

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility policy, the facility failed to ensure food was stored in a sanitary manner. Additionally, the facility failed to ensure the high-temperature dishwasher reached adequate temperatures to ensure disinfection of dishes. Finally, the facility failed to ensure food was served in a sanitary manner. This affected all residents except one (Resident #1) who was identified by the facility as receiving no food by mouth. The facility census was 27. Findings include: 1. Observation on 07/20/26 at 7:45 A.M. of the dry storage area of the kitchen revealed a box of sweet potatoes on top of the can storage rack. One sweet potato had a black fuzzy substance on the surface and when the box was touched, several gnats flew out. Observation on 07/20/26 at 7:50 A.M. of the walk-in cooler revealed one box of five individually wrapped cucumbers labeled as received on 06/19/26 that were mushy when touched. The following containers were opened and undated: a half-full 46-ounce box of thickened pomegranate-berry juice, a half-full 46-ounce box of thickened apple juice, a nearly full 46-ounce box of prune juice, and a one-quarter full 46-ounce box of thickened lemon water. Further observation revealed a one half-full 46-ounce box of thickened orange juice dated 05/04/26. There was a half-full two-gallon round plastic container with an unknown red substance dated 07/10/26 and not labeled with the contents and an eight-pound plastic container of fruit salad was opened and undated, with an expiration date of 07/11/26. Subsequent interview with Dietary Manager (DM) #21 verified the findings. DM #21 stated expired foods should be disposed of and food items should be dated and labeled. Observation on 07/20/26 at 8:15 A.M. of the refrigerator located across from the nurses' station on the 200-hall revealed one opened 32-ounce box of almond milk dated 10/31, one opened and undated eight ounce container of dirty soda coffee creamer, five undated four-ounce boxes of vanilla nutritional shakes, one opened and undated 46-ounce box of prune juice, one gallon zipper baggie containing three-quarters of a brown loaf that was unlabeled and undated, one opened and undated 10.5-ounce bottle of unsweet tea, and one opened can of extra creamy whipped topping with an expiration date of 04/26/26. Subsequent interview with DM #21 verified the findings and confirmed food items should be labeled and dated. Observation on 07/20/26 at 10:34 A.M. of the food storage area across from the 200-hall nurses' station revealed an opened and undated five-pound jar of peanut butter. Additionally, there was a 16-ounce bag of potato chips, a 16-ounce bag of tortilla chips, and a seven-ounce box of cheese crackers that were opened and undated. Interview on 07/20/26 at 10:42 A.M. with Certified Nurse Assistant (CNA) #40 confirmed the above findings at the food storage area across from the 200-hall nurses' station. CNA #40 verified the food was for resident consumption and further stated she was unsure of who maintained the food in the area. Interview on 07/21/26 at 8:00 A.M. with DM Manager #21 revealed food items brought into the facility by residents were to be labeled with the date it was brought in and an expiration date of five to seven days after. Continued interview revealed opened food items in the kitchen were to be (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labeled with the date opened, what the food item was, and an expiration date. Review of facility policy titled Food Storage, dated July 2026, revealed the facility would date items when they were opened. Review of facility policy titled Food Brought Into Facility, dated 06/09/22, revealed food items would be properly labeled. 2. Observation on 07/20/26 at 8:00 A.M. of the high-temperature dishwasher revealed the wash cycle reached 158 degrees Fahrenheit (F) and the rinse cycle reached 170 F. Further observation of the labels on the dishwasher revealed the wash temperature should reach 160 F and the rinse temperature should reach 180 F. Subsequent interview with DM #21 verified the wash and rinse temperatures and stated the temperatures were not high enough to disinfect the dishware. 3. Observation on 07/20/26 at 12:25 P.M. of Dietary [NAME] (DC) #18 preparing a plate of food for the lunch meal. DC #18 touched the surface of the steam table and a plate with her gloved hands. She then retrieved a hot dog bun with her contaminated gloved hand. Utilizing a fork, DC #18 then retrieved a hot dog and used her contaminated gloved hand to remove the hot dog from the fork and place it into the bun. Continued observation revealed DC #18 began preparing a second plate, still wearing the same gloves. DC #18 retrieved a hot dog bun with her contaminated gloved hand and placed it on the plate. DC #18 then used a fork to pick up a hot dog and used her contaminated gloved hand to pick up the hot dog bun to place the hot dog into the bun. Subsequent interview with DM #21 confirmed DC #18 touched food with her gloved hand, after touching non-food items, and should not have done so. Further observation revealed DM #21 provided verbal instruction to DC #18 to not touch food directly contaminated gloved hands. Review of the facility policy titled, Sanitation Procedure-Serving, dated July 2026 revealed the facility would serve food safely to prevent contamination.