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	IL6007512	A. BUILDING: _____ B. WING _____	C 02/02/2023

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PLEASANT VIEW LUTHER HOME	505 COLLEGE AVENUE OTTAWA, IL 61350

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S 000	Initial Comments Investigation of Facility Reported Incident of 12-20-22/IL155363	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 300.1210 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to initiate interventions to address a	S9999		

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S9999	Continued From page 2	S9999		

resident's risk for falls and failed to complete neurological assessments as required for a resident (R1) who had sustained an unwitnessed fall with head trauma. These failures resulted in R1 experiencing a fall with serious injury, which contributed to R1's death.

Findings include:

The facility Fall Reduction Protocol policy, dated (revised) 1/5/21, directs staff, "The intent of this 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. All residents will be assessed upon admission, following a fall, quarterly, or if the IDT (Intra Disciplinary Team) recognizes a significant change in resident condition. All residents are assessed on admission using the Admission Nursing Evaluation. Residents identified as being at risk for falls will have individualized care plan interventions."

The facility Neurological Assessment and Flow Sheet policy, dated (revised) 2/1/23, directs staff, "The neurological flow sheet shall be initiated when indicated by resident assessment and/or Physician order including but not limited to the following situations: Following a fall with a witnessed head injury; Following an un-witnessed fall of a resident taking anticoagulants; Following an un-witnessed fall of a resident with high-suspicion of a head injury. The neurological

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assessment will be completed every fifteen minutes for the first hour, every thirty minutes for the next hour, every one hour for the next two hours and then every twelve hours for the next seventy two hours. Neurological assessment and documentation on the flow sheet shall include: Date and time of assessment, Vital signs, Level of consciousness, Pupillary response and Limb response. The nurse shall document and report any pertinent changes in the resident's neurological status immediately to the physician. Significant changes in condition per the neurological assessment may result in transfer to the hospital for further evaluation and treatment."

R1's Hospital Transfer Sheet, dated 12/14/22 documents that R1 was discharged from a local hospital on 12/14/22 after a 2 day hospital stay for Influenza A and Pneumonia and admitted to the facility. Additionally, R1's diagnoses included: Atrial Fibrillation, Hypertension, Muscle Weakness and Need for Assistance with Personal Care.

R1's Admission Progress Notes, dated 12/14/22 at 4:20 P.M., document, "(R1) arrived (at) approx (approximately) 3:40p (P.M.) today via bus. Droplet precautions x 24 hours as long as remains afebrile, then can d/c (discontinue) iso (isolation) after the 24 hours. PT/OT (Physical Therapy/Occupational Therapy) aware of (R1's) arrival. (R1) hard 1 assist transfer with gait belt. Alert and oriented."

R1's facility Fall Risk Assessment, dated 12/14/22, documents R1's Fall Risk as Moderate Risk due to fall(s) in the past 3 months, secondary diagnoses (atrial fibrillation, weakness and requires assistance with activities of daily living), use of wheelchair and (requires) staff

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S9999	Continued From page 4 assist for ambulation, a weak gait, and overestimates or forgets limits. R1's facility Baseline Care Plan, dated 12/15/22, documents, "Safety Risks: (R1) has a history of falls." No interventions to address R1's fall risk are documented on R1's baseline care plan. R1's Physical Therapy Plan of Care, dated 12/15/22 and signed by V8 (Physical Therapist/PT) documents, "Functional Decline - (R1) presents to therapy with a decline in transfers and ambulation due to weakness and SOB (Shortness of Breath) due to influenza. Nursing has noticed a decrease in self care abilities resulting in decreased safety and an increased need for assistance. (R1) requires skilled physical therapy in order to improve safety and function. Without therapy (R1) at risk for falls and debility." R1's Occupational Therapy Plan of Care, dated 12/16/22 and signed by V9 (Occupational Therapist/OT) documents, "Evaluation examination identified deficits of dressing, toilet hygiene, mobility, transfers. Therapy is necessary to address deficits and improve function. Without therapy (R1) at risk for falls, further decline in in functional status." R1's Nursing Progress Notes, dated 12/20/2022 at 9:30 A.M. document," CNA (Certified Nursing Assistant) called writer into (R1's) room. (R1) in bathroom, lying on his back on the floor. States was going into the bathroom to use the toilet when his 'bad knee' (left) gave out and he fell backwards, hitting head on bathroom wall. No shoes on, (R1) in only socks. Rollator walker in front of toilet. Reminded (R1) he is still weak from hosp (hospital) stay and influenza, to please call	S9999		

