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	01/30/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, review of room temperature logs, and interview, the facility failed to ensure room temperatures and temperatures in common areas were maintained within the required range and for the comfort of residents. Room temperature monitoring revealed inappropriate room temperatures in four (rooms 147, 171, 270 and 275) of 11 resident rooms and three of seven common areas affecting seven residents (Residents #29, #40, #46, #52, #68, #72 and #73) and two unidentified residents. The census was 118.Findings Include: On 01/28/26 between 9:20 A.M. and 9:52 A.M., random room temperatures were monitored by Maintenance Technician #200, using the facility ambient thermometer. The following rooms/areas were identified to be outside the regulatory temperature ranges: (temperatures were measured in Fahrenheit)a. Review of Resident #52's medical record revealed diagnoses including type two diabetes mellitus and hypertension. A Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed a score of 12 (out of a potential high score of 15) which indicated moderate cognitive impairment. Review of Resident #29's medical record revealed diagnoses including osteoarthritis, peripheral autonomic neuropathy and adrenal gland disorders. A BIMS assessment dated [DATE] indicated Resident #29 was cognitively intact with a score of 15.Observation of the temperature in Resident #52 and #29's room revealed the room temperature ranged from 67 degrees on Resident #52's side of the room and 65-66 degrees on Resident #29's side of the room. Both residents stated it was cold. Resident #29 was observed wearing a sweater.On 01/28/26 at 11:18 A.M., during a follow-up interview, Resident #52 stated their room stayed cold. Resident #52 stated when staff entered the room they commented how cold it was so she had not discussed the issue with management since staff was aware. Resident #52 stated she had not observed anybody monitor the temperature in her room after they complained of how cold it felt.A subsequent interview with Resident #29 on 01/28/26 at 12:33 P.M. revealed she had spoken to multiple nurses about her room being cold. Resident #29 stated every other staff member that entered her room commented on how cold it was.b. The lounge outside room [ROOM NUMBER] measured between 62 and 66 degrees dependent on the area of the room tested. Maintenance Technician #200 stated the wall heating unit was supposed to heat the area but it was not working. Maintenance Technician #200 stated he discovered somebody had turned the heating unit on during the night and he had to turn it off as it was only blowing cold air.c. Review of Resident #72's medical record revealed diagnoses including multiple sclerosis, hypothyroidism, depression and anemia. A BIMS assessment dated [DATE] indicated Resident #72 was cognitively intact with a score of 15.Resident #72's room temperature was observed at 69 degrees. Resident #72 was lying in bed and stated to Maintenance Technician #200 that it was cold and after she left the room for a while and returned the cold air hits her in the face. Resident #72 requested plastic be placed on the window. Maintenance Technician #200 stated the room had a split heater unit which did not function correctly. On 01/28/26 at 11:22 A.M., Resident #72 stated she had (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spoken to multiple nurses (could not remember who all she told), other staff and the Administrator about her room being cold. Resident #72 stated the room had been cold for two months.d. The lounge outside room [ROOM NUMBER] was monitored at 69 degrees. No residents were present.e. The memory care lounge nearest the nursing station had multiple residents in the unit. One of the residents (unidentified) had a bath blanket wrapped around her shoulders while another had a blanket draped over her lap. The room temperature was 69 degrees. None of the residents were interviewable.f. Resident #73's room temperature was observed. The thermometer read between 68 and 70 degrees. Resident #73 was not interviewable. g. Resident #46's room temperature was observed between 68 and 69 degrees. Resident #46 was not in her room at the time and was not interviewable. On 01/28/26 at 10:20 A.M., the Director of Nursing (DON) stated nobody had reported there was a problem maintaining appropriate room temperatures and no residents had requested a room change due to the cold temperatures.On 01/28/26 at 10:45 A.M., the Administrator stated he believed the lower temperatures obtained that morning were related to extremely cold temperatures outside and denied he had received any complaints about room temperatures. On 01/28/26 