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	04/23/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, review of a self-reported incident (SRI), review of a witness statement, staff interview, and policy review, the facility failed to ensure residents were free from resident-to-resident sexual abuse. This affected one (Resident #21) of three residents reviewed for abuse. The facility census was 35.Findings Include:Review of the medical record for Resident #16 revealed the resident was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, hypertension, history of cerebral infarction, altered mental status, muscle weakness, history of falls, and adjustment disorder with mixed anxiety and depressed mood.Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact and able to make needs known. Additional documentation revealed the resident had a history of inappropriate behaviors and the need for behavioral monitoring, supervision, and intervention to ensure the safety of others.Review of Resident #16's hospital paperwork dated 10/30/25 noted the resident was previously incarcerated multiple times and was recently, in July 2025, convicted of gross sexual imposition.Review of the medical record for Resident #21 revealed the resident was admitted on [DATE] with diagnoses including severe intellectual disabilities; muscle weakness; and localization-related (focal) (partial) symptomatic epilepsy syndromes with complex partial seizure, intractable, without status epilepticus.Review of the most recent MDS assessment dated [DATE] revealed Resident #21 revealed the resident was rarely or never understood and had severely impaired cognitive skills for daily decision making.Review of Resident #16's nursing progress note dated 04/11/26 at 1:29 P.M. revealed the resident was observed inappropriately touching a female resident (#21). It was reported Resident #16 was pulling on Resident #21's brief and touched her private area. Both residents were immediately separated. A nurse spoke to Resident #16 to inform him of what was considered inappropriate touching and if the resident understood the situation. Resident #16 verbalized he was aware he was touching someone's private area and began saying sexually inappropriate and explicit things to the nurse. All appropriate parties were notified.Review of Resident #21's nursing progress note dated 04/11/26 with late entry at 3:57 P.M. revealed a nurse was notified by a nurse aide that a male resident (#16) was observed in the hallway engaged in sexually inappropriate behavior, including inappropriate touching, toward Resident #21. The residents were immediately separated and Resident #21 was assessed with no bruising, redness, bleeding, or signs of trauma. Resident #21 voiced no complaints of pain or discomfort and all appropriate parties were notified.Review of a self-reported incident dated 04/11/26 at 3:14 P.M. revealed Resident #16 was observed to be wheeling past Resident #21 who was seated in a wheelchair in the hallway. Resident #16 was observed to pull at the elastic waistband of Resident #21's pants and brief with one hand and placed his other hand near Resident #21's groin area. Staff immediately intervened and removed Resident #16 from the situation and placed the resident on one-on-one observation. Resident #16 was assessed and determined to have no signs or symptoms of injury and the resident remained at her (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	04/23/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosocial baseline. Through investigation the facility verified the allegation of sexual abuse between Resident #16 and Resident #21.Review of a written statement by Certified Nurse Aide (CNA) #201 dated 04/11/26 revealed when he was exiting the elevator he observed in the hallway Resident #16 pulling Resident #21's pants and brief out toward him and placed his hand inside Resident #16's brief and touched her private area. CNA #201 approached the two residents and Resident #16 removed his hands from Resident #21's pants. Resident #16 was removed from the floor and the nurse was notified of what happened.Interview with the Administrator and the Director of Nursing (DON) on 04/21/26 at 11:00 A.M. verified Resident #16 was observed pulling at Resident #21's pants and brief then inappropriately touching her private area. The Administrator and the DON confirmed staff immediately intervened to separate the two residents and Resident #16 was placed on a one-on-one observation. The Administrator and the DON stated an investigation was completed into the situation and the facility confirmed an allegation of resident-to-resident sexual abuse involving Resident #16 and Resident #21.Review of the facility abuse prevention policy, dated 08/25/25, revealed the facility defined sexual abuse as non-consensual sexual contact of any type and required staff to immediately report, investigate, and implement interventions to protect residents from abuse. The policy further required the facility to assess residents with behaviors that may lead to abuse, implement appropriate supervision and interventions, and take immediate action to prevent recurrence.The deficiency was corrected on 04/15/26 when the facility implemented the following corrective actions:- On 04/11/26, at approximately 12:00 P.M., staff immediately identified an inappropriate interaction and separated Resident #16 and Resident #21, stopping the behavior.- On 04/11/26, Resident #16 was removed from the area, returned to his assigned unit, and one-on-one observation was initiated immediately to ensure safety of others.- On 04/11/26, staff notified nursing immediately and appropriate supervisory staff were alerted to the incident.- On 04/11/26, two licensed nurses completed an immediate head-to-toe assessment of Resident #21 with no skin alterations, injuries, or signs of trauma identified. Resident #21 demonstrated no psychosocial changes, including no distress, grimacing, resistance to care, or change from baseline mental status.- On 04/11/26, Resident #21 was unable to provide a reliable account of the incident due to baseline cognitive impairment.- On 04/11/26, Resident #16 was interviewed and acknowledged awareness of inappropriate touching, and was educated by nursing staff on appropriate boundaries and unacceptable behavior.- On 04/11/26, responsible parties and physicians were notified of the incident and assessment findings for Resident #16 and Resident #21. No immediate new medical orders were received at that time.- On 04/11/26, the incident was reported to the State Survey Agency.- On 04/11/26, local law enforcement was notified and responded to the facility, conducted staff interviews, and determined no evidence collection was necessary at that time. Linens were bagged per facility policy; however, law enforcement declined to take possession of materials.- On 04/11/26, a witness (Resident #18) reported observing Resident #16 pulling down the brief of Resident #21 and touching the resident's private area in the hallway.- On 04/11/26, staff interview corroborated that upon approach, Resident #16 had his hand inside Resident #21's brief in the groin area and removed his hand when confronted.- On 04/11/26, findings from resident and staff interviews were consistent and supported the occurrence of inappropriate contact.- On 04/11/26, the facility implemented systemic corrective actions, including enhanced supervision, staff education, behavioral management interventions, and ongoing monitoring to prevent recurrence.- On 04/11/26 at approximately 4:30 P.M., Resident #16 was transferred via emergency medical services (EMS) for emergency psychiatric evaluation due to sexually inappropriate behaviors.- On 04/11/26 at approximately 8:30 P.M., findings from law enforcement interviews were reviewed with the responsible party of Resident #21, resulting in the request for hospital evaluation.- On 04/11/26 at approximately 9:00 P.M., Resident #21 was transferred via EMS to the hospital per responsible party request for further evaluation.- On 04/11/26 at approximately 9:30 P.M., Resident #16 returned to the facility with no new orders and one-on-one observation was re-initiated.- On 04/11/26, all interviewable residents were interviewed to determine (continued on next page)

