

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1036 South Perry Street Napoleon, OH 43545	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately for oxygen use and upon discharge. This affected three (#15, #18, and #199) of 17 residents reviewed for MDS assessments. The facility census was 46.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnosis including chronic obstructive pulmonary disease (COPD).</p> <p>Review of a physician order initiated 05/30/24 and discontinued 06/04/24 revealed Resident #18 was to receive oxygen therapy at two to four liters per minute (LPM) via nasal cannula (NC) every shift. The physician order initiated 06/04/24 and discontinued 08/05/24 revealed Resident #18 was to receive oxygen therapy at two to four LPM via NC every shift.</p> <p>Review of the comprehensive MDS admission assessment dated [DATE] revealed Resident #18 did not receive oxygen therapy.</p> <p>Interview on 09/04/24 at 3:32 P.M. with MDS Coordinator #184 confirmed the MDS assessment completed 06/06/24 for Resident #18 was coded incorrectly and should have reflected Resident #18 received oxygen therapy.</p> <p>2. Review of the medical record for Resident #199 revealed he was admitted on [DATE], discharged to the hospital on 08/25/24, and returned to the facility on [DATE].</p> <p>Review of a physician order initiated 08/16/24 and discontinued 08/29/24 revealed Resident #199 received oxygen via NC at two to three LPM every shift.</p> <p>Review of the comprehensive MDS assessment, dated 08/23/24, revealed Resident #199 did not receive oxygen therapy.</p> <p>Interview on 09/04/24 at 3:32 P.M. with MDS Coordinator #184 confirmed the MDS assessment completed 08/23/24 for Resident #199 was coded incorrectly and should have reflected Resident #199 received oxygen therapy.</p> <p>(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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the medical record for Resident #15 revealed an admitted [DATE] and discharged to the hospital on 03/26/24.</p> <p>Review of the discharge MDS assessment dated [DATE] revealed Resident #15 discharged on [DATE]. There was an additional MDS assessment dated [DATE] indicating a five-day MDS assessment was also completed on 03/26/24 and submitted on 04/08/24.</p> <p>Interview 09/03/24 at 4:22 P.M. with MDS Coordinator #184 confirmed Resident #15 discharged on [DATE] and did not return to the facility. MDS Coordinator #184 confirmed the five-day MDS assessment submitted on 04/08/24 was submitted in error.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44815</p> <p>Based on record review, staff interview, and review of the facility policy, the facility failed to ensure a baseline care plan reflected a resident's use of oxygen needs. This affected one (#199) of one resident reviewed for a baseline care plan. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #199 revealed he was admitted on [DATE], discharged to the hospital on 08/25/24, and returned to facility on 08/29/24.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment, dated 08/23/24, revealed Resident #199 had impaired cognition.</p> <p>Review of a physician order dated 08/29/24 revealed Resident #199 received oxygen at six liters per minute (LPM) via nasal cannula (NC) every shift.</p> <p>Review of the baseline care plan for Resident #199 revealed nothing regarding his reliance on continuous oxygen therapy.</p> <p>Interview on 09/05/24 at 11:31 A.M. with the Director of Nursing (DON) confirmed Resident #199's baseline care plan did not reflect his need for oxygen.</p> <p>Review of the policy titled Comprehensive/Baseline Care Plan, reviewed 06/2023, revealed the baseline care plan would be the temporary working care plan until the comprehensive care plan was completed.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on observation, record review, family and staff interviews, and review of the facility policy, the facility failed to ensure oxygen was administered per physician order. This affected two (#18 and #199) of two residents reviewed for oxygen use. The facility census was 46.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnosis including chronic obstructive pulmonary disease (COPD).</p> <p>Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 06/06/24, revealed Resident #18 had impaired cognition and did not reject care.</p> <p>Review of a current physician order initiated 08/05/24 revealed Resident #18 was to receive oxygen therapy at two to four liters per minute (LPM) via nasal cannula (NC) every shift.</p> <p>Observation on 09/03/24 at 1:54 P.M. revealed Resident #18 sitting in his wheelchair near the nurse's station. Resident #18's oxygen NC was applied and the oxygen tank gauge needle indicated the tank was empty.</p> <p>Interview on 09/03/24 at 1:55 P.M. with Licensed Practical Nurse (LPN) #200 verified Resident #18's oxygen tank gauge indicated the tank was empty and needed to be replaced.