

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  03/10/2026
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure resident rooms were clean, sanitary and that residents had clean linens. This affected two (#85 and #110) out of three residents observed for a homelike environment. The facility census was 121. Findings include: 1. Review of the medical record for Resident #85 revealed an admission date of 11/23/22 with diagnoses including chronic kidney disease, diabetes mellitus, heart failure and anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #85 had intact cognition. He had no behaviors and was dependent on staff for hygiene and transfers.</p> <p>Observation and interview on 03/05/26 at 12:38 P.M. with Resident #85 revealed he was in bed. There were dirty bed linens draped over his wheelchair, dirty incontinence care wipes on the floor beside his bed, a bed pad on the corner of his tray table with creams and medications and his recliner had a white powdery substance on the back and seat portion. Resident #85 stated they were from the midnight shift staff who did not take the dirty items out of his room. Psychotherapist #618 was present in the room and verified she had been there for at least 30 minutes and no staff had entered the room. Certified Nursing Assistant (CNA) #619 entered the room and verified the dirty wipes, soiled linens on his wheelchair and tray table was covered with incontinence care items. She stated the soiled linens were not in his room when she provided care earlier in the day. CNA #619 then proceeded to clean resident's room, however, after removing items from his tray table, did not clean or disinfect his tray table. CNA #619 left the room and came back at 12:55 P.M. with Resident #85's lunch tray and placed it on his tray table without ensuring his tray table was clean. She verified she had not properly cleaned his tray table prior to placing his lunch meal on it.</p> <p>Additional interview on 03/05/26 at 1:00 P.M. with Resident #85 revealed staff did not clean his room before leaving to ensure soiled items were removed. He stated the facility utilized agency staff and they did not know how to do their job.</p> <p>Review of the facility policy, Homelike Environment, dated February 2021, revealed facility staff and management should maximize to the extent possible characteristics of the facility that reflects a personalized homelike setting including clean, sanitary and orderly environment, clean bed and bath linens.</p> <p>2. Review of Resident #110's medical record revealed the resident was admitted on [DATE] and re-admitted on [DATE] with diagnoses including psychotic disorder with delusions, hemiplegia and quadriplegia. (continued on next page)</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #110's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Observation on 03/03/26 at 9:50 A.M. revealed Resident #110 had four pillows behind her head, and no pillow cases were observed on the pillows.</p> <p>Interview on 03/03/26 at 9:52 A.M. with Resident #110 confirmed she did not have pillow cases on her pillows, and she did not know why she did not have pillow cases, but she wanted some for her pillows.</p> <p>Interview on 03/03/26 at 9:58 A.M. with CNA #613 confirmed Resident #110 did not have pillow cases for the four pillows underneath of the resident's head and the midnight shift must have forgotten them.</p> <p>Interview on 03/03/26 at 3:51 P.M. with Registered Nurse (RN) #918 confirmed Resident #110 did not have pillow cases on her pillows and CNAs refused to provide care.</p> <p>Observation on 03/04/26 at 10:32 A.M. with Resident #110 revealed the resident had four pillows under her head. Two of the pillows had pillow cases and the other two plastic pillows did not have pillow cases. A subsequent interview with Resident #110 at the time of the observation revealed the staff ran out of pillow cases.</p> <p>Interviews on 03/04/26 at 10:40 A.M. with CNAs #855 and #949 revealed the supply closet did not have enough pillow cases on the floor to place on Resident #110's pillows.</p> <p>Observation on 03/04/26 at 10:42 A.M. with CNA #949 of the second-floor linen supply closet revealed three pillow cases were on the second shelf.</p> <p>Observation on 03/04/26 at 10:45 A.M. with Laundry Aide #714 revealed a laundry cart with approximately seven or eight pillowcases that were folded and placed on the laundry cart. A subsequent interview with Laundry Aide #714 at the time of the observation revealed the facility had an appropriate number of linens including pillow cases and a linen cart was sent to the floor twice a day.</p> <p>Review of the Homelike Environment policy dated 02/2021 revealed the facility staff and management maximizes to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean bed and bath linens that were in good condition.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2741949.</p>		

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<p>F 0600</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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews, review of in-room videos, review of the facility self-reported incident, and review of facility policy, the facility failed to ensure Resident #117 was free from physical abuse. This affected one (#117) of four residents reviewed for abuse. The facility census was 121. Findings include: Review of the medical record for Resident #117 revealed and admission date of 12/29/25. Diagnoses included but were not limited to neurocognitive disorder with Lewy Bodies dementia, generalized anxiety disorder and Alzheimer's disease with late onset. Resident #117 was also noted to receive hospice services. Review of Resident #117's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment and required maximum assistance for toileting hygiene. Review of Resident #117's care plan last reviewed on 01/14/26 revealed Resident #117 was receiving hospice services, was noted to have self-care deficits and required staff assistance with activities of daily living (ADLs) related to functional decline and impaired mobility. Resident #117 noted to required substantial/maximum assistance with toileting hygiene. Review of the nursing progress note for Resident #117 dated 01/08/26 timed at 10:52 P.M. revealed a skin sweep was completed with no areas of noted concern. No signs or symptoms of pain or distress were noted. Resident #117 was noted to be resting in bed. No evidence was noted of the family providing an in-room video or reporting an allegation of abuse. Review of Resident #117's video surveillance (20260206_101250), not timed but dated 01/08/26 revealed at the three second mark, Certified Nursing Assistant (CNA) #624 entered the room and kicked the right side of the Resident #117's mattress twice with her right foot. Resident #117's legs lifted up from the mattress and then down with each kick. CNA #624 proceeded to remove the resident's covers without speaking to her. Resident #117 stated You don't like me. CNA #624 stated Yes, I do. CNA #624 when responding to the resident proceeded to walk back towards the bathroom door. Resident #117 again stated, No, you don't like me. CNA #624 did not respond to Resident #117. Review of Resident #117's video surveillance (20260206_101253), not timed but dated 01/08/26 revealed at the 15 second mark, CNA #624 entered the room and approached Resident #117's bed, pulled back the covers and tapped Resident #117's left leg with a gloved fist. CNA #624 did not appear to speak to the resident. Resident #117's hands appeared to be up as if in confusion and CNA #624 was observed to leave the room without speaking to the resident. As CNA #624 left the room, Resident #117 continued to appear confused. Review of Resident #117's video surveillance (20260206_101242), not timed but dated 01/08/26 revealed CNA #624 provided incontinence care to the resident. At the seven second mark, Resident #117 was heard telling CNA #624 Thank you. There was no response from CNA #624. At the 15 second mark, Resident #117 was heard stating, I like you a lot. There was no response from CNA #624. At the 45 second mark, Resident #117 was heard again saying, Thank you. CNA #624 did not respond. At the one minute 23 second mark, Resident #117 was heard stating, You're so good at what you do, again there was no response from CNA #624. At the one minute 40 second mark, CNA #624 told Resident #117 to stand up and at one minute 45 seconds mark, Resident #117 moving toward the edge of the bed stated, You want me to stand up? CNA #624 was walking toward the bathroom. At one minute 48 seconds mark, CNA #624 told Resident #117 to Hold on, hold on in a loud and aggressive tone. At the two-minute mark, Resident #117 attempted to get out of bed and put her leg on the seat of the wheelchair and CNA #624 said, No, sit down and then ordered her in a loud aggressive manner to Sit back. Review of police report dated 01/08/26 for incident #2026-00000242 for Resident #117 timed at 10:06 P.M. revealed Resident #117's family reported abuse. Police Officer (PO) #626 reported he was dispatched to the facility on [DATE] at 10:02 P.M. PO #626 stated he spoke with Resident #117's family member via phone who reported they saw from a security camera in the room, a CNA identified as CNA #624 appear to strike Resident #117 on the leg with her hand. A second video was (continued on next page)</p>		

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<p>F 0600</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>also viewed which showed CNA #624 come back into the room and appears to either kick Resident #117 in the leg twice or kick the mattress she was sleeping on twice. The kick appeared to be more forceful than the hand strike. After viewing the video, PO #626 went into the facility and spoke with Registered Nurse (RN) #712. RN #712 watched the video and then told CNA #624 she needed to go home, and her actions would be investigated. PO #626 spoke to CNA# 624 who reported she did not strike the resident. She reported that Resident #117 had soiled herself twice that day, once right after she had just gotten changed into a new diaper. CNA #624 reported that she never lost her temper or patience with Resident #117, and she told her she Loved her. CNA #624 did not recall any actions she may have taken that could be misconstrued as striking Resident #117. PO #626 then met with Resident #117 and her family and informed them it would be investigated in accordance with the facility policy. PO #626 informed the family that the report would be turned over to the Prosecutor. Resident #117 was noted to be in good spirits and was unable to recall anything happening to her legs. Review of the facility's neglect Self-Reported Investigation (SRI) with tracking number #269600 dated 01/09/26 opened at 10:58 A.M. revealed on 01/08/26 a family member called police to report what they saw during review of an in-room camera (surveillance video). The family alleged that a staff member was observed kicking a resident's bed. Police and family arrived at the facility at approximately 10:30 P.M. on 01/08/26. The alleged staff member was removed from care immediately and suspended pending an investigation. Resident #117 was assessed. Upon reviewing the camera footage, the CNA #624 was observed contacting the resident's bed frame with her foot in a non-aggressive manner. CNA #624 proceeded to provide incontinence and dressing care in a [NAME] manner. During the care, CNA #624 was noted to touch the resident on her leg, appearing to cue Resident #117 during care. Upon interview with CNA #624, she indicated that she was attempting to scratch an itch on her foot by scratching her foot on the bed frame. CNA #624 stated that she was diabetic and experienced tingling in her feet when her blood sugar dropped, and she explained that she was wearing gloves and did not want to touch her foot due to infection control. Camera footage verified that she was wearing gloves. The facility conclusion/disposition was indicated as unsubstantiated as evidence indicates abuse, neglect or misappropriation did not occur. The investigation was completed by the Director of Nursing. Review of CNA #624's witness statement dated 01/09/26 revealed on 01/08/26 she was caring for Resident #117. CNA #624 stated she came in to check on Resident #117 when her foot itched and since she was wearing gloves, she used the bed frame to scratch her itchy foot. CNA #624 stated she was not trying to kick the resident but did not want to contaminate her gloves, so she had to use the bed to scratch her foot. CNA #624 also stated she tapped on the resident twice to let her know that she was about to provide personal care and to let the resident know it was time to get up for incontinence care. Incontinence care was provided and CNA #624 assisted to the common area. Review of the 01/09/26 skin assessment for Resident #117 revealed a skin tear to the left pinky toe. Review of the 01/09/26 nursing progress note for Resident #117 timed at 11:11 A.M. authored LPN #897 revealed the daughter and power-of-attorney (POA) were notified of the scratch to the right foot pinky toe and treatment order was in place for the resident. The treatment order was discontinued on 01/12/26 at 3:42 P.M. as the right foot pinky toe scratch was healed. Review of the 01/15/26 skin assessment for Resident #117 revealed the skin tear was resolved. Review of the hospice notes from 01/02/26 to 01/16/26 for Resident #117 did not reveal any notification of an allegation of abuse or assessment by the hospice nurse. Review of the hospice care plan for Resident #117 did not reveal any changes made following the allegations of abuse. Interview on 03/04/26 at 7:15 A.M. with CNA #740 revealed she was working the night of the incident on the Memory Care unit with Resident #117 but did not see the incident and was not asked to write a witness statement. Interview on 03/04/26 at 10:40 A.M. was attempted with Resident #117 revealed resident was pleasantly confused but unable to provide information related to the incident due to severe cognitive impairment. Interview on 03/05/26 at 11:19 A.M. with the Administrator and Director of Nursing (DON) stated the police came to the facility on the evening of (continued on next page)</p>		

