

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 11/24/2025
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)		
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure resident representatives received room change notification. This affected one resident (#121) of three residents reviewed for family notifications. The census was 129. Findings include: Review of the medical record for Resident #121 revealed an admission date of 06/07/23. Diagnoses included but not limited to acute kidney failure, dementia, and unspecified psychosis. Resident #121 resided on the secured, locked, memory care unit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 14 out of 15 on the Brief Interview Mental Status (BIMS) indicating intact cognition. Review of Resident #121's medical record revealed a progress note dated 10/10/25 at 11:13 A.M., late entry, the patient was moved from (current room) to (current room) and was showered and changed. There was no indication in the medical record Resident #121's representative received notification of the room change. Interview on 11/18/25 at 4:09 P.M. via phone with prior Director of Nursing (DON) #495 revealed the room change occurred right before he left and reported he was told it was taken care of. Interview with Resident #121 on 11/19/25 at 6:38 A.M. revealed in October (2025) she had a room change due to bed bugs and she liked her new room. Interview on 11/19/25 at 9:34 A.M. via phone with Nurse Practitioner (NP) #501 confirmed she was not notified by the facility regarding Resident #121's room change due to bed bugs. Interview on 11/19/25 at 10:06 A.M. via phone with Nurse Practitioner (NP) #500 confirmed he was not notified by the facility regarding Resident #121's room change due to bed bugs. Interview on 11/19/25 at 10:21 A.M. with Resident #121's son via phone confirmed he was not notified by the facility of his mother's room change due to bed bugs. The son further stated he received a call from two females at the facility the day before (11/18/25) asking if he had been notified by the facility of Resident #121's room change due to bed bugs. He reported he thought it was weird and told them he was not notified of the room change due to bed bugs. The son stated the DON apologized for the poor communication. Interview on 11/19/25 at 11:36 A.M. with Licensed Practical Nurse (LPN) #459 confirmed she discovered the bed bugs and immediately notified the prior DON #494, who told her he would take care of notification. LPN #459 confirmed she did not notify Resident #121's family regarding the room change due to bed bugs. Review of the facility policy, Room Change/Roommate Assignment, revised March 2021, revealed prior to changing a room or roommate assignment all parties involved in the change/assignment, (to include the residents and their representatives) are given at least a day notice of such change. This deficiency represents non-compliance investigated under Complaint Number 2646189.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365521	Facility ID: 365521 If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, policy review and review of material safety data sheet (MSDS), the facility failed to ensure possible hazardous areas and materials were properly secure on the memory care unit. This had the potential to affect 25 residents (#2, #8, #10, #12, #16, #30, #38, #39, #40, #45, #54, #60, #64, #65, #71, #79, #87, #89, #92, #94, #100, #115, #118, #121, and #129) that were able to ambulate and propel in wheelchairs on the memory care unit. Facility census was 129. Findings include: An observation of the memory care unit on 11/17/25 at 12:06 P.M. revealed the door to the soiled utility room located on Somerset Hall was unlocked. The soiled utility room had barrels for soiled linens and trash. Several wheelchairs and other equipment were located in the soiled utility room. An observation of the memory care unit on 11/18/25 at 2:31 P.M. revealed the door to the clean utility room located on Greenbriar Hall was unlocked. There were two containers with 160 wipes in each of Microkill Germicidal Wipes The shelving unit would be accessible to residents standing or sitting in a wheelchair. The wipes was labeled to keep out of the reach of children. An interview on 11/18/25 at 2:39 P.M. Housekeeping Supervisor #265 verified the door to the clean utility room was unlocked and items marked to keep out of the reach of children were within reach in the unlocked room. The supervisor verified the residents should not be able to access chemicals. Review of the MSDS Sheet revealed if ingested, rinse mouth and do not induce vomiting. Obtain emergency medical attention. Hazardous Areas, Devices and Equipment policy (no date) revealed all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards included equipment and devices that are left unattended, open areas or items that should be locked when not in use, access to toxic chemicals, and disabled locks, latches, or alarms. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous. The safety committee will recommend measures to ensure that vulnerable residents cannot access hazardous areas in the facility. The safety committee will periodically check for the implementation and integrity of measures intended to prevent residents from accessing hazardous areas. This deficiency represents non-compliance investigated under Complaint Number 2651378.