

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Crawford Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 Crawford Rd Cleveland, OH 44106	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on staff interview, medical record review, review of facility investigations, and review of the facility policy, the facility failed to ensure a resident was free from verbal abuse. This affected one (Resident #35) of three residents reviewed for abuse. The facility census was 33.</p> <p>Findings include:</p> <p>Record review for Resident #35 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified fracture of the left femur, unspecified fracture of lower end of left ulna, person injured in unspecified motor vehicle accident, bipolar disorder, generalized anxiety disorder, pain in the leg and muscle weakness.</p> <p>Record review of the Comprehensive Minimum Data Set (MDS) dated [DATE] revealed Resident #35 was cognitively intact. Resident #35 received scheduled and as needed pain medications.</p> <p>Record review of the care plan dated 07/26/24 revealed Resident #35 had potential for pain. Resident was able to verbalize pain. Potential for pain was related to the fracture of the left femur and left ulna. Interventions included administering pharmacological interventions as ordered by the physician and monitor effectiveness.</p> <p>Record review of Resident #35's progress notes revealed there was no progress note for 09/28/24.</p> <p>Review of the progress note for Resident #35 dated 10/01/24 at 10:50 A.M. completed by Mobile Director of Nursing (DON) #246 revealed Interdisciplinary Team (IDT) met and reviewed incident related to alleged verbal abuse. Investigation initiated. Resident declined to be seen by psych services. Resident has a history of making false accusations and being manipulative. Facility will continue to provide a safe environment for resident to reside in.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Facility Reported Incident (FRI) dated 09/30/24 revealed on 09/30/24, Resident #35 reported to management that she was yelled at and cursed at by Licensed Practical Nurse (LPN) #242. LPN #242 was suspended immediately pending investigation. Statements were gathered from LPN #242 and Resident #35 regarding the incident. Staff and resident interviews were conducted with no negative findings. Based on investigation, the incident was unsubstantiated. When Resident #35 was interviewed, she could not remember what exact day the alleged incident happened, but confirmed it was on the weekend. Resident #35 stated she requested pain medication from LPN #242 but did not receive it. Instead, she received what she believed to be a melatonin pill. Resident #35 says she approached the nurse and was met with attitude and told that she already gave her the pain pill. Resident #35 then proceeded back to her room and said she did not ask again. While in her room, Resident #35 claimed LPN #242 barged in and started yelling and cursing at Resident #35. Resident #35 claimed she was not physically hurt but she was startled by the LPN #242. When LPN #242 was interviewed, she explained she did give Resident #35 her pain medication. LPN #242 explained Resident #35 found her while she was on break and requested her medication. LPN #242 informed her that she already gave her the medication. LPN #242 explained how she has always been kind to Resident #35 and tried helping her. LPN #242 claimed she did not yell or curse at Resident #35 and feels as though Resident #35 is trying to get her in trouble for some sort of reason.</p> <p>Interview on 10/29/24 at 3:11 P.M. with State tested Nurse Aide (STNA) #218 confirmed she worked on 09/28/24 beginning at 7:00 A.M. STNA #218 revealed when she came in at 7:00 A.M., she heard Resident #35 swear and say LPN #242 did not give her medication. Resident #35 returned to her room. LPN #242 walked down the hall swearing loudly and went into Resident #35's room. Both LPN #242 and Resident #35 were cursing and yelling at each other. They both left Resident #35's room and went to the medication cart in the hall, both yelling and swearing at each other. STNA #218 confirmed LPN #242 called Resident #35 multiple degrading names. STNA #218 revealed LPN #201 calmed LPN #242 down. STNA #218 confirmed she was never interviewed about the incident.