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<p>F 0600</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>01/08/26 and they sent CNA #624 home. The facility suspended CNA #624 and ensured the safety of Resident #117. The Administrator stated he did not feel the incident was an intentional aggressive action against Resident #117 but did think the behavior was bizarre and classified it as neglect. The Administrator confirmed he did not feel using the bed to kick or scratch was not a dignified action when providing care for a resident. Phone interview on 03/05/26 at 2:29 P.M. with Licensed Practical Nurse (LPN) #712 revealed she did not hear or observe any concerns until the police showed up and she viewed the videos provided by Resident #117's family. LPN #712 stated following viewing the video, she confirmed she did not feel CNA #624's care was appropriate. LPN #712 stated she felt the kick to the bed was unnecessary and thought it appeared as if she was kicking the bed and did not accidentally fall into the bed. LPN #712 was not asked to write a witness statement. Interview on 03/09/26 at 8:48 A.M. with Resident #117's granddaughter indicated the family put a camera in the resident's room the day of the incident. The granddaughter stated she left the facility and when she got home she checked the video surveillance before going to bed and upon seeing the videos, she contacted the police and drove back to the facility. She stated they found Resident #117 at the nursing station sitting in a wheelchair across from CNA #624. The resident did not recall the incident. Phone interview on 03/09/26 at 9:30 A.M. with Registered Nurse (RN) Coordinator #981 revealed while she was working, LPN #712 came up to her with Police Officer #626. Police Officer #626 told her what had happened and showed the video surveillance. The first video showed CNA #624 aggressively slapping the resident's leg and the second video showed the CNA #624 kicking the bed. RN Coordinator #981 revealed it did not appear as an accidental action and appeared purposeful. Telephone interview on 03/09/26 at 10:37 A.M. with CNA #624 revealed she started working in the facility about one month prior to the incident. She stated she received orientation but was unsure who had signed off her orientation forms and confirmed she worked on multiple units. CNA #624 indicated on 01/08/26 during the night shift, Resident #117 had a bowel movement, and she went in to change her. She stated she had an itchy foot and kicked the bed rail. She later came in to change her, put on a brief and then pulled up the brief. CNA #624 indicated when she provided Resident #117's care, she just told her what she needed to do and did not interact with her and could not recall if she spoke to the resident. She stated she did not want to contaminate her hands with gloves, so she scratched her foot by kicking the bed. CNA #624 denied hitting Resident #117 and stated she tapped her on the leg to get her attention. Interview on 03/09/26 at 11:02 A.M. with Human Resources Manager #995 confirmed CNA #624's orientation forms were not signed off as completed by the nurse as required. Interview on 03/09/26 at 11:56 A.M. with Licensed Social Worker (LSW) #745 revealed Resident #117 was not provided psych services following the incident and stated hospices services would provide psych services. Telephone interview on 03/09/26 at 12:00 P.M. with Hospice RN #625 revealed hospice was not notified by the family of the incident of abuse. Hospice RN #625 confirmed the resident was not provided psych services. Telephone interview on 03/09/26 at 3:45 P.M. with the Medical Director indicated he did not recall being notified of Resident #117's allegation of abuse. Telephone interview on 03/10/26 at 10:35 A.M. with Police Receptionist #627 confirmed the incident involving Resident #117 on 01/08/26 was turned over to the prosecutor but no criminal charges were being pursued. Review of the 2016 facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property. Facility staff should immediately report all such allegations to the Administrator in accordance with the procedures in this policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with facility's crime reporting policy. This deficiency represents non-compliance investigated under Complaint Number 2741949.</p>		

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<p>F 0609</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, resident interview, staff interview, and policy review, the facility failed to implement their abuse policy when Resident #6's allegation of abuse and staff concerns regarding the neglect of care for Resident #10 were not reported to the Administrator. Additionally the facility failed to ensure Resident #47's injury of unknown origin were reported to the State Agency. This affected three (#6, #47 and #10) of four residents reviewed for abuse. The facility census was 121. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 11/28/2025. Diagnoses included ischemic cardiomyopathy, acute respiratory failure with hypoxia, chronic atrial fibrillation, chronic obstructive pulmonary disease with acute exacerbation, diabetes mellitus, anxiety disorder, and depression.</p> <p>Review of Resident #6's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact.</p> <p>Review of Resident #6's March 2026 physicians orders revealed and order for continuous oxygen at three liters via nasal cannula every shift.</p> <p>Observation on 03/03/2026 at 9:21 A.M. revealed Resident #6 was resting in bed with oxygen in place per a nasal cannula at four liters. Further observation of Resident #6's room revealed a motorized wheelchair with white box attached to the back of the wheelchair. The white box is labeled for a place to insert battery to power the resident's portable oxygen machine.</p> <p>Interview on 03/03/2026 at 9:21 A.M. Resident #6 reported two nights prior that he had become short of air after falling asleep in his motorized wheelchair. Resident #6 reported his oxygen battery had ran out of charge and he used his motorized wheelchair to go to the hall. He called out to Certified Nursing Assistant (CNA) #718 in a panic asking for her to change the battery. CNA #718 stated to him, you do not need to be rude. She changed the oxygen battery but did not turn the power on. He reported he asked CNA #718 to turn the machine on and she stated, do it yourself and walked away. He panicked again and used his motorized wheelchair to go to a different hall where two other CNAs were working and turned it on for him. Resident #6 stated he felt like CNA #718 was trying to kill him and it was an act of abuse. Additionally, the resident reported he was so upset he called 911 after the incident. Resident #6 stated he reported the incident the morning of 03/02/26 to the Unit Manager Licensed Practical Nurse (LPN) #889 and was told the incident would be investigated.</p> <p>Review of the facility Self-Reported Incidents (SRI) for March 2026 revealed the facility had not reported this alleged allegation to the State Agency.</p> <p>Review of Resident #6's nursing progress notes for 03/01/26 revealed no evidence of a respiratory assessment or a progress note regarding the alleged incident.</p> <p>Interview on 03/03/2026 at 1:10 P.M. with Unit Manager LPN #889 verified that Resident #6 reported to her a CNA over the weekend refused to change the battery on his oxygen concentrator. Unit Manager LPN #889 reported she was aware the resident called 911 after the incident and that he stated he felt like the CNA's actions were attempted murder. Unit Manager LPN #889 stated she did not report the incident to the Administrator but believed that Registered Nurse Coordinator #981 spoke with the CNA involved and was aware of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0609</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>Phone Interview on 03/03/2026 at 1:27 P.M. with CNA #702 revealed she was working 3:00 P.M. until 10:00 P.M. on 03/01/26 when Resident #6 came a crossed the building to her side requesting help. CNA #702 reported Resident #6 was anxious and upset and stated that the CNAs on the other side of the building refused to provide care and were rude to him. CNA #702 reported that the resident needed someone to turn his oxygen machine on and put him to bed and that he did not feel safe asking the other CNAs. CNA #702 reported she and CNA #865 assisted Resident #6, and that CNA #865 turned on the resident's oxygen machine. CNA #702 then stated she went over to the two CNAs (CNA #718 and Agency CNA #622) and asked what was going on. The CNAs reported they were not going to take care of him because he was being rude and they, do not care what he has to say. CNA #702 stated she then went to Agency LPN #623 and reported the incident.</p> <p>Phone interview on 03/03/2026 at 2:58 P.M. with Registered Nurse Coordinator #981 revealed she was unaware of the incident and had not spoken with CNA #718 or Unit Manager LPN #889 regarding Resident #6.</p> <p>Interview on 03/03/2026 at 5:02 P.M. with the Administrator and Director of Nursing (DON) revealed they were not aware of the allegations reported by Resident #6. The DON stated it is the facility policy for staff to report all allegations of abuse right away. She verified this was not done.</p> <p>Interview on 03/03/2026 at 5:07 P.M. CNA #865 reported that on 03/01/26 Resident #6 came to him upset alleging that the CNAs on the other side of the building were not taking care of him and would not turn his oxygen on. CNA #865 verified he turned the oxygen on for Resident #6. CNA #865 stated CNA #702, who was also present went to speak with the CNAs working on the other side of the building and when she came back she reported to him that the CNAs told her that they did not care.</p> <p>Phone interview on 03/04/26 at 1:39 P.M. LPN #977 revealed she was working on hall 200 but on the opposite side of where Resident #6's room was on 03/01/26. LPN #977 stated CNA #718 and Agency CNA #622 were assigned to Resident #6's care and they had reported Resident #6 was being mean to them and they were going to ask another CNA put him to bed for them. LPN #977 stated the two CNAs told her that Resident #6 stated he was going to call the police on them and that she heard him yell at them at one point, but she did not inquire why because she was busy with her medication pass.</p> <p>Phone interview on 03/09/26 at 12:23 P.M. CNA #718 reported last weekend while she was obtaining clean towels from the utility closet Resident #6 came to her frantically stating he needed his battery changed. She told him, calm down you do not need to yell. CNA #718 stated she changed the battery and handed him the old one to charge and went on about her business as she was heading back down the hall to change another resident. CNA #718 stated the nurse later told her that she forgot to turn the oxygen machine after she changed the battery and Resident #6 was upset as a result. CNA #718 stated the nurse said she tried to reassure Resident #6 that it was not intentional, but the resident did not believe her. CNA #718 verified the nurse had switched the assignment and had someone else to put Resident #6 to bed.</p> <p>Review of the undated policy, Abuse, Neglect, Exploration, and Misappropriation of Resident Property revealed the facility will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. It is the facility's policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, including Injuries of Unknown Source, in accordance with this policy. Facility staff should immediately report all such allegations to the Administrator and to the State Agency In accordance with the procedures in this policy. (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Saint Luke Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Applegrove Street NE North Canton, OH 44720	
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<p>F 0609</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>2. Review of the medical record for Resident #47 revealed an admission date of 01/06/10 with diagnoses of adult failure to thrive, paranoid schizophrenia (chronic mental health condition characterized by intense, irrational, and persistent hallucinations or delusions, often focusing on persecution or conspiracy) and dementia.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #47 had severely impaired cognition.</p> <p>Review of the Nurse Practitioner (NP) progress note dated 02/12/26 revealed Resident #47's skin was intact with no bruising to the extremities.</p> <p>Review of the physician's orders for Resident #47 for March 2026 revealed she was not on an anticoagulant or antiplatelet which could lead to her bruising more easily.</p> <p>Review of nursing progress notes from 02/03/26 through 03/04/26 for Resident #47 revealed there was no indication she had a bruise to her right forearm or assessments or an investigation had been completed.</p> <p>Observation on 03/02/26 at 11:06 A.M. of Resident #47 revealed a circular bruise that was purplish red in color approximately the size of a half dollar to her right forearm. Resident #47 was unable to answer questions correctly and was not able to state how she obtained the bruise on her right forearm.</p> <p>Observation on 03/04/26 at 8:28 A.M. of Resident #47 revealed a circular bruise that was purplish red in color. The bruise appeared to be diminishing as it was smaller and lighter in color. Director of Resident Services #892 was present and verified the bruise on Resident #47's right forearm.</p> <p>Interview on 03/04/26 at 9:57 A.M. with Regional Direct of Clinical Services #610 verified facility staff had not documented Resident #47 had a bruise to her right forearm and no assessment had been completed.</p> <p>Interview on 03/04/26 at 1:10 P.M. with Licensed Practical Nurse (LPN) #604 revealed she had noticed the bruise to Resident #47's right forearm but believed it was an old area as the nurse aides had not reported new skin issues, so she marked no new skins issues on Resident #47's shower sheet. LPN #604 stated she had not reported the bruise to anyone nor filled out any statements regarding the bruising.</p> <p>3. Review of the medical record for Resident #10 revealed an admission date of 01/30/26 with diagnoses including heart failure, hypertension, chronic kidney disease and diabetes mellitus. He was admitted to the facility with services for hospice.</p> <p>Review of the comprehensive MDS assessment dated [DATE] for Resident #10 revealed he had severely impaired cognition, dependent on staff for toileting, and occasionally incontinent of bowel.</p> <p>Review of the care plan dated 02/10/26 for Resident #10 revealed the resident had self-care deficit and required staff assistance with activities of daily related to functional decline, impaired mobility, weakness, end stage disease and age-related changes. The goal was the resident would be clean and well groomed. Interventions included for staff to treat resident respectfully during care. (continued on next page)</p>		

