STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365865	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Care Center	500 Community Drive Avon Lake, OH 44012

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on medical record review, interview, and facility policy review, the facility failed to report an incident of possible neglect involving Resident #195 to the State Agency as required. This affected one (Resident #195) of three residents reviewed for elopement. The facility census was 101. Findings include: Review of the medical record for Resident #195 revealed an admitted [DATE]. Diagnoses included but were not limited to cerebrovascular disease, palliative care, vascular dementia, insomnia, dementia, type II diabetes mellitus with chronic kidney disease, and anxiety disorder. Review of 12/13/24 admission Minimum Data Set (MDS) 3.0 for Resident #195 revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment with no behaviors noted. Review of activities of daily living (ADLs) revealed Resident #195 used a walker and wheelchair and was noted to walk 50 feet with partial moderate assistance and was independent to wheel his wheelchair 150 feet independently. Review of the facility incident tracking log for December 2024 revealed on 12/24/24 at 8:45 P.M. Resident #195 was noted to have an unwitnessed fall with the location noted as other with no noted injuries and the origin established. Review of witness statement dated 12/24/24 at 8:50 P.M. from CNA #59 revealed he had last seen Resident #195 at 8:35 P.M. in the dining room and then went on break. CNA #59 stated when he came back from break, CNA # 56 told him Resident #195 had fallen through the window in an unoccupied room, was observed outside, and was brought back inside the building safely. Review of the witness statement dated 12/24/24 timed at 8:50 P.M. from CNA #56 revealed she had last seen Resident #195 around 8:30 P.M. in the dining room. She was assisting Licensed Practical Nurse (LPN) #58 and then started walking down the 500 hall and Resident #199 stated a man was outside her window yelling for help. CNA #56 went to Resident #199's room and observed Resident #195 laying on the grass outside of Resident #199's window. CNA #56 ran to get LPN #58 and called for help from CNA #57, and they went outside. CNA #56 stated Resident #195 was confused and stated he got tangled in the window screen and pushed through it. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER: Main Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 500 Community Drive Avon Lake, OH 44012	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note for Resident #195 created on 12/25/24 at 6:37 A.M. dated 12/24/24 timed at 8:50 P.M. entered by the Director of Nursing (DON) revealed Resident was noted on the ground/floor attempting to crawl outside through window. Able to redirect resident. Assessed for injuries, not noted. Unable to state what he was doing due to the resident had a dementia diagnosis. Resident moved to secure unit and wander guard placed. Interview on 01/06/25 at 7:57 A.M. with Resident #199 confirmed she was unsure of the date, but after dinner she heard someone yelling for help outside of her window and heard something hit the window but was unsure what caused the noise. Resident #199 told the aide who was in the hall but was unsure of her name. Interview on 01/06/25 at 10:31 A.M. with the ADON revealed she received a text on 12/25/24 at 3:24 A.M. from LPN #58 stating Resident #195 had exited through a facility window, fell , and was found outside lying on the grass. The ADON confirmed Resident #195 was found outside and stated to initiate 15-minute checks. The ADON stated she would notify administration and obtain further instructions. The ADON notified the Director of Nursing (DON) on 12/25/24 at 3:34 A.M. and received a return call at 3:36 A.M. from the DON who stated she would contact the covering Administrator. Phone interview on 01/06/25 at 11:10 A.M. with Certified Nurse Assistant (CNA) #56 revealed she last saw Resident #195 around 8:00 P.M. in the dining room. Shortly before 9:00 P.M. she was walking in the hall and Resident #199 told her she heard someone yelling outside her window. CNA #56 went to Resident #199's room and upon lifting the blinds so Resident #195 lying on the grass outside the window. CNA #56 immediately went to get Licensed Practical Nurse (LPN) #58. LPN #58, CNA#56 and CNA #57 went outside to assist Resident #195. CNA #56 stated Resident #195 did not complain of pain and no injuries were observed. Phone interview on 01/06/25 at 11:45 A.M. with LPN #58 revealed he had last seen Resident #195 around 7:00 P.M. Shortly before 9:00 P.M. CNA #56 came to him stating Resident #195 was outside. LPN #58 and CNA #56 went outside and found Resident #195 lying on his left side on the grass outside of Resident #199's window. Resident #195 was assessed without noted injuries. LPN #58 confirmed he should have notified management immediately but did not contact the ADON till after 3:00 A.M. on 12/25/24. Interview on 01/06/25 at 12:55 P.M. with the DON revealed on 12/24/24 at 8:45 P.M. Resident #195 had an unwitnessed fall and was told he was found in an unoccupied room tangled in