

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/17/2024
NAME OF PROVIDER OR SUPPLIER  Lake Pointe Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3364 Kolbe Rd Lorain, OH 44053	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31638</p> <p>THIS DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THE ON-SITE INVESTIGATION.</p> <p>Based on observation, medical record review, staff interviews, review of a police report, review of a facility investigation, review of written statements, and review of facility corrective action documents, the facility failed to provide adequate supervision to prevent Resident #50, who had moderately impaired cognition, a diagnosis of vascular dementia with behavioral disturbances, and a previous incident of attempting to exit the facility, from leaving the facility unsupervised. This resulted in Immediate Jeopardy on 07/14/24 between approximately 3:00 P.M. and 5:44 P.M. when Resident #50 was able to presumably enter a locked elevator on the second floor with a group of community members and exit the locked front entrance with the group without staff knowledge and exit the facility unsupervised. The potential for serious life-threatening harm and/or injury occurred when the resident was missing for up to two hours and 45 minutes, ultimately being found by law enforcement at a local high school approximately three miles from the facility. This affected one (#50) of three residents reviewed for accident hazards/elopement. The facility identified four additional residents (#18, #63, #66, and #67) who were assessed at risk for elopement. The facility census was 91.</p> <p>On 09/05/24 at 10:06 A.M., the Administrator, the Director of Nursing (DON), and Corporate Clinical Support Nurse (CCSN) #600 were notified Immediate Jeopardy began on 07/14/24 at approximately 3:00 P.M. when staff last observed Resident #50 in the facility. Between 3:00 P.M. and 5:44 P.M., the resident was able to exit the facility unsupervised, after entering a locked elevator on the second floor with a group of community members visiting the facility, taking the elevator to the first floor, and exiting the facility with the group through the locked front entrance. Facility staff were unaware Resident #50 was missing until approximately 3:00 P.M. when the facility initiated an elopement protocol, and the resident was found by law enforcement at approximately 5:15 P.M. at a local high school located three miles from the facility and near heavily traveled roads with speeds up to 50 miles per hour. The resident was returned to the facility on [DATE] at 5:44 P.M. and assessed with no injuries or change in condition.</p> <p>The Immediate Jeopardy was removed and corrected on 07/15/24 when the facility implemented the following corrective actions:</p> <p>(continued on next page)</p>

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/14/24 at approximately 3:00 P.M., Resident #50 was not able to be located in the facility and an elopement protocol was initiated by Licensed Practical Nurse (LPN) #130. All other facility residents were accounted for during a head count completed at 3:02 P.M. Local law enforcement was notified to assist in the search for the resident who ultimately located Resident #50 at a local high school at 5:15 P.M. approximately three miles from the facility. Interview with Resident #50 revealed a female let him out of the front door and stated he did not know where he was going.</p> <p>On 07/14/24, the Administrator and Physician #700 were notified of Resident #50's elopement from the facility.</p> <p>On 07/14/24 at 5:44 P.M., Resident #50 was returned to the facility and at 5:45 P.M. was assessed by LPN #130 with no injuries or change in condition.</p> <p>On 07/14/24 at approximately 5:45 P.M., Resident #50 was placed on one-on-one direct care of staff pending an investigation. Resident #50 remained on one-on-one care with staff until discharge from the facility on 07/25/24.</p> <p>On 07/14/24, Resident #50 was re-assessed for elopement and unsafe wandering risk by LPN #130 and was placed at risk for elopement. Resident #50's care plan was updated on 07/14/24 to include the resident's elopement risk.</p> <p>On 07/14/24 at 5:45 P.M., the DON began education with all staff members regarding the facility's elopement management policy. All staff members completed education by the DON on 07/15/24 at 11:00 A.M.</p> <p>On 07/14/24 at 6:06 P.M., LPN #130 notified Resident #50's responsible party to provide information regarding the resident's elopement from the facility.</p> <p>On 07/14/24 at 7:00 P.M., Registered Nurse (RN) #210 obtained statements from staff working at the time Resident #50 eloped from the facility.