STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366110	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crawford Manor Healthcare Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 37097 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, closed medical record review, resident, family, and staff interviews, review of the National Weather Service forecast, and review of the facility Elopement Policy and Procedure, the facility failed to provide adequate supervision and intervention to prevent Resident #33, who had a history of wandering, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious harm, injury, or death when Resident #33 was seen (by camera footage) on 12/04/24 at 6:47 P.M. leaving the facility on foot with his rollator walker. The resident was missing from the facility for approximately one hour and 45 minutes without staff knowledge. The resident's whereabouts remained unknown until 12/05/24 at 12:07 A.M. when Resident #33's nephew found the resident approximately five miles from the facility in the garage of the home in the community where he had previously resided. On 12/04/24 temperatures were between 21 degrees and 37 degrees Fahrenheit with a severe winter weather warning in effect. Upon being found by his nephew, the resident was taken to the hospital for examination, admitted (to the hospital) and did not return to the facility. This affected one resident (#33) of six residents reviewed for elopement. The facility identified seven residents (#1, #9, #12, #20, #24, #27, and #32) who were at risk for elopement. The facility census was 34. On 12/18/24 at 4:37 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 12/04/24 at 6:47 P.M. when the facility failed to provide adequate supervision and intervention to prevent Resident #33 from eloping from the facility. Resident #33 exited the facility through the front door. At the time of the incident, a staff member reported hearing the door alarm sound but turned it off without investigation as the staff member assumed the alarm was activated by a person who had just delivered a food order. The Immediate Jeopardy was removed on 12/05/24 and deficiency corrected on 12/09/24 when the facility implemented the following corrective actions: On 12/04/24 at 8:24 P.M. Resident #33 was noted to be missing by Licensed Practical Nurse (LPN) #237. A facility wide search of both the internal and external facility property and surrounding areas was initiated. The resident was located on 12/05/24 at 12:07 A.M. and did not return to the facility following the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/04/24 at 8:24 P.M. LPN #237 notified the Director of Nursing (DON) that Resident #33 was missing. The LPN then notified the police. The DON notified the Administrator and Resident #33's family. On 12/04/24 at 8:30 P.M. the facility staff completed a head count and identified no other residents were missing. All other residents were accounted for in the facility. On 12/04/24 at 9:45 P.M. alarms on all doors were validated by the Regional Director of Clinical Services (RDCS) #245 for proper function and sound including annunciation to the second- floor nursing unit. No annunciator panel was found on the third-floor nursing unit. On 12/05/24 at 1:00 A.M. an Elopement Drill was conducted by the Administrator, the DON, and Assistant Director of Nursing (ADON) #240 and then conducted each shift for 72 hours by one of the following Leadership team members: the Administrator, the DON, LPN/ Minimum Data Set (MDS) #218, LPN/ Charge Nurse (CN) #237, or ADON #240 On 12/05/24 at 9:30 A.M. an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review plan / progress with the Medical Director. The meeting was attended by the Medical Director via phone, the Administrator, DON, ADON #240, Dietary Director #229, Activity Director #226, RDCS #245, and Scheduler/Medical Records #205. On 12/05/24 at 12:45 P.M. the Administrator conducted facility window checks to ensure all were secured with stop brackets to limit less than six-inch opening. No issues were identified. On 12/05/24 at 1:00 P.M. RDCS in conjunction with the Administrator validated the function of the outside exits, front door, back door (employee entrance) extending inspection beyond what the security camera observations that were completed, to include the third floor East stairwell door, third floor [NAME] stairwell door, second floor East stairwell door, second floor [NAME] stairwell door, first floor [NAME] exit door, therapy exit Door (end of hallway across from employee entrance). Each door was checked for local alarm sound when activated and the sound of the alarm was readily audible via the annunciator panel on the second floor. All functioned appropriately. The first-floor East exit door in the stairwell does alarm locally but was not alarming nor was it listed on the annunciator panel on the second floor. The first-floor [NAME] exit door in the stairwell does alarm locally but was not alarming on the annunciator panel on the second floor, where it is listed. A contracted company was contacted to obtain quote for connecting these exit doors with the annunciator panel on the second floor or other intervention. A door monitor was initiated. On 12/05/24 at 2:48 P.M. ADON #240 completed updated elopement observations for current residents, reviewed plan of care and updated as indicated for risk and interventions. On 12/05/24 at 3:00 P.M. the Administrator and ADON #240 completed the audit and update of the Elopement binders to reflect residents that are currently identified as risk for elopement (#1, #12, #20, #24, #27, #32, #34). On 12/05/24 the DON completed review of current residents Leave of Absence (LOA) orders, updated as indicated, reviewed plan of care and updated as indicated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/05/24 DON and ADON #240 completed updated smoking observations for the current residents who smoked (#2, #7, #8, #10, #17, #18, #27, #32, #35, and #36), reviewed each