STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510233	A. BUILDING: _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER OAKS INC	601 LUTZ RD BLOOMINGTON, IL 61704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Original Investigation Complaint #2565185/IL194038 Section 295.2030 b)5) Violation Section 295.5000 b)1)2)3) Violation	A 000		
A2030	Section 295.2030 Establishment Contacts This Regulation is not met as evidenced by: Section 295.2030 Establishment Contracts b) The establishment contract shall also include: 5) The establishment's policy concerning notification of a relative or other individual in an emergency, significant change in the resident's condition, or termination of residency. Violation Based on interview and record review, the establishment failed to follow their notification policy by not notifying a resident's family for a change of condition/hospital transfer for one (R1) of four residents reviewed in a sample of four. Findings include: On 6-13-25 at 12:00 pm, Z1 (R1's family) stated when R1 was sent to the hospital on 6-6-25, the establishment staff left him a message on his phone which he did not see for hours. Z1 stated the hospital called family and reported R1 was there. R1's progress notes dated 6-6-25 at 10:06 am documents that a message was left on Z1's	A2030		

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A2030	Continued From page 1 phone regarding R1's transfer to the hospital. There is no documentation that anyone else listed as a contact for R1 was notified of the transfer. The establishment's Change in Resident's Condition or Status 12-8-23 policy documents "Unless otherwise instructed by the resident, the nurse will notify the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status." "In the event of a medical emergency requiring immediate response (911 called) notify the resident's representative/family as appropriate." On 6-11-25 at 10:00 am, E2 (Acting Director of Nursing) and E7 (Temporary Memory Care Administrator) stated nursing staff should call the next resident emergency contact if the first contact cannot be reached if a resident is sent to the hospital. R1's contract signed 8-21-21 contains an addendum which states family/family's will be notified of a change of condition/hospitalization for R1.	A2030		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage b) Medication reminders include: 1) Reminding residents to take pre-dispensed, self-administered medication;	A5000		

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A5000	Continued From page 2	A5000		

2) Observing the resident; and
3) Documenting whether or not the resident took the medication.

Violation

Based on interview and record review, the establishment staff failed to observe a resident take their medication during medication reminders for (R1) , and failed to provide medications reminders for (R4), two of four residents reviewed for medications in sample of six.

Finding include:

1. On 6-13-25 at 12:00 pm, Z1 (R1's family) stated a couple of weeks ago, he found several intact untaken pills in R1's apartment. Z1 stated staff are to remind R1 to take her medications and stay and ensure she takes them. Z1 stated this has been a problem for the last year.

On 6-13-25 at 9:40 am, E2 (Acting Director of Nursing) stated family has met with them regarding pills found that R1 has not taken. E2 stated they were already in process of educating staff to observe residents taking their medications.

R1's current service plan dated 2-12-24 documents" Medication Management - requires reminders for medication administration and ordering of medications."

The establishment's Medication Reminders, Supervision of Self Administrations and Medication Administration 8-25-23 policy documents "Medication reminders include: Reminding residents to take pre-dispensed, self

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A5000	Continued From page 3 administered medication, observing the resident, and documenting whether or not the resident took the medications." 2. R4's Medication Observation form for 6-10-25 documents R4 only received his evening medications. R4's Medication Variance report documents that on 6-11-25, CNA (Certified Nursing Assistant) reported to the nurse that medications from 6/10 were still in the pill planner. It also states "education and disciplinary action provided for staff involved in missed medication." On 6-13-25 at 9:40 am, E2 stated there was confusion between the staff on 6-10-25 each thinking the other was in charge of R4's reminders that day. E2 verifed R4 only received his evening medications on 6-10-25. R4's 2-6-25 service plan documents R4 requires reminders for medication administration. R4's establishment provided physician's orders documents R4 is to receive the following medications during the day: Tylenol 1000 mg (Milligrams) for pain, Amlodipine 5 mg for blood pressure, Cyanocobalamin 1000 mcg (microgram) for Vitamin B12 deficiency, Hydroxyzine for behaviors, Sertraline 100 mg for behaviors, Pantoprazole 40 mg for stomach acid, plus several eye drops.	A5000		