</p> <p>Phone interview on 10/30/24 at 5:42 P.M. with LPN #201 revealed on 09/28/24, it was the beginning of her shift and the end of LPN #242's shift. LPN #201 revealed Resident #35 made an allegation LPN #242 stole her narcotic. Resident #35 returned to her room and went back to bed. LPN #242 was upset and began cursing and swearing, went to Resident #35's room while cursing down the hall and approached Resident #35 while she was in her bed. LPN #201 revealed she heard LPN #242 yelling at Resident #35 loudly calling her a crack-head and a bitch repeatedly repeating, How dare you, all I do for you, then continuing with calling the resident names. Resident #35 got out of bed and went in the hall. LPN #242 followed her to the hall and continued yelling loudly and swearing at Resident #35. The cursing and yelling went back and forth between Resident #35 and LPN #242. LPN #201 revealed she tried to intervene and calm down LPN #242. LPN #242 continued yelling, I don't give a (explicit language). LPN #201 revealed Resident #35 appeared upset and distraught. LPN #242 eventually left the building. LPN #201 revealed Resident #35 told her she was sad and scared, she was woke up to a nurse standing over her yelling and screaming. Resident #35 then left on a leave of absence. LPN #201 revealed she reported the incident to the previous Mobile DON #246.</p> <p>Review of the facility policy titled, Ohio Resident Abuse Policy, revised 07/11/24 revealed this facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of residents property by anyone. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158631.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on staff interview, medical record review, review of facility investigations, and review of the facility policy, the facility failed to thoroughly investigate an allegation of verbal abuse. This affected one (Resident #35) of four residents reviewed for abuse. The facility census was 33.</p> <p>Findings include:</p> <p>Record review for Resident #35 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified fracture of the left femur, unspecified fracture of lower end of left ulna, person injured in unspecified motor vehicle accident, bipolar disorder, generalized anxiety disorder, pain in the leg and muscle weakness.</p> <p>Record review of the Comprehensive Minimum Data Set (MDS) dated [DATE] revealed Resident #35 was cognitively intact.</p> <p>Record review of Resident #35's progress note revealed there was no progress note for 09/28/24.</p> <p>Review of the progress note for Resident #35 dated 10/01/24 at 10:50 A.M. completed by Mobile DON #246 revealed Interdisciplinary Team (IDT) met and reviewed an incident related to alleged verbal abuse. Investigation initiated. Resident declined to be seen by psych services. Resident has a history of making false accusations and being manipulative. Facility will continue to provide a safe environment for resident to reside in.</p> <p>Record review of the Facility Reported Incident (FRI) dated 09/30/24 revealed on 09/30/24, Resident #35 reported to management that she was yelled at and cursed at by Licensed Practical Nurse (LPN) #242. LPN #242 was suspended immediately pending investigation. Statements were gathered from LPN #242 and Resident #35 regarding the incident. Staff and resident interviews were conducted with no negative findings. Based on investigation, the incident was unsubstantiated. When Resident #35 was interviewed, she could not remember what exact day the alleged incident happened, but confirmed it was on the weekend. Resident #35 stated she requested pain medication from LPN #242 but did not receive it. Instead, she received what she believed to be a melatonin pill. Resident #35 says she approached the nurse and was met with attitude and told that she already gave her the pain pill. Resident #35 then proceeded back to her room and said she did not ask again. While in her room, Resident #35 claimed LPN #242 barged in and started yelling and cursing at Resident #35. Resident #35 claimed she was not physically hurt but she was startled by the LPN #242. When LPN #242 was interviewed, she explained she did give Resident #35 her pain medication. LPN #242 explained Resident #35 found her while she was on break and requested her medication. LPN #242 informed her that she already gave her the medication. LPN #242 explained how she has always been kind to Resident #35 and tried helping her. LPN #242 claimed she did not yell or curse at Resident #35 and feels as though Resident #35 is trying to get her in trouble for some sort of reason.</p> <p>Record review of the daily staff schedule for 09/27/24 7:00 P.M. to 09/28/24 7:00 A.M. revealed the following staff worked: LPNs #242 and #239 and State tested Nurse Aides (STNAs) #238, #243, and #209.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the daily staff schedule for 09/28/24 7:00 A.M. to 7:00 P.M. revealed the following staff worked: LPNs #201 and #244 and STNAs #231, #218, and #236.