resident's plan of care and updated as indicated. In addition, the facility posted lists on nursing units identifying supervised or independent smokers. On 12/05/24 at 4:40 P.M. the Administrator and DON completed staff education related to resident safety including elopement risk and interventions, and importance of alarm response and investigation. Staff who were not present at the facility were educated via phone. Newly hired staff would receive education as part of the orientation process. On 12/05/24 the Administrator completed the education of the Admissions Director related to the review of hospital paperwork prior to admission to identify special needs/safety concerns and communicate special needs with facility team. On 12/05/24 the Administrator and DON completed education of staff on what to do if a resident was stating they want to go home or leave the facility, or if they observe exit seeking behaviors. On 12/05/24 The Administrator and DON completed educating staff on how to identify resident smoking status if they had a resident state they were going outside to smoke. On 12/05/24 at 5:00 P.M. residents with a Brief Interview for Mental Status (BIMS) score 12 or above were educated that if they hear another resident making statements that they wanted to get out of the facility/[NAME] Manor they report to a staff member so that they could implement interventions for resident safety and determine if discharge planning was appropriate. The education was initiated by RDCS #245 and completed by LPN/Charge Nurse #207 43 and LPN/Charge Nurse #243 On 12/05/24 the Administrator contacted the contracted provider (Alta Protection Services) requesting service for the rear door staff entrance and front door due to the identified sensitivity related to the winds setting off the door alarms when no human activity taking place at the doors. Additionally requested a quote for the instillation of an annunciator panel on the third-floor nursing unit. Beginning 12/05/24 second floor staffing distribution, beginning night shift, would assign one team member to remain at the nursing station desk to be available to respond to door alarms. Nursing staff educated on this by the Director of Nursing and indication listed on the daily assignment sheet posting. On 12/09/24 the Administrator purchased audible monitors to be placed in the stairwell by first floor east and first-floor west outside exits, as it was determined that when the hallway door was closed the alarm sounding by the outside exit in the stairwell cannot be heard midway down the hall where the door monitor was located. Beginning 12/05/24 at 1:00 A.M. the Administrator, DON, or Designee would conduct an elopement drill on every shift for 72 hours beginning day shift, then weekly for four weeks, then monthly for two months. Results of the drills would be submitted to the QAPI Committee for further review and recommendations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning 12/05/24 Administrator, DON, or Designee would conduct elopement/ door alarm drills five times per week on various shifts for four weeks then monthly for two months for validation of appropriate staff response to triggered alarms and to ensure that staff are fluent with the alarm response process. Results of the drills would be submitted to the QAPI Committee for further review and recommendation. Beginning 12/05/24 Admissions/ re-Admissions referral information would be reviewed by the Director of Nursing/Designee to ensure risks were identified and interventions implemented. The reviews would continue for four weeks then monthly for two months with the results submitted to the QAPI Committee for further review and recommendation. Beginning 12/05/24 Administrator or Designee would audit scheduled smoking breaks two times per day, five times per week for four weeks then monthly for two months to ensure that residents assessed to smoke with supervision are being supervised during smoke breaks. The results of the audits would be submitted to the QAPI Committee for further review and recommendation. Beginning 12/05/24 Administrator or Designee would interview three residents two times per week for four weeks then monthly for two months to determine if they have heard another resident making statements that they want to get out of the facility/[NAME] Manor and if it was reported to facility staff. The results of the interviews would be submitted to the QAPI Committee for further review and recommendation. Beginning 12/05/24 Administrator or Designee would interview three staff members two times per week for four weeks then monthly for two months related to what they would do in response to door alarms, residents saying they are going smoking and if a resident makes a statement they want to get out of the facility/[NAME] Manor. The results of the interviews would be submitted to the QAPI committee for further review and recommendation. Findings Include: Review of the closed medical record for Resident #33 revealed an admitted [DATE] with diagnosis including muscle weakness, other symbolic dysfunctions, encephalopathy, and abnormalities of gait and mobility. The resident was discharged on [DATE] and did not return to the facility. Review of a progress note dated 12/02/24 at 1:53 P.M. revealed Resident #33 arrived at the facility from the hospital with a past medical history of heart failure, hypertension and memory loss. The resident had his natural teeth, ambulated with a rollator and had a steady gait. Review of the physician's orders dated 12/02/24 revealed Resident #33 was not to go on leave of absence (LOA) without supervision. Review of the Admission assessment dated [DATE] at 2:20 P.M. revealed Resident #33 was attentive, oriented, generally normal to person, place and time, with an intact memory. Review of the Functional Abilities assessment dated [DATE] at 4:43 P.M. revealed Resident #33 required supervision or touching assistance for sit to stand, transfers, and to walk 150 feet. Partial to