

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Saint Luke Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, record review, facility temperature log review, policy review and interview, the facility failed to ensure a clean, comfortable and homelike environment. The facility failed to ensure water temperatures were maintained at a comfortable level for resident bathing/showers, failed to maintain an adequate supply of clean bath linens for resident use and failed to ensure garbage bags were available and provided in resident rooms to contain trash. This affected 11 residents (#3, #20, #27, #30, #32, #44, #96, #100, #111, #113 and #124) reviewed for water temperatures, one resident (#40) reviewed for linen availability with the potential to affected an additional undetermined number of residents based on staff interview and four residents (#32, #40, #44, and #48) reviewed for garbage disposal. The facility census was 124. Findings include: During the onsite investigation, the following environmental concerns were identified:</p> <p>1. Review of facility concern logs for June 2025 revealed there was a concern with hot water running and resolution of repairs being made. In August 2025 there was a concern of water temperatures being Lukewarm. Review of the shower sheets for Resident #3, revealed on 08/07/25 nothing was checked as to shower given or not, on 08/07/25, a second line nothing was checked as to shower given or not, and on 08/18/25 there is a notation on the date NO hot water. Review of the shower sheets for Resident #100, revealed on 08/07/25 nothing was checked as to if a shower was given or not, on 08/11/25 nothing checked to as if a shower was given or not, and on 08/25/25 nothing checked to as if a shower was given or not. Review of the shower sheets for Resident #111 revealed for 08/07/25 nothing checked as to if a shower was given or not, another line for 08/07/25 checked as refused and on 08/8/25 stated No hot water. Interview on 08/27/25 at 6:39 A.M. with Certified Nursing Assistant (CNA) #378 revealed there had been no hot water on the memory care unit for the past couple weeks. CNA #378 reported this had affected the staff ability to assist with showers. Observation on 08/27/25 from 6:52 A.M. to 7:03 A.M. on the Memory Care Unit with CNA #378 of resident rooms of the water from the hot water spigot revealed the following: Resident #27's hot water spigot was turned on and the surveyor placed a hand in the running water which was very cold to touch and CNA #378 tested with her hand and confirmed the water coming out of the hot water spigot was cold. Resident #32's hot water spigot was turned on and the surveyor placed a hand in the running water revealed it was very cold to touch and CNA #378 placed her hand under the running water and confirmed the water coming out of the hot water spigot was cold. Resident #44's hot water spigot was turned on and the surveyor placed a hand in the running water and it was very cold to touch and CNA #378 placed her hand under the running water and confirmed the water coming out of the hot water spigot was cold. Interview on 08/27/25 from 6:46 A.M to 2:54 P.M. with Resident #3, #44, #100, #111 and #113, Resident #100's family and Resident #111's family revealed the water had been cold; there was insufficient water to take showers and this had been going on for weeks to months. Interview on 08/27/25 from 6:28 A.M. to 7:31 A.M. with Licensed Practical Nurse (LPN) #337, CNA #338, CNA #365, CNA #377, Registered Nurse (RN) #316 confirmed there has been no hot water on the Memory Care Unit and in some areas of the Long-Term Care Unit for the last few weeks. The staff members revealed this created an issue in taking residents to other areas of the facility for showering. Interview on 08/27/25 with Employee #381 confirmed there was no hot water in the resident rooms on memory care or in some areas of the long-term care units. Employee #381 reported the problem has been going on and off for months now. Observation on 08/27/25 from 8:52 A.M. to 9:09 A.M. of the water temperatures on the memory care unit and from 9:10 A.M. to 9:28 A.M. on the long term care unit revealed the following temperatures taken by Employee #381, using a facility thermometer in the rooms of Resident #20, #27, #30, and #32: The temperatures ranged from 82 degrees Fahrenheit (F), 88.8 degrees F, 87.8 degrees F and 92 degrees F. After letting the hot water run for three minutes and retested the temperatures ranged from 87.2 degrees F, 92.1 degrees F, and 94.1 degrees F. On the long-term care unit with Employee #381, using the facility thermometer revealed he took temperatures of the water in Resident #96, #113, and #124 rooms which ranged from 70.6 degrees F, 78.4 degrees F, and 80.9 degrees F. After letting the hot water spigot run for three minutes and retested the temperatures ranged from 92.1 degrees F, 93 degrees F, and 97.7 degrees F. Employee #381 confirmed the water was cold to lukewarm at the best and not at the acceptable temperatures for hot water. Interview on 08/27/25 at 3:30 P.M. with Mechanical Contractor #505 confirmed the hot water was not at the correct temperature in some areas of the facility. Mechanical Contractor #505 reported he gave the facility a quote to replace the two (2) boilers, he reported only one was working and the other one very old. Review of the temperature logs taken by the</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure care plans were comprehensive. This affected three residents (Resident #62, #93, and #125) of 10 residents reviewed for care plans. Facility census was 124. Findings include: 1. Review of the medical record for Resident #62 revealed an admission date of 08/02/25 and diagnoses included pneumonia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #62 had impaired cognition. Review of the physician order dated August 2025 revealed Resident #62 received Eliquis (anticoagulant) 5 milligram (mg) one (1) tablet in the morning and 1 tablet in the evening (HS).Review of the care plan dated 08/02/25 revealed there was no care plan for anticoagulant therapy.Interview on 08/28/25 at 10:27 A.M. with Minimum Data Set (MDS) Registered Nurse (RN) #260 confirmed there was no anticoagulant therapy care plan for Resident #62 and there should have been. Review of facility policy, Care Plans, Comprehensive, Person-Centered, revised 02/2025, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.2.Review of the medical record for Resident #93 revealed an admission date of 02/13/25. Diagnoses included surgical amputation.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #93 had intact cognition. Review of the physician order dated August 2025 revealed Resident #93 received Apixaban (anticoagulant) 2.5 MG give 1 tablet by po twice a day (BID) and give Clopidogrel Bisulfate 75 MG give 1 tablet PO in the morning.Review of the care plan dated 03/10/25 revealed there was no care plan for anticoagulant therapy.Interview on 08/28/25 at 10:27 A. M. with MDS RN #260 confirmed there was no anticoagulant therapy care plan for Resident #93 and there should have been. Interview on 08/28/25 at 10:27 A.M. with Registered Nurse (RN) #260 confirmed there were no anticoagulant care plans for Resident #93 and there should be.3. Review of the closed medical record for Resident #125 revealed an admission date of 07/16/25 and a discharge date of 07/31/25. Diagnosis included but not limited to fracture of sacrum pubis, and wedge compression fracture of T11-T12 Vertebra, malignant neoplasm of glottis, and chronic venous hypertension with ulcer of left lower extremity. Review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #125 had intact cognition. Review of the physician order dated July 2025 revealed Resident #125 was ordered Plavix 75 MG (anticoagulant) give 1 table PO in the morning.Review of the care plan dated 04/25/25 revealed there was no care plan for anticoagulant therapy.Interview on 08/28/25 at 10:27 A.M. with MDS RN #260 confirmed there was no anticoagulant therapy care plan for Resident #125 and there should have been.Review of facility policy, Care Plans, Comprehensive, Person-Centered, revised 02/2025, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.This is an incidental finding discovered during the complaint investigation.