| 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 04/24/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Main Street Care Center | 500 Community Drive<br>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.

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative and staff interviews, record review, review of the National Pressure Injury Advisory Panel 2025 guidelines and review of facility policy, the facility failed to evaluate and identify risk factors and define and implement interventions to prevent avoidable pressure injuries. Additionally, the facility failed to initiate treatment timely to the newly identified avoidable pressure injury. Actual Harm occurred on 07/19/25 when Resident #125 developed an avoidable deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.) to her right knee from an immobilizer that was not physician ordered or identified by the facility to be in place. This affected one (Resident #125) of three residents reviewed for wounds. The facility census was 113.Findings include:Review of Resident #125's medical record revealed an admission date of 01/14/25 and a discharge date of 02/20/26. Diagnoses included Alzheimer's Disease with late onset and dementia.Review of the care plan dated 01/15/25 and revised on 07/22/25 revealed Resident #125 had the potential for impairment of skin integrity including a history of deep tissue injury (DTI) to right buttock, history of moisture associated skin damage (MASD) to the buttocks, pressure injuries to the right and left heel, and history of area to the right knee. Goals included skin intervention/preventative measures to be maintained, and Resident #125 would have no avoidable skin breakdown. Interventions included minimizing pressure on bony prominences.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #125 had severe cognitive impairment and utilized a wheelchair. Resident #125 was dependent on staff for lower body dressing.Review of the progress note dated 07/07/25 revealed Resident #125 fell. Certified Nurse Practitioner (CNP) #430 was notified and a new order for a two-view x-ray to the right lower extremity and right hip was placed.The progress note dated 07/08/25 revealed Resident #125 complained of pain this morning (07/08/25) and advised Resident #125 would remain in bed and non-weight bearing (NWB) until x-ray results were known. Resident #125's right lower extremity was immobilized.The physician progress note dated 07/08/25 revealed Resident #125 had an acute hip fracture and to continue NWB status. There was no recommendation for an immobilizer to the right knee.Review of Resident #125's physician orders and progress notes dated 07/08/25 through 07/14/25 revealed there was no evidence a knee immobilizer was ordered. There was no evidence Resident #125 had a right knee immobilizer or if the skin was assessed in the right knee area.The physician progress note dated 07/09/25 at 10:09 A.M. revealed CNP #430 did not mention or recommend an immobilizer to the right knee.From 07/14/25 to 07/18/25, Resident #125 was in the hospital for right hip fracture with surgical repair. There were no recommendations for a right knee immobilizer.The progress note dated 07/18/25 revealed Resident #125 arrived at the facility from status post-surgical repair of the right hip. Resident #125 had a right knee abrasion measuring 6.0 centimeters (cm) in length by 0.5 cm in width with no depth and staging was marked not applicable. There was no mention of a right immobilizer or pressure injury present on the right knee.The progress note dated 07/19/25 revealed Resident #125's daughter was questioning nursing about markings on her right knee from an immobilizer that was on Resident #125 when she went to the hospital on [DATE] from her ortho appointment. Resident #125's daughter mentioned that she had no knowledge<br>(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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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #125 had a brace on until the surgeon called her prior to Resident #125's right hip surgery (07/14/26) and asked her why Resident #125 had a brace on. The medical record did not mention a right knee immobilizer/brace. A progress note dated 07/15/25 at 10:42 A.M. mentioned a right knee immobilizer being in place. (Resident #125 was in the hospital at this time.) Resident #125's daughter was advised immobilizers were generally ordered per ortho or if an immobilizer was ordered at the facility, physical therapy (PT) would have an order written for. The order was not found in Resident #125's medical record. Resident #125's daughter was encouraged to view Resident #125's video footage from her room to see if someone placed a knee immobilizer on Resident #125. Resident #125's daughter agreed that she would view the camera footage. Resident #125's right knee region was assessed with Resident #125's daughter present and areas of linear, closed indentations were present to the medial and lateral aspect of the knee to the back of the knee. Resident #125 denied pain to the area. Resident #125's right knee area would be assessed on 07/21/25 by Wound CNP (WCNP) #433.There was no physician order to treat the new area until 