STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. BUILDING _____ B. WING _____	09/16/2021

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

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification and Licensure survey.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	F 583		9/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/01/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide privacy during incontinence care and toileting for 2 of 12 residents (R8, R126) reviewed for privacy in the sample of 12. The findings include: 1. The September 2021 POS (Physician order sheet) documents R8 was re-admitted to the facility on 5/27/21 with multiple diagnoses including dementia and anxiety. The 7/3/21 quarterly facility assessment documents R8 has severe cognitive impairment. On 9/15/21 at 9:18 AM, V5 LPN (Licensed Practical Nurse) and V8 CNA (Certified Nursing Assistant) assisted R8 into the bathroom located in her room. R8's roommate was observed sitting in the room facing the bathroom. V5 and V8 wheeled R8 into the bathroom, and stood her up, pulled down her pants, and placed her on the toilet. During this process, the bathroom door was open, no privacy curtain was pulled to block the view of the bathroom, and no attempts were made to remove the roommate from the room. On 9/16/21 at 9:31 AM, V2 DON (Director of Nursing) said the bathroom door should be shut when residents are having care provided, or curtains should be pulled. The facility's undated policy for toileting- general procedure documents Procedure: 6. Pull the privacy curtain and close the door to the resident's room or bathroom.	F 583	F583 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3) (i)(ii) 483.10(h) Privacy and Confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and medical records. 483.10(h)(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. 483.10(h)(2)The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral(that is, spoken) written, and electronic communications including the right to send and promptly received unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. 483.10(h)(3) The resident has a right to secure and confidential personal and medical records except as provided at 483.70A(i)(2)or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long Term Care Ombudsman to examine a resident's medical, social and administrative records in accordance with State law.	

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F 583	Continued From page 2 2. On 9/15/21 at 9:15 AM, V2 Director of Nursing (DON) and V9 Certified Nursing Assistant (CNA) provided incontinence care for R126. R126 was in her bed. R126's pants were lowered to the knees, a soiled incontinent brief was removed, and the groin and buttock areas were cleaned. R126's window coverings were open during care. R126's window faces the front of the building. On 9/15/21 at 9:35 AM, V2 said the windows should have been covered while doing incontinence care on R126 to provide privacy. Then, V2 told V9 "we forgot to close the curtains". At 12:26 PM, V2 Director of Nursing said there is no facility policy for privacy, dignity or privacy during incontinence care. The 11/18 Illinois Long-Term Care Ombudsman Program Residents' Rights booklet showed your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care. A facility policy for privacy, dignity and privacy during incontinence care was requested and none were received.	F 583	1. The corrective actions which have been accomplished for those residents found to have been affected by this alleged deficient practice include: A) Staff in service was conducted on privacy and dignity with special attention to utilizing privacy curtains during toileting. (Attachment A) 2. Two residents in a sample of 12 residents had the potential to be affected by the alleged deficient practice. However, with the implementation of the 1A, above and the quality assurance measures mentioned in this Plan of Correction, the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A) The DON or designee will ensure compliance during daily QA rounds. 4. The following Quality Assurance programs have been implemented to ensure continued compliance. A) The Quality Assurance team will monitor compliance through the internal Quality Assurance Process. Completion Date: 9/17/21	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		9/17/21

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F 686	Continued From page 3 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify pressure injuries prior to becoming Stage two injuries and failed to ensure resident air mattresses were operated in accordance with manufacturer's recommendations for five of seven residents (R10, R1, R23, R5, R12) reviewed for pressure in the sample of 12. The findings include: 1. R10's face sheet showed an 84 year old female with diagnosis of neuropathy, heart failure, chronic kidney disease, generalized muscle weakness, and hypertension. This face sheet showed the resident speaks Gujarti (not English). R10's September 2021 physician order sheet showed an indwelling urinary catheter and a colostomy. On 09/14/21 at 10:16 AM, R10 was laying supine in bed with a sheet and blanket over her head. There was an air mattress on her bed. The settings showed the resident weight set at 180 pounds, there was no mode selected and the max inflate was off. At 11:47 AM, R10 was up in a chair in her room.	F 686	F686 483.25(c) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) 483.25(b) Skin Integrity 483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that that (i) a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable: and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 1. The corrective action for the alleged deficient practice have been achieved by the following: a. Nursing Staff was in-serviced by the Director of Nursing on the Preventative Skin Care Program, with a specific focus on timely identification, Braden Scores	