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, care conference postcard and letter invitation review, interviews and policy review the facility failed to ensure care plan meetings were offered timely, per preference, and in person. This affected one (Resident #40) of three residents reviewed for care plan meetings. The facility census was 124. Findings include: Review of the medical record for Resident #40 revealed an admission date of 09/16/22. Diagnoses included but not limited to encephalopathy, bipolar disorder, schizophrenia, psychosis and dementia. with behavioral disturbance. Review of the quarterly minimum data set (MDS) dated [DATE], revealed Resident #40 scored a zero on the brief interview mental status (BIMS) out of 15, resulting in severely impaired cognition. Resident #40 was dependent on staff for all her care needs to include toileting, showering, and eating. Interview on 09/10/25 at 9:45 A.M. with Resident #40's family member revealed she was not offered any care conferences in over five (5) months with the last care conference she had was over the phone on 03/18/25. She reported she usually received a letter in the mail to have the care conference over the phone but she has not received a letter in over 5 months and she would like to have the care conference in person. The family member stated the facility only offers care conference meetings over the phone. Interview on 09/11/25 at 7:43 A.M. with the Director of Nursing (DON) confirmed care plan meetings are to be held on admission, quarterly, annually, with significant change, and if the family requests. DON confirmed no evidence a care conference letter was mailed to Resident #40's family or RSVP received by the facility. DON reported the facility verbally calls or emails resident families to schedule care conferences. DON reported resident families have the choice of over the phone or in person care conference. Interview on 09/11/25 at 9:42 A.M. with Licensed Social Worker (LSW) #254 confirmed care plan meetings are to be held every quarter. LSW #254 confirmed Resident #40's last care conference was on 03/18/25 and did not have an RSVP for the 06/18/25 care plan meeting. LSW #254 confirmed letters are mailed for over the phone care plan meetings only and was unable to verify the resident's family member received a letter for the 06/18/25 meeting. Review of the facility document letter sent to residents ' families for care conferences revealed an invitation to attend care conference, stating at this time we are doing these meetings via telephone in lieu of in-house meetings. The letter further stated to call LSW #254 to RSVP if you were planning on attending or need to reschedule. Review of the facility documents/post card provided to residents regarding care plan meetings revealed residents are invited to attend, the meeting will be over the phone, and the resident was to notify front desk if they plan to attend. Review of facility policy, Care Plans, Comprehensive, Person-Centered, revised 02/20/25, revealed each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, to include participation. This deficiency represents non-compliance investigated under Master Complaint Number 2611431.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interviews and closed medical record review, the facility failed to ensure physician orders were followed and the physician was contacted with elevated blood pressure findings. This affected one resident (125). The facility census was 124. Findings included: Review of the closed medical record for Resident #125 revealed an admission date of 07/16/25 and a discharge date home of 07/21/25. Diagnosis included but not limited to fracture of sacrum pubis, and wedge compression fracture of T11-T12 Vertebra, malignant neoplasm of glottis, and chronic venous hypertension with ulcer of left lower extremity. Review of the physician orders dated 07/16/25 for Resident #125 revealed an order for orthostatic blood pressure (BP) times (x) three (3) shifts every shift for lying BP, sitting BP, and standing BP. Review of the physician orders dated 07/17/25 for Resident #125 revealed an order for transfers: two person physical assist every shift. Review of the blood pressure readings for Resident #125 revealed on 07/17/25 at 1:07 A.M. lying blood pressure (BP) was 186/99 and sitting BP was 189/99. No standing BP was taken. On 07/18/25 there were no BP readings recorded. On 07/19/25 at 1:21 P.M. a sitting BP of 191/81, no lying or standing BP was taken. On 07/20/25 at 6:21 P.M. a lying BP reading of 151/67 was taken, no sitting or standing BP was taken. On 07/21/25 at 8:14 A.M. lying BP was 210/104, and on 07/21/25 at 8:08 P.M. sitting BP was 144/84, no standing BP was recorded. On 07/22/25 at 5:20 A.M. a