STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265765	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Nursing Home	202 South West Street Concordia, MO 64020

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** Based on interview and record review, the facility failed to report a resident-to-resident altercation when Resident #3 hit Resident #14 out of 14 sampled residents. The facility census was 84 residents.Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated September 2022 showed:-All reports of resident abuse were reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management.-If resident abuse was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.-The administrator or the individual making the allegation immediately reports his or her suspicions to the following agencies:--The state licensing/certification agency responsible for surveying/licensing the facility.--The local/state ombudsman.--The resident's representative.--Law enforcement officials.--The resident's attending physician.--The facility medical director.-Immediately was defined as:--Within two hours of an allegation involving abuse or result in serious bodily injury.--Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.-Verbal/written notices to agencies were submitted via special carrier, fax, e-mail, or by telephone.-Notices included as appropriate:--The resident's name.--The resident's room number.--The type of abuse that was alleged.--The date and time the alleged incident occurred.--The name(s) of all persons involved in the alleged incident.--What immediate action was taken by the facility.1. Review of Resident #3's admission Record showed the resident admitted to the facility with a diagnosis of unspecified dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), unspecified severity, with agitation.Review of Resident #14's admission Record showed the resident admitted to the facility with a diagnosis of Alzheimer's Disease (a progressive, irreversible neurological disorder that destroys memory, thinking, and eventually the ability to function) with early onset.Review of a Health Status Note dated 2/20/26 at 9:10 P.M. completed by Licensed Practical Nurse (LPN) C showed:-Resident #3 had aggressive behaviors that day.-Resident #3 hit a resident.-The resident attempted to lock himself/herself in another resident's room while he/she had family in the room.-The resident attacked LPN C and a Certified Nursing Assistant (CNA) which included punching, spitting, and attempting to bite anyone within reach.-LPN C notified the resident's son after the altercation occurred.-LPN C notified the resident's physician after the altercation occurred.-There was no mention of notification to the Administrator or DON in the note. Review of Resident #3's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) dated 3/19/26 showed the resident had severely impaired cognition.Review of Resident #14's quarterly MDS dated [DATE] showed the resident had moderately impaired cognition.During an interview on 4/9/26 at 5:00 P.M. CNA B said:-He/She had worked on 2/20/26.-He/She had come into work after the incident occurred.-He/She could not remember if LPN C had discussed a resident-to-resident altercation with him/her.-A resident-to-resident altercation could be verbal or physical abuse and needed to be (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	reported immediately.-If he/she witnessed a resident-to-resident altercation, then he/she would report it to the nurse and/or the Director of Nursing (DON).-If LPN C did not report the resident-to-resident altercation, then LPN C should have reported the altercation.During an interview on 4/9/26 at 5:49 P.M. LPN B said:-All resident-to-resident altercations needed to be reported to the Administrator or DON immediately.-The facility had two hours to report an abuse allegation to the Department of Health and Senior Services (DHSS).-LPN C most likely told the DON and/or Administrator about the altercation but forgot to mention it in his/her note.-If LPN C did not report the altercation, then LPN C should have reported the incident immediately to the DON and/or Administrator.During an interview on 4/9/26 at 6:35 P.M. the Administrator and DON said:-They had not been told about the resident-to-resident altercation between Resident #3 and Resident #14 that occurred on 2/20/26.-They expected all staff members to report any kind of abuse immediately.-The facility has a two-hour window to report abuse to DHSS.-They did not report the altercation that occurred on 2/20/26 because they had not been told about it.-If they had been told about the resident-to-resident altercation on 2/20/26 then they would have reported the incident to DHSS within the regulated timeframe.During a phone interview on 4/10/26 at 2:33 P.M. LPN C said:-Resident #3 had been involved in altercations in the past.-He/She remembered the specific incident after reading him/her the Health Status Note from 2/20/26 at 9:10 P.M.-He/She could not initially remember the other resident involved in the incident.-He/She remembered texting the DON about the incident.-He/She still had the text to the DON and stated that Resident #14 had been the resident involved in the altercation with Resident #3.-No injury had occurred during the altercation.-He/She was not sure if the altercation counted as abuse because Resident #3 usually had aggressive behaviors towards the other resident's on the unit.-He/She thought a resident-to-resident altercation counted as abuse when there was malintent and injury.-He/She thought his/her text might not have been specific enough to indicate that Resident #3 had hit Resident #14.Review on 4/10/26 at 2:53 P.M. of LPN C's text to the DON showed:-The text message had been sent to the DON on 2/20/26 at 7:19 P.M.-Resident #3 and Resident #14 had hit each other again.-Resident #3 and Resident #14 were just grumpy old ladies and no injuries occurred. 2973592

