STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145953	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairieview Lutheran Home	403 North Fourth Street Danforth, IL 60930

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** Based on observation, interview, and record review, the facility failed to ensure resident safety by not placing foot pedals on a resident's wheelchair while propelling the resident. This failure resulted in R1 experiencing a fall from the wheelchair, facial lacerations to the forehead, eye, and nose requiring eleven sutures to close. The facility also failed to implement fall prevention interventions according to R1's care plan. R1 is one of three residents reviewed for accidents on a sample list of eight. Findings include: 1. R1's Census Detail dated 6/10/25 documents R1 was admitted to the facility 1/19/17. This same Census Detail documents R1 was at the hospital on 5/19/25. R1 Medical Diagnoses List dated 6/10/25 documents R1 experienced health conditions including Dementia, Morbid Obesity, Reduced Mobility, Need for Assistance with Personal Care, Anemia, Chronic Respiratory Failure with Hypoxia, Lumbar Disc Displacement, Difficulty Walking, History of Cerebral Vascular Accident, and Muscle Weakness. R1's Fall Risk Assessments dated 5/6/25, 3/23/25, and 2/10/25 all document R1 is at high risk for falls. R1's Minimum Data Set, dated [DATE] documents R1 received a Brief Interview for Mental Status of three, indicating R1 was severely cognitively impaired. R1 could only repeat two of three words (sock, blue, bed) provided by the tester, could not identify the correct year within 5 years, the correct month, nor the day of the week. R1 could only recall one of the three provided words at the end of this interview. This same Minimum Data Set documents R1 was dependent on staff for toileting, oral, and personal hygiene, as well as lower body dressing, placing on footwear, transitioning from lying to sitting, and for mobility in a wheelchair. R1's Nursing Progress Note dated 4/22/25 at 5:11 AM documents R1 was found by staff face down beside her bed. R1's Nursing Progress Note dated 3/22/25 at 10:57 PM documents R1 was found by staff on her knees beside the bed exhibiting increased signs of confusion. R1's Nursing Progress Note dated 5/15/25 at 11:41 AM documents R1 was very lethargic, was not engaging in conversation nor eating independently and was seated in the assisted dining portion of the dining room to receive staff assistance while eating. (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 - Actual harm Residents Affected - Few	R1's Nursing Progress Note dated 5/19/25 at 8:53 AM, documents R1 was being propelled by a staff Registered Nurse (V4) when R1 put her feet on the floor and fell forward out of the wheelchair. This same Note documents staff did not have pedals in place on R1's wheelchair at the time. This Nurses Note documents R1 experienced a facial laceration on the left side of her forehead, around the left eye, and on the bridge of her nose. This note documets R1 was sent to the local emergency room for evaluation. R1's Nursing Progress Note dated 5/19/25 at 1:53 PM documents R1 returned to the facility with an 8.5 centimeter laceration to her left forehead and 11 sutures in place, another 1 centimeter laceration under R1's left eye, and a 0,5 centimeter laceration on the bridge of R1's nose. R1's emergency room Report dated 5/19/25 documents and confirms R1 had experienced facial lacerations of 8.5 centimeters on the left side of R1's forehead, 1 centimeter under R1's left eye, and 0.5 centimeters on the bridge of R1's nose. This same report documents closure of R1's lacerations required 11 sutures. On 6/10/25 at 11:30 AM, V12, Physical Therapist, stated he did work with R1 as part of his skilled therapy case load back in March (2025). V12 stated R1 could propel her own wheelchair at that time but did have fluctuating mental and physical abilities, some good days and some bad days. V12 stated there was not a facility wide policy to place wheelchair pedals on every resident's wheelchair because many residents could still propel their own wheelchairs and the facility wanted to promote independence. V12 then stated there was not a process to evaluate residents for their need to utilize foot pedals on their wheelchairs. On 6/10/25 at 12:08 PM, V4, Registered Nurse, confirmed