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	11/05/2025

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin for one of four residents (R1) reviewed for accidents in the sample list of 10. Findings include:The facility's undated Final Report documents the following: on 9/21/25 the Certified Nursing Assistants (CNAs) were putting R1 to bed and noted bruising to sternum, under and across the right breast and under right arm. R1 complained of pain and had limited range of motion to right arm. On 9/22/25 more bruising was noted to R1's right chest above rib cage, R1 was short of breath with activity and later complained of chest pain, nausea, and was pale. R1 was sent to the local emergency room where R1's Hemoglobin was 5.9 (normal range 11. 6-15 grams per deciliter). R1 was given a reversal agent due to bleeding, and later had a brachiocephalic, right subclavian and right axillary artery angiogram that demonstrated an active bleed in the right anterior lateral chest that required two-vessel embolization with coils and gel foam. There were no reports of a fall or other mechanism of injury that may have directly caused R1's bruising and bleeding. R1 requires the use of a sit to stand lift for transfers, and the affected area is similar to the location of the stand lift sling, and the use of this lift does not cause this type of injury. R1 was playing balloon toss using her right arm and the facility questions if R1 may have torn something while playing and outstretching her arm. As a precaution R1's transfer status was changed from sit to stand lift to full mechanical lift. R1's Progress Note dated 9/21/25 at 7:09 PM, recorded by V15 Licensed Practical Nurse (LPN) documents the CNAs were putting R1 to bed and found bruising to sternum, under and across right breast and under right arm that matches up with the strap of the stand lift. R1 rated pain 5 out of 10 and had limited range of motion to right arm. R1's Nursing Notes document R1 returned to the facility on 9/28/25, admitted to hospice, and passed away on 10/4/25. The facility's September 2025 Housekeeping schedule documents one housekeeper worked on the memory care unit (R1's unit) on 9/21/25. The facility's September 2025 Activity Staff schedule documents three activity staff worked on R1's unit. The facility's Faith Place (memory care unit) Assignment sheets dated week of 9/20/25-9/26/25, document the following assignments: On 9/21/25 two nurses and six CNAs worked dayshift, two nurses and four CNAs worked evening shift. These same staff also worked on 9/20/25, with three of the evening shift CNAs as night shift. The facility's investigative file for R1's 9/21/25 bruising/injury, provided by V2 Director of Nursing, included only four staff Incident/Investigation Interview Forms. V27 CNA and V28 CNA interview forms dated 9/21/25 at 7:00 PM document they found large bruising underneath R1's breast, on the left side of R1's breast, and across R1's right side. These forms are not signed that a staff person interviewed V27 and V28, as indicated on the form. V13 CNA interview form dated 9/22/25 documents during last rounds V13 noticed a small bruise to R1's left arm, thought to be old, and that was the only bruise V13 observed. There is no documentation that these staff were asked the cause of R1's bruising/injury, if R1 had any falls, or how R1 had been standing for transfers in the sit to stand lift. V12 CNA interview form dated 9/22/25 documents V12 only noticed an old bruise to R1's left arm, R1 is anxious during transfers as she does not like the sit to stand lift, but there were no transfer issues during V12's shift. On 10/28/25 at 2:42 PM, V15 LPN stated V15 was alerted to a bruise on (R1's) right chest and arm by the CNAs on 9/21/25. V15 stated V15 felt the bruise lined up with the belt on the stand lift that R1 used to transfer. V15 denied any knowledge of any incidents that could have caused R1's bruising. On 10/28/25 between 4:01 PM and 4:43 PM, V27 and V28 CNAs stated they found R1's bruising on the evening of 9/21/25 prior to transferring her to bed, which was not noted when V28 had last cared for R1 the night before. V27 stated something must have happened during the dayshift. V28 described the bruise as purple, almost black, extending from the base of R1's neck down to the bottom of R1's abdomen, across from mid chest to right under arm before the elbow. V27 stated initially R1 was a stand pivot transfer but then R1 started using the sit to stand lift a few weeks prior. V27 stated R1 disliked the stand lift, R1 would tell us that she was hurting and didn't like the lift, and to put R1 down. V27 stated R1 couldn't stand in the lift for very long, so staff had to move R1 quickly. V27 and V28 were not aware of the cause of R1's injury, or any falls or incidents that could have caused R1's injury. On 10/29/25 at 8:55 AM, V21 Memory Care Director stated V21 did not work on 9/21/25 and received a text message that evening from V15 Licensed practical Nurse reporting R1's bruising. V21 stated no one saw anything happen and staff were unsure what caused the bruising. V21 stated V15 LPN told V21 that the bruise aligned with the stand lift sling, so V21 assumed that was the cause of R1's injury. On 10/29/25 at 1:27 PM, V1 Administrator stated V1 assisted collectively with nurse management for the investigation of R1's 9/21/25 bruising/injury. V1 stated V15 LPN, and the two CNAs were interviewed for this investigation

