

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/16/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Facility Reported Incident of 10/27/22/IL153352	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1010h) 300.1010i) 300.1210b) 300.1210c) 300.1210d)6)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.  Section 300.1010 Medical Care Policies  h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/16/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LUTHERAN HOME, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6901 NORTH GALENA ROAD PEORIA, IL 61614</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/16/2022
NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 2  These Requirements were not met evidenced by:  Based on observation, interview and record review, the facility failed to properly secure and use the correct sling during a mechanical transfer for one (R1) of three residents reviewed for mechanical transfers in a sample of four. These failures resulted in (R1) slipping through the slit/hole in the back of the sling and suffering a left hip fracture.  Findings include:  Facility "Event Reporting," revised 7-29-2021, documents "Events involving a resident, visitor, or other person (non-employee) that are outside of usual or normal happenings and present a potential liability, and events that are not in keeping with standards, policies, procedures or practices and may have an adverse outcome will be documented. An Adverse Event is defined as an undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the resident, or delivery of services."  Facility "Safe Lifting and Movement of Residents," revised 9/16/22, documents under "Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this community uses appropriate techniques and devices to lift and move residents."  Facility "Positioning & Moving," reviewed 9/16/22, documents under "Policy Statement: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/16/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>device. Center for Clinical Excellence Steps in the Procedure 1. Before using a lifting device, assess the resident's current condition. 2. Select a sling that is appropriate for the resident's size and the task. 9. Before resident is lifted, double check the security of the sling attachment."</p> <p>Facility report to state agency, dated 10/31/22 by V1 Administrator, documents "During a (mechanical) transfer on 10/27/22 (by V3 and V4 CNAs/certified nursing assistants), (R1's) bottom slid out of the sling and (R1) slipped approximately one inch back into (R1's) recliner that (R1) was being lifted out of. (R1) has limited upper body strength for positioning. (V5 LPN/Licensed Practical Nurse) was summoned to the room and assisted with repositioning (R1's) arm which was positioned between the recliner chair cushion and recliner arm area crease. (R1) was admitted to (local hospital) on 11/1/22 for ORIF/Open reduction internal fixation of the left hip."</p> <p>R1's hospital record, dated 10/31/2022 at 6:15 pm by V7 MD/Medical Doctor, documents "(R1) is 84 year old and presents to the ED/Emergency Department with a four day history of left hip pain. (R1) is immobile at baseline due to previous stroke. (R1) lives in a nursing home - she was being hoisted with a (mechanical) lift four days ago when she was dropped a few inches from the nursing home onto the bed. (R1) has been having pain to her left hip since that time, which worsened two days ago when she was being moved. Pain worsens with palpation and movement of left lower extremity."</p> <p>R1's hospital record, dated 10/31/22 at 11:47 pm to 11/01/22 12:47 am by V10 MD, documents "EXAM: X-RAY LEFT HIP. HISTORY: Left hip</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/16/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>pain. IMPRESSION: 1. Comminuted and displaced left intertrochanteric femur fracture."</p> <p>R1's hospital record, dated 11/1/22 at 12:05 pm by V12 PAC/Physician Assistant Certified, documents "ORTHOPEDIC CONSULT Date of service: 11/1/2022 Chief Complaint: LEFT HIP PAIN. Musculoskeletal - Left lower extremity - leg is shortened and externally rotated. Pain with palpation of hip. Pain in hip with log rolling of the leg. Xray: Left hip/femur - Comminuted and displaced left intertrochanteric femur fracture. Plan: We will plan to go to the OR today for ORIF left IT (Intertrochanteric) fracture."</p> <p>R1's hospital record, dated 11/3/22 at 9:01 pm by V8 APRN/Advanced Practice Registered Nurse, documents "(R1) was originally admitted on 11/1 with left femur intertrochanteric fracture. (R1) was dropped a couple of inches from her hoyer lift at the nursing home approximately four days prior to admission and had complained of persistent pain in the left hip since. (R1) underwent ORIF left intertrochanteric femur fracture on 11/1."</p> <p>R1's current facility careplan- documents "(R1) will maintain current level of abilities including lift transfers."</p> <p>R1's facility MDS/minimum data set, dated 10/31/22, documents R1 requires extensive assistance for transfers, and always incontinent of bowel and bladder. R1's 4/6/22 MDS documents R1 requires extensive assistance of two plus persons for transfers, impairment of both lower extremities, and always incontinent of bowel and bladder."