STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365521	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Luke Lutheran Home	220 Applegrove Street NE North Canton, OH 44720

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, facility email, medical record review, and policy review, the facility failed to ensure Resident #26 was treated with dignity and respect. This affected one (Resident #26) out of three residents reviewed for dignity and respect. The facility census was 141. Findings include: Review of the medical record revealed Resident #26 was admitted on [DATE] with diagnoses that included hypertension, chronic kidney disease stage four, dehydration, hyponatremia, polyarthritis, depressive disorder, diabetes mellitus, moderate calorie malnutrition, and anxiety disorder. Review of the Preferences for Routines and Activities dated 02/12/25 revealed it was very important to Resident #26 to choose her own bedtime. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 was cognitively intact. Resident #26 required partial to moderate assistance for transfer from chair to bed. Review of an email from Director of Nursing (DON) to Ombudsman dated 07/16/25 at 6:00 P.M. revealed Certified Nursing Assistant (CNA) #714 yelled at Resident #26's son in front of Resident #26. CNA #714 was frustrated due to challenging staff levels and wanted to put Resident #26 to bed. Resident #26 was still eating dinner and Resident #26's son stated it was too early for Resident #26 to go to bed. CNA #714 then informed Resident #26 and Resident #26's son that the resident would not be assisted into bed later. The nursing coordinator, Registered Nurse (RN) #688, asked CNA #714 about the interaction. CNA #714 responded with a poor attitude and stated she would just leave work. CNA #714 later met with the DON and CNA #714's unprofessional behavior was discussed. CNA #714 would be assigned to other locations and would not provide care for Resident #26 in the future. An interview on 07/28/25 at 9:05 A.M. Resident #26's son revealed on 07/13/25 around 5:45 P.M. Resident #26 was still eating dinner when CNA #714 entered the room, took Resident #26's dinner tray, and said Resident #26 had to go to bed now or not at all. Resident #26's son stated it was too early, and Resident #26 was still eating dinner. CNA #714 got mad and cursed at him and then CNA #714 left the room and was running down the hallway loudly cursing. An interview on 07/28/25 at 9:18 A.M. the Ombudsman revealed they were notified CNA #714 yelled and cursed in front of Resident #26. The Licensed Nursing Home Administrator told the Ombudsman that CNA #714 would be fired but then stated CNA #714 was a union worker and would not be terminated. An interview on 07/28/25 at 10:12 A.M. DON verified CNA #714 was inappropriate with Resident #26's son so interviews with staff were completed and an email was sent to the Ombudsman. The DON stated he did not feel Resident #26 was impacted because she was not put to bed at that time and CNA #714's frustration was directed at Resident #26's son, not Resident #26. The DON verified there was no documentation on 07/13/25 of the meal percentages Resident #26 ate. The DON stated he could not verify if Resident #26's dinner tray had been removed before Resident #26 was finished eating. An interview on 07/28/25 at 10:45 A.M. with Resident #26 verified CNA #714 told her she had to go to bed around 5:00 P.M. The Resident #26 stated she preferred to go to bed around 9:00 P.M. Review of the Goals of the Nursing Department (no date) revealed the resident is to be treated with dignity and respect at all times. Review of St [NAME] Lutheran Community Resident's [NAME] of Rights dated 12/01/16 revealed residents have the right to retire and rise in accordance with the resident's reasonable requests. This deficiency represents non-compliance investigated under Master Complaint Number OH002570130, OH001297228 (OH00166964).

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. (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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents had access to funds in a reasonable amount of time. This affected four residents (Resident #139, #38, #22, and #85) of four residents reviewed for resident funds. The facility managed 40 resident fund accounts. The facility census was 141. Findings include : 1. 1. Resident #139 was admitted to the facility on [DATE]. Medical diagnosis included type two diabetes, gastroesophageal reflux disease, hypothyroidism, hypertension, anxiety, osteoporosis, dementia, major depressive disorder, personality disorder, bipolar disorder.Review of Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed cognition was intact and did not exhibit hallucinations or delusions. Resident #139 was her own financial responsible party and Primary Payer source was Care Source Medicaid.Interview on 07/14/25 at 10:16 A.M. with Resident #139 revealed she could not receive fifty dollars from petty cash on 07/13/25. Resident #139 stated she needed her money for 07/14/25 because her friend was to buy lip gloss and face moisturizer for her. Resident #139 stated she felt disappointed she could not get her money. 2. 2. Resident #38 was admitted to the facility on [DATE]. Medical diagnosis included vascular dementia, major depressive disorder, agoraphobia, obsessive compulsive disorder, insomnia, transient ischemic attack, major depressive disorder, epilepsy, and anxiety. Review of Resident #38's MDS 3. 0 quarterly assessment revealed cognition was intact and Resident #38 did not have indications of psychosis. Resident #38's sister was the accounts receivable financial responsible party and Resident #38 primary payor source was Medicaid.Interview on 07/14/24 at 10:08 A.M. with Resident #38 revealed he requested twenty dollars from the receptionist on 07/12/25 and was told his money did not come in and waited a few more days to get his money. Resident #38 stated he felt helpless because he enjoyed buying soda pop with his money. Resident #38 stated he asked for twenty dollars on 07/12/25, 07/13/24 and 07/14/25. 3. 3. Resident #22 was admitted to the facility on [DATE]. Medical diagnosis included chronic respiratory failure, chronic pulmonary disease, myocardial infarction (MI) , depressive disorder, and insomnia. Review of Resident #22's MDS 3.0 annual assessment dated [DATE] revealed Resident #22 cognition was moderately intact and did not display indications of psychosis. Resident #22's daughter was the accounts receivable financial responsible party and Resident #22's primary payor source was Medicaid. Interview on 07/17/25 at 9:00 A.M. with Resident #22 revealed she had asked for money from the receptionist for the past week but was told there was no money to give her. Resident #22 stated she asked for twenty dollars, ten dollars then five dollars. Resident #22 stated she felt like she was broke. 4. 4. Resident #85 was admitted to the facility on [DATE]. Medical diagnosis included encounter aftercare following surgical amputation, diabetes mellitus, chronic obstructive pulmonary disease, atherosclerotic heart disease, hyponatremia, hypertension, acquired absence of left above knee , malignant neoplasm of uterus. Review of MDS 3.0 quarterly assessment dated [DATE] revealed Resident #85's cognition was intact and did not have indications of psychosis. Resident #85 was her own accounts receivable and financial party and primary payor source was Medicaid. Interview on 07/14/25 at 3:06 P.M. with Resident #85 revealed she asked for fifty dollars on 07/12/25 but was told by the receptionist the facility did not have any money. Resident #85 stated she felt betrayed. A Voice Message on 07/14/25 at 9:22 A.M. from The Ombudsman #728 revealed she was called by residents on 07/10/25 because the facility did not give residents access to their funds. Interview on 07/16/25 at 11:30 A.M. with licensed practical nurse (LPN) #600 revealed residents had approached her because they were denied access to the petty cash . Some facility staff had used their own money to pay for extra snacks and soda pop for residents. Interview on 07/16/25 at 4:01 P.M. with Registered Nurse (RN) coordinator #626 revealed concerns because several residents could not have access to their money. RN coordinator #626 stated the facility staff used their own money to buy residents chips and pop because residents did not have access to their money and stated Resident #22 thought she had no money. RN coordinator #626 was tearful during the interview. Interview on 07/17/25 at 1:30 P.M. with Chief Financial Officer (CFO) of [NAME] #1030 stated he was not aware there was a problem with the residents' petty cash access and would replenish the petty cash drawer immediately by sending a check to the facility. CFO #1030 stated there should always be enough cash to cover the petty cash drawer used to give residents access to their funds. Interview on 07/21/25 at 2:17 P.M. with the Administrator revealed he did not recall notification prior to the July fourth holiday weekend regarding lack of access to the discretionary account to fund the petty cash drawer in the facility. An interview on 07/22/25 at 11:40 A.M. with the

