

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 04/09/2025
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 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096</p> <p>Based on medical record review, staff interview and review of facility policy, the facility failed to ensure timely provider notification of critical laboratory (lab) values. This affected three (#53, #68, and #86) of four residents reviewed for laboratory services. The facility census was 85.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #86 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), cerebral infraction (stroke), malnutrition, anxiety and depression.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 03/17/25, revealed Resident #86 had intact cognition. The assessment indicated the resident was incontinent of bladder.</p> <p>Review of the care plan, dated 03/17/25, revealed Resident #86 was receiving antibiotic therapy. Interventions included administering antibiotic and observing for side effects and signs and symptoms of infection.</p> <p>Review of the lab service final report dated 03/21/25 at 5:49 P.M. revealed the urine culture resulted positive for Enterococcus faecalis, an organism that causes urinary tract infections (UTI).</p> <p>Review of the physician orders revealed on 03/25/25, an order for penicillin v potassium 500 milligram (mg), administered every eight hours to treat UTI (four days after lab results were receiving indicating the resident had a UTI).</p> <p>Review of the Medication Administration Record (MAR) for March 2025 confirmed penicillin v potassium 500 mg was administered from 03/25/25 through 04/02/25 at ordered.</p> <p>2. Review of the medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included Alzheimer, depression, anxiety, and gout.</p> <p>Review of the MDS assessment, dated 02/23/25, revealed Resident #86 had impaired cognition and was dependent on staff for toileting. The assessment indicated the resident was incontinent of bladder.</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 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan, dated 02/23/25, revealed Resident #86 had an infection related to a UTI. Interventions included administering an antibiotic and observing for side effects and signs and symptoms of infection.</p> <p>Review of the lab service final report, dated 03/14/25, revealed the urine culture resulted positive for Escherichia coli (E coli), an organism that causes UTIs.</p> <p>Review of the physicians orders revealed on 03/18/25, an order for sulfamethoxazole-trimethoprim (antibiotic) 800 mg-500 mg, administered every eight hours to treat a UTI (ordered four days after the lab results indicated the resident had a UTI).</p> <p>Review of the MAR for March 2025 confirmed sulfamethoxazole-trimethoprim 800 mg-100 mg was administered from 03/18/25 through 03/25/25 as ordered.</p> <p>3. Review of the medical record for Resident #68 revealed an admitted [DATE]. Diagnoses included acute kidney failure, paraplegia, Cushing's syndrome, cerebral infarction, stroke, and retention of urine.</p> <p>Review of the MDS assessment, dated 02/10/25, revealed Resident #68 had intact cognition and was dependent on staff for toileting. The assessment indicated the resident was incontinent of bladder.</p> <p>Review of the after-visit emergency room (ER) summary, dated 03/11/25, revealed Resident #68 had labs completed, which included urinalysis with reflex to culture (confirms the presence of a UTI).</p> <p>Review of the physicians orders revealed on 03/18/25, an order to administer sulfamethoxazole-trimethoprim 800 mg-100 mg every 12 hours for a UTI for seven days.</p> <p>Review of the MAR for March 2025 confirmed sulfamethoxazole-trimethoprim 800 mg-100 mg was administered from 03/18/25 through 03/24/25 (ordered seven days after labs indicated the resident had a UTI).</p> <p>Interview on 04/09/25 at 11:00 A.M. with the Director of Nursing (DON) verified there was a lapse in time from when the urine cultures were resulted to when the physician ordered antibiotics to treat UTIs for Resident #86, Resident #53, and Resident #68. The DON confirmed Resident #86 and Resident #53's urinalysis results were received on a Friday and were not addressed until the next week. The DON stated the facility had physicians on-call during the weekend to address lab results. The DON stated Resident #68's labs were completed when she went out to the ER and confirmed the facility did not follow-up until the concern was brought to their attention, at which time the Nurse Practitioner (NP) looked up the lab report and ordered the antibiotic to treat Resident #68's UTI.</p> <p>Review of the facility policy titled, Laboratory and Radiological Services Result Reporting, undated, revealed that there are clinical and physiological risk when laboratory, radiology, or other diagnostic services are not performed in a timely manner or the results of these services are not reported and acted upon quickly. Delays may adversely affect a resident's diagnosis, treatment assessment and intervention. Nurses will have a sense of urgency for reporting critical labs and radiological findings to the ordering prescriber and document reporting of such items in the progress notes.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH0016377.</p>		