</p> <p>V1 Administrator E-mail, dated 11/15/2022 at 4:49 PM, documents "We use the following lifts:</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/16/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>Hoyer (mechanical). We have Full Body Slings for the Hoyer-s/m/lg/xlarge; toileting slings for the Hoyer-s/m/lg/xlg; and shower slings for the Hoyer-s/m/large/xlarge."</p> <p>On 11/15/22 multiple residents were observed in the common area and their bedrooms with mechanical lift slings placed under the residents in their wheelchairs. Extra mechanical lift slings were observed in the "weight room" including shower/toileting slings, full body slings, and sit to stand slings.</p> <p>On 11/15/22 at 10:00 am, V1 Administrator stated "I was notified by staff about (R1) and I was told (R1) came down about an inch onto her chair. (R1) did not fall."</p> <p>On 11/15/22 at 10:30 am, V6 APN/Advanced Practice Nurse RN/Registered Nurse, stated "On 10/31/22 (R1) was lying in her recliner when I assessed her, she had hip pain and swelling, and left upper outer thigh pain. She did deny pain unless her leg was moved, her left lower extremity was shortened, yelled out in pain, and left lateral thigh was red. I ordered a left hip X-Ray."</p> <p>On 11/16/22 at 10:45 am, V5 LPN/Licensed Practical Nurse stated "I was working on 10/27/22 as (R1's) nurse. I also worked with (R1) on 10/28/22 and 10/31/22 when she was sent to the hospital due to an increase in her pain to the left hip that was not controlled with Tylenol. (V3 and V4 CNAs) called me to (R1's) room where they had (R1) in the chair with a mechanical sling that was up under her that had slipped. They couldn't get the sling out from under her, and she was leaning to the left side. It was not a full body sling, it was a toilet sling that had slipped up under her</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/16/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LUTHERAN HOME, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6901 NORTH GALENA ROAD PEORIA, IL 61614</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6</p> <p>arms, and the sling was the problem. The left arm pad of the toilet sling was up under her left arm and she was lying on her left arm. The sling they used was a toilet sling where you put your arms through the holes and then criss cross the sling across the thighs. After they took the sling off her I told them this sling is not what we use for transferring her. They used a toilet sling to transfer her but she does not get toileted so I am not sure why they used that sling on her. The toilet sling is small and not as much fabric to support the resident. We try to have a sling for each resident in their room unless it gets soiled then it is sent to laundry. The slings that are used go by their size from medium to xl. (R1) is incontinent of bowel and bladder at all times and wears incontinent briefs. (R1) has no trunk control and leans to the left side. All the extra slings are kept in the weight room where they are washed and air dried."</p> <p>On 11/15/22 at 12:00 pm, V15 and V16 both CNAs/Certified Nursing Assistants stated "A toilet sling is where the arms go thru like a vest, the sling then gets pulled down and wraps around to fit under the hips and criss cross around the thighs to where your bottom is left out to toilet, and we use them when toileting."</p> <p>On 11/15/22 at 12:15 pm, V3 CNA via phone stated "I was working on 10/27/22 and I was helping (V4 CNA) with a transfer of (R1). We were lifting her up and she fell through the bottom of the sling, and it was a shower or toilet sling we were using not a full body sling. The shower or toilet sling leaves a big gap where there is a hole where your bottom is, and it is easy to fall through because (R4) almost fell through it yesterday and she is a bigger lady. I have worked at (facility) since July 2022. There are multiple types of</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/16/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LUTHERAN HOME, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6901 NORTH GALENA ROAD PEORIA, IL 61614</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>slings hanging in the weight closet. I was spotting (R1) while (V4) was using the controls on the lift, and (V4) put the lift under (R1) before I got in the room."</p> <p>On 11/16/22 at 10:17 am, V4 agency CNA via phone stated "I was working as the CNA for (R1) on 10/27/22. It was a freak accident. The sling we (V3 and I) were using was the one in her room which had a slit in the back and buckles on the sling. One of the buckles came undone and (R1) then slipped through the slit/hole in the back of the sling. The buckles are plastic, it came unbuckled from the hooyer, and I had never used this type of sling before. I have been a CNA for 4 years. It is a newer hooyer lift with different slings and there are a bunch of different slings at (facility). I refrain from using the sling now. (R1) said it scared her."</p> <p>(A)</p>	S9999		