STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007595	A. BUILDING: _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW LUTHERAN HOME	403 NORTH FOURTH STREET DANFORTH, IL 60930

(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
S 000	Initial Comments Facility Reported Incident of 4/6/24/IL172096	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

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S9999	Continued From page 1	S9999		

comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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S9999	Continued From page 2	S9999		

These Requirements were not met evidenced by:

Based on interview and record review, the facility failed to provide safe and effective supervision of R1 during a transfer to prevent a traumatic fall. This failure resulted in R1 falling from a mechanical lift to the floor resulting in a hip fracture requiring emergency medical treatment and surgical repair at the hospital. R1 is one of four residents reviewed for accidents in the sample of four.

Findings include:

R1's medical diagnosis list (4/25/2024) documents R1's diagnoses include: Muscle Weakness, Paraplegia, History of Cerebral Infarction (partial brain tissue death due to disruption in blood flow), Osteoarthritis, Presence of Artificial Knee Joint, Apraxia (neurological disorder causing difficulty with skilled movements even when a person has the ability and desire to do them), Dementia, Major Depression Disorder, and Anxiety Disorder.

R1's quarterly assessment (2/6/2024) documents R1 has severely impaired cognition, upper and lower extremity impairment limiting range of motion, and is completely dependent on staff for all activities of daily living. The same record documents R1 requires staff assistance to transfer from a chair to a bed.

The facility Incident Report and Investigation (4/7/2024) documents V3 (Certified Nurse Aide) and V4 (Certified Nurse Aide) were transferring R1 from R1's reclining chair to R1's bed on 4/6/2024 using a sling and mechanical lift. The report further documents when V3 lifted R1's

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legs, one of the four main straps attaching the sling to the lift slipped free from the lift causing R1 to fall abruptly to the ground striking R1's left hip onto the metal frame of the lift. The same report documents upon assessment, R1's left leg was externally rotated and shortened after the fall and R1 was sent to the hospital emergency department for evaluation and treatment and subsequently was admitted to the hospital for a hip fracture and received surgery on 4/7/2024.

The hospital Emergency Department report (4/6/2024) documents R1 presented to the department after a fall from a lift in the nursing home for evaluation of left hip pain and a head injury (hematoma) and received fentanyl (narcotic medication used to treat severe pain) while in the emergency department. The same record documents R1 was diagnosed with a hip fracture and received orthopedic surgery on 4/7/2024.

On 4/26/2024 at 11:50 AM, V3 reported, "(R1) was kinda shocked at first (after falling from the lift to the ground) then started yelling in pain. (The) EMT (Emergency Medical Technicians) gave (R1) Fentanyl (narcotic medication used to treat severe pain) and (R1) was still screaming afterwards and they were wondering if (R1) was just scared." V3 reported R1 hit R1's head on the floor during the fall and R1 is still experiencing pain when staff move R1's leg.

On 4/26/2024 at 1:08 PM, V4 reported V4 and V3 had positioned R1 in the lift sling and R1 had been elevated into the air above R1's chair and when V3 adjusted R1's legs, the top left sling loop attached to the lift became free and R1 fell to the ground. V4 reported R1 continued to yell out in pain after falling from the lift to the ground. V4 reported attending a facility in-service after R1's

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S9999	Continued From page 4 fall where facility staff were instructed on making sure slings are attached properly when using mechanical lifts to transfer residents. R1's Order sheet (4/26/2024) documents R1 was ordered tramadol (narcotic medication used to treat moderate to severe pain) and daily surgical wound antiseptic treatment upon returning to the nursing home after R1's fall on 4/6/2024. R1's Care Plan (4/26/2024) documents R1 is at risk for falls and was revised on 4/8/2024 with the new fall intervention "Staff education on (mechanical lift) use." (A)	S9999		