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to ensure kitchen trash were covered. This affected all residents except for one (#1) resident who was identified by the facility as receiving no food by mouth. The facility census was 27. Findings include: Observation on 07/20/26 at 8:05 A.M. of the kitchen area revealed three 30-gallon trash cans without lids. One can was located next to the pot storage and was half full of garbage, one can was located next to the stove and was one-quarter full of garbage, and one can was located by the handwashing station and was one-quarter full of garbage. Interview on 07/20/26 at 8:06 A.M. with Dietary Manager #21 confirmed the trash cans did not have lids on them and they should be covered. Interview on 07/20/26 at 3:20 P.M. with the Administrator revealed the facility did not have a policy to address the need for trash cans to be covered.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review, the facility failed to notify the physician when a prescribed medication was not administered in accordance with physician orders due to a change in condition. This affected one (#13) of one resident reviewed for notification of changes. The facility census was 27. Findings include: Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included dementia, cognitive communication deficit, anxiety disorder and history of falling. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/01/26, revealed Resident #13 had a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive deficit. The resident exhibited no behaviors, required substantial assistance with eating, and was dependent on others for all other activities of daily living (ADL). Review of the physician order dated 01/13/26 revealed Resident #13 was ordered lorazepam (anti-anxiety medication) one milligram (mg) to be given by mouth three times a day related to anxiety disorder. Additionally, Resident #13 was to be observed closely for significant side effects of anti-anxiety medication, including drowsiness, slurred speech, dizziness, nausea, and aggressive or impulsive behavior. Review of the revised care plan, dated 06/15/26, revealed Resident #13 was to be monitored for adverse reactions to anti-anxiety therapy, which included drowsiness, lack of energy, clumsiness and slow reflexes. Review of the Medication Administration Record (MAR) for July 2026 revealed lorazepam was not administered to Resident #13 on 07/20/26 at 1:00 P.M. and 9:00 P.M. and on 07/21/26 at 5:00 A.M. Review of the nursing progress notes from 07/20/26 through 07/21/26 revealed no evidence Resident #13's physician was notified that lorazepam was not administered on 07/20/26 at 1:00 P.M. and 9:00 P.M. and 07/21/26 at 5:00 A.M. Interview on 07/21/26 at 2:05 P.M. with the Director of Nursing (DON) confirmed lorazepam was not administered to Resident #13 on 07/20/26 at 1:00 P.M. and 9:00 P.M. and 07/21/26 at 5:00 A.M. due to excessive sedation. Further interview with the DON verified there was no evidence the physician was notified. Review of the facility policy titled, Medication Administration, dated May 2019, revealed the physician should be notified when medications were not given, refused or other than time scheduled. and the notification documented in the resident's chart.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and policy review, the facility failed to ensure residents were free from chemical restraints. This affected one (#13) of five residents reviewed for unnecessary medications. The facility census was 27. Findings include: Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included dementia, cognitive communication deficit, anxiety disorder and history of falling. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/01/26, revealed Resident #13 had a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive deficit. The resident exhibited no behaviors, required substantial assistance with eating and was dependent on others for all other activities of daily living (ADL). Review of a physician order dated 01/13/26 revealed Resident #13 had an order for lorazepam (anti-anxiety medication) one milligram (mg) to be given by mouth three times a day related to anxiety disorder. Additionally, Resident #13 was to be observe closely for significant side effects of anti-anxiety medication, including drowsiness, slurred speech, dizziness, nausea, and aggressive or impulsive behavior. Review of the revised care plan, dated 06/15/26, revealed Resident #13 was to be monitored for adverse reactions to anti-anxiety therapy, which included drowsiness, lack of energy, clumsiness and slow reflexes. Further review of Resident #13's care plan revealed no non-pharmacological measures for staff to use to redirect resident when anxiety occurs. Observation on 07/20/26 at 10:05 A.M. revealed Resident #13 was in her wheelchair in the common area. Resident #13's eyes were closed and she appeared to be sleeping. Observation on 07/20/26 at 1:42 P.M. revealed Resident #13 was laid back in her wheelchair in the common area. The resident's eyes were closed and she appeared to be sleeping. Interview on 07/20/26 