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<p>F 0609</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>Review of undated pictures submitted via a complaint to the State Agency on 02/27/26, revealed an unidentified male, though named as Resident #10, covered in dried brown feces. The unidentified male was observed to be naked.</p> <p>Interview on 03/02/26 at 3:42 P.M. with the Administrator and DON revealed they were unaware of pictures taken by staff of Resident #10 during care. The DON stated she had heard that an aide CNA #603 had taken pictures showing a resident soiled but when she spoke to CNA #603, she denied taking pictures.</p> <p>Interview on 03/02/26 at 3:53 P.M. with CNA #916 verified another aide (CNA #603) had spoken to him about taking pictures of Resident #10 to send to the State Agency. CNA #916 stated he had not seen the pictures and verified he had not updated his supervisor or the DON as he was standing at the nurse's station and thought the nursing staff had heard the conversation and was aware of the pictures being taken.</p> <p>Interview on 03/03/26 at 6:49 P.M. with LPN #729 revealed she had heard rumors that an aide took pictures and was sending them to the state related to lack of care for the residents. LPN #729 stated she was unsure which resident was involved and verified she had not updated the DON related to possible pictures being taken of residents.</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation &amp; Misappropriation of Resident Property, dated 2016, revealed the facility staff did not follow their policy. The policy stated staff would investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property including injuries of unknown source. The facility staff should immediately report all such allegations to the Administrator and to the State Agency in accordance with the procedures in the policy. Injury of unknown source is defined as the source of the injury that was not observed by any person, or the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury, location of the injury or the number of injuries observed at one particular time or the incidence of injuries over time. Staff should be able to identify events such as suspicious bruising and trends that may constitute abuse. Neglect is defined as the failure of the facility, its employers or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. Staff should be able to identify events such as trends that may constitute abuse. Under the response section of the policy, it stated staff should report all incidents/allegations immediately to the Administrator or designee.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers 2791099 and 2741949.</p>		

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<p>F 0610</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>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, review of facility Self-Reported Incidents (SRIs) and policy review the facility failed to complete an investigation for Resident #47 and also failed to complete a thorough investigation for Resident #117 as required. This affected two (#47 and #117) of three residents reviewed for abuse. The facility census was 121. Findings include:1.Review of the medical record for Resident #117 revealed an admission date of 12/29/25. Diagnoses included but were not limited to neurocognitive disorder with Lewy Bodies, generalized anxiety disorder, chronic pain syndrome and Alzheimer's dementia.</p> <p>Review of the physician's orders revealed an order dated 12/30/25 for Resident #117 for hospice services.</p> <p>Review of the 01/02/26 admission Minimum Data Set (MDS) 3.0 for Resident #117 revealed a Brief Interview of Mental Status (BIMs) of four which indicated severe cognitive impairment. Resident #117 was noted to require maximum staff assistance with toileting.</p> <p>Review of the facility Self-Reported Incident (SRI) dated 01/09/26 opened at 10:58 A.M. for Resident #117 revealed the report indicated an allegation was reported by the resident's family. Resident #117 was indicated to not have provided meaningful information due to dementia. No negative effects were observed at the time of the observation of Resident #117. The narrative of the incident dated 01/08/26 timed at 10:30 P.M. revealed on 01/08/26 a family member called police to report they witnessed the in-room camera alleged a staff member (Certified Nursing Assistant (CNA) #624) kicking a resident's bed. Police and family arrived at the facility at approximately 10:30 P.M. on 01/08/26. Alleged staff member was removed and suspended pending investigation. Resident #117 was assessed for injuries and distress. Review of the investigation did not reveal any written staff statements other than from CNA #624. The facility census for 01/09/26 was included and indicated an audit with check marks on all of the interviewable residents with a statement at the bottom stating that all residents report feeling safe, had no signs or symptoms of distress, and there were no needs at this time. No evidence was provided as to what responses each interviewed resident had provided. There was no documentation regarding how the non interviewable residents were assessed.</p> <p>Review of the 01/09/26 employee counseling form for CNA #624 revealed on 01/08/26 a work performance and department policy violation with a description of failure to follow proper resident care procedures/improper brief change. CNA #624 was noted as terminated on 01/09/26 via telephone by the Director of Nursing (DON) and Administrator.</p> <p>Interview on 03/05/26 at 11:19 A.M. with the Administrator and DON confirmed the Administrator did not feel the incident was an intentional aggressive action against the resident and stated he thought CNA #624's behavior was bizarre but did not feel it was classified as neglect. The Administrator also confirmed kicking the bed was not an appropriate provision of care. The DON confirmed she was unable to provide written evidence of staff interviews other than CNA #624 or individual resident responses other than a check mark on the census form following the reported allegation on 01/08/26.</p> <p>Phone interview on 03/09/26 at 8:45 A.M. with Resident #117's granddaughter stated she viewed the video the evening of 01/08/26 and called the police while she was enroute to the facility about abuse towards Resident #117. (continued on next page)</p>		

