STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007512	A. BUILDING: _____ B. WING _____	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW LUTHER HOME	505 COLLEGE AVENUE OTTAWA, IL 61350

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall	S9999		

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S9999	Continued From page 2 be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3210 General	S9999		
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to use proper transfer technique, identify root cause, and ensure fall interventions were provided and implemented for resident falls for two (R19 and R32) residents reviewed for falls. These failures resulted in R32 having pain and sustaining a lumbar fracture. Findings include: The facility Fall Reduction Protocol, Revised 1/5/2021, documents "Policy Statement: The intent of the requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: Identifying hazard(s) and risk(s); Evaluating and analyzing hazard(s) and risk(s); Implementing interventions to reduce hazard(s) and risk(s); and Monitoring for effectiveness and modifying interventions when necessary." "Procedures following fall... includes			

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S9999	Continued From page 3 the completion of... E. Review and Update Plan of Care." 1. The current Care Plan for R32 includes the following diagnoses: Muscle weakness, Wedge compression fracture of fourth lumbar vertebra, Urinary retention, and Chronic Respiratory Failure with Hypoxia. Congestive heart failure, and Supraventricular Tachycardia. This same Care Plan documents R32 is a high risk for falls related to confusion, gait/balance problems, poor communication/comprehension, and unaware of safety needs. This Care Plan includes the following interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach, encourage use and answer promptly. For no apparent acute injury, determine and address causative factors of the fall. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/IDT (Interdisciplinary Team) as to causes. If resident is a fall risk, initiate fall risk precautions. The Quarterly MDS (Minimum Data Set) Assessment for R32, dated 10/22/22, documents R32 with impaired cognition with periods of wandering behavior, requires extensive assist of two staff for bed mobility, transfers, dressing and toileting and requires total assist of two for bathing. This same MDS documents R32 has functional limitations in range of motion to both upper and lower extremities. The Fall Risk Evaluations for R32, dated 7/1/22, 7/14/22, 7/29/22, and 8/3/22 all document R32 is "At Risk" for falls. R32's Fall Risk Evaluation, dated 9/5/22 documents "NA" (not applicable) for	S9999		

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S9999	Continued From page 4 risk of falling. All of these evaluations document R32 with history of falls during last three months, balance problem while standing and walking and requires assistive device for gait and balance. R32's un-witnessed fall reports dated 7/8/22, 7/11/22, and 7/14/22 document R32 had falls. These reports did not document a root cause or intervention to prevent further falls. R32's un-witnessed fall reports dated 7/29/2022, 8/23/2022, 9/5/2022 and 9/28/2022 document R32 had falls. These reports do not document a root cause for the falls. The #70 Un-Witnessed fall report for R32, dated 7/2/22 at 2:30 am, documents "Resident found lying on the floor, right side of bed. Resident was laying on his right side with right arm under head, left arm at side and both legs extended out in front of him. Resident stated, "I rolled out of bed." This report documents R32 received an abrasion to left elbow and front of left knee and bruise to left elbow. This investigative report does not include a completed root cause analysis or fall intervention to prevent further falls. The #104 Un-witnessed fall report for R32, dated 8/3/22 at 1:20 pm, documents "Staff member alerted resident was observed laying on floor, he was on L (left) side, skin tear to R (right) forearm... Call light was on floor next to w/c (wheelchair), it was not on... There were numerous papers and newspapers on the bed he was attending to during cleansing of wound and dressing of wound." Other documentation included "Footwear was on but one shoe not tied up, off heel upon observation and assessment." This investigative report does not include a completed root cause analysis or fall intervention	S9999		

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S9999	Continued From page 5 to prevent further falls. The #114 Un-witnessed fall report for R32, dated 8/7/22 at 9:00 am, documents "Resident observed on floor. Res unable to give description." This report documents R32 received a skin tear to his left elbow. This investigative report does not include a completed root cause analysis or fall intervention to prevent further falls. The #173 Un-witnessed fall report for R32, dated 9/25/22 at 11:45 pm, documents "Entering room resident was found laying up against wall behind door. Right shoulder resting on floor, back up against wall and legs extended out in front of him. Resident stated, 'I was going out to put the mail on the chair.'" This report documents R32 received a skin tear to the back of his left hand. This investigative report does not include a completed root cause analysis or fall intervention to prevent further falls. The #209 Un-witnessed fall report for R32, dated 10/25/22 at 11:30 pm, documents "Resident was found on the floor next to the bed at 2330 (11:30pm) (Urinary) catheter is pulled out with missing tip. Resident is sent to ER (emergency room) for potential injury in the urinary tract." This investigative report does not include a completed root cause analysis or fall intervention to prevent further falls. The Skilled Nursing Visit for R32, dated 9/28/22 documents R32 was seen by V17 PCP (Primary Care Physician). V17 PCP documented "(R32) stumbled and fell while (at facility). Within 48 hours began having more severe lumbosacral pain. History of lumbar stenosis with previous laminectomy (back surgery) May 2022. Imaging here suggested mild compression deformity L1	S9999		

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S9999	Continued From page 6	S9999		

that is probably acute on CT scan. Patient's pain was reasonably well controlled with Tylenol alone, though at times he had some spasms of pain. Gabapentin low-dose to be added for pain control in addition to Tylenol. (Family) at the bedside and (Family) was brought up-to-date on diagnosis, prognosis, treatment plan. (R32) will return to the facility in improved condition. Assessment by problem: 1. Vertebral fracture, mild compression deformity L1-vertebrae, with good pain control with Tylenol at present though he has spasms of pain at times. Scheduled Tylenol 650 mg qid (four times a day). Add Gabapentin 100 mg TID (three times a day). Return to the nursing facility and begin PT/OT."

