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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
	145768	A. Building B. Wing	12/13/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 30678 Based on observation, interview, and record review the facility failed to ensure a resident call light was in reach for two (R4 and R12) of 17 residents reviewed for call lights in the sample of 26. Findings include: The facility Call Light Response policy and procedure, dated 1/30/24, documents The policy statement To answer call lights and meet resident need(s) in a timely, dignified, and respectful manner. Call lights will be placed within reach of the resident. 1. On 12/12/24 at 8:15 am, R4 was lying in bed on her back with eyes closed. R4's call light noted resting on the floor behind R4's headboard and out of R4's reach. On 12/12/24 at 2:11 pm, R4 was lying in bed on her back and awake. R4's call light noted resting on the floor behind R4's headboard out of R4's reach. R4 mumbled she is unable to locate her call light. On 12/12/24 at 2:20 pm, V11 CNA (Certified Nursing Assistant) stated R4 has a sensitive touch call light and uses the call light at times. V11 CNA stated R4's call light should not be on the floor behind R4's headboard and should be placed where R4 can reach it. V11 CNA stated she would fix it. On 12/12/24 at 2:27 pm, V1 Administrator stated all resident call lights should be within the resident reach at all times whether they use them or not. 31285 2. R12's current Care Plan addresses R12's frequent bowel incontinence with an intervention stating Instruct [R12] to use call light. Answer call light promptly and keep nurse call light within easy reach; and R12's care plan addressing Risk for Falls, with a documented intervention to remind [R12] to call for assistance before attempting to get out of bed. 12/12/24 at 7:50 a.m. R12 was awake and laying in bed. R12 stated I am waiting to have a (bowel movement). At that time, R12's call light was clipped to the cord at the wall, out of her reach. On 12/12/24, at 8:00 a.m., V6/Registered Nurse verified R12's call light should be within her reach and not clipped on the wall.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 38805 Based on observation, interview and record review the facility failed to place the facility's annual State Survey Results in a readily accessible location for residents for viewing. This failure has the potential to affect all 69 Residents residing at the facility. Findings include: The facility's Resident Rights Policy, dated 1/30/24 document: Policy Statement: Staff shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of the (facility) community. These rights include the resident's right to: H. Be supported by the (facility) community in exercising their rights; M. Exercise rights not delegated to a legal representative; and W. Examine survey results. The facility's Long-Term Care Facility Application for Medicare and Medicaid (Centers for Medicare and Medicaid Services/CMS 671) Form, dated 12/10/24, document 69 residents reside in the facility. On 12/11/24 at 1:00 p m, Residents R2, R6, R22, R25, and R53 attended the Resident Council Meeting. Residents confirmed they did not know where the State Survey Results/Binder was located. On 12/11/24 at 1:40 p.m., the facility's State Survey Results/Binder, white in color, was noted on the counter at the facility's nursing station; the counter was 42 inches in height from floor to counter top; and the Binder was placed inside a file folder holder (along with other miscellaneous binders, all white in color) so that the name of the Binder faced upward toward the ceiling. On 12/12/24 at 8:55 a.m., V8 Office Assistant stated that a resident had to ask (V8) to get the Survey Results Binder from the counter for the resident. On 12/11/24 at 1:40 p.m., V12 Activity Director stated that she organizes the Resident Council Meetings with the residents each month. V12 indicated that she was not sure if residents in wheelchairs would be able to reach the Binder. V12 also confirmed she was not sure if residents knew where the Survey Binder was located and residents should have access to the Binder. V12 stated, I will let them know at the next Resident Council Meeting where it is; I just got into this role a few months ago; that is one of their rights to know where the Survey Results are.