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<p>F 0610</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>Phone interview on 03/09/26 at 9:30 A.M. with Registered Nurse Coordinator #981 confirmed she was working when Licensed Practical Nurse (LPN) #712 came to her with Police Officer #626 to view the videos and was not asked to write a witness statement.</p> <p>Phone interview on 03/09/26 at 10:38 A.M. with CNA #628 confirmed she was working the night of 01/08/26 and was not asked to write a witness statement.</p> <p>Phone interview on 03/09/26 at 3:45 P.M. with the Medical Director confirmed he did not recall being notified of an allegation of abuse for Resident #117.</p> <p>Review of the 2016 facility policy called; Abuse, Neglect, Exploitation and Misappropriation of Resident Property revealed it is the facility's policy to investigation all alleged violation involving abuse, neglect, exploitation, mistreatment of a resident or misappropriation of Resident property, including all injuries of unknown source, in accordance with this policy. On page five, under section F, number two indicated to interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents, family member), and employees who worked closely with the accused employee(s), and/or alleged victim of the day of the incident. If there are no direct witness, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. Under number three in section F stated evidence of the investigation should be documented.</p> <p>2. Review of the medical record for Resident #47 revealed an admission date of 01/06/10 with diagnoses of adult failure to thrive, paranoid schizophrenia (chronic mental health condition characterized by intense, irrational, and persistent hallucinations or delusions, often focusing on persecution or conspiracy) and dementia.</p> <p>Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #47 had severely impaired cognition.</p> <p>Review of the Nurse Practitioner (NP) progress note dated 02/12/26 revealed Resident #47's skin was intact with no bruising to the extremities.</p> <p>Review of the physician's orders for Resident #47 for March 2026 revealed she was not on an anticoagulant or antiplatelet which could lead to her bruising more easily.</p> <p>Review of nursing progress notes from 02/03/26 through 03/04/26 for Resident #47 revealed there was no indication she had a bruise to her right forearm or assessments or an investigation had been completed.</p> <p>Observation on 03/02/26 at 11:06 A.M. of Resident #47 revealed a circular bruise that was purplish red in color approximately the size of a half dollar to her right forearm. Resident #47 was unable to answer questions correctly and was not able to state how she obtained the bruise on her right forearm.</p> <p>Observation on 03/04/26 at 8:28 A.M. of Resident #47 revealed a circular bruise that was purplish red in color, which appeared to be diminishing. Director of Resident Services #892 was present and verified the bruise on Resident #47's right forearm. (continued on next page)</p>		

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<p>F 0610</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>Interview on 03/04/26 at 9:57 A.M. with Regional Direct of Clinical Services #610 verified facility staff had not documented Resident #47 had a bruise to her right forearm and no assessment was completed.</p> <p>Interview on 03/04/26 at 10:05 A.M. with the DON verified the facility had not performed an investigation related to Resident #47's bruise to her right forearm as staff had not brought it to her attention.</p> <p>Interview on 03/04/26 at 1:10 P.M. with LPN #604 revealed she had worked on 03/04/26 during the dayshift. She stated she had noticed the bruise to Resident #47's right forearm but believed it was an old area as the nurse aides had not reported new skin issues, so she marked no new skins issues on Resident #47's shower sheet. LPN #604 stated she had not reported the bruise to anyone nor filled out any statements.</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation &amp; Misappropriation of Resident Property, dated 2016, revealed the facility staff did not follow their policy. The policy stated staff would investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property including injuries of unknown source. The facility staff should immediately report all such allegations to the Administrator and to the State Agency in accordance with the procedures in the policy. Injury of unknown source is defined as the source of the injury that was not observed by any person, or the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury, location of the injury or the number of injuries observed at one particular time or the incidence of injuries over time. Staff should be able to identify events such as suspicious bruising and trends that may constitute abuse. Under the response section of the policy, it stated staff should report all incidents/allegations immediately to the Administrator or designee. Once the Administrator was notified, an investigation of the allegation violation would be conducted and documented.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2741949 and Complaint Number 2741907.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, interview, and policy review, the facility failed to ensure staff provided assistance with activities of daily living (ADL's) including toileting, showering and shaving for Residents #1, #4, #13, and #57. This affected five (#1, #4, #13, and #57) of 14 residents reviewed for ADL's. The facility census was 121. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 04/20/23 with diagnoses chronic respiratory failure, diabetes mellitus and repeated falls.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. He was able to understand staff and staff understood him. He had no behaviors noted on the assessment. He was dependent on staff for ADLs.</p> <p>Review of the shower schedule, undated, revealed Resident #1's showers were scheduled on Sunday and Thursday afternoons.</p> <p>Review of the shower sheets and electronic medical record from 01/01/26 through 03/01/26 for Resident #1 revealed the did not have showers on 01/11/26, 01/15/26, 01/29/26, 02/01/26, 02/08/26, 02/12/26 and 02/19/26.</p> <p>Interview on 03/02/26 at 12:33 P.M. with Resident #1 revealed he had not been receiving his showers on Sunday and Thursday as scheduled. The resident stated most of the time, he received only one shower per week. Resident #1 stated he would like to have showers at least twice per week.</p> <p>Interview on 03/05/26 at 9:58 A.M. with the Director of Nursing (DON) verified she had provided all of the shower documentation for Resident #1.</p> <p>2. Review of the medical record for Resident #4 revealed an admission date of 05/31/24 with diagnoses chronic kidney disease, hypertension, hemiplegia affecting left non-dominant side and anxiety.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #4 had intact cognition, had no behaviors or rejection of care. Resident #4 required substantial to maximum assistance from staff for showers and bathing herself.</p> <p>Review of the shower schedule, undated, revealed Resident #4's showers were scheduled on Mondays and Thursdays on dayshift.</p> <p>Review of the shower sheets and electronic medical record from 01/01/26 through 03/01/26 for Resident #4 revealed the resident did not have showers on 01/01/26, 01/06/26, 01/08/26, 01/10/26, 01/19/26, 01/25/26, 02/05/26, 02/16/26, 02/19/26, 02/23/26 and 02/26/26.</p> <p>Interview on 03/03/26 at 8:30 A.M. with Resident #4 revealed she was not getting her showers as scheduled per her preference.</p> <p>Interview on 03/05/26 at 9:58 A.M. with the DON verified she had provided all of the shower documentation for Resident #4. (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of the medical record for Resident #57 revealed an admission date of 05/08/24 with diagnoses of depression, chronic pain and anemia.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 had intact cognition, had no behaviors or rejection of care. Resident #57 needed substantial to maximum assistance from staff for showers. Resident #57 was occasionally incontinent of urine.</p> <p>Review of the shower schedule, undated, revealed Resident #57's showers were scheduled on Mondays and Thursdays on dayshift.</p> <p>Review of the shower sheets and electronic medical record from 01/01/26 through 03/01/26 for Resident #57 revealed the resident did not have showers on 01/16/26, 01/19/26, 01/23/26, 01/26/26 and 02/25/26.</p> <p>Interview on 03/02/26 at 12:43 P.M. with Resident #57 revealed she was not getting showers like she should. She stated she had to argue with staff to ensure she gets some showers.</p> <p>Interview on 03/05/26 at 9:58 A.M. with the DON verified she had provided all of the shower documentation for Resident #57.</p> <p>4. Review of the medical record for Resident #13 revealed an admission date of 07/26/2024. Diagnoses included Alzheimer's disease, senile degeneration of the brain, depression, adult failure to thrive, history of falling, and unspecified dementia.</p> <p>Review of Resident #13 significant change MDS assessment dated [DATE] revealed the resident had a moderate cognitive impairment.</p> <p>Observations of Resident #13 on 03/02/2026 at 12:53 P.M. and 03/03/2026 at 4:01 P.M. revealed the female resident had a significant amount of grey/white chin hair approximately one inch long.</p> <p>Interview on 03/03/2026 at 4:01 P.M. with Licensed Practical Nurse (LPN) #961 verified resident is unable to complete her own shaving and she would have someone shave her.</p> <p>Interview on 03/04/2026 at 9:05 A.M. Resident #13 stated she prefers to have her chin hair shaved. She asked if someone could shave her at this time. Observation at this time revealed the chin hair was still present.</p> <p>Interview on 03/04/2026 at 9:08 A.M. LPN #986 verified Resident #13 chin hair had not been shaved and reported she would find someone to assist her.</p> <p>Review of Resident #13's progress notes revealed no refusals in March 2026 for shaving related to personal care or assistance with activities of daily living.</p> <p>Review of Resident #13's behavioral tracking for March 2026 revealed no concerns related to refusals of care.</p> <p>Review of Resident #13's care plan dated 9/8/2025 revealed the resident had a self-care deficit and impaired mobility due to a diagnosis of dementia, senile degeneration of brain, muscle weakness and history of fracture. The goals stated the resident will be clean and well-groomed with needs met (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>through the next review. Interventions included dependent assistance with upper body dressing, personal hygiene, and showers and bathing.</p> <p>Review of the facility policy called; Activities of Daily Living (ADL), Supporting, dated April 2025 revealed residents are provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently are to receive the services necessary to maintain good nutrition, grooming and person and oral hygiene. Appropriate care and services are provided for resident who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (eating, including meals and snacks), and communications (including speech, language and other functional communication systems). The care, treatment, and services are provided to ensure their ADLs do not diminish unless the circumstances of their clinical condition(s) demonstrate diminishing ADLs are unavoidable.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2799697 and Complaint Number 2741949.</p>		