</p> <p>Observation on 09/04/24 at 7:49 A.M. revealed Resident #18 sitting in his wheelchair in the dining room. Resident #18 was wearing a NC connected to an oxygen tank in the carrier on the back of his wheelchair. Further observation revealed the oxygen tank gauge indicated the tank was empty.</p> <p>Interview and observation on 09/04/24 at 7:50 A.M. with LPN #194 confirmed Resident #18's oxygen tank was empty. LPN #194 stated Resident #18 used approximately five tanks of oxygen daily.</p> <p>2. Review of the medical record for Resident #199 revealed he was admitted on [DATE], discharged to the hospital on 08/25/24, and returned to facility on 08/29/24.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment, dated 08/23/24, revealed Resident #199 had impaired cognition.</p> <p>Review of a physician order dated 08/29/24 revealed Resident #199 received oxygen at six LPM via NC every shift.</p> <p>Interview on 09/03/24 at 11:16 A.M. with Resident #199's family member revealed she was concerned because she observed Resident #199 sitting in his recliner in his room while his oxygen NC remained on his bed. Resident #199's family stated they placed the NC on Resident #199.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 09/05/24 at 7:31 A.M. with LPN #204 confirmed Resident #199 was lying in bed on his back and the NC was not in place. Further observation and interview with LPN #204 revealed Resident #199's NC was under him.</p> <p>Interview on 09/05/24 at 7:33 A.M. with State tested Nurse Aide (STNA) #196 revealed her shift began at 6:30 A.M. and she had not yet provided care to Resident #199.</p> <p>Interview on 09/05/24 at 7:34 A.M. with STNA #205 revealed her shift began at 6:30 A.M. and she had not yet provided care to Resident #199.</p> <p>Review of the policy titled Oxygen Administration, dated 07/2022, revealed oxygen was provided to facilitate breathing and oxygen should be provided at the prescribed amount.</p>

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<p>F 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>35031</p> <p>Based on personnel file review and staff interview, the facility failed to ensure one of four State tested Nursing Assistants (STNA) received an annual performance review. This had the potential to affect all 46 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the personnel file of STNA #195 revealed a hire date of 05/19/23. The file was absent of any yearly performance review having been completed.</p> <p>Interview on 09/05/24 at 11:00 A.M. with Human Resources #202 verified there was no yearly performance review completed for STNA #195.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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>44815</p> <p>Based on observation, staff interview, and review of the menu spreadsheets, the facility failed to ensure residents received proper portions of protein and vegetables. This affected all 46 residents in the facility who receive food from the kitchen. Additionally, the facility failed to ensure residents on a pureed diet received proper portions of carbohydrate. This affected six (#2, #7, #19, #20, #32, and #36) residents identified on a pureed diet. The facility census was 46.</p> <p>Findings include:</p> <p>1. Observation on 09/04/24 at 11:45 A.M. revealed [NAME] #157 taking temperatures of noon menu items. The chicken Philly sandwiches were already prepared with chicken, onion, and peppers portioned into the bun. Concurrent interview with [NAME] #157 stated another staff prepared the sandwiches.</p> <p>Interview on 09/04/24 at 11:52 A.M. with Dietary Manager (DM) #183 revealed the facility used an outside company to provide menus and spreadsheets. DM #183 stated the facility began with a new company in May 2024 and the new menus did not provide portion sizes on the spreadsheets; therefore, DM #183 did not know what portion of chicken and vegetables to provide in the chicken Philly sandwich.</p> <p>Interview on 09/04/24 at 12:03 P.M. with Dietary Aide (DA) #161 revealed she prepared the chicken Philly sandwich. DA #161 stated she grilled chicken slices, onions, and peppers together, then used a four-ounce scoop to portion the chicken-vegetable mixture into buns. DA #161 stated if the scoop seemed to have more vegetables than meat, she would sometimes add extra chicken to the sandwich.</p> <p>Interview and observation on 09/04/24 at 12:07 P.M. with [NAME] #157 revealed she already pre-portioned the cucumber salad into plastic containers. [NAME] #157 stated she used a two-and-two-thirds cup scoop to portion the cucumber salad.</p> <p>Observation of meal service on 09/04/24 beginning at 12:14 P.M. revealed [NAME] #157 serving one sandwich and one portion of cucumber salad to residents on a regular diet. Further observation revealed [NAME] #157 served one sandwich, with ground chicken and vegetables, with peas and carrots to residents on a mechanical soft diet, and served pureed soup, a pureed sandwich, and pureed chicken and vegetables to residents on a pureed diet.