

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  St Luke Lutheran Community-Portage Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Latham LN Akron, OH 44319	

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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35771</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to accommodate Resident #13's preference in regard to transferring out of bed. This affected one (Resident #13) of three residents revealed for mechanical lift transfers.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses of cerebral infarction, hemiplegia affecting left non-dominant side, alcoholic fatty liver, morbid obesity, diabetes, restlessness and agitation, and depression. Review of the of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #13 was moderately cognitively impaired, required substantial/maximal assistance with rolling left and right in bed, was totally dependent on staff for transferring from the bed to the chair and used a wheelchair for mobility. Review of the self-care deficit care plan updated 09/26/23 revealed Resident #13 had a self-care deficit related to status post cerebral vascular accident (CVA) with left-sided weakness, impaired balance, and medical condition. Interventions included Hoyer (mechanical lift) assist and used a motorized wheelchair.</p> <p>An initial observation on 07/30/24 at 4:20 P.M. revealed Resident #13 was sitting in his electric wheelchair while propelling around the units. Interview, during the observation, with Resident #13 revealed the staff did not always get him out of bed when he wanted. Resident #13 stated he needed a mechanical lift to transfer out and into bed and he preferred to get out bed in the morning after he finished eating breakfast.</p> <p>Observation on 08/05/24 at 7:40 A.M. revealed Resident #13 was lying in his bed, asleep and his electric wheelchair was plugged in, charging outside his room. At 8:10 A.M., Resident #13 was awake, looking at his cellphone. At 8:36 A.M., the meal cart was delivered to the units and staff were passing breakfast trays. At 10:35 A.M., Resident #13 continued to lay in bed, looking at his cellphone. Interview, during the observation, with Resident #13 revealed he asked a state tested nurse aide (unknown name) to get out of bed however the state tested nurse aide (STNA) told him to wait until after he had a bowel movement. Resident #13 stated, I hate when they do that.</p> <p>Interview on 08/05/24 at 10:38 A.M. with STNA #3 verified she was Resident #13's STNA that day. STNA #3 verified that Resident #13 asked to get out of bed that morning and STNA #3 stated that she would get him out of bed after he had a bowel movement and after she finished her showers [for other residents].</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 08/05/24 at 11:15 A.M. revealed Resident #13's electric wheelchair continued to sit outside his room. At 11:25 A.M., Agency STNA #3 was observed sitting at the nursing station chatting with Agency STNA #6. At 11:55 A.M., Resident #13 continued to lay in bed, and he was asleep. At 12:05 P.M., the Director of Nursing served Resident #13 his lunch while the resident was still in bed and his electric wheelchair was outside his room.</p> <p>Interview on 08/05/24 at 12:30 P.M. with the interim Administrator and Director of Nursing (DON) verified Resident #13 should have been assisted out of bed when he requested to get out of bed.</p> <p>Review of the facility's AM Care policy dated September 2013 revealed nursing personnel would perform AM care on all residents who needed assistance. Non-ambulatory residents: transfer to wheelchair.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155952.</p>		