07/21/25.Review of Resident #125's Wound Care Notes dated 07/21/25 at 9:04 A.M. and written by WCNP #433 revealed Resident #125 had a deep tissue pressure injury (DTPI) to her right knee extending circumferentially which appeared to be from a brace. Nursing reported they were looking into what type of brace was applied and by who. The DTPI was present on admission (There was no documentation upon re-admission on [DATE] there was a pressure injury) and was full thickness. Measurement was 32.0 cm in length, 1.0 cm in width, and depth was unable to be determined. The clustered wound with intact skin bridge present. The wound was 40 percent purple or maroon discoloration and 30 percent epithelial. Linear dark purple and maroon discoloration extending circumferentially around the knee. Skin was intact and non-blanching. Treatment was to cleanse with normal saline, apply skin prep and leave open to the air.The facilities Wound Tracker dated 08/11/25 revealed Resident #125's right knee wound was resolved.Interview on 04/14/26 at 10:50 A.M. with Power of Attorney (POA) #431 revealed Resident #125 had a fall and fractured her right hip. POA #431 indicated Resident #125's leg and hip were hurting her and a brace was put on her right knee. POA #431 did not know Resident #125 had a right knee brace put on and the surgeon called her to ask if something was wrong with her knee because Resident #125 had a knee brace on. The orthopedic surgeon thought he missed something and x-rayed her right knee to make sure everything was okay. POA #431 revealed the facility staff denied the facility put a brace on Resident #125.Interview on 04/16/26 at 1:13 P.M. with Director of Rehabilitation (DOR) #434 revealed there was nothing in Resident #125's therapy notes about donning an immobilizer. DOR #434 indicated therapy did not issue an immobilizer, they would put it on but not issue it, and the immobilizer usually came from the hospital. Resident #125 was discharged from Physical Therapy (PT) on 07/07/25. DOR #434 indicated it was possible an immobilizer could be put on too tight, and it had to be snug to provide support. DOR #434 reviewed Resident #125's progress notes and stated after reviewing the notes, he thought Physician #432 ordered the immobilizer. Resident #125's progress notes also stated non-weight bearing to the right lower extremity unless Resident #125 had an ortho appointment. DOR #434 indicated PT #435 provided Resident #125's therapy and if she put the immobilizer on, she did not document it. PT #435 no longer worked at the facility. Interview on 04/16/26 at 2:44 P.M. with DOR #434 and PT #435 revealed PT #435 did not remember much about the situation with Resident #125. PT #435 indicated nursing told her Resident #125 had a fall with injury and either Physician #432 or CNP #430 told her to hold off doing anything regarding therapy and asked her to put an immobilizer on Resident #125's right knee. PT #435 was told to put the immobilizer on and either Physician #432 or CNP #430 would put the order in. PT #435 was not sure how long the immobilizer was supposed to be on, she thought until the x-ray results were reported, and put Resident #125's immobilizer on per physician orders. PT #435 stated she did not know anything else about the immobilizer.Interview on 04/20/26 at 4:36 P.M. with Wound Nurse (WN) #325 confirmed there were no orders in Resident #125's medical record about a right knee immobilizer. WN #325 indicated he heard Resident #125's right knee wound was from an immobilizer, (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | but he did not remember a lot about the situation and was not sure why there was no order. WN #325 revealed Resident #125 was readmitted to the facility on [DATE] and was not seen by WNP #433 until 07/21/25.Review of the National Pressure Injury Advisory Panel 2025 guidelines for the International Guidelines for Prevention and Treatment of Pressure Ulcers/Injuries revealed regardless of age or clinical setting, a resident should be considered at risk for a pressure injury as soon as a medical device is applied. Further review of the guidelines revealed staff should frequently evaluate and where feasible, resize or reposition medical devices used in residents at risk. Continued review of the guidelines revealed the provider should develop standardized protocols for reducing the risk of device related pressure injuries based on the device type.Review of the facility policy titled Wound Prevention and Management Policy revised 10/2022 revealed it was the policy of the facility that, upon admission, all residents would have a comprehensive skin assessment to identify current skin breakdown and identify pressure ulcer risk factors. A preventative plan of care and intervention would be initiated for any residents determined to be at risk, to reduce the possibility of further breakdown.This deficiency represents non-compliance investigated under Complaint Number 2572317. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative and staff interviews, record review, policy review, and review of the National Institute for Health's National Library of Medicine (NIH) publications, the facility failed to ensure a resident who was at a high risk for falls was assessed for the cause of falls and ensure interventions were implemented to prevent additional falls. Actual Harm occurred on 04/10/25 when Resident #125 was found on the floor in her room and sustained a closed compression fracture of lumbar 3 (L3) vertebra. The facility stated the fall was related to orthostatic hypotension (sudden drop in blood pressure occurring when standing up from a sitting or lying position defined as a systolic drop of greater than or equal to 20 millimeters of mercury (mm Hg) or diastolic greater than or equal to 10 mm Hg within three minutes); however, there was no evidence the resident was assessed to have orthostatic hypotension. Resident #125 fell again on 05/10/25 with no injuries, 06/02/25 with no injuries, 06/04/25 went to the emergency room (ER) and received two staples on top of her head, 07/07/25 sustained a right hip fracture requiring surgery, and on 02/13/26 with multiple fractures including a closed fracture of multiple ribs to the left side, a closed fracture of left wrist, and a facial laceration requiring eight sutures. Resident #125 had purple ecchymosis (a large bruise caused by blood leaking from broken vessels into subcutaneous tissue) to the left cheek and red ecchymosis to the left shoulder and scattered ecchymosis to right upper extremity and bilateral lower extremities. Resident #125 passed away on 02/20/25 and the Death Certificate stated the manner of death was accident and the underlying cause was due to sequelae of blunt impacts to the head, trunk, and left arm with fractures and soft tissue injuries due to falls. This affected one (Resident #125) of three residents reviewed for falls. The facility census was 113.Findings include:Review of Resident #125's medical record revealed an admission date of 01/14/25 and a discharge date of 02/20/26. Diagnoses included Alzheimer's disease with late onset, paroxysmal atrial fibrillation, fracture of carpal bone of the left wrist, multiple fractures of the ribs on the left side, laceration of head, dementia, and anxiety disorder.Review of the care plan dated 01/15/25 revealed Resident #125 had a safety concern and the potential for falls, injury. Resident #125's safety would be maintained, and she would have minimal risk of injury and falls. An intervention on 01/15/25 included to encourage non-skid footwear at all times; an intervention on 04/10/25 included encourage Resident #125 to be in the common areas while awake; on 05/10/25 an intervention was initiated to encourage Resident #125 to lay in her recliner while she was in her room every shift; on 06/03/25 an intervention to place a reminder sign in Resident #125's room to remind her to use the call light for assistance; and on 02/13/26, an intervention to complete visual checks every 30 minutes for three days was initiated.The care plan dated 01/15/25 revealed Resident #125 had the potential for altered behavior patterns, disruptive interactions, agitation and/or anxiety. Resident #125 reached for objects not present and fidgeted in her chair. Resident #125 would be calm in a secure environment, and her safety would be maintained. Interventions included a fidget blanket starting on 02/17/26. Review of Resident #125's Falls Risk assessment dated [DATE] revealed Resident #125 was at a higher risk for falls.Review of Resident #125's progress notes dated 04/10/25 at 10:54 A.M. revealed the nurse was alerted by the housekeeper (unidentified) that Resident #125 was on the floor in her room. Resident #125 was found sitting on the floor. Resident #125 stated she heard voices in the hall and fell when she went to check on this. Resident #125 denied pain or discomfort and was able to move all extremities with no issues. Resident #125's vital signs were checked and the resident had orthostatic hypotension. (There was no evidence in the medical record of orthostatic hypotension at the time of the fall.) The physician ordered Resident #125 to be transported to the ER for evaluation.The progress note dated 04/10/25 revealed a follow up investigation that was completed for the fall, and the immediate intervention was orthostatic blood pressures. Other interventions were to encourage Resident #125 to be in the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | common areas while awake and therapy screening for safety.The comprehensive fall investigation was not available to view including witness statements because they were quality assurance protected information (QAPI). The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall, determine Resident #125's orthostatic blood pressure by obtaining vital signs, and determine the cause of the fall.Review of the After Visit Summary for a hospital stay from 04/10/25 through 04/12/25 revealed Resident #125 was admitted for a fall and proctitis (inflammation of the rectum's lining). Resident #125 had an unwitnessed fall and stated in the ER that her head, lower back and legs hurt. Resident #125 had a computed tomography (CT) scan of the abdomen and pelvis and a closed compression fracture of L3 vertebra was found. Resident #125 was admitted for observation to control her lumbar fracture pain and to monitor overnight for bright red blood per rectum and