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  03/10/2026
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, staff interview, and policy review, the facility failed to ensure adequate monitoring, assessments, and wound treatments were completed as ordered. This affected one (#31) of one resident reviewed for wounds. The facility census was 121. Findings include: Review of Resident #31's medical record revealed the resident was admitted on [DATE] and expired in the facility on [DATE]. Diagnoses included Alzheimer's disease, and peripheral vascular disease. Resident #31 was discharged to the hospital on [DATE] and returned to the facility on [DATE] status post (s/p) right great toe amputation on [DATE].</p> <p>Review of Resident #31's Discharge Return Anticipated MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.</p> <p>Review of Resident #31's admission Assessment form (readmission) dated [DATE] revealed the resident was unable to understand and had surgical incisions of the right hip and right great toes.</p> <p>Review of Resident #31's history and physical dated [DATE] revealed the resident was readmitted to the facility on [DATE]. The resident was sent to the emergency room (ER) on [DATE] with a worsening wound on the right foot with progressive swelling and redness. The resident was found to have sepsis and osteomyelitis and underwent an amputation of the right great toe with metatarsal resection and sesamoid complex of the right foot, with irrigation and debridement (I&amp;D) of the right medial heel on [DATE]. The resident underwent a primary closure of the right heel and application of a wound vac on [DATE]. Infectious Disease recommended six weeks of Doxycycline and Augmentin. The resident underwent an angiogram and angioplasty in the right leg by a vascular surgeon on [DATE].</p> <p>Review of Resident #31's physician orders revealed an order dated [DATE] for Doxycycline oral tablet 100 milligrams (mg), one tablet by mouth two times a day for a wound infection for sixty-six administrations due at 6:00 A.M. and 6:00 P.M.</p> <p>Review of Resident #31's medication administration record (MAR) from [DATE] to [DATE] revealed no evidence the Doxycycline antibiotic was administered on [DATE] at 6:00 A.M., [DATE] at 6:00 A.M., [DATE] at 6:00 A.M., [DATE] at 6:00 A.M., [DATE] at 6:00 P.M., [DATE] at 6:00 A.M., and [DATE] at 6:00 A.M.</p> <p>Review of Resident #31's wound assessment dated [DATE] revealed the resident had a right second toe diabetic ulcer first acquired [DATE] which measured 2.9 centimeters (cm) length by 1.2 cm width with undetermined depth and the wound bed was necrotic with dried eschar, a right plantar foot diabetic wound first acquired [DATE] measuring 1.2 cm length by 2.0 cm width by 1.1 cm depth, a right fourth lateral toe web diabetic ulcer first acquired [DATE] which measured 1.0 cm length by 0.5 cm width by 0.1 cm depth. The form listed the wound bed as granulation tissue. Resident #31 also had and a right four toe tip diabetic ulcer first acquired [DATE] which measured 1.0 cm length by 1.6 cm width by undetermined depth with eschar to the wound bed, a right toe amputation which measured 6.2 cm length by 2.2 cm width by undetermined depth with granulation tissue listed on the wound bed, a left plantar foot diabetic ulcer first acquired [DATE] which measured 2.0 cm length by 1.5 cm width by undetermined depth. The wound assessment indicated the right 5th toe healed as of [DATE].</p> <p>Review of Resident #31's physician orders revealed an order dated [DATE] to cleanse the right great (continued on next page)</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>toe amputation site with normal saline (NS), pat dry, apply calcium alginate to the wound bed, cover with an abdominal dressing daily and as needed until resolved. Orders dated [DATE] to cleanse the right second, fourth, and fifth toes by flossing a 4x4 gauze with NS between the toes; dry thoroughly, weave mesalt (sodium chloride impregnated wound dressing designed to cleanse heavily exuding, infected and sloughy wounds) rope between the toes, cover with an abdominal dressing and kerlix daily and as needed until resolved and an order to cleanse the right plantar foot with NS, pat dry, apply an abdominal dressing and kerlix over the incision site daily and as needed until resolved. Both orders were discontinued on [DATE] and new physician orders were written which included the right second through fifth toes to be cleansed by flossing with a 4X4 gauze with NS between the toes, dry thoroughly, apply betadine to the wound beds and cover with an abdominal dressing and kerlix daily and as needed until resolved, an order to cleanse the right plantar foot incision with NS, pat dry, apply oil emulsion followed by calcium alginate cut to size. Cover with an abdominal dressing and kerlix daily and as needed until resolved, an order to cleanse the right fourth lateral toe with NS soaked 4x4 gauze flossed between the toes, apply betadine-soaked gauze to the wound bed, cover with an abdominal pad and kerlix daily and as needed until resolved. Another order written [DATE] included to cleanse the right great toe amputation with NS, pat dry, apply oil emulsion followed by calcium alginate cut to size, cover with an abdominal dressing and kerlix daily and as needed until resolved. The right plantar foot order was updated on [DATE] and read to cleanse with NS, pat dry, apply mesalt rope packing too the wound bed and tunneling at 3:00 o'clock using a cotton tip applicator and cover with an abdominal pad and kerlix daily and as needed until resolved.</p> <p>Further review of physician orders revealed a new order dated order dated [DATE] to cleanse the left medial plantar foot with normal saline, pat dry and cover with a dry dressing every shift until healed. The order was discontinued on [DATE] and a new order was written to cleanse with NS, pat dry, apply betadine to the wound bed daily and every night shift starting [DATE]. Other orders dated [DATE] included to cleanse the right second to fifth toes by flossing 4x4 gauze with NS between toes, dry thoroughly, apply betadine to the wound beds, cover with an abdominal dressing and kerlix until healed, and to cleanse the right plantar foot with NS, pat dry, apply mesalt rope packing to the wound bed and tunneling at 3:00 o'clock using cotton tip applicator and cover with abdominal pad and kerlix daily and as needed until resolved. Orders dated [DATE] were for the right fourth lateral toe to cleanse with NS soaked 4x4 gauze flossed between the toes, apply betadine-soaked gauze to the wound bed, cover with an abdominal dressing and kerlix daily and as needed until resolved and for the right great toe amputation to be cleansed with NS, pat dry, apply oil emulsion followed by calcium alginate cut to size, cover with an abdominal dressing and kerlix daily and as needed until resolved.</p> <p>Review of Resident #31's treatment administration records (TARS) from [DATE] to [DATE] revealed no evidence wound care was completed for the right second to fifth toes on [DATE], [DATE], [DATE] and [DATE], for the right plantar foot incision on [DATE], [DATE], [DATE], and [DATE], no evidence wound care was completed for the right fourth lateral toe on [DATE], [DATE], and [DATE], no evidence wound care was completed for the right great toe amputation on [DATE], [DATE], [DATE], and [DATE], and no evidence wound care was completed to the left medial foot on [DATE].</p> <p>Telephone interview on [DATE] at 12:13 P.M. with RN Wound Nurse (WN) #727 revealed Resident #31's diabetic foot ulcers started out as a closed callus. RN WN #727 confirmed two days later the wound became necrotic and the resident was sent to the hospital for osteomyelitis. She stated the toenails were thicker but not unmanageable. RN WN #727 also confirmed she was unaware Resident #31 was not administered multiple doses of the resident's antibiotics and doxycycline antibiotics were in the pyxis medication system which staff were able to access. RN WN #727 also confirmed (continued on next page)</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>Resident #727's medical record did not have evidence of wound care for multiple wounds on the right and left feet.</p> <p>Telephone interview on [DATE] at 12:43 P.M. with Wound Nurse Practitioner (NP) #632 revealed Resident #31 had multiple incisions and gangrenous toes. Wound NP #632 indicated the resident would self-propel and hit his feet against things while on the secured Memory Care unit and the resident also had poor nutrition. Wound NP #632 denied concern with Resident #31's wound care.</p> <p>Review of the Wound Care policy revised 10/2010 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2799697.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, staff interview, and policy review, the facility failed to implement pressure ulcer prevention interventions and treatments. This affected one (#10) of three residents reviewed for pressure ulcers. The facility census was 121. Findings include: Review of the medical record for Resident #10 revealed an admission date of 01/30/26 with diagnoses including heart failure, diabetes mellitus and muscle weakness.</p> <p>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 was dependent for toileting, showers and transfers. Resident #10 was occasionally incontinent of bowel. He had no skin impairment noted on this assessment.</p> <p>Review of the care plan dated 02/10/26 for Resident #10 revealed he was at risk for skin breakdown related to incontinence of bowel, having an indwelling device, impaired mobility, weakness and age-related changes. Interventions included to notify the physician of skin problems and treatments would be initiated per orders.</p> <p>Review of the nursing progress note dated 03/02/26 at 10:41 P.M. for Resident #10 revealed an aide had discovered a pressure wound to his coccyx. The nurse was updated and performed an assessment. The coccyx wound measured 0.5 centimeters by 0.2 centimeters with scant bleeding. The wound was cleaned with normal saline and Vitamin A and D ointment was applied followed by powder and a dry foam dressing was placed. Resident #10's son was updated.</p> <p>Review of the physician orders for 03/02/26 through 03/04/26 at 2:00 P.M. revealed there were no treatment orders to Resident #10's coccyx pressure ulcer.</p> <p>Observation of wound care on 03/04/26 at 2:01 P.M. with Registered Nurse (RN) #727 to Resident #10 revealed he did not have a treatment to his coccyx. RN #727 verified there was no treatment to his coccyx for his pressure ulcer. Upon further interview with RN #727 she verified there were no physician's orders for wound care or treatment to Resident #10's pressure ulcer from when the wound was first observed on 03/02/26 until observation on 03/04/26.</p> <p>Review of the facility policy titled, Prevention of Pressure Injuries, dated April 2020, revealed the facility would evaluate, report and document potential changes in the skin. Staff were to review the interventions and strategies for effectiveness.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2799697.</p>		

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<p>F 0689</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure Resident #117 received a thorough fall investigation and failed to ensure fall interventions were in place for Resident #8. This affected two (#117 and #8) of four residents reviewed for falls. The facility census was 121. Findings include: 1. Review of the medical record for Resident #117 revealed the resident was admitted on [DATE] with diagnoses including Lewy Bodies Dementia, chronic pain syndrome and Alzheimer's disease.</p> <p>Review of Resident #117's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #117's care plan dated 01/01/26 revealed a risk for falls characterized by history of falls/injury and multiple risk factors. Interventions included analyzing previous resident falls to determine whether pattern/trend can be addressed, call light accessible, and if a fall occurs, assess factors leading to fall and notify the doctor and family of occurrences.</p> <p>Review of Resident #117's Fall Risk assessment dated [DATE] revealed the resident was high risk for falls.</p> <p>Review of Resident #117's video surveillance dated 03/05/26 at 2:08 A.M. revealed the resident was dressed in shorts and shirt. She was sitting on her floor in front of the door and had appeared to have fallen. Two staff members are observed responding.</p> <p>Further review revealed Resident #117's fall dated 03/05/26 at 2:08 A.M. was not documented in the resident's medical record.</p> <p>Interview on 03/05/26 at 1:06 P.M. with Resident #117's family members confirmed they were not notified of the fall on 03/05/26 at 2:08 A.M.</p> <p>Interview on 03/09/2026 at 9:05 A.M. the Director of Nursing (DON) stated she spoke with Licensed Practical Nurse (LPN) #973 who worked on 03/05/26. LPN #973 reported to her that they were already doing neurological checks from a fall that happened earlier that day and this is why she did not document the fall. The DON stated she provided education, went back and made notifications, and started a fall investigation for the late report.</p> <p>2. Review of Resident #8's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease, essential hypertension and generalized anxiety disorder.</p> <p>Review of Resident #8's physician orders revealed an order dated 12/10/24 to encourage the resident to wear non-slip socks while in bed as tolerated.</p> <p>Review of Resident #8's fall care plan dated 12/10/24 and revised 08/22/25 revealed an intervention dated for non-slip socks to be worn while in bed as the resident allows.</p> <p>Review of Resident #8's Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls. (continued on next page)</p>		