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to honor Resident #145's power-of-attorney (POA) request for Depakote (mood stabilizer) to be held. This affected one (Resident #145) out of three residents reviewed for choices. The facility census was 141.Findings include:Review of the medical record revealed Resident #145 was admitted on [DATE] with diagnoses that included ataxia, dementia, psoriatic arthropathy, recurrent depressive disorder, wandering, and adult failure to thrive. A progress note dated 07/02/25 at 9:20 A.M. revealed Resident #145's POA visited and had multiple questions. Resident #145's POA re-iterated she did not want Resident #145 on any medications containing a black box warning. The POA's conversation and concerns were reported in a binder for the provider to address. A psychiatric evaluation note dated 07/10/25 revealed Resident #145 was a [AGE] year-old male presented for initial psychiatric evaluation. The assessment note revealed Resident #145 was to continue Zoloft (antidepressant) 25 milligram (mg) at bedtime and Vistaril (sedative to treat anxiety) 25 mg as needed for anxiety. A new order was written for Depakote 125 mg twice a day. The medication administration record (MAR) revealed Resident #145 received Depakote 125 mg on 07/10/25 at bedtime, on 07/11/25 upon rising and at bedtime, was refused on 07/12/25 upon rising, administered on 07/12/25 at bedtime and on 07/13/25 upon rising. A progress note dated 07/13/25 at 12:24 P.M. revealed a new order was received to discontinue Depakote and start Lamictal (mood stabilizer) 25 mg at bedtime.An interview on 07/14/25 at 10:36 A.M. Resident #145's POA stated she had informed the staff the evening of 07/10/25 that she did not want Resident #145 administered Depakote 125 mg until she talked with the psychiatric doctor. On the evening of 07/11/25, Resident #145 stated he did not feel right. Resident #145's POA assured him; he was not getting any different medication. On 07/13/25, Resident #145's POA noticed a different looking pill in Resident #145's medication cup. Licensed Practical Nurse (LPN) #589 stated there were not any new medications, but the manufacturers can change the way the medications look. Resident #145's POA requested a copy of the MAR and noted that Resident #145 had received Depakote. LPN #721 told the POA there was a note to hold the Depakote but some of the nurses may not have seen it.An interview on 07/22/25 at 10:13 A.M. LPN #589 verified Resident #145's POA had questioned Depakote being administered to Resident #145. LPN #589 verified she was not aware there had been a hold put on Resident #145's Depakote. LPN #589 verified Depakote was administered to Resident #145 between 07/10/25 and 07/13/25. An interview on 07/22/25 at 11:13 A.M. LPN #721 verified a hold could not be placed on Resident #145's Depakote without a doctor's order. LPN #721 verbally passed on in report that Resident #145's POA did not want Depakote administered. LPN #721 verified some of the nurses felt Resident #145 needed the Depakote and the nurses did not look in the communication book for the doctors to see the note about holding the Depakote. This deficiency is an incidental finding discovered during the complaint investigation.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify Resident #145's family and physician in a timely manner of changes in behavior and medications. This affected one (Resident #145) out of three reviewed for notifications. Facility census was 141.Findings include:Review of the medical record revealed Resident #145 was admitted on [DATE] with diagnoses that included ataxia, dementia, psoriatic arthropathy, recurrent depressive disorder, wandering, and adult failure to thrive.A care plan dated 06/25/25 revealed Resident #145 had inappropriate behavior and was resistive to care. Interventions included allowing flexibility in activities of daily living routine to accommodate mood, elicit family input for best approaches to resident, and if Resident #145 refused care, and leave Resident #145 and return in 5-10 minutes. a. A progress note dated 06/29/25 at 2:39 A.M. revealed Resident #145 had a skin tear to the left elbow that measured one centimeter (cm) long and three cm wide. An additional progress noted dated 06/29/25 at 4:42 A.M. revealed Resident #145 had been up most of the night pacing and trying to go into other resident rooms. Resident #145 was very difficult to redirect. A progress note dated 06/29/25 at 2:50 P.M. revealed Resident #145's spouse was notified of skin tear to Resident #145's left elbow. At 2:51 P.M. Resident #145's spouse stated they would like to be notified anytime day or night, no matter the time, of any incidents or information of importance. The medication administration record (MAR) revealed from 06/29/25 to 07/16/25 the nurses acknowledged the order to notify Resident #145's wife of incidents at any time. b. A progress note dated 07/06/25 at 10:34 A.M. revealed at 6:15 A.M. a certified nursing assistant (CNA) called the nurse and said Resident #145 had beat up a couple staff and was trying to go into other resident rooms. The police had been called and arrived at the facility. Resident #145 was transported to the hospital at 6:50 A.M. for evaluation. c. A progress note dated 07/06/25 at 3:11 P.M. revealed Physician #888 was notified of the incident with Resident #145 that occurred with staff resulting in a transfer to the hospital. A care plan dated 07/07/25 revealed Resident #145 had a problematic manner in which Resident #145 acted characterized by ineffective coping; agitation related to physical aggressive toward staff, striking and knocking down staff members when care attempted, and difficult to redirect. Resident #145 could also be verbally sharp with staff or others. Interventions include to be careful not to invade Resident #145's personal space, elicit family input for best approaches to resident, and give Resident #145 an item or task in an attempt to distract. Review of the treatment administration record (TAR) revealed from 07/10/25 through 07/16/25 the nurses were signing each shift that Resident #145 was to be told his wife would be called immediately upon any acting out and his wife would come see him. d. A progress note dated 07/14/25 at 6:30 A.M. revealed Resident #145 was exit seeking and trying to open doors. Resident #145 also wandered into another resident room. A progress note dated 07/14/25 at 6:41 A.M. revealed Resident #145 was angrily hitting door and exit seeking. A progress note dated 07/14/25 at 6:50 A.M. revealed Resident #145 was hitting the glass exit door and stated he wanted to go home. A progress note dated 07/14/25 at 2:02 P.M. revealed Resident #145 left with family. An interview on 07/14/25 at 10:36 A.M. Resident #145's wife verified she was not notified of the incident the morning of 07/06/25 until Resident #145 was at the hospital. Resident #145's wife also verified she was not notified the morning of 07/14/25 that Resident #145 had behaviors and was exit seeking. An interview on 07/14/25 at 3:07 P.M. Physician #888 verified he was the medical director and Resident #145's physician. Physician #888 stated he was made aware of the incident on 07/06/25 with Resident #145 and staff but was unable to recall when he was notified. Physician #888 verified he was notified sometime after the incident occurred. An interview on 07/14/25 at 1:34 P.M. DON verified there was no documentation of Resident #145's wife being notified of Resident #145's behaviors on 07/06/25 prior to sending Resident #145 to the hospital and Physician #888 being notified in a timely manner on 07/06/25. DON also verified there was not documentation of Resident #145's wife being notified on 07/14/25 when Resident #145 was having behaviors and exit seeking. Review of the notification policy (no date) revealed the purpose of the policy was to ensure timely, accurate, and appropriate communication with resident's families or legal representatives regarding significant changes in a resident's condition, incidents, or other matters affecting the resident's health, safety, or well-being. A significant change is defined as a change in the resident's physical, mental, or psychosocial status that is significant enough to warrant medical intervention, care plan review, or impacts the resident's well-being. An incident is an event that affects the resident's safety, health, or well-being, including accidents, injuries, or elopements. Staff shall notify the resident's responsible party as soon as