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an investigation was completed after a resident-to-resident altercation occurred when Resident #3 hit Resident #14 out of 14 residents sampled residents. The facility census was 84 residents. Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated September 2022 showed:-All allegations were thoroughly investigated.-The Administrator initiated investigations.-Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations.-The individual conducting the investigation at a minimum:--Reviewed the documentation and evidence.--Reviewed the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident.--Observed the alleged victim, including his/her interactions with staff and other residents.--Interviewed the person(s) reporting the incident.--Interviewed the resident (as medically appropriate) or the resident's representative.--Interviewed the resident's attending physician as needed to determine the resident's condition.--Interviewed the staff members (on all shifts) who had contact with the resident during the period of the alleged incident.--Interviewed the resident's roommate, family members, and visitors.--Reviewed all events leading up to the alleged incident.--Documented the investigation completely and thoroughly.1. Review of Resident #3's admission Record showed the resident admitted to the facility with a diagnosis of unspecified dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), unspecified severity, with agitation.Review of Resident #14's admission Record showed the resident admitted to the facility with a diagnosis of Alzheimer's Disease (a progressive, irreversible neurological disorder that destroys memory, thinking, and eventually the ability to function) with early onset.Review of a Health Status Note dated 2/20/26 at 9:10 P.M. completed by Licensed Practical Nurse (LPN) C showed:-Resident #3 had aggressive behaviors that day.-Resident #3 hit a resident.-The resident attempted to lock himself/herself in another resident's room while he/she had family in the room.-The resident attacked LPN C and a Certified Nursing Assistant (CNA) which included punching, spitting, and attempting to bite anyone within reach.-LPN C notified the resident's son after the altercation occurred.-LPN C notified the resident's physician after the altercation occurred.Review of Resident #3's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) dated 3/19/26 showed the resident had severely impaired cognition.Review of Resident #14's quarterly MDS dated [DATE] showed the resident had moderately impaired cognition.During an interview on 4/9/26 at 5:00 P.M. CNA B said:-An investigation needed to be completed when an allegation of abuse was reported.-The Administrator was responsible for completing abuse investigations.During an interview on 4/9/26 at 5:49 P.M. LPN B said:-When an allegation of abuse was reported an investigation needed to be completed.-The Administrator was responsible for completing the abuse investigations.-He/She was unsure of the timeframe of when the investigation needed to be completed.During an interview on 4/9/26 at 6:35 P.M. the Director of Nursing (DON) and the Administrator said:-They had not been told about the resident-to-resident altercation between Resident #3 and Resident #14 that occurred on 2/20/26.-They did not complete an investigation related to the resident-to-resident altercation between Resident #3 and Resident #14 that occurred on 2/20/26.-They would have completed an investigation related to the resident-to-resident altercation between Resident #3 and Resident #14 that occurred on 2/20/26 if it had been reported to them.-An investigation should have been completed investigation related to the resident-to-resident altercation between Resident #3 and Resident #14 that occurred on 2/20/26. 2973592

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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 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 ensure International Normalized Ratio (INR- used to monitor the effectiveness of blood thinning drugs) tests were ordered upon admission and completed for one sampled resident (Resident #4) out of 14 sampled residents. The facility census was 84 residents.Review of the facility's policy titled Anticoagulation (the use of medicine commonly called blood thinners, to prevent or treat harmful blood clots)-Clinical Protocol dated November 2018 showed:-As part of the initial assessment, the physician and staff would identify individuals who were currently anticoagulated.-In addition, the should assess and document/report the following:--Current anticoagulation therapy, including drug and current dosage.