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 05/08/2025

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 Facility Reported Incident dated 4/10/25/IL191219	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 observation, interview and record review the facility failed to identify environmental hazards and implement fall prevention interventions for a resident who has a history of falls. This failure resulted in R1 tripping over a resident's wheelchair, falling and hitting his head on the floor sustaining a C1 (neck) fracture. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 5.

Findings include:

R1's Final Incident Report dated 4/14/25 shows (R1) is alert to self only. He requires the assistance of one caregiver to complete activities of daily living. He ambulates with his walker. On 4/10/25, (R1) finished breakfast in the dining room and began ambulating back to his room when he tripped and fell to the ground ...(R1) complained of right shoulder pain and head pain. (R1) had a vomiting episode and superficial abrasion to right side of forehead he was transferred to the ER for evaluation. (R1) had

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S9999	Continued From page 2	S9999		

imaging performed in the ER that showed a C1 fracture.

R1's face sheet shows he is an 82-year-old male with diagnoses including Alzheimer's, vascular dementia, type 2 diabetes, muscle weakness and hypertension.

R1's Fall Risk Assessment dated 3/20/25 shows he is a HIGH fall risk, has a weak gait and overestimates or forgets limits.

On 5/7/25 at 11:53 AM, the dining room table where R1 sat shows a wall behind the chair and a water cooler stand to the left. The space behind the chair was narrow, this surveyor could not walk through the space going forward, this surveyor turned her body to the side to fit through the space. R5 was sitting at the table on the opposite side of the table away from water cooler, she was sitted in a recliner chair with oversized wheels.

On 5/7/25 at 9:32 AM, V13 (Certified Nursing Assistant-CNA) said she was R1's CNA on 4/10/25. During the breakfast meal, she was sitting at the back table feeding other residents. R1 was sitting in the middle of the table with one resident to the right of him and R5 was sitting next to him on the left. She heard R1 fall, R1 was laying on the floor on his right side he had a gash to his forehead, and he threw up immediately after falling. R1 was trying to leave the table going from the left side and there was not enough room for him to go through, he tripped over the wheelchair. R5's wheelchair wheels are huge when she sits on the side of the table where the wall is there her there is not enough room to get by. R1 is alert, he self-transfers, we encourage him to use his walker and he can get up independently.

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On 5/7/25 at 9:55 AM, V12 (CNA) said on 4/10/25 she was in the dining room during the breakfast meal. She was sitting at the table assisting another resident with feeding. R1 was sitting in the middle with one resident to his right and R5 to his left. She saw R1 get up from this table and he stepped over R5's wheelchair, tripped and fell landing on his right side. R1 threw up right away after falling and had a cut on the side of his head. R5's wheelchair wheels stick out a lot in the back, her wheels were almost touching the water cooler located behind her. There was not enough room for him to walk through. R1 is a fall risk and is supposed to use a walker when ambulating, he walks independently. Since the incident we place R5 on the opposite of the table so she's not blocking the space.

On 5/7/25 at 11:18 AM, V15 (CNA) said on 4/10/25 she was in the dining room assisting with feeding. R1 tripped leaving the dining room, because R5's wheelchair was in the way. R1 is supposed to use the walker when he gets up but does not like to use it.

On 5/7/25 at 10:10 AM, V11 (RN) said on 4/10/25, R1 was in the dining room sitting at the table he was in the middle between two residents. There is a resident (R5) who has a larger wheelchair sitting to his left, R5's wheelchair was positioned at an angle, R1 tried to go over R5's wheelchair and he was not able to get through without stepping over her the wheelchair wheel. R1 fell on his right side hitting his head on the floor, he had a good size abrasion to his forehead. There is wall behind his chair and a water cooler to the left side. R1's walker was against the wall, there was not enough space behind his chair for R1 to use his walker. R1's had numerous falls, he does not

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pay attention, he shuffles when he walks, is impulsive and gets up by himself. R1 should have been placed at the end of the table where he had room to use his walker when he got up, he used to sit at the end of the table. R1 had a previous incident of tripping over a chair.

R1's Fall Incident Reports shows he had a fall on 1/23/25, 2/3/25, and 3/20/25.

R1's current care plan initiated on 3/24/23 shows he is at risk for falls related to confusion and history of prior falls.

R1's fall interventions include anticipate the needs of the resident, ensure appropriate footwear, resident to use rolling walker for support and balance with all transfers and ambulation, skilled therapy evaluation. The care plan shows the last fall intervention was on 12/20/24. R1's care plan shows he transfers with limited extensive assist.

R1's Fall Prevention and Post-Falls Management Policy revised 2025 states, "The nursing staff, in conjunction with the attending physician ...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 ...Fall Risk Factors: environmental factors that contribute to the risk of falls ....obstacle's in the footpath ...the staff will seek to identify environmental factors that may contribute to falling such as lighting or room layout ..."

(B)