</p> <p>Review of the facility file/investigation revealed multiple staff interviews were located in the file revealing no concerns related to the allegations. Review of the staff interviews revealed there were no interviews from any staff who worked on 09/27/24 7:00 P.M. to 7:00 A.M. shift (except LPN #242) or 09/28/24 7:00 A.M. to 7:00 P.M. shift. Staff interviews not present in the investigation file included LPNs #239, #201, and #244 and STNAs #238, #243, #209, #231, #218, or #236.</p> <p>Interview on 10/29/24 at 3:33 P.M. with the Administrator and Regional Director of Clinical Services (RDCS) #245 revealed the Administrator and Previous Mobile DON #245 completed the investigation regarding Resident #35 and LPN #242 on 09/30/24. The Administrator revealed Mobile DON #245 was the Acting DON at the time of the investigation. The Administrator and RDCS #245 confirmed there were no interviews in the investigation file for any of the staff when the alleged incident occurred except for LPN #242. The Administrator did not respond as to why none of the staff were interviewed that may have been present during the alleged incident. RDCS #245 confirmed the staff that worked during the time the alleged incident occurred was not interviewed and confirmed only staff that did not work during the alleged incident was interviewed.</p> <p>Interview on 10/29/24 at 3:11 P.M. with State tested Nurse Aide (STNA) #218 confirmed she worked on 09/28/24 beginning at 7:00 A.M. STNA #218 revealed when she came in at 7:00 A.M., she heard Resident #35 swear and say LPN #242 did not give her medication. Resident #35 returned to her room. LPN #242 walked down the hall swearing loudly and went into Resident #35's room. Both LPN #242 and Resident #35 were cursing and yelling at each other. They both left Resident #35's room and went to the medication cart in the hall, both yelling and swearing at each other. STNA #218 confirmed LPN #242 called Resident #35 multiple degrading names. STNA #218 revealed LPN #201 calmed LPN #242 down. STNA #218 confirmed she was never interviewed about the incident.</p> <p>Phone interview on 10/30/24 at 5:42 P.M. with LPN #201 revealed on 09/28/24, it was the beginning of her shift and the end of LPN #242's shift. LPN #201 revealed Resident #35 made an allegation LPN #242 stole her narcotic. Resident #35 returned to her room and went back to bed. LPN #242 was upset and began cursing and swearing, went to Resident #35's room while cursing down the hall and approached Resident #35 while she was in her bed. LPN #201 revealed she heard LPN #242 yelling at Resident #35 loudly calling her a crack-head and a bitch repeatedly repeating, How dare you, all I do for you, then continuing with calling the resident names. Resident #35 got out of bed and went in the hall. LPN #242 followed her to the hall and continued yelling loudly and swearing at Resident #35. The cursing and yelling went back and forth between Resident #35 and LPN #242. LPN #201 revealed she tried to intervene and calm down LPN #242. LPN #242 continued yelling, I don't give a (explicit language). LPN #201 revealed Resident #35 appeared upset and distraught. LPN #242 eventually left the building. LPN #201 revealed Resident #35 told her she was sad and scared, she was woke up to a nurse standing over her yelling and screaming. Resident #35 then left on a leave of absence. LPN #201 revealed she reported the incident to the previous Mobile DON #246.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Ohio Resident Abuse Policy, revised 07/11/24 included once the Administrator and the DOH are notified, an investigation of the allegation or suspicion will be conducted. The investigation protocol included interviewing the resident, the accused, and all witnesses. Witnesses generally, include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident and employees who worked closely with the accused employee and or the alleged victim the day of the incident.</p> <p>This deficiency was an incidental finding found during the complaint investigation.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on medical record review, observation, staff interview, and review of manufacturer's guidelines, the facility failed to ensure the medication error rate did not exceed five percent (%). The facility had two medication errors of 31 opportunities for an error rate of 6.45%. This affected one (Residents #32) of four residents reviewed for medication administration. The facility census was 33 residents.</p> <p>Findings include:</p> <p>Record review for Resident #32 revealed an admitted [DATE]. Diagnoses included chronic idiopathic constipation and centrilobular emphysema.