moderate assistance was needed to go up or down 12 stairs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the baseline care plan dated 12/02/24 revealed Resident #33 would be monitored to minimize risk of wandering and/or elopement and interventions put in place as needed. There were no additional interventions listed. Review of the Elopement assessment dated [DATE] at 9:43 AM revealed Resident #33 was not identified as an elopement risk. Review of the Admission Minimum Data Set (MDS) 3.0 assessment revealed it had not been completed and was in progress. Review of a progress note dated 12/04/24 at 8:30 P.M. authored by Licensed Practical Nurse (LPN) #243 revealed LPN #243 went to obtain vital signs for the resident, he was noted to not be in his room or bathroom, staff looked on the unit and within the facility and it was determined that he was not in the facility. Staff searched the surrounding parking lot area. The Director of Nursing (DON) and Administrator were notified. Resident #33's niece was called and asked if they had taken the resident out, and notified the resident was not at the facility. The Cleveland Police were contacted and informed. The resident's physician was notified. Review of the facility LOA sign-out book revealed Resident #33 did not sign-out when he left the faciity on [DATE]. Review of the National Weather Service forecast at www.weather.gov revealed the weather in the Cleveland area on 12/04/24 included a high temperature of 37 degrees Fahrenheit (F) and low of 21 degrees F. Review of the Self-Reported Incident and related facility investigation, dated 12/04/24, revealed Resident #33 was admitted on [DATE] to a room on the third floor. Per the hospital paperwork he had a history of wandering which was not reflected in the initial elopement observation. Following dinner Resident #33 got on the elevator with a Certified Nursing Assistant (CNA) #217 and they had a normal conversation riding down the elevator. Resident #33 made a statement that he was going out to smoke. CNA #217 primarily worked on the second floor and had not met Resident #33 given he was only at the facility for two days and was unaware that he did not smoke. The CNA got off the elevator on the second floor and Resident #33 remained on the elevator which was going down to the first floor. When the night shift nurse went to obtain vital signs for Resident #33 at 8:24 P.M. it was determined he was not in the room. Facility staff immediately began to search, internally, externally on property by foot and in personal cars searching the surrounding area. Facility administration and regional staff were notified and responded to the facility for support. The Administrator pulled the security camera footage, and determined the resident exited the front door with his rollator at 6:47 P.M. wearing plaid flannel pajama pants, a zip up sweatshirt and a ball cap. He began walking down the street, sat on his rollator at the corner for approximately two minutes then continued walking down the street and out of camera view. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Efforts to find the resident continued through the night until the resident was located by his nephew at the resident's own home where he previously resided, in the garage with the garage door closed 12:07 A.M. on 12/05/24. The family alleged that the resident was jumped while he was out indicating that he had a broken nose, all his teeth knocked out and his face all cut up. The recommendation to transport him to the emergency room (ER) for evaluation was made to the family by facility staff. The nephew drove back to the facility with the resident to pick up the resident's niece to go to the emergency room . When facility staff requested to see the resident, the family refused and made threats towards the staff making a statement 38 and hot which was interpreted as a reference to a gun. So, the facility staff was unable to determine if the resident had any injuries and/or the extent of any injuries. Resident #33's niece was given a copy of the face sheet and physician orders to take to the emergency room , and the Director of Nursing called report into the hospital emergency room (ER) related to the situation and family transporting to them. The following morning 12/05/24 at 7:30 A.M. the Director of Nursing called the hospital for a status update on the resident and was told that he was admitted with a diagnosis of dementia, x-rays were negative, there were no fractures identified, and a computed tomography (CT) scan was completed with no findings. The facility was unable to validate if any serious injury resulted, but the resident was not safe when he exited the facility due to the cold, windy and rainy weather on that day. Further review of the facility investigation revealed that based on review of the camera footage, there was a Door Dash delivery car visible on the camera footage, approximately 10 minutes prior to the resident exiting the facility. The Door Dash driver came up the elevator and delivered the food to a resident on the second floor, then left the facility. A staff member that was on the second floor at the time of the food delivery returned to the first floor approximately five to 10 minutes following the door dash driver. When they got to the first floor they heard the front entrance alarm sounding. The staff member reset the front door alarm but did not investigate the reason for it sounding. The facility substantiated that resident neglect did occur. Review of the witness statement dated 12/04/24 and authored by LPN #237 revealed she identified Resident #33 as missing around 7:30 P.M. to 7:45 P.M., initiated the search, called code, contacted the DON and called 911 emergency services. Review of the witness statement dated 12/05/24 and authored by CNA #217 revealed on 12/04/24 she got on the elevator on the third floor with Resident #33. She had a short conversation with him about going out to smoke a cigarette. The elevator opened on the second floor and the CNA got out. She did not remember hearing an alarm sound after that. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/17/24 at 11:21 A.M. with the Administrator, DON and RDCS #245 revealed Resident #33 didn't have a designated power of attorney (POA) or guardian. There had not been an evaluation by a Nurse Practitioner (NP) or physician because Resident #33 was only at the facility for a little over 48 hours. The administrative staff revealed the resident's hospital admission record showed history of wandering but stated this was missed on the elopement assessment. Corrective action and education were done with Admission Director, and the facility was currently auditing all admissions for any risk. The facility currently had a staff member assigned as a door monitor 24 hours a day because two exit doors were not connected to the enunciator panel. The facility believed Resident #33's ability to elope was partially caused when there was a food delivery to the second floor, and the delivery person was known to exit. Staff turned off the alarm without investigation assuming it had been the food delivery person. After reviewing the Self-Reported Incident (SRI) the Administrator, DON and RDCS #245 verified the elopement had occurred, they had substantiated the incident had occurred and had developed a plan to prevent it happening again. An interview on 12/17/24 at 11:39 A.M. with LPN/MDS #218 revealed she was on the second floor on 12/04/24 when a Door Dash delivery arrived. When she came back down, the (door) alarm was ringing. LPN #218 stated she knew Door Dash had just left so she turned off the alarm. The LPN/MDS nurse revealed if the release bar (on the door) was held it alarmed and after 15 seconds, it released. She stated a lot of delivery people didn't want to go back up to the second floor and look for someone to let them out. LPN/MDS #218's office was downstairs so some days it happened a lot. Currently the facility had a staff member serving as a door monitor. They monitored if a resident was trying to leave and helped visitors exit. Staff were now expected to investigate, go outside to do a quick check of the perimeter, and call upstairs for staff to do a headcount. An interview on 12/18/24 at 10:00 A.M. with Resident #33's niece revealed the family was unaware the resident had cognitive issues until 11/2024 when he was taken to the hospital after he was found wandering a long way from his house in the middle of the night. The family of Resident #33 decided he wasn't safe living alone, so they moved him into the facility on [DATE]. On 12/04/24 the resident's niece received a call from the facility at 8:34 P.M. asking if she had taken the resident out, as he was not at the facility. She stated she called her mom and brother and then went to the facility. She stated the family searched the facility along with the staff. Resident #33's nephew went out to search the area. There was a severe Winter weather warning going on for Cleveland. The niece watched the video surveillance with the administrator. Resident #33 exited the front door of the facility at 6:47 P.M. without a jacket or gloves. He walked across the street, sat down on his rollator for a couple minutes and then went on down the street and out of sight. A little after midnight the nephew found Resident #33 at his previous address in the garage. The resident's niece stated the resident had been assaulted, his teeth were knocked out and knuckles scraped. The niece stated her brother got Resident #33 in his car, came back to the facility to pick her up at the facility and they took him to the hospital ER. The resident's niece stated the physician said the resident's injuries were consistent with an assault. The niece stated the admission person was aware of her uncle's dementia and stated the facility where the resident had been admitted to was a locked facility, residents were to be monitored and if an alarm went off staff would check. Attempts to obtain the hospital records during the complaint investigation for Resident #33 related to this incident were unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/18/24 at 3:39 P.M. interview with LPN #243 revealed she was in the facility on 12/04/24, the day Resident #33 eloped but worked on the second floor. LPN #243 remembered the door alarm went off that evening but then stated it was silenced. After LPN #243 punched out and left the facility another employee called a little after 7:30 P.M. and told her they couldn't find Resident #33. She started driving around the area looking for the resident. Other staff were doing the same. Interview on 12/18/24 at 4:30 P.M. with CNA #217 revealed on 12/04/24 she was assisting staff on the third floor and got on the elevator to go back to her own assignment on the second floor. Resident #33 was already on the elevator when she got on. The CNA stated they (she and the resident) made small talk, and the resident mentioned he was going out to smoke. CNA #217 got off the elevator at the second floor and Resident #33 went down to first. It was the first time the CNA had met Resident #33. The CNA stated she wasn't even sure he was one of the facility residents or a visitor. Interview on 12/19/24 at 10:56 A.M. with LPN #237 revealed on 12/04/24 at around 7:35 P.M. the LPN went to obtain Resident #33's vital signs and then realized the resident was missing. She stated she checked all the rooms on the third floor and then called a code. All staff started looking around the facility for the resident. When he was not found in the building, she stated she called the DON and 911. Review of the facility Elopement Unauthorized Absence Policy dated 08/02/24 revealed the purpose of the policy was to identify a resident's risk for elopement, prevent a resident from exiting the facility without the knowledge of the staff and to delineate the reporting process if an elopement occurs. This deficiency represents non-compliance investigated under Control Number OH00160618.