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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Care Center	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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to safely transfer a resident using a mechanical lift for 1 of 3 residents (R53) reviewed for accidents in a sample if 29.The Immediate Jeopardy began on 9/14/2025 at 7:45AM, when the facility failed to provide a safe transfer using a mechanical lift. The failure resulted in (R53) falling from the mechanical lift and sustaining a head injury leading to R53's death. V1(Administrator), V2 (Director of Nursing/DON), and V14 (Licensed Practical Nurse/ Quality Assurance Nurse/QAC) were notified of the Immediate Jeopardy on 9/26/25 at 10:10AM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on 9/15/25, prior to the start of the survey and was therefore past noncompliance. Past noncompliance-no plan of correction required.Findings include:R53's document titled Face Sheet includes an admission date of 12/12/2023 with a discharge date of 9/17/2025. R53's diagnoses include chronic combined systolic congestive and diastolic heart failure, transient ischemic attack, pneumonia, osteoporosis, dyspnea, and altered mental status. R53 was admitted under Hospice care on 12/11/2024 with diagnosis of acute respiratory failure with hypoxia. R53's MDS (Minimum Data Set) dated 6/21/2025, includes a BIMS (Brief Interview for Mental Status) documents resident is rarely understood. Section GG Functional Abilities documents R53 is dependent with oral hygiene, toilet hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left to right and tub/shower transfer. Document shows shower/bath self, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer and toilet transfer were not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. R53's care plan documents under problem dated 6/21/2025, dependent of 2 staff for ADL's (Activity of Daily Living) related to declining health. Alert with confusion, aphasic. On hospice care. Transfers per mechanical lift. Non-ambulatory per staff. Vision impairment, wears glasses. Hearing impaired. Section of goal dated 9/21/2025, shows R53 will complete transfers using mechanical lift and 2 staff assist by review. Approach dated 6/21/2025, R53 is transferred per lift. On bath days transfer her directly from the bed to the shower lift and after bathing directly from the shower lift back to bed. Ensure R53 is secured to the shower lift while in transport. R53 transfers with mechanical lift. Instruct R53 in safe and proper technique with the lift. Give verbal cues for hand placement and proper positioning as she can assist. On 9/16/2025 under approach, if mechanical lift is used for transfers slings/belt is tattered, torn, worn, remove immediately from circulation and notify nursing supervisor or replace.R53's Incident Report dated 9/14/2025 at 7:45AM documents, R53's condition before incident was checked normal. Assistive device used was yes, mechanical lift sling. Description of exactly what happened is documented as CNA (Certified Nursing Assistant) transferring resident in sling attached to mechanical lift, a strap on sling broke, right blue upper strap broke with resident over the floor. She fell out of sling laying on her right side x 2 raised areas on upper back of head and 1 raised area on upper right side of head. Assessment of upper and lower extremities within normal limits. Right upper extremity forearm bruising. Will continue neuro checks within normal limits. Level of consciousness: Alert and oriented x 2. Authored by V9 (Licensed Practical Nurse/LPN).R53's (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse's Notes document as follows:9/14/2025 at 9:30AM, CNA reported during transfer with mechanical lift, right upper strap on sling broke. R53 fell out of sling, was on her right side on floor in resident's room. Upper and lower extremities within normal limits, posterior upper head x2 swollen areas and right upper head. Neuro checks, right upper extremity bruise on forearm, vital signs 151/82, Temp 98 degrees, pulse 106, Respirations 32 and Oxygen saturation at 84% on room air. Power of Attorney aware and son aware. Hospice aware and fax to physician. 9/14/2025 at 9:55AM, CNA came and got nurse, R53's respirations through her mouth. Oxygen saturations 88%, 2 liters per nasal cannula, message sent to hospice for oxygen mask due to mouth breathing. 9/14/2025 at 2:00PM, R53 had 2 large emesis undigested food. Vital signs 156/92, temp 97.7, pulse 130, respirations 32, and oxygen level at 88 % with 5 liters per nasal cannula.9/15/2025 at 12:00AM, R53 opens OU (both eyes) no verbal response, grimaces with touch. Pupils sluggish and equal round. No response when asked to squeeze hands. Followed finger movement for 1-2 seconds. 7 centimeter round soft area to upper crown of head. Purple bruising to right forearm. Medications given.9/15/2025 at 4:00PM, R53 non to minimal responsive. Does not open eyes, pupils round and equal and sluggish. Grimaces when arm moved to do blood pressure check. No change in condition and pulse remains in 130's.9/16/2025 at 9:00 AM, Ativan and Oxycodone given as ordered, Turn and repositioned, non-responsive, bilateral upper and bilateral lower extremities flaccid. 