lying BP reading was 192/92 and on 07/22/25 at 1:07 P.M. sitting BP was 163/101, no standing BP reading done. On 07/24/25 at 3:02 P.M. a sitting BP reading was 145/101 and on 07/23/25 at 9:12 P.M. a sitting BP reading was 152/96, no lying or standing BP's were recorded. On 07/24/25 at 8:07 A.M. a sitting BP reading of 144/86 and on 07/24/25 at 9:06 P.M. a sitting BP reading of 145/85 was recorded. On 07/25/25 at 1:50 P.M. a lying BP of 142/76 was recorded. On 07/26/25 at 06:54 A.M. a sitting BP reading of 178/89 was recorded and on 07/26/25 at 11:22 A.M. a sitting BP reading of 173/86 was recorded. On 07/26/25 at 7:29 P.M. was sitting BP reading of 150/67 recorded. Review of the progress notes dated July 2025 for Resident #125 revealed no progress notes regarding notification to the physician regarding blood pressure readings. Review of the physician orders dated 07/24/25 revealed an order for Amlodipine Besylate (medication used to treat high BP) 5 milligram (mg) to give one (1) tablet by mouth (PO) daily for hypertension (high blood pressure). Review of the Medication Administration Records (MARS) and Treatment Administration Records (TARS) for July 2025 revealed on 07/24/25 Resident #125 received Amlodipine as ordered. Interview on 08/27/25 at 2:52 P.M. with the Director of Nursing (DON) confirmed physician orders were not followed for the orthostatic BP's to be taken lying, sitting, and standing. The DON confirmed for high BP's, the physician should be notified, and the nurse should document in the progress notes regarding the notification. Interview on 09/02/25 at 7:25 A.M. with Assistant Director of Nursing (ADON) #261 confirmed there was no notification to physician regarding the high blood pressure readings and the order upon admission for BP's to be taken, lying, sitting, and standing were not followed as ordered. Interview on 09/02/25 at 8:23 A.M. with Registered Nurse (RN) Coordinator #319 confirmed physician orders were not followed as ordered. RN Coordinator #319 confirmed for high BP's, the physician should be notified, and the nurse should document in the progress notes regarding the notification. The RN Coordinator confirmed a high blood pressure is anything over 140/70's. Interview on 09/02/25 at 10:01 A.M. with Physician #500 confirmed he wasn't notified of high BP readings for Resident #125. Physician #500 reported he would expect to be notified for a systolic (top number of a blood pressure reading) BP of 160 or above and a diastolic (bottom number of a blood pressure reading) BP reading of 90 or above. Physician #500 confirmed he expected nursing staff to follow his orders to include orthostatic BP readings, lying, sitting and standing. This is an incidental finding discovered during the complaint investigation.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on observation, interviews and policy review, the facility failed to ensure meals were served timely on the Memory Care Unit. This affected all 33 residents residing on the Memory Care Units (Resident #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, and #51). The facility Census was 124. Findings include: Interview on 09/10/25 at 9:45 A.M. with Resident #40's family reported the food trays are always late to the dining room by almost an hour. Observation on 09/11/25 at 12:00 P.M of the dining room in Memory Care Unit revealed 17 residents were seated and awaiting their lunch meals. Interview on 09/11/25 at 12:13 P.M. with Certified Nursing Assistant (CNA) #353 confirmed meals are late. Interview on 09/11/25 at 12:13 P.M. with CNA #408 confirmed meals are late. Observation on 09/11/25 at 12:37 P.M. revealed the first meal cart arrived to the unit. Seven (7) staff (two unidentified staff and CNA #345, CNA #353, CNA #375, CNA #408, and Licensed Practical Nurse (LPN) #331) started passing the meal trays to the residents. Interview on 09/11/25 at 12:46 P.M. with CNA #375 confirmed meals are always late. Interview on 09/11/25 at 12:31 P.M. with Resident #38's family confirmed meals are late, usually at least 30 minutes late. Interview on 09/11/25 at 1:46 P.M. with Dietary Aide #270 confirmed the lunch meal trays were late. Interview on 09/11/25 at 1:46 P.M. with Dietary Manager #200 confirmed the lunch meal trays were late to Memory Care Unit and when asked what may cause the meal delivery to be late, stated staff