STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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 03/13/25/IL188525	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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
S9999	Continued From page 1	S9999		

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.

These requirements were not met as evidence by:

Based on interview and record review the facility failed to follow implemented fall interventions for one of three (R1) residents reviewed for accidents in a sample of three. This failure resulted in R1 sustaining a fracture of the distal left radius.

This past non-compliance occurred between 03/13/25 and 03/17/25.

Findings include:

R1's Resident Face Sheet documents an admission date of 12/06/23 with diagnoses including: fracture of other parts of pelvis, initial encounter for closed fracture, Crohn's disease of small intestine with intestinal obstruction, sequelae of cerebral infarction, generalized abdominal pain, gastrointestinal hemorrhage, partial intestinal obstruction, pyridoxine deficiency, vitamin D deficiency, major depressive disorder, chronic pain, macular degeneration, and weakness. R1's Minimum Data Set (MDS) dated 02/07/25 documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R1 is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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
S9999	Continued From page 2	S9999		

cognitively intact. The same MDS documents that R1 requires substantial/ maximal assistance for lying to sitting on side of the bed and sit to stand transfers.

R1's current Care Plan documents a problem area starting 02/07/25 of falls with an intervention of: motion alarm to bed and sensor pad to recliner to alert staff of self-transfers dated 03/14/25.

On 03/26/25 at 2:20 PM, R1was observed lying in bed with a wrist brace on her left wrist. R1's motion alarm was in place and was turned on. R1 stated she fell and hurt her wrist. R1 said she was reaching for something and fell. R1 said it doesn't hurt too bad.

On 03/27/25 at 10:30 AM, R1 was observed sitting in her wheelchair with her left wrist in a brace in the dining room.

R1's Nurse's Note dated 03/13/25 at 5:00 PM documents: CNA's (Certified Nurse Aides) noted resd (resident) sitting on the floor by the bed. Resident had tried to get up to go the BRM (bathroom) incontinent BM (bowel movement), alert/confused. R1 c/o (complains of) pain to left wrist/hand, mild edema noted with no discoloration at this time. Flexing the wrist causes pain and tender to the touch. There is redness noted to left knee. Moving all other extremities with pain. R1 is able to bear weight on legs with pain. No other signs of injury and did not hit her head. R1's bed was in the low position. V6 (Medical Doctor) was notified by phone. An x-ray for the left wrist was ordered.

R1's Nurse's Notes dated 03/13/25 at 8:00 PM documents (company name) here and x-ray

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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
S9999	Continued From page 3	S9999		

completed.

R1's Nurse's Note dated 3/14/25 at 4:29 AM, documents the left wrist x-ray results were sent to the MD (Medical Doctor) and documents "Impression: apparent nonarticular fracture of the distal left radius.

R1's Post Fall Investigation dated 03/14/25 documents a fall on 03/13/25 at 4:00 PM with the questions "what mechanical devises were in use?" with personal alarm checked "yes", "was the mechanical device in good repair?" with "no" checked, and "it was not turned on- motion alarm on bed" was written in next to the "no". The section titled "Summary" documents: "action plan (s)/intervention etc. if warranted:" documents that staff were re-educated to turn on R1's motion alarm while she's in bed and not to close R1's room door while R1 is in room due to safety concerns. The same investigation documents factors contributing to the fall of: R1 has a history of falls and requires assistance with transfers, R1 attempted to self-transfer and has poor safety awareness, impaired vision, unsteady gait, and did not utilize the call light. R1's motion alarm was on the bed and was not turned on and her room door was closed.

R1's Resident Incident Report dated 03/13/25 at 4:00 PM documents: "did resident have a personal alarm?" with 'yes' circled and motion alarm written in next to the answer; "if yes, was alarm sounding? " with 'no' circled; "if no, why not?" with "wasn't on" written in. "Name and title of witness'/employees that witnessed the incident or was the first staff to come upon incident:" with V8 and V9 (Certified Nurse aides) names written in. The section titled, "type of injury:" documents: with swelling checked and "where are injuries"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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
S9999	Continued From page 4	S9999		

with left hand /wrist written in. "Does the resident have some kind of personal alarm?" with 'yes' checked, "if yes, was it sounding?" with 'no' being checked, "If no, why not?" with 'was not in place' written in.

On 03/27/25 at 11:07 AM, V8 (CNA) stated, she was working the hall when R1 fell, she did not see her fall, she did not hear the alarm going off. The alarm was not turned on, it must have just been missed by accident.

On 03/27/25 at 12:11 PM, V4 (Registered Nurse) stated R1 did have a motion alarm, if she is in bed the alarm should be turned on. R1 is very unsteady and thinks she can get up and walk on her own. R1 now has a pull alarm also. V4 said after R1 fell, all the staff were re-educated on assuring that motion alarms are turned on when residents are put to bed.

On 03/27/25 at 12:18 PM, V5 (CNA) stated R1 does have a motion alarm, she had it prior to her fall. V5 said if residents have motion alarms, they should make sure they are turned on when they are in bed. V5 said after R1 fell all the staff were re-educated on making sure alarms are turned on and in place when residents are in bed.

On 03/27/25 at 12:35 PM, V7 (Care Plan Coordinator) stated R1 had a motion alarm prior to her falling and injuring her wrist on 03/13/25. After the fall, V7 added the pull alarm, to leave R1's door open if she is in her room, and staff were re-educated to make sure the motion alarms are turned on if residents are in bed.

On 03/27/25 at 12:50 PM, V1 (Administrator) stated that prior to R1 falling on 03/13/25, R1 had a motion alarm and the alarm was not turned on.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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
S9999	Continued From page 5	S9999		

V1 said the alarm was just missed when the CNA assisted R1 to bed. V1 said the alarm will not prevent her from falling but it could alert them to get to her immediately and hopefully prevent her from falling that way and it was an intervention they had in place for R1 and it should have been on. V1 said all staff were educated after R1's fall to make sure all alarms are turned on when residents are assisted to bed. The staff had a QA meeting to discuss the fall, reasoning behind the fall, and methods to prevent the occurrence from happening again in the future. The staff are checking alarms to make sure they are in place and motion alarms are turned on.

The undated facility policy titled, "Safety Alarm Policy" documents under "Purpose" to "monitor movement of residents that have a high risk for falls and alert staff when a resident may be leaving a bed, a chair or other designated location."

Prior to the survey date, the facility took the following actions to correct the non-compliance:

1. A Quality Assurance and Performance Improvement meeting was held on 03/17/25. In attendance - V1, V2 (Director of Nursing/DON), V10 (Social Service Director), V11 (Human Resources),V12 (Activities Director), V13 (Maintenance Director), and V15 (Care Plan Coordinator).

2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected.

3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005599	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	702 WEST CUMBERLAND ALTAMONT, IL 62411

(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
S9999	Continued From page 6 and V2 (DON) provided in-service to nursing staff to ensure personal alarms and motion alarms are turned on after putting residents to bed. Completed on 03/17/25. All motion alarms were checked and in the on position when residents were in bed. 4. Plan to monitor performance to ensure solutions are sustained: motion alarm audits to be conducted weekly x 4 weeks by V2. The first complete facility audit was completed on 03/14/25. (B)	S9999		