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<p>F 0689</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>Review of Resident #8's medical records revealed the resident had sustained falls on 01/20/26, 02/01/26/ 02/14/26 and 02/26/26.</p> <p>Review of Resident #8's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had severe cognitive impairment.</p> <p>Attempted interview on 03/09/26 at 9:12 A.M. with Resident #8 and the resident was not interviewable. Observation at 9:13 A.M. at the time of the interview revealed the resident was lying in bed and her bilateral feet were uncovered. Non-slip gripper socks were not observed on her feet, and the gripper socks were not on the bed or on the floor near the bed.</p> <p>Interview on 03/09/26 at 9:17 A.M. with Certified Nursing Assistant (CNA) #992 confirmed Resident #8 was to have bilateral gripper socks on while in bed and the gripper socks were not observed on or near the resident to prevent the resident from further falls.</p> <p>Review of the facility policy, Falls and Fall Risk, Managing dated March 2018 under the section titled Monitoring Subsequent Falls and Fall Risk revealed staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of failing. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has been resolved. If the resident continues to fall, staff will re-evaluate the situation and decide whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers 2741907 and 2799697.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure medications were administered as ordered. This affected three (#1, #4 and #47) of seven residents reviewed for medications administration. The facility census was 121. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 04/20/23 with diagnoses including chronic respiratory failure, diabetes mellitus, chronic kidney disease and depression. Review of the current physician's orders revealed Resident #1 had orders dated 01/31/26 for Albuterol Sulfate Inhalation 2.5 milligrams (mg) per 3 milliliters (mL), inhale orally three times a day for shortness of breath, Clonidine 0.1 mg every eight hours for hypertension, Gabapentin 400 mg three times a day for pain, and Hydralazine 100 mg three times a day for hypertension. Review of the Medication Administration Record (MAR) for February 2026 for Resident #1 revealed Albuterol Sulfate was not administered on 02/05/26, 02/08/26 and 02/22/26 at 6:00 A.M. and on 02/22/26 at 2:00 P.M. Clonidine was not administered on 02/05/26, 02/08/26 and 02/22/26 at 6:00 A.M. and on 02/22/26 at 2:00 P.M. Gabapentin 400 mg was not administered on 02/05/26, 02/08/26 and 02/22/26 at 6:00 A.M. and on 02/22/26 at 2:00 P.M., and Resident #1's Hydralazine 100 mg was not administered on 02/05/26, 02/08/26 and 02/22/26 at 6:00 A.M. and on 02/22/26 at 2:00 P.M. Review of the nursing progress notes from 02/05/26 through 03/01/26 for Resident #1 revealed there was no indication as to why the Albuterol Sulfate, Clonidine, Gabapentin and Hydralazine were not administered as ordered on 02/05/26, 02/08/26, and 02/22/26 and there was no documentation of the physician updated on the medications not being administered. Interview on 03/02/26 at 12:33 P.M. with Resident #1 revealed at times medications are not administered as ordered. Interview on 03/04/26 at 11:41 A.M. with the Director of Nursing (DON) verified Resident #1's medications were not administered as ordered on 02/05/26, 02/08/26, and 02/22/26. The DON had no explanation as to why medications were not administered as ordered on those dates and further verified there was no documentation in Resident #1's medical record to indicate why the medications were not administered and further verified there was no documentation of the physician being notified of the medications not being administered. 2. Review of the medical record for Resident #4 revealed an admission date of 05/31/24 with diagnoses including chronic kidney disease, depression, anxiety and diabetes mellitus. Review of the current physician's orders for Resident #4 revealed the resident had orders for Gabapentin 300 mg three times a day for pain dated 08/03/25, Lipitor 40 mg at bedtime for hyperlipidemia dated 08/03/25, Pantoprazole Sodium 40 mg in the morning for gastroesophageal reflux disease dated 08/04/26, and cranberry 450 mg twice a day for prophylaxis for urinary tract infections dated 08/06/25. Review of the MAR for January and February 2026 for Resident #4 revealed nursing staff had placed a code nine on the MAR, which meant other, for her Gabapentin 300 mg on 01/10/26 at 9:45 A.M., Lipitor 50 mg at bedtime; Pantoprazole Sodium 40 mg on 01/18/26 at 10:04 A.M.; and cranberry 450 mg on 02/24/26 at 10:48 A.M. Review of the nursing progress notes from 01/10/26 through 03/03/26 for Resident #4 revealed Gabapentin 300 mg was not administered on 01/10/26 at 9:45 A.M. due to being on order. On 01/12/26 Resident #4's Lipitor 50 mg was not administered at bedtime due to being on order. On 01/18/26 at 10:04 A.M. the nursing progress note stated Pantoprazole Sodium 40 mg was not administered in the morning due to being on order. On 02/24/26 at 10:48 A.M. Resident #4's cranberry 450 mg was unavailable on the cart to be administered. There was no documentation in the medical record that the physician was updated that the medications were not administered. Interview on 03/03/26 at 8:30 A.M. with Resident #4 revealed she did not receive her medications like she should from nursing staff. Interview on 03/04/26 at 11:41 A.M. with the DON verified Resident #4's Gabapentin on 01/10/26 at 9:45 A.M., Lipitor on 01/12/26, Pantoprazole Sodium on 01/18/26, and cranberry on 02/24/26 at 10:48 A.M. was not administered and the physician was not notified. 3. Review of the medical record for Resident #47 revealed an (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>admission date of 02/23/13 with diagnoses including paranoid schizophrenia (chronic mental health condition characterized by intense, irrational, and persistent hallucinations or delusions, often focusing on persecution or conspiracy), adult failure to thrive, depression, pain and dementia. Review of the current physician's orders for Resident #47 revealed orders for Aricept 10 mg in the afternoon for Alzheimer's Disease dated 06/15/22, and an order for Sodium Chloride tablet 1 gram three times a day for low sodium dated 05/09/25. Review of the MAR for February and March 2026 for Resident #47 revealed nursing staff had placed a code nine on the MAR, which meant other, for the Sodium Chloride 1 gram on 02/25/26 at 4:59 P.M., on 02/25/26 at 8:00 P.M., on 02/26/26 at 8:20 A.M., on 03/01/26 at 3:55 P.M., on 03/01/26 at 5:24 P.M., on 03/03/26 at 10:54 A.M. as well as her Aricept 10 mg on 03/01/26 at 3:52 P.M. Review of the nursing progress notes from 02/03/26 through 03/03/26 for Resident #47 revealed Sodium Chloride 1 gram was not available and on order on 02/25/26 at 4:59 P.M., on 02/25/26 at 8:00 P.M., on 02/26/26 at 8:20 A.M., on 03/01/26 at 3:55 P.M., 03/01/26 at 5:24 P.M. and on 03/03/26 at 10:54 A.M. On 03/01/26 at 3:52 P.M. Resident #47's Aricept 10 mg was on order and not able to be administered. Further review of the nursing progress notes revealed there was no documentation that the physician was updated on the medications not being administered. Interview on 03/04/26 at 11:41 A.M. with the DON verified Resident #47 did not receive Sodium Chloride 1 gram on 02/25/26 at 4:59 P.M., on 02/25/26 at 8:00 P.M., on 02/26/26 at 8:20 A.M., on 03/01/26 at 3:55 P.M., on 03/01/26 at 5:24 P.M., on 03/03/26 at 10:54 A.M., and Aricept 10 mg on 03/01/26 at 3:52 P.M. as ordered. The DON had no explanation as to why they were not administered and further verified the physician was not notified of the medications not being administered. Review of the facility policy titled, Administering Medications, dated April 2019, revealed medications were to be administered in a safe and timely manner in accordance with the prescriber orders including any required time frames. This deficiency represents non-compliance investigated under Complaint Number 2791849.</p>		