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, including review of facility billing/financial information, review of email communication, review of the facility Abuse/Neglect policy and procedure and interviews, the facility neglected to meet financial obligations for the delivery of care and maintenance and to operate in a manner to ensure all bills were being paid timely to prevent potential interruption in services and to meet the total care needs of all residents admitted to and/or retained in the facility. This had the potential to affect all 141 residents residing in the facility. Findings include:1. Interview on 06/27/25 at 11:04 A.M. with Former Medical Director (FMD) #727 revealed he had not been paid for the last thirteen months he worked for the facility (May of 2034 to May of 2025). FMD #727 stated when he started to ask for payment in the fall of 2024 he eventually received a termination note on 04/30/25 that as of 06/01/25 was his last day as the medical director. Review of document titled Medical Director Invoice billed to Saint Luke's for the month of March, April, May 2025 , revealed a total of twenty-five thousand two hundred dollars was due. Interview on 07/07/25 at 4:09 P.M. revealed the Administrator was not aware FMD #727 had not been paid and stated he would reach out to Corporate regarding payment after review of the March, April, May 2025 Medical Director invoice. 2. Interview on 06/30/25 at 10:10 A.M. with Former Activities Director (FAD) #624 revealed concern Pastor #733 had not been paid for his services since February 2025. Interview on 07/01/25 at 4:00 P.M. with Activities Aid # 629 revealed Pastor #733 was the Chaplin/Religious director for the facility , he provided spiritual support for the facility. Interview on 07/02/25 at 3:16 P.M. with Pastor #733 revealed he was the chaplain in the facility and provided religious services twice a week. Pastor #733 stated he received an email offer for payment of one hundred seventy-five dollars per week. Pastor #733 stated his last payment received from the facility was February 2025. He did not receive payment for services in March, April, May or June 2025 for a total of twelve weeks. Review of a copy of email exchange dated 04/16/25 revealed the former administrator approved Pastor #733 to provide services twice a week for the residents and was to be paid one hundred seventy-five dollars per week. Review of a copy of email exchange dated 06/26/25 from Pastor #733 to the Administrator revealed a payment had not been received for services the past four months and requested the matter be addressed urgently. Interview on 07/07/25 at 4:09 P.M. with the Administrator revealed he was unaware Pastor #733 had not been paid after review of email exchange dated 06/26/25 from Pastor #733 to the Administrator. 3. Interview on 07/01/25 at 1:20 P.M. with Former Activities Director (FAD) #624 revealed lawn care had stopped coming and the landscaping outside the Dementia Unit patio had not been done all year. Interview on 07/07/25 at 2:30 P.M. with the Director of Maintenance #575 revealed [NAME] Lawn care would cut the facility's grass, spray for weeds and trim bushes and trees but the facility did not pay [NAME] Lawn care bill. The Administrator wanted the facility maintenance crew to provide lawn maintenance instead, but the facility did not provide equipment to maintain the landscaping of the facility. Observation on 07/07/25 at 2:43 P.M. with the Director of Maintenance #575 revealed grass and weeds were growing from cracks in the parking lot that measured four to sixteen inches long, the grass in the front of the building and along the facility was tall reaching past ankle length. Bushes outside resident's rooms were overgrown and the Dementia Unit patio had a thick blanket of dried leaves surrounding the outside of the patio. Interview on 07/07/25 at 3:00 P.M. with the owner of [NAME] Landscaping revealed the company had stopped services as of April 2024 because the facility did not pay their bill. Review of document titled [NAME] Landscaping, invoice #0006330, dated 05/17/25 revealed nine thousand seven hundred ninety-two dollars and fifty cents was a balance due for the April and May 2025 invoice. Interview on 07/07/25 at 4:09 P.M. with the Administrator revealed he was unaware [NAME] Lawn care company had not been paid and stopped services after review of invoice #0006330. 4. An Interview on 06/30/25 with Registered Dietitian (RD) # 732 revealed the facility had been warned about overdue invoices and the possibility of suspended services. Interview on 07/01/25 at 2:45 P.M. with RD #730, who received payments and provided overdue notices for Nutri Tech, revealed the facility had an ongoing delay in payments since June 2024 . Nutri tech provided contract RD services, and the Administrator was notified of need for payment. RD #730 stated the facility was in breach of contract and owed Nutri Tech sixteen thousand dollars. Review of document title Nutri Tech invoice number 3218 billed to Saint Luke's dated 05/31/25 revealed a due date of 06/30/25 for the amount of eight thousand sixty-four dollars. Interview on 07/01/25 at 4:33 p.m. with the Administrator revealed he was not aware of the risk of no further RD services and stated

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility investigation, self-reported incident (SRI), and policy review, the facility failed to complete a thorough and adequate investigation in a timely manner. This affected one (Resident #145) out of two reviewed for abuse. The facility census was 141.Findings include: Review of the medical record revealed Resident #145 was admitted on [DATE] with diagnoses that included ataxia, dementia, psoriatic arthropathy, recurrent depressive disorder, wandering, and adult failure to thrive.A care plan dated 06/25/25 revealed Resident #145 had inappropriate behavior and was resistive to care. Interventions to allow flexibility in the activities of daily living routine to accommodate mood, elicit family input for best approaches to Resident #145, and leave and return in five to ten minutes if Resident #145 refuses care. Review of video footage of the hall and common area outside Resident #145's room revealed on 07/06/25 at 5:46 A.M. Resident #145 walked out into the hallway wearing only a disposable incontinence brief. Resident #145 had a slow gait and was looking down at the floor. Resident #145 stopped and rubbed his face and looked around. At 5:47 A.M. Resident #145 walked down the hall and entered the next room on the left (Resident #67). CNA #568 stated, Honey, that is a woman's room, and you cannot go in there. CNA #568 entered the room and calmly told Resident #145 that his room was over there. CNA #800 stated you must come out of that room. CNA #800 stood in the doorway with arms crossed. At 5:48 and nine seconds A. M. Resident #145 exited Resident #67's room and walked slowly back towards his room. At 5:48 and 15 seconds CNA #800 stated your room is right there and that is where you need to go. At 5:48 and 20 seconds Resident #145 stated something about court. At 5:48 and 22 seconds CNA #586 stated we will meet you there, but I suggest if we go to court, you put some clothes on which are in your room. At 5:48 and 33 seconds, Resident #145 turned away from his room and started toward Resident #51's room which was located directly across the hall from Resident #145's room. At 5:48 and 34 seconds CNA #586 raised her voice and told Resident #145 do not go into a patient's room. At 5:48 and 35 seconds CNA #586 again stated in an even louder voice Do not go in a patient's room. At 5:48 and 40 seconds CNA #586 and CNA #800 entered Resident #51's room with Resident #145. CNA #800 stated in a firm voice, you cannot go in here that is a woman's room. At 5:48 and 43 seconds CNA #800 yelled stop and CNA #586 yelled don't touch her. At 5:48 and 45 seconds, CNA #586 exits the room and said that's it, I'm calling the cops. At 5:48 and 47 seconds, CNA #800 also exits the room. At 5:48 and 56 seconds, CNA #586 reenters the room and said, I will not let you near my patients. You will get out. At 5:49 AM CNA #586 said in a loud voice, yes, you will and then repeated yes you will in a louder voice. At 5:49 AM and seven seconds, CNA #586 yelled out, He's beating the (expletive) out of me. CNA #800 yelled, I'm coming. At 5:49 and 15 seconds CNA #800 entered the room and CNA #586 stated, he threw me on the floor. At 5:49 and 21 seconds yelling in loud voices from CNA #586 and CNA #800 included: you can get out, OUT, You are on a memory care unit, Get out, You need to go now, out. At 5:49 and 30 seconds can see Resident #145 slowly approached the doorway from Resident #51's room to the hallway. CNA #568 and CNA #800 can be heard telling Resident #145 it was not his house, and he was at a nursing facility. At 5:50 and 24 seconds, CNA #568 called 911. A CNA can be heard stating Resident #145 was a new resident, was combative, and staff had been injured, and Resident #145 was threatening other residents. CNA #568 stated there was not proper staffing and there was not a nurse on the unit. CNA #568 stated a police officer was needed if the facility was not going to staff properly. At 5:51 and 40 seconds AM CNA #800 walked out of the room and was on the phone standing in the hallway. CNA #568 was still in Resident #51's room and on the phone with 911. CNA #568 stated she did not need a medic yet but may if Resident #145 did not stop. CNA #800 spoke up and said Resident #145 had tossed both CNA's and was extremely combative. At 5:51 and 49 seconds, Resident #145 stepped out of view back into Resident #51's room. Both CNA's told Resident #145 to leave the room. CNA #568 stated she needed the police soon. At 5:52 and two seconds CNA #568 yelled ouch and in a firm voice stated you need to move. At 5:52 and 19 seconds CNA #568 stated there was no one at the front door to let the police in. CNA #800 stated you need to get out of this room. This is a woman's room, NOW! At 5:53 and 15 seconds CNA #568 was heard saying do not go near my patient in a loud voice and then again in a louder voice. At 5:53 at 23 seconds, CNA #800 stated let's go and CNA #586 stated Protect your license, protect your licenses. At 5:54 at 19 seconds, Resident #145 can be observed again standing at the doorway to Resident #51's room. At 5:55 and four seconds, Resident #145 stepped slowly back into Resident #51's