9/17/2025 at 12:00AM, Respiration gurgling, and lung sounds rhonchi (coarse) all throughout. Turned and repositioned medications given.9/17/2025 at 1:45AM, this nurse entered resident's room, upon entering resident noted to be still, no audible pulse, no audible blood pressure, respirations ceased. Family notified of resident passing.R53's Hospice Progress notes document:On 9/14/2025, Skilled nurse visit PRN (as needed) visit due to fall. R53 had emesis x 2. New order for Zofran 4.8 milligrams (mg) as needed. R53 is restful at visit. Pupils sluggish. Waking to verbal stimuli. Respiratory rate at 28. New order to schedule Oxycodone 5 mg every 4 hours and Ativan 1 mg every 4 hours. Discontinue Ativan at bedtime. Skilled Nurse to return on 9/15/2025.On 9/15/2025 Skilled nurse visit, R53 restful at visit 0/10 Pain scale O2 at 4 liters per nasal cannula. Heart rate 150-60's. Report was given to director, daughter and V2. Discontinue scheduled routine medications. Continue Oxycodone 0.25 milliliters every 4 hours and Ativan 1mg every 4 hours. Comfort meds continue. R53 changed to daily visits. Skilled nurse to return tomorrow 9/16/2025. On 9/16/2025 Skilled nurse visit, R53 unresponsive. 0/10 pain scale, decrease urine, breathing steady, even. Getting comfort meds. Skilled nurse to return on 9/17/2025.R53's Neurological Assessment documents neuros started on 9/14/2025 at 7:45AM. Noted changes to Neurological Assessment was on 9/15/2025 pupils were 3 millimeters and sluggish reaction. On 9/16/2025 at 6AM document shows extremities both left and right were flaccid and pupils both Left and Right were 3 millimeters and non-reactive. On 9/16/2025 at 2:00PM assessment documents pupils were 2 millimeters and non-reactive and both right and left extremities were flaccid.An undated final report sent to IDPH on R53 documents in part, This is our final report regarding the incident that occurred on 9/14/2025 . In our initial report, it was reported that there were 2 CNA's present at the time of the transfer and fall. During our investigation and after conducting staff interviews, it was noted that there was one CNA at the time of the transfer and fall. The sling that broke during the transfer was examined and there were not torn or compromised areas to the mechanical lift sling, other than the loop that broke during transfer . The CNA that was transferring the resident was disciplined for not following facility Hoyer lift policy. On 9/17/25 at 1:45 a.m. the resident passed away.On 9/24/2025 at 10:57AM, V6 CNA (Certified Nurse Assistant) stated she was the only CNA that was using the mechanical lift to transfer R53 from the bed to the wheelchair on 9/14/25. V6 stated the transfer was in motion when the strap broke and R53 fell to the ground headfirst hitting her head. V6 stated she immediately yelled for help and the nurses came down and assessed R53. V6 stated R53 had bumps noted to the right side of her head which is the side of the head that R53 landed on. V6 stated that she has since received education that mechanical lifts must only be used with 2 qualified staff members present. V6 stated that using 1 staff member for mechanical lifts was not unusual on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the weekends due to staffing shortage but she will never do that again. V6 stated she only works the weekends on dayshift.On 9/24/2025 at 11:58AM, V8 (Hospice Nurse) stated she has cared for R53 and is familiar with her. V8 stated R1's baseline was mostly nonverbal; she was up in wheelchair for meals, and she required a mechanical lift for transfers. V8 stated R53 required assistance for all her ADL's. V8 was asked if she felt R53's fall that occurred on 9/14/2025 attributed to R53's death, V8 stated, Yes definitely. V8 then stated, I can't confirm that without scans of course but she had a rapid change in condition that consisted of a change and decrease in her level of consciousness, she began to have vomiting, and inability to eat and keep food down. V8 was asked if she felt like R53 was at the end-of-life cycle prior to the fall on 9/14/2025, V8 stated, I do not feel like she was at that point prior to the fall. V8 then stated, She was not in the condition yet that I would have talked with the resident's family to inform them that death was near or even a month away. V8 stated it was the family that did not want R53 sent to the hospital. V8 stated after the fall R53 had a rapid decline and then passed away soon after the fall. V8 stated she was not aware of the death certificate being completed or what the cause of death would be documented on the death certificate.On 9/24/2025 at 2:00PM, V9 (LPN) stated she was the nurse in charge of R53 on 9/14/2025. V9 stated she was asked to go to R53's room because R53 had fallen out of the sling of the mechanical lift onto the floor. V9 stated the lift sling broke. V9 stated V6 was in the room with R53 and was taking the sling out from under R53. V9 stated R53 was still alert as her