STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146184	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Oaks	601 Lutz Road Bloomington, IL 61704

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe transfer for one of three residents (R2) reviewed for falls on the sample list of three. Findings include: R2's Minimum Data Set (MDS) dated [DATE] documents R2 has a Progressive Neurological Condition, Parkinson's disease with Dyskinesia, muscle weakness, abnormalities of gait/mobility, need for assistance with personal care and severe cognitive impairment. This MDS also documents that R2 requires partial to moderate assistance with getting to a standing position from sitting in a chair, wheelchair, or on the side of the bed. R2's Care Plan dated 5/22/25 with a revision on 9/03/25 documents R2 is at risk for falls related to generalized weakness and gait instability secondary to Parkinson's Disease. R2's Morse Fall Scale dated 8/20/25 documents R2 is at High Risk for Falling. On 11/04/25 at 1:43 PM, V2 (Director of Nursing (DON)) provided an incident report dated 10/29/25 documenting that R2 had a witnessed fall on 10/29/25. On 11/04/25 at 10:20 AM, V5 (Certified Nurse Assistant (CNA)) entered R2's room. R2 was seated in a recliner. R2 was difficult to understand and appeared to be confused at surveyor's introduction. V5 CNA proceeded to assist R2 with a transfer from R2's recliner to R2's wheelchair without the use of a gait belt. V5 CNA confirmed she did not use the gait belt to assist R2 in the transfer. V5 CNA stated usually V5 CNA will use the gait belt when R2 is anxious as she was with the transfer, and sometimes R2 does not need the gait belt for a safe transfer. On 11/05/25 at 9:32 AM, in a phone interview with V11 (Registered Nurse (RN)), V11 RN stated that all staff are expected to use a gait belt when transferring or walking with R2. On 11/05/2025 at 10:35 AM, V17 (Physical Therapist (PT)) stated R2 requires light touch assistance from staff when transferring and walking and that staff should always use a gait belt when transferring or walking R2. On 11/4/25 at 3:55 pm, V2 (Director of Nursing (DON)) and surveyor exited R1's room, R2 was being assisted into a wheelchair by a private sitter. V2, DON opened R2's door so the private sitter could push the wheelchair into R2's room. V2 confirmed the gait belt was rolled up and lying on the counter just inside R2's room. V2 confirmed I expect all staff to use the gait belt for resident transfers. R2 should have had a gait belt on, she has Parkinson's. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Falls Prevention and Post-Falls Management Policy dated 10/11/22 with a revision on 9/06/24 documents the following: The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and other members of the multidisciplinary team, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility repeatedly failed to maintain complete and accurate medical records for two of three (R1and R3) residents reviewed for falls on the sample list of three.Findings include: 1.) On 11/04/25 at 1:43 PM, V2 (Director of Nursing (DON)) provided an incident report dated 11/03/25 documenting that R3 had an unwitnessed fall on 11/03/25. In reviewing R3's Electronic Medical Record (EMR) there were no nurses' notes documenting R3's fall on 11/03/25. On 11/05/25 at 2:00 PM, V2 confirmed there were no nurses' notes in R3's EMR documenting R3's fall on 11/03/25. V2 stated documentation for R3 could be found in the daily skilled nursing notes under assessments. R3's skilled daily nursing notes dated 11/03/25 (Day and Night Shift) do not document R3's fall. On 11/05/25 at 9:50 am V16 (Physical Therapy Assistant (PTA)) stated, R3 fell transferring himself from his wheelchair to his recliner and R3 told V16 PTA that he had just slid off the front of the recliner. V16 PTA stated they placed a non-skid device in R3's recliner chair after R3's fall on 11/03/25. V16 PTA demonstrated, using a gait belt, and had R3 stand up from the recliner with a walker. V16 PTA confirmed the presence of non-skid device (twelve inches long by 15 inches wide) in the seat of R3's recliner. V16 PTA stated the non-skid device was added as an intervention after R3's fall on 11/03/25. On 11/05/25 at 2:00 PM, V2 DON stated that the non-skid device was not added to R3's Care Plan as an intervention. 