Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007504	A. BUILDING: ______ B. WING ______	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW REHAB & HCC	500 NORTH JACKSON STREET MORRISON, IL 61270

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)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 300.1010 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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: 2) All treatments and procedures shall be administered as ordered by the physician 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to assess and monitor a resident (R7) with a history of pneumonia showing a change in condition. This failure	S9999		

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resulted in R7 being admitted to the hospital in poor condition.
The findings include:

The Physician Order Sheet (POS) for R7 shows diagnosis to include anemia, coronary artery disease and chronic obstructive pulmonary disease. The POS shows orders for oxygen at 2-4 liters via a nasal cannula as needed to keep the oxygen saturations above 90%. The facility assessment dated 4/12/23 shows R7 to be cognitively intact.

On 5/23/23 at 9:21 AM, R7 was observed being taken from the bathroom by staff and placed in her wheelchair. R7 immediately fell asleep, and her breathing sounded congested. R7 would wake up when her name was said but would immediately fall back to sleep. R7 had an oxygen concentrator in her room but it was not being used. At 9:30AM, V3 Licensed Practical Nurse (LPN) was asked about R7's current condition and V3 said R7 has been like this lately due to her medications being changed.

On 5/23/23 at 10:16 AM, R7 continued to sit in her wheelchair in her room asleep, leaning over to the right, with her right hand hanging down. R7's breathing sounds congested, and she was coughing.

On 5/23/23 at 10:44 AM, R7 was still in her room asleep in her wheelchair, both hands are hanging down by her side.

On 5/23/23 at 11:48 AM, R7 was moved to the dining room leaning over to the right, still sleeping, hands hanging down. The staff and other residents were saying her name and she would wake up for a very short period and

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immediately fall back to sleep. R7 was spilling her lunch on the floor. R7 could be heard coughing at times. At 12:48PM, R7 had been pushed into the activity room and was still asleep in her wheelchair with her hands hanging down by her side and leaning to the right side. At 1:16 PM, R7 was still in the activity room, asleep in her wheelchair.

On 5/23/23 at 1:20PM, R7 was pushed down the hall by 2 Certified Nursing Assistants (CNA). One CNA was pushing the wheelchair and the other was holding her legs up. V3 came into R7's room and checked her blood pressure and oxygen saturations. V3 applied the oxygen nasal cannula to R7 and was observed adjusting the oxygen and rechecking her oxygen saturations. V3 left the room and returned with a oxygen mask which she then applied to R7 and continued to check R7's oxygen saturation. V3 left the room again and returned with a nebulizer treatment for R7. V3 said she had notified the Nurse Practitioner for a chest x-ray order. R7 continued to have a difficult time staying awake and following commands.

On 5/23/23 at 1:55 PM, R7 was in bed asleep, and her oxygen is set at 8 liters using the mask. R7 was observed using her abdominal muscles to breath.

On 5/23/23at 2:59 PM, R7 was asleep in bed with her oxygen at 8 liters per mask, using accessory muscles to breath.

On 5/24/23 at 8:00AM, R7 was not in her room. R7's medical record shows a note dated 5/23/23 at 3PM by V3 that R7 was having a hard time staying awake, was lethargic and slept through lunch. V3 documented that R7's oxygen

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S9999	Continued From page 4 saturation was 81% and she had started oxygen at 6 liters via a mask. V3 wrote she had contacted the NP and an order was received for a chest Xray and cough syrup. The note also shows a nebulizer treatment was completed and R7's saturations went up to 91% on 6 liters of oxygen. No further nursing notes were made by V3 that day for R7 regarding her change in condition. On 5/24/23 at 9:15 AM, V5 NP said she would have expected the nurse on duty to intervene and assess her earlier in the day since you informed her of the lethargy, cough and congestion. V5 said earlier intervention does have better outcomes. On 5/24/23 at 1:53 PM, V7 CNA said R7 does act more tired in the morning and will fall asleep quickly but yesterday was different, she spilled food on her for breakfast and for lunch. She usually perks up after breakfast but yesterday she did not. That was different "I told the nurse she was acting differently that day." On 5/25/23 at 8:17 AM, V6 LPN said she was the nurse who sent R7 out to the hospital. V6 said she was told in report at 6 PM that R7 was very sleepy, her oxygen saturations were in the 70's and was having a hard time breathing, hard to arouse. "When I went in around 8PM to give meds, her skin was gray, she was having a hard time breathing and was hard to arouse, she would not take her meds, she was short of breath and had crackles in her lungs and was spitting up green sputum." V6 said she called the NP and was told to send her to the emergency room. V6 said she later called the hospital to check on R7 and was told she had to be transferred to another hospital for high flow oxygen.	S9999		

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S9999	Continued From page 5 On 5/25/23 at 9:54 AM, V3 said when this surveyor approached her about R7, she felt it was just the usual behavior for R7. She did not feel the need to go check her. V3 said when she saw the CNA's bring her down the hall holding up her feet, she decided to go check her. Her oxygen saturations were 71 % at that time. V3 said she started the oxygen and gave R7 a breathing treatment and notified the NP that R7 was unresponsive, had low oxygen saturations and was coughing. "I received an order for a chest x-ray and cough syrup". V3 said R7 had just had pneumonia last month and getting a chest X-ray was standard protocol for shortness of breath. The nursing progress notes for R7 shows V6 documented at 8PM that R7's color was gray, she was very lethargic, short of breath and R7 could not tell V6 where she was. R7 was coughing up green phlegm. The chest X-ray report came back showing R7 had pneumonia. The NP was notified and R7 was to be sent to the emergency room. There were no nursing notes showing R7 was monitored or assessed between 3 PM and 8PM on 5/23/23. The emergency room note from the local hospital R7 was first sent to shows R7 was brought to the hospital by ambulance for shortness of breath and pneumonia. The note shows the report they received from the nursing home was R7 had been short of breath that day and her oxygen saturations were in the 70's and that no call had been made earlier for a patient evaluation. R7's temperature was recorded as 100.7 and oxygen saturations were 86%. The note also shows R7 was transferred to another hospital in poor	S9999		

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condition. The records for R7 shows a COBRA transfer record to send R7 to another hospital for a higher level of care due to her unstable condition.

The hospital notes from the second hospital R7 was sent to shows a plan to treat her bilateral pneumonia, respiratory failure and sepsis.

The X-ray obtained at the facility dated 5/23/23 showed a right basilar pneumonia.

R7's facility care plan shows for chronic obstructive pulmonary disease (COPD) with interventions to include: instruct and monitor for early signs of COPD exacerbation such as confusion or excessive sleepiness, shortness of breath and coughing.

The facility policy with a revision date of 12/7/17 for notification for change in resident condition or status shows the facility shall promptly notify appropriate individuals such as NP or the residents attending physician when there has been a marked change in relation to usual signs or symptoms.

(A)