STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home for the Aged	800 West Oakton Street Arlington Hts, IL 60004

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to ensure continuity of medications for a resident being discharged to home. This applies to 1 of 3 residents (R1) reviewed for discharge planning in the sample of 3. The findings include: R1's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include metabolic encephalopathy (brain damage), acute kidney failure, diabetes type II, need for assistance, difficulty in walking, weakness, and depression. R1's 4/8/24 progress note from 8:03 PM showed, R1 was discharged home and .discharge instruction handed over to the POA. (Power of Attorney) On 4/16/24 at 2:14 PM, V4 R1's POA/Daughter stated she is the POA and her sister V13 R1's Daughter was the family representative at the facility for R1's discharge. V4 stated she had been told by the facility R1 would be sent home with any medications that remained, which would be approximately two or three days. V4 said, at some point during R1's stay, she was told R1 would be discharged home with whatever medication remained at the facility, which would be 2 to 3 days worth of medications. V4 said R1 was not discharged home with any medications. V4 said she then went to R1's pharmacy to pick up his daily medications and they were not available. V4 stated the pharmacy took R1's discharge medication list and they reached out to R1's primary care doctor for refills. V4 stated the refill process took 2 to 3 days. V4 said R1 is an insulin diabetic; however, she was able to find R1's insulin and a few of his other medications. V4 said the medications, which were not available, were atorvastatin (high cholesterol medication), gabapentin (pain pill), glipizide (diabetes medication), metoprolol (high blood pressure medication), and citalopram (depression medication). V4 said at no time during the several discharge meetings, did the facility discuss his medications or how the medications would be continued at home. R1's April 2024 Medication Administration Record (MAR) showed, on April 8, 2024, R1 was taking daily gabapentin, atorvastatin, citalopram, glipizide, and metoprolol. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. Building B. Wing	04/16/2024

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 1:53 PM, V9 Licensed Practical Nurse (LPN) stated she did not give R1's family any medications when he went home. V9 stated the discharge medication list was given to V13 as R1 was being discharged . V9 stated the facility recently changed pharmacies and the previous pharmacy provided pill packs, which contained all the residents' medications in a single pouch. V9 said the facility would only keep 3 days of the packs on hand at a time and the remainder would be sent home with the resident on discharge. V9 stated the new pharmacy sends punch cards which are not sent with the residents on discharge. V9 stated she did not check with the family to ensure they had sufficient medications prior to discharging R1 home. V9 stated she received a call from R1's family stating they did not have any medication for R1. V9 stated, I told her I had done everything I needed to do, and I had given her all the paperwork. On 4/16/24 at 2:35 PM, V2 Director of Nursing (DON) stated she had worked at the facility for one month and the change in pharmacies happened shortly after her arrival. V2 stated if a resident or family stated they did not have any medications at home she would send some with the resident. On 4/16/24 at 2:35 PM, V3 Assistant DON stated the discharging nurse has the responsibility to ensure a resident has a supply of medications at home or prescriptions in hand prior to discharge. V3 said if a family stated they did not have medications at home the nurse should contact the physician and the provider can the send electronic scripts to the pharmacy. V3 said it was the policy, with the previous pharmacy, to send all pill packs home with the resident, which would be a couple of days' worth of medications. V3 stated the facility does not yet have a policy regarding discharge medications for the new pharmacy. V3 stated R1 was in the facility during the change in pharmacies and said it is likely the family was told they would be sent home with medications. V3 stated medications will be discussed with the family at care plan meetings by nursing staff. V3 said the importance of continuing medications after discharge is to ensure adequate treatment of residents' medical conditions. R1's 3/5/24, 3/13/24, 3/26/24, and 4/2/24 care plan meeting notes showed, therapy, social services, and family attended. The meeting attendees did not include nursing. The facility's Discharge Planning and Summary policy (revised 4/16/24) showed, The skilled nursing facility will implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effective transition them to post-discharge care, and the reduction of factors leading to the preventable readmissions. The policy showed, Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.