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 _____	C 01/11/2024

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PLEASANT VIEW LUTHER HOME	505 COLLEGE AVENUE OTTAWA, IL 61350

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S 000	Initial Comments Complaint Investigation 23210823/IL168264	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 b) 300.1210 b) 300.1210 d)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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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	S9999		

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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:
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.

These REQUIREMENTS are not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident safety during van transport, and failed to report a resident's injury for one (R1) of four residents reviewed for falls in a sample of three. This failure resulted in a 5th metacarpal fracture of R1's hand.

Findings include:

R1's current clinical record documents R1 is cognitively intact, and has diagnoses including generalized muscle weakness, low back pain, history of falls, and a left artificial hip joint (since 05/2023).

R1's Incident note, dated 11/21/23, by V9, Licensed Practical Nurse/LPN, documents, "Resident slid from w/c (wheelchair) while exiting transport van. Small abrasion to forehead. Bleeding stopped and no c/o (complaint of) pain

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elsewhere. Neuros (neurological signs) WNL (within normal limits). On blood thinner. Witnessed by (V4) CNA (Certified Nursing Assistant). Ambulance call for transport to ER (Emergency Room) further evaluation."

R1's Incident note, dated 11/21/23, by V8, LPN, documents "Resident returned from (named ER/Emergency Room) due to fall. CT (Computerized Tomography) was normal. Multiple abrasions on left hand/knuckles, right kneecap, and top of head. No complaint of pain."

R1's Medication Administration Record/MAR, dated November 2023, documents, "Monitor laceration to top of scalp, left hand/knuckles and left kneecap - report any redness, warmth, or drainage to NP (Nurse Practitioner) or MD (Medical Director) every shift for monitoring for 7 days. Start date 11/22/23. D/C (Discontinue) Date 11/24/23."

R1's Radiology Report, date of service 11/24/23, documents, "Hand 2V (two views), Left Results: There is a fracture involving the 5th metacarpal with minimal callus and mild displacement. There is associated soft tissue swelling ...Conclusion: Left hand fracture as described." This radiology report documents a report date of 11/25/23 at 1:02 AM.

R1's written Physician Progress Notes, dated 11/27/23, documents "Needs a brace for left hand - 5th metacarpal fracture. Please schedule and appointment with orthopedics for left hand fracture" and was "noted" by V5, Registered Nurse/RN on 11/27/23 a 1:24 PM.

R1's Physician Progress Note, dated 11/28/23 and signed by V11, R1's physician, documents,

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"Diagnosis and all orders for this visit: Closed displaced fracture of neck of fifth metacarpal bone of left hand, initial encounter. History of Present Illness: Fell during transport, injured right (left) hand. Had an x-ray at the facility that shows a metacarpal fracture right (left) hand."

R1's Discharge Instructions, dated 11/29/23, documents, "Follow up with ortho (orthopedics) and keep splint on nwb (no weight bearing) to left hand." This document is signed by R1 and e-signed by V8, LPN.

On 01/10/24, at 10:07 AM, V10 R1's family member stated R1's left hand was fractured in two places after his last fall on 11/21/23. V10 stated R1's left hand is his prominent hand and he can't do anything with a brace on. At this time, V10 confirmed (R1) is seeing an orthopedic doctor and had a second x-ray which showed that one bone is healing, but the other one isn't.

On 01/10/24, at 3:07 PM, V4, CNA/Transportation Driver, stated the following: "I picked (R1) up from hospital (on 11/21/23). When we pulled up to the front door entrance, I lowered the ramp down. I told (R1) to keep his feet up so we could get him down, and he said 'yeah yeah' sarcastically. When we started going down slowly he started to try to put his hands on the wheels to try to help and I said 'no no gotta keep your hands up.' As soon as I said that he put his feet down where the end of the ramp met the ground. Then he fell forward and fell on his forehead. The first point of contact was his head." V4 continued to state, "During the wheelchair going down residents have to keep their feet up. He didn't have any footrests or a bag on the back of his wheelchair. I am prn (work as needed) and not sure if he was supposed to have footrests on his wheelchair.

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He needed constant reassurance to keep his feet up. If residents are unable to keep feet up at times you might have to incline them up so their foot pedals aren't hitting against the ramp. I did not tilt him back. Regardless if able to keep feet up or not everyone should have footrests on their wheelchairs. He could keep his feet up, but wanted to help. If he would have had footrests, he would have had his feet up, and I would have only had to watch his hands which were easier to stop and less likely to incur injury. I am not the typical transport person and was filling in for (V7, Main Transportation Driver)."

On 01/11/24, at 9:19 AM, V7, Main Transportation Driver/CNA, stated V7 does the training for the van and their bus. V7 stated, "I show them how to manually lower the ramp on the van. I tell them to line it (the wheelchair) up with the ramp and to go slow. I ask the resident to keep their hands on their lap and their feet on the foot pedals. We have foot pedals for every wheelchair. They should have them on during transport, but some do refuse. (If refuse) I definitely tell them they will have to keep their feet up and watch that they do. When going down the ramp, I have them lift their feet up. I have transported (R1) before and no problems. I know he self propels and will put his feet down, so I have to watch for it. He might have refused the pedals that day. I don't know why there weren't foot pedals on that day since I wasn't here. (R1) probably put his feet down...The safety of our residents is number one priority. It is important to watch their hands and feet and go slow."

