STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366280	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Community-Portage Lakes	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interviews, review of facility policy, and review of a facility self-reported incident (SRI) investigation, the facility failed to ensure Resident #7 was free from staff to resident physical abuse. This affected one resident (#7) of three residents reviewed for abuse. The facility census was 38. Actual harm occurred on 09/09/24 when Resident #7 was physically abused by a State tested Nursing Assistant (STNA) during care resulting in large areas of bruising to both of the resident's arms. Bruising to the left upper arm measured 4.5 centimeters (cm) in length by 3.0 cm width and was described as purple to dark red in color. Bruising to the right upper arm measured 15.0 cm in length by 6.0 cm with and was described as deep purple and dark red with intact skin. A facility SRI dated 09/09/24 indicated Resident #7 reported pain as a result of in incident, however the type or level of pain was not described. An interview with Resident #7 by the Director of Nursing (DON) on 09/09/24 about the nature of his injuries revealed the resident reported the STNA had been rough with him. An interview with Resident #7's daughter revealed this bruising was not the first time Resident #7 had sustained bruising from staff as a result of rough care. In addition to the actual physical harm/pain caused to the resident, by using the reasonable person concept, Resident #7 would have experienced psychosocial harm as a result of the physical abuse since there was an expectation the resident would not be harmed by staff providing his care. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including hypertensive heart disease without heart failure, asthma with status asthmaticus, dementia with agitation, depression, type two diabetes mellitus, pulmonary fibrosis, left eye cataract, dizziness, and insomnia. Review of the care plan dated 07/29/24 revealed Resident #7 had a self-care deficit related to multiple medical conditions. The care plan was updated on 09/09/24 to reflect Resident #7 had bilateral arm bruising with an added intervention to monitor the bilateral arm bruising and report any other type of skin abnormality. Further review of Resident #7's care plan revealed an update dated 09/13/24 which noted Resident #7 demonstrated anxiety and resistance with transfers. Interventions included breaking tasks into manageable subtasks, providing cuing and prompting as needed, allowing for frequent rest periods, and monitoring for signs of fatigue, frustration, being overwhelmed, or intolerance to care. (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

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 09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Community-Portage Lakes	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 08/02/24 revealed Resident #7 had intact cognition. Resident #7 was always continent of urine but required substantial assistance for toileting hygiene, bathing, personal hygiene, chair to bed transfers, and toilet transfers. The MDS did not indicate the use of anticoagulants. Review of a nurse's note dated 09/09/24 timed at 3:15 P.M. revealed Certified Nurse Practitioner (CNP) #300 and the resident's family were notified Resident #7 sustained bruises to both of his arms. Review of the Skin and Wound assessment dated [DATE] revealed in-house acquired bruising to Resident #7's left upper arm measuring 4.5 centimeters (cm) by 3.0 cm by 0.0 cm, described as purple to dark red in color with no pain. Review of a second Skin and Wound Assessment completed on 09/09/24 revealed in-house acquired bruising to Resident #7's right upper arm measuring 15.0 cm by 6.0 cm by 0.0 cm, described as deep purple and dark red with intact skin and no pain. Review of the progress notes dated 09/10/24 timed at 10:47 A.M., authored by CNP #300, revealed an assessment of bilateral arm contusions with additional similar discolorations over the antecubital region of both arms. At the time of this assessment, Resident #7 was noted to have full range of motion of both arms and no indicators of pain. Review of the nursing progress note dated 09/10/24 timed at 1:50 P.M. revealed an x-ray was taken of the right humerus with no acute osseous abnormality noted. Review of a facility SRI submitted to the Ohio Department of Health (ODH) Enhanced Information Dissemination & Collection (EIDC) on-line system on 09/09/24 revealed Hospice Nurse #329 reported to the facility Administrator that Resident #7 sustained bruising on his right upper arm after the assigned STNA from the prior night shift was too rough with him. The SRI initial report revealed Resident #7 did report pain and the Nurse Manager reported Resident #7 sustained bruising on both the right and left upper arms. Resident #7 was interviewed by the DON on 09/09/24 about the nature of his injuries and reported the STNA had been rough with him. Review of the findings for the incident investigation competed on 09/13/24 revealed the facility did not substantiate abuse had occurred due to the nurse on duty at the time, Licensed Practical Nurse (LPN) #323, reported the alleged perpetrator, STNA #332, was not rough with Resident #7 when she requested STNA #332 to stay with him while he was in the bathroom. Review of LPN #323's undated witness statement revealed no indication she was present at the time of Resident #7's injuries but did indicate STNA #332 was witnessed entering Resident #7's room later that shift. Review of a witness statements from Hospice Nurse #329 dated 09/09/24 (untimed), STNA #333 (undated and untimed), and STNA #334 dated 09/09/24 timed 11:19 A.M. revealed none had witnessed the cause of Resident #7's bilateral arm bruises. Review of the witness statement from STNA #332 forwarded from the staffing agency to the facility on [DATE] at 3:47 P.M. revealed no knowledge of abuse and no confirmation she provided care to Resident #7 on the night shift scheduled from 11:00 P.M. on 09/08/24 to 09/09/24 at 7:00 A.M. (continued on next page)