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F 686	Continued From page 4 Both feet were dangling unsupported. Both feet had black socks on. There were no heel protectors on. On 9/15/21, R10's air mattress settings remain the same as observed on 9/14/21. On 9/15/21 at 1:35 PM, V2 Director of Nursing (DON) accompanied this surveyor to look at R10's air mattress. V2 said she and maintenance set up the air mattresses. V2 was asked who I could speak to in maintenance and V2 responded the position was currently vacant. V2 said she had no training on the use, set up, or troubleshooting of any of the facility's air mattresses. R10 was in bed when V2 looked at her air mattress. This surveyor showed V2's current weight of 138.8 pounds and asked why the air mattress was set at 180 pounds. V2 turned the weight on the mattress down to 150 pounds. This surveyor pointed out that no mode was selected and V2 selected a mode. V2 was asked why the weight was wrong and why no mode was selected and V2 said "I don't know how to answer that". The max inflate option was off and V2 left it off. On 9/15/21 at 11:08 AM, V2 said wounds should be identified prior to a stage II. On 09/16/21 at 08:48 AM, V2 said that no one in the facility had been trained on the safe use of either R10's or R23's air mattress. V2 confirmed the facility still has no manufacturer's operating manual for R10's air mattress to assist with safe operation or trouble shooting. V2 said the facility did not have R23's air mattress manual until it was requested by this surveyor. R10's 7/12/21 facility assessment showed R10 was dependent for bed mobility, dressing, toilet	F 686	and following care plans. (Attachment A) b. The facility has obtained a wound care Physician to assist with proper treatments of all skin conditions in facility. (Attachment B) c. Nursing in serviced on all air mattresses in facility, including need for physician's orders for mattress and setting (Attachment C) d. Physician's order for air mattress settings was obtained for R23 and R10 and have been set to the correct setting (attachment D) e. Regional Clinical Director completed in service for Administrator and Director of Nursing on Air Mattress manuals, operation and settings which included how to contact the companies for troubleshooting.(Attachment E) f. MDS Coordinator audited current residents' Braden scores to ensure accuracy to assist in timely identification. (Attachment F) 2. Five of seven residents had the potential to be affected by the alleged deficiency. However due to the implementation of a-f the alleged deficient practice will not recur. 3. The following systemic measures have been implemented to ensure the alleged deficient practice does not recur. a. The DON/ designee will monitor for compliance during QA daily rounds. 4. The following quality assurance plans have been implemented to ensure continued compliance: a. The quality assurance team will monitor for compliance through the	

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F 686	Continued From page 5 use, personal hygiene, and bathing. This assessment showed R10 required extensive assistance for transfers, had an indwelling catheter and ostomy. R10's 5/25/19 pressure ulcer care plan showed to use a pressure reducing air mattress. R10's September 2021 physician order sheet (POS) (printed 9/15/21) showed no orders for an air mattress. R10's monthly weight record showed for September 2021 a weight of 138.8 pounds. R10's pressure injury risk assessments dated 6/5/21, 7/7/21, and 7/20/21 showed a high risk score. R10's September 2021 treatment administration record (TAR) showed an order dated 2/15/21 for heel protectors on at all times. The facility's 1/18 Pressure Sore Prevention Guidelines showed it is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as high and moderate risk for skin breakdown. The manufacturer's user manual for R10's air mattress was requested and not received. R10's February 2021 weekly wound assessments showed a Stage 2 facility acquired pressure injury to the right buttock dated 2/2/21. This wound measured 2.6 centimeters (cm) X 2.5 cm X <0.1 cm. R10's March 2021 weekly wound assessment showed a facility acquired unstageable deep tissue injury to the left heel found on 3/11/21. This wound measured 1.0 cm X 2.8 cm. R10's July 2021 weekly wound assessment showed a facility acquired Stage 2 pressure injury to the coccyx found on 7/20/21. This wound measured 4.5 cm X 3.0 cm X 0.1 cm.	F 686	internal quality assurance process.	