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to assess, monitor, and thoroughly evaluate one resident (R1) for post fall injury and appropriate mode of mechanical lift of four residents reviewed for injury and transfer in a sample list of ten. This failure caused delay of treatment for R1's arterial bleed which required multiple transfusions and emergency surgical repair which eventually led to R1's death.The Immediate Jeopardy began on [DATE] when R1 fell and was not adequately assessed for injury or appropriateness of initiation of sit-to-stand lift. V1, Administrator was notified of the Immediate Jeopardy on [DATE] at 2:27PM. The surveyor confirmed by observation, record review, interview that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1's Hospital documentation dated [DATE] includes the following diagnoses: Generalized Anxiety Disorder, Major Depression, Alzheimer's Disease, Psychotic Disturbance, Morbid Obesity, Osteoarthritis Right Shoulder, History of Cerebral Vascular Accident with Hemiparesis and Hemiplegia, Ataxia, History of Falls, Bilateral Knee Replacement, Right Rotator Cuff Repair, Anticoagulant Use, and Right Total Hip Replacement. R1's Minimum Data Set (MDS) dated [DATE] documents R1 was totally dependent on staff for all Activities of Daily Living (ADLs). This MDS documents R1 was severely cognitively impaired. R1's Progress Note dated [DATE] at 9:29 AM documents Staff stated resident (R1) lost her balance walking to the bathroom. Stated she (R1) fell into her wheelchair and fell to the floor on her right side and turned herself to sit on her bottom. Staff stated she did not see her hit her head. Gait belt was in use. Resident was complaining of right hip pain. Full head-to-toe assessment completed. When staff assisted resident off the floor and laid her down on her bed she complained of left hip pain. Family, physician, DON (Director of Nursing) and Unit director notified of fall. Physician ordered two-view x-ray of bilateral hips and pelvis stat. (contracted in house Xray Company) was called for x-ray.R1's Progress Note dated [DATE] at 10:15AM documents Staff notified this nurse that resident (R1) had a bruise to her right ear and jaw line, also bruise to right elbow. Physician, Power of Attorney (POA), Director of Nursing (DON), and Unit Director notified.R1's Progress Note dated [DATE] at 9:32PM by V18 Restorative Nurse documents Updated transfer status as follows: Transfers with use of stand lift and two (staff) assistance. Updated the following NURSING REHAB/RESTORATIVE: Transfer Program: (R1) transfers with use of stand lift stand two staff assist PRECAUTIONS: Risk for falls, Shortness of Breath, Fatigues Easily.No measurements of the bruise are documented following the [DATE] fall and a complete baseline assessment of the injury is not documented. An assessment for safe appropriate use of the sit-to-stand lift is not documented. The Weekly Skin Assessments dated [DATE], [DATE] ,[DATE], and [DATE] make no mention of the progression of the bruise first noted [DATE]. The Weekly Skin Assessments dated [DATE] and [DATE] document only scattered bruising. No sites are documented, and no measurements are documented. The right elbow bruise is only mentioned in the [DATE] skin assessment.No progress notes are documented assessing the bruising until [DATE] at 7:09PM by V15, Licensed Practical Nurse (LPN) CNAs were putting resident to bed and noted bruising to sternum and under and across right breast and under right arm that matches up with the strap of stand lift. (R1) does have some pain 5/10 and has limited ROM to right arm. V25 Medical Director was notified and was told of bruising and that (R1) also takes blood thinners. (V25) stated that as long as there is no bleeding it's ok just to monitor area. POA (Power of Attorney) and unit director notified.On [DATE] at 5:00PM, V15 stated When I called V25, I reminded V25 (R1) was on Apixaban (anticoagulant) but he did not give me an order to hold it. V25 just said monitor and as long as there is not bleeding there are no other orders.R1's Progress Note dated [DATE] at 8:52AM documents This nurse observed more bruising to residents upper left and right chest above ribcage. Resident short of breath with activity. PRN Tylenol given, and resident requested to lay down. (V21) unit director, and V2 DON (Director of Nursing), notified. (V2) requested x-ray to be done. Notified (V25) Medical Director for order. Waiting for reply.On [DATE] at 1:02PM, documents Resident had a change of condition from this morning. She (R1) became very pale, shortness of breath, and dry heaves. More bruising was starting to appear from this morning from the sit to stand sling. (V25) notified and agreed to send her to hospital. Resident POA (Power of Attorney) notified agreed to send (R1) to hospital. Ambulance arrived at 1pm and (R1) left facility at 1:05pm. Multiple bruises to R1s right side wrapping around to her mid back, bruising to right arm and into her right armpit. Bruising starting to appear to right upper shoulder by her

