STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145768	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Hillside Village	6901 North Galena Road Peoria, IL 61614

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 - Minimal harm or potential for 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** Based on interview, observation and record review, the facility failed to de-escalate a resident prior to transfer, investigate incident to identify the root cause and implement interventions to potentially prevent further events for 2 of 3 residents (R1, R3) reviewed for falls in a sample of 4.Findings include:The Event Reporting policy dated 7/29/21 documents an adverse event is defined as an unexpected occurrence which was not expected within normal course of care of disease process and condition of the resident. An adverse event may or may not result in injury and may or may not have resulted from a medical or healthcare error. A witness statement form is used only for witnesses who observed the adverse event. The Administrator, Director of Nursing, Risk Designee and their delegates should conduct investigations. Reporting of abuse/neglect of reasonably suspected resident abuse and/or neglect will be reported to the state agency. 1. R1 was admitted on [DATE] with diagnoses of Hemiplegia following a Cerebral Infarct, Dementia, Severe with Agitation and Mood Disturbance, Major Depressive Disorder severe with Psychiatric Disorder, Insomnia, and Sensorineural Hearing Loss. R1 was discharged home on 6/2/25. The May 2025 Medication Administration Report documented the following medications were ordered and administered as ordered each day from 5/1/25 through 5/31/25: Melatonin (sleep aid) 5 mg one time daily at night, Quetiapine (antipsychotic) 75 mg one time daily at night, Sertraline (treats depression and anxiety) 75 mg one time daily, Eliquis (blood thinner) 5 mg twice daily, Prevagen (supports brain health and improves memory loss) one tablet daily and Memantine (treats moderate to severe dementia) 5 mg daily. R1's Care Plan documents R1 was on anticoagulants and was at risk for bleeding, had verbal/physical rejection of cares due to behavioral symptoms directed toward staff, experienced delusions and paranoia particularly in the evening, became fixated on certain staff members and made false accusations, was at risk for falls and was at risk for developing impaired skin integrity. The Care Plan's interventions included to implement safety/fall precautions, use extra caution with manually transferring, administer medication as ordered, redirect with conversation or talk about family, children are very involved in care, offer to call son to speak with R1 to help with de-escalation when R1 expresses signs of heightened expressions, report falls to physician and responsible party and use lifting device or draw sheet to reduce friction. R1's Progress Notes dated 5/10/25 at 12:30 AM documented R1 slid out of bed and was on the floor at 9:43 PM on 05/09/25. R1 was combative, physically and verbally abusive. R1 sustained 3 skin tears, no skin loss: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- large skin tear on Left Forearm; 6 cm L (length) x 10 cm (centimeter) W (width) x 0.1cm D (depth) - small skin tear on Left Forearm; 2 cm L x 2cm W x 0.1 cm D - small skin tear on posterior arm; 2 cm L x 2cm W x 0.1 cm D Skin tears were treated per facility protocol (cleansed, triple antibiotic ointment, steri-strips and foam border dressing). The Physician on call, V2 (Director of Nursing) and V5 (R1's Family Member/POA) notified. Neurological checks could not be completed due to resident refusal. The investigation report provided by V2 (Director of Nursing) titled Falls documented R1 fell on 5/9/25, sustained skin tears, care plan was updated and family was notified. The report did not include interviews of witnesses, cause of the skin tears or that any further investigation was conducted. On 10/14/15 at 3:46 PM, V4 (Certified Nurse Aide) stated V7 (Registered Nurse) asked V4 to come into R1's room and help because she had fallen and was on the floor. R1 did not want staff to touch her. R1 was laying on her elbow. V4 and V9 (Certified Nurse Aide) put a gait belt on R1 but she was combative. R1 said I don't want to see you. Get out of here. R1 was cussing at staff and yelling racial slurs. During the transfer, R1 started flailing her arms again and we noticed her arm was bleeding when she raised it. V4 stated he was unsure if R1 was initially laying on her arm and staff didn't see R1's blood and/or skin tears or if it happened during the transfer. On 10/15/25 at 2:11 PM, V9 (Certified Nurse Aide) stated she was at the foot end and V4 at the head end of R1. R1 combative and called V9 names. Upon lifting R1 into bed, R1 already had blood spots. V9 stated I think (V4) may have grabbed (R1) hard because (R1) was fighting us and her skin tore. I think it was from the transfer not the fall. (V4) would never do that on purpose. (V4) is great and would never hurt anyone. On 10/15/25 at 12:30 PM, V1 (Administrator) and V2 (Director of Nursing) both verbally agreed R1's fall should have been investigated and the root cause for the skin tears determined and had not been. R1 should have been de-escalated prior to transfer by utilizing interventions as instructed on the care plan such as to use extra caution with manually transferring, notified the Physician for an as needed medication to calm R1, redirected with conversation or talked about family, offered to call V5 (R1's Family Member) to speak with R1 to assist with de-escalation and/or used a lifting device or draw sheet to reduce the risk of injury during transfer back to bed. 2. R3 was admitted to the facility on [DATE] with the following diagnoses: Guillain-Barre Syndrome, Parkinson's Disease, Alzheimer's Disease, Osteoporosis, Anxiety, Hypertension, left and right foot drop, and Peripheral Vascular Disease. R3's Minimum Data Set (MDS) dated [DATE] indicates R3 is cognitively intact. On 10/14/25 at 12:50 PM, R3 stated she fell recently (10/10/25) and cracked her knee cap. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Clinical Notes Report on 10/11/25 at 3:44 AM documents, At 0200, resident transferred from [NAME] Health Methodist emergency room back to the facility after being evaluated and treated for ground level fall. Diagnosed with Closed Displaced Fracture of Left Patella. R3's Care Plan intervention for falls with creation date of 10/11/25 documents the following: place call don't fall sign in resident's room to remind resident to call for assistance. R3's Clinical Notes Report does not contain documentation a fall occurred on 10/10/25 at 3:15 PM, a head to toe assessment was conducted by a nurse, required notifications were made or reason for transfer to the hospital. On 10/15/25 at 1:39 PM Call, don't fall sign not in place in R3's room. On 10/15/25 at 11:14 AM, V14 (Certified Nursing Assistant) reports she is not aware of any new interventions since R3's fall on 10/10/25. On 10/15/25 at 1:45 PM, V13 (Registered Nurse) reports the facility's Call, don't fall signs are placed in resident rooms where residents can see the sign. V13 verified R3 does not have a Call, don't fall sign in her room. On 10/15/25 at 2:02 PM, V2 (Director of Nursing) confirmed R3's fall on 10/10/25 at 3:15 PM is not documented in R3's medical record and a Call, don't fall sign should be posted in R3's room.