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	04/23/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if additional inappropriate contact or safety concerns existed. No concerns were identified.- On 04/11/26, all non-interviewable residents received head-to-toe assessments to identify any signs of abuse or injury. No concerns were identified.- On 04/11/26, the facility conducted a review of residents with similar behaviors to ensure appropriate interventions and supervision were in place. No concerns were identified.- On 04/11/26, all staff received abuse prevention education, including recognition of inappropriate sexual contact, reporting requirements, and intervention expectations.- On 04/11/26, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was completed with the interdisciplinary team (IDT), the Medical Director, and leadership to review the incident and interventions.- Beginning 04/11/26, weekly monitoring was initiated including interviews with five residents weekly for four (4) weeks and then monthly for two (2) months. Head-to-toe assessments of non-interviewable residents will occur weekly for 4 weeks and then monthly for 2 months with results monitored and reviewed through QAPI and revised as indicated. As of 04/23/26, no concerns were identified.- On 04/12/26 at approximately 2:00 A.M., Resident #21 returned to the facility with no new orders and continued to be monitored.- On 04/12/26, medication adjustments were initiated for Resident #16, including behavioral and psychotropic medications.- On 04/13/26, pharmacy medication review was completed for Resident #16 with no additional recommendations.- On 04/13/26, Resident #16 was evaluated via Telehealth by psychiatric services, and a new diagnosis of inappropriate sexual behavior was added with additional treatment planning.- On 04/13/26, Resident #21 was interviewed and reported feeling safe within the facility.- On 04/14/26, Resident #16 was re-evaluated via Telehealth psychiatric services and reported awareness of inappropriate behavior but inability to control impulses.- On 04/14/26, Resident #16 was again transferred via EMS for emergency psychiatric evaluation due to continued inappropriate behaviors.- On 04/14/26 at approximately 11:30 P.M., Resident #16 returned to the facility with no new relevant orders, and one-on-one observation was re-initiated and remained on-going. No concerns further incidents were identified.- On 04/15/26, Depo-Provera (drug used to control sexual behaviors) was received and administered to Resident #16 as part of behavior management.This deficiency represents non-compliance investigated under Complaint Number 2986375.