normal and was lying on her right side. V9 stated she did neuro checks and checked all of her extremities. V9 stated at the time of assessment R53 had a knot to her right side of her head and one in the middle of the back of her head. V9 stated we then placed another sling under her and put her back to bed via mechanical lift. V9 stated R53 ate breakfast and lunch, and a little later R53 started having emesis and had a look of pain and fear. V9 stated hospice was called and told us to give her Ativan and Oxycodone every 4 hours. V9 stated she did see a decline in R53's condition but the decline was the vomiting and increased pain. V9 stated she worked the next day on 9/15/2025 and when she got to work, she was told that R53 was no longer responsive to anything. V9 stated R53's condition pretty much stayed the same throughout the day. V9 stated R53 was no longer able to tolerate eating or drinking. V9 stated R53 did have a change in condition after the fall. V9 explained by saying R53 would be assisted up for meals and assisted with feeding and was alert but answer sometimes with a yes or no answer. V9 stated the family did not want R53 sent to the hospital.On 9/24/2025 at 3:54PM, V10 (Physician) stated R53's care was managed by Hospice, but he would check in on R53 when he did rounds. V10 stated would usually see R53 sitting in the dining room when he was making rounds. V10 stated R53 had a long hospital stay a few months ago and the family decided to send R53 back under the services of Hospice. V10 stated R53 was declining slowly after the long illness and was an aspiration risk. V10 was asked if he was aware of the fall that R53 had on 9/14/2025, V10 stated yes. V10 was asked if he felt this contributed to R1's death, V10 stated with a head injury to a resident of her age it is never good. V10 then asked, What did hospice say about this? V10 was told that the hospice nurse felt the fall and injury attributed to R53's death. V10 then stated, I have to agree with Hospice on that statement.On 9//26/2025 a 10:20AM, V1 (Administrator) and V2 (DON) were present and V1 stated, We know the fall caused the change in condition and death of R53. It was an unfortunate accident. V1 stated we immediately started working on everything the day of the event and V14 was already here working and started by inspecting all slings and educating the nursing staff.R53's death certificate has date/time of death as 9/17/2025 at 1:45AM with cause of death Respiratory Failure with Hypoxia. On 9/26/2025 at 11:49 AM spoke with V7 Coroner regarding R53's death certificate. V7 verified that the death certificate listed a cause of death as respiratory failure with hypoxia. V7 stated she and the physician were unaware of R53 falling out of a mechanical lift causing a head injury that led to death. V7 stated the Hospice Physician will have to make the changes to the death certificate due to the death certificate should have cause of death was accidental instead of respiratory failure. Policy titled Mechanical Lift with revision date of 9/15/2025 documents under ?Policy Use care, discretion and 2 staff members to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	maintain resident's safety during transfers. Under Procedures #13 mechanical slings are to be inspected daily prior to use per CNA, #15 if sling is tattered, torn, worn; remove immediately from circulation and notify nursing supervision for replacement.The Immediate Jeopardy that began on 9/14/2025 was removed and corrected on 9/15/25 when the facility took the following steps to systemically correct the noncompliance prior to the start of the survey:On 09/14/25, V14 was present and gave verbal education on Hoyer transfers to all nursing staff present.On 09/14/25, all Hoyer slings in use were examined by QAC Nurse for torn or compromised areas.On 09/15/25 and 09/18/25, a QA/QAPI meeting was held to discuss the incident and initiate corrective actions. On 9/15/25 a QAPI was created to prevent reoccurrence of such incident. A monitoring tool was created to audit over the next 4 weeks: 5 Hoyer lifts daily times 4 days, then 3 Hoyer lifts daily times 3 days, then 1 Hoyer lift daily times 6 days to ensure that 2 staff members are using the Hoyer lift properly on the residents who require a Hoyer lift for transfers. The QAPI will be overseen by QAC or designee. 09/15/25, Hoyer lift policy was reviewed and revised by the DON (Director of Nursing), LNHA (Licensed Nursing Home Administrator) and QAC.On 09/15/25, DON performed 1 on 1 education with nursing staff, that were on duty, in which the Hoyer lift policy was reviewed with emphasis on using two assists with all Hoyer transfers and inspection of slings. The staff that were not scheduled on 09/15/25, were educated on their next scheduled shift. On 09/15/25, all Hoyer slings and Sit to Stand belts were inspected by DON and LNHA. Any slings in question were removed from rotation, discarded and new slings ordered.On 09/15/25, a numbered list of Hoyer Slings and Sit to Stand Belts was created by QAC. From this list a Hoyer/Sit to Stand Sling Quarterly Inspection Log was created. This form was completed