receive intravenous antibiotics for proctitis. Resident #125 improved and her symptoms resolved. Review of Resident #125's physician orders dated 04/13/25 revealed to always encourage non-skid footwear every shift. The fall plan of care revealed on 01/15/25, there was already an intervention for non-skid footwear.Review of Resident #125's physician orders dated 04/30/25 revealed single room isolation, and contact precautions for Clostridioides difficile (C. diff). The order was discontinued on 05/27/25.The progress note dated 05/10/25 at 9:01 P.M. revealed the nurse was called to the room due to Resident #125 was sitting on the floor in front of her wheelchair. It was reported that Resident #125 was very restless all day and trying to stand up by herself. Resident #125 had full range of motion with no skin concerns and no evidence of injury. The daughter requested that Resident #125 was put in her recliner more often with her legs elevated.The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show that the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall including proper footwear, address Resident #25's restlessness, and determine the cause of the fall.The progress note dated 06/02/25 at 3:08 P.M. revealed Resident #125's daughter-in-law stated she was watching the camera and Resident #125 was walking around the room, sitting on the arm of the recliner then fell onto the floor. Resident #125's daughter-in-law called to notify the nurse that Resident #125 was on the floor. Resident #125's range of motion was within normal limits, neuro checks were initiated and no injury was noted. An intervention was to wear proper footwear or non-slip socks while out of bed. (The fall plan of care revealed on 01/15/25, there was already an intervention for non-skid footwear and on 04/13/25, there was a physician order for non-skid footwear.)The comprehensive fall investigation was not available to view because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall including the previous fall intervention of non-skid footwear (care plan intervention on 01/15/25 and physician order on 04/13/25), determine the cause of the fall, and implement appropriate interventions which could have included staff education and/or discipline to ensure fall interventions were implemented.The progress note dated 06/04/25 at 8:43 A.M. revealed Resident #125 was found on the floor of her room lying on her right side next to the rollator (wheeled walker). Resident #125 had a gash to the top of her head, and a bruise was noted to her right wrist. Resident #125 was sent to the ER due to being on a blood thinner per an unidentified Certified Nurse Practitioner (CNP). A new intervention was to place Resident #125 on every 15-minute checks while on isolation precautions (Isolation precautions were discontinued on 05/27/25).The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall and determine the cause of the fall.The progress note dated 06/04/25 revealed Resident #125 returned from the ER with two staples on top of her head. Resident #125 denied pain or discomfort.The progress note dated 07/07/25 at 9:09 P.M. revealed while she was assisting another resident (unidentified) the nurse (unidentified) heard Resident #125 yelling for help. Resident #125 was leaning on the scheduler's door and sitting on the floor in front of her wheelchair. Resident #125 stated she was getting help to get up (continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | and fell and hit her head. Resident #125's vital signs were stable, and her range of motion was abnormal to the right lower extremity and right hip. Resident #125 stated it was painful and no deformity or discoloration was noted. Resident #125's head did not have bumps, lacerations or discoloration. Two staff assisted Resident #125 to her wheelchair then into bed. CNP #430 was notified and a new order for a two-view x-ray to the right lower extremity and right hip was placed.The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall and to determine the cause of the fall.The progress note dated 07/08/25 at 1:21 P.M. revealed Power of Attorney (POA) #431 was contacted and Resident #125's x-ray results (right hip fracture) were discussed with her. POA #431 was asked if she wanted to send Resident #125 out or she would like an orthopedic appointment set up for her. A hospice consultation or palliative care consultation was also discussed. POA #431 indicated she wanted to call her siblings to discuss the situation and would call back. The progress note dated 07/08/25 at 1:41 P.M. revealed POA #431 called and stated she would like for the facility to set up an orthopedic appointment for Resident #125. POA #431 also stated she would like a hospice to consult to be set up.The progress note dated 07/08/25 at 1:43 P.M. revealed Resident #125 was non-weight bearing (NWB) per CNP #430 and a new physician's order was written for Resident #125 to use a mechanical lift until her follow-up appointment was completed.The progress note dated 07/08/25 at 4:00 P.M. revealed an immediate intervention related to the fall on 07/07/25 was for a dump wheelchair (the measurement of how much lower the rear of a seat is compared to the front, enhancing stability. It