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	04/23/2026

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 - Actual harm 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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, self-reported incident (SRI) review, review of a witness statement, and staff interview, the facility failed to ensure a resident was provided adequate assistance with activities of daily living (ADLs) to prevent an avoidable fall with injury. Actual harm occurred to Resident #28 on 03/19/26 when a nurse aide assisted the resident with bed mobility without another staff member present and Resident #28 fell to the floor. Resident #28 had care plan interventions and therapy recommendations in place at the time of the fall indicating two staff members were to assist the resident with ADLs and bed mobility. Resident #28 subsequently sustained an abrasion on the right shin and a laceration on the left foot requiring hospitalization and six sutures to close. This affected one (Resident #28) of three residents reviewed for accidents. The census was 35. Findings Include: Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses that included hemiplegia, dementia, muscle weakness, impaired mobility, and a history of falls. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was severely cognitively impaired and required extensive assistance with ADLs and mobility.Review of the comprehensive care plan dated 06/19/24 revealed Resident #28 required two-person assistance for bed mobility, transfers, toileting, and bathing, and required the use of a mechanical lift for transfers. Further review of the care plan revealed staff were instructed to assist the resident with all ADLs due to impaired mobility, hemiplegia, and cognitive impairment.Review of a nursing progress note dated 03/20/26 at 1:47 A.M., regarding a fall on 03/19/26, revealed the nurse was called to Resident #28's room by a nurse aide and found the resident laying on the floor between the bed and the wall. Resident #28 was assessed to be alert, oriented, and denied pain. The nurse and nurse aide assisted Resident #28 to bed using a mechanical (Hoyer) lift and an abrasion was noted to the resident's right shin. Review of a subsequent nursing progress note dated 03/20/26 at 8:03 A.M. revealed Resident #28 was assessed with two wounds including an abrasion to the right shin and a laceration to the left foot.Review of a therapy note dated 03/20/26 at 2:41 P.M. revealed Resident #28 was screened by therapy as a result of a fall on 03/19/26. The resident was noted with increased left foot pain following the fall and nursing was aware. Per the electronic medical record (EMR) and Resident #28's report, the resident was receiving care with a single nurse aide when a fall out of bed occurred. Therapy recommendation and the resident's current plan of care in place at the time of the fall indicated Resident #28 needed two-person assistance for all ADLs and all bed mobility tasks. Therapy deferred the fall to nursing and the physician with no new recommendations at that time. Review of a nursing progress note dated 03/20/26 at 5:23 P.M. revealed, upon nursing assessment, the laceration to Resident #28's left foot appeared to require more treatment than what could be provided at the facility, so the resident was transferred to the hospital for evaluation and treatment.Review of a nursing progress note dated 03/21/26 at 8:56 A.M. revealed Resident #28 returned to the facility at 8:35 A.M. following a fall with injury. Resident #28 received six sutures to the wound on his left foot to be removed in seven to 10 days and Neosporin to be applied to the wound.Review of a SRI dated 03/20/26 at 1:36 P.M. revealed, on 03/20/26 during morning meeting, the Administrator was made aware of a situation of possible neglect with a nurse aide and Resident #28 during the night of 03/19/26. Further review revealed Certified Nurse Aide (CNA) #454 repositioned Resident #28 in bed with no other staff assistance, and the resident was rolled from bed onto the floor where he sustained injuries to his right shin and left foot. CNA #454 had just completed facility orientation the day prior, and upon arrival at the facility on 03/19/26, discovered her electronic credentials were missing and was inexperienced in using the facility electronic medical record. This resulted in CNA #454 not (continued on next page)

