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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145380	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Care Center	702 West Cumberland Altamont, IL 62411

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to ensure a resident was free from staff to resident verbal abuse for one (R1) of five residents reviewed for abuse in the sample of five. Findings include: R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Major Depressive Disorder, Hypertension, and Cerebral Infarction by history. R1's Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status Score of 14, indicating R1 has minimal deficits in cognition. R1's Care Plan dated 9/6/24 documented problem areas, (R1) may display short-term and long-term memory problems. R1's Nurses Notes, all authored by V7, Licensed Practical Nurse (LPN), documented the following: 11/8/24, 5:00pm, This nurse was called down to (R1's) room for a complaint of a skin tear. When I arrived I noted a large skin tear (to the) left forearm with large amount of bleeding. Pressure was applied to get bleeding to slow down. (V3, Certified Nursing Assistant/CNA) stated resident was in bedside table and he pulled resident wheelchair back and resident got a skin tear from arm being between bed and bedside table. Resident states, 'He grabbed my arm.' Noticing such a large skin tear, asked other nurse to look at it since it didn't look like it could be approximated with (trade name wound closure strips).Decision was made to send to ER (emergency room) for treatment. Notified (V10, Physician/Medical Director) per fax. Called (V5, R1's Power of Attorney) and made aware. Called and gave report to ER. Called (local medical transport company) for transportation. Resident was confused earlier, asking this nurse to take him to get his truck from his wife. (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Abuse Investigation Witness Statement dated 11/8/24 at 7:45pm, signed by V3, CNA, stated, Upon entering (R1's) room, he was reaching down trying to pick something up off the floor. Trying to move the wheelchair to pick up what he was after and I noticed the chair was wedged between the bed, nightstand, and recliner. I lifted the rear of the wheelchair to get him unstuck. I was able to get him turned around and that's when I noticed the injury. Freaking out over the size of it. I hurried to find another CNA to grab a nurse. I found (V6, CNA) in another resident's room and asked her to get (V7). I went back to (R1's) room and he was starting to mess with the skin tear, with a loud, panicked voice I stated, Stop messing with it, grabbed his hands and rested them on the arms of the wheelchair, slowly and gently. (R1) started to blame me for the injury, saying, 'If you didn't twist my arm, that wouldn't have happened.' I stated, I didn't freaking do it, I didn't grab on your arm til you was messing with the laceration, being accused for a second time of causing it, being flustered and overwhelmed by the size of the skin tear. I also said, I wouldn't be that fu**ing stupid. I would not grab your arm and twist it. I apologized for cursing, it just slipped out due to the overwhelmingness of the situation. (V7 and V6) then arrived and took over. An Abuse Investigation Witness Statement dated 11/8/24 at 8:15pm, signed by V6, stated,(V8, LPN) asked me to take a package to a resident on the North Hall. I was talking to the resident and (V3) came running in and told me to grab (V7) because (R1) had a skin tear. On my way up to the nurses station, I heard (V3) yelling at (R1). (V3) said, 'I didn't fu**ing do it. You fu**ing did it .stupid.' (V7) and I went down to (R1's) room and (V3) said he didn't know what happened. (V3) asked if we needed help and (V7) told him that her and I could handle it. (V3) left the room. (V7) tried to dress the wound but since it was bleeding so much, she decided to send him to the ER. On 11/13/24 at 9:50am, R1 was awake and alert to himself, he could not name the facility, nor the current President. He was able to state it was November 2024 but could not give the date or day of the week. R1 exhibited evidence of significant cognitive slowing, in part evidenced by very delayed verbal responses. The Surveyor asked R1 if any staff at the facility had ever hurt him, and R1 stated, Yes, a few days ago, that guy who works here, with R1 pointing to his left forearm which was bandaged, saying, He twisted it.' R1 was unable to state the name of the staff member, but told the Surveyor to look at the report. R1 stated he does not know why the staff member did this, but the staff member was looking through R1's greeting cards, and R1 told him to stop looking at them, and then he twisted R1's arm. R1 stated he was sent to the ER for treatment and came back to the facility the same night. R1 stated he has not seen the staff member since the event occurred. R1 stated the arm is not painful, and he denied having any lasting emotional effects from the incident. R1 stated he did not recall this staff member yelling at him, or calling him names. On 11/13/24 at 10:45am,V7 corroborated the events of 11/8/24 as outlined above in her Nurses Notes. V7 stated V3 reported that R1 was leaning forward in his wheelchair and V3 was afraid he would fall forward, so V3 pulled the wheelchair backward, with the left forearm making contact with something, causing the skin tear. V7 stated R1 told her that V3 was looking through R1's greeting cards and R1 told him to stop doing it. V7 stated she did not report the allegation of abuse to V1, Administrator, because what V3 said happened made sense, and R1 had been confused earlier in the day. V7 stated she was later told by V1 that V7 should have contacted V1 immediately after the allegation was made. V7 stated staff also received re-education on the Abuse Policy. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:40pm, V3 stated he was working 7am to 7pm on 11/8/24. V3 stated he went into R1's room around 5pm to take him to the dining room, and saw R1, sitting in his wheelchair, wedged between the bed, the nightstand, and the recliner. V3 stated R1 was leaning forward and V3 was afraid he would fall. V3 stated he grabbed the wheelchair and pulled it back. V3 stated there were greeting cards scattered on the floor, and V3 bent over to pick them up. V3 stated R1 then accused V3 of stealing his cards, and at that point V3 saw a large skin tear on R1's left forearm. V3 stated he picked up R1's arm to examine it, and R1 said, You twisted my arm. V3 stated he went to get help, and when he came back, R1 was messing with the skin tear which was then bleeding profusely. V3 stated he told R1 not to touch the area. V3 stated, I get freaked out when I see a lot of blood. (R1) kept saying I twisted his arm, and I was arguing with him, and I said,' 'I'm not that fu**ing stupid, to grab and twist your arm ' V3 stated he did not yell at R1 or call him stupid. V3 stated at that point, V7 came in to deal with the wound, so he went to take care of other residents. V3 stated he worked the remainder of his shift and left at 7:00pm. V3 stated R1 was sent to ER and V3 had no further contact with him. V3 stated he had no previous issues with R1 prior to this event. On 11/13/24 at 1:20pm, V6 corroborated the details of 11/8/24 as per her interview statement as referenced above. V6 stated within minutes of hearing V3 yell at R1, she told V8, LPN, about it, and, (V8) said she would investigate it. On 11/14/24 at 10:25am, V1 confirmed she is the facility's Abuse Coordinator. V1 stated she found out about the abuse allegation on 11/8/24 in the evening when V12, Director of Administrative Services, called her to say the police had called the facility, wanting to come interview residents and staff about an abuse allegation. V1 stated she then began an immediate abuse investigation. V1 stated after the interviews and the incident re-creation, the physical abuse allegation will be unfounded. V1 stated since V3 admitted to cursing in front of R1, which is a violation of the facility's Abuse Policy, verbal abuse will be substantiated and V3 will be terminated from employment. The facility's Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, Facility Abuse Management Policy and Procedures dated November 2024 stated, (The facility) affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of their personal property, corporal punishment and/or involuntary seclusion. (The facility) therefore; prohibits abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, voluntary seclusion, use of physical or chemical restraints not required to treat the resident's medical symptoms, and has attempted to establish a resident sensitive and resident secure environment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to immediately report an allegation of staff to resident verbal and physical abuse to the facility's Abuse Coordinator for one resident (R1) of five residents reviewed for abuse in the sample of five. Findings include: R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Major Depressive Disorder, Hypertension, and Cerebral Infarction by history. R1's Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status Score of 14, indicating R1 has minimal deficits in cognition. R1's Care Plan dated 9/6/24 documented problem areas, (R1) may display short-term and long-term memory problems, (R1) has potential for skin breakdown. At present is on aspirin therapy which may increase his potential for bruising and bleeding, and (R1 has) potential for falls related to unsteady gait, weakness and fatigue. (R1 has a) history of falls. (R1 is) alert and oriented with occasional confusion. R1's Nurses Notes, all authored by V7, Licensed Practical Nurse (LPN), documented the following: 11/8/24, 5:00pm, This nurse was called down to (R1's) room for a complaint of a skin tear. When I arrived I noted a large skin tear (to the) left forearm with large amount of bleeding. Pressure was applied to get bleeding to slow down. (V3, Certified Nursing Assistant/CNA) stated resident was in bedside table and he pulled resident wheelchair back and resident got a skin tear from arm being between bed and bedside table. Resident states, 'He grabbed my arm.' Noticing such a large skin tear, asked other nurse to look at it since it didn't look like it could be approximated with (trade name wound closure strips).Decision was made to send to ER for treatment. Notified (V10, Physician/Medical Director) per fax. Called (V5, R1's Power of Attorney) and made aware. Called and gave report to ER. Called (local medical transport company) for transportation. Resident was confused earlier, asking this nurse to take him to get his truck from his wife. 11/8/24, no time noted: Pressure dressing applied to slow bleeding. 