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	12/28/2023

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** 42011 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on record review, review of a facility self-reported incident, facility policy review and interview, the facility failed to prevent unauthorized videos from being taken and shared on social media by a staff member of Resident #20 and Resident #23. This affected two residents of three residents reviewed for abuse. Findings include: Record review for Resident #23 revealed an admitted [DATE] with diagnoses including syncope and collapse. Record review of the Medicare Five Day Minimum Data Set (MDS) dated [DATE] revealed Resident #23 was cognitively intact. The assessment revealed Resident #23 had no behaviors of inattention or disorganized thinking. Review of the closed medical record for Resident #20 revealed an admitted [DATE] with diagnoses including chronic pulmonary embolism, asthma, schizoaffective disorder, gastroesophageal reflux disease, depression, hypertension, anemia, seizures, hyperlipidemia, and alcohol dependence with withdrawal delirium. Resident #20 was discharged on [DATE]. Review of a progress note dated 12/11/23 at 10:33 A.M. revealed Resident #20 had an incident with an unnamed other guy and he was not aware of any video taken. Resident #20 reported he did not care and it was not a big deal to him. A note dated 12/11/23 at 6:51 P.M. revealed Resident #20's representative was notified of the situation that occurred. (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: 366110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/28/2023
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility self-reported incident dated 12/11/23 at 4:48 P.M. and created by Regional Director of Clinical Services (RDCS) #845 revealed Administration was informed on 12/11/23 at approximately 2:30 P.M. that a dietary staff member (Dietary Assistant #846) video recorded two residents on Friday 12/08/23 at approximately 6:00 P.M. outside in the smoking area when the two residents were having a disagreement and were having words. It was reported the video was posted to Instagram and air dropped to other staff. The one staff member who the video was air dropped to said she had no idea on her phone about air drop or even how to retrieve anything. Human Resource Director (HRD) #822 did check the phone and the video was air dropped and the staff member said she had no idea. The video was then deleted from the phone. When the alleged wrong doer was interviewed, he denied taking any video and when security camera footage was pointed out to him he said well what does it matter, you are going to fire me anyway and got up and walked out of the facility and did not cooperate with the remainder of his interview. Interview on 12/26/23 at 10:49 A.M. with Resident #23 revealed, They filmed me and placed it on social media, I didn't know at the time that was what was going on but I saw the video later that night, hell yea it bothered me, I don't do social media for a reason, they had no right, it makes me mad and upset. It was me and another guy, a resident, we got in an argument, it did not get physical but it was about to but it didn't, he's gone now. They had no right putting it on social media. Resident #23 reiterated the incident of being video recorded and placed on social media was very upsetting. The resident stated his picture had never been on social media and he never wanted it to be. Interview on 12/26/23 at 12:48 P.M. with Regional Director of Clinical Services (RDCS) #845 and the Administrator revealed an incident was brought to their attention on 12/11/23 that Dietary Assistant #846 videotaped on his phone two residents, Resident ##20 and #23 outside near the smoking area of the facility having words. Resident #20 threw his cane in the direction of Resident #23 (no contact was made). Dietary Assistant #846 then posted the video of the two residents to his Instagram (social media account) and air dropped it to other staff. RDCS #845 revealed when a staff member who worked that day, State tested Nursing Assistant (STNA) #801, was interviewed, the video of Resident #20 and #23 having the altercation was on her phone. Review of the facility cameras confirmed Dietary Assistant #846 had his phone placed in front of him pointing towards the two residents, Resident #20 and #23, during the resident's altercation. Review of the facility policy titled, Ohio Resident Abuse Policy, revised 07/14/20 revealed the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. The deficiency was corrected on 12/12/23 when the facility implemented the following corrective action: On 12/11/23 a facility self-reported incident was initiated and submitted to the State agency. On 12/11/23 an investigation of the incident was initiated by the Administrator and RDCS #845. The investigation included interviews of all interviewable residents including Resident #20 and #23. All residents revealed they felt safe at the facility. On 12/11/23 staff were interviewed. STNA #801 still had the video on her phone. Dietary [NAME] #812 revealed Dietary Assistant #846 showed her the video. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/23 staff education was initiated 12/12/23 for all staff on Resident Rights, HIPPA Compliance and Abuse. Staff education was completed on 12/12/23. On 12/12/23 Resident #20 was discharged to home. On 12/12/23 five staff member files were reviewed including Dietary Assistant #846 to ensure compliance of HIPPA, Social Networking Media Policy, and Abuse training. The facility implemented a plan for Resident #23 to have weekly follow up with SWD #822. Interview on 12/27/23 between 7:54 A.M. and 4:00 P.M. with LPN #815, STNA #801 and #808 confirmed they received training on Resident Rights, HIPPA Compliance and Abuse. No additional concerns related to abuse or staff video recording residents was identified to occur between 12/12/23 and 12/28/23.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure care planning conferences were conducted at least quarterly. This affected two (Residents #6 and #27) of three reviewed for care planning. The facility census was 39. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including alcohol dependence with alcohol induced persisting dementia, muscle weakness, foot drop, and personal history of COVID-19. Review of care plan conference summary dated 10/26/23 revealed Resident #6 had signed as an attendee. Further review of the medical record revealed there was no documentation of care conferences conducted for Resident #6 between October 2022 and October 2023. Interview on 12/26/23 at 10:24 A.M. of Resident #6 confirmed he had not been invited to care planning conferences. Interview on 12/27/23 at 11:03 A.M. with Admissions Coordinator/Social Worker Designee (AC/SWD) #842 confirmed she was unaware that the facility should conduct care conferences with residents. Interview on 12/27/23 at 1:54 P.M. AC/SWD #842 and Registered Nurse (RN) #845 confirmed the facility could provide no documentation of care conferences for Resident #6 between October 2022 to October 2023 except for the care conference completed on 10/26/23. 42011 2. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including systemic inflammatory response syndrome, bacteremia, dependence on renal dialysis, anemia, acute hepatitis C, sepsis, depression, dementia with other behavioral disturbances, and end stage renal disease. Record review of the admission Minimum Data Set (MDS) assessment for Resident #27 dated 11/14/23 revealed the resident was cognitively intact. Review of the medical record for Resident #27 from 02/09/23 through 12/28/23 revealed there was no documentation regarding care conferences being held for the resident. Review of the nurse progress note for Resident #27 dated 07/12/23 completed by Licensed Practical Nurse (LPN) #815 revealed a care conference was held for the resident 07/12/23 at 11:00 A.M with both the resident and the resident's guardian in attendance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/27/23 at 11:03 A.M. with AC/SWD #842 confirmed Resident #27 did not have an initial care conference and had only one quarterly care conference (on 07/12/23) since admission on 02/09/23. AC/SWD #842 confirmed Resident #27 should have had an initial care conference upon admission and then a care conference each quarter while residing in the facility. Review of the facility policy titled Comprehensive Care Planning Policy, dated 07/19/19 revealed the facility care plan coordinator was responsible for resident care plan conferences. The policy also indicated care planning conferences would be conducted weekly to include new admissions within the previous seven days, residents who returned from the hospital within the previous seven days, residents who had a significant change within the previous seven days, and residents who had a 90-day assessment or annual assessment completed within the previous seven days.

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F 0689 Level of Harm - Minimal harm or potential for 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** 42011 Based on record review, observation, staff and resident interview, and review of the facility policy, the facility failed to complete assessments and care plans regarding resident smoking. This affected one (Resident #42) of three residents reviewed for smoking. The facility census was 39. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral vascular disease affecting left dominant side, pathological fracture of the hip, and chronic obstructive pulmonary disease (COPD.) Review of the admission Minimum Data Set (MDS) assessment for Resident #42 dated 11/16/23 revealed the resident was cognitively intact and required substantial assistance with upper body dressing and personal hygiene and was dependent for lower body dressing. Review of the care plan for Resident #42 undated revealed there was no care plan for smoking. Review of safe smoking assessment for Resident #42 dated 11/10/23 completed by Licensed Practical Nurse (LPN) #901 revealed the resident did not smoke, was a non-smoker, and intended not to smoke. Record review of the physician orders for Resident #42 revealed an order dated 11/11/23 for resident to receive a transdermal nicotine patch to be applied once daily for smoking cessation for 24 hours and remove per schedule. The order was discontinued on 12/22/23. Review of the November and December Medication Administration Records (MARs) for Resident #42 revealed on 11/13/23, 11/14/23, 11/15/23, 11/25/23, 12/20/23, 12/21/23, and 12/22/23 the nicotine patch was either not available or refused by the resident. Review of the MAR for Resident #42 revealed the