</p> <p>Observation and interview on 09/04/24 at 12:38 P.M. with [NAME] #157 revealed meal service was complete. [NAME] #157 verified the scoops she used during service were a three-and-one-fourth ounce scoop for pureed soup, a three-and-one-fourth ounce scoop for pureed sandwich, and a two-and-two-thirds ounce scoop for peas and carrots, and pureed peas and carrots.</p> <p>Interview on 09/04/24 at 12:40 P.M. with DM #183, with concurrent review of the menu and recipes revealed the chicken Philly sandwich should have included three ounces of chicken. Additionally, the recipe did not include peppers or onions. DM #183 confirmed she could not verify residents received three ounces of chicken in their sandwiches due to DA #161 using a four-ounce scoop to portion chicken mixed with onions and peppers.</p> <p>(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 - Many</p>	<p>Further review of the menu with DM #183 revealed the cucumber salad portion should have been four ounces rather than the two-and-two-thirds ounces provided. There was no guidance for portions sizes or preparation methods for mechanical soft or pureed items.</p> <p>Follow-up interview on 09/04/24 at approximately 3:30 P.M. with DM #183 revealed she received a spreadsheet with portion sizes for mechanical soft and pureed menu items from the outside company who provided their menus. Concurrent review of the menu spreadsheet revealed residents on a mechanical soft diet should have received one chicken Philly sandwich with ground meat and four ounces of soft cucumber salad. DM #183 again confirmed she could not verify the portion of protein provided in the mechanical soft chicken Philly sandwich, and confirmed residents on a mechanical soft diet did not receive four ounces of cucumber salad, or four ounces of alternative vegetable.</p> <p>The spreadsheet revealed residents on a pureed diet should receive six ounces of pureed vegetable garden soup, four ounces of pureed chicken Philly cheesesteak and four ounces of pureed cucumber salad. DM #183 confirmed no recipe was provided for pureed chicken Philly cheesesteak and therefore she could not verify what portion of protein or carbohydrate residents on a pureed diet should have received. Additionally, DM #183 confirmed residents on a pureed diet did not receive four ounces of vegetables.</p> <p>2. Observation and interview on 09/04/24 at 10:04 A.M. revealed [NAME] #157 preparing pureed chicken Philly sandwich for six residents on a pureed diet for the noon meal. [NAME] #157 placed a large, unmeasured portion of grilled chicken, onions, and vegetables with two sandwich rolls into the blender. [NAME] #157 used cheese sauce to thin the mixture to an appropriate consistency. [NAME] #157 confirmed she used two rolls for six residents to help thicken the mixture.</p> <p>Observation after meal service was completed on 09/04/24 at 12:38 P.M. revealed some pureed chicken/vegetable/bread mixture remained in the pan.</p> <p>Interview and concurrent review of the menu, spreadsheet, and recipes with DM #183 on 09/04/24 at approximately 3:30 P.M. confirmed she did not have a recipe for preparing pureed chicken Philly sandwich and could not verify residents on a pureed diet were served the appropriate portions of carbohydrate. Additionally, DM #183 confirmed the pureed preparation made by [NAME] #157 with an unmeasured amount of chicken and vegetables with two rolls was not adequate to provide the expected portion of one roll per person.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44815</p> <p>Based on medical record review, family and staff interviews, and review of the facility policy, the facility failed to ensure the medical record reflected a change in condition. This affected one (#20) of 13 residents reviewed for medical record accuracies. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #20 revealed a readmitted [DATE] with diagnosis including dementia.</p> <p>Review of the nursing progress notes dated 04/05/24 revealed a note dated 04/05/24 at 6:43 A.M. stating Resident #20 had a reddened area on her right hip and the physician was notified. The progress note dated 04/06/24 at 11:24 P.M. revealed Resident #20 was admitted to the hospital for bradycardia. There was no documentation of Resident #20 having a change in condition on 04/06/24, the physician being notified of the change in condition on 04/06/24, and the physician ordering to send Resident #20 to the emergency roiaognom on [DATE].</p> <p>Review of the hospital records for Resident #20 revealed she was admitted to the Emergency Department (ED) on 04/06/24 at 5:25 P.M. and was discharged from the hospital on 04/07/24.