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	365521	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an assessment was completed before Resident #145 was placed on the secure/memory care unit. This affected one (Resident #145) out of three reviewed for placement on the secure unit. The facility census was 141. Findings include:Review of the medical record revealed Resident #145 was admitted on [DATE] with diagnoses that included ataxia, dementia, psoriatic arthropathy, recurrent depressive disorder, wandering, and adult failure to thrive.A care plan dated 06/25/25 revealed Resident #145 wanted to go home and was an elopement risk related to behaviors of pacing the halls and wandering into resident rooms. Interventions included to check function of secure tech bracelet weekly, reinforce reasons for placement, and encourage family involvement/support.Review of the medical record revealed no evidence of an assessment being completed to ensure Resident #145 was appropriate for placement on a secure unit.An interview on 07/14/25 at 8:46 A.M. Director of Nursing (DON) verified Resident #145 did not have an assessment completed prior to admission on the secure unit.A Functional Assessment for the secure unit admission dated 07/14/25 revealed Resident #145 had severe mentation impairment, was uncooperative, and resistive. Resident #145 had behaviors of wandering, being verbally and physically abusive, being socially inappropriate, resistive to care, wandering, and exit seeking. Resident #145 had a history of attempts to exit home prior to admission, had periods of aggression, and was aggressive with spouse at home. Resident #145 would roam the halls at the facility looking for his wife. Resident #145 could be agitated, hit doors, and wander into other resident rooms. Resident #145 had recently attempted to exit the building. Resident #145 did exit the secure unit causing the alarm to sound. This deficiency is an incidental finding discovered during the complaint investigation.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident #145 had an individualized care plan in place to address behaviors. This affected one (Resident #145) out of three residents reviewed for care plans. The facility census was 141.Findings include:Review of the medical record revealed Resident #145 was admitted on [DATE] with diagnoses that included ataxia, dementia, psoriatic arthropathy, recurrent depressive disorder, wandering, and adult failure to thrive.A care plan dated 06/25/25 revealed Resident #145 had inappropriate behavior and was resistive to care. Interventions included to allow flexibility in activities of daily living routine to accommodate mood, elicit family input for best approaches to resident, and if resident refuses care, leave and return in five to ten minutes. The Kardex report printed 07/14/24 for the Certified Nursing Assistants (CNA) revealed no indication of Resident #145 having behaviors or interventions for behaviors. The CNA report sheet (no date) revealed Resident #145 was up ad lib and wandered. There was no documentation of any other behaviors or interventions for behaviors or wandering. An interview on 07/09/25 at 8:01 A.M. Director of Nursing (DON) revealed Resident #145 was not a good fit for the facility. The facility had a memory care unit, not a behavior unit. DON stated he did not want to admit Resident #145 to the facility because of the behaviors described in the hospital records. DON also stated if there were multiple males on the memory care unit, it caused problems. An additional interview on 07/10/25 at 9:01 A.M. DON again stated he did not think Resident #145 was a good fit for the facility because of red flags of why Resident #145 was hospitalized . DON stated Resident #145 was younger ([AGE] years old), had beaten his wife, and had to be given two milligrams of Haldol (antipsychotic) at the hospital and then Resident #145 was okay. DON stated he did not want to admit Resident #145, but the admissions person went ahead and admitted Resident #145. DON stated he was on vacation when Resident #145 was admitted . DON verified there were no interventions put in place to address Resident #145's behaviors and the DON concerns. An interview on 07/10/25 at 1:59 P.M. Social Service #645 revealed a referral for Resident #145 to receive psychiatric services had been sent on 07/01/25. Psychiatric services were scheduled to see Resident #145 on 07/10/25. An interview on 07/14/25 at 9:22 A.M. Licensed Nursing Home Administrator (LNHA) verified there were questions and concerns about admitting Resident #145, but the family toured the facility and stated the hospital had overexaggerated Resident #145's behaviors. An interview on 07/14/25 at 10:12 A.M. DON stated the memory care unit was not for residents with behaviors. The memory care unit was mainly for residents that wandered. This deficiency is an incidental finding discovered during the complaint investigation.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to provide residents who were dependent with bathing, two showers a week. This affected one (Resident #77) out of three reviewed for activities of daily living (ADL). The facility census was 141.Findings include:Review of the medical record revealed Resident #77 was admitted on [DATE] with diagnoses that included multiple sclerosis, recurrent depressive disorders, and chronic kidney disease.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #77 was cognitively intact. The MDS also revealed Resident #77 was dependent on staff for bathing. Review of the bathing documentation revealed Resident #77 received a shower on 07/03/25, 07/10/25, and 07/17/25. Resident #77 received a bed bath on 07/24/25. An interview on 07/28/25 at 1:55 P.M. Director of Nursing (DON) verified Resident #77 did not receive a shower twice a week as scheduled. An interview on 07/28/25 at 2:41 P.M. Resident #77 verified she only received one shower a week. Resident #77 stated she had not received a shower for approximately two weeks. Resident #77 stated she preferred a shower over a bed bath and wanted showered twice a week. Resident #77 stated there was one Certified Nursing Assistant (CNA) that made sure she received a shower, but that CNA had been off work for at least a week. Resident #77 stated the other CNA's stated there were not enough staff to provide a shower. Review of the ADL policy (no date) revealed CNA's and nursing staff are responsible for providing daily ADL care and documenting services rendered. This deficiency represents noncompliance investigated under Master Complaint Number OH002570130 and Complaint Number OH001297234 (OH00167429)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interviews, the facility failed to implement a comprehensive and resident centered plan to prevent and/or treat the development of pressure ulcers. Actual harm occurred beginning on 06/08/25 when Resident #95, who was at high risk for pressure ulcer development and dependent on staff for activities of daily living, developed an avoidable Stage II pressure ulcer (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose [fat] is not visible, and deeper tissues are not visible. Granulation tissue, slough and eschar are not present) to the left buttock. The wound was not comprehensively assessed, wound treatments were not consistently provided and appropriate staff were not notified of the development of the pressure ulcer. The pressure ulcer subsequently declined and on 07/17/25 was assessed to be a Stage III (full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible) pressure ulcer to the left buttock. Resident #95 also developed an additional facility acquired Stage III pressure ulcer to her left buttock as a result of the lack of adequate, comprehensive and individualized interventions and monitoring. This affected one resident (#95) of three residents reviewed for pressure ulcers. Findings include:Review of the medical record revealed Resident #95 was admitted on [DATE] with diagnoses that included Alzheimer's disease, anxiety disorder, and psychosis.A plan of care revised 01/12/23 revealed Resident #95 had a self-care deficit