| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018044 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/05/2025 |
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| PRAIRIEVIEW LUTHERAN HOME | 403 NORTH FOURTH STREET , DANFORTH, Illinois, 60930 |

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| S0000 | Initial Comments<br><br>Complaint Investigation 2651783/25610408 | S0000 | | 11/21/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure violations<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210c)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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. Restorative measures shall include, at a minimum, the following procedures: | S9999 | | 11/21/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>These Requirements were not met evidenced by:<br><br>Based on interview, and record review the facility failed to assess, monitor, and thoroughly evaluate one resident (R1) for post fall injury and appropriate mode of mechanical lift of four residents reviewed for injury and transfer in a sample list of ten. This failure caused delay of treatment for R1's arterial bleed which required multiple transfusions and emergency surgical repair which eventually led to R1's death.<br><br>Findings include:<br><br>R1's Hospital documentation dated 9/22/25 includes the following diagnoses: Generalized Anxiety Disorder, Major Depression, Alzheimer's Disease, Psychotic Disturbance, Morbid Obesity, Osteoarthritis Right Shoulder, History of Cerebral Vascular Accident with Hemiparesis and Hemiplegia, Ataxia, History of Falls, Bilateral Knee Replacement, Right Rotator Cuff Repair, Anticoagulant Use, and Right Total Hip Replacement.<br><br>R1's Minimum Data Set (MDS) dated 9/10/25 documents R1 was totally dependent on staff for all Activities of Daily Living (ADLs). This MDS documents R1 was severely cognitively impaired.<br><br>R1's Progress Note dated 08/19/2025 at 9:29 AM documents "Staff stated resident (R1) lost her balance walking to the bathroom. Stated she (R1) fell into her wheelchair and fell to the floor on her right side and turned herself to sit on her bottom. Staff stated she did not see her hit her head. Gait belt was in use. Resident was complaining of right hip pain. Full head-to-toe assessment completed. When staff assisted resident off the floor and laid her down on her bed she complained of left hip pain. Family, physician, DON (Director of Nursing) and Unit director notified of fall. Physician ordered two-view x-ray of bilateral hips and pelvis stat. (contracted in house Xray Company) was called for x-ray."<br><br>R1's Progress Note dated 08/19/2025 at 10:15AM documents "Staff notified this nurse that resident (R1) had a bruise to her right ear and jaw line, also bruise to right elbow. Physician, Power of Attorney (POA), | S9999 | | |

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| S9999 | Continued from page 2<br>Director of Nursing (DON), and Unit Director notified."<br><br>R1's Progress Note dated 8/19/2025 at 9:32PM by V18 Restorative Nurse documents "Updated transfer status as follows: Transfers with use of stand lift and two (staff) assistance. Updated the following NURSING REHAB/RESTORATIVE: Transfer Program: (R1) transfers with use of stand lift stand two staff assist PRECAUTIONS: Risk for falls, Shortness of Breath, Fatigues Easily."<br><br>No measurements of the bruise are documented following the 8/19/25 fall and a complete baseline assessment of the injury is not documented. An assessment for safe appropriate use of the sit-to-stand lift is not documented.<br><br>The Weekly Skin Assessments dated 9/1/25, 9/11/25 ,9/12/25, and 9/19/25 make no mention of the progression of the bruise first noted 8/19/25. The Weekly Skin Assessments dated 8/28/25 and 9/4/25 document only "scattered bruising". No sites are documented, and no measurements are documented. The right elbow bruise is only mentioned in the 8/28/25 skin assessment.<br><br>No progress notes are documented assessing the bruising until 9/19/25 at 7:09PM by V15, Licensed Practical Nurse (LPN) "CNAs were putting resident to bed and noted bruising to sternum and under and across right breast and under right arm that matches up with the strap of stand lift. (R1) does have some pain 5/10 and has limited ROM to right arm. V25 Medical Director was notified and was told of bruising and that (R1) also takes blood thinners. (V25) stated that as long as there is no bleeding it's ok just to monitor area. POA (Power of Attorney) and unit director notified."<br><br>On 10/29/25 at 5:00PM, V15 stated "When I called V25, I reminded V25 (R1) was on Apixaban (anticoagulant) but he did not give me an order to hold it. V25 just said monitor and as long as there is not bleeding there are no other orders."<br><br>R1's Progress Note dated 09/22/2025 at 8:52AM documents "This nurse observed more bruising to residents upper left and right chest above ribcage. Resident short of breath with activity. PRN Tylenol given, and resident requested to lay down. (V21) unit director, and V2 DON (Director of Nursing), notified. (V2) requested x-ray to be done. Notified (V25) Medical Director for order. Waiting for reply.<br><br>On 09/22/2025 at 1:02PM, documents "Resident had a | S9999 | | |