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 09/30/2024
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/24/24 at 10:07 A.M. with Resident #7 confirmed he remembered a couple of girls being too rough with him and hurting his arms, but he could not recall any additional details. During the interview, Resident #7 used hand gestures to demonstrate his arms being grabbed. Observation at that time revealed a medium purplish to yellow healing bruise on his right forearm, a yellow healing bruise to his right upper arm, and a faint yellowish bruise to his left upper arm. Interview on 09/24/24 at 10:10 A.M. with the daughter of Resident #7 (Daughter #1) confirmed the resident had sustained bruises to both of his arms on 09/09/24 and a few weeks prior. She further stated the previous DON was informed of the first incident and the STNAs involved were not allowed back in the facility and the family was shocked when the resident was injured again in the same manner. Interview on 09/24/24 at 11:28 A.M. with the power of attorney (POA) for Resident #7's healthcare (Daughter #2) confirmed Resident #7 sustained bruises on his arms on two separate occasions by staff handling him too roughly during night shifts. The POA further revealed both incidents were first assessed and reported by the Hospice nurses and the previous DON was involved in investigating and terminating facility privileges to the perpetrators after the first incident, which she was unable to confirm the date of. Daughter #2 further indicated the current DON had informed the family the staff responsible for Resident #7's injuries reported on 09/09/24 were not allowed back to the facility. The POA had no knowledge of who the named alleged perpetrators were for either incident. Telephone interview on 09/24/24 with Hospice Nursing Supervisor #327 at 11:39 A.M. confirmed Resident #7 sustained two separate negative events leading to bruising of his arms, one reported by Hospice Nurse #329 on 09/09/24 and one reported by Hospice Nurse #328 on 08/28/24. Telephone interview on 09/24/24 at 12:47 P.M. with Hospice Nurse #328 confirmed she visited Resident #7 on 08/28/24 for a (hospice) recertification visit and noted bruises on his arms in various stages, some new around both upper arms. Hospice Nurse #328 further stated Resident #7 reported an STNA, described as a short, heavy-set black lady, threw him onto the bed like he was a rag doll (Hospice Nurse #328 said those were his exact words). Hospice Nurse #328 stated she was informed by the previous DON the girl Resident #7 reported was agency staff and was placed on the do not return list as a result of the incident. Hospice Nurse #328 was unaware of any additional follow-up. Interview on 09/24/24 at 4:05 P.M. with STNA #325 confirmed Resident #7 informed her he had been handled too roughly and was injured by another staff member. During the interview, STNA #325 confirmed she reported it to the nurse who informed her the facility was aware and involved staff would not be allowed to return to the facility. (continued on next page)

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 09/30/2024
NAME OF PROVIDER OR SUPPLIER St Luke Lutheran Community-Portage Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Latham LN Akron, OH 44319	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 09/24/24 at 5:32 P.M. with LPN #323 revealed she was the only nurse on duty on the night shift beginning 09/08/24 until 09/09/24 and that STNA #332 from a staffing agency was the STNA assigned to the hall where Resident #7 resided. LPN #323 further confirmed she was not present in Resident #7's room for any chair, bed, or toilet transfers but had found Resident #7 on the toilet by himself and instructed STNA #332 to stay with Resident #7 and not leave him unattended while in the bathroom because he was a fall risk. LPN #323 stated there was no bruising to Resident #7's arms when she left him with STNA #332, and she had not seen his arms or been present during any other care by STNA #332 after that encounter. The next night, LPN #323 noticed the bruising on Resident #7's right arm and stated it looked suspicious of a fracture. According to LPN #323, Resident #7 stated the aide from the previous night had to show him who was the boss, so she threw him near the couch in the room. LPN #323 revealed she immediately reported this information to the DON via telephone and was informed the facility was aware and investigating and the aide involved would not be allowed back in the facility. LPN #323 confirmed an x-ray was ordered. The x-ray showed there was no fracture. Telephone interview on 09/25/24 at 7:06 A.M. with STNA #309 confirmed knowledge of bilateral arm bruises on Resident #7, stating there was no reason for that sort of bruising if he was handled properly, as