are not timely serving up the trays. Interview on 09/11/25 at 1:52 P.M. with Dietary Supervisor #406 confirmed the lunch meal trays were late to Memory Care Unit. When asked what causes the meals trays to be late coming from the kitchen the supervisor stated they were just late sometimes. Review of the policy, Meal Times, undated, revealed for the Memory Care Unit first meal cart to be delivered at 12:00 P.M., (Laurel Valley 1) and second meal cart to be delivered at 12:15 P.M., (Laurel Valley 2) for the lunch meal. Review of the facility policy, Food Palatability Policy, undated, revealed meal trays will be delivered promptly to ensure freshness and quality. This deficiency represents non-compliance investigated under Master Complaint Number 2611431.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement infection control procedures during medication administration. This affected one resident (#100) of five residents observed for medication administration. The facility census was 124. Findings include: Review of record for Resident #100 revealed an admission date of 08/20/22. Diagnosis included but not limited to volvulus, history of malignant neoplasm of the breast and skin, and absence of parts of the digestive tract and of both cervix and uterus. Review of the quarterly minimum data set (MDS) dated [DATE] revealed Resident #100 had intact cognition. Review of the physician orders for August 2025 revealed Resident #100 was ordered Vitamin D3 50 microgram (mcg) give two capsules by mouth (PO) in the morning. Observation of medication administration on 08/28/25 at 8:15 A. M. revealed with Registered Nurse (RN) #316 administered Vitamin D3 50 mcg one capsule to Resident #100. RN #316 then realized the order was for Vitamin D3 50 mcg to administer two capsules. RN #316 administered Vitamin D3 50 mcg one capsule to Resident #100 and then went to the medication cart. RN #316 used hand sanitizer then removed the bottle of Vitamin D3 50 mcg from the medication cart and placed two (2) capsules in the medicine cup. RN #316 then realized she only needed one additional Vitamin D3 50 mcg capsule. RN #316 removed one Vitamin D3 capsule from the medicine cup with her bare hands, touching the other Vitamin D3 in the medicine cup and placed the Vitamin D3 she removed from the medicine cup, back into the Vitamin D3 bottle with the other pills remaining in the bottle. RN #316 then administered Vitamin D3 50 mcg one capsule to Resident #316. Interview on 08/28/25 at 8:27 A.M. with RN #316 confirmed she used her bare hands to remove one Vitamin D3 capsule from the medicine cup, touching the remaining one Vitamin D3 capsule and put the removed Vitamin D3 in the original medication bottle. RN #316 reported she didn't think she did anything wrong because she used hand sanitizer prior to touching the Vitamin D3 capsules. Interview on 08/28/25 at 9:22 A.M. with the Director of Nursing (DON) confirmed staff were not to use their bare hands to touch resident medication and not return the medication to the original bottle. The DON reported he would discard the Vitamin D3 medication bottle. Interview on 08/28/25 at 10:41 A.M. with RN Nursing Coordinator #319 confirmed nurses are not to touch pills with their bare hands, they should use gloves. Review of facility policy, Infection Prevention and Control Program, undated, revealed It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection. This deficiency is an incidental finding discovered during the investigation.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility temperature log review, policy review and interview, the facility failed to ensure the boiler systems were functional and operational for resident/staff access to adequate hot water. This had the potential to affect all 124 residents residing in the facility. Findings Include: Review of facility concern logs for [DATE] revealed there was a concern with hot water running and resolution of repairs being made. In [DATE] there was a concern of water temperatures being Lukewarm. Interview on [DATE] at 6:39 A.M. with Certified Nursing Assistant (CNA) #378 revealed there had been no hot water on the memory care unit for the past couple weeks. CNA #378 reported this had affected the staff ability to assist with showers. Observation on [DATE] from 6:52 A.M. to 7:03 A.M. on the Memory Care Unit with CNA #378 