Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	07/26/2024

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 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32619

Based on interview, observation, and record review, the facility failed to supervise a confused resident during toileting for 1 of 2 residents (R32) reviewed for falls in the sample of 25. This failure resulted in R32 falling and sustaining skin tears to the right hand and a laceration to the forehead which required 13 sutures to close.

The findings include:

R32's Face Sheet documented an admitted [DATE] and listed diagnoses including History of Right Femur Fracture with Surgical Repair, Diabetes Type 2, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure (CHF).

R32's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status Score of 8, indicating R32 has moderate deficits in cognition. The same MDS documented that R32 requires partial to moderate assistance for toileting, which is defined as, Helper (staff) does more than half the effort: Helper lifts or holds trunk or limbs and provides more than half the effort.

R32's Fall Risk Assessment documents an assessment completed on 2/14/24 with a score of 18, and assessments completed on 4/19/24 and 7/1/24, each documenting a score of 16, indicating R32 is at high risk for falls. The Fall Risk Assessment document notes a total score of 10 or above represents high risk.

R32's Care Plan with a review date of 7/8/24 documented a problem area, Potential for falls related to unsteady gait, weakness and fatigue. (R32) (was) a new admit to the facility with surgical aftercare from a right femur fracture. (R32) had a fall at home resulting in the fracture. (R32) is alert with forgetfulness, (and) has a diagnosis of Alzheimer's. Transfers with 2 (staff) assist, toe touch weight bearing to right lower extremity, staff propelled wheelchair for long distances. Diagnosis of COPD. Hard of hearing, does not wear hearing aids. Occasionally incontinent of urine and continent of bowel. Does have pain to right lower extremity. (As needed) pain medications. Poor safety awareness. Able to make needs known to staff. This problem area had a corresponding intervention of Supervision when toileting if indicated, which was added to the Care Plan on 5/10/24.