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| S9999 | Continued from page 3<br>change of condition from this morning. She (R1) became very pale, shortness of breath, and dry heaves. More bruising was starting to appear from this morning from the sit to stand sling. (V25) notified and agreed to send her to hospital. Resident POA (Power of Attorney) notified agreed to send (R1) to hospital. Ambulance arrived at 1pm and (R1) left facility at 1:05pm.<br>Multiple bruises to R1s right side wrapping around to her mid back, bruising to right arm and into her right armpit. Bruising starting to appear to right upper shoulder by her neck, over left shoulder, and above both ribcages. T 97.4, B/P 114/83, P 143, R 18, 98% on room air. Report given to Emergency Room doctor. Bed hold form went with resident to (local) hospital."<br><br>On 10/29/25 at 9:25 AM, V16 LPN stated it was passed on in morning report on 9/22/25 by V15 that the CNAs had found bruising the night prior while assisting (R1) for bed, and the bruising looked consistent with the stand lift. V16 stated V15 reported there was little bruising to R1's right side, breast and back. V16 stated V16 went in to assess R1 prior to breakfast and the bruise extended midline chest to midback and right armpit down the right arm. V16 stated V16 immediately notified V25 Physician, who said he had already put Eliquis on hold and asked what more V16 wanted him to do. V16 stated V16 asked for a chest x-ray and he (V25) told her (V16) to do what she wanted. V16 stated V16 ordered a portable chest x-ray but before they got here R1's condition changed. V16 stated R1 was regurgitating, dry heaving, and short of breath, and the bruising had grown in size now extending up R1's chest along bra strap. V16 stated V16 notified R1's POA multiple times and they decided to send R1 to the hospital. V16 stated V16 watched the cameras and could see that R1 was playing balloon toss prior to the bruise being found, and R1 had no signs of pain or injury at that time. V16 questioned whether R1 bumped something while playing balloon toss. V16 stated the bruising was consistent with the sit to stand sling and staff were baffled by how the injury could have happened. V16 stated V16 had not observed R1's transfers but knows that it took two to three staff for her sit to stand lift transfers due to prior reports that R1 would not stand fully upright, knees bent and slouched putting weight on R1s armpits. V16 stated R1 had to be close to the object transferring to, such as the toilet, as R1 could not withstand distance to transfer from the toilet to the bed, so R1 had to transfer back to the wheelchair and then use stand lift to put R1 in bed. V16 stated V16 was unsure if R1 had fallen, and no falls had been reported to her. V16 stated V16 speculates that R1 fell forward while using the sit to stand lift but does not know that for sure. | S9999 | | |

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| S9999 | Continued from page 4<br><br>R1's Medication Administration Record dated 9/19/25 documents the 8:00AM dose of Eliquis was administered.<br><br>On 11/3/25 at 10:13AM, V16 stated V16 went into (R1's) room and gave (R1's) medication including the Eliquis before breakfast. (R1) was still in bed then and V16 didn't see the extent of the bruises until the CNA's got (R1) out of bed.<br><br>R1's CAT (Computerized Axial Tomography) report dated 9/22/25 states "Significant soft tissue contusion and a large subcutaneous hematoma extending from lateral aspect of right shoulder into upper arm and right lateral chest wall." R1 was admitted to the hospital on 9/22/25 related to the results of this scan and an order for Interventional Radiology consult was written. Per 9/22/25 hospital record upon arrival R1's Hemoglobin was documented as 5.9 grams per deciliter with the normal range being 11.6 to 15 grams per deciliter. R1 received multiple transfusions and underwent a "two vessel embolization with coils and Gelfoam" to stop the bleeding into R1's chest and arm.<br><br>R1's progress notes document R1 returned to the facility on 9/28/25 at 7:24PM. (R1) was placed on hospice and expired on 10/4/25. R1's death certificate documents R1's cause of death as Metabolic Encephalopathy due to Blood Loss Amenia due to Chest Wall Hematoma. This death Certificate was signed by V25, Medical Director.<br><br>On 10/28/25 at 2:25PM, V26 Interventional Radiologist who performed R1's procedure to stop the arterial bleeding stated "I believe the injury to (R1's) chest wall was consistent with an injury caused by a sit to stand lift. I don't think there is any possibility it was caused by a foam pool noodle. The injury was caused by significant blunt force trauma to R1's chest wall. I think if I were doing a root cause analysis, I would say what could have been done sooner was (R1) could have been sent to the Emergency Room the night before prior to (R1) losing so much blood. I do not believe (R1) would have died quite so soon were it not for the Arterial bleed."<br><br>On 11/4/25 at 1:49PM, V25 was interviewed by phone. V25 stated that if he had known about the extent of R1's bruise he might have held the blood thinner and had R1 sent to emergency room. V25 stated "I did not see the patient." V25 stated if he states to monitor, he expects more than one assessment per 12-hour shift.<br><br>R1's progress noted document R1 was discharged from the | S9999 | | |