nicotine patch was discontinued on 12/22/23. Observation on 12/26/23 at 2:44 P.M. revealed LPN #901assisted Resident #42 outside to the smoking area and lit the resident's cigarette. Further observation revealed Resident #42 was not wearing a smoking apron while he smoked. Interview on 12/26/23 at 2:44 P.M. of LPN #901 confirmed Resident #42 smoked cigarettes and required staff assistance to and from the smoking area and to light his cigarettes. Interview on 12/26/23 at 3:21 P.M. with Resident #42 confirmed he quit smoking [AGE] years prior to admission to the facility, and then he started smoking cigarettes again in August 2023. Resident #42 confirmed he had been smoking cigarettes since he was admitted to the facility in November 2023 and staff assisted him with smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 12/26/23 at 3:24 P.M. and on 12/28/23 at 11:01 A.M. with the Director of Nursing (DON) confirmed when Resident #42 was admitted to the facility he did not smoke cigarettes and he wore a nicotine patch. The DON confirmed Resident #42 had expressed a desire to begin smoking around 12/22/23 and his nicotine patch was discontinued. Further interview with the DON confirmed the facility did not complete an updated smoking assessment for Resident #42 nor did they implement a care plan with safe smoking interventions for the resident. The DON confirmed the smoking assessment should be completed prior to residents' smoking to determine if the resident needed a smoking apron or other safety interventions and what level of supervision with smoking was required. Interview on 12/28/23 at 11:01 A.M. with Activity Director (AD) #820 confirmed she and her assistants took residents out to smoke several times a day as an activity for them. AD #820 confirmed she had taken Resident #42 outside to smoke on several occasions since admission. Review of the facility policy titled Resident Smoking Policy dated 12/20/22 revealed during the admission process the nursing staff would ask residents if they smoked or if they had a desire or intent to smoke while in the facility. Anyone answering yes was further assessed for smoking safety awareness and the need for reasonable physical or safety accommodations. The smoking assessment was to be completed thereafter on readmission, quarterly, or and with any significant change in the resident's condition.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, staff interview, and resident interview, the facility failed to provide suprapubic catheter site care for one (Resident #5) of one resident reviewed for catheter care. The facility census was 39. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and neuromuscular dysfunction of the bladder. Record review of the admission Minimum Data Set (MDS) assessment for Resident #5 dated 11/15/23 revealed the resident had moderate cognitive impairment and functional impairment to the upper and lower extremity on one side and required substantial assistance with personal hygiene. Review of the care plan for Resident #5 dated 10/31/23 revealed the resident had a neurogenic bladder. Interventions included staff should provide catheter care per routine. Review of the physician orders for Resident #5 dated 11/08/23 revealed an order to cleanse the suprapubic site with soap and water, pat dry, and leave open to air every shift. Review of the admission/readmission evaluation for Resident #5 dated 12/14/23 revealed the resident was admitted to the hospital on 12/04/23 with diagnoses of aspiration and hypoxia and was readmitted to the facility on [DATE] with a suprapubic catheter still in place. Review of the physician orders for Resident #5 dated 12/14/23 revealed there were no orders for daily suprapubic catheter care. Interview on 12/27/23 at 2:00 P.M. with Regional Director of Clinical Services (RDCS) #845 confirmed the facility staff did not obtain orders for Resident #5 for catheter care to his suprapubic catheter site upon the resident's readmission to the facility on [DATE]. Interview on 12/28/23 at 8:49 A.M. with Registered Nurse (RN) #900 confirmed Resident #5 did not have orders for catheter care to his suprapubic catheter site. RN #900 further confirmed she was an agency nurse and didn't know the residents well. RN #900 confirmed she had worked at the facility one day a week ago and did not provide catheter care for Resident #5 on that date or on 12/28/23 because there were no orders to do so. Interview on 12/28/23 at 9:00 A.M. with Resident #5 confirmed staff did not perform suprapubic site care upon after his return from the hospital on 12/14/23.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed up on in a timely manner. This affected three residents (#22, #25, and #26) of five residents reviewed for unnecessary medications. The facility census was 39. Findings include: 1. Review of the medical record for Resident #22 revealed admitted [DATE] with diagnoses including anxiety disorder, chronic obstructive pulmonary disease, and viral hepatitis. Review of the pharmacy consultation report dated 11/13/23 revealed the pharmacy recommended discontinuing Famotidine (acid reducer) medication as Resident #22 was already receiving Omeprazole (acid reducer), and evidence supporting combination gastroprotective therapy was limited. There was no physician signature; however, it was noted the physician was contacted via phone on 12/26/23 and agreed to discontinue Famotidine. Review of the physician orders revealed Famotidine 20 milligrams (mg) remained an effective order as of 12/28/23 at 8:01 A.M. Interview on 12/28/23 at 8:45 A.M. with Regional Registered Nurse (RN) #845, Director of Nursing (DON), and Administrator revealed they had identified issues regarding pharmacy recommendations. Regional RN #845 confirmed the pharmacy recommendation for Resident #22 was not followed up on in a timely manner. 