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/24/24 at 11:04 AM, R32 was observed in her room. R32 was alert only to herself. R32 was noted to have a scar of about 1.5 inches in length to her forehead. V5, Licensed Practical Nurse, who was present, stated the scar was from a fall which occurred a few months ago resulting in R32 requiring stitches. R32's Post Fall Investigation dated 3/3/24 at 8:15am documented, Resd. (resident) (attempted) self-transf. (transfer) from commode to bed. Resd. was noted laying on her back between the BRM (bathroom) et (and) bed. Lac. (laceration) to forehead. Sent to ER (emergency room). Under Mental Status of Resident, Confused/disoriented is marked for prior to and following the fall. R32's Emergency Department Note dated 3/3/24 documented, Patient is an [AGE] years (sic) female with a history of Diabetes, Hypertension, A-Fib (Atrial Fibrillation), COPD, Dementia, and CHF. Presents today with complaints of (this) morning she tripped over bedside commode and somehow hit her head and caused some skin tears to her right hand. Under Medical Decision Making it documents Due to the patients age, did do a CT (Computed Tomography) of the head which was negative. The laceration/skin tear to her forehead was a bit wide so did my best to repair as much as we could. Under Lac (laceration) Repair it documents the under laceration details the location is forehead, is 4.5 cm (centimeters) in length, and number of sutures is 13. On 07/25/24 at 11:35am, V6, Certified Nursing Assistant (CNA), stated she was working with R32 the morning of the fall. V6 stated she and V7, CNA, who is now retired, put R32 onto the bedside commode with her call light in reach and told her to push the call light when she was done. V6 stated R32 was wearing non-skid socks. V6 stated 8:00am is the busiest time of the day with most residents needing toileting assistance, so she and V7 both left the room to attend to other residents. V6 stated when she and V7 re-entered the room, R32 was on the floor lying on her back and was bleeding from her forehead. V6 stated R32 stated she was trying to get back into bed and fell . V6 stated she cannot remember if R32's call light was on. V6 stated R32's ability to use the call light is, Hit or miss. V6 stated after the fall, CNA staff were educated not to leave R32 alone while on the toilet or bedside commode. On 7/25/24 at 11:52am, V2, Director of Nurses, stated she was not very familiar with the details of the fall and did not really recall the circumstances. V2 stated she was of the understanding that maybe R32 self-transferred onto the bedside commode and then fell while trying to self-transfer to bed. V2 stated she did recall educating staff to respond to R32's call light in a timely manner. A Fall Prevention Policy and Procedure dated 6/16/23 documented, The purpose of the Fall Prevention and Management Program is to 1. Identify residents at risk for falls. 2. Initiate preventative approaches if needed. 3. provide appropriate strategies and interventions directed to resident, environmental factors, and staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on observation, interview, and record review the facility failed to follow enhanced barrier precautions for 8 of 12 residents (R5, R6, R8, R12, R18, R25, R35 and R41) reviewed for infection control in the sample of 25. The Findings Include: On the initial tour of the facility on 07/23/2024 beginning at 9:25 AM, there was one resident (R21) observed in the facility with signage indicating enhanced barrier precautions. During the tour of the facility R5, R6, R8, R12, R18, R25, and R35 were all observed to have indwelling catheters. On 07/23/2024 a Matrix for Providers (Form CMS 802) was provided by the facility with no residents marked for transmission-based precautions. On the same form documented under number 5 under pressure ulcers, R12 and R21 are the only two residents listed. On 07/23/2024 at 1:26 P.M., V3 (Minimum Data Set/Infection Preventionist) stated they have one resident on Enhanced Barrier Precautions. V3 stated R21 was on Enhanced Barrier Precautions for having MRSA (Methicillin-Resistant Staphylococcus Aureas) of the wound. On 07/23/2024 at 1:56 P.M., a tour of north hall noted to have one resident (R21) had signage on their door indicating they were on Enhanced Barrier Precautions (EBP). On 07/23/2024 2:00 P.M., no rooms were observed to have signage on the door indicating they were on EBP on the south hall. On 07/24/2024 at 12:48 P.M., V4 (Registered Nurse) stated a resident on enhanced barrier precautions you have to don gloves to go in the resident room. V4 stated she is unsure of what Enhanced Barrier Precautions are. On 07/24/2024 at 12:52 P.M., V5 (Licensed Practical Nurse) stated that she is not for sure what Enhanced Barrier Precautions means. On 07/24/2024 at 1:36 P.M., V2 (Director of Nursing) stated she was unaware the Enhanced Barrier Precautions are for residents with wounds and indwelling medical devices. V2 stated that V3 writes the polices for isolation and infection control practices. On 07/24/2024 at 2:24 P.M., V3 (Minimum Data Set/Infection Preventionist) stated she was unaware of wounds and indwelling medical devices were part of Enhanced Barrier Precautions. V3 stated she has started educating the nurses and the rest of the staff on Enhanced Barrier Precautions. R5's Resident Face Sheet documented an admitted [DATE]. R5's Resident Face Sheet documented diagnoses including retention of urine and urinary tract infection. R5's Physician Order Form with a date of July 2024 documented an order for a 16 FR (French) indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Resident Face Sheet documented an admitted [DATE]. R6's Resident Face Sheet documented the following diagnoses: pneumonia, acute respiratory failure, weakness, chronic obstructive pulmonary disease, insomnia, chronic pain, chronic combined systolic and diastolic heart failure, vitamin d deficiency, hyperlipidemia, hypokalemia, constipation, arthroplasty, osteoarthritis, gastro-esophageal reflux disease without esophagitis, hypothyroidism and essential hypertension. R6's Physician Order Form dated July 2024 documented an order for a 16 FR indwelling catheter. R8's Resident Face Sheet documented an admitted [DATE]. R8's Resident Face Sheet documented diagnoses including gross hematuria. R8's Physician Orders dated July 2024 documented an order for a 16 French indwelling catheter. R12's Resident Face Sheet documented an admitted [DATE]. R12's Resident Face Sheet documented diagnoses including acute kidney failure, urinary tract infection, neuromuscular dysfunction of bladder, retention of urine, and chronic kidney disease. R12's Physician's Order Form with a date of July 2024 documented an order for a 16 Fr indwelling catheter. R18's Resident Face Sheet documented an admitted [DATE]. R18's Resident Face Sheet documented the following diagnoses: cerebral infarction, dysphagia, hemiplegia and hemiparesis following cerebral infarction, lump in right breast, hypothyroidism, vitamin d deficiency, hyperlipidemia, essential primary hypertension and insomnia. R18's Physician Order Form for July 2024 documented an order for a 16 Fr indwelling catheter. R25's Resident Face Sheet documented an admitted [DATE]. R25's Resident Face Sheet documented diagnoses including neuromuscular dysfunction of bladder. R25's Physician's Order dated July 2024 documented an order for 16 fr indwelling catheter. R35's Resident Face Sheet documented an admitted [DATE]. R35's Resident Face Sheet documented diagnoses including retention of urine. R35's Physician Order Sheet documented an order for a 16 fr indwelling catheter. R41's Resident Face Sheet documented and admitted [DATE]. R41's Resident Face Sheet documented the following diagnoses: anemia, syncope and collapse, hypercholesteremia, vitamin deficiency, generalized anxiety disorder, restless leg syndrome, allergic rhinitis, gastro-esophageal reflux disease, and constipation. R41's Physician Orders documented an order to apply santyl on left outer calf, Apply to necrotic skin / tissue daily then apply nonadherent dressing, and wrap with gauze until healed. According to Centers for Disease Control at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO (Multidrug Resistant Organisms) colonization status and Infection or colonization with an MDRO.