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	10/28/2024

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 - 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** 38522 Based on observation, interview, record review and facility policy review, the facility failed to ensure fall interventions were in place to prevent Resident #32 from falling. This affected one resident (#32) out of three residents reviewed for falls. The facility census was 62. Findings include: Review of Resident #32's medical record revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia with anxiety, depression, anxiety, glaucoma, chronic kidney disease stage 3A and dysphagia. Review of Resident #32's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 was cognitively impaired, rejected care one to three days in the seven day look-back period, was dependent on staff for toileting, lying to sitting on the side of the bed, sitting to standing, toilet transfers and chair to bed transfers. Resident #32 did not have any falls since the previous assessment. Review of Resident #32's physician's orders revealed an order dated 07/19/24 for transfers: mechanical sit-to-stand lift with two-person assist. Review of Resident #32's care plan for activities of daily living (ADL) self-care performance deficit related to impaired physical mobility and weakness dated 06/05/23 and revised 09/05/24 revealed Resident #32's ADL's fluctuate due to cognitive impairment and combativeness during care. A listed intervention included transfer (07/19/24) mechanical sit to stand lift with two person assist. Review of Resident #32's care plan for fall risk related to gait/balance problems related to impaired mobility and dementia diagnosis dated 06/05/23 and revised 06/04/24 listed an intervention including dycem to recliner every shift initiated on 03/28/24 and revised on 05/01/24. Review of Resident #32's Kardex (care card) as of 10/28/24 revealed dycem (sticky surface used to prevent slipping and falls) was to be on all seated surfaces every shift and as of 07/19/24, Resident #32 transferred via mechanical sit to stand lift with two person assist. Review of the facility's Resident Information Sheet (RIS) as of 10/22/24 revealed Resident #32 required a mechanical sit to stand lift and two person assist for 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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident report for Resident #32 dated 09/19/24 at 10:00 P.M. and completed by Licensed Practical Nurse (LPN) #142 and LPN #145 included a statement from State tested Nursing Assistant (STNA) #191 which indicated he was taking care of (wrong resident name) and used a gait belt to help with transfer. As I was help[ing] transfer him he became resistant and was grabbing and as I had him on the side of the bed he was resisting and became combative so he was lowered to the floor. I came and asked the nurse for assistance. Review of a nurses' note dated 09/20/24 at 12:47 A.M. and authored by LPN #142 revealed at 10:00 P.M. the STNA notified staff that Resident #32 was combative and resistant with care, unable to complete transfer from wheelchair to bed and was lowered to the floor. Vitals were obtained. No injury was noted and able to complete full range of motion (ROM) without difficulty or pain. Staff assisted Resident #32 off of floor and into bed. When asked what happened prior to fall, Resident #32 stated I don't know. Review of Resident #32's nurses' note dated 09/20/24 at 1:08 P.M. and authored by Assistant Director of Nursing (ADON)/Registered Nurse (RN) #157 revealed incident occurred secondary to agency STNA not transferring resident according to the Resident Information Sheet he was given at the start of his shift. Interdisciplinary Team (IDT) discussed the incident and agreed the STNA was listed as do-not-return (DNR) to the facility and staff were educated to review the RIS at the beginning of their shift. Interview on 10/24/24 at 1:15 P.M. with Resident #32 revealed he had a past fall but could not indicate when he had fallen. Observation on 10/24/24 at 2:43 P.M. revealed Resident #32 was seated in a recliner in his room with his wife, Resident #61, also present. No dycem was noted on the recliner and Resident #32 was trying to get out of the recliner and did not appear to be steady during the observation. Interview on 10/24/24 at 2:47 P.M. with LPN #145 verified Resident #32 did not have dycem on the recliner he was currently sitting in. Interview on 10/24/24 at 2:51 P.M. with the Director of Nursing (DON) verified Resident #32 was to have dycem under him if he was seated in his recliner and confirmed this intervention had been in place since 05/01/24. Interview on 10/24/24 at 3:58 P.M. with STNA #191 revealed over a month ago, he was working at the facility as an agency STNA and used a gait belt on Resident #32 to transfer him to bed. Resident #32 was resistive and STNA #191 stated he was losing his own balance so he slid Resident #32 to the floor. STNA #191 stated this was not a fall and shared he was handed a paper on the residents' care needs while working at the facility which indicated Resident #32 was to be a sit to stand lift for transfers per the paper. When asked why he transferred Resident #32 alone and with a gait belt, STNA #191 stated the sit to stand lift was not around. STNA #191 denied Resident #32 having any injuries as a result of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/24 at 4:18 P.M. with LPN #142 revealed LPN #145 had let her know as the supervisor Resident #32 had a fall during transfer without injury. LPN #142 confirmed Resident #32 required a sit to stand lift with one or two people to transfer but she would need to see his care plan to further state how many people were required to complete the transfer as ordered. LPN #142 verified Resident #145 was not to be transferred manually with a gait belt. Interview on 10/28/24 at 8:17 A.M. with Director of Therapy (DOT) #193 confirmed Resident #32 was a sit to stand lift with two people for transfers and had maintained this status since July 2024. Follow-up interview on 10/8/24 at 9:59 A.M. with the DON verified on 09/19/24, STNA #191 did not transfer Resident #32 per physician's orders, which resulted in a fall without injury. The DON verified Resident #32 had been a mechanical sit to stand lift with two person assist for transfers since 07/19/24 and confirmed STNA #191 did not use the assistance of another staff member and did not utilize the sit to stand lift as ordered while transferring Resident #32. The DON shared STNA #191 had been provided accurate information about Resident #32's status including his transfer needs upon coming onto his shift via the Resident Information Sheets also provided during the survey. Review of the facility policy, No-Lift, revised July 2024 revealed residents that are unable to move independently or require increased assistance of one staff member a mechanical lift will be used to transport the resident from one point to another. Refer to therapy for situations best suited for the full mechanical lift (Hoyer), sit-to-stand and Sara Steady. Upon admission of a resident who is not mobile, the admitting licensed nurse will write an order to have rehabilitation evaluate the resident. Therapy will come to the resident's room to complete an evaluation on the resident's mobility to include what type of transfer should be used with the resident and if necessary therapy will identify which lift is appropriate to use when transferring the resident. The therapist will the notify the admitting licensed nurse/MDS coordinator which transport modality is appropriate and this information will be placed on the care plan and the RIS sheet for the STNA. When any staff member is working with a resident who requires a lift they must use the lift recommended by the therapy department and may not transfer the resident without the use of the lift. At quarterly and change of condition therapy will evaluate for the continued need for the lift. It is the responsibility of the charge nurse/RN supervisor to hold all staff accountable for the use of the lift. If any staff member is observed transferring a resident without the use of a lift when it has been recommended they do so then the progressive discipline process will commence. Review of the undated document, Agency Education, no date, revealed please utilize your Resident Information Sheets that have been provided for you. Turn them into your charge nurse at the end of your shift. Be alert to resident-specific needs, several are fall risks, several residents will not call for assistance. Patience is needed as several residents may be resistive to care. Review of the undated document, Resident Information Sheets, revealed please note the Resident Information Sheets are to be utilized by all staff and are designed to follow the physician order as well as the plan of care. It is vital that the transfer orders for the resident are followed. For residents that are assist times one or assist times two and do not require the use of Hoyer, Sara Steady to sit-to-stand, a gait belt is necessary for the completion of the transfer. This deficiency represents noncompliance investigated under Master Complaint Number OH00158661 and Complaint Number OH00158355.