he described large bright red bruises on both arms, including from the forearm all the way to his upper arm. During the interview, STNA #309 revealed Resident #7 informed STNA #309 the night aides were too rough with him during a previous incident as well and gave no indicators that would cause facility staff not to believe Resident #7. STNA #309 further stated when the conversation with Resident #7 was reported to the previous DON, the STNA was informed the facility was aware and that two female STNAs were not allowed back to work in the facility as a result of the incidents. STNA #309 denied receiving any in-service or training related to abuse after the reported injuries sustained by Resident #7. Telephone interview on 09/25/24 at 8:56 A.M. with STNA #306 confirmed she had knowledge Resident #7 had bright red bruises on both arms. During the interview, STNA #306 was unable to recall the date she first noted bilateral arm bruising, but stated she reported the bruises to the nurse on duty who informed her the incident was under investigation. STNA #306 stated when Resident #7 was asked about the origin of the bruises, he responded that the aide from the previous night had to show me who's boss. Interview on 09/25/24 at 10:35 A.M. with Hospice Nurse #329 confirmed that on 09/09/24 she noted large bright red bruises on both of Resident #7's arms. She further confirmed Resident #7 would occasionally get small, scattered marks on his skin, but stated this was different, they looked like two hand grasps and were new skin concern areas. During the interview, Hospice Nurse #329 confirmed Resident #7 had occasional short-term memory issues, but was alert and oriented to person, place, time, and situation and could see no reason to doubt his recall of events. Hospice Nurse #329 also stated that the facility seemed to believe Resident #7 right away. She also confirmed that when she reported the incident to her supervisor, she was informed that Hospice Nurse #328 had reported an incident of bruising that occurred previously after being handled too rough by facility staff. (continued on next page)

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 09/30/2024
NAME OF PROVIDER OR SUPPLIER St Luke Lutheran Community-Portage Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Latham LN Akron, OH 44319	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/25/24 at 1:31 P.M. with STNA #326 confirmed awareness that Resident #7 sustained bruises on his arms somewhere around the end of August 2024 or the beginning of September 2024 then heard there was a second similar incident not long after. STNA #326 was not certain of the date(s) of injury. During the interview, STNA #326 stated some of the other aides may not have the patience required for Resident #7's night-time confusion and this was reported to the previous DON. STNA #326 was not aware of the outcome after reporting to the previous DON. Interview with the current DON on 09/25/24 between 2:30 P.M. and 2:50 P.M. confirmed she placed two agency STNAs (STNAs #332 and #334) on the do not return list because she felt they were both being dishonest and could not confirm with 100 percent certainty which one of them may have been providing care to Resident #7 the night he sustained bilateral arm bruising and accused staff of being too rough with him. During the interview, the DON confirmed she had no reason not to believe Resident #7's report of how he sustained the bruises, but added he did have a tendency to display some confusion and agitation in the late afternoon or evenings and thought the injuries could possibly have been incidentally caused during a difficult transfer. The DON also confirmed after learning on 09/24/24 that the Hospice staff, Resident #7, and Resident #7's two daughters reported there was a previous incident involving staff causing bruises by handling too roughly, she went to the room and spoke with the daughter who was Resident #7's POA for care. Resident #7's POA confirmed there was an incident in August 2024 where Hospice Nurse #328 reported bilateral arm bruising Resident #7 told her happened when the aide was too rough with him. According to the DON, the POA stated this was reported to the previous DON who immediately placed that staff member on the facility's do not return list, though she did not know who the alleged perpetrator was determined to be. Interview on 09/25/24 at 3:00 P.M. with the Administrator confirmed there had been no thorough/comprehensive investigation completed regarding the bruises reported by the Hospice Nurse to the previous DON on 08/28/24 and that he was waiting for Hospice to provide additional information at which time he planned to move forward with an investigation. He reported this was all new information to him and was awaiting additional information before moving forward. Review of the policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property dated 11/28/16 revealed the facility was to take steps to identify and prevent resident harm, including injury caused by rough handling during resident care. The definition of abuse included the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Mistreatment was defined as inappropriate treatment or exploitation of resident. The policy indicated willful meant the individual must have acted deliberately, not that the individual must have attended to inflict injury or harm. This deficiency represents non-compliance investigated under Complaint Number OH00157332.