and impaired mobility due to dementia. Interventions included a super soaker brief due to diuretic use and transfer with a mechanical lift. A plan of care revised 11/22/23 revealed Resident #95 required assistance with toileting and was incontinent. Interventions included to encourage Resident #95 to perform toileting and hygiene every two hours while awake and assist as necessary and check for wetness on rounds during the night. A plan of care revised 11/22/23 revealed Resident #95 had the potential for skin breakdown due to Resident #95 requiring assistance with mobility needs and incontinence. Interventions included weekly skin checks performed by a licensed nurse, barrier cream after each incontinence care and as needed, turn and reposition Resident #95 every two hours and as needed as the resident will allow, a pressure reduction cushion to wheelchair, and the physician, unit manager, nursing staff, and family would be notified of skin problems and a treatment would be initiated as ordered. On 03/01/25 Resident #95 weighed 109 pounds. On 04/02/25 Resident #95 weighed 108 pounds. On 05/02/25 Resident #95 weighed 108 pounds.The quarterly Minimum Data Set (MDS)dated 05/13/25 revealed Resident #95 had a memory problem and was dependent on staff for toileting, rolling left to right, and from sitting to lying. The MDS also revealed Resident #95 was always incontinent of bowel and bladder. The MDS revealed Resident #95 had no skin concerns. The quarterly Braden Scale for Determination Pressure Sore risk dated 05/23/25 revealed Resident #95 was at high risk. Resident #95 scored a 10 with a score below 12 identified as high risk. Resident #95 had very limited ability to respond meaningful to pressure related discomfort, had constant moisture, was chair fast, was completely immobile, and required moderate to maximum (staff) assistance in moving. A weekly skin check marked on the treatment administration record (TAR) dated 06/02/25 revealed Resident #95 had no evidence of skin impairment.On 06/04/25 Resident #95 weighed 103 pounds.A nursing progress note dated 06/08/25 at 7:23 P.M. by an agency nurse revealed Resident #95 had an open area to the left buttocks that measured 0.5 centimeters (cm) long, 0.5 cm wide, and less than 0.1 cm deep. A new order was received for Resident #95's left buttock to be cleansed with normal saline and a foam dressing applied every day at bedtime and as needed.A weekly skin check marked on the treatment administration record (TAR) dated 06/09/25 revealed Resident #95 had no evidence of skin impairment.A dietary note by Registered Dietician (RD) #732 dated 06/09/25 at 9:34 P.M. revealed Resident #95's current weight was 103 pounds. Resident #95 had a significant weight loss of 16 pounds in the last six months. The weight loss was not planned by the doctor but likely expected per the progress note (the resident had been receiving hospice services since 11/09/23). The current nutrition plan was to be continued, and Resident #95 would be monitored and followed up on. Review of the TAR revealed no evidence the treatment to the left buttock area was completed as ordered on 06/11/25, 06/24/25, or 06/26/25. A weekly skin check marked on the TAR dated 06/16/25 revealed Resident #95 had no documented evidence of skin impairment.A weekly skin check marked on the TAR dated 06/23/25 revealed Resident #95 had no documented evidence of skin impairment.A hospice interdisciplinary team visit note dated 06/24/25 at 12:00

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and policy review, the facility failed to ensure medications were secure on the memory care unit. This had the potential to affect all 35 residents on the memory care unit. The facility census was 141. Findings include:An observation on 07/09/25 at 9:54 A.M. revealed nine residents were in the dining room on the memory care unit. A medication cart was sitting against the wall in the dining room. The medication cart lock was not pushed in to lock the cart. A large bottle of acetaminophen (for fever or pain) 500 milligrams was sitting on the top of the medication cart. The lid was off the acetaminophen and lying on the cart. There were approximately 15 to 20 tablets in the open bottle of acetaminophen. A Certified Nursing Assistant (CNA) was assisting residents out of the dining room. On 07/09/25 at 9:55 A.M. Licensed Practical Nurse (LPN) #639 came quickly down the hallway and stated she had just stepped away for a moment. LPN #639 verified the medication cart was unlocked and there was an open bottle of acetaminophen sitting on top of the medication cart. On 07/14/25 at 10:12 A.M. Director of Nursing stated all residents on the memory care unit have a diagnosis of dementia. The memory care unit was mainly for residents that were at risk for wandering.Medication storage (no date) revealed with the exception of emergency drug kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. This deficiency is an incidental finding discovered during the complaint investigation.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, policy review, and staffing schedules, the facility failed to ensure they were adequately staffed to ensure Residents (#7, #9, #14, #17, #20, #22, #23, #24, #25, #26, #28, #29, #32, #33, #37, #38, #41, #44, #50, #51, #52, #59, #62, #66, #73, #74, #75, #77, #89, #92, #95, #96, #100, #110, #115, #122, #125, #126, #127, #135, #139, and #145) were adequately supervised, provided incontinence care, had medications administered as ordered, had treatments completed as ordered, and received meal trays. This affected 42 Residents(#7, #9, #14, #17, #20, #22, #23, #24, #25, #26, #28, #29, #32, #33, #37, #38, #41, #44, #50, #51, #52, #59, #62, #66, #73, #74, #75, #77, #89, #92, #95, #96, #100, #110, #115, #122, #125, #126, #127, #135, #139, and #145) out of 141 residents. However, this had the potential to affect all residents. The facility census was 141. Findings include:1. Review of the call light times for 07/05/25 revealed at 7:24 A.M. Resident #110's call light was on for two hours and 46 minutes. At 9:07 A.M. Resident #100's call light was on for one hour and five minutes. At 9:37 A.M. Resident #89's call light was on for 37 minutes. At 10:29 A.M. Resident #92's call light was on for 35 minutes. At 1:51 P.M. Resident #139's call light was on for 31 minutes. At 2:17 P.M. Resident #115's call light was on for one hour and 26 minutes. At 2:27 P.M. Resident #100's call light was on for one hour and 17 minutes. An interview on 07/15/25 at 11:01 A.M. Resident #22 stated call lights take a long time to be answered and then she forgets what she needed. An interview on 07/22/25 at 9:24 A.M. DON verified the facility did not have adequate staff the weekend of 07/04/25. The DON stated he was on vacation and did not run the per patient day (PPD) to calculate the amount of nursing care hours allotted to each resident. DON verified the PPD for 07/05/25 and 07/06/25 did not meet the state requirement of 2.5 PPD. An interview on 07/28/25 at 10:49 A.M. Resident #31 revealed there were not enough staff to provide appropriate care. Call lights could take one and a half hours to be answered, and showers were not being done. Resident #31 stated she has to call the facility nurse coordinator at times to get someone to assist her. 2. Review of the medication administration records (MAR) and treatment administration records (TAR) revealed the following residents did not receive scheduled medications and had treatments completed as ordered: a. Resident #145's bilateral heels did not have skin prep applied on 07/05/25 at 11:00 P.M. b. Resident #37's bilateral buttocks were not cleansed, and stoma powder and A&D ointment were not applied on 07/05/25 at 11:00 P.M. c. Resident #50's bilateral heels did not have skin prep applied on 07/05/25 at 11:00 P.M. d. Resident #74's bilateral heels did not have skin prep applied on 07/05/25 and 11:00 P.M. e. Resident #95's Norco (for moderate to severe pain) 5-325 mg and Lorazepam (for anxiety) 0.5 mg was not administered on 07/05/25 at 10:00 P.M. The left buttock was not cleansed and foam dressing was not applied on 07/05/25 at 11:00 P.M. f. Resident #122's bilateral heels did not have skin prep applied on 07/05/25 at 11:00 P.M. g. Resident #126's left buttock was not cleansed, and stoma powder and A&D ointment were not applied on 07/05/25 at 11:00 P.M. h. Resident #52's bilateral heels did not have skin prep applied, and sacrum/bilateral buttocks were not cleansed, and stoma powder and A&D ointment were not applied on 07/05/25 at 11:00 P.M. Levothyroxine (to treat hypothyroidism) 137 micrograms (mcg) was not administered 07/06/25 at 5:00 A.M. i. Resident #14's right heel did not have skin prep applied on 07/05/25 at 11:00 P.M. and Levothyroxine 25 mg was not administered on 07/06/25 at 6:00 A.M. j. Resident #20's Levothyroxine 100 mcg was not administered on 07/06/25 at 5:00 A.M. k. Resident #32's Synthroid (to treat hypothyroidism) 100 mcg was not administered on 07/60/25 at 5:00 A.M. l. Resident #44's Metoprolol (to treat high blood pressure) 25 mg was not administered on 07/06/25 at 6:00 A.M. m. Resident #51's Levothyroxine 88 mcg was not administered on 07/06/25 at 5:00 A.M. n. Resident #96's Levothyroxine 150 mcg was not administered on 07/06/25 at 5:00 A.M. o. Resident #122's Oxycodone (opioid for moderate to severe pain) 5 mg was not administered on 07/06/25 at 6:00 A.M. p. Resident #125's Klonopin (to treat anxiety) 0.5 mg was not administered on 07/06/25 at 6:00 A.M. q. Resident #127's Pantoprazole (to treat acid reflux) 40 mg and Tylenol Arthritis (pain reliever) 1300 mg was not administered on 07/06/25 at 6:00 A.M. r. Resident #73's Biofreeze (topical analgesic) was not applied on 07/05/25 at 10:00 P.M. Skin prep was not applied to bilateral heels on 07/05/25 at 11:00 P.M. Midodrine (to treat low blood pressure) 5 mg was not administered on 07/05/25 at 10:00 P.M. and 07/06/25 at 6:00 A.M. Levothyroxine 25 mcg was not administered on 07/06/25 at 6:00 A.M. Review of the time sheets revealed the agency Licensed Practical Nurse (LPN) #925 working the memory care unit clocked out on 07/06/25 at 1:28 A.M. and did not work the entire shift as scheduled. The state minimum direct care daily average of 2.50

