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	01/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interviews, and facility policy review, the facility failed to maintain resident medical records in a secure environment that safeguarded it from unauthorized use and prevented loss or destruction. This affected an unidentified number of discharged residents. The facility census was 61.Findings include:Interview on 12/30/25 at 12:30 P.M. with Director of Nursing (DON) regarding storage of resident medical records revealed storage of any current residents' records were kept in the locked business office area for confidentiality but stated being unsure of where discharged residents' records were kept.Observation on 12/30/25 at 12:55 P.M. of a detached storage garage on the facility grounds with Director of Maintenance (DOM) #210 revealed it was an unlocked storage area which contained general storage of maintenance equipment and a large amount of banker boxes filled with files. Near the entrance of the garage door were approximately ten opened and unsealed boxes piled on top of each other which contained confidential medical and personal information of discharged residents. At the back of the garage on multiple wooden shelves were additional unsealed banker boxes which contained numerous resident medical and personal records, which included resident shower sheets and assessment sheets. The total number of unsecured boxes exceeded 30. The garage area was easily accessible to any unauthorized individual and was not locked. The residents' records were also not under any climate control to prevent mold, pests, or any environmental changes which could damage the files. A few of the boxes by the garage entrance had damaged corners and were not completely closed. Interview at the time of the observation with DOM #210 revealed he was told to move the boxes to the garage, was unaware of what all the boxes contained and did not realize the garage needed to be locked or that the files needed to be secured as well as protected from the environment. A follow-up interview on 12/30/25 at 1:20 P.M. with the DON revealed she was aware of some resident records being kept in the garage but not of the amount. During the survey, the facility was unable to provide a list of residents by name whose records were being stored in the unsecured garage. Review of facility policy titled, Confidentiality of Information and Personal Privacy revised October 2017 revealed the facility protected and safeguarded resident confidentiality and personal privacy and that access to resident personal and medical records was limited to authorized staff and business associates. This violation is an example of noncompliance investigated under Master Complaint Number 2694466.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interviews, and facility policy, the facility failed to ensure residents had a clean, comfortable, and homelike environment. This affected five Residents (#15, #19, #24, #25 and #41) out of five residents reviewed for environment. The facility census was 61.Findings include:1. Observation on 12/29/25 at 10:00 A.M. with Maintenance Director (MD) #210 of Residents #24 and #25's room revealed packaging tape wrapped around the window curtains over the window. A strong draft of cold air was felt leaking around the closed curtains. The bathroom had stained and dirty flooring as well as a black substance around the faucet fixtures. The bathroom door had a large piece of wood missing and the door edges were uneven and rough having potential for splintering. The air pressure alarm for Resident #25's mattress was alarming. Interview at the time of the observation with Residents #24 and #25 and MD #210 revealed the residents complained to MD #210 regarding the draft of cold air leaking from the window. MD #210 provided Resident #25 with wide packaging tape to seal the window over the curtains due to the resident's bed location being next to the window. MD #210 stated he would fix the window, however; the residents complained it had been over a month. Resident #24 stated she had asked MD #210 to either fix the low-pressure alarm or provide a new mattress because the alarm would sound whether in or out of the bed. Interview with Regional Maintenance Director (RMD) #211 on 12/29/25 at 10:30 A.M. verified the heavy draft from Resident #24's and #25's window and stated he would remove the tape and seal the window. RMD #211 stated it was unacceptable to just place tape over the drapes to seal it. RMD #211 also verified the bathroom floor being stained and dirty and stated the floor should be replaced. RMD #211 confirmed the black substance around the faucets and damage to the inside of the bathroom door. RMD #211 stated he would refer the cleaning to housekeeping and fix the bathroom door. RMD #211 also confirmed the air mattress alarming and stated it may be a leak in one of the valves. He would check the mattress and if unable to repair it would order a new one. 2. Observation on 12/29/25 at 10:11 A.M. of Resident #41's room revealed two deep wall gashes from mid wall down to the floor with wall debris on floor behind the bed. Interview at the time of the observation with Resident #41 revealed the wall had been that way for a couple of months and that staff were aware. Observation on 12/29/25 at 10:20 A.M. of Resident #41's wall behind the bed with Licensed Practical Nurse (LPN) #234 verified the observed findings. Interview at the time of the observation with LPN #234 revealed the damage to the wall from the resident's bed had been fixed before by maintenance. LPN #41 stated the current state of the wall had been that way for about one month and stated she would inform maintenance. 3. Observation on 12/29/25 at 10:24 A.M. of Resident #19's room revealed the bathroom floor was stained and dirty. There was a heavy leak of air from the window which had a pillow placed over it to defer the draft. The resident's bed was located next to window, and the bathroom was notably stained with blackened areas. The mirror and sink in the bathroom were dirty with dirt built up around the faucets. Interview at the time of the observation with Resident #19 and RMD #211 revealed Resident #19 complained that the window had been leaking cold air and although maintenance and administration were notified one month ago, nothing had been done. RMD #211 verified the large cold air draft coming from Resident #19's window as well as the stained bathroom floor and unclean sink and mirror area. RMD #211 also confirmed there was a pillow placed in the window to defer the cold air draft coming in and stated he would also seal the window. RMD #211 also stated the flooring in the bathroom should (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be replaced and was stained from prior cleaning products, and there was a plan to replace the bathroom floors in the future. 4. Observation on 12/29/25 at 11:23 A.M. of Resident #15 revealed the resident in bed covered with three blankets. Interview at the time of the observation with Resident #15 revealed he wanted the air conditioner (AC) unit out of the window because it was causing his room to be cold. Resident #15 complained he had asked staff to remove the AC unit for the last two months when it had started to get cold outside. Review of Resident 15's medical record revealed a therapy note dated 12/18/25 at 9:46 A.M. in which a case manager met with Resident #15 in his room and was observed lying in bed covered with multiple blankets. Resident #15 reported feeling cold due to an AC unit remaining installed in the window. Interview on 12/29/25 at 11:28 A.M. with RMD #211 verified Resident #15's AC unit was still installed in the resident's window. RMD #211 stated the AC units were typically removed in September and should have been removed a long time ago. Review of the facility policy labeled Quality of Life-Homelike Environment, undated revealed the facility staff and management maximized to the extent possible the characteristics of the facility that reflect a personalized, homelike setting, which included a clean, sanitary and orderly environment with comfortable and safe temperatures. Review of the facility policy labeled Homelike Environment, revised February 2021, revealed residents were provided a safe, clean, comfortable, sanitary and homelike environment.