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for help. (R1) alert, denies pain other that soreness from lying on floor. Noted bleeding from top of head, R (right) wrist and R (right) forearm. PERRL (Pupils Equal and Reactive to Light). ROM (Range of Motion) done to all extrem (extremities). Denied pain other than to left knee, which he states he cannot bend all the way anyway, old surgical scar to left knee present. States no increased pain to knee post fall, states it is his norm (normal). Bleeding had already subsided to top of head. Up to w/c (wheelchair) with 3 assist and gait belt. Top of head left with abrasion and laceration within abrasion. Abrasion meas (measures) 5.0 x 1.8 cm (Centimeters) x 0.1 cm. Laceration within meas (measures) 4.0 x 0.3 cm x 0.2 cm. Top of head Right with abrasion meas (measures) 3.0 cm x 2.5 cm x 0.1 cm. R (right) wrist skin tear meas (measures) 2.0 cm x 0.3 cm x 0.1 cm v-shaped. R (right) forearm skin tear meas (measures) 3.4 cm x 2.0 cm x 0.1 cm. All areas cleansed with normal saline, TAO (Triple Antibiotic Ointment) and multiple steri strips applied. NP (Nurse Practitioner) updated when arrived and saw (R1). Oozing small amt (amount) of blood to frontal aspect of left head laceration. New order to send to ER (Emergency Room). 911 called. Message to son with cond (condition) report. Transferred to ER. ER called with update. Rec'd (Received) call from ER approx (approximately) 4:30p (P.M.) that (R1) will be returning to facility. They gave him a tetanus shot, CT (Computerized Tomography) of head neg (negative), steri-strips left in place and small pressure dressing applied over top of laceration as still oozing small amt (amount) of blood. Rec'd (Received) call this afternoon from son, updated. States his dad 'very stubborn.' PT (Physical Therapy) updated earlier today re (in reference to): fall."

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S9999	Continued From page 6 R1's Emergency Room Notes, dated 12/20/22 document, "(R1) with past medical history of Atrial Fibrillation on Eliquis (Blood thinner), difficulty ambulating who presents to emergency department after sustaining a mechanical fall. Per EMS (Emergency Medical Staff) nursing home staff stated (R1) is a 3-person lift assist and should not be ambulating by himself. (R1) attempted to ambulate by himself, fell hitting head against the wall. (R1) sustained an abrasion/small superficial laceration to top of head, was bleeding, therefore EMS was contacted and (R1) was transferred to the emergency department. (R1) did not have any LOC (Loss of Consciousness). CT (Computerized Tomography) of Cervical Spine and Head are negative. Clinical Impression: Closed Head Injury, Laceration of Scalp." R1's Neurological Checks, dated 12/20/22 document that neurological checks were initiated on R1 at 9:30 A.M. Subsequent neurological checks were completed at 9:45 A.M., 10:00 A.M., 10:15 A.M.,10:30 A.M., 11:00 A.M., 11:30 A.M., 1:15 P.M.,1:15 A.M. on 12/21/22. R1's neurological assessment and vital signs are incomplete for the next required assessment on 12/21/22 at 1:15 P.M. R1's Nursing Progress Notes, dated 12/23/2022 at 7:10 A.M. document, "Writer called to (R1's) room by CNAs (Certified Nursing Assistants). CNAs report that they entered (R1's) room and (R1) in bed with lg (large) amount of emesis. They assisted (R1) into chair, when (R1) went unresponsive for approx (approximately) 5 sec (seconds), then came around. (R1) sitting upright when writer entered room. Awake, answering questions, but slowly. Color pale, skin warm/dry. Arms and hands mottling. O2 (oxygen) sat	S9999		