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| S9999 | Continued from page 5<br>hospital 9/28/25 at 3:00PM. R1 expired at the facility on hospice services on 10/4/25.<br><br>On 10/29/25 at 8:55 AM, V21 Memory Care Director stated V21 was not working on 9/21/25 and received a message from V15 LPN that night after supper, informing V21 of R1's bruising. V21 was not aware at that time of the extent of the bruising. V21 stated no one had seen anything happen and staff were unsure what caused the bruise. V21 stated V15 said the bruise aligned with the stand lift sling, so V21 assumed that was the cause of R1's bruising. V21 confirmed V15 should have documented a measurement of the bruise. V21 stated that is something we will need to do education on.<br><br>On 11/3/25 at 9:35 AM, V2 DON stated V15 LPN should have checked on R1 once more during the night and re-measured the bruising at that time.<br><br>On 10/28/25 at 4:51 PM, V27 CNA stated R1's bruising was found by V28 and V27 on the evening of 9/21/25. V27 stated V28 had worked the night before and it wasn't there, so something must have happened during the dayshift the day we found it. V27 stated initially R1 was a stand pivot transfer but then she started using the sit to stand lift a few weeks prior to her passing away. V27 stated R1 disliked the stand lift, and would tell us that she was hurting and didn't like the lift. V27 stated R1 would tell us to put her down. V27 stated R1 couldn't stand in the lift for very long, so staff had to move her quickly.<br><br>On 10/28/25 at 4:43 PM, V28 CNA stated V27 and V28 found R1's bruising prior to transferring R1 to bed. V28 stated the bruising was purple, almost black, and extended from R1's neck to the bottom of the abdomen, across from mid chest to right under arm just before the elbow. V28 stated it was a pretty large bruise and V28 had not noticed the bruising when she had previously cared for R1 prior to the evening of 9/21/25.<br><br>On 10/29/25 at 8:15 AM, V30 Housekeeper stated before R1 was sent to the hospital (9/21/25), it was a Sunday morning. V30 stated V30 would often give back rubs and noticed that morning that R1 had purple/red/pink bruising to the right side of her neck/collar bone area, right side of face, and left wrist. V30 stated V30 did not report this to anyone since she is "just a housekeeper." V30 stated an unidentified CNA told her that R1 had fallen out of the stand lift that morning. At 10:08 AM, V30 clarified V30 was off work after 9/7/25 and stated the date previously mentioned must have been during the first week of September or late | S9999 | | |

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| S9999 | Continued from page 6<br>August 2025.<br><br>On 10/29/25 at 12:20 PM, V44 CNA stated R1 transferred with the sit to stand lift and would complain to staff that R1 didn't like it. V44 stated staff had to tell R1 to cooperate and stand up, and sometimes R1 would not cooperate. V44 stated then we would wait for R1 to push herself up, but sometimes R1 would have her butt sticking out, knees bent slightly, and the sling underneath her armpits bearing weight. V44 stated R1 was only able to tolerate standing in the lift for short duration. V44 stated V44 had not mentioned this to any nurses or restorative nurse. V44 stated V44 had only heard that R1 had a bruise on her left side/armpit area following the August fall, but V44 did not see this bruise. V44 stated R1 would complain of R1's side hurting when the stand lift belt was tightened.<br><br>On 10/29/25 at 10:30AM, V18 Restorative Nurse stated R1 was not assessed by therapy to ensure the safety of the sit-to-stand lift. R1 stated "I observed one transfer with (R1) and the sit-to-stand lift. I don't have an assessment to determine when a sit-to-stand or other lift is appropriate and the only documentation I have is an Endurance-Functional Ability Assessment." This assessment was provided and does not include safety assessment for sit-to-stand lift.<br><br>On 10/28/25 at 8:13 AM, V20 Physical Therapist stated R1 was last on therapy caseload in 2024. At that time R1 was one or two assist and was walking. R1 was not on therapy after that as she refused whenever they would try to pick her up. V20 did not work with R1 on sit to stand lift transfers.<br><br>On 10/29/25 at 1:51 PM, V2 DON stated V2 had nothing to provide that therapy assessed/evaluated R1's use of sit to stand lift.<br><br>Facility submitted abatement plan at 9:26 PM on 11/3/25. Abatement plan returned to the facility at 10:21 AM on 11/4/25 for revision. Received revised version at 11:53 AM. Returned for revisions 12:13 PM. Received final revised version 12:32 PM. Notified facility that abatement plan was accepted 1:08 PM.<br><br>(A) | S9999 | | |