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NAME OF PROVIDER OR SUPPLIER: St Luke Lutheran Community-Portage Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE: 615 Latham LN Akron, OH 44319	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interviews, review of facility policy, and review of facility self-reported incident (SRI) investigation, the facility failed to ensure allegations of potential abuse were thoroughly investigated, thereby preventing further similar instances of abuse involving the same resident. This affected one resident (Resident #7) of three residents reviewed for abuse. The facility census was 38. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including hypertensive heart disease without heart failure, asthma with status asthmaticus, dementia with agitation, depression, type two diabetes mellitus, pulmonary fibrosis, left eye cataract, dizziness, and insomnia. Review if the admission Minimum Data Set (MDS) 3.0 assessment completed on 08/02/24 revealed Resident #7 had intact cognition. Resident #7 was always continent of urine but required substantial assistance for toileting hygiene, bathing, personal hygiene, chair to bed transfers, and toilet transfers. The MDS did not indicate the use of anticoagulants. Review of the care plan dated 07/29/24 revealed Resident #7 had a self-care deficit related to multiple medical conditions. Further review of the care plan revealed on 09/09/24 Resident #7 was noted to have bilateral arm bruising with an added intervention to monitor the bilateral arm bruising and report any other type of skin abnormality. On 09/13/24, the care plan noted Resident #7 demonstrated anxiety and resistance with transfers. Interventions included breaking tasks into manageable subtasks, providing cuing and prompting as needed, allowing for frequent rest periods, and monitoring for signs of fatigue, frustration, being overwhelmed, or intolerance to care. Review of the nurses note dated 09/09/24 timed at 3:15 P.M. revealed Certified Nurse Practitioner (CNP) #300 and the resident's family were notified that Resident #7 sustained bruises to both of his arms. Review of the progress note dated 09/10/24 timed at 10:47 A.M. entered by CNP #300 revealed an assessment of bilateral arm contusions with additional similar discolorations over the antecubital region of both arms. At the time of this assessment, Resident #7 was noted to have full range of motion of both arms and no indicators of pain. Review of the nursing progress note dated 09/10/24 timed at 1:50 P.M. revealed an x-ray was taken of the right humorous with no acute osseous abnormality noted. Review of the assessments revealed Resident #7 had no weekly skin assessments completed since the date of admission to present. There was no skin or wound assessment completed on 08/28/24. Review of the Skin and Wound assessment dated [DATE] revealed in-house acquired bruising to Resident #7's left upper arm measuring 4.5 centimeters (cm) by 3.0 cm by 0.0 cm, described as purple to dark red in color with no pain. Review of a second Skin and Wound Assessment completed on 09/09/24 revealed in-house acquired bruising to Resident #7's right upper arm measuring 15.0 cm by 6.0 cm by 0.0 cm, described as deep purple and dark red with intact skin and no pain. (continued on next page)

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	366280	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Community-Portage Lakes	615 Latham LN Akron, OH 44319

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility SRI submitted to the Ohio Department of Health (ODH) Enhanced Information Dissemination & Collection (EIDC) on-line system on 09/09/24 revealed Hospice Nurse #329 reported to the facility Administrator that Resident #7 sustained bruising on his right upper arm after the assigned State tested Nurse Aide (STNA) from the prior night shift was too rough with him. The SRI initial report revealed Resident #7 did report pain and the Nurse Manager reported Resident #7 sustained bruising on both the right and left upper arms. Resident #7 was interviewed by the Director of Nursing (DON) on 09/09/24 about the nature of his injuries and reported the STNA had been rough with him. Review of the facility SRI submitted to the ODH EIDC on-line system on 09/25/24 revealed the facility opened an investigation into allegations made by Resident #7 to Hospice Nurse (#328) on 08/28/24. The preliminary incident detail did not include Resident #7's power of attorney (POA) corroboration of this being a separate occurrence from the incident reported 09/09/24. Review of the incident investigation findings for the incident reported on 09/09/24 revealed the facility did not substantiate abuse had occurred due to the nurse on duty at the time, Licensed Practical Nurse (LPN) #323, reported the alleged perpetrator, STNA #332, was not rough with Resident #7 when she requested STNA #332 to stay with him while he was in the bathroom. Review of LPN #323's witness statement (dated?) revealed no indication she was present at the time of Resident #7's injuries but did indicate STNA #332 was witnessed entering Resident #7's room later that shift. Further review of the investigation documentation revealed written witness statements were collected but there was no documentation of witness or alleged perpetrator interviews. The written witness statements were collected through email or in writing from Hospice Nurse #329, LPN #323 (as noted above), STNA #332, STNA #333, and STNA#334. Review of the in-service sign-in sheet dated 09/11/24 on abuse, neglect, and misappropriation revealed a total of nine signatures, including the DON. Interview on 09/24/24 at 10:07 A.M. with Resident #7 confirmed he remembered a couple of girls being too rough with him and hurting his arms, but he could not recall any additional details. During the interview, Resident #7 used hand gestures to demonstrate his arms being grabbed. Observation at that time revealed a medium purplish to yellow healing bruise on his right forearm, a yellow healing