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Luke Lutheran Home	220 Applegrove Street NE North Canton, OH 44720

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of facility recorded video footage with sound, observation of police officer body camera footage, medical record review, facility incident review, review of a self-reported incident, interview, dementia training curriculum review, facility assessment review and policy review the facility failed to ensure Resident #145, who was cognitively impaired and had a diagnosis of dementia, was provided adequate, necessary kind, appropriate and dignified dementia care to meet his total care needs. This resulted in immediate jeopardy and the potential for serious harm and injury on 07/06/25 at 5:46 A.M. when the resident began to wander throughout the facility secured dementia unit. Certified Nursing Assistant (CNA) #800 and CNA #568 were observed on video to yell at the resident to get out of other resident rooms, to go back to his room, the facility was not his home and to stop hitting staff or they would call the police, and he would go to jail. The lack of planned and appropriate intervention, lack of appropriately trained staff to care for the residents (including Resident #145), on the specialty unit, and lack of staff supervision resulted in police being called to the facility to assist with the resident. The CNAs falsely reported to the police resident behaviors, and the resident was unnecessarily transferred to the hospital emergency room and returned to the facility the same day. The facility consultant psychiatrist then implemented the use of Depakote (an anti-seizure medication that can be used as a psychotropic medication), to the resident's treatment plan to manage the resident's behaviors. This affected one resident (Resident #145) of three residents reviewed. The facility census was 141.On 07/16/25 at 1:45 P.M., the Administrator, Director of Nursing (DON) and Assistant Director of Nursing were notified Immediate Jeopardy began on 07/06/25 at 5:46 A.M. when Resident #145 began to wander on the facility secured dementia unit. CNA #800 and CNA #568 were observed on video to yell at the resident to get out of other resident rooms, to go back to his room, the facility was not his home and to stop hitting staff or they would call the police, and he would go to jail. The police were contacted to assist in the care of Resident #145 and the resident was unnecessarily transferred to the hospital after CNA #585 and CNA #800 falsely reported resident behaviors to the police department and facility nursing staff. Facility Administration failed to complete a thorough investigation of the incident, failed to review the facility recorded security camera video footage with sound from the secured dementia unit common area, failed to ensure staff responded appropriately to a population in their facility requiring specialized training and permitted CNA #585 and #800 to return to work on 07/06/25 to provide care to the residents on the secured dementia unit, including Resident #145.The Immediate Jeopardy was removed on 07/18/25 when the facility implemented the following corrections: On 07/16/25 (no time provided) Certified Nursing Assistant (CNA) #568 and #800 were suspended and a full internal investigation was initiated. CNA #800 was placed on the do not return list and CNA #568 will remain on suspension pending the outcome of the investigation. On 7/16/25 (no time provided) Pharmacist #300 completed a medication regimen review for Resident #145 and no changes were recommended. On 07/16/25 at 4:00 P.M. Social Services #400 contacted Resident #145's wife to discuss the facility's plan to involve the resident's family in future behavioral interventions such as notifying the resident's spouse anytime, day or night, of behaviors and/or incidents. The resident's wife plans to spend some nights with the resident and the staff will ask the resident's spouse to assist and/or be present during any behaviors. On 07/16/25 Social Services #502 implemented the facility Notification Protocol for Resident #145 which required staff to immediately notify Resident #145's wife of significant behaviors or interventions. If immediate notification was unable to be made, the resident's wife/family would be notified within 12 hours. The spouse's input would be incorporated into the resident's care plan to reduce reliance on restrictive interventions. Beginning 07/16/25 and continuing until all 105 nursing staff (18 Registered Nurses, 22 licensed practical nurses and 65 CNA) are educated prior to their next scheduled shift on the secured unit, in-person by the DON or designee related to preventing and responding to catastrophic reactions, trauma-informed dementia care, use of calm, kind, respectful tone: zero tolerance for threats or intimidation, communication and behavioral de-escalation during high stress situations via training materials and using sign in sheets. Information packets will be available for agency staff to review and sign prior to working on the secured unit. Beginning 07/16/25 incident review by the charge nurse and DON is required before calling external authorities. The medical director or on-call physician's input is also required unless there is an immediate life-threatening emergency. De-escalation and resident specific interventions must be exhausted first. This will be included in the all-staff education provided by the DON/designee. On 07/17/25 Psychiatry

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and test tray results, the facility failed to maintain palatable and appetizing food temperatures. This had the potential to affect all but two residents (Resident #68 and Resident #66) who did not receive a meal tray from the kitchen. The census was 144. Findings include: 1. Review of Resident #39's medical record revealed an admission date of 03/27/23. Medical diagnosis included nontraumatic intracranial hemorrhage, pneumonia, depression, anxiety, bipolar and dementia. Review of Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed cognition was moderately impaired. No rejection of care was noted. Resident #39 needed supervision to eat. Review of Nutrition assessment dated [DATE] revealed Resident #39 was on a regular diet consistency, regular liquid consistency with a no added salt restriction. Interview on 07/02/25 at 1:02 P.M. with Resident #39 who stated the chicken was too hard to chew and cut, ,therefore, she did not eat the chicken and she stated the food was cold. 2. Record review of Resident #65 revealed an admission date of 06/19/25. Medical diagnosis included carcinoma of rectum, cirrhosis of liver, abdominal pain, retention of urine and severe protein calorie malnutrition. Review of the admission MDS assessment dated [DATE] revealed Resident #65's cognition was intact and needed set up assistance to eat. Review of physician order dated 06/20/25 revealed Resident #65 was ordered a low fiber diet, with thin liquid consistency. Interview with Resident #65 on 06/26/25 at 11:40 A.M. revealed Resident #65 stated the food in the facility tasted bad. 3. Record review of Resident #33 revealed an admission date of 11/18/19. Medical diagnosis included compression fracture of lumbar, osteoporosis, malignant neoplasm of breast and pancreas. Review of the MDS 3.0 quarterly assessment dated [DATE] revealed cognition was intact and Resident #33 needed set up assistance to eat. Review of physician orders dated 11/19/19 revealed Resident #33 had a regular diet order with thin liquid consistency. Interview with Resident #33 on 06/30/25 at 12:32 P.M. revealed Resident #33 stated the food was terrible. On 06/30/25 at 12:50 P.M. a test tray was sent to the Dementia Unit. At 1:10 P.M. all trays were passed. Temperatures were tested by Dietary Shift leader #638 that revealed the cottage cheese temperature was 66. 