STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365793	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Center at Laurel Lake	200 Laurel Lake Dr Hudson, OH 44236

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** 48567 Based on record review, interview, and review of facility policy, the facility failed to ensure Resident #33 was transferred in a manner that would prevent a fall with major injury. This affected one resident (Resident #33) of three residents reviewed for safe transfers. The facility census was 61. Actual harm occurred on 06/23/24 when Resident #33, who required staff assistance and use of a transfer device due to repeated falls and poor safety awareness, was transferred without the device and sustained a fall and fracture of the right femur. State tested Nurse Aid (STNA) #384 ignored guidance from other staff and Resident's #33's spouse indicating the need to use a transfer device and attempted to transfer Resident #33 independently which resulted in Resident #33 falling. When observed by the nurse, Resident #33 was on the floor screaming in pain with her right leg externally rotated. Resident #33 required emergent transfer to the hospital and subsequent surgical repair of a fractured right femur. Findings include: Review of Resident #33's medical record revealed an admitted [DATE] and a re-entry date of 04/10/24 with diagnoses including late onset Alzheimer's disease, anxiety disorder, vascular dementia, repeated falls, muscle weakness, stage three chronic kidney disease, generalized osteoarthritis, atrial fibrillation, long-term use of anticoagulants, and unsteadiness on feet. Review of Resident #33's diagnoses list revealed the resident did not have a diagnosis of osteoporosis. Review of the physician orders revealed an order dated 12/15/23 for a Sara Steady device (a standing and/or transfer aid designed for residents with balance, lower extremity, mobility or walking disabilities) to be used for transfers. The order further revealed staff could use a Sit to Stand device (mechanical transfer device that assists residents from one seated surface to another) as needed for transfers. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 had severely impaired cognition and was dependent for all transfers. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan dated 04/10/24 revealed Resident #33 was at risk for falls secondary to a decline in cognition and mobility, poor safety awareness, and incontinence. Interventions included keeping the call light within reach, offering and assisting Resident #33 to bed after dinner, offering and assisting Resident #33 to the dining room for meals, and offering to assist toileting Resident #33 with toileting before and after meals and at bedtime. Further review of the care plan for falls revealed there were no interventions or instructions on how staff were to assist with the transfers for meals, bedtime, and toileting. Review of the progress notes revealed an incident note dated 05/15/24 detailing that blood was noted on the paddle of the Sara Steady device and Resident #33 sustained a V-shaped skin tear to her right elbow measuring three centimeters (cm) by 1.2 cm while being transferred. The note further revealed the STNA was educated to be more careful when transferring Resident #33 with the device. Review of the progress note dated 06/03/24 revealed the interdisciplinary team (IDT) reviewed bruising to Resident #33's right inner forearm, measuring 10.3 cm by 4.4 cm, which was determined to be the result of the resident being transferred incorrectly and the staff member's elbow contacting Resident #33's right forearm. Review of the progress note dated 06/23/24 revealed the nurse was called to Resident #33's room and found her on the floor with her left leg against the bed frame and her right leg externally rotated as Resident #33 was noted to be screaming in pain. Further review of the progress note revealed the fall occurred as the STNA was transferring Resident #33 into her wheelchair. Resident #33 was transported via ambulance to local hospital for evaluation and treatment after a call was placed to emergency medical services (911). Review of the nursing nursing progress note dated 06/25/24 at 6:18 A.M. revealed an update was received from the resident's son who reported his mother was doing well after her surgery related to a fractured femur. Interview on 06/25/24 at 2:08 P.M. with Resident #34, who was the spouse and roommate of Resident #33 revealed Resident #33 was in the hospital because the aide dropped her and she had to have surgery. During the interview, Resident #34 revealed he informed the STNA Resident #33 required a device to move her, but the STNA (STNA #384) disregarded his suggestion and proceeded to try to pick-up Resident #33 without a device and dropped her before she could place her into her wheelchair. Interview on 06/25/24 at 3:20 P.M. with Therapy Department Manager #383 confirmed Resident #33's transfer status was evaluated by the Therapy Department in December 2023, and it was determined she required a Sara Steady lift for all transfers and a Sit to Stand mechanical lift for transfers as needed, depending on decline in cognitive status or increase in weakness. During the interview, Therapy Department Manager #383 confirmed Resident #33 should not have been transferred without the use of a transfer device and one-to-two-person assistance was to be used with the Sara Steady lift and two-person assistance was required with any type of mechanical lift, such as the Sit to stand or Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/25/24 with the Director of Nursing (DON) at 3:50 P.M. confirmed Resident #33 had an order to use the Sara Steady for all transfers and a sit to stand lift if needed. The DON further confirmed no device was used during the transfer of Resident #33 which led to her fall on 06/23/24, despite evidence of other staff informing STNA #384 a transfer device was required. The DON confirmed Resident #33 sustained a fracture of the right femur as a result of the fall on 06/23/24. Interview on 06/25/24 with the Assistant Director of Nursing (ADON) at 4:00 P.M. confirmed bruising sustained to Resident #33's forearm on 05/31/24 was determined by the IDT on 06/03/24 to be the result of an improper transfer and the fall sustained by Resident #33 on 06/23/24 was the result of STNA #384 not providing a safe transfer by using one of the ordered transfer devices. Further interview with the ADON confirmed STNA #384 was provided an assignment that specified Resident #33 required a Sara Steady for transfers and a sit to stand as needed for transfers. Review of the Resident assignment sheet for the Appleblossom unit, last updated on 06/20/24, revealed there was written instruction for on-duty staff that Resident #33 required a Sara Steady for transfers or a sit to stand as needed. Review of the facility fall investigation completed 06/25/24 revealed witness statements from three other staff on duty indicating STNA #383 was reminded by staff and by Resident #34, Resident #33's spouse and roommate, that Resident #33 required a lift for transfers. Review of the facility policy titled No Lift last reviewed in September 2023 revealed residents who required increased assistance of one staff member were to be evaluated by the therapy department for the most appropriate type of mechanical lift device. Further review of the policy revealed staff were not to transfer the resident without using the lift recommended by the Therapy Department. This deficiency represents non-compliance investigated under Complaint Number OH00154309.