interview on 04/14/25 at 10:00 A.M. with Resident #65 revealed her oxygen was to be at three lpm, and the oxygen tubing had not been changed in a couple of weeks. Interview on 04/14/25 at 10:04 A.M. with LPN #585 verified Resident #65's oxygen tubing had not been changed since 04/03/25 and they confirmed the oxygen was set at 3.5 lpm and not three lpm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled Supplemental Oxygen using Nasal Cannula revealed oxygen is to be administered per physician orders, and oxygen tubing is to be labeled and dated when opened and changed every seven days.