--Recent labs, including therapeutic dose monitoring.--Other current medications.--All active diagnoses.-The physician should monitor the INR very closely while the individual was receiving warfarin (a blood thinner), to ensure INR stabilized within a therapeutic range.-The physician would order appropriate lab testing to monitor anticoagulant therapy and potential complications.-If warfarin was used, staff should use a warfarin flow sheet or some comparable means to follow trends in anticoagulant dosage and response in individuals on warfarin.1. Review of Resident #4's admission Record showed the resident admitted to the facility on [DATE] with the following diagnoses:-Unspecified symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage (a life-threatening type of stroke caused by bleeding into the space surrounding the brain).-Presence of prosthetic heart valve.Review of the resident's care plan dated 2/27/26 showed the resident was on anticoagulant therapy with an intervention for labs and diagnostics as ordered, report abnormal results to the resident's physician.Review of the resident's Order Summary Report dated March 2026 showed:-An order for Warfarin Sodium Oral Tablet, give five milligrams (mg) by mouth in the evening.-No INR test orders in place. Review of the resident's discharge summary from the local hospital on 4/8/26 showed:-The resident was on warfarin five mg.-The resident had a high INR upon admission to the hospital.-The resident needed his/her INR checked early next week, following admission to the facility.-The resident needed closer follow-up with weekly INR checks for the next several weeks.During an interview on 4/8/26 at 11:30 A.M. the Director of Nursing (DON) said:-The Assistant Director of Nursing (ADON) was responsible for putting all admission orders into the residents' Electronic Medical Records (EMRs).-The ADON no longer worked at the facility.-The resident had not had any INR testing completed while at the facility.During an interview on 4/9/26 at 9:37 A.M. Registered Nurse (RN) A said:-He/She was not responsible for putting in admission orders into the residents' EMRs.-The ADON was responsible for putting all admission orders into the residents' EMRs.-The ADON no longer worked at the facility.During an interview on 4/9/26 at 11:49 A.M. Physician A said:-He/She expected the facility to follow all discharge instructions.-He/She usually requested for staff to ask for the discharge summaries for all residents admitted to the facility under his/her care so everything could be reviewed.-To his/her knowledge, the facility puts in all discharge instructions when a resident admitted to the facility.-He/She expected the facility to ensure all discharge instructions were followed and ordered when a resident admitted to the facility.-INRs were checked per resident need.-The resident's INR orders should have been put into the resident's EMR.-The resident should have had weekly INR orders in place with his/her history while at the hospital.During an interview om 4/9/26 at 12:55 P.M. the Unit Manager said:-The ADON was responsible for putting in all admission orders into the residents' EMRs.-The ADON no longer worked at the facility.-He/She was unsure if anyone ensured all orders were in place after the ADON put in the admission orders.-Lab orders were also to be put into the labs ordering system.-He/She had not seen the resident's discharge paperwork.-Based of the instructions he/she saw when handed the resident's discharge paperwork, he/she would have put INR testing orders into the resident's EMR.-He/She would have also called Physician A to ensure that the doctor agreed with the INR order.During an interview on 4/9/26 at 6:35 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M. the DON said:-He/She was unsure why the ADON had not put all of the resident's admission orders into the resident's EMR.-There was not anyone that went behind the ADON to ensure all orders were in place.-The resident should have had INR testing completed while at the facility. -The facility had an anticoagulation policy in place and was unsure how the testing was missed.2959995

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to ensure appropriate behavioral monitoring was in place for one sampled resident (Resident #3) out of 14 sampled residents. The facility census was 84 residents.Review of the facility's policy titled Behavioral Assessment, Intervention, and Monitoring dated February 2025 showed:-Residents would have minimal complications associated with the management of altered or impaired behavior.-Behavioral symptoms were identified using facility-approved behavioral screening tools and comprehensive assessment.-The facility complied with regulatory requirements related to the use of psychotropic medications.- Behavior was the response of an individual to a wide variety of factors.-These factors may include medical, physical, psychosocial, psychiatric, or environmental causes.-Behavior was regulated by the brain and was influenced by past experiences, personality traits, environment, and interactions with other people.-Behavior could be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that could not be articulated.