STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365623	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Pointe Health Care	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)
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** 43061 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff followed the smoking policy and ensured safe resident smoking practices. This affected one (Resident #22) of one resident reviewed for smoking. The facility census was 91 residents. Findings include: Review of the medical record for Resident #22 revealed a readmitted [DATE] with diagnoses including chronic respiratory failure, aphasia, type 2 diabetes mellitus (DM), multiple subsegmental thrombotic pulmonary emboli, heart failure, and history of transient ischemic attack (TIA). Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 07/15/24 revealed the resident had intact cognition. Review of the care plan for Resident #22 dated 07/15/24 revealed the resident had a history of utilizing nicotine. Interventions included if resident utilized nicotine products to complete smoking evaluation, provide safe smoking devices if required, and educate resident and resident representative to designated smoking areas and long-term side effects of extended nicotine use Review of the smoking assessment for Resident #22 dated 10/02/24 completed by the Director of Nursing (DON) revealed the resident used a nicotine patch. Review of the physician's orders for Resident #22 dated January 2025 revealed there were no orders for smoking. Review of the smoking assessment for Resident #22 dated 01/23/25 timed at 9:56 A.M. per the DON revealed the resident required supervision for smoking and was unable to light his own cigarette. Observation on 01/23/25 at 9:47 A.M. of Resident #22's room revealed there was a pack of cigarettes and a lighter on the resident's overbed tray. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 9:48 A.M. with Registered Nurse (RN) #231 confirmed there was a pack of cigarettes and a lighter on Resident #22's overbed tray. RN #231 confirmed residents were not permitted to keep smoking supplies in their room. RN #231 reported all smoking supplies were to be kept in a locked and secured place. Interview on 01/23/25 at 9:53 A.M. with the DON confirmed residents were not permitted to have smoking supplies, to include cigarettes and lighter in their rooms. The DON verified smoking supplies were to be kept in secured locked units per the facility smoking policy. Review of facility policy titled Resident Smoking Guidelines undated, revealed the facility would promote resident centered care by providing a safe smoking area for residents. Residents would be assessed by an interdisciplinary team (IDT). Staff would store smoking materials in a secured area when not in use by the residents for both independent and supervised smokers.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to maintain acceptable infection control practices during medication administration to prevent the spread of infection. This affected one resident (Resident #46) of three residents reviewed for medications. The facility census was 91 residents. Findings include: Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including peripheral vascular disease and malignant neoplasm of stomach. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #46 dated 12/28/24 revealed the resident had intact cognition. Review of the physician's orders for Resident #46 dated January 2025 revealed an order for Gabapentin 100 milligram (mg) capsule by mouth. Observation of medication administration for Resident #46 on 01/23/25 at 8:55 A.M. per Licensed Practical Nurse (LPN) revealed the nurse removed the resident's Gabapentin capsule from the packaging and dropped the capsule on the medication cart. LPN #254 picked the capsule up off the medication cart and placed it in a medicine cup. LPN #254 opened the capsule and poured the contents in the same medicine cup and mixed with applesauce. LPN #254 took the medication into Resident #46's room and administered the medications to the resident. Interview on 01/23/24 at 9:11 A.M. with LPN #254 confirmed she administered Resident #46's medication after dropping on the medication cart. Interview on 01/23/25 at 9:12 A.M. with the Director of Nursing (DON) confirmed if a nurse dropped medication onto the medication cart, they were to dispose of it and get a new pill. Review of the facility policy titled Medication Administration undated revealed dropped medications would be discarded. This deficiency represents noncompliance investigated under Complaint OH00161498.