11/8/24, 5:30pm: (Transport company) here to transfer to ER. 11/8/24,10:30pm:Returned to facility via facility van. Complaining of right knee pain. Tylenol given. Eating evening meal. Alert. (V5) here. (V5) states (trade name wound closure strips) were applied to the area with (trade name gauze bandage) wrap (at the ER). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Emergency Department Note dated 11/8/24 documented, (R1) is a [AGE] year old male with a past history of Constipation, Cerebral Vascular Accident, Depression, Gastroesophageal Reflux Disease, Hypertension, Serum Lipids high, and Weakness who presents for evaluation of skin tear to left arm. Patient reports that Aid was in room going through his birthday cards when patient told him it was then out of his business to be in his birthday cards. The Aid reached for patient's arm and jerked it away in a twisting manner, causing a skin tear. Medical decision making: [AGE] year old who presents with a skin tear. X-ray shows no acute fractures. Rest, Tylenol, dressing changes twice a day. Return if worsening symptoms. No questions or concerns at this time. A (State Agency) Facility Reported Incident dated 11/8/24 documented,(R1): Date of Occurrence: 11/8/24 at 5:00pm. Large laceration-skin tear. Left forearm, greater than 5cm (centimeters). Bleeding. Sent resident to ER (emergency room) for sutures. Met with (local) Police Officer this evening around 7:30pm. He informed me he was called to the hospital related to (R1), reporting a staff member twisting his arm. An Abuse Investigation Witness Statement dated 11/8/24 at 7:45pm, signed by V3, CNA, stated, Upon entering (R1's) room, he was reaching down trying to pick something up off the floor. Trying to move the wheelchair to pick up what he was after and I noticed the chair was wedged between the bed, nightstand, and recliner. I lifted the rear of the wheelchair to get him unstuck. I was able to get him turned around and that's when I noticed the injury. Freaking out over the size of it. I hurried to find another CNA to grab a nurse. I found (V6, CNA) in another resident's room and asked her to get (V7 Licensed Practical Nurse/LPN). I went back to (R1's) room and he was starting to mess with the skin tear, with a loud, panicked voice I stated, Stop messing with it, grabbed his hands and rested them on the arms of the wheelchair, slowly and gently. (R1) started to blame me for the injury, saying, 'If you didn't twist my arm, that wouldn't have happened.' I stated, I didn't freaking do it, I didn't grab on your arm til you was messing with the laceration, being accused for a second time of causing it, being flustered and overwhelmed by the size of the skin tear. I also said, I wouldn't be that fu**ing stupid. I would not grab your arm and twist it. I apologized for cursing, it just slipped out due to the overwhelmingness of the situation. (V7 and V6) then arrived and took over. An Abuse Investigation Witness Statement dated 11/8/24 at 8:15pm, signed by V6, stated,(V8, LPN) asked me to take a package to a resident on the North Hall. I was talking to the resident and (V3) came running in and told me to grab (V7) because (R1) had a skin tear. On my way up to the nurses station, I heard (V3) yelling at (R1). (V3) said, 'I didn't fu**ing do it. You fu**ing did it .stupid.' (V7) and I went down to (R1's) room and (V3) said he didn't know what happened. (V3) asked if we needed help and (V7) told him that her and I could handle it. (V3) left the room. (V7) tried to dress the wound but since it was bleeding so much, she decided to send him to the ER. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 9:50am, R1 was awake and alert to himself, he could not name the facility, nor the current President. He was able to state it was November 2024 but could not give the date or day of the week. R1 exhibited evidence of significant cognitive slowing, in part evidenced by very delayed verbal responses. The Surveyor asked R1 if any staff at the facility had ever hurt him, and R1 stated, Yes, a few days ago, that guy who works here, with R1 pointing to his left forearm which was bandaged, saying, He twisted it.' R1 was unable to state the name of the staff member, but told the Surveyor to, 'Look at the report.' R1 stated he does not know why the staff member did this, but the staff member was looking through R1's greeting cards, and R1 told him to stop looking at them, and then he twisted R1's arm. R1 stated he was sent to the ER for treatment and came back to the facility the same night. R1 stated he has not seen the staff member since the event occurred. R1 stated the arm is not painful, and he denied having any lasting emotional effects from the incident. R1 stated he did not recall this staff