at 1:42 P.M. with Licensed Practical Nurse (LPN) #30 revealed Resident #13 was awake and talking the previous day. Observation on 07/21/26 at 7:15 A.M. revealed Resident #13 was sitting in her wheelchair at the dining table with her head down and eyes closed. Activities Director (AD) #2 came over and sat next to Resident #13, spoke the resident's name and touched her left arm. Resident #13 did not wake up with verbal or tactile stimulation. Observation on 07/21/26 at 10:33 A.M. revealed Resident #13 was lying back in her wheelchair near the nurses' station with her eyes closed. Resident #13 opened her eyes when her name was called. Observation on 07/21/26 at 11:46 A.M. revealed Resident #13 in her wheelchair sitting at the dining table. Resident #13 was leaning forward with her head resting on the dining table. Resident #13 lifted her head when her name was called and then sat back in her wheelchair with her head tilted back and eyes closed. Interview on 07/21/26 at 11:55 A.M., Registered Nurse (RN) #53 stated it seemed Resident #13 did not have control of her upper body. Concurrent observation of Resident #13 revealed the resident leaned her upper body forward and laid her head back onto dining table. Observation on 07/21/26 at 1:55 P.M. revealed Resident #13 was sitting in her wheelchair in the common area with her chin down to her chest and her eyes closed. Interview on 07/21/26 at 2:05 P.M. with the Director of Nursing (DON) verified Resident #13 had been sleeping a lot the past two days. The DON confirmed Resident #13 received scheduled lorazepam due to the resident continually trying to get out out her wheelchair, and other behaviors. IA follow-up interview on 07/21/26 at 4:00 P.M. with the DON verified the reason for using scheduled lorazepam for Resident #13 was to prevent the resident from getting out of her wheelchair. The DON stated the only non-pharmacological measure used prior to scheduling the use of lorazepam was a physical therapy consultation. The DON verified there were no further non-pharmacological measures attempted. Review of the facility policy (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Restraints, last reviewed July 2026, revealed a chemical restraint was defined as a psychopharmacological drug that was used for discipline or convenience and not required to treat medical symptoms. Additionally, chemical restraints would not be used to limit or control resident behavior for the convenience of staff. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, revised December 2019, revealed residents had the right to be free from abuse, neglect, exploitation and misappropriation of resident property. This included, but not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint that was not required to treat the resident's medical symptoms.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews, resident interviews, and review of facility policy, the facility failed to ensure care and services in accordance with professional standards of practice for the management of edema. This affected one (Resident #21) of one resident reviewed for edema. The facility census was 27. Findings include: Review of the medical record for Resident #21 revealed she was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, lymphedema, and heart failure. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/07/26, revealed Resident #21 was cognitively intact and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a walker and a wheelchair independently and was independent with transfers. She was independent with all activities of daily living (ADLs). She had medically complex medical conditions including heart failure and lymphedema. Review of the care plan focus area initiated 01/19/26 revealed Resident #21 had fluid overload related to congestive heart failure (CHF), edema, and lymphedema. Interventions included to monitor and document any signs and symptoms of fluid overload, including sudden weight gain, and compression stockings on in the morning and removed at night as tolerated. Review of a physician order dated 03/27/25 revealed Resident #21 had an order for monthly weights. Further review revealed an order dated 03/03/26 for compression wraps to be applied during the day to her bilateral lower extremities. Review of weight monitoring from July 2025 through July 2026 revealed Resident #21's weights were obtained weekly in July 2025 and August 2025, monthly from September 2025 through December 2025, daily from 01/01/26 through 01/08/26, and then monthly from February 2026 through July 2026. Review of the nursing progress notes and nursing assessments from July 2025 through July 2026 revealed edema monitoring was noted on 02/15/26 and 03/22/26. Interview on 07/22/26 at 9:55 A.M. with Licensed Practical Nurse (LPN) #30 confirmed bilateral lower extremity edema and weights were not monitored daily for Resident #21. Interview on 07/22/26 at approximately 12:15 P.M. with the Director of Nursing (DON) confirmed there was no documentation of edema monitoring for Resident #21 and weights were only monitored monthly, adding both should be monitored more frequently with the resident's diagnoses of edema and heart failure. A follow-up interview on 07/22/26 at 2:00 P.M. with LPN #30 revealed standard interventions for residents with heart failure should include monitoring daily weights, edema, and blood pressure to ensure resident stability. Observation on 07/22/26 at 2:05 P.M. of Resident #21's room revealed her compression wraps were on the floor next to her chair and not applied to her bilateral lower extremities as ordered. Concurrent interview with Resident #21 revealed she had not been asked to have her weight monitored daily nor had she refused to have her weight monitored daily. Continued interview revealed she had not had her compression wraps applied on this day. Interview on 07/22/26 at 2:10 P.M. with Certified Nurse Assistant (CNA) #47 revealed she provided bathing assistance for Resident #21 earlier in the day. CNA #47 verified the resident's compression wraps were not on when she took her to the shower room, and the compression wraps were not applied after the shower. Interview on 07/22/26 at 2:15 P.M. with LPN #30 confirmed Resident #21's compression wraps were not on as ordered.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, the facility failed to maintain pre and post-dialysis treatment communication with the dialysis center. This affected one (Resident #6) of one resident identified by the facility as receiving dialysis services. The facility census was 27. Findings include: Review of the medical record for Resident #6 revealed he was admitted on [DATE] with diagnoses including osteomyelitis of the left foot, non-pressure chronic ulcer of the left heel and midfoot, end stage renal disease, peripheral vascular disease, atrial fibrillation, and Type Two diabetes mellitus. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact and did not display any behaviors nor refusals of care at the time of the assessment. Review of a physician order dated 05/23/26 revealed Resident #6 had dialysis on Mondays, Wednesdays, and Fridays. Review of the care plan for Resident #6 revealed an intervention dated 03/27/26 for dialysis related to end stage renal disease. Review of the dialysis treatment communication forms for Resident #6 revealed two forms, dated 04/17/26 and 07/17/26, had been obtained. Interview on 07/22/26 at 9:50 A.M. with Licensed Practical Nurse (LPN) #30 revealed she had not seen any dialysis treatment communication forms for Resident #6 and management was working on obtaining them. Interview on 07/22/26 at 11:30 A.M. with the Director of Nursing verified the facility did not maintain pre and post-dialysis treatment communication with the dialysis center and should have been.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews, and review of facility policy, the facility failed to ensure appropriate hand hygiene was performed during wound care. This affected one (Resident #6) of one resident observed for wound care. The facility census was 27. Findings include: Review of the medical record for Resident #6 revealed he was admitted on [DATE] with diagnoses including osteomyelitis of the left foot, non-pressure chronic ulcer of the left heel and midfoot, end stage renal disease, peripheral vascular disease, atrial fibrillation, and Type Two diabetes mellitus. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact and did not display any behaviors nor refusals of care at the time of the assessment. Resident #6 had a diabetic foot ulcer. Review of a physician order dated 07/16/26 revealed Resident #6 had an order for negative pressure wound therapy to the diabetic wound on his right foot. Instructions included: cleanse the wound and peri-wound with soap and water, dry intact skin completely, soak the wound for five minutes in hypochlorous acid wound cleanser, apply skin prep and drape to the peri-wound, apply green foam to wound bed, set negative pressure wound therapy machine to 125 millimeters of mercury (mmHg), wrap with fluff gauze, and change every Tuesday and Friday. Observation on 07/21/26 at 2:15 P.M. of Registered Nurse (RN) #53 performing wound care for Resident #6 revealed she removed the soiled dressing from his right foot, removed her gloves, and did not perform hand hygiene prior to putting on new gloves and proceeding with the soak step of his wound care. Continued observation revealed she obtained the wound vac power supply from the floor, connected the power cord to the negative pressure wound therapy machine, removed her gloves, and did not perform hand hygiene prior to putting on new gloves and proceeding with placing the sponge in the wound bed. Interview on 07/21/26 at 3:00 P.M. with RN #53 and Unit Manager (UM) #69 confirmed hand hygiene was not performed between glove changes and should have been while completing wound care for Resident #6. Review of the facility policy titled, Clean Dressing Application, dated July 2026, revealed the procedure statement was to prevent infection in an open area. Further review revealed after removing and discarding soiled gloves, wash hands before applying new gloves. Review of the facility policy titled, Hand Hygiene, dated May 2020, revealed the policy statement was the facility considered hand hygiene the primary means to prevent the spread of infections. Further review revealed hand hygiene should be performed before applying sterile gloves and after removing gloves.		