

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Homestead II		STREET ADDRESS, CITY, STATE, ZIP CODE 60 Wood St Painesville, OH 44077	
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. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and self-reported incident (SRI) review, the facility failed to provide adequate supervision for a Resident #45 for an outside appointment. This affected one (Resident #45) of four residents reviewed for appointments. The facility census was 44. Findings include: Review of the closed medical record for Resident #45 revealed an admission date of 06/24/25. Diagnoses included gastrointestinal tumor, malignant neoplasm of the liver and bile duct, chronic obstructive pulmonary disease (COPD). There was no diagnosis of dementia. The resident was discharged home on [DATE]. Review of the plan of care dated 06/24/25 revealed Resident #45 required supervised leave of absence (LOA). Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 had intact cognition. Review of the baseline care plan report dated 07/01/25 and reviewed with Resident #45 and family revealed Resident #45's appointments on 07/03/25 and on 07/10/25 stated daughter to transport written beside the appointments. The appointment on 07/07/25 did not have anything written beside it. Review of the Director of Nursing (DON's) note dated 07/07/25 at 6:40 A.M. per charge nurse, Resident #45 left the facility via Lake [NAME] for his scheduled urology appointment. Review of facility SRI tracking number 262468 and investigation dated 07/07/25 revealed Resident #45 was admitted to the facility on [DATE] with multiple follow-up doctor appointments. The appointments were placed in Matrix, and transportation was set up with Lake [NAME] transportation services. A care plan meeting for short term residents (PATH meeting) was held with the resident and his daughter where she stated that she may be cancelling appointments. She was advised at that time to let the nursing staff know so the transportation could be cancelled and the order removed from our system. On 07/03/25 Resident#45 attended an appointment using Lake [NAME] services without incident. On 07/07/25 the resident had a scheduled urology appointment, Lake [NAME] transported him leaving the building around 6:40 A.M. Around 9:22 A.M. the facility received a call from the urology department that the resident had not been picked up. Resident #45's return trip was scheduled for 8:45 A.M. to 9:15 A.M. The building contacted Lake [NAME] for an estimated time of arrival (ETA) and it was reported Resident #45 was marked as will call. The facility informed Lake [NAME] that Resident #45 needed a return trip. Lake [NAME] stated that he would be picked up. Resident #45's daughter called the facility around 10:30 A.M. stating that the appointment had been cancelled and questioned why the resident had gone to the appointment. The resident's daughter was unable to state who she informed at the facility that she had cancelled the appointment. No nursing staff at the building were notified of the appointment being cancelled. The urology office was called by the facility to confirm that the appointment had been cancelled, and the scheduling department stated that it had been cancelled and rescheduled for 07/07/25. Resident #45's daughter drove to the appointment office and picked up Resident #45. She took the resident back to his assisted living apartment rather than returning to the facility. Interview on 09/05/25 at 8:54 A.M. the DON revealed the facility typically asks family to go on appointments with a resident. Depending on cognition, the facility will send a staff member with the resident. Transportation was usually arranged through Lake [NAME]. Pick up and return times are scheduled. Lake [NAME] had a 30-minute window. Interview on 09/05/25 at 10:58 A.M. with Receptionist/Human Resources (HR)/Payroll #203 revealed on 07/07/25 the facility received a phone call between 10:00 A.M. to 10:30 A.M. from a doctor's office saying Resident #45 was waiting to be picked up from his appointment. She called Lake [NAME] and was told pick up was marked as will call. Receptionist/HR/payroll #203 told them it couldn't be because the facility had a return time written down. Lake [NAME] informed her that they had already been there and left. With Lake [NAME] you call and wait on hold or have option for them to call you back. The facility was talking to the doctor's office, Lake [NAME], and the office again. The doctor's office also called the resident's daughter. Resident #45's daughter called and said she would pick the resident up, but she wasn't bringing him back here. Interview on 09/05/25 at 1:29 PM. With Resident #45's daughter said she didn't even know the facility was taking the resident to an appointment that day. She had cancelled the appointment. The facility didn't call her. At the last appointment she had come to the facility to go with her father to an appointment, and the facility had arranged for a staff member to go with him. When she picked up her father from the appointment 07/07/25, he was very upset and very hungry. He had not had anything to eat that day and it was almost noon. She could not believe the facility had sent him to the appointment unattended. Interview on 09/05/25 at 1:50 P M the DON verified Resident #45 had been sent to the appointment 07/07/25 unaccompanied by</p>		