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to safely transfer a resident (R7) resulting in a fall and failed to investigate this fall for one of four residents (R7) reviewed for accidents in the sample list of 10. On 10/27/25 at 10:14 AM, R7 stated R7 had a recent fall while trying to get into bed with staff assistance. R7 stated a gait belt was not used during this transfer. R7's Minimum Data Set, dated [DATE] documents R7 as cognitively intact, R7 requires partial/moderate staff assistance for chair/bed transfers, and R7 had two or more falls without injury since the prior assessment. R7's Care Plan dated 8/26/24 documents R7 is at risk for falls, R7 has a transfer restorative program due to weakness and R7 transfers with one assist, gait belt, and grab bar or walker. R7's Endurance-Functional Mobility assessment dated [DATE] documents R7 transfers with one assist with use of gait belt, grab bar or walker. R7's Nursing Note dated 9/4/2025 at 8:22 PM documents R7 was being assisted into bed from his wheelchair, R7 let go of the bed rail, R7's knees weakened and R7 was assisted to the floor. R7 did not sustain any injuries. The post fall intervention was to use two assist for transfers in/out of bed. The Accident Investigation/Interview Form dated 9/4/25 documents V19 Certified Nursing Assistant (CNA) assisted R7 with transfer from wheelchair to bed, R7 let go of the railing, R7's knees became weak, and R7 was lowered to the floor. This form does not document whether a gait belt was used. There is no documentation that this fall was thoroughly investigated. On 10/27/25 at 1:18 PM, V2 Director of Nursing stated the nurse documented R7's fall in the 9/4/25 nursing note but didn't complete an incident report. V2 confirmed there was no fall investigation packet completed for this fall. On 10/27/25 at 3:09 PM, V19 CNA confirmed V19 assisted R7 during the fall on 9/4/25. In reference to this fall, V19 stated V19 transferred R7 from the bathroom into the wheelchair and V19 was in the process of transferring R7 into bed. V19 stated R7 went to grab the siderail on his bed, R7 let go with one of his hands to grab his pants while standing, R7 lost his balance and fell. V19 stated at that time R7 was a one assist for transfers. V19 stated V19 did not use a gait belt during this transfer. On 10/28/25 at 3:58 PM, V18 Licensed Practical Nurse confirmed V18 completed R7's Endurance-Functional Mobility assessment dated [DATE] and confirmed R7's transfer status at that time was one assist and gait belt. V18 stated staff would also have R7 use the grab bars in his bathroom, on recliner, and on bed, and/or wheeled walker. The facility's undated Managing Falls and Fall Risk policy documents: 1. The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g. (for example), dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review the facility failed to have the physician document and sign progress notes for each visit for five of six residents (R1, R2, R5, R9, R10) reviewed for physician visits in the sample list of 10. 1.) R1's undated Face Sheet documents R1's primary physician as V25. R1's Progress Notes, recorded by V10 Licensed Practical Nurse, document V25 evaluated R1 on 6/27/25, 8/22/25 and 9/9/25. As of 11/3/25, R1's electronic medical record (EMR) did not include any Physician Progress Notes by V25. 2.) R2's undated Face Sheet documents R2's primary physician as V25. R2's Progress Notes, recorded by V10, document V25 evaluated R2 on 6/27/25, 8/22/25, and 10/24/25. As of 11/3/25, R2's EMR did not include any Physician Progress Notes by V25. 3.) R5's undated Face Sheet documents R5's primary physician as V25. R5's Progress Notes, recorded by V10, document V25 evaluated R5 on 6/27/25, 8/22/25, and 10/24/25. As of 11/3/25, R5's EMR did not include any Physician Progress Notes by V25. 4.) R9's undated Face Sheet documents R9's primary physician as V25. R9's Progress Notes, recorded by V10, document V25 evaluated R9 on 6/27/25, 8/22/25, and 10/24/25. As of 11/3/25, R9's EMR did not include any Physician Progress Notes by V25. 5.) R10's undated Face Sheet documents R10's primary physician as V25. R10's Progress Notes, recorded by V10, document V25 evaluated R10 on 6/27/25, 8/22/25, and 10/24/25. As of 11/3/25, R10's EMR did not include any Physician Progress Notes by V25. On 11/4/25 at 8:10 AM, V2 Director of Nursing stated the physician visit notes are documented under the assessments or uploaded into the resident's EMR in the miscellaneous section. V2 stated sometimes they have to request for the physician to send them to the facility. At this time V25's Progress Notes were requested for R1, R2, R5, R9 and R10. At 9:55 AM, V2 stated V2 had to request V25's Progress Notes. On 11/4/25 at 1:49 PM, V25 stated V25 sees each resident at least every 60 days, tries to open a progress note at the time of each visit and tries to have an office day to complete the visit notes, but that doesn't always happen.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review the facility failed to ensure all staff were trained on the facility's Quality Assurance Performance Improvement Program. This failure affects all 84 residents in the facility. The facility's Facility assessment dated as reviewed 9/26/25 includes staff education/training upon hire and annually through (web-based training and education system), new employee orientation, and in-services. This Facility Assessment does not include QAPI training as one of the topics that staff will be trained on. On 11/4/25 at 10:55 AM, employee education and training were reviewed with V48 Human Resources and V48 was asked about QAPI training. V48 confirmed there was no documentation of QAPI training in the (web-based training and education system) or as part of the facility's new employee orientation training. V48 stated V48 will have to follow up with V33 Nurse Educator to see if there is any training on QAPI. At 12:35 PM, V48 stated QAPI training has not been completed since 2020. On 11/4/25 at 1:16 PM, V33 Nurse Educator confirmed QAPI training has not been completed. V33 stated V33 just added QAPI training in (web-based training and education system) for all staff and the staff have a week to complete it. The facility's Resident Roster dated 10/27/25 documents a census of 84 residents.