the window screen found on the floor. DON stated she was never told Resident #195 was found outside of the facility. DON confirmed she reviewed the staff witness statements and confirmed the statement from CNA #59 stated he was told Resident #195 was found outside of the building and brought back in safely. DON confirmed the witness statement completed by CNA #56 stated she observed Resident #195 through the window of the unoccupied room and observed the resident outside of the building lying on the ground. DON confirmed she was notified by the ADON on 12/25/24 at approximately 4:00 A.M. and she made the Administrator on call aware. Resident #195 was moved to the secured unit for safety. DON confirmed LPN #58 did not complete a nursing progress note and did not write a witness statement following the incident and staff were unaware Resident #195 was outside of the facility until Resident #199 told CNA #56. DON confirmed no other witness statements were obtained. DON also confirmed if a resident is found outside it would be considered an elopement. DON stated she did not complete an elopement incident investigation or a self-reported incident report to the State Agency because it was a new behavior and thought it was a change in status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365865	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Care Center	500 Community Drive Avon Lake, OH 44012

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 01/2022 revised facility policy called; Missing Person/Elopement Policy revealed an elopement is identified as an unauthorized exit from the facility involving a resident whose cognitive status and safety awareness are impaired. Once it is established a resident is missing, the following staff members are notified immediately: Charge nurse, Administrator, Director of Nursing and Quality Assurance. In the absence of Nursing Administration, the charge nurse will be responsible for keeping the above-mentioned informed of the progress of the search. When the resident is located and safety is assured, the Nursing Supervisor or Charge Nurse will perform and document a detailed physical, mental and emotional assessment of the resident. All persons listed above will be informed of the resident's status. A detailed investigation as to the circumstances surrounding the elopement will be completed by the Director of Nursing, Administrator, or designee following each incidence of resident elopement from the facility premises. Staff education will be provided during the orientation process, annually and on an as needed basis. Education will include a missing person drill on each shift to ensure understanding of the missing person/elopement policy and procedure. Review of the 02/2022 revised facility protocol called; Reporting of Key Facility Events Protocol revealed it the facility protocol that the on-call nurse will be notified immediately if an elopement event occurs. The on-call nurse will be responsible to notify the facility Administrator and/or Director of Nursing. It is the protocol that the DON or Administrator will notify the corporate team timely. The policy listed an elopement to incide any exit outside of the skilled nursing facility door, even if only for a moment. This deficiency represents non-compliance investigated under Complaint Number OH00161157.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Main Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Community Drive Avon Lake, OH 44012	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on medical record review, interviews, facility incident report review, the facility failed to maintain an accurate medical record. This affected one (Resident #195) of three residents reviewed for accuracy of medical records. The facility census was 101. Findings include: Review of the medical record for Resident #195 revealed an admitted [DATE]. Diagnoses included but were not limited to cerebrovascular disease, palliative care, vascular dementia, insomnia, dementia, type II diabetes mellitus with chronic kidney disease, and anxiety disorder. Review of 12/13/24 admission Minimum Data Set (MDS) 3.0 for Resident #195 revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment with no behaviors noted. Review of activities of daily living (ADLs) revealed Resident #195 used a walker and wheelchair and was noted to walk 50 feet with partial moderate assistance and was independent to wheel his wheelchair 150 feet independently. Review of the facility incident tracking log for December 2024 revealed on 12/24/24 at 8:45 P.M. Resident #195 was noted to have an unwitnessed fall with the location noted as other with no noted injuries and the origin established. Review of the 12/24/24 fall assessment timed at 4:18 A.M. completed by the Assistant Director of Nursing (ADON) for Resident #195 revealed he was high risk for falls. Review of the 12/24/24 safety assessment timed at 4:20 A.M. completed by the ADON for Resident #195 revealed the resident had an unwitnessed fall on 12/24/24 at 12:00 A.M. No injuries were noted. Intervention was to place Resident #195 on the secured unit. Review of the nursing progress note for Resident #195 created on 12/25/24 at 6:37 A.M. dated 12/24/24 