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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. 30678 Based on observation, interview, and record review the facility failed to ensure fall interventions were in place for one (R4) and failed to complete fall risk assessments and root cause analysis for two (R4 and R51) of ten residents reviewed for falls in the sample of 26. Findings include: The facility's Management of Fall Risk policy and procedure, dated 1/30/24, documents Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Each resident will be assessed for the risk factors for falling on admission, quarterly, with change in condition, and upon return from a health care facility. The facility Fall Log, documents R4 had a fall on 8/3/24 at 3:00 am and R51 had falls on 9/2/24 at 1:15 am, 9/27/24 at 6:45 am, and 10/24/24 at 12:30 am. 1. The current Care Plan for R4 documents R4 is at risk for falls and includes the following interventions as: Fall risk assessment to be completed on admission, quarterly, if significant changes, and with falls; Provide environmental adaptations - maintain bed in lowest position while (R4) is in bed; call light within reach; Use call light to ask for help instead of reach for object that is out of reach; Floor mats as indicated while resident is in bed. The Investigation Report for R4's 8/3/24 fall documents: Resident heard by staff yelling. Upon entry resident was noted to be lying on the floor between her bed and recliner chair on her right side. The bed was in the least position. Resident could not tell what happened due to dementia. Vitals obtained; skin assessment completed. ROM completed with grimacing noted to right shoulder. Resident was then helped back into bed by staff. Incontinence care provided. Bed in lowest position and call light within reach. Intervention documented to Provide (rolled edge) mattress for comfort and safety. This investigation does not include a root cause analysis that identifies the reason for R4's fall. The Fall Risk assessment for R4, was not completed until 19 days after R4's 8/3/24 fall on 8/22/24. This Fall Risk assessment documents R4 as a High Risk or falls. On 12/12/24 at 8:12 am, R4 was lying in a low bed with rolled edged mattress in place with her eyes closed. R4's call light was resting on the floor behind R4's headboard out of R4's reach. R4's fall mat was folded and resting against R4's closet and not in use. On 12/12/24 at 2:15 pm, R4 was lying in low bed with call light resting on the floor behind R4's headboard out of R4's reach. On 12/12/24 at 8:15 am, V6 RN (Registered Nurses) confirmed R4 is at risk for falls and should have the fall mat on the floor, on the left side of her bed when (R4) is in bed and the CNAs should place the mat on the floor when they leave her room. V6 also confirmed call lights should be within resident reach at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 2:20 pm, V11 CNA (Certified Nursing Assistant) stated R4 has a sensitive touch call light and does use the call light at times. V11 CNA stated R4's call light should not be on the floor behind R4's headboard and should be placed where R4 can reach it. V11 CNA retrieved R4's call light from behind R4's headboard and placed it within R4's reach. 2. The current Care Plan for R51, documents R51 is at risk for falls/injury and documents an intervention as: Fall risk assessment to be completed on admission, quarterly, if significant changes, and with falls. The fall investigations for R51 dated 9/2/24, 9/27/24 and 10/24/24 do not include root cause analysis was completed to identify potential cause of R51's falls. The facility was unable to provide Fall Risk assessments for R51 after R51's falls on 9/2/24, 9/27/24, and 10/24/24. The Fall Investigation for R51's fall, dated 9/2/24 at 2:15 am, documents (R51) was on the call light at 2:15 am, sitting on the floor and calling out for her family to come get her back in bed. Resident was confused, not following commands, yelling, verbally abusive and paranoid. Intervention Offer to call son to speak with resident to help with de-escalation when resident expresses signs of heightened expressions. There is no Fall Risk assessment completed after this fall. The Fall Investigation for R51's fall dated, 9/27/24 at 6:45 am, documents R51 stated I had to pee really bad, so I shouted for help and when no one came, I pulled back the sheets and tried to grab the handlebar to get out of bed, but then I slid down on the floor and my back started hurting. There is no Fall Risk assessment completed after this fall. The Fall Investigation for R51's fall, dated 10/24/24 at 12:30 am, documents (R51) discovered on floor next to bed. (R51) noted with call light in hand. (R51) unable to answer questions about or to answer questions about events. (R51) noted alert to person and place - normal base line. (R51) able to move all extremities without difficulty. Floor mat next to bed while resident is in bed for safety. (R51) was just rounded on 30 minutes prior, call light within reach and noted sleeping. There is no Fall Risk assessment completed after this fall. On 12/11/24 at 2:45 pm, V2 DON (Director of Nursing) was unable to provide root cause analysis regarding R4 and R51's falls. V2 DON confirmed the resident fall investigations for R4 and R51 do not include root cause analysis to help determine why R4 and R51 fell . V2 DON stated, I understand what you are saying and confirmed not all the fall interventions are appropriate for each resident fall related to the root cause of the fall. V2 DON stated the facility discusses resident falls weekly on Thursdays and he will incorporate root cause analysis in future weekly meetings. V2 DON stated fall risk assessments are to be completed quarterly and after each resident fall and confirmed there were no fall assessments completed after R4 and R51's falls.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 30678 Based on observation, interview, and record review the facility failed to assess residents for the use of bedrails for two (R26 and R61) of six residents reviewed for bedrails in the sample of 26. Findings include: The facility's Proper Use of Bed Assistive Devices policy and procedure dated 1/30/24, documents The purposes of these guidelines are to ensure the safe use of bed Assistive devices as resident mobility aids and to prohibit the use of bed assistive devices as restraints unless necessary to treat a resident's medical symptoms. Bed assistive devices include side rails, assist rails, and other bed positioning devices. An assessment will be made to determine the resident's symptoms or reason for using the bed assistive device upon initiation, quarterly, and as needed. 1. On 12/10/24 at 10:46 am, there were quarter bed rails noted to each side of R26's bed in the up position. The Bed Assistive Device Assessment's for R26, dated 9/18/24 and 12/7/24 are blank and do not document an assessment having been completed for the use of R26's bed rails. Both assessments document no bed rails are being used for R26 and therefore, no consent is needed. 2. On 12/11/24 at 8:12 am, R61 was lying in bed with quarter bed rails in the upright position on bilateral sides of his bed. The Bed Assistive Device Assessments for R61, dated 11/4/24 and 12/5/24 are blank and do not document R61 being assessed for the use of bedrolls. On 12/12/24 at 11:30 am, V2 DON (Director of Nursing) confirmed bed rail assessments were not completed for R26 and R61 and stated he is unsure why they were not completed. On 12/12/24 at 12:23 pm, V2 DON confirmed that R61's bedrail assessment was not completed on 11/4/24 or 12/6/24 and is using this as an education opportunity for the Nurses.