bruise to his right upper arm, and a faint yellowish bruise to his left upper arm. Interview on 09/24/24 at 10:10 A.M. with the daughter of Resident #7 (Daughter #1) confirmed he sustained bruises to both of his arms on 09/09/24 and a few weeks prior. She further stated the previous DON was informed of the first incident and the STNAs involved were not allowed back in the facility and they were shocked when he was injured again in the same manner. During the interview, Resident #7's daughter did verbalize she was pleased with the swift outcome of restricting the alleged perpetrators from returning to the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 11:28 A.M. with the power of attorney (POA) for Resident #7's healthcare (Daughter #2) confirmed Resident #7 sustained bruises on his arms on two separate occasions by staff handling him too roughly during night shifts. The POA further confirmed both incidents were first assessed and reported by the Hospice nurses and the previous DON was involved in investigating and terminating facility privileges to the perpetrators after the first incident, which she was unable to confirm the date. She further confirmed the current DON had informed the family the staff responsible for Resident #7's injuries reported on 09/09/24 were not allowed back to the facility. The POA had no knowledge of who the named alleged perpetrators were for either incident. Telephone interview on 09/24/24 with Hospice Nursing Supervisor #327 at 11:39 A.M. confirmed Resident #7 sustained two separate negative events leading to bruising of his arms, one reported by Hospice Nurse #329 on 09/09/24 and one reported by Hospice Nurse #328 on 08/28/24. Hospice Supervisor #327 further confirmed the facility followed up after both incidents and reported the involved staff were no longer allowed in the facility. Telephone interview on 09/24/24 at 12:47 P.M. with Hospice Nurse #328 confirmed she visited Resident #7 on 08/28/24 for a recertification visit and noted bruises on his arms in various stages, some new around both upper arms. Hospice Nurse #328 stated Resident #7 reported an STNA, described as a short, heavy-set black lady, threw him onto the bed like he was a rag doll (Hospice Nurse #328 said those were his exact words). Hospice Nurse #328 stated she was informed by the previous DON the girl Resident #7 reported was agency staff and was placed on the do not return list. She was unaware of any additional follow-up. Interview on 04/24/24 at 4:45 P.M. with the Administrator regarding the determination of the investigation for the incident reported on 09/09/24 confirmed the facility concluded the allegation was unsubstantiated because he thought LPN #323's witness statement pointed to the LPN being present during the toilet transfer, which was when he thought Resident #7 sustained the bruising, and LPN #323 indicated in the witness statement that she did not witness any rough care at that time. Telephone interview on 09/24/24 at 5:32 P.M. with LPN #323 revealed she was the only nurse on duty on the night shift 09/08/24 - 09/09/24 and that STNA #332 from the staffing agency was the STNA assigned to the [NAME] Hall room [ROOM NUMBER], where Resident #7 resided. LPN #323 further confirmed she was not present in Resident #7's room for any chair, bed, or toilet transfers but had found Resident #7 on the toilet by himself and instructed STNA #332 to stay with Resident #7 and not leave him unattended while in the bathroom because he was a fall risk. LPN #323 confirmed that there was no bruising to Resident #7's arms when she left him with STNA #332, and she had not seen his arms or been present during any other care rendered by STNA #332 after that encounter. The next night, LPN #323 noticed the bruising on Resident #7's right arm looked suspicious of a fracture. According to LPN #323, Resident #7 stated the aide from the previous night had to show him who was the boss, so she threw him near the couch in the room. LPN #323 also confirmed she immediately reported this information to the DON via telephone and was informed the facility was aware and investigating and the aide involved would not be allowed back in the facility. (continued on next page)

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St Luke Lutheran Community-Portage Lakes	615 Latham LN Akron, OH 44319

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 10:35 A.M. with Hospice Nurse #329 confirmed that on 09/09/24 she noted large bright red bruises on both of Resident #7's arms. She further confirmed Resident #7 would occasionally get small, scattered marks on his skin, but stated this was different, they looked like two hand grasps and were new skin concern areas. During the interview, Hospice Nurse #329 revealed Resident #7 had occasional short-term memory issues, but was alert and oriented to person, place, time, and situation and could see no reason to doubt his recall of events. Hospice Nurse #329 also stated that the facility seemed to believe Resident #7 right away. She also confirmed that when she reported the incident to her supervisor, she was informed that Hospice Nurse #328 had reported an incident of bruising that occurred previously after being handled too rough by facility staff. Interview with the current DON on 09/25/24 between 2:30 P.M. and 2:50 P.M. revealed she placed two agency STNAs (STNAs #332 and #334) on the do not return list because she felt they were both being dishonest and could not confirm with 100% certainty which one of them may have been providing care to Resident #7 the night he sustained bilateral arm bruising and accused staff of being too rough with him. During the interview, the DON confirmed she had no reason not to believe Resident #7's report of how he sustained the bruises, but added he did have a tendency to display some confusion and agitation in the late afternoon or evenings and thought the injuries could possibly have been incidentally caused during a difficult transfer. The DON also confirmed after learning on 09/24/24 that the Hospice