The Skilled Nursing Visit for R32, dated 10/27/22 documents R32 was seen by V16 APRN (Advance Practice Registered Nurse). V16 documented R32 was admitted to the local hospital from 9/27/22 to 9/28/22 for a closed compression fracture of L1 (first vertebra of lumbar spine) after a fall. "(R32) was sent to (local) ER with c/o (complaints of) back pain after a recent fall. Found to have an acute compression deformity of L4 with grade 1 (mild degree) retrolisthesis (vertebra slip backward on one another and graded 1-4 based on percentage of backward displacement) at L3-L4. CT (computed tomography) showed no evidence of instability. Started on Gabapentin and scheduled Tylenol due to occasional pain spasms in back. History of laminectomy in May 2022 due to lumbar stenosis. Discharged back to (facility) for rehab (rehabilitation)." Assessment/Plan: documents "Compression fracture: Conservative treatment, PT/OT (Physical and Occupational therapy), Continue scheduled Tylenol and Gabapentin. Consider starting Fosamax (treats bone loss) for osteoporosis.

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S9999	Continued From page 7 On 11/01/22 at 11:35 AM, R32 was lying in bed on his back, head of bed elevated, mats on the floor to both sides of R32's bed. R32's bed was elevated in a high position up off the floor, R32 sat up on the side of the bed, looked toward the open bedroom door, yelled out for help and then laid back down on his bed. There were no staff noted near R32's room or in the hallway at this time. On 11/02/22 at 09:21 AM, R32 was lying in bed on his left side with blue and purple bruising to his left forearm and left healing with a healing skin tear to his left elbow. R32 stated "I fell down a while ago. I don't know how many times." On 11/3/22 at 11:50 AM, R32 was lying in bed on his right side with his eyes closed. R32's call light was behind R32, hanging over the headboard out of R32's reach. The floor mats were not on the floor next to R32's bed. The floor mats were folded up and in between the dresser and the closet in R32's room. On 11/4/22 at 10:00 AM V2 DON/Director of Nursing confirmed that R32 was a high risk for falls, mats should have been on the floor next to R32's bed, R32's bed should have been lowered to the floor, and R32's fall investigations did not include a completed root cause analysis or did not have a fall intervention put into place to prevent further falls. V2 also confirmed R32 did complain of back pain after his fall on 9/25/22 and R32 was sent to the local hospital and returned with a diagnosis of lumbar fracture. 2. The Diagnosis Report for R19 includes the following diagnoses for R19: Fracture of lower	S9999		

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S9999	Continued From page 8 end of left tibia, Open wound left lower leg, History of falling, and Morbid obesity. The Witnessed fall report #154 for R19, dated 9/16/22 at 1:48 pm, documents "Two nurse's aides were assisting to get resident up in w/c (wheelchair) for physical therapy. Resident stated she didn't want to have the mechanical lift for transfer. Stated she's been using the slide board approved by PT (Physical Therapy). While resident was transferring, she wasn't properly on the slide board for her transfer. The nurses aides lowered her to the floor. Resident didn't hit her head and left leg was supported. Resident description: Resident stated she was transferring into w/c with slide board and wasn't properly on the slide board for transfer." This report documents R6 RN/Registered Nurse prepared the fall report and V7 CNA/Certified Nursing Assistant, and V8 CNA witnessed the fall. On 11/02/22 at 10:37 AM, R19 was lying in bed with a metal surgical rod extending out of her left leg. R19 stated she fell at home, broke her leg, came to the facility for therapy and is not to bear any weight on her left leg. R19 stated on 9/16/22 the staff were transferring her with a sliding board, weren't listening to her, the wheelchair wasn't positioned right, and she ended up on the floor. On 11/03/22 at 11:41 AM, R19 stated "I haven't used the sliding board since I fell. The staff use the mechanical lift to get me up. Only Therapy uses the sliding board with me." On 11/03/22 at 2:05 PM V7 CNA stated on 9/16/22 V7 and V15 CNA were transferring R19 from her bed to her wheelchair with a sliding board. V7 stated she told R19 she didn't feel good about using the sliding board to transfer R19 but R19 kept saying therapy said she could	S9999		

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S9999	Continued From page 9 use it and cleared her to use it. After R19's fall, V7 stated that (V7) asked V8 PT/Physical Therapist about using the sliding board and V8 PT said he did not release R19, and we should be using the mechanical lift. V7 CNA stated R19 was not sitting right on the board, has an air mattress and moved too fast, and was lowered to the floor. On 11/03/22 at 2:10 PM V6 RN stated she was the Nurse for R19 on the day R19 fell. V6 RN stated the CNA's used a transfer sliding board, on R19's air mattress, and R19 started sliding before V7 and V15 (CNA's) were ready and they had to lower R19 to the floor. On 11/03/22 at 2:19 PM, V8 (PT) stated therapy has been working with R19 on sliding board transfers in therapy only and no one should have been transferring her with the sliding board except therapy. Sliding boards are not to be used on air mattresses and R19 should have been a mechanical lift for transfers. On 11/3/22 at 2:30 pm, V2 DON/Director of Nursing confirmed V7, and V15 CNA's should not have been using a sliding board while transferring R19 from her bed to the wheelchair. (B)	S9999		