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F 686	Continued From page 6	F 686		

2. R1's face sheet showed an 86 year old female with diagnosis of dementia, need for assistance with personal care, and generalized muscle weakness.

R1's 6/10/21 facility assessment showed resident is rarely/never understood. This assessment showed R1 was dependent for bed mobility, transfer, locomotion, dressing, eating, toilet use, and personal hygiene. The assessment showed R1 was frequently incontinent of bowel and bladder, was at risk for developing pressure injuries and R1 did not have any unhealed pressure injuries.

R1's pressure injury assessments dated 4/12/21, 6/2/21, 6/10/21, and 7/23/21 showed a high risk score.

R1's weekly wound assessment form showed a Stage 2 pressure injury to the right medial heel acquired in the facility was found on 7/23/21. This wound measured 2.3 cm X 2.7 cm X 0.1 cm. Another wound, a Stage 2 pressure injury acquired in the facility was found on 7/23/21 to the left lateral heel. This wound measured 2.2 cm X 3.5 cm.

3. R23's face sheet showed an 83 year old male with diagnosis of dementia, diabetes, heart failure, rheumatoid arthritis, unsteadiness on feet, and need for assistance with personal care.

On 09/14/21 at 09:58 AM, R23 was resting in bed with his eyes closed. There was a low air loss mattress on the bed. The mattress pump was set to firm, the alternating indicator was on, the pressure was set to normal (as opposed to low

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F 686	Continued From page 7	F 686		

pressure) and the indicator was set to normal pressure (as opposed to option of low pressure). At 11:07 AM, V6 Certified Nursing Assistant (CNA) and V7 CNA performed incontinence care for R23 as he was incontinent of urine.

On 9/15/21, R23's air mattress settings remained the same as observed on 9/14/21.

On 09/15/21 at 10:20 AM, V4 Registered Nurse said she found a new open area to R23's his coccyx. This surveyor had requested to observe a skin check on R23 with staff prior to this finding.

On 9/15/21 at 1:50 PM, V2 accompanied this surveyor to look at R23's air mattress. V2 said she and maintenance set up the air mattresses. V2 was asked who I could speak to in maintenance and V2 responded the position was currently vacant. V2 said she had no training on the use, set up or troubleshooting of any of the facility's air mattresses. R23 was in bed when V2 looked at his air mattress. V2 said "his rear end is to the bottom. The alternating should be off "and it is correctly set at "firm".

R23's 8/28/21 facility assessment showed R23 was not cognitively intact and was dependent on staff for bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. This assessment showed no unhealed pressure injuries.

R23's pressure injury risk assessments dated 5/6/21, 6/5/21. And 8/24/21 showed a high risk score.

R23's monthly weight log showed a September 2021 weight of 171 pounds.

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F 686	Continued From page 8	F 686		

R23's September 2021 physician order sheet showed no order or settings for the air mattress.

R23's weekly wound tracking form showed a new Stage 2 pressure wound acquired in the facility with an onset date of 9/15/21. The wound is to the right of the coccyx and measured 3.0 cm X 0.9 cm X <0.1 cm.

The manufacturer's user manual for R23's air mattress was not available. After requesting the manual one was downloaded and copied for this surveyor. The front cover of the manual showed Important: Do not operate the mattress system without first reading and understanding this manual! Save this manual for future use. The manual showed higher pressure output (firmness) will better support the heavier weight user. Please consult your physician for an appropriate setting. Troubleshooting-Patient is bottoming out; Pressure setting might be inadequate for patient; adjust comfort range one to two levels higher and wait a few minutes for maximum comfort. The pump pressure adjust knob- higher pressure output will better support heavier-weight user. Please consult your physician for an appropriate setting.
4. The September 2021 POS shows R5's admission date to be 7/3/2017 with multiple diagnoses including diabetes, anemia, PVD (Peripheral Vascular Disease) and Parkinson's disease.

