

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Lutheran Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2825 Bloomfield Road Cape Girardeau, MO 63703	
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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to maintain a system to safeguard resident trust petty cash by commingling money from other sources with resident trust petty cash and by failing to reconcile the resident trust petty cash account. This had the potential to affect all residents whose funds were maintained by the facility. The facility census was 181. The facility did not provide a policy regarding the management, reconciliation, and safeguarding of resident trust petty cash. Observation of the resident petty cash box count and review of the petty cash log on 07/10/26 at 11:15 A.M., showed:- Administrative Assistant E counted \$474.50 in resident trust petty cash. The petty cash log showed receipts totaling \$435.38. The available cash and receipts did not reconcile to the expected petty cash balance of \$600, resulting in a \$309.88 discrepancy;- Because resident trust petty cash was commingled with nonresident funds and the account did not reconcile, staff could not accurately account for resident funds maintained by the facility. During an interview on 07/10/26 at 11:15 A.M., Administrative Assistant E said sometimes families gave money to the front desk for the family meal tickets instead of going through the business office, so it caused a discrepancy with the resident trust petty cash. The facility had a couple of events in the last month where they had more visitors which likely caused the cash box balance to be off. He/She would have to go through the receipts and find where the discrepancy was. The facility did have a system in place to keep track of the money, but the family and staff didn't all know it and just knew the visitor meal ticket money needed to be brought up to the front, which resulted in the money being put in with the resident petty cash. The facility kept \$600 on hand in the resident trust petty cash. He/She filled out a paper log sheet and collected the receipts from the residents to track who received money. The business office reconciled the account periodically and replenished the petty cash box. He/She gave some cash from the box to the front desk to have on hand to give change to residents when needed. He/She would expect the cash box to contain the expected balance of \$600. During an interview on 07/10/26 at 1:00 P.M., the Administrator, Director of Nursing and Assistant Director of Nursing said they would expect the resident petty cash to be balanced and the resident cash to not be comingled with other sources of money.		

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 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** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility) assessments accurately reflected residents' clinical status for two (Residents #12 and #18) out of 35 sampled residents. The facility inaccurately coded Resident #12 as receiving hospice services when the resident was not enrolled in hospice and inaccurately coded Resident #18 as receiving insulin during the MDS look-back period when no insulin was administered. These inaccurate assessments had the potential to affect resident care planning, quality measures, and the accuracy of federally required resident assessment data. The facility census was 181. The facility did not provide a policy for MDS accuracy. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2025, showed: - The MDS must accurately reflect the resident's status; - An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable; - Information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period). 1. Review of Resident #12's medical record showed: - admission date of 08/18/24; - Diagnoses of unspecified cirrhosis of liver (permanent scarring that damages the liver and interferes with functioning) and unspecified, chronic respiratory failure with hypoxia (lungs are not able to get enough oxygen into the blood); - The medical record contained no physician orders, hospice election statement, hospice admission agreement, or other documentation indicating Resident #12 was enrolled in hospice services. Review of the quarterly MDS dated [DATE] showed: - The resident received hospice services. Review of the resident's physician order sheet (POS), dated 06/30/26, showed: - No order for hospice services. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 07/08/26, showed: - The resident's care plan did not identify hospice services. During an interview on 07/09/26 2:07 P.M., Licensed Practical Nurse (LPN) C said Resident #12 was not receiving hospice services because the family had declined hospice. During an interview on 07/10/2026 at 11:10 A.M., MDS LPN D said hospice coding on the MDS should be determined by reviewing physician orders or confirming the resident's hospice status with nursing staff. 