- Behavioral interventions referred to individualized, nonpharmacological approaches to care that were provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical, or psychosocial well-being.-As part of the comprehensive assessment, staff evaluated the following:--The resident's usual patterns of cognition, mood, and behavior.--The resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts.--The resident's typical or past responses to stress, fatigue, fear, anxiety, frustration, and other triggers.--The resident's previous patterns of coping with stress, anxiety, and depression.-The nursing staff would identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition which included:--Onset, duration, intensity, and frequency of behavioral symptoms.--Underlying medical conditions.--Any recent precipitating or relevant factors or environmental triggers.-Appearance and alertness of the resident and related observations.-A circumstance that warranted a behavioral assessment of a resident included new or worsening change in status or condition.-New onset or changes in behavior were evaluated and documented, regardless of degree of risk to the resident or others.-The interdisciplinary team (IDT) evaluated behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and developed a plan of care accordingly.-The care plan included at a minimum:--A description of the behavioral symptoms.--Targeted and individualized interventions for behavioral and/or psychosocial symptoms.--The rationale for the interventions and approaches.--Specific and measurable goals for targeted behaviors.--How staff will monitor the effectiveness of the interventions.-Interventions were individualized and part of an overall care environment that supported physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's stress or loss of abilities.-The resident and family or representative were involved in the development and implementation of the care plan.-The IDT monitored for and documented any new, worsening, or improves symptoms in the resident's behavior, mood, and function.-Interventions were adjusted based on impact on behavior and other symptoms.1. Review of Resident #3's admission Record showed he/she admitted to the facility with a diagnosis of unspecified dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), unspecified severity, with agitation.NOTE: The resident's admission Record also indicated that the resident had been diagnosed with generalized anxiety disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats) on 3/17/25.Review of a Health Status Note dated 1/31/26 at 8:30 P.M. regarding Resident #3 (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed:-The resident was having aggressive behaviors that day and evening.-The resident was yelling at other residents and pushing at them when they did not do what he/she wanted.-The resident was also pushing and hitting employees that were attempting to redirect the resident away from other residents.-The resident was yelling when a resident or staff member did not move in the direction he/she wanted them to.-The resident punched the Certified Medication Technician (CMT) in the jaw and sternum.-The resident eventually laid down and fell asleep.Review of a Health Status Note dated 2/8/26 at 5:43 P.M. regarding Resident #3 showed:-The resident had been combative since 11:00 A.M. that morning.-The resident was unable to be re-directed.-The resident was hitting, kicking, and pushing staff.-The resident refused to eat at any meal.-The resident's family took the resident out for about an hour and the resident refused to eat with them.-The resident's seemed to be daily in the last few days.-The Director of Nursing (DON) was notified of the resident's escalating behaviors.Review of a Health Status Note dated 2/20/26 at 9:10 P.M. regarding Resident #3 showed:-The resident had aggressive behaviors that day.-The resident had hit another resident.-The resident attempted to lock himself/herself in another resident's room.-The resident attacked the nurse and CNA.-The resident was punching, spitting, and attempting to bite anyone within reach.-It took two staff members to get the resident back to his/her room and away from other residents.-When the resident was in his/her room, the resident calmed down and started to make his/her bed.-The resident then continued to wander around attempting to enter other residents' rooms and behaving aggressively.-The nurse had contacted the physician and the resident's son.-The son requested to be contacted when the resident had aggressive behaviors.-By the time the nurse got back to the resident, he/she had laid himself/herself down in bed.Review of a Health Status Note dated 2/22/26 at 5:12 P.M. regarding Resident #3 showed:-The nurse had made a call to the resident's son to discuss agitation and combative behavior.-The resident had been happy early in the day and let the nurse feed him/her lunch.-At approximately 2:00 P.M. the resident became agitated and very combative with staff and towards other residents.-Staff sat with the resident one-to-one (1:1- a term used by healthcare support workers whose role was to provide one-to-one nursing or observation care to an individual patient/resident for a period of time) to avoid behaviors.-The resident had refused supper up to that point in time.Review of a Health Status Note dated 3/16/26 regarding Resident #3 showed:-A Certified Nursing Assistant (CNA) had reported to the nurse that the resident had hit another resident with a plastic hanger from his/her room.