helps maintain pelvic position, prevent sliding forward, and aids propulsion.) for positioning.The physician progress note dated 07/08/25 and written by Physician #432 revealed Resident #125 had an acute hip fracture, continue NWB status. Recommended evaluation in the hospital to discuss surgical versus non-surgical options; however, the family was deciding on hospice versus evaluation in the hospital. A new order for a hospice consultation was placed.The physician progress note dated 07/09/25 at 10:09 A.M. written by CNP #430 revealed Resident #125 had an acute intertrochanteric right femoral fracture as noted. Resident #125's family did not want her sent to the hospital and were agreeable to a hospice consultation. Resident #125 would be monitored for pain and NWB orders were in place.The progress note dated 07/14/25 at 5:52 P.M. revealed POA #431 was contacted, and she reported that Resident #125 was being taken for emergency surgery and would not be returning that day (07/14/25).The care plan dated 07/22/25 included Resident #125 had altered family acceptance, Do Not Resuscitate (DNR) status, hospice services and impending loss of life. Resident #125's wishes would be honored, comfort maintained and death would be with dignity. Interventions included reporting verbal distress, position for comfort and reporting increased restlessness.Review of the significant change Minimum Data Set assessment dated [DATE] revealed Resident #125 was unable to complete the Brief Interview for Mental Status (BIMS). Resident #125 used a wheelchair and was dependent on staff for activities of daily living (ADLs) including mobility, transferring, toileting hygiene, lower body dressing, and personal hygiene.The progress notes dated 02/13/26 at 6:56 A.M. revealed the nurse was in the middle medication pass and saw Resident #125 in the dining room with another resident. Licensed Practical Nurse (LPN) #364 administered medication to an unidentified resident and when she returned to the dining area, Resident #125 was laying on her left side, her glasses were smashed and blood was noted from her left eyebrow. Resident #125 complained of left sided hip pain. Tylenol was offered, the staff did not move Resident #125, and they waited with her until Emergency Medical Services (EMS) arrived. Resident #125 was moved onto the stretcher and transported to the local hospital.Review of Resident #125's late entry progress notes dated 02/13/26 revealed Resident #125 experienced an unwitnessed fall. Resident #125's care plan was updated to reflect a wedge cushion for assistance with seating and every 30-minute checks for three days. Hospice, family and the provider agreed with the interventions.The progress notes dated 02/13/26 at 6:00 P.M. included Resident #125 returned from the ER at 10:00 A.M. Resident #125 was diagnosed (continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | with closed fracture of multiple ribs to the left side, closed fracture of left wrist, and a facial laceration with eight sutures in place and the area was draining a large amount of serosanguinous drainage. Resident #125 was to follow up with orthopedic. Resident #125 had purple ecchymosis to the left cheek and red ecchymosis to the left shoulder and scattered ecchymosis to right upper extremity and bilateral lower extremities. Resident #125 appeared to be anxious and in pain with facial grimacing, moaning and calling out. As needed anxiety and pain medication were provided with effect. Splint in place to left upper extremity. Resident #125's family was at the bedside.The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall, revealing how long Resident #125 was lying on the ground to determine adequate supervision and rule out neglect, and determine the cause of the fall.The progress notes dated 02/20/26 revealed at 2:21 A.M., Resident #125's skin was warm to touch, and she had an absence of vital signs and pupillary response and was pronounced by two nurses. Hospice services were notified.Review of the Certificate of Death dated 02/20/26 revealed Resident #125 had adult failure to thrive, and the manner of death was accident. The place of injury was the nursing home memory care unit dining area and the injury date and time were 02/13/26 at approximately 5:20 A.M. The underlying cause was due to sequelae of blunt impacts to the head, trunk, and left arm with fractures and soft tissue injuries due to falls. Other significant conditions contributing to the death but not resulting in underlying causes were dementia, recent hip fracture, atrial fibrillation, hypertension, chronic kidney disease, and osteoporosis. During an interview on 04/14/26 at 10:50 A.M., Power of Attorney (POA) #431 revealed Resident #125 experienced a broken hip in July 2025 and fell again on 02/13/26. POA #431 stated Resident #125 had fallen on her face first out of her padded wheelchair. Resident #125 had broken multiple ribs, had a broken arm, a broken wrist and had a huge laceration on the side of her face. POA #431 indicated Resident #125 passed away on 02/20/26 at the facility. POA #431 revealed this was the fourth fall that required an ER visit. The other three falls were on 04/10/25, Resident #125 had a fall and was found