</p> <p>Review of a progress note dated 04/07/24 at 12:24 A.M. revealed Resident #20's hospital admitting diagnoses were updated to include altered level of consciousness, hypoglycemia, urinary tract infection, congestive heart failure, and medication effect.</p> <p>Telephone interview on 09/03/24 at 2:51 P.M. with Resident #20's daughter revealed she was notified regarding Resident #20's 04/06/24 hospital admission.</p> <p>Interview on 09/04/24 at 3:04 P.M. with the Director of Nursing (DON) confirmed Resident #20's electronic medical record contained no details regarding the change in condition leading to her hospitalization on [DATE]. The DON further stated she would expect a progress note detailing the change in condition, including documentation regarding notification of the physician, and the order received to send the resident to the hospital, and notification of the resident's representative.</p> <p>Review of the policy titled Notification of Resident's Condition, dated 04/2024, revealed completed notifications would be documented in the medical record.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41528</p> <p>Based on medical record review, review of immunization records, resident and staff interview, review of policy, and review of the Centers of Disease Control and Prevention (CDC) guidance, the facility failed to offer the residents the COVID-19 vaccination per CDC recommendations. This affected three (#18, #29, and #45) of nine residents reviewed for COVID-19 vaccination. The facility census was 46.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) and schizophrenia. Review of the Minimum Data Set (MDS) assessment, dated 06/06/24, revealed Resident #18 had impaired cognition.</p> <p>Review of the immunization record, dated 09/05/24, revealed Resident #18 last COVID-19 vaccine was 10/03/22. There was no record of Resident #29 being offered the COVID-19 vaccination since admission.</p> <p>Interview on 09/05/24 at 1:25 P.M. with Infection Preventionist #189 revealed new admission residents receive the vaccine upon request. Infection Preventionist #189 verified new admissions were not offered the COVID-19 or provided education. Infection Preventionist #189 verified Resident #18 was not offered or educated regarding the COVID-19 vaccination.</p> <p>2. Review of the medical record revealed Resident #29 was admitted on [DATE]. Diagnoses type two diabetes mellitus with diabetic neuropathy and inflammatory disorders of scrotum. Review of the MDS assessment, dated 06/25/24, revealed the resident was cognitively intact.</p> <p>Review of the immunization record, dated 06/28/24, revealed Resident #29 last COVID-19 vaccination was on 12/20/21. There was no record of Resident #29 being offered the COVID-19 vaccination since admission.</p> <p>Interview on 09/05/24 at 1:29 P.M. with Resident #29 verified not being offered the COVID-19 vaccine.</p> <p>Interview on 09/05/24 at 1:25 P.M. with Infection Preventionist #189 revealed new admission residents receive the vaccine upon request. Infection Preventionist #189 verified new admissions were not offered the COVID-19 or provided education. Infection Preventionist #189 verified Resident #29 was not offered or educated regarding the COVID-19 vaccination.</p> <p>3. Review of the medical record revealed Resident #45 was admitted on [DATE]. Diagnoses included dementia. Review of the MDS assessment, dated 06/25/24, revealed the resident was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the immunization record, dated 06/28/24, revealed Resident #45 last COVID-19 vaccination was on 12/20/21. There was no record of Resident #29 being offered the COVID-19 vaccination since admission.</p> <p>Interview on 09/05/24 at 1:25 P.M. with Infection Preventionist #189 revealed new admission residents receive the vaccine upon request. Infection Preventionist #189 verified new admissions were not offered the COVID-19 or provided education. Infection Preventionist #189 verified Resident #45 was not offered or educated regarding the COVID-19 vaccination.</p> <p>Review of the facility's Vaccination Policy, reviewed August 2023, revealed new, current residents and staff will be offered vaccines that aid in prevention infectious diseases unless the vaccine is medically contraindicated or the resident or staff member has already been vaccinated.</p> <p>Review of the CDC guidance titled Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States, updated 08/23/24 and located at <a href="https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html">https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html</a>, revealed the CDC recommends that people receive all recommended COVID-19 vaccine doses. Vaccination is especially important for people at highest risk of severe COVID-19, including people ages [AGE] years and older; people with underlying medical conditions, including immune compromise; people living in long-term care facilities; and pregnant people to protect themselves and their infants.</p>		