-The resident had not remembered who the CNA was and had swung at the CNA multiple times.-The CNA was able to redirect and deescalate the resident.-The resident did not have any concerns at that time.Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated March 2026 showed the resident did not have any behaviors from the evening of 3/27/26 through 3/31/26.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) dated 3/19/26 showed:-The resident had severely impaired cognition.-The resident had physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) which occurred between one and three days during the seven-day look back period.-The resident has verbal symptoms directed toward others (threatening others, screaming at others, cursing at others) which occurred between one and three days during the seven-day look back period.-The resident had other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred between one and three days during the seven-day look back period.Review of a Health Status Note dated 3/22/26 at 4:42 P.M. regarding Resident #3 showed:-The resident had been agitated most of the afternoon.-The resident had attempted to hit other residents but had been redirected by staff.-The resident had been put on o1:1 observation due to his/her combative and agitated demeanor.-The resident had to be followed everywhere he/she went to avoid confrontations with other residents.-The resident was very hard to re-direct.Review of the resident's care plan dated 3/26/26 (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed:-The resident had the potential for changes in mood and behavior related to his/her diagnosis of dementia and that the resident had increased agitation at times with a goal of not harming self or others over the next review period.-The resident's goal had not been updated since 4/24/24.-The following interventions were in place:--Administer medications as ordered on the physician order sheet (POS)/MAR.--Monitor/document for side effects and effectiveness.--Approach the resident in a calm manner.--Assess for need to toilet or assist with cares after incontinent episodes.--Assess for signs and symptoms of hunger/thirst.--Assess for signs and symptoms of pain/discomfort and treat before becoming breakthrough pain.--Call the resident by his/her name when approaching the resident.--The resident was usually redirected.-The resident's interventions had not been updated since 2024.Review of the resident's order summary report dated April 2026 showed:-An order for behaviors-monitor for the following:--Itching.--Picking at skin.--Restlessness (agitation).--Hitting.--Increase in complaints.--Biting.--Kicking.--Spitting.--Cussing.--Racial slurs.--Elopement.--Stealing.--Delusions.--Hallucinations.--Psychosis.--Aggression.--Refusing care.-The order was dated 3/26/26.Review of the resident's MAR/TAR dated April 2026 showed the resident did not have any behaviors from 4/1/26 through the morning of 4/9/26.Review of a Health Status Note dated 4/4/26 at 6:23 P.M. regarding Resident #3 showed:-The nurse had been called back to the unit because the resident had become agitated with staff.-The resident was aggressively pulling on the old nurse station gate, and the gate came off its hinges.-In an attempt to redirect the resident, the nurse was struck in the face and caused a bloody lip.-Another staff member had heard the noise in the hallway.-The nurse was then able to contain the resident to prevent any harm to residents.-The nurse did a skin assessment, and it showed the resident had bruising to his/her right arm.-The resident denied any pain.-When the nurse asked the resident what happened, the resident had no knowledge of the incident.During an interview on 4/9/26 at approximately 3:00 P.M. Nursing Assistant (NA) B said:-The resident was aggressive pretty often, more than once a week.-If the resident was in the mood to fight with staff, then the staff just left the resident alone.-He/She had not been educated on how to manage behaviors.-The main intervention he/she used with the resident was to leave him/her alone.-He/She didn't really feel like he/she was properly trained to be on the special care unit.During an interview on 4/9/26 at approximately 3:20 P.M. Licensed Practical Nurse (LPN) A said:-The resident had cycles of behaviors.-The resident could become very physically aggressive towards the staff.-The resident's behaviors have increased in the last few months.-The resident has had a general decline in health in the last two months.-The resident wasn't always easily redirectable.-When the resident had a behavior, the nurses were supposed to document a note in the resident's Electronic Medical Record (EMR).-He/She was not always very good about documenting the resident's behaviors because the resident had a baseline of behaviors that the resident usually exhibited.-The behaviors the resident exhibited that were a part of the resident's baseline included:--Complaining.--Racial slurs.--Stealing.--Delusions.-As part of the resident's decline in health the resident has had an increase in hitting and general aggression.-He/She did not feel the staff that worked on the special care unit were prepared to work on the unit.