of resident rooms of the water from the hot water spigot revealed the following: Resident #27's hot water spigot was turned on and the surveyor placed a hand in the running water which was very cold to touch and CNA #378 tested with her hand and confirmed the water coming out of the hot water spigot was cold. Resident #32's hot water spigot was turned on and the surveyor placed a hand in the running water revealed it was very cold to touch and CNA #378 placed her hand under the running water and confirmed the water coming out of the hot water spigot was cold. Resident #44's hot water spigot was turned on and the surveyor placed a hand in the running water and it was very cold to touch and CNA #378 placed her hand under the running water and confirmed the water coming out of the hot water spigot was cold. Interview on [DATE] from 6:46 A.M. to 2:54 P.M. with Resident #3, #44, #100, #111 and #113, Resident #100's family and Resident #111's family revealed the water had been cold; there was insufficient water to take showers and this had been going on for weeks to months. Interview on [DATE] from 6:28 A.M. to 7:31 A.M. with Licensed Practical Nurse (LPN) #337, CNA #338, CNA #365, CNA #377, Registered Nurse (RN) #316 confirmed there has been no hot water on the Memory Care Unit and in some areas of the Long-Term Care Unit for the last few weeks. Interview on [DATE] with Employee #381 confirmed there was no hot water in the resident rooms on memory care or areas of the long-term care units. Employee #381 reported the problem has been going on and off for months now. Observation on [DATE] from 8:52 A.M. to 9:09 A.M. of the water temperatures on the memory care unit and from 9:10 A.M. to 9:28 A.M. on the long term care unit revealed the following temperatures taken by Employee #381, using a facility thermometer in the rooms of Resident #20, #27, #30, and #32: The temperatures ranged from 82 degrees Fahrenheit (F), 88.8 degrees F, 87.8 degrees F and 92 degrees F. After letting the hot water run for three minutes and retested the temperatures ranged from 87.2 degrees F, 92.1 degrees F, and 94.1 degrees F. On the long-term care unit with Employee #381, using the facility thermometer revealed he took temperatures of the water in Resident #96, #113, and #124 rooms which ranged from 70.6 degrees F, 78.4 degrees F, and 80.9 degrees F. After letting the hot water spigot run for three minutes and retested the temperatures ranged from 92.1 degrees F, 93 degrees F, and 97.7 degrees F. Employee #381 confirmed the water was cold to lukewarm at the best and not at the acceptable temperatures for hot water. Interview on [DATE] at 3:30 P.M. with Mechanical Contractor #505 revealed the facility hot water was not at the correct temperatures in the facility due to issues with their existing boilers. Mechanical Contractor #505 reported he gave the facility a quote to replace the two (2) boilers, he reported only one was working and the other one very old. Review of the temperature logs taken by the facility for [DATE], [DATE], and [DATE], revealed in [DATE] to [DATE] staff documented issues with the hot water and still having issues with hot water. Documentation for [DATE], [DATE] and [DATE] was blank. Documentation for [DATE] and [DATE] revealed Hot water tank broke yesterday no hot water today and for [DATE] still no hot water today. On [DATE] staff documented No hot water today. On [DATE], [DATE], [DATE], [DATE], [DATE] staff documented there was no hot water. On [DATE] the form was blank. Documentation on [DATE] and [DATE] revealed no hot water today ([DATE]) water temperatures in the 90's. On [DATE] and [DATE] staff documented water temperatures between 90 and 101 degrees Fahrenheit. Interview on [DATE] at 10:58 A.M. with Maintenance Tech (MT) #380 revealed the facility was operating on one boiler for hot water and the kitchen and laundry would get the hot water first. They would use all the hot water leaving the rest of the building without hot water. The boiler system would try to catch itself up overnight. The kitchen had a single booster to the dishwasher to ensure they were meeting metrics for dishwashing but they weren't having hot water for cooking. Laundry was having a hard time getting hot water nast 90 degrees Fahrenheit (F). The facility swanned to a different chemical system before the boiler system</p>		