staff, Resident #7, and Resident #7's two daughters reported there was a previous incident involving staff causing bruises by handling too roughly, she went to the room and spoke with the daughter who was Resident #7's POA for healthcare. The DON stated Resident #7's POA confirmed there was an incident in August 2024 where Hospice Nurse #328 reported bilateral arm bruising Resident #7 told her happened when the aide was too rough with him. According to the DON, the POA stated this was reported to the previous DON who immediately placed that staff member on the facility's do not return list, though she did not know who the alleged perpetrator was determined to be. She confirmed there was no facility record of this previously reported incident. A follow-up interview with the Administrator on 09/25/24 at 3:00 P.M. confirmed he was unaware two staff were placed on the do not return list after the reported incident on 09/09/24 and he could not determine the cause of the bruises on Resident #7's arms because he was not clinical. The Administrator stated the information found by the DON on 09/24/24 after interviewing Resident #7's POA and the information gained from the surveyor regarding LPN #323 not being a witness to Resident #7's injuries was all new news to him and he would have to interview LPN #323 prior to determining whether to reopen and continue to investigate the allegation of abuse on 09/09/24 and he would have to investigate the allegation of abuse alleged to have been reported to the previous DON on 08/28/24. Review of the policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property dated 11/28/16 revealed the facility was to take steps to identify and prevent resident harm, including injury caused by rough handling during resident care. The policy further revealed all alleged incidents involving suspected abuse or injuries of unknown origin were to be reported to the Administrator and the Ohio Department of Health and investigated. Information gathered during the investigation was to be thoroughly analyzed to determine whether the allegation could be substantiated. This deficiency represents non-compliance investigated under Complaint Number OH00157332.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Community-Portage Lakes	615 Latham LN Akron, OH 44319

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and review of facility policy, the facility failed to review and revise the comprehensive care plan as resident needs and required interventions changed. This affected one resident (Resident #10) of three residents whose care plans were reviewed for timely and appropriate interventions. The facility census was 38. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including senile degeneration of the brain, dysphagia, hemiplegia or hemiparesis of the left dominant side following a cerebrovascular accident, major depressive disorder, anxiety disorder, and neuromuscular dysfunction. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/03/24 revealed Resident #10 had severely impaired cognition, impaired range of motion on one side and was dependent for eating. The MDS also revealed Resident #10 was not on any mechanically altered or therapeutic diet. Review of the physician orders revealed the following meal related orders: An order dated 02/29/24 for staff to assist with meals. An order date 03/06/24 directing that Resident #10 needed to be asked to go to the dining room for all meals to be fed and if she refused, please feed Resident #10 in her room. Orders dated 06/28/24 for Resident #10 to have a regular diet with regular texture and thin liquids, as well as a pleasure diet as tolerated. An order dated 08/10/24 to verify meal intake was documented in the orange folder in Resident #10's room. Review of the care plan initiated 03/01/24 revealed Resident #10 had self-care deficits requiring staff assistance with activities of daily living (ADLs). There were no interventions related to level of assistance needed for eating. Further review of the care plan revealed that Resident #10 was at risk for altered nutrition or hydration related to needing meal assistance, depression, difficulty chewing or swallowing, increased confusion in the evenings, and a mechanically altered diet. Interventions included honoring preferences, providing a mechanical soft, chopped diet, and encouraging completion of meals. There were no care plan interventions that spoke to Resident #10's abilities or level of feeding assistance requirements, encouraging to eat in the dining room, logging the amount eaten in the orange folder, resident food preferences, resident history of meal refusals, or that the diet had been upgraded to a regular texture diet and pleasure diet as tolerated on 06/28/24. Review of the progress notes and assessments from 05/01/24 through 09/25/24 revealed no information regarding interdisciplinary care planning meetings or outcomes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dietary/Nutrition assessment dated [DATE] revealed Resident #10 was upgraded to a regular diet on 06/28/24 and was allowed a pleasure diet as tolerated. Resident #10 was to receive staff assistance with every meal and she had a tendency to sundown late afternoons or evenings which sometimes caused variability with her appetite. Resident #10 was to be asked if she wanted to eat in the dining room for all meals and may be fed in her room upon refusal. Interview on 09/24/24 at 10:22 A.M. with Resident #10 revealed sometimes staff assisted her with meals and sometimes they did not. She also stated the level of assistance varied, from feeding her to cutting things up and letting her eat while watching. Observation at this time revealed there was no orange folder in Resident #10's room on which to log meal intake. At this time, Resident #10's daughter stated it had been missing for a few days. Resident #10 revealed it was removed from the room on 09/21/24. Interview on 09/24/24 at 10:48 A.M. with Licensed Practical Nurse (LPN) #335 revealed she was informed there was a binder the