to have a lumbar fracture. In June 2026, Resident #125 got up from her wheelchair, fell and hit her head, was transported to the ER and had to have staples near the back of her head. On 07/07/25, Resident #125 was found by the nursing station on the floor and had fallen and had a hip fracture. During an interview on 04/16/25 at 8:45 A.M., the Administrator revealed she was unable to provide Resident #125's comprehensive fall investigations including witness statements because they were QAPI. The Administrator stated she was unable to read the investigations to the surveyor because the investigations were QAPI. During an interview on 04/16/26 at 9:20 A.M., the Administrator, the Director of Nursing (DON) and Director of Clinical Services (DCS) #429 revealed DCS #429 reviewed the investigations and answered questions but did not let the surveyors review the fall investigations and did not read the investigations to the surveyors. Resident #125 had a fall on 04/10/25 and she was trying to ambulate on her own in the room without staff assistance. Resident #125 heard voices and was trying to see what was happening in the hall. The immediate intervention was to encourage Resident #125 to be in the common area when she was awake. DCS #429 indicated the root cause of the fall was due to orthostatic hypotension blood pressure but confirmed she did not see an orthostatic blood pressure recorded in Resident #125's progress notes when she had the fall. DCS #429 was unable to provide details of events leading up to the fall such as when Resident #125 was last seen etcetera (etc.). DCS #429 confirmed Resident #125 was wearing footwear when she fell. On 05/10/25, Resident #125 was found sitting on the floor in front of her wheelchair. DCS #429 indicated Resident #125 wanted to come out of her room, but she was in isolation and was restless. DCS #429 stated the intervention was the staff staying with Resident #125 until she was no longer restless. On 06/02/25, DCS #429 revealed Resident #125's daughter called to notify the nurse that Resident #125 sat on the arm of her recliner and fell to the floor. DCS #429 confirmed Resident #125 was not wearing proper footwear and had nothing on her feet. The immediate intervention was non-slip socks. DCS<br>(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 04/24/2026 |
|---|---|---|---|
| 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.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | #429 revealed the predisposing factors were impaired memory, confusion, weakness, gait imbalance, improper footwear and she had a C Diff infection. The DON indicated Resident #125 was antsy and restless because she could not come out of her room for C. diff. When asked what interventions were provided when Resident #125 had restlessness and was being antsy, the DON said she had a fidget blanket but confirmed the fidget blanket was not initiated until 02/17/26. No additional interventions were provided related to Resident #125's restlessness and being antsy. DCS #429 revealed Resident #125 was often antsy and restless even when she wasn't in isolation for C Diff. Resident #125 had an unwitnessed fall on 06/04/25 and she was moved to a room closer to the nursing station for more interaction and oversight. DCS #429 stated Resident #125 was self-ambulating, fell and was found next to her rollator. Resident #125 was last seen about 10 minutes prior to the fall. An intervention was to complete safety checks every 15 minutes while Resident #125 was in isolation and when asked for the evidence that the safety checks were completed the DON and DCS #429 indicated they would look for the safety checks. No evidence was provided that showed the safety checks were completed every 15 minutes while Resident #125 was in isolation for C Diff. DCS #429 indicated on 07/07/25, Resident #125 was taken off the secured unit because she was not ambulating, not exit seeking and the daughter agreed and assisted with the move. Resident #125 had a fall by the nursing station and was observed sitting in front of the scheduler's door and leaning on the door. Resident #125 was last seen about 20 minutes prior to the fall sitting in her padded wheelchair. Resident #125 said she was getting help with getting up. The new intervention was a dump wheelchair. Resident #125 had an intertrochanteric right femoral fracture and was not transported to the hospital because the family did not want her to be sent to the ER. The family wanted her to have an orthopedic appointment and to consult hospice services. On 07/14/25, the facility found out Resident #125 was transported from the orthopedic appointment to the hospital and was going to have emergency surgery for her hip fracture. DCS #429 revealed on 02/13/26, Resident #125 had a fall early in the morning in the dining area of the secured unit. The nurse was passing medications and when she walked back to the dining area, she found Resident #125 on the floor. Resident #125 stated her face and hip hurt and she was transported to the ER. Resident #125 returned to the facility on [DATE]. DCS #429 indicated she was not sure what caused the fall. A new intervention was a wedge cushion to the left side of the padded wheelchair