On 01/11/24, at 3:30 PM, V2, Director of Nursing/DON, stated, "A couple of different possibilities (that may have caused R1's hand fracture) - he did land on his left side when he

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was with therapy. It was the only fall he specifically landed on the left side. The last fall during the transport, I was told he landed more face first and got the abrasions. The radiology report doesn't say it is acute. I am not sure when if first occurred. The Nurse Practitioner documented left hand edema but no pain on 11/24/23. During the fall, it was reported to me that he did not have footrests on the wheelchair. He self propelled often, so don't believe he had them on." At this time, V2 confirmed it is the transportation driver's responsibility to keep residents safe during transfer. V2 stated it is not V2's expectation for residents to self-propel out of the van.

On 01/11/24, at 4:06 PM, V11 R1's physician stated, "I looked at the films at that visit. I agree the quality of the film isn't great. It is not possible to know whether it (the fracture) is new or old. (R1) was asymptomatic enough to have no concern about his hand. He had no complaint of pain only swelling when Nurse Practitioner ordered the x-ray. My sense is that it is subacute whether than acute. I can not be certain of when the fracture occurred, but it most likely happened with a fall."

On 01/11/24, at 3:13 PM, V2, Director of Nursing/DON, stated V2 first saw R1's radiology report of R1's hand fracture yesterday. V2 stated, "The radiology report doesn't say it is acute. I am not sure when if first occurred. The Nurse Practitioner documented edema but no pain on 11/24/23, so I am not sure when it happened. The Nurse Practitioner ordered the hand x-ray. Not sure if it is a new fracture. Had I known about it then I would have reported it to (State Agency) then. (R1) had a fracture so would have reported it anyway even if can't point to any particular

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incident." V2 confirmed at this time, it should have been communicated to V2, and V2 should have reported it. As of 1/11/24, this incident had not been reported to the State Agency.

The facility's Abuse and Neglect of a Resident policy, dated 6/16/23, documents, "Definitions - Serious Bodily Injury: An injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse." This policy continues with "9. External Reporting of Abuse Allegations: The resident's representative and the Department of Public Health shall be informed immediately. Immediately, and not to exceed, but not later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury, to the administrator of the facility and to other officials (including State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with state law. The Preliminary Incident Investigation report shall be sent to the Department of Public Health ...Within five (5) working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation will be sent to the Department of Public Health."

The facility's Incident Reports - Clinical Department policy, dated 9/3/23, documents, "Policy Statement: An incident is any happening

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which is not consistent with the routine operation of the facility or the care of a particular resident. It may be an accident or a situation which might result in an accident. The nurse should complete an incident report after each accident/situation i.e. falls, bruises, skin tears, resident to resident abuse, and elopement. This facility shall notify the Department of Public Health of any accident or incident, which has, or likely to have significant effect on the health, safety, or welfare of a resident. In implementing this policy the following shall apply to ensure appropriate follow up care in the event of an accident/incident: 8. This facility shall notify the Department of Public Health of any incident or accident that meets their reporting guidelines ...10. A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. 11. The facility shall maintain a file of all written reports of incidents or accidents involving residents."

The facility's Wheelchair Leg Rests policy, dated 8/5/23, documents, "Policy Statement: It is the intent of this policy to allow residents/patients to be transported safely in wheelchairs. To this end, wheelchairs will be equipped with leg rests that fit the wheel chair properly and are accessible for use at all times. Procedure: 3. Wheelchair leg rests are to be in position on the wheelchair in the following situations: a. The patient is being propelled by employees, family members, volunteers, therapists, etc ...5. General safety precautions when using wheelchair leg rests: c. Once the patient is seated in the wheelchair, make certain the footrests are lowered and secured with the resident's feet in place before releasing the brakes and moving the wheelchair."

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S9999	Continued From page 8 The facility's Job Description Certified Nursing Aide, undated, documents "Primary Responsibilities: Use proper techniques for resident escort and transfer." The facility's Falls Prevention and Post-Falls Management policy, dated 8/8/23, documents, "Resident-Centered Approaches to Fall Risk Assessment: 8. In conjunction with the attending physician, staff will identify and implement relevant interventions (for example hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling." The facility's van Installation Instructions manual, undated, documents "Other items to consider when determining floor anchorage placement: "Tiedowns should have a clear path from floor anchorages to the wheelchair frame without infringing on any parts of the wheelchair (E.g. (for example) footrests)." This Instruction manual includes numerous photos of a manikin sitting in a wheelchair. All of the photos show the manikin's feet resting on the wheelchair footrests. (B)	S9999		