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	12/02/2025

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 properly install foot pedals (R58), identify oxygen tubing and call light cord as trip hazards resulting in a fall (R1) and properly transfer R1 following a fall. These failures affect two of six residents (R1, R58) reviewed for accidents in the sample list of 29. These failures resulted in R58's left leg fracture and R1's right hip and right arm fracture. Findings include: The facility's Fall and Fall Risk Management policy documents that staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling. This policy also documents fall risk factors, including environmental factors that contribute to the risk of falls, such as improperly fitted or maintained wheelchairs and unsafe or absent footwear. 1.) On 9/5/2025, R58's nursing progress notes state: While (V25, R58's Power of Attorney) was pushing resident (R58) in wheelchair outside during fall [NAME], when resident (R58) went from cement lot to grass, R58's foot caught on ground and (V25) was unaware and continued to push wheelchair per resident. Resident (R58) denies any pain or discomfort while sitting still. (R58) states discomfort with movement. Local 2–3+ edema noted below knee. Dr. (Doctor) notified and POA (Power of Attorney) made aware. Orders received to send resident to hospital. Management made aware. On 9/29/25 at 11:05 AM, R58 was in the dining room in R58's wheelchair with foot pedals on. R58 stated that she was outside at the fall festival when V25 was pushing her wheelchair without foot pedals, and V25 pushed R58 from the pavement to the grass because there were a lot of people. R58 stated the wheelchair got stuck in the grass and her leg was caught under the wheelchair. R58 stated that no staff were outside to help. R58 was brought inside and sent to the emergency room and returned with a diagnosis of left tibial fracture in two places and small joint effusion. R58's Left Knee X-ray dated 9/5/25 documents frontal view suggesting an impaction fracture of the medial tibial plateau, and the lateral view indicates a comminuted proximal tibial fracture (shinbone near the knee). Further imaging such as computed tomography (CT) was recommended. R58's Left Knee CT dated 9/5/25 documents evaluation due to left knee pain and swelling following fall from wheelchair. CT indicated fracture of the posterior tibial plateau involving medial and lateral aspects extending anteriorly into tibial metadiaphysis. On 9/30/2025 at 1:45 PM, V15, Certified Nursing Assistant, stated R58 did not have foot pedals on when her husband took her out to the fall festival, and that R58 is supposed to have foot pedals on. (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	On 12/2/25 at 11:00 AM, V2, Director of Nursing, stated R58 should have had foot pedals on appropriately, and if someone saw them incorrectly used, they should have stopped and helped/educated V25. On 12/2/2025 at 1:37 PM, V19 (Nurse Practitioner) stated R58's foot pedals should be on appropriately. V19 stated that when R58's POA was pushing R58 in her wheelchair, R58's foot being caught contributed to R58's fracture. V19 stated facility staff should have helped V25 when observing R58 being pushed with the foot pedals incorrectly placed. On 9/30/2025 at 2:15 PM, video footage of R58's incident on 9/5/2025 was viewed with V1, Administrator. The video showed R58's wheelchair foot pedals were on but were off to the side of the wheelchair, with R58's legs out in front of her. V25 attempted to place the foot pedals in proper position but was unable to and left them on the side of the wheelchair while pushing R58 outside to the fall festival. Staff walked past R58 and V25 and did not offer assistance or adjust R58's foot pedals prior to V25 taking R58 outside. V1 confirmed staff should have provided education or assistance with R58's foot pedals. 2.) On 9/29/2025 at 11:04 AM, R1 stated she thought she fell in the facility around July when she got up to go to the bathroom around 2:00 AM. R1 stated she took herself to the bathroom and did not call for staff until after she fell, and the fall caused a broken arm and hip that required surgery. R1 was unable to recall additional information regarding the fall. R1 was sitting in a recliner in her room, which was next to the bathroom wall. R1 was wearing oxygen via nasal cannula. R1's admission Minimum Data Set, dated [DATE] documents R1 as cognitively intact and requiring supervision/touch to partial/moderate assistance from staff with transfers, and supervision/touch assistance with walking. This assessment documents R1 had not had any falls since admission on [DATE]. R1's Care Plan revised 9/11/25 documents R1 has memory impairment and is forgetful; R1 is at risk for falls related to deconditioning, gait/balance problems, history of falls, and psychotropic medications. R1's Nursing Note dated 8/13/2025 at 3:41 AM documents that Certified Nursing Assistants (CNAs) were rounding and heard R1 calling for help. R1 was found lying on the floor with her head toward the foot of the bed, on her back with her feet straight out. R1 had a skin tear to the right upper forearm, left wrist, and above the right eyebrow, and had a contusion to the right upper forehead. R1 complained of right hip and right elbow pain. R1 reported she was trying to go to the bathroom and tripped on her oxygen tubing. R1 left by ambulance at 3:35 AM. The Investigation Report for Falls dated 8/13/25 documents R1 reported she was trying to go to the bathroom and environmental safety issues listed include cords—oxygen and call light. R1's fall investigation file, provided by V2, Director of Nursing (DON), included interview statements dated 8/13/25 with V10 CNA and V12 Licensed Practical Nurse (LPN). These statements describe R1's fall as documented in the 8/13/25 nursing note. R1's Hospital admission and Physical dated 8/13/25 at 4:18 AM documents evaluation for fall. R1 reported she attempted to get out of bed on her own, tripped on her oxygen tubing, and fell, hitting the right side of her head. R1 was found to have a right nondisplaced femoral neck fracture and a nondisplaced distal right humeral fracture, and Orthopedic Surgery was consulted. R1's Orthopedic Surgery Operative Report dated 8/13/25 at 2:03 PM documents a partial right hip replacement and application of a right long-arm cast. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Physician Progress Note dated 8/19/25 at 9:34 AM, recorded by V19, Nurse Practitioner, documents R1 recently admitted for long-term care and fell on 8/13, resulting in right humeral fracture and right hip fracture, post-surgical repair. R1 now requires two staff for transfers and reports that transfers are not going well, but is working with therapy on strength and tolerance. On 9/30/25 at 4:58 PM, V10 CNA stated V10 found R1 on the floor early on 8/13/25, tangled in oxygen tubing. V10 stated R1 liked to sleep in the recliner, and the call-light cord and oxygen tubing had to stretch across the room, and possibly R1 tripped over one of these, causing the fall. V10 stated R1 complained of right hip pain while on the floor, and V10 was surprised how the nurses transferred R1 into bed. V10 stated they scooped under R1's shoulders and legs, which caused R1 to scream out in pain. V10 stated a full mechanical lift should have been used or R1 should have remained on the floor until emergency services arrived. V10 stated if R1's room setup had been changed prior to the fall, it could have prevented the cords from being a trip hazard. V10 stated R1's room was changed after the fall, placing the recliner near the wall with the call-light box. On 12/1/25 at 9:29 AM, V11 LPN described R1's fall according to the 8/13/25 nursing note. V11 stated it was not in R1's best interest to have cords draped across the floor. R1 had to go over the oxygen tubing and call-light cord to get to where she was found between the foot of the bed and the recliner. R1 was found lying on her back toward her right side, and V11 questioned whether R1 had fractures based on her position and her complaints of right arm and hip pain. On 12/1/25 at 2:30 PM, V18 LPN stated R1 reported she went to stand and tripped over her oxygen tubing. V18 stated the oxygen tubing was across the floor from the bathroom to R1's recliner. V18 stated R1 was transferred off the floor with three people—one lifting R1's shoulders, one her legs, and one her waist/bottom. V18 stated a full mechanical lift was not used because R1 was lightweight and did not have complaints of pain or signs of impaired range of motion, external rotation, or leg shortening. V18 confirmed R1 did not bear weight during this transfer. V18 agreed that oxygen tubing caused the fall and stated R1's room was rearranged afterward. On 12/1/25 at 1:50 PM, V2 DON stated V2 investigated R1's 8/13/25 fall and the root cause was R1 tripping over her oxygen tubing. A new intervention was rearrangement of R1's room. On 12/2/25 at 10:31 AM, V2 stated that after a fall, a resident should be transferred off the floor either by using a full mechanical lift or by using a gait belt with two-staff assist if the resident can bear weight. On 12/1/25 at 2:42 PM, V19 Nurse Practitioner stated R1's fall caused R1's right hip and humerus fractures. V19 stated staff should have used a full mechanical lift or left R1 on the floor until emergency services arrived. V19 stated it would not be appropriate to arm-and-leg lift R1 from the floor into bed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a physician ordered nutritional supplement for one of four residents (R1) reviewed for nutrition in the sample list of 29. Findings include: On 9/29/2025 at 11:12 AM R1 stated R1 has lost weight since admitting to the facility and her most recent weight was around 80 pounds (lb). There was a bottle of (nutritional supplement) on R1's overbed table. R1 stated R1 is suppose to get one bottle three times per day, but R1 is lucky to get one. R1 was thin, with bony prominences visible. On 9/30/25 at 12:01 PM R1 had lunch in her room. R1 ate half of a pork burger sandwich, peach gelatin, and dessert. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. R1's MDS dated [DATE] documents R1 scored on the higher end of moderate cognitive impairment. R1's active care plan documents R1 has malignant neoplasm of right lower lung and small cell B-cell lymphoma, types of cancer. R1's Physician Order dated 8/25/25 documents to give 237 milliliter (ml) bottle of (nutritional supplement) three times daily. R1's Care Plan Meeting Note dated 8/26/2025 at 3:15 PM documents the interdisciplinary team met with R1's family due to significant change. This note documents R1's weight was 83.6 lbs. down from 93 lbs. in July and R1's intakes have been poor. R1's nutritional supplement was increased to three times per day yesterday. R1's weight log documents R1's weights as follows:94 on 7/6/2597 on 7/23/2593.2 on 8/4/2583.6 on 8/25/2585 on 9/7/2586.6 on 9/10/2585.4 on 9/17/2583 on 9/24/25 R1's Nutrition Note dated 9/29/2025 at 7:39 AM documents R1 had a 10 lb weight loss in one month, current body mass index is 14.2, and R1 has malnutrition. R1 is on a regular diet with (nutritional supplement) three times daily which exceeds R1's estimated needs. R1's Nursing notes dated 9/29/25 at 11:41 AM and 9/30/25 at 8:33 AM and 11:31 AM documents (nutritional supplement) 237 ml was not available to be given as ordered. There is no follow up communication with the physician or dietitian to obtain orders for alternative supplement to give. On 9/30/25 at 2:20 PM V4 Licensed Practical Nurse stated the facility has been out of (nutritional supplement) since yesterday and V4 was unsure when the supply was suppose to arrive. V4 stated V6 Ancillary Clerk is responsible for ordering the supplement. V4 stated there isn't an order to give anything in place of that supplement. V4 stated the facility has other supplements available, but nothing has been given in it's place since there isn't a physician's order.On 9/30/25 at 2:30 PM V6 stated V6 orders two cases of (nutritional supplement) every two weeks, which is 48 bottles, and V6 placed an order today that should arrive tomorrow. The storage room was viewed with V6 that contained other nutritional supplements, but there was no supply of R1's ordered supplement. V6 stated V6 was not aware that the facility was out of this supplement. 9/30/25 at 2:43 PM V2 Director of Nursing stated if a supplement is unavailable then the nurses should contact the doctor to get an order for something else to give in it's place until the supply arrives.