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	08/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of facility self-reported incidents (SRIs), and review of the facility policy, the facility failed to ensure allegations of potential abuse and neglect were reported to the State Agency as required. This affected three residents (#57, #58, and #67) of five residents reviewed for abuse and neglect. The facility census was 70.Findings include:1.Review of the medical record for Resident #57 revealed an admission date of 07/19/25 and diagnoses including delirium due to known physiological condition, vascular dementia, anxiety disorder, aphasia, cognitive communication deficit, cerebral infarction, and persistent atrial fibrillation. Review of the 07/19/25 care plan for Resident #57 revealed potential for physically aggressive behavior related to dementia. Interventions included monitoring and documenting any signs and symptoms of the resident posing danger to self and others. Review of behavior note dated 07/21/25 revealed Resident #57 had grabbed the nurse's arm and started yelling. Resident #57 was also noted to make several attempts to get out of bed on his own and when staff intervened, he would become aggressive. Resident #57 was noted to become aggressive towards his wife as well. Review of Psychiatric Evaluation dated 07/23/25 revealed Resident #57 had history of insomnia, anxiety, depression, and vascular dementia. Resident #57 admitted to the facility following hospitalization for [NAME] procedure. Resident #57 was noted to be combative coming out of anesthesia and has been experiencing delirium related to anesthesia. Resident #57 was noted to have intermittent agitation and aggression since admission and was not getting along with his roommate. Resident #57's wife did not wish for medication changes at this time. Review of physician progress note dated 07/23/25 revealed Resident #57 was status post [NAME] procedure. The procedure was noted to be uncomplicated, however Resident #57 had noted delirium following the procedure with waxing and waning of mental status and confusion. Review of nursing note dated 07/23/25 revealed Resident #57 was combative with staff during care. It was also noted Resident #57's wife appeared to be the only consoling factor and only person able to re-direct. Resident #57 required one on one care while wife was away. Review of nursing note dated 07/24/25 revealed Resident #57 was being aggressive with his wife during toileting, and it was observed by staff that wife became aggressive back. Social services and the administrator were made aware. There were no noted injuries or effects. Review of Brief Interview for Mental Status (BIMS) evaluation dated 07/25/25 revealed Resident #57 scored 4.0 indicating severe cognitive impairment. Interview on 07/31/25 at 1:37 P.M. with Licensed Nursing Home Administrator (LNHA) revealed Resident #57 and his wife normally resided in the independent living (IL) together. LNHA indicated Resident #57 had come for a rehabilitation stay following hospitalization. LNHA indicated Resident #57 needed psych services while admitted for behaviors. LNHA indicated on 07/24/25 staff found Resident #57's wife attempting to toilet him. Resident #57 was being resistive, and his wife was getting angry/frustrated. LNHA indicated her staff reported their concerns with the situation to her and she brought his wife into her office to talk about it. LNHA indicated his wife reported tapping him on the bottom to get him to comply. LNHA indicated she did not feel the situation was abusive and his wife was just frustrated. LNHA indicated Resident #57's wife had cared for him for a long time but had a decline and she was experiencing caregiver burn out. LNHA indicated they had offered Resident #57's wife counseling services with their Chaplin and resources for caregiver burnout. Interview on 07/31/25 at 2:28 P.M. with Licensed Practical Nurse (LPN) #242 revealed one of her aides told her Resident #57's wife was toileting Resident #57 on her own and Resident #57 was becoming aggressive with her. LPN #242 indicated his wife also was becoming aggressive. LPN #242 was asked to describe aggressive, and she indicated it was not abuse but she was not there so she could not describe it. LPN #242 stated she inspected Resident#57's skin and there were no red areas on his bottom or injuries. Interview on 08/04/25 at 9:21 A.M. with CNA #221 revealed on 07/24/25 she was assisting Resident #57's wife to get Resident #57 up out of bed to go to the bathroom and Resident #57 punched his wife on the left side of her abdomen. Resident #57's wife reacted and slapped Resident #57 with force on his right facial cheek with her right hand. CNA #221 stated Resident #57's wife instructed her to leave the room and CNA #221 proceeded to leave Resident #57 and his wife alone in the room and went to report the incident to Licensed Practical Nurse (LPN) #242. LPN #242 instructed CNA #221 to fill out an incident report and CNA #221 proceeded to fill out a witness statement and give it to LPN #242. Interview on 08/04/25 at 9:53 A.M. with LPN #242 revealed CNA #221 reported to her that Resident #57 hit his wife while trying to get him up to the bathroom and Resident #57's wife proceeded to slap him in the face. LPN #242 stated she went back in