by DON, QAC, LNHA or designee.On 09/16/25, QAC or designee completed Mechanical Lift Competency Checklists with CNA staff that were on duty. The staff that were not scheduled on 09/16/25, were educated on their next scheduled shift. On 09/16/25, QAC nurse added the following approach to all resident's care plans. If a mechanical lift is used for transfers, sling/belts are to be inspected daily prior to use. If sling/belt is tattered, torn, worn; remove immediately from circulation and notify nursing supervisor for replacement.The QAPI that has been developed is ongoing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide aseptic catheter care for one of one residents (R5) reviewed for catheters in the sample of 29.Findings include:R5's Face Sheet documented an admission Date of 8/18/25 and listed Diagnoses including, Hypothyroidism and Alzheimer's Dementia. R5's Minimum Data Set, dated [DATE] documented that R5 has minimal deficits in cognition.R5's 9/8/25 Urinalysis documented the presence of 4+ leukocytes, red blood cells, and Enterococcus in the urine. R5's current Physicians Orders documented orders for an indwelling urinary catheter number 16 French with 5 cubic centimeter balloon, and Macrobid 100 milligrams one tablet twice daily start 9/10/25 for 10 days. R5's Care Plan dated 9/7/25 did not document a problem area of nor interventions for a catheter.On 9/23/25 at 1:53pm, R5 was alert and oriented to person, place, and time. R5 stated she was recently hospitalized and came to the facility with a catheter due to having a dropped bladder, and that she has had a history of urinary tract infections (UTIs).On 9/25/25 at 11:17am, V13, Certified Nursing Assistant/CNA, was observed providing catheter care for R5. After handwashing, V13 donned clean gloves, and then picked up an ink pen off the floor. V13 then provided catheter care with the contaminated gloves on. V13 cleansed the perineal area, then placed the contaminated washcloth in a basin of water for rinsing. V13 then put a clean washcloth in the now contaminated water and used it to rinse the perineal area. V13 then took a towel which was being used as a barrier between the basins and the nightstand and used this contaminated towel to dry the perineal area.On 9/26/25 at 8:58 V2, Director of Nurses, stated R5 has a history of UTI's (Urinary Tract Infections) and just finished antibiotics. V2 stated she will be reeducating CNA staff on aseptic catheter care.On 9/26/25 at V12, Registered Nurse/Care Plan Coordinator, stated R5 came back from a recent hospitalization with the catheter, and V12 did not add an associated problem area or interventions to the care plan, but will do so now.An undated Urinary Catheter Care Policy documented, Catheter care is performed appropriately to prevent complications caused by the presence of an indwelling urinary catheter. Routine daily care of indwelling catheters is controversial in reducing catheter associated urinary tract infections. Daily perineal care does however contribute to improved hygiene. Catheter care will be performed three times daily to decrease the risk of nosocomial urinary tract infections and to improve personal hygiene of the residents with indwelling catheters.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review the facility failed to provide at least 80 square feet of living space for 2 of 2 residents (R8 and R28) reviewed for room size in a sample of 29.The Findings Include: On 9/26/25 at approximately 9:30 AM, R13 was sitting in her room. R13 was noted to not have a roommate. The room was a smaller sized bedroom with one bed, a recliner, an overbed table, 1 nightstand, two chairs, and an inset closet inside the room.On 9/26/25 at approximately 10:00 AM, R17 was sitting in his room. R17 was noted to not have a roommate. The room was smaller in size with one bed, recliner, overbed table, a chair, two nightstands, and an inset closet inside the room.On 09/26/25 at 10:30AM, V14 (Quality Assurance Nurse) measured R13 and R17's bedroom sizes. The rooms measured 11 feet 13 feet 6 inches, indicating that the rooms were 151.47 square (sq.) feet (ft.), or 75.74 sq. ft. per bed. The measurements did not include the closet or the inset dresser area.On 9/26/25 at 10:30 AM, V14 stated that both of these rooms, occupied by R13 and R17, have a room size waiver. V14 stated these rooms are double occupancy rooms that are utilized as single bed rooms. V14 stated the rooms occupied by R13 and R17 do not meet the required room size and have a room waiver and are both Medicare and Medicaid certified.A facility room roster provided by the facility on 9/23/25 and dated 9/23/25, documents R13 and R17 reside in the rooms observed.Inquiries regarding the size of these rooms during the survey from 09/23/25 to 09/30/25, found no concerns or negative interviews from residents or families of residents who reside in the waivered rooms. During an interview, on 09/24/25 with residents between 10:00 AM-10:00 AM, R13 and R17 voiced no concerns with the size of their rooms.Review of 6 months of Resident Council meeting minutes indicated no concerns related to the size of the rooms.