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S9999	Continued From page 7 (saturation) 90% RA (Room Air). Initiated O2 (oxygen) at 3L Liters)/nc (nasal cannula). (Vital signs) 113/79, R (respirations) 28, P (pulse) 110. Loud audible congestion. Accucheck 258. Emesis was brown with mucus. Called 911 for transport to ER. Writer called ER with report and called son with cond (condition) change update, states will meet (R1) at hosp (hospital). Writer called ER at 1p (P.M.) to check on (R1's) status, ER nurse states they are transferring (R1) to (Trauma Center) with dx (diagnosis) of T9 (Thoracic) fx (fracture), R (right) hemothorax, L (left) rib fractures, and left pelvic fx (fracture). NP (Nurse Practitioner) updated. DON (Director of Nurses) updated." R1's (hospital) Discharge (Death) Summary, dated 12/24/22 documents, "(R1) resident at (facility) with a brief episode of loss of consciousness and vomitus visible on his clothing. EMS brought (R1) to the emergency department. Found to have audible airway noise, tachypnecic and hypoxemic with 4 liter/minute oxygen flow rate. Chest x-ray showed opacification right hemothorax. CT scan confirmed a large amount of pleural fluid, rib fractures and thoracic vertebral fracture, unstable. (R1) had been evaluated by ED staff 4 days prior after fall at the same facility. (R1) has not had any additional falls since this injury. (R1) was lucid, alert during this ED evaluation and son and daughter-in-law at the bedside. All affirmed (R1's) wish for no invasive interventions. Neurosurgery was consulted regarding (R1's) vertebral fracture and felt that it was unstable and required evaluation for operative fixation. Likewise chest tube/thoracotomy would be necessary to evacuate the pleural effusion. Transfer and evaluation for these procedures was ruled out by (R1) and his family. (R1) was	S9999		

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S9999	Continued From page 8 admitted to the medical unit. Within a few hour's time (R1) expired peacefully." R1's Certificate of Death, dated 12/24/2022 documents, "Influenza, Pneumonia, Multiple Chest Injuries Due to a Fall." On 2/1/2023 at 10:40 A.M., V2 (Director of Nursing/DON) stated, "(R1) was at risk for falls from admission as he had fallen previously and was very weak due to recent Influenza and hospitalization. (R1's) Fall Risk Assessment was completed on admission and showed him at risk. A care plan should have been instituted upon admission with interventions to prevent falls. His baseline care plan was completed on 12/15/22 by V6 (Assistant Director of Nursing/ADON). (R1) did not have a care plan for falls started on admission or upon completion of the baseline care plan (on 12/15/22). R1 did not have a plan of care initiated until after his fall on 12/20/22. Neuro (logical) Checks include a neurological assessment and vital signs. They are to be completed per the scheduled times." At that time, V2 (DON) verified the missing neuro checks for R1. On 2/1/2023 at 10:54 A.M., V4 (CNA) stated, "I have been a CNA for the past 34 years, at this facility. I remember (R1). He needed help walking to the bathroom and his walker. He was weak and unsteady. I don't recall any specific interventions for him due to being at risk for falls. I don't recall ever reading (R1's) care plan." On 2/1/23 at 11:19 A.M., V3 (Registered Nurse/RN), Previous Employee, stated, "I was recently an employee of the facility for the past 20 years. I have since taken a new position. I worked fulltime on the 4th floor, where (R1) was a	S9999		