to help with positioning. DCS #429 indicated Resident #125 passed away on 02/20/26. An email was sent on 04/16/26 at 4:20 P.M. to the DON and the Administrator and requested the fall investigation to determine if the facility completed comprehensive investigations and determined the root cause for the falls pertaining to the following dates: 04/10/25, 05/10/25, 06/02/25, 06/04/25, 07/01/25, 07/07/25 and 2/13/26. There was no response to the email, and investigations were not provided during the survey.During an interview on 04/20/26 at 3:19 P.M., Certified Nursing Assistant (CNA) #357 revealed she was working on 02/13/26 when Resident #125 experienced a fall. CNA #357 revealed LPN #364 was very busy administering medications and providing treatments and couldn't watch residents closely. CNA #357 indicated on 02/13/26 when Resident #125 fell, there was one other aide (CNA #314) and a nurse (LPN #364) working. CNA #357 revealed CNA #314 and herself were providing morning care to residents and assisting them out of bed. Resident #125 was assisted out of bed at around 5:30 A.M. and taken to the dining room and was put in a relaxed position in her padded wheelchair. Resident #125 was sitting in a semi reclined position but not tilted back. CNA #357 revealed LPN #364 was in the dining room and she was in Resident #55's room with CNA #314 when they heard LPN #364 yell. LPN #364 was yelling out that a resident was on the floor. LPN #364 told CNA #357 that she took medication to a (unidentified) resident and heard a thud and found Resident #125 on the floor. CNA #357 revealed when the day shift aides came in for work and found out Resident #125 had fallen and been taken to the ER; they told her Resident #125 had been restless in her chair during the day shift on 02/12/26. CNA #357 indicated the day shift aides did not tell her that in report when they were leaving for the day (02/12/26). CNA #357 stated she received report from the day shift CNA, but they did not tell her (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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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #125 was scooting forward and trying to get out of her chair. Resident #125 was trying to reach for something in the air that was not there. During an interview on 04/20/26 at 4:10 P.M., the DON confirmed Resident #125 was not wearing proper footwear when she fell on [DATE].During a telephone interview on 04/22/26 at 9:09 A.M., CNA #347 revealed on 02/13/26, LPN #364 last saw Resident #125 about five to ten minutes before she fell and CNA #347 last saw Resident #125 about 10 to 15 minutes before she fell. CNA #347 indicated she assisted Resident #125 to the dining room and made sure the wheelchair was locked before she walked away. No activity was provided because Resident #125 appeared to go back to sleep and was not moving around in her chair. CNA #347 did not remember if Resident #125's wheelchair was dumped, but she was in a reclining, relaxed position, and not tilted back. CNA #347 indicated Resident #84 was in the dining room with Resident #125 when Resident #125 fell.Review of an email sent from the Administrator dated 04/22/26 revealed the Administrator stated Resident #125 was last seen within approximately ten minutes before she fell on [DATE], her chair was a dump chair and presented at baseline in the dining room prior to the fall.Attempts to interview LPN #364 and CNA #314 during the survey were unsuccessful.Review of the facility policy titled Fall Management and Incident Intervention Protocol revised 07/2022 revealed it was the policy of the facility to conduct an investigation into the potential causative factors for each resident incident, including those classified as a fall. In addition, residents would be assessed as to their risk of sustaining a fall. Interventions would be implemented and evaluated in order to decrease the incidence of residents, including falls, and to minimize the risk of injury. New interventions would be added to the resident plan of care and would be communicated to the relevant nursing staff. All falls would be reviewed by the Focus Group. Members would review events of the incident and discuss possible recommendations and alterations to the resident's plan of care. Review of the National Institute for Health's National Library of Medicine publication titled Can Agitated Behavior of Nursing Home Residents with Dementia be Prevented With the Use of Standardized Stimuli dated June 2023, included studies have shown that non-pharmacological interventions could be effective in decreasing agitation without the risk of the potential side-effects of medication, while simultaneously address the underlying unmet needs of the older person. As most nursing home residents spend much of their time unoccupied, a significant portion of their agitation is attributable to unmet needs related to boredom and confusion. Studies have found music, using simulated animal-assisted therapy such as a stuffed or robotic animal, social contact, structured activities, and self-identity interventions show effects in lowering agitation.This deficiency represents non-compliance investigated under Complaint Number 2572317. |