</p> <p>On 07/14/24 at 8:00 P.M., wandering observation tools were completed on all residents by LPN #100, LPN #130, and RN #210, and overseen by the DON, to identify any other residents at risk for elopement. All facility elopement books were reviewed to ensure accuracy and all resident care plans were reviewed and revised as necessary to ensure all interventions were current and in place.</p> <p>On 07/15/24 at 9:10 A.M., Unit Manager LPN #150 completed an elopement drill with no concerns identified.</p> <p>On 07/17/24, 07/24/24, 07/30/24, and 08/07/24, Assistant Director of Nursing (ADON) #535, in collaboration with the DON, completed elopement drills with all staff following protocols and no concerns noted. Results of the elopement drills were reviewed in Quality Assurance and Performance Improvement (QAPI) meetings.</p> <p>The facility QAPI committee held meetings on 07/31/24 and 08/29/24, with Physician #700 in attendance, to discuss results of the elopement drills with no further concerns.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of two (#13 and #18) additional resident medical records reviewed for elopement risk revealed no concerns.</p> <p>Review of the facility incident log between 06/20/24 to current revealed the facility had no other residents elope from the facility since Resident #50's elopement on 07/14/24.</p> <p>Observation on 09/05/24 at 12:05 P.M., revealed the locking mechanism to enter the elevator on the second floor was working appropriately.</p> <p>Observation on 09/05/24 between 12:10 P.M. and 12:15 P.M. with Receptionist #500 verified the locking mechanisms on the first-floor front exit door and elevator were working appropriately.</p> <p>Interviews on 09/09/24 between 9:13 A.M. and 2:10 P.M. with Receptionist #500, LPN #100, LPN 120, State tested Nurse Aide (STNA) #320, and STNA #370 revealed all staff were knowledgeable of the facility elopement policy and verified they were educated on the facility's elopement policy and protocol including what to do when a resident was missing.</p> <p>Findings included:</p> <p>Review of Resident #50's medical record revealed an admitted [DATE]. Diagnoses included vascular dementia with behavioral disturbances, cerebral infarction, and homelessness.</p> <p>Review of Resident #50's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with moderately impaired cognitive function and was independent with ambulating and all activities of daily living (ADLs). The resident did not require an assistive device for walking.</p> <p>Review of Resident #50's Nursing Assessment Evaluation dated 07/11/24 revealed the resident was admitted to the facility on [DATE] at 9:00 A.M. for a change in mental status. The resident was assessed as alert and oriented to three spheres (person, place, and time) with no exit-seeking behaviors or wandering since admission, and it was unknown if the resident had a history of exit-seeking. Resident #50 required no assistance with transfers and the resident was assessed as not at risk for elopement.</p> <p>Review of Resident #50's care plan dated 07/12/24 revealed the resident was independent for ADLs and ambulation.</p> <p>Review of Resident #50's nursing progress note dated 07/13/24 at 11:22 A.M. revealed the resident exhibited agitation and attempted to leave the facility. The staff were unable to redirect the resident, so a one-time dose of an antipsychotic medication (Seroquel) was ordered to calm him. A urinalysis and blood work were also ordered by the physician.</p> <p>Further review of Resident #50's care plan and physician orders revealed no immediate interventions were put in place to address Resident #50's exit-seeking behaviors. Additionally, there was no documentation of a repeat assessment completed to determine the resident's elopement risk related to the incident on 07/13/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #50's nursing progress note dated 07/14/24 revealed the resident was unable to be located for medication administration and was not found in the immediate area. An elopement alert was initiated, and contacts were notified including the medical director and local police department. Resident #50 was found by the police and returned to the facility at 5:45 P.M. A head-to-toe assessment of the resident found no acute changes or injuries. The resident was immediately placed on one-to-one observation and all parties were notified of Resident #50's return to the facility.</p> <p>Review of a police incident report dated 07/14/24 at 5:15:37 P.M. revealed an incident was initiated for a suspicious condition related to Resident #50. Further review revealed an entry was created on 07/14/24 at 5:43:30 P.M. that an officer was flagged down by an unnamed male at 5:15 P.M. On 07/14/24 at 5:44:15 P.M. , the officer took Resident #50 back to the facility and the resident was released to the staff.