2. Review of the medical record for Resident #25 revealed admitted [DATE] with diagnoses including schizophrenia, intellectual disabilities, overactive bladder, diabetes mellitus, and hypertension. Review of the pharmacy consultation report dated 05/12/23 revealed the pharmacy recommended to change Oxybutynin (bladder relaxant) medication for overactive bladder to Tolterodine (bladder relaxant) as Oxybutynin had highly anticholinergic effects and may increase the risk of adverse events. The physician agreed to change medication to Tolterodine and signed pharmacy recommendation on 06/20/23. Review of the physician orders revealed Oxybutynin 15 mg remained an effective order until 07/19/23, and Tolterodine 4 mg was not started until 07/19/23. Interview on 12/28/23 at 8:45 A.M. with Regional RN #845, DON, and Administrator revealed they had identified issues regarding pharmacy recommendations. Regional RN #845 confirmed the pharmacy recommendation for Resident #25 was not followed up on in a timely manner. 3. Review of the medical record for Resident #26 admitted [DATE] with diagnoses including hyperlipidemia, chronic pulmonary edema, recurrent depressive disorders, and dementia without behavioral disturbance. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders revealed Resident #25 had an order for a complete blood count (CBC) and basic metabolic panel (BMP) labs starting 10/14/22 and then every six months. The order remained in effect until 06/26/23. Review of the pharmacy consultation report dated 05/12/23 revealed the pharmacy identified Resident #26 had order for CBC and BMP lab draw due in April 2023, and the labs were not available in the medical record for review. The facility noted a CBC and BMP lab draw were scheduled for 05/19/23. There was no documented evidence of a CBC and BMP lab collected for 05/19/23. Review of the pharmacy consultation report dated 06/15/23 revealed the pharmacy recommended Resident #26 had order for CBC and BMP every six months which was last drawn 10/14/22. There were no labs available in the medical record for review. The facility noted a CBC and BMP lab draw were scheduled 06/20/23. Review of laboratory results for a CBC and BMP revealed specimen was collected on 06/20/23. Interview on 12/28/23 at 8:45 A.M. with Regional RN #845, DON, and Administrator revealed they had identified issues regarding pharmacy recommendations. Regional RN #845 confirmed the pharmacy recommendation for Resident #26 was not followed up on in a timely manner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure weights were documented accurately for Resident #41. This affected one resident (#41) of three residents reviewed for nutrition. The facility census was 39. Findings include: Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including third degree burns to multiple sites of the left shoulder and upper limb, third degree burns to the left lower limb, gastrostomy status, hypertension, morbid obesity, protein-calorie malnutrition, and history of pulmonary embolism. Review of the hospital summary dated 11/28/23 revealed Resident #41's weight was measured at 238 pounds on 11/25/23. Review of the facility weight records for Resident #41 indicated she weighed 238 pounds on 11/28/23, 239 pounds on 12/05/23, 215 pounds on 12/12/23, and 215 pounds on 12/19/23. On 12/28/23 at 10:08 A.M., interview with Registered Dietitian (RD) #847 and the Administrator stated Resident #41's initial weight on 11/28/23 was obtained from the hospital records, the weight on 12/05/23 was self-reported because Resident #41 refused to be weighed due to pain from her burn wounds, and the weights on 12/12/23 and 12/19/23 were the only weights obtained in house. RD #847 stated the weights on 12/12/23 and 12/19/23 were more accurate because they were obtained in house. Review of the facility policy titled Resident Weight Policy, dated 12/12/23, revealed residents would be weighed no later than 24 hours after admission, weekly for the first four weeks after admission, and monthly or more often if risks were identified, or as ordered. The policy indicated nursing was responsible for obtaining weights, and weights would be recorded in the electronic health record.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on interview, record review, review of the facility policy and Centers for Disease Control and Prevention (CDC) guidelines the facility field to ensure pneumococcal vaccinations were offered and provided as recommended by the CDC. This affected three residents (#11, #21, and #26) of five residents reviewed for pneumococcal vaccinations. The facility census was 39. