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 05/14/2025

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PRAIRIEVIEW LUTHERAN HOME	403 NORTH FOURTH STREET DANFORTH, IL 60930

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S 000	Initial Comments Investigation to Facility Reported Incident of 4/3/25/IL191019	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	S9999		

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resident to meet the total nursing and personal care needs of the resident.
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 EVIDENCED BY:

Based on interview and record review, the facility failed to identify an electric lift chair as a fall hazard, develop and implement post fall interventions, and thoroughly investigate falls for one of three (R1) reviewed for falls in the sample list of three. This failure resulted in R1 falling and sustaining a left femoral neck fracture requiring surgical repair.

Findings include:

R1's Minimum Data Set dated 2/4/25 documents R1 had severe cognitive impairment and required substantial/maximal assistance from staff when moving from sitting to standing, for chair/bed transfers, and when walking. R1's Fall Risk Assessment dated 2/4/25 documents R1 was at high risk for falling.

R1's Care Plan dated 9/15/22 documents R1 was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, and vision/hearing problems. Interventions included silent recliner alarm for poor safety

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awareness (7/31/23), check function and placement of alarm every shift, nonskid mat in recliner (9/5/23) and transfer/ambulate with standby assist, gait belt and four wheeled walker.

R1's Nursing Note dated 4/11/2024 at 11:25 PM documents nurse and Certified Nursing Assistant (CNA) entered R1's room to find R1 sitting on the floor leaning up against the heater in front of the recliner that was in a forward tilt position. R1 was unable to recall how she fell. R1 was sitting in the recliner prior to the fall. R1's Interdisciplinary Team (IDT) Note dated 4/12/2024 at 12:31 PM documents the IDT met to review R1's unwitnessed fall. R1 recently tested positive for COVID-19 with weakness likely. Physical Therapy to evaluate and treat as ordered. R1's Therapy Initiation dated 4/15/24 documents R1's family declined therapy. There are no other documented post fall interventions for this fall in R1's medical record.

R1's Nursing Note dated 4/3/2025 at 2:23 PM documents R1 had an unwitnessed fall in her room while attempting to self transfer. R1's call light was within reach. R1 acquired a hematoma (bruising/swelling) to the left side of her head behind her ear and a skin tear to the left thumb. R1 was transferred to the local hospital.

The Incident Investigation/Interview Form dated 4/8/25, completed by V5 CNA, documents V5 passed by R1's room and saw R1 on the floor in front of R1's electric recliner/lift chair, which was "all the way up." R1's call light was not on. This form does not document a malfunction with R1's chair alarm. The undated Incident Investigation/Interview Form, completed by V9 LPN documents V5 CNA alerted nurse to R1 being on the floor. R1 was on the floor in front of

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the recliner, the call light was within reach, and R1 was sleeping in the recliner prior to the fall. The Incident Investigation/Interview Form dated 4/3/25, completed by V10 CNA, documents V10 did not witness R1's fall and does not include any additional information. The facility's final report of R1's 4/3/25 fall documents was on 4/3/25 at 2:00 PM. R1 was found on the floor in front of her recliner, and R1 was transferred to the hospital. R1's left hip computed tomography showed a nondisplaced left femoral neck fracture. Surgery was completed on 4/4/25, and the hospital notified the facility on 4/6/25 that R1 passed away. R1's hospital discharge summary documents likely etiology is acute cardiopulmonary arrest given her advanced age and underlying heart disease. This final report does not identify the root cause of R1's fall or any post fall interventions. There is no documentation that the pressure alarm malfunctioned, that the facility identified the lift chair to be a safety/fall hazard, or if a nonskid mat was in R1's recliner.

R1's Hospital History and Physical dated 4/3/25 documents R1 admitted after a fall, R1 was found to having bruising to the left hip and radiograph imaging showed a left femoral neck fracture. R1's surgical consult note dated 4/4/25 documents R1 initially presented with left hip pain post fall and shortened/externally rotated left leg with bruising. A computed tomography scan noted a nondisplaced valgus-impacted femoral neck fracture. R1's Operative Note dated 4/4/25 documents R1 received open reduction internal fixation surgical repair of the left femur fracture.