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitively intact. Resident #32 required set up or clean up assist with eating, substantial/maximum assist with personal hygiene and dressing. Resident #32 used a wheelchair for mobility. Resident #32 had chronic lung disease.</p> <p>Record review of the care plan for Resident #32 edited 10/11/24 revealed Resident #32 had emphysema. Interventions included to provide nebulizers.</p> <p>Record review of the physician orders for Resident #32 included sennosides-docusate sodium tablet, 8.6-50 milligrams (mg), one tablet twice a day 8:00 A.M. and 4:00 P.M. for constipation dated 10/25/24, and arformoterol solution for nebulization: 15 micrograms (mcg)/two milliliters (ml), give two ml inhalation every 12 hours 9:00 A.M. and 9:00 P.M. for centrilobular emphysema.</p> <p>Observation on 10/29/24 at 9:30 A.M. of medication administration for Resident #32 revealed Licensed Practical Nurse (LPN) #241 confirmed Resident #32's sennosides-docusate sodium tablet, 8.6-50 mg was unavailable for the A.M. administration. LPN #241 also revealed arformoterol solution for nebulization was not stored appropriately and was also unavailable for the A.M. administration.</p> <p>Observation on 10/29/24 at 1:35 P.M. of medication administration for Resident #32 revealed LPN #241 revealed she found the sennosides-docusate sodium tablet for Resident #32 that was due in the A.M. Observation revealed LPN #32 administered geri-kot 8.6 milligrams (mg) to Resident #32.</p> <p>Interview on 10/29/24 at 1:37 P.M. with LPN #241 confirmed the geri-kot (generic for Senna) 8.6 mg did not include the docusate sodium 50 mg. LPN #241 confirmed Resident #32 did not receive the correct dose of sennosides-docusate sodium tablet, 8.6-50 mg and did not receive the arformoterol solution for nebulization per the physicians orders.</p> <p>Review of the facility policy titled, Genera; Dose Preparation and Medication Administration, revised 04/30/24 revealed to verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158631.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to store medication per the manufacturers recommendations. This affected one (Resident #32) of four residents reviewed for medication administration. The facility census was 33.</p> <p>Findings include:</p> <p>Record review for Resident #32 revealed an admitted [DATE]. Diagnosis included centrilobular emphysema.</p> <p>Record review of the care plan for Resident #32 edited [DATE] revealed Resident #32 had emphysema. Interventions included to provide nebulizers.</p> <p>Record review of the physician orders for Resident #32 included arformoterol solution for nebulization: 15 micrograms (mcg)/two milliliters (ml), give two ml inhalation every 12 hours for centrilobular emphysema.</p> <p>Observation on [DATE] at 9:30 A.M. of medication administration for Resident #32 revealed Licensed Practical Nurse (LPN) #241 confirmed the arformoterol solution for nebulization was for Resident #32, and it was stored in the bottom drawer of the medication cart with additional resident medications. LPN #241 confirmed there was one foil pouch (containing 10 doses) unopened and one foil pouch opened with two remaining doses. The date dispensed on both pouches was [DATE]. The expiration date was not visible. Review of the label on the pouches revealed refrigerate - do not freeze, keep arformoterol in the foil pouch it came in and in the refrigerator. Unopened foil pouches can be stored at room temperature for up to six weeks. Throw away any unused medication after six weeks. LPN #241 confirmed the arformoterol solution was not stored appropriately and was unavailable for the A.M. administration.</p> <p>Record review of the facility policy titled, Storage and Expiration Dating of Medications and Biological's, revised [DATE] revealed the facility should ensure that medications and biological's that have an expired date on the label; have been retained longer than recommended by manufacturer or supplier guidelines; or have been contaminated or deteriorated are stored separate from other medications until destroyed or returned to the pharmacy. Once any medication or biological package is opened, facility should follow manufacturer guidelines with respect to opened dates for opened medications. Facility should ensure that medications and biological's are stored at their appropriate temperatures according to the United States Pharmacopoeia guidelines for temperature ranges and manufacturer guidance.</p> <p>This deficiency is an incidental finding found during the complaint investigation.</p>		