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility policy, the facility failed to complete an investigation into allegations of physical abuse for Resident #57 and failed to complete an investigation into potential neglect for Residents #58 and #67. This affected three residents (#57, #58, and #67) of four reviewed for abuse and neglect. The facility census was 70.Findings include:1. Review of the medical record for Resident #57 revealed an admission date of 07/19/25 and diagnoses including delirium due to known physiological condition, vascular dementia, anxiety disorder, aphasia, cognitive communication deficit, cerebral infarction, and persistent atrial fibrillation.Review of the 07/19/25 care plan for Resident #57 revealed the resident had the potential for physically aggressive behavior related to dementia. Interventions included monitoring and documenting any signs and symptoms of the resident posing danger to self and others.Review of a behavior note dated 07/21/25 revealed Resident #57 had grabbed the nurse's arm and started yelling. Resident #57 was also noted to make several attempts to get out of bed on his own and when staff intervened, he would become aggressive. Resident #57 was noted to become aggressive towards his wife as well.Review of a Psychiatric Evaluation dated 07/23/25 revealed Resident #57 had history of insomnia, anxiety, depression, and vascular dementia. Resident #57 admitted to the facility following hospitalization for a cardiac procedure. Resident #57 was noted to be combative coming out of anesthesia and had been experiencing delirium related to anesthesia. Resident #57 was noted to have intermittent agitation and aggression since admission and was not getting along with his roommate. Resident #57's wife did not wish for medication changes at this time. Review of physician progress note dated 07/23/25 revealed Resident #57 was status post-procedure. The procedure was noted to be uncomplicated, however, Resident #57 had noted delirium following the procedure with waxing and waning of mental status and confusion.Review of a nursing note dated 07/23/25 revealed Resident #57 was combative with staff during care. It was also noted Resident #57's wife appeared to be the only consoling factor and only person able to re-direct him. Resident #57 required one-on-one care while his wife was away.Review of nursing note dated 07/24/25 revealed Resident #57 was being aggressive with his wife during toileting, and it was observed by staff that the wife became aggressive back. Social services and the Administrator were made aware. There were no noted injuries or effects to Resident #57. Review of Brief Interview for Mental Status (BIMS) evaluation dated 07/25/25 revealed Resident #57 scored 4.0 indicating severe cognitive impairment.Interview on 07/31/25 at 1:37 P.M. with the Administrator revealed Resident #57 and his wife normally resided in the independent living (IL) together. The Administrator indicated Resident #57 had come to the facility for a rehabilitation stay following a hospitalization. The Administrator indicated Resident #57 needed psychiatric services while admitted for behaviors. The Administrator indicated on 07/24/25, staff found Resident #57's wife attempting to toilet him. Resident #57 was being resistive, and his wife was getting angry and frustrated with him. The Administrator indicated her staff reported their concerns with the situation to her and she brought his wife into her office to talk about it. The Administrator indicated his wife reported tapping Resident #57 on the bottom to get him to comply. The Administrator stated she did not feel the situation was abusive and his wife was just frustrated. The Administrator indicated Resident #57's wife had cared for him for a long time but had a decline and she was experiencing caregiver burn out. The Administrator reported they had offered Resident #57's wife counseling services with their Chaplain and resources for caregiver burnout.Interview on 07/31/25 at 2:28 P.M. with Licensed Practical Nurse (LPN) #242 revealed one of her aides told her Resident #57's wife was toileting Resident #57 on her own and Resident #57 was becoming aggressive with her. LPN #242 indicated the resident's wife also was becoming aggressive. LPN #242 was asked to describe aggressive, and she indicated it was not abuse but she was not there, so she could not describe it. LPN #242 stated she inspectedInterview on 08/04/25 at 9:21 A.M. with Certified Nursing Assistant (CNA) #221 revealed on 07/24/25 she was assisting Resident #57's wife to get Resident #57 up out of bed to go to the bathroom and Resident #57 punched his wife on the left side of her abdomen. Resident #57's wife reacted and slapped Resident #57 with force on his right facial cheek with her right hand. CNA #221 stated Resident #57's wife instructed her to leave the room and CNA #221 proceeded to leave Resident #57 and his wife alone in the room and went to report the incident to Licensed Practical Nurse (LPN) #242. LPN #242 instructed CNA #221 to fill out an incident report and CNA #221 proceeded to fill out a witness statement and gave it to LPN #242.A follow up interview on 08/04/25 at 9:53 A.M. with LPN #242 revealed CNA #221 reported to her that