The facility pressure ulcer risk assessment of 7/15/21 shows R5 is a high risk for developing pressure ulcers.

The facility's 7/1/21 functional status for ADL's

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F 686	Continued From page 9	F 686		

(Activities of Daily Living) shows R5 requires extensive assist of one staff for bed mobility, transfers, and personal hygiene. The cognitive assessment shows R5 has severe cognitive impairment.

The weekly wound tracking for July 2021 documents on 7/15/21, a facility acquired stage II pressure injury to R5's coccyx/ left buttock was identified. The wound measured 2.0 cm by 1.5 cm and was 0.1 cm in depth. The wound was noted to be deteriorating with minimal drainage.

On 9/14/21, R5 was observed sitting up in his wheelchair, he had a urinary drainage bag under his wheelchair. He had large foam boots on both of his heels.

On 9/15/21 at 11:14 AM, V2 said R5 should be a daily skin check. Pressure injuries should have been found prior to becoming a stage II.

5. The September 2021 POS shows R12 was admitted 7/30/19 with diagnoses including diabetes.

The facility assessment for pressure ulcer risk shows R12 is at high risk for pressure ulcer due to being chairfast and having very limited mobility.

The July 2021 weekly wound tracking documents the left heel with a reoccurring pressure area had developed a stage II pressure injury measuring 1.5 cm x 2.4 cm. The wound was assessed to be deteriorating.

On 09/14/21 at 02:01 PM, R12 was observed to have a small purple area on her left inner heel.

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F 686	Continued From page 10 On 9/15/21 at 11:08 AM, V2 said R12 has the same area that opens. V2 said R12 digs her heels into the bed, those areas that break down are on the bed. She should have skin checks daily because of the Braden score (risk assessment). V2 said the wounds should be identified prior to a stage II, that is a good sized open area, the shower sheet should have reflected a problem and should have been reported to the nurse.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have fall prevention interventions in place and failed to safely transfer residents with a gait belt for three of five residents (R23, R8, R21) reviewed for falls in the sample of 12. This failure resulted in R23 falling onto the floor and sustaining an impacted left femoral neck fracture requiring surgery. The findings include: On 09/14/21 at 09:58 AM, R23 was resting in bed	F 689	F689 Free of Accident Hazards/Supervision/Devices CFR(s):483.25(d)(1)(2) 483.25 (d) Accidents. The facility must ensure that 483.25(d)(1)The resident environment remains as free of accident hazards as possible and 483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. 1) Corrective actions which will be accomplished for those residents found to have been affected by the deficient	9/17/21