-He/She did not feel like the facility was doing appropriate education for the special care unit.-The resident was not very redirectable and usually just did whatever he/she wanted.During an interview on 4/9/26 at approximately 3:45 P.M. the MDS Coordinator said:-He/She had been in his/her position for one and a half years.-He/She had not been educated on care plans.-No other staff besides him/her were involved in care plans.-Nurses were the only staff members with access to care plans.-The CNAs had charting that they could complete related to resident behaviors.-The nurses were also responsible for behavioral monitoring.-The nurses were expected to put a note in residents' EMRs when behaviors were exhibited.-The resident's care plan was accurate but could have been more specific.-It was all about how staff approached the resident when exhibiting a behavior.During an interview on 4/9/26 at 4:26 P.M. CNA A said:-The resident was exhibiting more behaviors recently.-The resident was more aggressive than he/she had been in the past.-The resident was redirectable and when addressing the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265765	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Nursing Home	202 South West Street Concordia, MO 64020

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's behaviors, he/she was usually able to take the resident away from the situation.-It was a day-to-day issue with the resident, meaning some days he/she responded well to staff intervention and some days he/she did not.-Care plans should be up to date with appropriate interventions.-He/She was unable to get into care plans but would share any pertinent information to the nurse.During an interview on 4/9/26 at 5:00 P.M. CNA B said:-The resident had increased behaviors.-The resident mainly had an increase in aggressiveness with more physical contact.-The resident's behaviors had been worse in the last two months.-There was not a specific time of day in which the resident exhibited more behaviors.-The resident typically exhibited behaviors multiple times a week.-Staff could not approach the resident with matching energies when the resident was exhibiting behaviors.-The resident usually responded well to sweet talk.-He/She tried to learn about the resident's past so it would be easier to redirect them.-He/She no longer had access to care plans.-If he/she had a question about a resident's care plan then he/she would just ask the nurse.-The resident's care plan was not up to date or accurate.-The resident's care plan needed to be updated to reflect the resident's current status.During an interview on 4/9/26 at 5:49 P.M. LPN B said:-He/She was quite familiar with the resident.-The resident has had an increase in behaviors.-The resident had increased aggression and restlessness.-He/She felt the facility did not keep the special care unit appropriately staffed during the night shift due to the resident's increased behaviors.-He/She could pull up resident care plans but did not change or edit the care plans.-The resident's care plan needed to be updated to reflect the resident's current behaviors and interventions he/she responded to.-It was all in how staff approached the resident when he/she was exhibiting a behavior.-The resident was no longer easily redirectable.-The resident needed a calm approach and there were some nicknames that he/she liked to be called which would help him/her calm down.-He/She was not very good at charting the resident's behaviors.-Before the behavioral monitoring was put into place, the nurses were expected to document a note when the resident had a behavior.-The current order in place for the resident's behavioral monitoring could be marked with a Y for yes, the resident had behaviors or with a N for no exhibited behaviors.-If staff marked Y the staff were note directed automatically to put a note into the resident's EMR.-He/She usually marked N regardless of if the resident had a behavior because nurse management would not really do anything with the information if he/she marked Y.-The resident's March MAR/TAR was not accurate related to the resident's behavioral monitoring.-The resident's April MAR/TAR was not accurate related to the resident's behavioral monitoring.During an interview on 4/9/26 at 6:35 P.M. the DON and the Administrator said:-The resident had increased behaviors.-The resident's behaviors seemed to have increased in the last month.-The resident's care plan was not up to date.-The resident's care plan needed to be up to date and reflect the resident's current status.-The MDS Coordinator was the only person that could edit care plans.-The resident had a medication change on 3/26/26 which was why the behavioral monitoring was put in place.-The resident did not have ordered behavioral monitoring in place prior to 3/26/26.-The CNAs could document behaviors within their charting.-Any time a resident exhibited a behavior the nurses needed to document a note.-The nurses were still expected to document a note when the resident exhibited any behaviors when marking Y on the MAR/TAR.-The resident's April MAR/TAR was not accurate related to the resident's behavioral monitoring.-Staff should have marked Y on 4/4.26 when the resident had pulled the gate off the hinges and hit staff. 2973592