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	04/23/2026

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 - Actual harm Residents Affected - Few	having access to resident-specific care needs from the medical record prior to providing care. Review of CNA #454's witness statement dated 03/20/26 revealed, on 03/19/26, she was getting Resident #28 ready for bed and completing his ADLs. CNA #454 documented she undressed the resident to clean him up and noticed Resident #28 needed new bed sheets, so she went to get clean sheets. Upon returning to the room, CNA #454 documented she moved the resident's bed close to the wall, locked the bed wheels, and got the bed sheets and washcloths to clean the resident. CNA #454 documented she rolled Resident #28 over to begin cleaning him and in the process the resident rolled over the side of the bed. CNA #454 checked on the resident and then went to get a nurse. CNA #454 and the nurse assisted Resident #28 from the floor to his bed with a Hoyer lift. After the resident was in bed, the nurse informed CNA #454 that any resident who required a Hoyer lift should always be assisted with two staff members for everything. Interview with the Administrator on 04/21/26 at 2:30 P.M. verified CNA #454 performed bed mobility for Resident #28 without assistance from another staff member on 03/19/26 which resulted in the resident falling from bed necessitating the resident to be sent to the hospital for injuries sustained from the fall which required sutures. The Administrator confirmed CNA #454 did not follow Resident #28's care plan intervention and therapy recommendation in place at the time of the fall for two staff members to perform all ADLs and bed mobility for the resident. The deficiency was corrected on 03/20/26 after the facility implemented the following corrective actions: - On 03/19/26 at 9:50 P.M., the on-call medical doctor was notified of the incident involving Resident #28. A head-to-toe assessment was completed, and injuries were noted to the resident's right shin and left foot. - On 03/19/26 at 9:45 P.M., a message was left for Resident's #28's guardian for notification of the incident.- On 03/20/26 at approximately 9:30 A.M., the facility interdisciplinary team (IDT) reviewed the incident and identified Resident #28's plan of care and profile indicated he required two staff member assistance for bathing, toileting hygiene, and bed mobility at the time of the incident.- On 03/20/26, a statement was obtained from the CNA #454 who was performing care at the time of Resident #28's fall and was removed from the schedule pending the outcome of the investigation. CNA #454 reported she left her facility electronic medical records credentials at home and was unable to log into the system to see Resident #28's profile, so she was unaware Resident #28 required two staff assistance with bed mobility.- On 03/20/26 a SRI was filed for an alleged incident of neglect for staff not utilizing care planned level of assistance for Resident #28's bed mobility during care. CNA #454 was removed from the schedule pending the investigation.- On 03/20/26 at 2:30 P.M, an occupational therapy screen was completed, and no changes were recommended to Resident #28's plan of care.- On 03/20/26 at 3:00 P.M., the Administrator and the Director of Nursing (DON) updated Resident #28's guardian on the incident and the pending investigation.- On 03/20/26 at 4:00 P.M., the IDT reviewed Resident #28's plan of care and profile. An intervention was implemented for a bariatric bed and mattress.- On 03/20/26, the DON/Designee reviewed all residents that required two staff member assistance for bathing, toileting hygiene, and/or bed mobility care needs to ensure the assistance was reflected accurately on the residents' care plans and profiles. No concerns were noted.- On 03/20/26, the Administrator/Designee questioned all interviewable residents to ensure they had not felt they were neglected in any way, and they felt their care needs were being provided per their care plans. No concerns were identified. - On 03/20/26 the DON/Designee completed a head-to-toe assessment of all non-interviewable residents to assess for any indication of care not being performed per the resident's care plan. No concerns were noted with no identification of any new skin impairments or deviations from the residents' psychosocial baseline. - On 03/20/26, information technology (IT) support contact information was immediately posted at each nurse's station and by the time clock with instructions on how to obtain access, including the after-hours telephone number.- On 03/20/26, the DON/Designee educated all nursing staff related to the expectation of accessing the resident profile prior to providing care to each resident, how to access the profile, and how to identify the number of staff assistance required for ADL care and mobility needs on the profile. - On 03/20/26, the Administrator/Designee educated (continued on next page)

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	04/23/2026

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 - Actual harm Residents Affected - Few	all staff on the abuse policy and procedure, with emphasis on what constitutes neglect with regards to staff providing care needs per residents' care plans.- On 03/20/26, a Quality Assurance and Performance Improvement (QAPI) meeting was held to address the incident with Resident #28.- Beginning on 03/20/26, the DON and/or Designee will complete an observation audit for three residents two times weekly for four weeks then monthly for two months to ensure residents who required two staff member assistance were being cared for appropriately per the plan of care and profile.- Beginning on 03/20/26, the DON and/or Designee will interview three clinical staff two times weekly for four weeks then monthly for two months to ensure that clinical staff have the credentials to be able to access the resident profile and can identify where to find the level of care needs on the resident profile.- Beginning on 03/20/26, the Administrator and/or Designee will interview three interviewable residents two times weekly for four weeks then monthly for two months for receipt of care needs and any unreported abuse allegations.- Beginning on 03/20/26, the DON and/or Designee will complete head-to-toe assessments on three non-interviewable weekly for four weeks then monthly for two months to ensure that there have been no new skin impairments or deviations from the residents' psychosocial baseline indicative of care not being performed per the care plan.This deficiency represents an incidental finding discovered during investigation of Complaint Number 2986375.