2). R1's Fall, Final Investigation dated 10/22/25 signed by V2, Director of Nursing documents the following: Conclusion: The resident was attempting to reposition herself in bed when she inadvertently fell from the bed, causing the mattress to dislodge and fall with her. This unwitnessed fall resulted in a subarachnoid hemorrhage and fractures of the nasal bones. The resident's care plan has been revised to include additional safety interventions, specifically maintaining the bed in the lowest position and ensuring that floor mats are in place whenever the resident is resting in bed. There is no documentation by V2, Director of Nursing, in resident chart (R1's above investigation is not part of R1's clinical medical record) of the fall. On 11/05/25 at 12:49 V4, Registered Nurse (RN) stated I did not do vital signs or neuros (neurological checks) on (R1) because the (V2, DON) Director of Nursing was covering the unit while I (V4) was on a fifteen-minute break. V4, RN stated I returned to the unit and saw (R1) on the floor with blood all over the place. The DON (V2) and a CNA (V8) were with (R1) and the DON (V2) was holding a cloth on (R1's) nose. Within five minutes the fire department arrived. They told the DON (V2) not to move (R1) any further, after she had positioned her to a side lying position to hold the cloth on her (R1's) face. V4, RN also stated she charted what she saw herself, but did not document what occurred while V4 was on break. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/04/25 at 3:45 pm V2, Director of Nursing (DON) confirmed R1's documentation as follows: V2, DON stated The nurse (V4, Registered Nurse) was off the unit for a break at the time of (R1's) fall (10/22/25). When (V4, Registered Nurse) returned, she did the only documentation (fall 10/22/25). I should have written the note, since I was the nurse at the time (while V4 was on a break). I see the CNA's (V8, Certified Nursing Assistant) statement on the investigation says (R1) was seated on the side of her bed. That is not accurate. (R1) was laying at the foot of her bed, before the fall. 3). R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a Brief Interview of Mental Status score of 12 out of a possible 15 indicating moderate cognitive impairment. Uses a walker and a wheelchair. There is no side rail/enabler documented on the MDS. R1's admission assessment dated [DATE] does not document R1 had a side rail/enabler. R1's Fall Risk Assessment on admission, dated 9/8/25 documents R1 is at a moderated risk for falls with a score of 40. R1's Current Care Plan documents the following: R1) has limited physical mobility r/t (related /to) left hip fracture. (R1) will demonstrate the appropriate use of enabler bars to increase mobility through the review date. Date Initiated: 09/09/2025. R1's Device Evaluation dated 10/27/25 upon readmission from the hospital to the facility does not document R1 uses an enabler side rail bars. On 11/04/25 at 9:55 am R1 was lying in a low bed. R1's low bed that did not have enabler side rails attached. R1 had a facial bruise under her left eye and stated the bruise was caused by a recent fall from her bed (10/22/25). R1 rubbed her fingers over the bridge of her nose and said she has a nasal fracture from the same fall. On 11/5/25 at 11:00 am V2, Director of Nursing (DON) reviewed R1's care plan above that was initiated on 09/09/25. V2 stated (R1) has never had enabler side rails for bed mobility. That is an error. I have her enabler assessment, as you can see, she does not have any enablers for bed mobility. (R1) therapies notes reflect the same (confirmed). The Care Plan Coordinator (V18) must have added the enabler intervention in error. On 11/5/25 at 11:05 am V18, Care Plan Coordinator/ Minimum Data Set Coordinator stated I (V18) had added the bed enabler rails to (R1's) care plan in error. (R1) did not have the enabler rails. That is a documentation error and I fixed the care plan. I work in another facility and the enablers are standard intervention for a resident that has been admitted post femur fracture. That is my guess, as to why I put that. The facility policy Medical Records dated 01/15/25 documents the following: POLICY STATEMENT:The organization must ensure that all members of the healthcare team have access to accurate and timely documentation regarding the resident's/client's overall physical, mental and psychosocial status. A medical record that is maintained in accordance with laws, regulations and professional standards of practice also verifies the organization's bills for items and services. In implementing this policy, the following shall apply.1. Each team member and agent must comply with the following requirements:A. Maintain sufficient documentation in the medical record to support the resident's/client's diagnosis, justify the items and services rendered to the resident/client, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document the course of treatment and results, and promote the continuity of the resident's/client's care. The facility Falls Prevention and Post-Falls Management dated 9/06/24 documents the following: Documentation:When a resident falls, the following information should be recorded in the resident's medical record:1. The condition in which the resident was found (e.g., resident found lying on the floor betweenbed and chair).2. Assessment data, including vital signs and any obvious injuries.3. Interventions, first aid, or treatment administered.4. Notification of the physician and family, as indicated.5. Completion of a falls risk assessment.6. Appropriate interventions taken to prevent future falls.7. The signature and title of the person recording the data