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including diabetes mellitus, cerebral infarction, chronic kidney disease, moderate protein calorie malnutrition, congestive heart failure, and chronic obstructive pulmonary disease. Review of the progress note dated 12/18/23 revealed Resident #11 was noted to be lethargic, had a productive cough, and had rattling sounds audible upon breathing with continuous oxygen. The Nurse Practitioner assessed Resident #11 and provided prophylactic treatment for pneumonia due to worsening respiratory symptoms. Review of the physician's order dated 12/18/23 revealed Resident #11 was receiving Levaquin (antibiotic) for pneumonia prophylaxis for ten days. Review of the immunization report dated 12/27/23 revealed Resident #11 had received Pneumovax 23 on 02/15/21. There was no additional evidence of pneumococcal vaccinations provided. Review of the undated CDC Pneumococcal Vaccine Timing for Adults factsheet revealed Pneumovax 15 or Pneumovax 20 would be recommended at least one year after last dose of Pneumovax 23 to complete vaccination series. Interview on 12/28/23 at 10:08 A.M. with Interim Infection Preventionist (IP) #845 revealed she was unsure why Resident #11 had not been offered additional doses of pneumococcal vaccination as recommended by CDC. Interim IP #845 confirmed Resident #11 would be eligible for a dose of pneumovax 20. A follow up interview on 12/28/23 at 11:08 A.M. with Interim IP #845 revealed Resident #11 was agreeable to receiving Pneumovax 20, and Resident #11's hospice services were also in agreement. 2. Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including epilepsy, chronic migraine, malignant neoplasm of brain stem, and conversion disorder with seizures or convulsions. Review of the immunization report dated 12/27/23 revealed Resident #21 was not eligible for Pneumovax 20 vaccination. Review of the undated CDC Pneumococcal Vaccine Timing for Adults factsheet revealed Pneumovax 15 or Pneumovax 20 would be recommended for an adult with an immunocompromising condition such as malignancy. (continued on next page)

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 12/28/2023
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)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/28/23 at 10:08 A.M. with Interim IP #845 revealed she was unsure why Resident #21 had not been offered dose of pneumococcal vaccination as recommended by CDC. A follow up interview on 12/28/23 at 11:08 A.M. with Interim IP #845 revealed Resident #21 had no reported allergies or contraindication for use of pneumococcal vaccination. Interim IP confirmed Resident #21 would be eligible for a dose of Pneumovax 20. Resident #21 was agreeable to receiving Pneumovax 20. 3. Review of the medical record for Resident #26 revealed an admitted [DATE] and diagnoses including personal history of malignant neoplasm of breast, chronic pulmonary edema, dementia, cardiomegaly, and asthma. Review of the immunization report dated 12/27/23 revealed Resident #26 had received Pneumovax 23 on 02/11/21. There was no additional evidence of pneumococcal vaccinations provided. Review of the undated CDC Pneumococcal Vaccine Timing for Adults factsheet revealed Pneumovax 15 or Pneumovax 20 would be recommended at least one year after last dose of Pneumovax 23 to complete vaccination series. Interview on 12/28/23 at 10:08 A.M. with Interim IP #845 revealed she was unsure why Resident #26 had not been offered additional doses of pneumococcal vaccination as recommended by CDC. Interim IP confirmed Resident #26 would be eligible for a dose of Pneumovax 20. A follow up interview on 12/28/23 at 11:08 A.M. with Interim IP #845 revealed Resident #26 was agreeable to receiving Pneumovax 20. Review of the facility policy Pneumococcal Vaccine Policy - Resident, dated 08/19/20, revealed administration of pneumococcal vaccinations or revaccinations would be made in accordance with current CDC recommendations.

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 12/28/2023
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)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44808 Based on observation, staff interview, interview with contracted pest control staff, and review of the facility policy the facility failed to ensure food storage areas were free from pests. This had the potential to affect all residents except for Resident #5 identified by the facility as receiving no food from the kitchen. The facility census was 39. Findings include: On 12/26/23 from 8:39 A.M. to 8:51 A.M., the initial tour of the kitchen and food storage areas with Dietary Director #834 revealed there were multiple small black insects flying around and on the walls of the dry food storage room located in the kitchen. This was verified at the time of observation by Dietary Director #834, who identified the insects as either gnats or drain flies. On 12/27/23 at 12:21 P.M., interview with Pest Control Services Representative #902 confirmed he treated the facility's kitchen for drain flies on 12/26/23 and he stated, the facility staff needed better sanitation practices in the kitchen to prevent future issues with pests. Review of the pest control logs for December 2023 revealed routine pest control services were performed in the kitchen on 12/06/23 and there was no indication that treatments were specific to drain flies or fruit flies until 12/26/23. Review of the facility policy titled Pest Control Policy, dated 08/12/18, revealed routine pest control procedures would be in place to prevent pest infiltration and appropriate actions would be taken to eliminate any reported pest situation in the kitchen or dietary department.