2. Review of Resident #18's medical record showed: - admission date of 04/12/26; - A diagnosis of type 2 diabetes mellitus (DM &ndash; metabolic disease) without complications. Review of the resident's June 2026 POS showed: - An order for metformin extended release (treats type 2 DM) 500 milligrams (mg) two tablets by mouth two times a day for DM, dated of 04/12/26; - An order for Ozempic pen-injector (treats type 2 DM) 2 mg/3 milliliters (ml) inject 0.25 mg subcutaneously (under the skin) in the morning every Tuesday for DM, dated 04/14/26; - No order for insulin. Review of the resident's MDS, dated [DATE], showed: - Received one insulin injection during the seven days look back period. Review of the resident's medication administration record (MAR), dated April 2026, showed: - The MAR documented administration of Ozempic on 04/14/26 and 04/21/26. No insulin administration was documented during the seven-day MDS look-back period; - During the MDS seven-day look-back period, the MAR documented administration of Ozempic and no insulin administration. During an interview on 07/10/26 at 12:19 P.M., MDS Registered Nurse (RN) F said Ozempic was not insulin and the MAR should be reviewed to determine medications administered during the MDS look-back period. During an interview on 07/10/26 at 1:15 P.M., the Administrator and the Director of Nursing said they would expect the MDS to accurately reflect the resident's medical record current condition.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders by failing to administer a physician-ordered as needed (PRN) antihypertensive medication when the systolic blood pressure (SBP - top number. Normal range: 90-120) exceeded the ordered treatment parameter of greater than 160 millimeters of mercury (mmHg) for one resident (Resident #173) out of 35 sampled residents. The facility census was 181. Review of the facility policy titled, Medication Transcription, undated, showed:- PRN ordered medications are administered only as needed according to a designated time frame identified in the order;- The licensed nurse assesses the resident and makes the decision when to administer the PRN medication. 1. Review of Resident #173's physician order sheet (POS) showed:- admitted on [DATE];- Diagnoses of hypertension (high blood pressure) and falls;- A physician order for hydralazine 10 milligram (mg) by mouth every eight hours PRN for SBP greater than 160 mmHg, dated 04/16/26;- A physician order to check the blood pressure every eight hours with a PRN medication available for SBP greater than 160 mmHg, dated 04/18/26. Review of the resident's medication administration record (MAR) and treatment administration record (TAR) from May 2026 - July 9, 2026 showed:- Staff failed to administer the ordered PRN hydralazine 22 out of 68 opportunities when the resident's SBP exceeded the physician-ordered parameter of greater than 160 mmHg;- For May 2026, the resident did not receive the PRN hydralazine dose for a SBP above 160 mmHg on 05/19 at 5:09 P.M., 05/21 at 5:08 P.M., 05/24 at 5:07 P.M., 05/27 at 6:21 A.M., 05/27 at 4:55 P.M., and on 05/28 at 5:06 P.M., with a total of six out of 28 opportunities missed;- For June 2026, the resident did not receive the PRN hydralazine dose for a SBP above 160 mmHg on 06/05 at 4:35 P.M., 06/06 at 5:19 P.M., 06/07 at 5:34 P.M., 06/10 at 5:00 P.M., 06/11 at 6:07 A.M., 06/15 at 4:22 P.M., 06/16 at 5:07 P.M., 06/18 at 6:12 A.M., 06/21/26 at 5:10 P.M., 06/27 at 4:53 P.M., 06/29/26 at 5:05 P.M., and on 06/30 at 5:01 P.M., with a total of 12 out of 32 opportunities missed;- For July 2026, the resident did not receive the PRN hydralazine dose for a SBP above 160 mmHg on 07/02 at 4:49 P.M., 07/03 at 5:22 P.M., 07/05 at 5:04 P.M., and on 07/07 at 5:37 A.M., with a total of four out of eight opportunities missed. Review of the resident's medical record showed:- No documentation supporting a clinical reason for withholding the physician-ordered PRN hydralazine during any of the 22 missed opportunities;- No documentation staff assessed the resident when the SBP exceeded 160mmHg;- No documentation why the hydralazine PRN dose was withheld when the SPB exceeded 160 mmHg;- No documentation why the PRN hydralazine was withheld- No documentation the physician was notified each time the blood pressure exceeded the ordered parameter, and the hydralazine was not given;- No documentation the nurse assessed the resident and determined the hydralazine PRN dose was clinically inappropriate;- Resident with severely impaired cognition (the ability to think, remember, understand, and make decisions) that limited the resident's ability to recognize elevated blood pressure symptoms or request the ordered medication. During an interview on 07/09/26 at 1:40 P.M., LPN A said Resident #173's blood pressure often ran high and had an order to check the blood pressure three times a day. The blood pressure order was for two times on night shift and once on day shift. The resident had a PRN order if the BP got high enough and the resident did get the PRN medication several times. He/She administered the PRN hydralazine whenever the resident's SBP exceeded the ordered parameter unless a physician provided other directions. After the PRN medication was administered, he/she would recheck the blood pressure in about two hours to see if it was effective. During an interview on 07/10/26 at 10:25 A.M., LPN B said Resident #173 had an order to check his/her BP every eight hours. The resident had a PRN order if the BP got high enough. The (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident did get the PRN medication often, but not every day. LPN B gave the