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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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure residents were free of significant medication errors. This finding affected two (Residents #85 and #141) of seven residents reviewed for medication administration. The facility census was 121. Findings include: 1. Review of Resident #141's medical record revealed the resident was admitted on [DATE] and discharged back to the assisted living facility on 02/06/26. Diagnoses included cellulitis, anemia and depression.</p> <p>Review of Resident #141's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.</p> <p>Review of Resident #141's care plan dated 01/23/26 revealed the resident was on an antibiotic and an intervention was to administer medications as ordered.</p> <p>Review of Resident #141's physician orders revealed an order dated 01/10/26 for meropenem (broad-spectrum intravenous (IV) antibiotic used to treat severe bacterial infections), one gram intravenously every eight hours for cellulitis to the bilateral lower extremities until 02/06/26.</p> <p>Review of Resident #141's Medication Administration Records (MAR) revealed Licensed Practical Nurse (LPN) #604 documented administration of the meropenem on 01/27/26 at 2:00 P.M</p> <p>Review of the facility witness statement dated 01/26/26 authored by LPN #604 revealed the nurse attempted to administer the meropenem IV antibiotic at approximately 11:00 A.M. on 01/26/26 and the nurse accidentally administered Daptomycin (a bactericidal antibiotic administered IV to treat severe gram-positive infections) instead. The witness statement stated the nurse did not realize she had grabbed the wrong medication. Resident #141 approached the nurse and reported the wrong medication at approximately 11:10 A.M. The nurse rechecked the medication and realized it was the incorrect medication and stopped the infusion.</p> <p>Interview on 03/02/26 at 9:19 A.M. with Resident #141 verified she reported she had received the wrong medication on 01/26/26 and reported the wrong medication was an antibiotic for another resident.</p> <p>Telephone interview on 03/04/26 at 12:55 P.M. with LPN #604 revealed she accidentally administered Resident #33's antibiotic to Resident #141 because the antibiotics looked alike. When questioned, LPN #604 stated she did not double check to ensure she was infusing the correct antibiotic until Resident #141 brought the error to her attention approximately ten minutes after the infusion was started. LPN #604 she stopped the antibiotic, called the nurse practitioner (NP), and continued to monitor Resident #141.</p> <p>2. Review of the medical record for Resident #85 revealed an admission date of 11/23/22 with diagnoses including chronic respiratory failure, diabetes mellitus, depression and anxiety.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #85 had intact cognition, had clear speech, was understood by staff and understood staff, and had no behaviors on this assessment.</p> <p>Review of the physician's order for Resident #85 revealed an order dated 03/02/26 for Lorazepam (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>one milligram (mg) every eight hours for anxiety.</p> <p>Review of the MAR for March 2026 revealed Resident #85 did not receive his Lorazepam on 03/02/26 at 6:00 A.M., 2:00 P.M. and 10:00 P.M. or on 03/03/26 and 03/04/26 at 2:00 P.M.</p> <p>Review of the nursing progress note dated 03/02/26 and timed 1:50 P.M. stated the Lorazepam was on order and they were waiting on pharmacy to deliver. The progress notes on 03/02/26 at 10:57 P.M. stated drug not available and the pharmacy was notified. Further review of the nursing progress notes revealed no documentation on why the Lorazepam was not administered on 03/03/26 or 03/04/26.</p> <p>Interview on 03/05/26 at 12:38 P.M. with Resident #85 verified he had not received his medications as ordered, stating the facility had failed to order the medication.</p> <p>Interview on 03/05/26 at 12:40 P.M. with Psychotherapist #618 revealed Resident #85 had high anxiety and was very upset that he had not been receiving his medications as ordered.</p> <p>Interview on 03/05/26 at 1:14 P.M. with LPN #889 verified Resident #85's Lorazepam was not administered as ordered on the dates listed above because it was unavailable.</p> <p>Review of the Medication Administration Policy dated 04/2019 revealed medication revealed medications are to be administered in a safe and timely manner, and as prescribed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2791849.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on medical record review, interview and policy review the facility did not honor dietary preferences for three (Residents #8, #14, and #45) residents and did not tell or offer the family of Resident #8, who was cognitively impaired, the option to complete weekly menus. This had the potential to affect all resident receiving meals from the facility. The facility indicated three residents (Residents #1, #63 and #136) who received nothing by mouth. The facility census was 121. Findings Include: 1. Review of the medical record for Resident #8 revealed an admission date of 09/08/23. Diagnoses included but were not limited to Alzheimer's disease, displaced comminuted fracture of shaft of left humerus with routine healing, and age-related physical debility.</p> <p>Review of the 08/25/25 physician order revealed and order for a regular mechanical soft diet with thin liquids with ice cream at lunch and dinner.</p> <p>Review of the 10/22/25 dietary note revealed the mini nutrition assessment was completed and noted no significant weight changes in the past three months. No noted evidence of dietary modifications or family involvement for preferences to increase intake. Resident #8 was noted to have a body mass index (BMI) of 18 with an average intake of 65% over the past 14 days and 42 meals reviewed.</p> <p>Review of the 02/13/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #8 revealed a Brief Interview of Mental Status (BIMS) of 0 which indicated severe cognitive impairment. Resident #8 was noted to require moderate assistance for eating and receive a mechanically altered diet.</p> <p>Review of the 02/13/26 nutrition assessment for Resident #8 revealed no noted resident preference updates or evidence of family involvement with the assessment. BMI was noted to 18.1 and no significant weight changes were noted.</p> <p>Review of the care plan for Resident #8 revealed it was last reviewed on 02/22/26. No noted changes in nutrition care plan since 10/22/25.</p> <p>Interview on 03/02/26 at 3:37 P.M. with Resident #8's son revealed due to her cognitive impairment, she is not able to remember to request alternative food items and stated family has not been asked to update preferences or told they could fill out weekly menus.</p> <p>Interview on 03/05/26 at 1:40 P.M. with Registered Dietitian (RD) #925 revealed she updates resident preferences upon admission and at least quarterly. RD #925 stated every resident/family should be offered the chance to do weekly menus. RD #925 stated she was unable to provide evidence that Resident #8's family had been offered the chance to complete menus or update dietary preferences since she has only worked at the facility for about six weeks.</p> <p>2. Review of the medical record for Resident #14 revealed and admission date of 02/05/26. Diagnoses included but were not limited to unspecified fracture of the lower end of the right radius, anxiety disorder, morbid obesity, and need for assistance with personal care.</p> <p>Review of the physician order dated 02/05/26 for Resident #14 revealed an order for a regular diet with thin liquids.</p> <p>Review of the 02/10/26 dietary Nutrition Assessment for Resident #14 revealed a regular diet and set (continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>up assistance required for meals. No comments were listed in the comments section under diet orders.</p> <p>Review of the 02/10/26 Medicare five-day Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) of 13 which indicated intact cognition. Resident #14 was noted to be dependent for all activities of daily living (ADLs).</p> <p>Review of Resident #14's care plan revealed potential risk for altered nutritional status related to fracture, reflex sympathetic dystrophy. Resident #14 was noted to have some meal refusals. Interventions listed included but were not limited to provide, serve diet as ordered. RD to evaluate and make diet change recommendations as needed.</p> <p>Interview on 03/02/26 at 12:45 P.M. with Resident #14 revealed the first day she told staff she did not like, and they stated they would let the kitchen know, but she continues to receive chicken. She stated she receives daily menus but has not consistently had staff offer to assist her to fill them out.</p> <p>Review of the facility diet ticket for Resident #14 dated 03/05/26 revealed a regular diet with no specified preferences listed.</p> <p>Interview on 03/05/26 at 1:40 P.M. with RD #925 confirmed Resident #14's dietary ticket did not list a dislike of chicken, was unable to provide evidence of resident preferences being documented and also confirmed staff are supposed to assist with filling out the daily menus. RD #925 stated daily menus go down on the breakfast care for the following but was unsure whether staff are consistently passing them out or if staff are consistently assisting resident who require assistance filling out the menus.</p> <p>3. Review of Resident #45's medical record revealed the facility admission date was 06/28/22 with a diagnosis of unspecified dementia and a regular diet order with regular texture, and thin liquids.</p> <p>Review of Resident #45's care plan, dated 06/27/22, for the potential of alteration in nutrition revealed the risk for the overall decline in activities of daily living (ADL) due to advanced age and decline in cognition with an intervention to review food likes, dislikes, and meal preferences as needed.</p> <p>Observation on 03/04/26 at 8:00 A.M. of Resident #45's breakfast tray revealed water, juice, hard-boiled egg, oatmeal, hash brown, and a cake like pastry that contained yellow pieces of possibly fruit. The tray meal ticket revealed the choice of cereal, hard-boiled egg, blueberry muffin, hash brown, milk, coffee, and juice. During the observation, Resident #45 appeared upset. Resident #45 indicated all that was requested was frosted flakes, coffee, and milk.</p> <p>Interview on 03/04/26 at 8:06 A.M. with Certified Nursing Assistant (CNA) #860 confirmed Resident #45's tray was incorrect. CNA #860 indicated dietary messed up residents' orders all the time.</p> <p>Observation on 03/04/26 at 8:14 A.M. with CNA #860 brought Resident #45 frosted flakes, milk, and coffee.</p> <p>Observation on 03/04/2026 at 8:24 A.M. revealed Resident #45 was finishing the frosted flakes and coffee. During the observation Resident #45 appeared happy and indicated not understanding why meals were always wrong. (continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/05/26 at 8:42 A.M. with Resident #45 indicated breakfast was terrible and did not get what was ordered.</p> <p>Interview on 03/05/26 at 10:46 A.M. with Dietician #925 revealed being aware of the concern Resident #45 had about not receiving the food that was ordered. Dietician #925 indicated the dietary staff was having a hard time knowing what each resident wanted. In April 2026, the dietary department will be changing to a meal tracker system to organize the kitchen to better serve the residents and ensure residents are getting what they ordered.</p> <p>Review of therapeutic diets policy, revision date 10/17, revealed diets will be determined in accordance with the resident's informed choices, preferences, treatment goals, and wishes.</p> <p>Review of the 2001 facility policy called; Therapeutic Diets revealed diet will be determined in accordance with the resident's informed choices, preferences, treatment goal and wishes. The dietitian, nursing staff and attending physician will regularly review the need for, and resident acceptance of prescribed therapeutic diets.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2799697.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview and review of the facility policy the facility failed to ensure palatable meals for residents receiving meals from the kitchen. This affected two (#14 and #134) and had to the potential to affect all residents who received meals from the kitchen. The facility identified three residents (#1, #63 and #136) who received nothing by mouth. The facility census was 121. Findings include: 1. Review of the medical record for Resident #14 revealed an admission date of 02/05/26. Diagnoses included unspecified fracture of the lower end of the right radius, anxiety disorder, morbid obesity and need for assistance with personal care. Review of the physician order dated 02/05/26 for Resident #14 revealed a diet order for a regular diet with thin liquids. Review of the 02/10/26 Medicare five-day Minimum Data Set (MDS) assessment for Resident #14 revealed a Brief interview of Mental Status (BIMS) of 13 which indicated intact cognition. Resident #14 was noted to be dependent upon staff for eating and all activities of daily living (ADLs). Interview on 03/02/26 at 12:45 P.M. with Resident #14 revealed food is not always hot by the time staff are able to assist her with her meals. 2. Review of the medical record for Resident #134 revealed an admission date of 02/25/26. Diagnoses included displaced transverse fracture of right and left patella, osteoporosis with current fracture, congestive heart failure and chronic kidney disease. Review of the 02/25/26 admission assessment for Resident #134 revealed she was cognitively intact and was independent for eating meals. Review of the physician orders dated 03/03/26 for Resident #134 revealed a regular diet with thin liquids. Interview on 03/02/26 at 1:08 P.M. with Resident #134 revealed meals are frequently cold and do not taste good. Interview on 03/04/26 at 10:47 A.M. with the Administrator revealed due to repairs to the dish machine being completed, the facility would be using disposable plates for the lunch service. Observation on 03/04/26 at 11:34 A.M. with [NAME] #988 of the meal tray line revealed the following temperatures for the food on the steam table: bean soup was 170 degrees Fahrenheit (F); pureed bean soup, 170 degrees F; chicken, 152 degrees F; mechanical soft chicken, 171 degrees F; pureed chicken, 170 degrees F; mashed potatoes, 160 degrees F; pureed bread, 160 degrees F; gravy, 160 degrees F; chicken tenders, 150 degrees F; green beans, 148 degrees F; Tator tots, 168 degrees F; and grilled cheese, 146 degrees F. Observation on 03/04/26 at 11:40 A.M. revealed 11 kitchen delivery carts for tray beverage were loaded with food items and requested beverages such as coffee, tea, milk, and fruit juices. The food delivery carts contained no source of heat or refrigeration. Observation on 03/04/26 at 11:47 A.M. with [NAME] #988 revealed meal tray line service began with Styrofoam cups and plates covered with a dome lid. Soup was placed in a paper bowl and covered with a lid. Metal eating utensils were used. Observation on 03/04/26 at 1:38 P.M. revealed the last meal cart was prepared and a test tray was requested. The test tray was sampled at 1:46 P.M. with Dietary Director #845 following the last resident tray being served. The following temperatures on the test tray were observed: the bean soup was 141.6 degrees F; the yogurt was 73 degrees F; milk was 61.3 degrees F; mashed potatoes, 132.4 degrees F; mechanical chicken, 101.3 degrees F; and pureed bread, 119.3 degrees F. Taste test of the items with Dietary Director #845 revealed the mechanical chicken did not taste warm enough for his preference, the pureed bread was bland and not warm enough, the bean soup was warm enough but tasted bland and the Dietary Director #845 stated the soup needed more seasoning. Dietary Director #845 confirmed the cold items were not held at appropriate temperature to maintain a safe meal service. The Dietary Director #845 stated if he were a resident he would have wanted the items to be warmer as the hot foods were not at a personal preferable temperature and he would also want more seasoning. Review of the facility policy called Community Dining and Meal Service Policy last reviewed on 12/01/25 revealed the dining experience will be person centered with the purpose of enhancing each individual patient's/resident's quality of life and will be supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals and will support each individual's daily nutritional and special dietary needs. This deficiency represents non-compliance investigated under Master Complaint Number 2799697.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on record review and interview, the facility failed to ensure an effective administration staff. This finding had the potential to affect all residents residing in the facility. The facility census was 121. Findings include: 1. Observation and subsequent interviews on 01/08/26 revealed Certified Nursing Assistant (CNA) #624 kicked Resident #117's bed and hit the resident with a closed fist. Further reviews revealed CNA #624's Nursing Orientation Checklist dated 12/05/25 did not have evidence of the entire second page of care including resident property sheet process, falls management program, gait belt, safe transfers, safety, sit-to-stand, mechanical lift, using your maxi move, call system basics, sensor alarms, resident alarms, shift to shift walking rounds, morning care, management of difficult behaviors, avoiding bruising and skin tears in the elderly, dementia bathing, restraints, mood and behavior patterns. The form was noted dated or signed by the employee or staff member completing the orientation. Interview on 03/09/26 at 11:02 A.M. with Human Resources (HR) #995 confirmed the above findings. 2. Review of Resident #6's medical record and subsequent observation on 03/02/26 revealed the resident reported an allegation of neglect to the nursing staff who did not report to the administrative staff and no investigation was initiated for neglect. Interview on 03/03/2026 5:02 PM with the Administrator verified he was not informed of Resident #6's allegation of neglect. 3. Review of Residents #10 and #47's medical records and subsequent observations revealed the staff did not report other staff taking Resident #10's pictures during care and staff did not report Resident #47's bruising to the right arm. Interview on 03/02/26 at 3:42 P.M. with the Administrator and Director of Nursing (DON) confirmed staff had not reported that other staff were taking Resident #10's pictures during care. Interview on 03/04/26 at 11:41 A.M. with the DON confirmed Resident #47's bruising to the right arm was not adequately assessed and monitored. 4. Interview on 03/09/26 at 2:35 p.m. with the Administrator and the DON confirmed they took over a failing building and were in the process of replacing staff. The Administrator confirmed that new management took over and were trying to address these issues. Further interview on 03/09/26 at 2:50 p.m. with the Administrator confirmed he took over the building 08/04/25. 5. Telephone interview on 03/09/26 at 3:46 P.M. with the Medical Director confirmed he was not aware of the identified concerns and would work with the facility administration to correct the issues for an effective administration. This deficiency represents non-compliance investigated under Complaints 2790371 and 2741949.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview and review of maintenance logs and repair invoices, the facility failed to ensure kitchen equipment repairs were completed timely. This had the potential to affect all residents receiving meals from the kitchen. The facility indicated three (Residents #1, #63 and #136) receiving nothing by mouth. The facility census was 121. Findings include:1. Observation on 03/02/26 at 9:20 A.M. during the kitchen initial tour with Dietary Supervisor #958 revealed the high temperature dish washer was working but had a visible leak. Observation at the time revealed the dish machine running with water leaking out the side and was draining down the wall behind the dish machine near electrical outlets onto the floor. A large puddle of water was observed on the floor which was approximately an inch deep and staff working the dish machine appeared to have wet shoes standing in front of the dish machine. Unnamed dish machine worker stated it was a pain to stand in the water while trying to keep the dishes moving. Interview at the time of the observation with Dietary Supervisor #958 confirmed the dish machine had been leaking for about three weeks.Review of maintenance work order #600 dated 02/16/26 timed at 11:37 A.M. with a priority level of critical revealed there was noted water leaking and running out from under the dishwasher in dietary. The status of the work order was changed to completed on 02/16/26 at 11:37 A.M.Review of maintenance work order #610 dated 02/17/26 timed at 9:15 A.M. with a priority level of critical revealed maintenance checked the leak yesterday but the problem still exists and getting worse. The status of the work order was changed to completed on 02/17/26 at 2:17 P.M.Interview on 03/03/26 at 9:56 A.M. with Maintenance Director #827 confirmed the dish machine concern was reported on 02/13/26 but he was not working and did not work again until 02/16/26. Maintenance Director #827 attempted to fix the dish machine on 02/16/26, but another concern was reported on 02/17/26 which stated the leak was getting worse. Maintenance Director #827 stated he had not had a chance to schedule the repair since the survey team was here. Maintenance Director #827 confirmed he was calling a repair service then to get a service scheduled.Interview on 03/04/26 at 1:56 P.M. with Dietary Director #845 confirmed the dish machine was reported on 02/16/26 by another staff member and stated he was told maintenance came to look at it on 02/17/26 but was not fixed until 03/04/26.Phone interview on 03/10/26 at 12:28 P.M. with Plumbing Contractor #634 confirmed they were not contacted regarding repairs to the dish machine prior to 03/03/26. While at the facility, piping was replaced with copper pipes and also installed new isolation valves. Repairs have been made in the past and have failed causing the leaks.2. Observation on 03/04/26 at 9:35 A.M. with Dietary Supervisor #958 of pureed food preparation revealed when Dietary Supervisor #958 placed the ham and bean soup in the robot coupe (commercial food processor), the food processor was missing the center part of the cover which sealed the cover but also provided a handle to turn and scrape the sides of the machine while running. Observation at the time revealed Dietary Supervisor #958 attempt to cover the hole in the top cover with aluminum foil. Upon turning on the food processor, the soup sprayed out from underneath the aluminum foil and sprayed out onto the surrounding countertop and onto dishes on the rack behind it. Dietary Supervisor #958 confirmed the missing piece made it much more difficult and time consuming to puree items to obtain smooth consistency due to not being able to use the center piece to scrape the sides while the machine was running. Dietary Supervisor #958 confirmed the part had been missing for at least several weeks and was unsure if the parts had been ordered.Review of the phone text dated 02/04/26 from Dietary Manager #845 revealed a text exchange to Corporate Dietary #629 revealed information for the necessary parts were sent and requested to be ordered for the Robot Coupe.Review of the email dated 02/26/26 dated 02/26/26 from Corporate Dietary #629 timed at 8:00 A.M. revealed he was still working on the quote and hoped to order it that day.Review of the email dated 02/27/26 from Corporate Dietary #629 revealed the parts for the Robot Coupe were ordered.Interview on 03/05/26 at 10:33 A.M. with Dietary Manager #845 confirmed the Robot Coupe part had been ordered on 02/27/26 and was supposed to be delivered but had not been received. (continued on next page)</p>		