On 5/12/25 at 10:39 AM V5 CNA stated V5 walked past R1's room and saw R1 lying on the floor. V5 stated R1's chair pressure alarm was not plugged into the call light box, so the call light

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did not activate like it was suppose to. V5 stated R1 used an electric lift chair recliner and R1 had a history of using the lift chair remote, so we would try to keep it out of R1's reach. At the time of the fall on 4/3/25, R1's lift chair was in the highest elevated position with the seat all of the way up and the controls were dangling along the side of the chair within R1's reach. V5 was asked what could have been done to prevent the fall. V5 stated making sure all the cords for the alarm were plugged in. At 11:31 AM V5 stated R1 used a nonskid mat in her recliner and V5 was not for sure but thinks the mat was in place when R1 fell.

On 5/12/25 at 11:06 AM V10 CNA stated V10 was assigned to R1's hall on 4/3/25. V10 stated R1's fall had something to do with R1's alarm not sounding. V10 confirmed V10 had transferred R1 into the electric lift chair/recliner after lunch. V10 was unsure how often chair alarms should be checked for functioning. V10 stated silenced alarms do not sound, it triggers the call light indicated with a certain color for alarms. V10 stated the sensor pad cord connects into the call light box on the wall of the room. V10 was unsure if R1's sensor alarm was connected to the call light box when V10 transferred R1 on 4/3/25. V10 described R1 as confusing, no ability to recall or retain information and required heavy assistance from staff for transfers. V10 stated V10 was told that R1 has a history of attempting to self transfer and V10 was unsure where she had placed R1's chair remote. V10 was asked what could have been done to prevent the fall. V10 stated checking the alarms, but the alarm doesn't trigger until after the resident has already fallen. At 11:27 AM V10 stated V10 used a nonskid mat in the lift chair, but was unsure if it was in place during R1's 4/3/25 fall.

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On 5/12/25 at 11:35 AM V8 Director of Rehab stated R1 had not been on therapy caseload within the last year. V8 stated R1 had a prior fall out of the recliner and was suppose to have therapy at that time, but R1's family declined.

On 5/12/25 at 11:45 AM V12 Licensed Practical Nurse stated R1 was confused and had a history of prior fall from R1's electric lift chair/recliner, which is why R1 used an alarm in her chair.

On 5/12/25 at 11:54 AM V2 Director of Nursing stated therapy was R1's post fall intervention for 4/11/24 fall. V2 confirmed all of R1's 4/3/25 fall investigation documentation was provided. V2 stated the root cause of was R1 attempted to self transfer. V2 stated the CNAs on the floor that day were interviewed regarding the fall and per V5, R1's chair alarm was not working. V2 confirmed nonskid mat and silenced chair alarms were current fall interventions for R1, and information regarding these interventions were not documented as part of R1's fall investigation. V2 confirmed the lift chair was not identified to be a contributing factor in R1's falls. V2 stated the facility does not do any kind of assessment for the use of electronic lift chairs. V1 Administrator and V2 confirmed the facility does not have a policy regarding the use of these chairs. On 5/14/25 at 9:01 AM V2 confirmed R1's family declined therapy, the post fall intervention for R1's 4/11/24 fall. At 9:09 AM V2 stated there were no other interventions that were implemented for R1's 4/11/24 fall.

On 5/12/25 between 2:11 PM and 2:25 PM V16, R1's Physician, confirmed R1's fall was the cause of R1's left femur fracture.

The facility's undated Managing Falls and Fall

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S9999	Continued From page 6 Risk policy documents staff will implement a resident-centered fall prevention plan to reduce fall risk factors for resident's at risk for falls or with a history of falls. This policy documents staff will monitor and document response to fall interventions, if the resident continues to fall then staff will re-evaluate whether the intervention remains appropriate or if change is needed. This policy documents the physician will help staff reconsider possible causes that many not have been identified. (A)	S9999		