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure Resident #81 was administered intravenous antibiotics as ordered resulting in a significant medication error. This affected one (Resident #81) out of three residents reviewed for medication administration. Facility census was 129. Findings include: A review of the medical record revealed Resident #81 was admitted on [DATE] with diagnoses that included sepsis due to pseudomonas, osteomyelitis of right ankle and foot, and type 2 diabetes. Resident #81 was ordered to receive intravenous antibiotics. Review of Printable Hospital Discharge Form in the medical record revealed on 10/21/25 at 10:58 A.M. Hospital Case Manager #497 wrote the only other option if Avycaz (intravenous antibiotic to treat serious Gram-negative bacterial infections, a combination antibiotic of ceftazidime and avibactam) was too expensive, would be Fetroja (an antibiotic to treat serious bacterial infections). Hospital Case Manager #497 asked to be notified if one or the other antibiotics were obtainable and Resident #81 was ready for discharge (from the hospital and admitted to the facility). On 10/21/25 at 11:13 A.M. Admission/Marketing #445 replied that Fetroja was almost double the price so Avycaz would be used. Admission/Marketing #445 also asked who would be starting the authorization. On 10/21/25 at 11:46 A.M. Hospital Case Manager #497 replied the authorization would be started if the facility could take Resident #81. At 11:47 A.M. Hospital Case Manager also wrote that Resident #81 required Daptomycin (IV antibiotic used to treat infections caused by gram-positive bacteria) in addition to Avycaz. On 10/21/25 at 11:51 A.M. Admission/Marketing #445 requested the stop dates for Avycaz and Daptomycin. On 10/21/25 at 11:54 A.M. Hospital Case Manager #497 revealed the stop date for Avycaz was 11/27/25 and the stop date for Daptomycin was 11/29/25. On 10/21/25 at 11:56 A.M. Admission/Marketing #445 told Hospital Case Manager #497 to start the authorization. Review of physician orders dated 10/22/25 revealed Resident #81 was ordered ceftazidime (broad-spectrum antibiotic to treat a serious bacterial infections) 1.25 grams every eight hours until 11/29/25. This was ordered by the infectious disease physician upon discharge from the hospital. Review of Pharmacy provided information revealed ceftazidime was a cephalosporin (broad-spectrum antibiotic used to treat infections caused by gram-negative and gram-positive bacteria) was provided in one and two grams. Avycaz was a cephalosporin combination available in decimal numbered dosages. Review of the medication administration record (MAR) dated 10/22/25 at 11:56 P.M. revealed ceftazidime 1.25 gram was not available in the facility. A plan of care dated 10/22/25 revealed Resident #81 received intravenous medication. Interventions included to change the intravenous site and tubing per facility protocol, to monitor intake and output, and monitor/document/report signs and symptoms of infection or infiltration. A nurse note dated 10/22/25 at 3:30 P.M. revealed pharmacy contacted Licensed Practical Nurse (LPN) #477 that ceftazidime did not come in 1.25 gram. LPN #477 contacted the infectious disease specialist and was waiting for a call back. A nurse note dated 10/23/25 at 2:55 P.M. revealed the infectious disease specialist ordered Avycaz 1.25 gram. The director of nursing (DON) and Resident #81 were notified. A physician order dated 10/24/25 revealed Resident #81 was ordered Avycaz 1.25 grams every eight hours. A nurse note dated 10/24/25 at 5:07 A.M. revealed Resident #81's Avycaz was not available due to a billing issue. Pharmacy faxed a permission form for approval to bill the facility for the medication. The permission form needed signed by the DON or Assistant Director of Nursing (ADON). The form was left with the nursing coordinator, and a message was left with the medical doctor. A nurse note dated 10/24/25 at 9:43 A.M. revealed the approval form was signed by the ADON and faxed to the pharmacy. A nurse note dated 10/25/25 at 6:30 A.M. revealed Avycaz was not delivered. The pharmacy was contacted and stated they were checking due to the high cost of the medication. Review of the MAR revealed Avycaz was administered to Resident #81 on 10/25/25 at 2:00 P.M. The Medicare 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #81 was cognitively intact, and medications included the administration of antibiotics. An interview on 11/20/25 at 9:22 A.M. with the Administrator verified the pharmacy requested authorization to bill the facility for Avycaz, and the previous DON did not address the authorization in a timely manner resulting in missed doses of intravenous medication. An interview on 11/20/25 at 9:57 A.M. with Admission/Marketing #445 revealed the Printable Discharge Form was communication between himself and the hospital case managers. Admission/Marketing #445 verified the facility was notified Resident #81 required intravenous antibiotics and Avycaz was expensive and the facility would admit Resident #81. An interview on 11/24/25 at 8:05 A.M. the current DON stated she was not the DON in October 2025. The</p>		