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  03/10/2026
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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the undated facility policy titled Community Equipment Policy Statement revealed all foodservice equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. This deficiency represents non-compliance investigated under Complaint Number 2799697.</p>		

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  03/10/2026
NAME OF PROVIDER OR SUPPLIER  Saint Luke Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Applegrove Street NE North Canton, OH 44720	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, staff interview, family interview, and review of facility policy, the facility failed to ensure a clean and sanitary environment and failed to ensure patient care equipment was maintained in good repair. This finding affected six (Residents #4, #34, #69, #87, #134 and #137) of eleven resident rooms reviewed for environmental concerns. The facility census is 121. Findings include: Observations on 03/05/26 from 11:54 A.M. to 12:19 P.M. with Maintenance Director (MD) #827 of resident rooms revealed: Resident #4's bed remote had wires coming out of the remote and the facility had placed tape around the cord from about halfway up the cord to the remote itself. The cord was attached to the bed. Resident #34's curtain rod was bent and the rod with the curtains attached was hanging down at an angle above the residents bed. Resident #69's carpet had multiple stains and deep drywall scratches with missing paint. Review of Resident #87's wheelchair revealed dried brown debris was on the footrest clips on both the right and left side. The daughter who was seated in the room at the time of the observation indicated the debris was probably dried stool. Resident #134's wall behind the recliner had deep drywall scratches and grooves in the wall with missing paint. Resident #137's carpet had multiple stains. Interview on 03/05/26 at 12:20 P.M. with MD #827 confirmed the above findings. Review of the Homelike Environment policy revised 02/2021 revealed residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. This deficiency represents non-compliance investigated under Complaint Number 2741949.</p>		