7 degrees Fahrenheit, the whole milk temperature was 62.9 degrees Fahrenheit. The mixed vegetables temperature was 133.7 degrees Fahrenheit, mashed potatoes were 131.1 degrees Fahrenheit, plain noodles was 113 degrees Fahrenheit and the chicken was at 127 degrees Fahrenheit. The food was cold to taste and the mixed vegetables had no seasoning. The noodles presented as a clump on the plate and tasted cold. Dietary Shift Leader #638 verified the chicken was hard and chewy and verified the test tray food temperatures was not appropriate at the time of observation. Review of facility document Food for Thought Meeting Minutes, dated 05/19/25, revealed residents had concerns because the warming plates were not warm enough. The Food Service Director #716 was not able to provide additional Food for Thought Meeting Minutes for the months of April and June 2025. Review of the facility policy titled Food Palatability, dated May 2021, revealed the meals must be well seasoned and palatable.This deficiency is an incidental finding discovered during the complaint investigation.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident #37 was provided with a diet texture as ordered. This had the potential to affect eight residents (Resident #34, #81, #95, #97, #98, #101, #134, and #135) who received puree diets. The facility census was 141. Findings include: Resident #37 was admitted to the facility on [DATE]. Medical diagnosis included Alzheimer's disease, osteoarthritis, hypertension, major depressive disorder, type two diabetes, dementia and encephalopathy. Review of physician orders dated 02/23/24 revealed Resident #37 was ordered a puree diet with thin liquid consistency. Review of Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE], revealed Resident #37 had short and long term memory problems. Resident #37 needed moderate assistance to eat and had no loss of liquids from mouth or was holding food in mouth or choking during meals during the review period. Resident #37 was on a mechanically altered and therapeutic diet. Review of Nutritoin assessment dated [DATE] revealed Resident #37 was on a puree diet consistency but could have mechanical soft desserts. The puree diet was appropriate for nutritional management of dysphagia. Observation on 06/30/25 at 12:19 P.M. revealed the facility lunch tray line was in process and puree vegetables, puree chicken and mashed potatoes was set in the food steamer for service. The puree mixed vegetables were observed to have multiple lumps, the puree chicken was not smooth and had multiple lumps. Interview on 06/30/25 at 12:20 P. M. at 12:20 P.M. with Dietary Shift Leader #638 verified the puree chicken and puree vegetables in the steam table was not smooth and stated the chicken and vegetables needed to be smoother. Interview on 06/30/25 at 12:21 P.M. with [NAME] #523 verified the puree chicken and puree vegetables was not smooth and stated it was difficult to puree chicken. On 06/30/25 at 12:47 P.M. Dietary Director #716 observed the puree chicken and puree vegetables in the steam table and verified the puree food was lumpy, and could be smoother. Observation on 07/01/25 at 1:00 P.M. of the Dementia unit dining room revealed Resident #37 was observed spitting out puree chicken. Interview on 07/01/25 at 1:02 P.M. with Certified Nursing Assistant (CNA) revealed Resident #37 spit out her food because of the chunks in her puree chicken, CNA #667 verified the puree chicken was not a smooth consistency. Review of facility policy titled Puree Texture Modification, revised 02/01/25, revealed the regular menu items were puree to a smooth pudding/mashed potato like consistency. This deficiency represents noncompliance investigated under Complaint Number OH001297228 (OH00166964).

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, review of facility billing/financial information, review of the facility assessment, review of the Administrator's job description, and interviews the facility failed to ensure effective and efficient administration to meet the total care needs of all residents in the facility. The facility census was 141. Findings include: Review of survey history revealed the facility was cited neglect for financial solvency and this had not been resolved or corrected as of the 08/04/25 survey resulting in a recite for neglect and substandard quality of care.On 07/08/25 at 10:10 A.M. an interview with Human Resources #509 revealed the Administrator started his position August 26, 2024. 2. On 06/27/25 at 11:04 A.M. an interview with FMD #727 revealed the facility terminated his position on 04/30/25 as the medical director and had not paid for his services for the past thirteen months.Review of document titled Medical Director Invoice Number 03022025, billed to the facility, revealed services rendered as Medical Director: January, February, June, July, August, September, October, November and December 2024 totaled $16,200.00 and January, February, March, April and May 2025 totaled $900.00. The payment was due in full for all past invoices that totaled $25,200. 00. Interview on 07/07/25 at 4:09 P.M. revealed the Administrator was not aware FMD #727 had not been paid and stated he would reach out to Corporate regarding payment after review of the March, April, May 2025 Medical Director invoice. 3. On 07/02/25 1:20 P.M. an interview with the Activities Director #624 revealed concerns the pastor, who provided chaplain care.On 07/02/25 at 3:16 P.M. interview with Pastor #733 revealed his duties included Thursday and Sunday services, spiritual care in rooms for residents, and family support. Pastor #733 stated he had contacted the facility for lack of payment for the past twelve weeks. Review of email correspondence dated 04/16/24 at 2:26 P.M. written by former administrator #738 revealed Pastor #744 would provide services to residents two times per week for $175 per week. Review of email correspondence dated 06/26/25 at 3:37 P.M. written by Pastor #733 revealed Pastor #733 brought to the Administrator's attention the lack of payment for the past four months. Interview on 07/01/25 at 4:33 P.M. revealed the Administrator was not aware of nonpayment to Pastor #733. 4. Interview on 07/01/25 at 1:20 P. M. with Former Activities Director (FAD) #624 revealed lawn care had stopped coming and the landscaping outside the Dementia Unit patio had not been done all year and residents had complained to her. On 07/02/25 at 3:15 P.M. an interview with the Maintenance director revealed they did not have the staff to landscape the lawn or equipment after the landscaper stopped service at the beginning of June. On 07/02/25 at 3:20 P.M. an observation of the facility property revealed , a thick blanket of old dried leaves scattered across the Dementia Unit patio that settled into the corners along the edge of the patio. The bushes bordering the patio were uneven and overgrown, the trees were not pruned. The grass was overgrown and unkept throughout the facility with grass and weeds growing from cracks in the parking lot measuring 4 to 6 inches tall. On 07/02/25 at 2:35 P.M and interview with [NAME] Landscaping owner #735 revealed his company did provide landscaping, and lawn service to the facility but stopped service 06/01/25 because the facility did not pay the bill. Review of [NAME] Landscaping invoice Number 0006330 , due date 05/17/25 revealed a balance due of $9,364.01 for services such as spring cleanup, mulch, April mowing, weed control, May mowing and May weed control. It was noted the last week of mowing service for may was added to the invoice due to delay in payment. Interview on 07/07/25 at 4:09 P.M. with the Administrator revealed he was unaware [NAME] Lawn care company had not been paid and stopped services after review of invoice #0006330.5. An Interview on 06/30/25 with Registered Dietitian (RD) # 732 revealed the facility had been warned about overdue invoices and the possibility of suspended services.Review of a copy of email exchange between the parties of Nutri Tech and St. Luke's administration dated 06/20/25 at 9:02 A.M. revealed RD #730 reached out to the Administrator regarding termination of services. The email exchange revealed the Administrator met with RD #730 the Friday prior. The email mail informed the Administrator that due to ongoing payment delays which resulted in missed compensation to the dietitians, Nutri Tech formally issued a thirty-day notice of termination of services as of 07/18/25. The Administrator was notified that Nutri Tech would continue to provide services throughout 07/18/25 contingent on outstanding invoices did not exceed thirty days past due . Nutri Tech offered to remain past the 07/18/25 deadline if the facility was open to a prepayment model. Review of a copy of email exchange between the parties of Nutri Tech and St. Luke's administration revealed on 06/30/25 at 3:42 P.M. RD CEO #739 reached out the Administration regarding payment was due for dietitian services and [NAME] had not honored the payment terms in the