medication as ordered and did not know why staff would not give it. Once administering the PRN medication, he/she would recheck the blood pressure in about two hours to see if it was effective. He/She would document the blood pressures in the resident's medical record. During an interview on 07/10/26 at 1:15 P.M., the Director of Nursing (DON) said she would expect a PRN order for a BP medication to be given if it was needed. She would expect the medication to be given as ordered and for there to be a follow up on the PRN medication to see if it was effective and charted somewhere in the resident's medical record where anyone could find it. Certified Nurse Assistants (CNAs) checked the vital signs which included the blood pressure. The CNAs gave the results to the nurse for the nurse to document, but the nurse could check the vital signs as well. The nurse was ultimately responsible for documenting the blood pressure results.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an individualized, person-centered care plan to address post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event) triggers and interventions for one (Resident #7) of three sampled residents reviewed for behavioral health. Although the resident had a diagnosis of PTSD, documented trauma history, and identified individualized triggers and care preferences, the facility failed to identify those triggers or interventions on the resident's care plan. As a result, staff lacked guidance to consistently provide trauma-informed care and reduce the risk of triggering the resident's PTSD symptoms. The facility census was 181. Review of facility policy titled, Care Planning - Interdisciplinary Team, undated, showed:- The planning process is to maximize and maintain each resident's optimal physical, psychosocial, and functional status;- The individualized comprehensive care plan shall include measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs;- The care planning/interdisciplinary team is responsible for the periodic review and updating of care plans at least quarterly. 1. Review of Resident #7's medical record showed:- admitted on [DATE];- Diagnoses of anxiety (persistent worry and fear about everyday situations), personality disorder (long-term patterns of behavior and inner experiences that differ significantly from what is expected), disorganized schizophrenia (a subtype of schizophrenia where a person struggles primarily with disorganized thinking, speech, and emotion regulation), major depressive disorder (a serious mental health condition characterized by persistent sadness, hopelessness, and a loss of interest in activities), and PTSD. Review of the resident's Level II Screening Pre-admission Screening and Resident Review (PASRR - an in-depth person-centered assessment required for nursing facility applicants suspected of having a serious mental illness, intellectual disability, or related condition), dated 02/16/24, showed:- Diagnosis of PTSD. Review of the resident's Trauma Informed Care Screening, dated 07/15/24, showed:- Experienced physical and emotional abuse and the loss of a loved one;- No individualized PTSD triggers were identified despite the resident's diagnosis of PTSD. Review of the resident's care plan, revised 05/21/26, showed:- The care plan did not identify the resident's individualized PTSD triggers, preference for female caregivers, or individualized interventions to prevent exposure to known psychological triggers and minimize emotional distress;- Because the resident's individualized PTSD triggers and preferred interventions were not included in the care plan, staff responsible for providing daily care were not given direction to consistently avoid known triggers or implement trauma-informed interventions. During an interview on 07/09/26 at 9:13 A.M., Resident #7 said exposure to certain men's cologne, men's body odor, and visible hair on men's arms or hands triggered PTSD symptoms. Resident #7 said he/she preferred receiving care from female staff members because those triggers caused emotional distress. Review of the resident's individualized trauma-informed care screening, dated 07/15/24, documented a history of physical and emotional abuse and the loss of a loved one. However, the screening did not identify the resident's individualized PTSD triggers or preference for female caregivers. Despite the resident identifying those specific triggers during interview, the individualized triggers were not reflected on the trauma-informed screening or incorporated into the resident's care plan. During an interview on 07/14/26 at 1:57 P.M., Social Worker (SW) G said the trauma informed care screening was completed on admission or if he/she were made aware of any changes for a resident. During an (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 07/14/26 at 2:09 P.M., Registered Nurse (RN) H said he/she was involved in the care planning process. The information for residents with PTSD was collected from the resident or the resident's family. He/She said PTSD triggers and interventions should be listed on the care plan. During an interview on 07/10/26 at 1:15 P.M., the Administrator and the Director of Nursing said residents diagnosed with PTSD should have individualized triggers and interventions identified and incorporated into the care plan.		