timed at 8:50 P.M. entered by the Director of Nursing (DON) revealed Resident was noted on the ground/floor attempting to crawl outside through window. Able to redirect resident. Assessed for injuries, not noted. Unable to state what he was doing due to the resident had a dementia diagnosis. Resident moved to secure unit and wander guard placed. Review of witness statement dated 12/24/24 at 8:50 P.M. from CNA #59 revealed he had last seen Resident #195 at 8:35 P.M. in the dining room and then went on break. CNA #59 stated when he came back from break shortly after 9:00 P.M., CNA # 56 told him Resident #195 had fallen through the window in room [ROOM NUMBER] and was brought back inside the building safely. Review of the witness statement dated 12/24/24 timed at 8:50 P.M. from CNA #56 revealed she had last seen Resident #195 around 8:30 P.M. in the dining room. She was walking down the 500 hall and Resident #199 stated a man was outside her window yelling for help. CNA #56 went to Resident #199's room and observed Resident #195 laying on the grass outside of Resident #199's window. CNA #56 ran to get LPN #58 and called for help from CNA #57, and they went outside. CNA #56 stated Resident #195 was confused and stated he got tangled in the window screen and pushed through it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Main Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Community Drive Avon Lake, OH 44012	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/06/25 at 7:57 A.M. with Resident #199 confirmed she was unsure of the date, but after dinner she heard someone yelling for help outside of her window and heard something hit the window but was unsure what caused the noise. Resident #199 told the aide who was in the hall but was unsure of her name. Interview on 01/06/25 at 10:31 A.M. with the ADON revealed she received a text on 12/25/24 at 3:24 A.M. from LPN #58 stating Resident #195 had exited through a facility window, fell and was found outside lying on the grass. ADON confirmed Resident #195 was found outside and stated to initiate 15-minute checks. ADON stated she would notify administration and obtain further instructions. ADON notified the Director of Nursing (DON) on 12/25/24 at 3:34 A.M. of the elopement and received a return call at 3:36 A.M. from the DON who stated she would contact the covering Administrator. Phone interview on 01/06/25 at 11:10 A.M. with Certified Nurse Assistant (CNA) #56 revealed she last saw Resident #195 around 8:00 P.M. in the dining room. Shortly before 9:00 P.M. she was walking in the hall and Resident #199 told her she heard someone yelling outside her window. CNA #56 went to Resident #199's room and upon lifting the blinds so Resident #195 lying on the grass outside the window. CNA #56 immediately went to get Licensed Practical Nurse (LPN) #58. LPN #58, CNA#56 and CNA #57 went outside to assist Resident #195. CNA #56 stated Resident #195 did not complain of pain and no injuries were observed. Phone interview on 01/06/25 at 11:30 A.M. with CNA #57 confirmed he received a call from CNA #56 for assistance around 9:00 P.M. on 12/24/24. He observed Resident #195 lying on the ground outside of the facility. CNA #57 went to get Resident #195's wheelchair and then assisted LPN #58, and CNA #56 to get Resident #195 up and back into the facility. Phone interview on 01/06/25 at 11:45 A.M. with LPN #58 revealed he had last seen Resident #195 around 7:00 P.M. Shortly before 9:00 P.M. CNA #56 came to him stating Resident #195 was outside. LPN #58 and CNA #56 went outside and found Resident #195 lying on his left side on the grass outside of Resident #199's window. Resident #195 was assessed without noted injuries. LPN #58 confirmed he should have notified management immediately but did not contact the ADON till after 2:00 A.M. on 12/25/24. Interview on 01/06/25 at 12:55 P.M. with the DON revealed on 12/24/24 at 8:45 P.M. Resident #195 had an unwitnessed fall and she was told he was found in room [ROOM NUMBER] tangled in the window screen found on the floor. DON stated she was never told Resident #195 was found outside of the facility. DON confirmed she reviewed the staff witness statements and confirmed the statement from CNA #59 stated he was told Resident #195 was found outside of the building and brought back in safely. DON confirmed the witness statement completed by CNA #56 stated she observed Resident #195 through the window of Resident #199's room outside of the building lying on the ground. DON confirmed she was notified by the ADON on 12/25/24 at approximately 4:00 A.M. and she made the administrator on call aware. DON also confirmed if a resident is found outside it would be considered an elopement. DON stated she did not complete an elopement incident investigation or a self-reported incident report to the State Agency because it was a new behavior and thought it was a change in status. Interview on 01/06/24 at 1:31 P.M. with the ADON confirmed she erroneously entered the fall risk and safety assessment on 12/24/24 at 4:18 A.M. and 4:20 A.M. and both assessments were completed on 12/25/24 at the respective times listed. This deficiency represents non-compliance investigated under Complaint Number OH00161157.