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Record review, facility policy review, facility assessment, and interviews , the facility failed to ensure an effective governing body, legally responsible for establishing and implementing policies regarding the management and operation of the facility, including but not limited to compliance with all financial obligations for the delivery of care. This had the potential to affect all 141 residents in the facility. Findings include:Review of the facility survey history revealed on 05/12/25 a complaint survey was completed which resulted in concerns related to financial solvency under neglect at substandard quality of care However, at the time of the complaint survey completed 08/04/25, the facility failed to ensure their governing body was effective in establishing and implementing policies in regard to the management and operation of the facility, which included ongoing compliance with all financial obligations for the delivery of care as detailed below.1. On 06/27/25 at 11:04 A.M. an interview with former medical director #727 revealed the facility terminated his position on 04/30/25 as the medical director and had not paid for his services for the past thirteen months. A2. An Interview on 06/30/25 with Registered Dietitian (RD) # 732 revealed the facility had been warned about overdue invoices and the possibility of suspended services.3. 3. On 07/02/25 at 2:35 P.M and interview with [NAME] Landscaping owner #735 revealed his company did provide landscaping, and lawn service to the facility but stopped service 06/01/25 because the facility did not pay the bill. 4. On 07/02/25 at 3:16 P.M. interview with Pastor #733 revealed his duties included Thursday and Sunday services, spiritual care in rooms for residents, and family support. Pastor #733 stated he had contacted the facility for lack of payment for the past twelve weeks.4. A Voice Message on 07/14/25 at 9:22 A.M. from The Ombudsman #728 revealed she was called by residents 07/10/25 because the facility refused to give residents access to their funds. Interview with the administrator on 07/01/25,revealed he was not aware of nonpayment to the pastor or registered dietitian and on 07/07/25 the Administrator verified he was unaware of the outstanding balances owed to the former medical director, and landscaping . On 07/21/25 The Administrator stated the facility had a community board that was the governing body that he reported to and was unsure when the Board met. Interview on 07/22/25 at 8:35 A.M. with the Director of Nursing revealed the facility was owned by the governing body of Saint [NAME] but managed by [NAME]. Interview on 07/22/25 at 9:51 A.M. with the Administrator revealed the facility had a governing body but he did not meet the board members or know if the governing body had meetings. Interview on 07/22/25 at 1:44 P.M. with community board member #1014 revealed he was not the active chairman since February 20205 and was unsure if the community board members had a meeting since then. Community board member #1014 stated [NAME] was the managing organization that was to report to the board members. Interview on 07/25/25 at 12:04 P.M. with community board member # 1013 revealed he was the acting chairman of the community board for the facility since February 2025. Community board member #1013 was not aware of the financial solvency issues during the 05/12/25 survey and current survey findings. Community board member #1013 was not able to produce attendance or dates of Community Board meetings with the facility Administrator and stated the role of the Board of Directors was to support and encourage the staff. Review of facility document titled St. [NAME] Lutheran Community revealed the Executive Leadership consisted of the Board of Directors (community board member #1012, community board member #1013, community board member #1014, community board member #1015, community board member #1016 and community board member #1017) [NAME] CEO #1018, [NAME] CFO #1019, the Administrator and the DON. Review of facility policy titled Governing Body, undated, revealed the governing body shall be legally and ethically responsible for the oversight of the organization. They approve the annual budget and review monthly financial reports. Ensure responsible stewardship, safeguard the facility tax exempt status. This deficiency represents noncompliance identified under Complaint Number OH001297223 (OH00166843)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interviews and facility policy review, the facility failed to maintain a sanitary and homelike environment. This affected three residents (Resident #11, #53 and #65) but had the potential to affect all 141 residents. Findings include:1.Resident #11 was admitted to the facility on [DATE]. Medical diagnosis included fracture of femur, cerebral infarction, major depression , hypertension and hemiplegia.Review of Minimum Data Set (MDS) 3.0 annual assessment revealed Resident #11's cognition was not intact and did not reject care. Observation on 06/26/25 at 7:57 A.M. of Resident #11's room revealed old spoons, cracker wrappers, old mild and cereal from 06/25/25. Licensed Practical Nurse (LPN) #500 verified the findings and stated she was unsure if housekeeping cleaned Resident 11's room. 2.Observation on 06/30/25 from 9:30 A.M. to 11:19 A.M. with Maintenance worker #607 revealed the shower room on the Twin Hills unit had a black ring inside the toilet bowel above the water line, and mildew on the shower floor. The second shower room on Twin Hills had feces on the tiled floor and a black ring inside the toilet bowel above the water line. These findings were verified by Maintenance worker #607. 3.An observation with Certified Nurse Assistant (CNA) #736 revealed the shower room on the Cypress Point unit had light brown ring in the toilet bowel above the water line and under the brim of the toilet. Yellow stains that smelled of urine was in the corner of the bathroom by the toilet and a reddish brown streak on the shower ledge was observed. CNA # 736 stated no housekeeper was scheduled to work the Cypress Unit that morning. 4. Resident #53 was admitted to the facility on [DATE]. Medical diagnosis included polyarthritis, depression, hypokalemia, weakness and hypertension. Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #53's cognition was intact. Resident #53 did not display hallucinations or delusions or reject care. An interview on 06/30/25 at 12:05 P.M. with Resident #53 revealed there was not a housekeeper assigned to her unit, so her daughter had to clean her room. Resident #53 stated ants were in her room and her trash was too full. Observation of Resident #53's room revealed the trash can was filled to the top, the anti-slip strips were peeling from the ground, and the perimeter of her room had black grime like dust and ants crawling by the window. Interview on 06/30/25 at 12:08 P.M. with Housekeeper #549 revealed Twin Hills unit and Cypress Point unit did not have a housekeeper assigned to the units because of staffing. If a unit did not have a housekeeper assigned the CNAs were to clean, but not all the cleaning could get done. Interview on 06/30/25 with Resident #53's daughter revealed she had to clean her mother's room because housekeeping did not come to her mother's room. Interview on 06/30/25 with Ombudsman #728 revealed residents had issues regarding the cleanliness of the facility. 5. Resident #65 was admitted to the facility on [DATE]. Medical diagnosis included carcinoma of rectum, cirrhosis of the liver, retention of urine, and severe obesity. Observation on 07/02/25 at 11:55 A.M. of Resident #53's room revealed the floor tiles had thick dark grime accumulation along the edge of the room, the floor tiles had a dull film of grime and the dresser had a coating of dust on the surface. Interview on 07/02/25 at 12:00 P.M. with Resident #53 verified his room was not cleaned and stated a housekeeper had not been in his room for weeks. 6.Observation on 07/07/25 at 10:00 A.M. with the Director of Nursing (DON) revealed the patio for the Dementia unit had a rusted iron fence that had signs of corrosion, a thick blanket of dried leaves scattered across the patio that settled in the corners along the edge of the patio. The bushes bordering the patio were uneven and overgrown, the trees were observed to not be pruned. The grass was overgrown in the court yard. The observation of the patio was verified by the DON. Review of housekeeping job duties, undated, revealed housekeeping was to disinfect residents rooms such as toilets, sinks. Empty trash cans and place a new trash liner, wipe surfaces such as dressers, windowsills. The restroom was to be mopped. Review of facility policy titled Safe Homelike Environment, dated 04/01/20, revealed the facility would provide a safe, clean, comfortable and homelike environment. Environment referred to any environment in the facility that was frequented by residents such as residents rooms, bathrooms and outdoor patios. This deficiency represents non-compliance investigated under Complaint Number OH001297236 (OH00166952), OH001297234 (OH00167429) and OH001297228 (OH00166964).