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resident. I remember (R1). I remember when (R1) was admitted to the building. I admitted him. I didn't start a care plan on admission for him. The MDS (Minimum Data Set) person (EMPLOYEE) usually does that a couple of days after admission. (R1) came from the apartments, here on campus. (R1) had lived there for many years. (R1) had also been a resident here previously and I was his nurse. When (R1) came to us from the hospital, (R1) was very weak due to his hospitalization and his diagnosis of influenza. (R1) was definitely at risk for falling. (R1) had frequently fallen at his apartment. I had spoken with his son many times and he told us from the start that (R1) was very stubborn and independent. (R1) needed one, sometimes two staff members to get him up and ambulate with him to the bathroom, due to his weakness. From the very beginning of his stay, we had caught him a couple of times trying to get up on his own. (R1) was very independent and private. (R1) was a proud man and didn't want to ask for help to use the bathroom. (V4/CNA) came to get me the morning (R1) fell in the bathroom and told me (R1) was on the floor. (R1) had not put his call light on and (R1) was wearing socks. (R1) was on the floor just inside the bathroom door, but his walker was across the room, near the toilet. You could tell where (R1) had fallen against the wall because there was dried blood on the wall behind (R1). (R1) had skin tears on both arms and an abrasion with a laceration to the top of his head. We assessed (R1) and then me, (V4) and another one of the CNAs got (R1) up into his wheelchair. I got (R1's) skin tears cleaned up and bandaged, but (R1's) head wound kept oozing blood. (R1) was on Eliquis. The facility NP (Nurse Practitioner) was in the building, and I had her come up and look at (R1). She said since (R1) had an unwitnessed fall and was on Eliquis, (R1)

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needed to go to the ER and be checked out. I called (R1's) son and then we transferred (R1) to the ER. (R1) came back later that afternoon. They said they did a CT Scan in the ER and it was negative, and they applied a pressure dressing to (R1's) head wound and left the bandage I had placed, in place. I was also here on the 23rd when we found (R1) that morning with the large red/brown emesis and in respiratory distress. We sent (R1) immediately to the ER."

On 2/1/23 at 12:50 P.M., V7 (ADON/MDS Coordinator) stated, "I was the ADON previously, but have been transitioning into the MDS position. We found the previous MDS person was not completing her work. Our nurses don't do a care plan on admission. They do the Fall Risk Assessment on admission. But a care plan is completed with the Baseline Care Plan, which is typically done 48 hours after admission. I don't know why (R1's) Baseline Care Plan does not include any interventions for R1's fall risk. (R1's) Fall Risk Care Plan was not initiated until 12/21/22, the day after (R1) fell."

On 2/1/23 at 2:30 P.M., V8 (PT) verified he evaluated R1 on 12/15/22 and his concern was for R1's safety as R1 was at high risk to fall due to his weakness from his recent illness.

On 2/2/23 at 9:51 A.M., V10 (CNA) stated, "I remember (R1). (R1) was weak and sometimes it took two of us to get (R1) up and walk him to the bathroom. (R1) was caught a few times trying to get up by himself. I don't recall what (R1's) care plan was."

On 2/2/23 at 9:57 A.M., V9 (OT) stated, "I was R1's therapist. I evaluated (R1), two days after he was admitted. (R1) was alert, cooperative, but

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S9999	Continued From page 11 very weak. (R1) had been hospitalized with a respiratory infection and (R1) was still recovering. (R1) was very insistent that he wanted to go back to his apartment, here on campus. I documented on my report that (R1) was a high risk for falls due to all of those things, plus (R1) was impulsive." On 2/2/23 at 11:19 A.M., V11 (R1's Power of Attorney/POA) stated, "I admitted (R1) to the facility on 12/14/22. I was not with (R1) when he admitted but spoke with the facility on the telephone. I told them at that time that (R1) was stubborn and independent and had fallen many times at his apartment." (A)	S9999		