member yelling at him, or calling him names. On 11/13/24 at 10:45am, V7 corroborated the events of 11/8/24 as outlined above in her Nurses Notes. V7 stated V3 reported that R1 was leaning forward in his wheelchair and V3 was afraid he would fall forward, so V3 pulled the wheelchair backward, with the left forearm making contact with something, causing the skin tear. V7 stated R1 told her that V3 was looking through R1's greeting cards and R1 told him to stop doing it. V7 stated she did not report the allegation of abuse to V1, Administrator, because what V3 said happened made sense, and R1 had been confused earlier in the day. V7 stated she was later told by V1 that V7 should have contacted V1 immediately after the allegation was made. V7 stated staff also received re-education on the Abuse Policy. On 11/13/24 at 12:40pm, V3 stated he was working 7am to 7pm on 11/8/24. V3 stated he went into R1's room around 5pm to take him to the dining room, and saw R1, sitting in his wheelchair, wedged between the bed, the nightstand, and the recliner. V3 stated R1 was leaning forward and V3 was afraid he would fall. V3 stated he grabbed the wheelchair and pulled it back. V3 stated there were greeting cards scattered on the floor, and V3 bent over to pick them up. V3 stated R1 then accused V3 of stealing his cards, and at that point V3 saw a large skin tear on R1's left forearm. V3 stated he picked up R1's arm to examine it, and R1 said, You twisted my arm. V3 stated he went to get help, and when he came back, R1 was messing with the skin tear which was then bleeding profusely. V3 stated he told R1 not to touch the area. V3 stated, I get freaked out when I see a lot of blood. (R1) kept saying I twisted his arm, and I was arguing with him, and I said,' 'I'm not that fu**ng stupid, to grab and twist your arm ' V3 stated he did not yell at R1 or call him stupid. V3 stated at that point, V7 came in to deal with the wound, so he went to take care of other residents. V3 stated he worked the remainder of his shift and left at 7:00pm. V3 stated R1 was sent to ER and V3 had no further contact with him. V3 stated he had no previous issues with R1 prior to this event. On 11/13/24 at 1:20pm, V6 corroborated the details of 11/8/24 as per her interview statement as referenced above. V6 stated within minutes of hearing V3 yell at R1, she told V8, LPN, about it, and, (V8) said she would investigate it. On 11/13/24 at 1:40pm, V5 stated some time in the evening on 11/8/24, she was notified by V7 that R1 had sustained a skin tear. V5 stated she was then called by an ER nurse, who said that R1 was there, and, They were calling in a report of elder abuse because he said that one of the staff twisted his arm. V5 stated later that evening, V1 had spoken to her and said the facility was starting an abuse investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 2:50pm, V8 stated on 11/8/24 at about 5pm she was alerted by V7 that R1 had a skin tear, and they worked together to assess the wound and control the bleeding. V8 stated R1 told V8, 'He (V3) grabbed my arm. V8 stated V6 reported to V8, 'That she heard (V3) yelling at (R1) but doesn't recall telling (V6) she would investigate it.' V8 confirmed she did not notify the Administrator about the incident. V8 stated after the event, staff were retrained on the Abuse Policy, and V1 told V8 she should have notified V1 immediately of R1's abuse allegation. On 11/14/24 at 9:40am, V2, Director of Nurses, stated R1 has very fragile skin and is prone to skin tears. V2 stated she has heard no complaints from residents or staff about V3, and she has only disciplined V3 for occasional tardiness. V2 stated abuse is to be reported immediately to V1. V2 stated she does not think V7 or V8 violated the abuse policy by not reporting to V1, because they thought the skin tear was an accident, and that R1 was confused when he said V3 hurt him. On 11/14/24 at 10:25am, V1 confirmed she is the facility's Abuse Coordinator. V1 stated she found out about the abuse allegation on 11/8/24 in the evening when V12, Director of Administrative Services, called her to say the police had called the facility, wanting to come interview residents and staff about an abuse allegation. V1 stated she then began an immediate abuse investigation. V1 stated after the interviews and the incident re-creation, the physical abuse allegation will be unfounded. V1 stated since V3 admitted to cursing in front of R1, which is a violation of the facility's Abuse Policy, verbal abuse will be substantiated and V3 will be terminated from employment. V1 stated she did not believe V7 and V8 failed to follow the Abuse Policy by not immediately reporting it to her, because they believed it was an accident and not abuse. The facility's Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, Facility Abuse Management Policy and Procedures dated November 2024 stated, It is the policy of (the facility) to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation Any employee of (the facility) or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator. A), Definitions: Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again (42CFR 483.13b Interpretive Guidelines).