at 11:26 A.M., Resident #40 was observed sitting in a wheelchair in the doorway of her room, wearing mittens. Resident #40 stated it was freezing. Resident #40 stated her room had been cold on 01/27/26 and 01/28/26. Resident #40 stated she had not said anything to staff because she believed they were aware.On 01/28/26 at 11:37 A.M., Certified Nursing Assistant (CNA) #205 stated Twin Hills hall was always freezing, especially rooms [ROOM NUMBER]. Resident #40 wore mittens all the time, even in warmer weather. CNA #205 stated she had attempted to turn on the heating unit in the lounge outside room [ROOM NUMBER] and it only blew cold air. CNA #205 stated she had not personally reported the concerns with the room temperatures because she was sure management was aware as residents had informed her the facility placed plastic on the windows because they knew windows were drafty.On 01/28/26 at 11:42 A.M., CNA #210 stated she had gone to visit Resident #40 after she returned from her lunch break and her room was freezing.On 01/28/26 at 12:18 P.M., CNA #215 stated it was cold on Twin Hills on 01/21/26 and it was cold today with Resident #40 and another male resident, she was unable to identify, complaining about cold room temperatures. CNA #215 was unsure if management was aware of complaints of cold temperature prior to residents voicing concerns to maintenance that morning (01/28/26).On 01/29/26 at 3:55 P.M., Licensed Plumbing Company Representative #220 stated with the cold weather, the boiler system must function in tip top shape to maintain room temperatures. On 01/28/26 one of the radiators had been turned off in the sitting area on one of the halls but he was unable to state which hall. The air handler units had fan coils which needed cleaned of all dust and debris.This deficiency represents non-compliance investigated under Complaint Number 2712498.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, policy review, and interview, the facility failed to ensure medications remained in their original labeled packaging and failed to ensure insulin pens and vials were appropriately labeled and not used past the expiration date. Improper medication storage was identified in two of four medication carts observed. This affected three residents (Residents#22, #86 and #113). The facility census was 118.Findings Include: 1. On 01/28/26 at 12:30 P.M., the Ridgeview medication cart was observed with Licensed Practical Nurse (LPN) #230. There was an unlabeled vial of open Lantus insulin. The vial was not designated as belonging to a specific resident. On 01/28/26 at 12:30 P.M., LPN #230 stated the vial of Lantus insulin had to belong to Resident #86 because he was the only resident whose medications were stored on the cart that received Lantus insulin. LPN #230 verified the vial was unlabeled with no specific residents, instructions for use, or documentation of when the vial was opened. LPN #230 stated she would have to discard the vial.2. On 01/28/26 at 12:51 P.M., Registered Nurse (RN) #230 was observed preparing insulin lispro for administration to Resident #113. On 01/28/26 at 12:57 P.M., after the insulin lispro was administered, RN #230 verified the insulin label indicated it was refilled 12/10/25 but the opened date was not legible. Pharmacy representative #235 had approached the medication cart and verified the date the insulin was opened was not legible and, therefore, should not be used.3. During further investigation into medication storage on the Southern Hills medication cart with RN #230 on 01/28/26 between 1:05 P.M. and 1:13 P.M., the following medication storage concerns were identified and verified with RN #230:a. Resident #22 had an open Humalog pen with no date as to when it was opened. b. Resident #113 had Lantus with a date of 12/23/25 recorded as an open date. c. Two loose pills were located in the cart which were unable to be identified.Review of Medscape information regarding insulin revealed insulin should be kept unrefrigerated opened insulin should be discarded after 28 days.Review of the facility's Medication Labeling and Storage policy (revised February 2023) revealed medication labels must include the resident's name. Multi-dose vials that had been opened or accessed (e.g. needle punctured) were to be dated and discarded within 28 days unless the manufacturer specified a shorter or longer date for the open vial. If medication containers had missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying those items. Medications were stored in the packaging, containers or other dispensing systems in which they were received. The nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.This deficiency represents non-compliance investigated under Complaint Number 2712498.