STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365441	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Pointe Rehabilitation and Nursing Center	22 Parrish Road Conneaut, OH 44030

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** 37097 Based on record review, review of the facility investigation, and interview the facility failed to maintain a safe environment to prevent accidents for Resident #44. This affected one resident (#44) of three resident reviewed for accidents. The facility census was 54. Findings include: Review of Resident #44's medical record revealed an admitted [DATE] with diagnoses including paraplegia, traumatic brain injury, suicidal ideations, transsexualism, suicidal behavior, conversion disorder with seizures, cognitive communication deficit, major depressive disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder. Review of Resident #44's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. She required setup or clean up help with eating, oral hygiene, substantial to maximal assistance with toileting hygiene, dressing, personal hygiene, showers, and bed mobility. Transfers were completed with the use of the Hoyer (mechanical) lift and two staff members. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's care plan dated 08/19/24 revealed there was a care plan present related to psychosocial well-being fluctuations related to mental health and mood disorders. Resident #44 had a legal guardian due to her mental health fluctuations with delusions, auditory hallucinations, and suicidal ideations. The goal was to be the resident will verbalize feelings related to her emotional state. Interventions included staff to assist with identification of potential solutions to present problems, assist to identify causative and contributing factors, assist to reduce or eliminate causative factors, assist to set realistic goals, avoid loud tones and loud noises in general due to they may trigger PTSD memories, staff were to encourage tolerance to increase communication between residents, family, and caregivers related to care and living environment, and staff were to explain all procedures, treatments, medications, results of lab work and tests, her conditions and any changes, rules, and options. Additionally, there was a care plan reviewed for a history or trauma related to PTSD, sexual assault, self-harm and traumatic brain injury. The goal was the resident would exhibit minimal signs and symptoms of stress or PTSD triggers as evidence by presenting with a calm appearance or voicing on set of triggers. Interventions included all activities in activities room were to be supervised by a staff member at all times, staff were to approach the resident in an unhurried manner, be respectful verbally of the resident's personal space, all staff were to avoid culturally inappropriate or insensitive items in the physical environment, help the resident to manage conflict appropriately, include the resident and/or responsible party in treatment plan, update the physician as indicated by change in condition or treatment, keep noise levels low, keep the resident in touch with their community, cultural heritage, former lifestyle, and religious practices. Staff were to maintain health interpersonal boundaries, provide community required interventions as indicated, provide low lighting when indicated, provide support groups including via [NAME] to provide therapeutic behavior services, room to randomly be searched and any and all items would be removed from the resident's room if they could be harmful or used to cause harm to self, including but not limited to cords, rope, silverware, batteries etc. Staff were to speak in a calm manner, staff were to be aware of their own emotional responses to the resident's trauma. Staff were to update the physician as indicated for change in condition and treatment, utilize calm music throughout the task, and staff were to make sure the resident felt welcome and supported. All staff were to adjust tone and volume of speech to achieve a calming environment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's progress notes dated 07/30/24 at 4:44 P.M. authored by Licensed Practical Nurse (LPN) #205 revealed the resident turned on her call light and stated, I cut myself. The resident was observed with an activity's cutter (box cutter) and a superficial laceration to her left wrist. The activity cutter was removed from the room, and the area was cleansed with normal saline and left open to air. The resident stated she took the cutter from the activities room, and she did not know why she did it. One on one and emotional support were provided and effective. One on one staff provided at this time for the resident's safety. The Nurse Practitioner was notified and gave an order to send the resident to the emergency room (ER) for evaluation and treatment for psych services to evaluate. Resident #44's guardian and mother were notified of the transfer and of the incident. Emergency medical services (EMS) were notified as well as the police. Further review of Resident #44's progress notes revealed on 07/31/24 the Interdisciplinary Team (IDT) had a meeting and reviewed the incident. The resident's room was searched, and all items which could be used for self-harming were removed. The Guardian was made aware. At this time, the Guardian made the Director of Nursing (DON) aware the hospital was giving her a hard time getting psych assistance for the resident. The DON called the ER, and they stated she was denied from five behavioral units. The DON provided additional places the resident could go. The ER called back at 5:00 P.M. and stated they could not find placement, they felt she was no longer at risk, and she would be returned to the facility. Progress notes revealed the resident did not require treatment to the left wrist and returned to the facility on [DATE] at 9:00 P. M. with new orders for Bactrim DS 800-160 milligrams (mg) (antibiotic) twice a day for five days because she was positive for a urinary tract infection (UTI). Interview on 11/04/24 at 11:02 A.M. with Activity Director (AD) #203 revealed on 07/30/24, Resident #44 was brought down to the small activity room by staff. Resident #44 put a box cutter that was on the table in her bag and took it to her room and cut her wrist. She was sent to the hospital. AD #203 stated the facility administrative team spoke to her about the incident. She stated she was not disciplined for it due to the box cutter being the old maintenance directors, and she stated she never heard about it again after that. Interview on 11/04/24 at 1:28 P.M. with the DON revealed the DON provided a screen shot of AD #203's social media page indicating AD #203 lied to surveyors to get the facility in trouble for the incident that occurred on 07/30/24 regarding Resident #44. The DON stated AD #203 had turned in her notice and was quitting and just wanted to cause trouble. The DON stated that through the investigation completed by facility administrative team, it was determined the box cutter was in the small activity room on a shelf, and it was very dusty, dirty, and dull. Resident #44 informed the DON that she found it in the activity room and decided to self-harm. She placed it in a small spiderman backpack that belonged to AD #203's son, propelled herself down to her room, she stopped staff in the hallway and asked to be laid down in the bed, which they did, when she was in bed, she asked for her tray table and the backpack. Ten to 15 minutes later, Resident #44 turned her call light on and as soon as staff entered the room she pulled the box cutter out and attempted to cut her wrist. (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 11/04/24 at 2:00 P.M. with LPN #205 revealed she was assigned to care for Resident #44 on 07/30/24 when she obtained a box cutter from the activity room and attempted to cut her left wrist with it. LPN #205 stated Resident #44 self-propelled down to the small activity room and when she returned, she had a spiderman bookbag on her lap and requested to be put to bed. The assigned certified nurse aide (CNA) requested help, and two staff members used the Hoyer lift and put the resident to bed. Approximately ten to 15 minutes later, Resident #44 put her call light on, and when LPN #205 entered the room, Resident #44 took out the box cutter and attempted to cut her wrist. LPN #205 stated Resident #44 had a superficial laceration or scratch to her left wrist. She immediately removed the box cutter from Resident #44 and attended to her left wrist. LPN #205 stated she cleansed the area with normal saline and left it open to air as it was not bleeding and was not deep at all. She notified the Nurse Practitioner and the Guardian. She was instructed by the Nurse Practitioner to send the resident to the ER. LPN #205 stated the resident had one on one supervision until she left the facility with EMS. LPN #205 stated she notified the DON and Administrator and was instructed to search the resident's room and to obtain statements from all the staff in the facility. LPN #205 stated the backpack had AD #203's sons initials in it. Review of the facility investigation dated 07/30/24 revealed all like residents were interviewed, skin assessments were completed on all residents at risk for self-harm, all staff were interviewed, and witness statements were obtained. The investigation determined Resident #44 found the box cutter in the small activity room on a shelf, it appeared to have been there for some time as it had dust built up on it. It was determined the box cutter was left there by an old maintenance man who no longer worked at the facility due to his initials being found on the box cutter. All areas of the facility were searched for any items residents could use for self-harm and if found, items were removed. This deficiency represents non-compliance investigated under Master Complaint Number OH00159634 and Complaint Number OH00159198.