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NAME OF PROVIDER OR SUPPLIER Main Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Community Drive Avon Lake, OH 44012	

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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	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** 45442 Based on medical record review, interviews, facility incident report review, and facility policy review, the facility failed to provide adequate supervision to prevent the elopement of one resident (Resident #195) out of three residents reviewed for elopements. The facility census was 101. Findings include: Review of the medical record for Resident #195 revealed an admitted [DATE]. Diagnoses included but were not limited to cerebrovascular disease, palliative care, vascular dementia, insomnia, dementia, type II diabetes mellitus with chronic kidney disease, and anxiety disorder. Review of the 12/06/24 admission fall assessment for Resident #195 revealed he was alert and oriented to time and place, required adaptive equipment, had dementia, and had noted unsteady gait. Intervention was a reminder sign to ask for assistance when ambulating or transferring. Review of the 12/06/24 elopement risk assessment for Resident #195 revealed a diagnosis of dementia and no noted attempts to exit facility. Resident #195 was noted to be mobile in a wheelchair and was not noted to be at risk for elopement. Review of the plan of care dated 12/07/24 revealed no indication Resident #195 was at risk for elopement/wandering. Resident #195 was noted to have knowledge deficit and require assistance with decision making as needed. Review of 12/13/24 admission Minimum Data Set (MDS) 3.0 for Resident #195 revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment with no behaviors noted. Review of activities of daily living (ADLs) revealed Resident #195 used a walker and wheelchair and was noted to walk 50 feet with partial moderate assistance and was independent to wheel his wheelchair 150 feet independently. Review of the 12/24/24 fall assessment timed at 4:18 A.M. completed by the Assistant Director of Nursing (ADON) for Resident #195 revealed he was high risk for falls. Review of the 12/24/24 safety assessment timed at 4:20 A.M. completed by the ADON for Resident #195 revealed the resident had an unwitnessed fall on 12/24/24 at 12:00 A.M. No injuries were noted. Intervention was to place Resident #195 on the secured unit. Review of the facility incident tracking log for December 2024 revealed on 12/24/24 at 8:45 P.M. Resident #195 was noted to have an unwitnessed fall with the location noted as other with no noted injuries and the origin established. (continued on next page)

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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	Review of the witness statement dated 12/24/24 at 8:50 P.M. from Certified Nursing Assistant (CNA) #59 revealed he had last seen Resident #195 at 8:35 P.M. in the dining room and then went on break. CNA #59 stated when he came back from break, CNA # 56 told him Resident #195 had fallen through the window in an unoccupied room, was observed outside, and was brought back inside the building safely. Review of the witness statement dated 12/24/24 timed at 8:50 P.M. from CNA #56 revealed she had last seen Resident #195 around 8:30 P.M. in the dining room. She was assisting Licensed Practical Nurse (LPN) #58 and then started walking down the 500 hall and Resident #199 stated a man was outside her window yelling for help. CNA #56 went to Resident #199's room and observed Resident #195 laying on the grass outside of Resident #199's window. CNA #56 ran to get LPN #58 and called for help from CNA #57, and they went outside. CNA #56 stated Resident #195 was confused and stated he got tangled in the window screen and pushed through it. Review of the nursing progress note for Resident #195 created on 12/25/24 at 6:37 A.M. dated 12/24/24 timed at 8:50 P.M. entered by the Director of Nursing (DON) revealed Resident was noted on the ground/floor attempting to crawl outside through window. Able to redirect resident. Assessed for injuries, not noted. Unable to state what he was doing due to the resident had a dementia diagnosis. Resident moved to secure unit and wander guard placed. Interview on 01/06/25 at 7:57 A.M. with Resident #199 confirmed she was unsure of the date, but after dinner she heard someone yelling for help outside of her window