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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365020 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/24/2025 |
| NAME OF PROVIDER OR SUPPLIER Lutheran Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2116 Dover Center Rd Westlake, OH 44145 | |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed. (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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| <p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, review of facility education in-service, review of a disciplinary action form, and staff interview, the facility failed to ensure care and services for a peripherally inserted central catheter (PICC) line site were completed as ordered. This affected one resident (#70) of three residents reviewed for intravenous (IV) access. The facility census was 66. Findings include: Review of the medical record for Resident #70 revealed an admission date of 08/21/25 and discharge date of 09/13/25. Diagnoses included Evan's syndrome (an autoimmune disorder where the immune system destroys its own blood cells), systemic lupus erythematosus, hereditary hemolytic anemia, long term use of antibiotics, and drug or chemical induced diabetes mellitus with hyperglycemia. Review of the admission assessment dated [DATE] revealed Resident #70 admitted to the facility from the hospital for urinary tract infection (UTI) and was being treated with antibiotics (ATB). It was noted Resident #70 had PICC line to right upper extremity (RUE). Review of Resident #70's physician order dated 08/23/25 revealed an order to change the RUE PICC line site dressing every week on Sundays. An additional order dated 08/23/25 noted Resident #70 had an upcoming follow-up appointment with a hematology center on 09/05/25 at 11:30 A.M. for a scheduled treatment. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2025 revealed Licensed Practical Nurse (LPN) #800 had signed off for the dressing change for Resident #70's PICC line site dressing on 08/24/25 and Agency LPN #801 had signed off the dressing change for Resident #70's PICC dressing on 08/31/25. Review of the MAR and TAR for September 2025 revealed no evidence of any dressing changes to Resident #70's RUE PICC line site. The order was discontinued on 09/07/25. Review of Resident #70's progress notes revealed a note dated 09/05/25 which indicated Resident #70's PICC site had been discontinued. Review of a progress note dated 09/08/25 revealed Resident #70 was seen by Nurse Practitioner (NP) #809. The note referenced Resident #70 had completed IV antibiotic treatment on 08/31/25. NP #809 noted Resident #70's PICC line was placed on 08/20/25. It was noted Resident #70 had a follow-up appointment with hematology on 09/05/25 and her PICC line was removed at the appointment. The note indicated the PICC line was removed as it was discovered the PICC line dressing was never changed since placement. Blood cultures were drawn and the PICC line was removed at the hematology appointment. Interview on 11/20/25 at 1:06 P.M. with Infusion Center Nurse #810 revealed on 09/05/25, Resident #70's PICC line dressing was noted to be very visibly soiled and was dated for 08/20/25. Infusion Center Nurse #810 stated Resident #70's PICC line was removed at the appointment on 09/05/25. Interview on 11/24/25 at 8:26 A.M. with the Director of Nursing (DON) revealed education was completed for all nurses on PICC line site care. The DON indicated LPN #800 was written up for signing off on Resident #70's PICC line dressing that she did not complete. The DON stated she was not working at this facility during this time. Interview on 11/24/25 at 9:49 A.M. with Assistant Director of Nursing (ADON) revealed she was the facility's infection preventionist. The ADON reported Resident #70 was admitted to the facility with IV access to administer IV ATB to treat a urinary tract infection. The ADON noted Resident #70 went to multiple infusion appointments during admission. The ADON stated she was notified by infusion clinic that Resident #70's PICC line dressing had not been changed at the facility. The ADON stated LPN #800 and Agency LPN #801 signed off on the treatments in Resident #70's MAR/TAR without actually completing the dressing change. The ADON indicated she was unable to recall the exact date on the dressing, however stated it was not changed for about two weeks. The ADON stated LPN #800 was written up and Agency LPN #801 was marked on the do not return (DNR) list. The ADON stated Resident #70 had no adverse effects of missing two dressing changes that she was aware of. The ADON indicated it was the policy of the facility to change IV site dressings every Sunday. Interview on 11/24/25 at 12:52 P.M. with Agency LPN #801 revealed it was the weekend when she picked up a shift at the facility. Agency LPN #801 stated she had requested dressing supplies for Resident #70's PICC line from the supervisor; however, the supervisor did not return with the dressing supplies. Agency LPN #801 did not recall or provide additional information related to Resident #70. Interview on 11/24/25 at 2:29 P.M. with LPN #800 revealed the nurse confirmed she had received disciplinary action related to not completing Resident #70's PICC line dressing changes. LPN #800 stated she thought she had completed all the dressings on her assignment, including Resident #70's. LPN #800 also stated she had to do an in-service on PICC line site care. LPN #800 did not recall or provide additional information related to Resident #70. Review of</p> | | |