she was the staff member propelling R1 to breakfast when R1 fell out of the wheelchair. V4 stated she did not put foot pedals on the wheelchair for R1 because R1 would still propel herself in the facility. V4 further stated R1 could move her own wheelchair but could not necessarily locate her own room, or any intended destination, and often would come to the nurses station and ask for someone to take her to her room. V4 stated R1 had not had prior problems holding her legs and feet up while a staff member was propelling the wheelchair for R1. V4 then stated there had been a prior nearly identical incident involving R8 about a year prior to the incident involving R1, where R8 was being propelled by a staff member, put her feet on the floor, and then R8 fell face first out of the wheelchair. R1's Nursing Progress Note dated 6/22/24 at 5:30 PM confirms a kitchen staff member was propelling R1 from the dining room when R1 put her feet down and then tumbled face first onto the floor. On 6/10/25 at 9:10 AM, R1 was lying in bed in her own room. R1 had a pale colored non-pigmented scar on the left side of her forehead approximately 9 centimeters long curving around and beside R1's left eye, with a shape like an inverted V (^) over her left eye. There was an area approximately 1 centimeter long of a dark red scab at the peak shaped area over R1's left eye. On 6/10/25 at 11:15 AM, V6, Certified Nursing Assistant, was propelling R4 through a carpeted hallway into the dining room while R4 was holding his legs and feet up off the floor. On 6/10/25 at 11:25 AM, V5, Spouse of R5, was propelling R5 through a carpeted hallway into the main dining room while R5 was holding his legs and feet off the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/10/25 at 11:49 AM, V9, Housekeeper, was propelling R6 through a carpeted hallway from the dining room and to the central nurses station. V9 stated he worked in the housekeeping department and was responsible for cleaning resident rooms, hallways and the dining room. V9 stated he assisted residents out of the dining room so he can get started cleaning the dining room. On 6/10/25 at 11:53 AM, V10, Spouse of R7, was propelling R7 along the carpeted hallway from the main dining room and then outside of the facility while R7 was holding his legs and feet up off the floor. On 6/11/25 at 8:35 AM, V11, Certified Nursing Assistant, was propelling R7 through a carpeted hallway to the main dining room while R7 was holding his legs and feet up off the floor. On 6/11/25 at 9:35 AM, V2, Director of Nursing, stated she had worked at the facility seven and one half years and did have a recollection of the prior incident involving R8. V2 acknowledged there had not been a process implemented after the incident with R8 to evaluate or assess residents for their need to utilize foot pedals on their wheelchairs and stated she had been searching for an assessment tool after this incident involving R1. 2. R1's Care Plan for fall prevention dated as initiated 3/14/22 documents R1 is at risk for falls due to confusion, deconditioning, gait and balance problems, and is unaware of her safety needs. The fall prevention interventions to be implemented by staff include to have R1's bed in the lowest position when R1 is in bed and to have a safety mat (padded floor mat) on the left side of the bed, dated as initiated 8/3/23 with a most recent revision on 3/24/25. These care plan fall prevention interventions were also included on R1's Physician Order Sheets. On 6/11/25 at 9:15 AM, R1 was lying in bed in her own room. R1's bed was not in the lowest position being approximately 16 inches up from the floor. R1's safety mat was folded and leaning against the wall on the opposite side of the room from R1's bed. On 6/11/25 at 9:20 AM, V1, Administrator, observed these findings and simply made an audible growling sound. V1 then instructed an (unidentified) Certified Nursing Assistant to go check R1's room because the bed was not down and the mat was not by the bed. On 6/11/25 at 9:35 AM, V2, Director of Nursing, when informed of the findings of R1's bed not being in the lowest position and the safety mat not being in place, simply stated, Yeah. On 6/11/25 at 1:44 PM, V13, Minimum Data Set Coordinator/ Care Plan Coordinator, confirmed the bed in the lowest position and the safety mat are still current fall prevention interventions for R1.