and heard something hit the window but was unsure what caused the noise. Resident #199 told the aide who was in the hall but was unsure of her name. Interview on 01/06/25 at 10:09 A.M. with Resident #195 was attempted but did not recall any fall or being outside of the facility. Interview on 01/06/25 at 10:31 A.M. with the ADON revealed she received a text on 12/25/24 at 3:24 A.M. from LPN #58 stating Resident #195 had exited through a facility window, fell , and was found outside lying on the grass. The ADON confirmed Resident #195 was found outside and stated to initiate 15-minute checks. The ADON stated she would notify administration and obtain further instructions. The ADON notified the DON on 12/25/24 at 3:34 A.M. and received a return call at 3:36 A.M. from the DON who stated she would contact the covering Administrator. Phone interview on 01/06/25 at 11:10 A.M. with CNA #56 revealed she last saw Resident #195 around 8:00 P.M. in the dining room. Shortly before 9:00 P.M. she was walking in the hall and Resident #199 told her she heard someone yelling outside her window. CNA #56 went to Resident #199's room and upon lifting the blinds so Resident #195 lying on the grass outside the window. CNA #56 immediately went to get LPN #58. LPN #58, CNA #56 and CNA #57 went outside to assist Resident #195. CNA #56 stated Resident #195 did not complain of pain and no injuries were observed. Resident #195 was safely returned into the building. Phone interview on 01/06/25 at 11:30 A.M. with CNA #57 confirmed he received a call from CNA #56 for assistance around 9:00 P.M. on 12/24/24. He observed Resident #195 lying on the ground outside of the facility. CNA #57 went to get Resident #195's wheelchair and then assisted LPN #58, and CNA #56 to get Resident #195 up and back into the facility. (continued on next page)

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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	Phone interview on 01/06/25 at 11:45 A.M. with LPN #58 revealed he had last seen Resident #195 around 7:00 P.M. Shortly before 9:00 P.M. CNA #56 came to him stating Resident #195 was outside. LPN #58 and CNA #56 went outside and found Resident #195 lying on his left side on the grass outside of Resident #199's window. Resident #195 was assessed without noted injuries. LPN #58 confirmed he should have notified management immediately but did not contact the ADON till after 3:00 A.M. on 12/25/24. Interview on 01/06/25 at 12:55 P.M. with the DON revealed on 12/24/24 at 8:45 P.M. Resident #195 had an unwitnessed fall and was told he was found in an unoccupied room tangled in the window screen found on the floor. DON stated she was never told Resident #195 was found outside of the facility. DON confirmed she reviewed the staff witness statements and confirmed the statement from CNA #59 stated he was told Resident #195 was found outside of the building and brought back in safely. DON confirmed the witness statement completed by CNA #56 stated she observed Resident #195 through the window of the unoccupied room and observed the resident outside of the building lying on the ground. DON confirmed she was notified by the ADON on 12/25/24 at approximately 4:00 A.M. and she made the Administrator on call aware. Resident #195 was moved to the secured unit for safety. DON confirmed LPN #58 did not complete a nursing progress note and did not write a witness statement following the incident and staff were unaware Resident #195 was outside of the facility until Resident #199 told CNA #56. DON confirmed no other witness statements were obtained. DON also confirmed if a resident is found outside it would be considered an elopement. DON stated she did not complete an elopement incident investigation or a self-reported incident report because it was a new behavior and thought it was a change in status. Review of the 01/2022 revised facility policy Missing Person/Elopement Policy revealed an elopement is identified as an unauthorized exit from the facility involving a resident whose cognitive status and safety awareness are impaired. This deficiency represents non-compliance investigated under Complaint Number OH00161157.