</p> <p>Review of the facility incident report dated 07/14/24 revealed Resident #50 was last seen in the common area at 3:00 P.M. and the resident was wearing a black colored t-shirt and jeans. The weather was warm and cloudy. Resident #50 was interviewed on 07/14/24 at 6:08 P.M. and he indicated a lady let him out of the front door and he walked through to the outside. Resident #50 indicated he did not know where he was going. Resident #50 was last seen on 07/14/24 at 3:00 P.M. downstairs by the front door and was noted as missing at 5:00 P.M. when he could not be located for medication administration. The elopement process was initiated, with the resident located and returned to the facility without injuries or pain. The resident was placed on one-to-one observation pending results of the investigation and alternate placement.</p> <p>Review of a written statement dated 07/14/24 by LPN #130 revealed Resident #50 was last observed by her on 07/14/24 at 3:00 P.M. and was wearing a black shirt and jeans. There was an elopement search initiated, no leave of absence (LOA) for Resident #50 was found, and contacts were made regarding Resident #50's whereabouts. Further review of the written statement revealed Resident #50 returned to the facility on [DATE] at 5:45 P.M. with a head-to-toe assessment completed with no pain or discomfort voiced by the resident. The written statement also noted the temperature was 80 degrees Fahrenheit (F) and it was cloudy and humid.</p> <p>Interview with the DON on 09/04/24 at 8:11 A.M. revealed Resident #50 attempted to elope the facility on 07/13/24 and a one-time dose of an antipsychotic medication was administered per physician orders. The DON stated the medication helped to calm the resident. On 07/14/24, Resident #50 had on street clothes, got on the elevator, and walked out of the facility with a large group of visitors. At approximately 3:00 P.M., the resident was unable to be located for medication administration and an elopement alert was initiated. The resident was found by the local police department at the local high school and returned to the facility at 5:45 P.M. The DON stated Resident #50 was assessed with no injuries upon return to the facility. Resident #50 was immediately put on one-on-one care and remained under on-on-one care until he was discharged to a memory care facility on 07/25/24.</p> <p>Interview with Receptionist #500 on 09/04/24 at 9:13 A.M. revealed she was working on 07/14/24 and felt Resident #50 left with a large church group. Receptionist #500 verified that staff must put in a code to get down the elevator from the second floor where Resident #50 resided, and an additional code had to be put in to exit the front doors. Receptionist #50 verified she never saw Resident #50 in the group of visitors that left on 07/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation of the facility environment on 09/05/24 between 12:00 P.M. and 12:15 P.M. revealed all residents in the facility resided on the second floor and the elevator and stairway both were locked and required a code to exit the unit. Further observation revealed, once downstairs, the front doors were locked, and a coded keypad was available, or the receptionist had a lock release button at the desk to open the doors. Observation of all keypads revealed all locking and releasing mechanisms were in good working order.</p> <p>Observation of the exterior environment on 09/05/25 between 12:15 P.M. and 12:35 P.M. revealed the facility was located along a heavily traveled four-lane road with maximum speed limits of 50 miles per hour. There was a Great Lake ([NAME]) located just north of the facility approximately one-quarter of a mile walking distance from the facility. Further observation of the exterior environment revealed the driving distance from the facility to the local high school where Resident #50 was located on 07/14/24 was three miles.</p> <p>Review of a website for historical weather conditions at, <a href="https://www.wunderground.com/history/daily/us/oh/Lorain/KCLE/date/2024-7-14">https://www.wunderground.com/history/daily/us/oh/Lorain/KCLE/date/2024-7-14</a> revealed the outside temperature was 86 degrees F on 07/14/24 at 2:51 P.M., reached a high of 88 degrees F at 4:51 P.M., and returned to 86 degrees F at 5:51 P.M. The humidity level ranges between 53 percent (%) and 58% and it was cloudy to mostly cloud during that timeframe.</p> <p>Review of the undated facility policy titled, Elopement Management, revealed failure to provide adequate supervision for cognitively impaired residents who leave the facility or safe area and are unaccounted for was considered elopement. Following location of the involved resident the facility leadership will review preventions systems to identify performance opportunities.</p> <p>This deficiency represents an incidental finding discovered during investigation of Master Complaint OH00157563, Complaint Number OH00156113, and Complaint Number OH00156104.</p>		