aides were required to document on after they fed Resident #10. LPN #335 stated the folder was at the nurses' station (she pointed out its location), was not sure why it was there, and could not speak to why the logs had some missing information, as well as some dates written in out of sequence. Review of the meal intake logs from 08/10/24 to 09/24/24 revealed inconsistency with date sequences and how the logs were being filled out. Most dates were accounted for but appeared to contain some overlap with different details. For example, 09/13/24 was on top of one page and noted Resident 10 refused breakfast but was noted at the bottom of a different page noting she ate 75% of her breakfast, while the top of the page noted Resident #10 ate a hotdog and was fed by her daughter on 09/13/24 but the bottom of the previous page noted she ate 25% of her breakfast. Another example included each meal entry dated 09/23/24 was blank; however, the line below it marked 09/24 appeared to have a light mark over the four that looked like a three, and indicated breakfast was refused but Resident #10 had coffee cake and yogurt and ate 50% of her lunch, which had not yet been served on 09/24/24 at the time this form was being reviewed. There was no entry for dinner for 09/23/24 in either row. Interview on 09/24/24 at 3:30 P.M. with State tested Nurse Aide (STNA) #324 revealed she was aware staff were supposed to provide feeding assistance but was unclear on how much, since Resident #10 demonstrated the ability to hold her own cup and eat finger foods independently. STNA #324 also confirmed Resident #10 had a history of meal refusals and would often tell staff her boyfriend would be bringing her food and would become agitated at times if staff kept offering her tray. STNA #324 was uncertain if the resident's care plan mentioned staff were to log meal intakes in the orange folder, but stated the previous Director of Nursing (DON) told them to do so and pass it on to other staff in report. Interview on 09/24/24 at 4:05 P.M. with STNA #325 revealed Resident #10 refused meal trays and preferred to wait until her daughter or boyfriend brought in food from home or take-out. STNA #325 was not aware of any paper log on which staff were to document meal intake. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 with STNA #326 confirmed the care plan did not say what level of assistance was required to feed Resident #10. She further stated she was initially told she needed some assistance and supervision with finger foods, but then was told she was a total feed, despite Resident #10's ability to have some independence when offered finger foods. STNA #326 revealed the previous and the current DON educated aides on documenting on the log and further confirmed the log was not in Resident #10's room on 09/24/24. Interview on 09/25/24 with the DON from 2:30 P.M. to 2:50 P.M. revealed interdisciplinary team (IDT) meetings were held quarterly and with changes in condition and each resident's care plan should be reviewed and updated as necessary at that time, based on the assessments and the meeting outcomes. The DON used to document IDT meetings on a specific form, but those forms stopped being utilized at some point with the previous DON. The DON said there were multiple care conferences regarding Resident #10, and she was not in attendance for the last meetings, so she was unaware the care plan had not been updated. The DON confirmed Resident #10's care plan did not accurately reflect her current diet orders, level of assistance required with meals, history of refusals, encouraging meals in the dining room, or logging meal intake. During a follow-up interview with the DON on 09/25/24 at 3:44 P.M., she confirmed there was no record of any care conference meetings, including dates, attendees, progress toward goals, or meeting outcomes/need for new interventions. Review of the policy titled Comprehensive Care Plans, undated (but from a 2024 compliance manual) revealed the facility was to develop and implement a comprehensive person-centered care plan based on an assessment of each resident's needs and strengths which incorporated the residents personal and cultural preferences, as well as the care and services required to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. The policy further revealed all care assessment areas (CAA's) from the MDS assessment were to be considered during the development of the care plan. This deficiency represents non-compliance investigated under Complaint Number OH00157294.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, review of call light audits, and review of facility policy, the facility failed to maintain a resident call system that adequately communicated resident calls directly to a staff member or to a centralized location to alert staff to a resident in need. This had the potential to affect all residents in the facility. The facility census was 38. Findings include: Observation of the call lights from the centralized common area (between all four halls) on 09/24/24 from 9:36 A.M. to 10:00 A.M. revealed the following: room [ROOM NUMBER]: At 9:36 A.M. the call light was on. It was not observed what time room [ROOM NUMBER]'s light was triggered. This light was answered at 9:46 A.M. for a total of 10 minutes. room [ROOM NUMBER]: At 9:38 A.M., room [ROOM NUMBER]'s light was noted to be lit above the room door. Staff responded to the call light at 9:55 A.M. for a total of 17 minutes observed. room [ROOM NUMBER]: At 9:38 A.M. the light at the end of the North hallway was on, indicating the suite around the corner triggered the light. Staff responded to the light at 9:48 A.M. for a total of 10 minutes observed. At 9:52 A.M., the call light in room [ROOM NUMBER] was activated, State tested Nurse Aide (STNA) responded at 9:56 A.M. During observation of the call lights, no audible sound was noted. There was no light panel near the nurses' station indicating call lights were triggered. During the 24-minute observation, Licensed Practice Nurse (LPN) #321 was observed