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 06/20/2024

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

(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 Complaint Investigation #2424638/IL174317	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 300.1210 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.	S9999		

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S9999	Continued From page 1	S9999		

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 were not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident safety during assisted ambulation for one (R1) resident of four reviewed for falls in a sample of four. This failure resulted in R1 receiving a fractured femur followed by a decline in condition and subsequent death.

Findings include:

The facility's Falls Prevention and Post-Falls Management policy, dated 8/8/23, documents "Policy: The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and other members of the multidisciplinary team, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information." This policy also states "Resident-Centered Approaches to Fall Risk Assessment: 5. The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, Excessive motor activity,

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S9999	Continued From page 2	S9999		

activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition."

The facility's Gait Belt/Transfers policy, dated 10/10/23, documents "All staff members who assist resident to transfer or ambulate will be required to use a gait belt during these procedures. In implementing this policy, the following shall apply...B. Gait belt must be used with all assisted transfer or ambulating procedure."

R1's current Physician Order Sheet/POS documents diagnoses including but not limited to Alzheimer's Disease with late onset, General Anxiety Disorder, Chronic Kidney Disease, Muscle Weakness (generalized), and Displaced Intertrochanteric Fracture of Left Femur.

R1's Minimum Data Set/MDS assessment, dated 1/23/24, documents R1 with moderately impaired cognition, requiring partial/moderate assistance for ambulation of 10 feet and 50 feet with two turns, and substantial/maximum assistance to walk 150 feet.

R1's Fall Risk Assessment, dated 1/23/24, documents R1 as a moderate risk for falling.

R1's Facility Reported Incident, dated 3/13/24, documents "Resident was ambulating with CNA (Certified Nursing Assistant) and wheeled walker when she tripped over her feet. Sent to ER (Emergency Room) for evaluation, found to have left hip fracture."

R1's Hospital records include an x-ray of R1's left hip with pelvis, dated 3/12/24, with a radiology report that documents "Impression: 1. Intertrochanteric fracture of the left femur as

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described."

On 6/18/24, at 2:41pm, V3 Registered Nurse/RN stated the following: "That day I remember it was dinner time around 6pm and I was on the other side in the other dining room. I heard some commotion on the other side, so I ran over to the other dining room. Then I saw (R1) on the floor. So, I assessed (R1) and then noticed she had limited movement on her left side. That night she was talking but had pain. I had asked (V4 Certified Nursing Assistant/CNA) what happened. There was one other person in dining room at the time. (V4) was the one walking with (R1). (V4) said (R1) was walking and (R1) tripped over the little threshold portion of the floor between the carpet and flooring. I asked more questions like was she by her and she said yes. Then later one of the CNAs (does not recall name) said (V4) was on her phone. Once we got (R1) in the chair we noticed she couldn't put weight on her leg. I asked (R1) what happened. (R1) is very outspoken. (R1) said something along the lines of 'She wasn't walking with me. She was on her phone.' I saw that (R1) did not have a gait belt on. (R1) was a one assist with stand-by so (V4) probably should have had one (gait belt) on her. (R1) just had her walker."

On 6/18/24, at 3:42pm, V2 Director of Nursing stated "I know (R1) did walk most times to the dining room with a CNA. Not sure if (V4 CNA) used a gait belt. I know that is our standard. That is what is expected. I don't remember asking (V4) if she used one."

On 6/20/24, at 2:15pm, V4 CNA stated that R1 tripped over a rubber piece of the floor while V4 was walking with R1 to the dining room. V4 stated "I did not have a gait belt on her at that time. I

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should have, but for the most part she was independent, and she was coming out the door and I didn't grab it quick enough, and we just kept going." This writer asked V4 what V4 could have done differently that might have prevented the fall and V4 stated "Obviously used a gait belt."

R1's clinical record documents the following: Progress Note, dated 4/1/24, states R1 returned from the hospital after surgery for her fractured femur; R1 has confusion, which was a new level of impaired cognition, and now requires cueing. Progress Note, dated 4/5/24, stated R1 was lethargic and unable to take medication. Physician Order Sheet/POS documents an order, dated 4/5/24, for R1 to be admitted to Hospice. Progress Note, dated 4/8/24, documents R1 expired with family at her bedside.

R1's Death Certificate documents cause of death: Aspiration Pneumonia due to Congestive Hypertensive Cardiovascular Disease; Significant Conditions Contributing to Death: Fracture of the Femur due to a fall and Chronic Kidney Disease.

On 6/20/24, at 10:20am, V7 (R1's physician) stated the following: "No question about it that (R1's) fall with fracture exacerbated her decline and subsequent death. She was so frail." V7 also stated "With her age, long bone fracture, and a surgical procedure, (R1's) mortality risk was high within the first six months for complications, including death. Even without surgery her risks were high."

(A)