STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home for the Aged	800 West Oakton Street Arlington Hts, IL 60004

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Based on interview and record review the facility failed to safely reposition a resident during care. This failure resulted in R1 falling from her bed and sustaining a right patella fracture. This applies to 1 of 4 residents (R1) reviewed for safety in the sample of 6.The findings include:R1's face sheet shows she has diagnoses including Cerebrovascular Accident, hemiplegia of the right side, dysarthria and pain in right leg.R1's active care plan initiated on 5/29/23 she has impaired cognitive and decision making, limited physical mobility, is at risk for falls, and requires staff assistance for turning and bed mobility with instruction cues and hand guidance. A nursing progress note completed for R1 on 8/25/25 at 10:00 PM states, @ 9:15 pm someone calling this writer's name. I immediately attended to the room where the name calling coming from and upon entering the room noted resident (R1) on her back lying on the floor with both legs extended with {V6) holding resident's head. Per {V6} she's giving a bed bath and resident rolled off the bed and fell on the floor. A nursing progress note completed on 8/26/25 at 6:40 PM, shows that R1 had continued to complain of pain to her right knee and an X-ray was ordered which confirmed a patellar fracture. A Radiology Results Report dated 8/26/25 confirms that R1 has a mildly displaced fracture of the superior margin of her patella. R1's Physician Order Summary shows an order dated 8/28/25 for R1 to be non-weight bearing and use an immobilizer for her right lower extremity at all times for her Patella fracture. On 9/15/25 at 10:53 AM, R1 said she was getting a bed bath and when the staff person rolled her to her right side she fell from the bed. R1 said she hit her right knee, and it still hurts. R1 said she cannot use her right arm at all and needs help to turn from side to side and that day she felt close to the edge of the bed. R1 said she has a big bed now but her bed before was much smaller. On 9/15/25 at 11:04 AM, V6 (Certified Nursing Assistant/CNA) said when they are changing R1 in bed they have been using 2 people because she cannot use her right side to help turn. V6 said R1's former bed was small and R1 would come close to the edge. On 9/15/25 at 12:45 PM, V14 (CNA) said she was the only person in the room giving {R1} a bed bath and she had a basin of water that R1 wanted to feel the temperature of in the process of that she spilled the basin of water over the bed and the mattress. V14 said she did not have enough towels to get everything dry, so she was going to change her sheets. V14 said when she had R1 turn to her left side everything was fine, and then she had R1 turn to the right side and would be facing her, but everything was wet and slippery and R1 could not hold the side rail and lost her balance and started falling off the bed. V14 said she also lost her balance trying to prevent R1 from rolling off the bed. V14 said she did not physically see R1 hit her knee during the fall, but she must have because she has a fracture from the fall. V14 said R1 cannot use her right side at all and needs staff help to turn and R1 had a much smaller bed before the fall and now her bigger bed it is much better. V14 said she does feel that the mattress being wet slippery contributed to R1 rolling off the bed. V14 said R1 can make her needs known and uses her call light but she can be forgetful.On 9/15/25 at 2:19 PM, V2 (Director of Nursing) said she would expect a CNA to go get a second person to assist in turning a resident if water had spilled on the mattress and it was slippery.The facility provided Fall Prevention and Post Falls Management policy last revised on 9/6/24 shows factors that could contribute to a residents fall include, wet surfaces, cognitive impairment and poor grip strength.