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38523 Based on closed record review, staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #202) of three residents reviewed for medication administration. The facility census was 101. Findings include: Review of the closed medical record for Resident #202 revealed an admitted [DATE] with medical diagnoses including Parkinson's disease, dementia, and adjustment disorder with mixed anxiety and depressed mood. Resident #202 was admitted for a short, few-day respite stay. Review of Resident #202's physician's orders revealed an order dated 12/20/24 was placed for Carbidopa/Levodopa 23.75 milligrams (mg)-95 mg capsule, take one capsule by mouth four times daily for treatment of Parkinson's disease. Review of Resident #202's Medication Administration Record (MAR) for December 2024 revealed on 12/20/24, Resident #202 was administered Carbidopa/Levodopa one capsule at lunch and dinner and hour of sleep (hs). On 12/21/24, Resident #202 was administered Carbidopa/Levodopa 23.75-95 mg one capsule at breakfast, lunch, dinner, and hs. On 12/22/24, Resident #202 was administered Carbidopa/Levodopa 23. 75-95 mg one capsule at breakfast, lunch, dinner, and hs. On 12/24/24, Resident #202 was administered Carbidopa/Levodopa 23.75-95 mg at breakfast. Review of the facility's Medication Error Log for December 2024 revealed a medication error occurred for Resident #202 on 12/23/24. The error was listed as having reaching the resident but had no listed adverse outcome. Review of the Medication Incident Report, dated 12/23/24, revealed Resident #202 was supposed to receive three capsules of Carbidopa/Levodopa 23.75-95 mg, four times a day. Resident #202 only received one capsule with each dose, equaling one-third of the ordered dose. The report indicated Resident #202 required increased monitoring, but the error led to no actual harm. The report listed education and counseling was provided to RN #64. Review of Resident #202's progress notes revealed an order dated 12/23/24 at 7:51 A.M. indicating the resident was found declined from baseline. The provider was alerted and agreeable to send the resident to a local hospital for evaluation. A subsequent note dated 12/23/24 at 11:52 A.M. noted the resident was observed with an altered mental status, talked/communicated less, was drowsy, and had decreased mobility. A third note dated 12/23/24 at 4:18 P.M. revealed a conversation with Resident #202's wife who communicated Resident #202 was admitted to the hospital for observation overnight, and the wife would be taking the resident home from the hospital at discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Care Center	500 Community Drive Avon Lake, OH 44012

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/25 at 9:00 A.M. with the DON and Administrator revealed Resident #202 was admitted to the facility on [DATE] by Registered Nurse (RN) #64. The admission paperwork was reviewed by the DON on Monday morning 12/23/24, and she identified a discrepancy when RN #64 transcribed Resident #202's admission order of Carbidopa/Levodopa 23.75-95 mg. The written admission orders called for Resident #202 to receive Carbidopa/Levodopa 23.75-95 mg, take three capsules by mouth four times a day at 7:00 A.M., 11:00 A.M., 3:00 P.M. and 7:00 P.M. RN #64 transcribed the order into the electronic health record as Carbidopa/Levodopa 23.75-95 mg one capsule to be given by mouth four times a day. The DON confirmed Resident #202 only received one-third of his ordered dose from 12/20/24 to 12/23/24. Interview on 01/13/25 at 2:26 P.M. with RN #64 revealed she was the nurse on duty and admitted Resident #202 on 12/20/24. RN #64 stated she transcribed the resident's medication incorrectly upon admission. She felt terrible when the DON told her she found a medication transcription and subsequent administration error for Resident #202 on 12/20/24, 12/21/24, 12/22/24 and 12/23/24. RN #64 noted a change in Resident #202's mental status on 12/23/24. She notified the provider, family, and sent the resident to the hospital. Resident #202 did not return to the facility. Review of the Medication Administration Policy, dated 03/22 revealed licensed nurses will ensure the six medication rights are followed: right resident, right drug, right dose, right time, right route, and right documentation. Any errors should be reported to the DON, resident physician, and resident/resident representative. Review of the Physician Order Policy dated 07/14 revealed the facility's policy is to follow physicians' orders as directed by the attending physician. Written orders obtained from the physician will be transcribed into the electronic health record for delivery. This deficiency represents non-compliance investigated under Master Complaint Number OH00161334.