sitting at the nurses' station and for approximately 10 to 15 minutes of this observation a second nurse, LPN #335, also sat at the nurse's station. While the lights remained lit in the hallway, one STNA was in the bathing room, one STNA was assisting a resident in room [ROOM NUMBER] and then room [ROOM NUMBER], and one STNA was observed entering a resident's room in the [NAME] Hall. Additionally, two staff from the therapy department and one office staff member walked by rooms [ROOM NUMBERS]. Interview on 09/23/24 at 4:43 P.M. with Resident #23 revealed it took quite some time for staff to answer call lights. No specifics were provided during the interview. Interview on 09/24/24 at 10:22 A.M. with Resident #10 revealed she was concerned with call light response times. When asked how long she must wait, she exclaimed that they sometimes never came but was unable to provide details. During the interview, Resident #10's daughter stated the call light was put on around 10:00 A.M. over the weekend and at 2:00 P.M. Resident #10 called her daughter for help because staff did not respond to her call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 09/24/24 at 10:43 A.M. with LPN #321 confirmed call lights did not emit an audible sound, but lit up outside the resident's door and the signal went to a pager that the STNAs were supposed to carry. When asked how the nurses knew if the lights were activated when they were sitting at the nurse's station, LPN #321 stated there was no centralized panel at the nurses' station and nurses were also supposed to be alerted through a pager. LPN #321 confirmed she had no pager. Observation at this time revealed three pagers in a basket at the nurses station with no batteries. Interview on 09/24/24 at 10:48 A.M. with LPN #335 confirmed she was unaware the call lights in rooms [ROOM NUMBER] were on between 9:40 A.M. and 10:00 A.M. when she was at the nurses' station and further confirmed she did not know about a pager for call light alerts. Interview on 09/24/24 at 3:50 P.M. with STNA #324 confirmed the pagers for the call lights had no batteries so she had not been carrying one. STNA #324 further confirmed the only way to know if a resident activated a call light was to watch the lights in the hall and whoever saw the light should be the first responder to the resident call. Interview on 09/24/24 at 4:05 P.M. with STNA #325 confirmed call lights should be answered immediately or as soon as possible, but the only way to know if one was activated was to be up and moving around the assigned halls. STNA #325 further confirmed she would not know a call light was going off in her assigned area if she was not in the hall watching because the pagers for the alerts were not in use. STNA #325 was unable to specify exactly how long staff had been without the pagers, but stated it has been a while and stated they needed batteries and set-up to work correctly. Interview on 09/24/24 at 4:25 P.M. with STNA #322 confirmed it was her belief only one pager in the facility was working and it was being used in the Assisted Living section of the facility. STNA #322 stated the STNAs must constantly be looking at the lights above the doors as the only method of call light notification. Interview on 09/24/24 at 4:40 P.M. with the Director of Nursing (DON) revealed it was the responsibility of all staff to respond timely to call lights. There was not a set time frame, but lights should be answered immediately or as soon as able by whoever saw the light first. Interview on 09/25/24 at 12:16 P.M. with Resident #13 revealed call lights took a while to get answered, stating it had taken up to one to two hours at times to get staff to answer her light. Interview on 09/25/24 at 1:31 P.M. with STNA #326 revealed staff were educated on the call system requiring the use of pagers for alerts, but nobody had been using them, except on the assisted living unit. STNA #326 further confirmed the only way to determine if a call light was going off was to be watching above all the doors and not to be at the nurses' station. Review of a 24-hour look-back audit for call light response times for room [ROOM NUMBER] between 09/23/24 and 09/24/24 revealed the following response times greater than 20 minutes: 09/23/24 from 11:14 P.M. to 12:10 A.M., 55 minutes and 52 seconds 09/24/24 from 5:54 A.M. to 6:17 A.M., 23 minutes and 38 seconds 09/2424 from 9:19 A.M. to 9:46 A.M., 27 minutes and 30 seconds (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a 24-hour look-back audit for call light response times for Rooms 111 between 09/23/24 and 09/24/24 revealed the following response times greater than 20 minutes: 09/23/24 from 7:12 A.M. to 7:32 A.M., 20 minutes and 51 seconds 09/23/24 from 10:42 A.M. to 11:06 A.M., 24 minutes and 12 seconds 09/24/24 from 9:14 A.M. to 9:48 A.M., 34 minutes and 48 seconds Review of a 24-hour look-back audit for call light response times for room [ROOM NUMBER] between 09/23/24 and 09/24/24 revealed the following response times greater than 20 minutes: 09/23/24 from 7:21 A.M. to 7:46 A.M., 24 minutes and 57 seconds 09/23/24 from 8:31 A.M. to 8:57 A.M. 26 minutes and 22 seconds 09/23/24 from 9:08 A.M. to 9:59 A.M., 51 minutes and 14 seconds 09/23/24 from 2:34 A.M. to 3:11 A.M., 37 minutes and 13 seconds 09/23/24 from 4:25 A.M. to 4:55 A.M., 30 minutes and 27 seconds 09/23/24 from 6:43 A.M. to 7:07 A.M., 23 minutes and 49 seconds 09/23/24 from 8:04 A.M. to 8:33 A.M., 28 minutes and 37 seconds 09/24/24 from 8:22 A.M. to 9:15 A.M., 52 minutes and 37 seconds 09/24/24 from 9:15 A.M. to 9:37 A.M., 21 minutes and 14 seconds Review of the facility policy Call Lights: Accessibility and Timely Response dated September 2023 revealed the facility was to ensure call lights went to the staff members directly or that the calls went to a centralized staff work area. The policy further revealed staff members who saw or heard the activated call light were responsible for responding. This deficiency represents non-compliance investigated under Complaint Number OH00157294.