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F 689	Continued From page 11 with his eyes closed. The right side of his head adjacent to the eye and upward was bruised. There was a small band aid to the top of his head on the right side. R23 did not respond when spoken to. On 09/14/21 at 11:07 AM, V6 Certified Nursing Assistant (CNA) and V7 CNA were preparing to transfer R23 from the chair to bed. There were steri-strips to R23's right hand and a 4 inch X 4 inch padded dressing to the top of the head posteriorly. V7 placed a gait belt around R23's waist. V6 and V7 lifted R23 under his arms and lifted R23's full body weight during the transfer. R23's feet slid across the floor during the transfer as R23 did not bear any weight to his legs. At 11:34 AM, V6 and V7 entered R23's room with a total mechanical lift to transfer R23 from the bed to the chair. This surveyor asked V7 why a lift was being used this time and V7 said "because you were concerned about him not bearing weight". There was a dressing in place to R23's left hip. R23 cried out in pain when being turned from side to side in bed and yelled "Jesus Christ". On 9/14/21, V3 Licensed Practical Nurse (LPN) said when R23 fell on 8/20/21 she heard the fall from the nurse's station. When she got to R23's room he was laying on the floor. On 9/15/21 at 12:26 PM, V2 Director of Nursing (DON) said a resident's care plan tells you how much assistance a resident requires for transfers. V2 said "If a resident can't bear weight, they should be a mechanical lift" (total mechanical lift). R23 was to be weight bearing as tolerated (on the left leg). R23 used a total mechanical lift as needed.	F 689	practice: A) DON in serviced nursing department on safe resident handling, proper gait belt usage, fall prevention, safety devices, changes in resident condition, AIMS fall pathways and change in care plan notices with a specific focus on following care plan interventions. (Attachment A) 2) Three out of five out of a sample of twelve, had the potential to be affected by the alleged deficient practice, however, due to the implementation of 1(A) the alleged deficient practice will not recur. 3) Upon review of the facility's systemic measures, the systemic measures that have been implemented to ensure the alleged deficient practice does not recur: A) The Director of Nursing/Designee monitors safety devices, proper resident handling daily and completes a fall assessment audit weekly - this was implemented on 8/23/21 and will end on 10/1/2021.(Attachment B) 4) Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: A) The Quality Assurance team will monitor compliance through the internal Quality Assurance process. Completion Date: 9/17/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. BUILDING _____ B. WING _____	09/16/2021

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F 689	Continued From page 12	F 689		

On 09/16/21 at 08:35 AM, V11 CNA said, the morning of 8/20/21, me and V3 Licensed Practical Nurse heard R23 fall. We were at the nurses' station. We heard him hit the floor so me and V3 ran in there. R23 was laying on his right side next to the bed. Prior to that he was in bed. He was bleeding from the back of his head and complained of pain to the right leg. There were no alarms on and the floor mat was not in place. The floor mat was on the other side of the room.

On 9/16/21 at 9:38 AM, V13 Nurse Practitioner said she expects fall prevention interventions to be in place if they are indicated. R23's alarm wouldn't have prevented his fall but if R23's fall mat had been in place it could have lessened the injury. R23's fractured hip was caused from the fall to the floor.

R23's face sheet showed admission to the facility on 5/6/21.

R23's 5/10/21 nurses note showed he was found on the floor in his room lying on his back.

R23's 5/12/21 care plan intervention showed to use a chair/bed pressure alarm.

R23's 8/3/21 fall care plan showed the resident has been known to attempt to get out of bed unattended, mat on floor. Resident has dementia and poor safety awareness. He is confused and unaware of safety limitations at times.
The facility's 8/26/21 incident summary showed on 8/20/21 at 6:20 AM, V3 Licensed Practical Nurse and V11 CNA heard a noise come from R23's room and R23 was found on the floor next to his bed.

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F 689	Continued From page 13	F 689		

R23's 8/20/21 CT scan of the left lower extremity showed an impacted left femoral neck fracture. R23's 8/21/21 post op left hip x-ray showed recent left hip arthroplasty hardware intact.

During the survey, there was a poster on the wall in the staff bathroom that showed- Always ask yourself, is this the safest transfer for our resident? Can't bear weight for 5 seconds or more? Get a lift! Safer transfers for residents are safer transfers for caregivers.

R23's local hospital history and physical showed the patient was found on the ground and is a known total mechanical lift patient. The patient has not ambulated for some time. He has no history of recent hip fractures. The patient did not receive any pain medications or anything else when he fell, he was just transferred here to the hospital. A CT of the left lower extremity showed an impacted femoral neck fracture and a large joint effusion (fluid accumulation). He has some scalp abrasion and a skin tear on his scalp.

R23's 8/24/21 local hospital discharge summary showed the patient had an unwitnessed fall at the facility and injured his left hip. The patient underwent a left hip hemiarthroplasty (partial hip replacement)

R23's 8/28/21 facility assessment showed R23 was not cognitively intact and was dependent on staff for bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. This assessment showed no unhealed pressure injuries. This assessment showed R23 was not steady and only able to stabilize with staff assistance for surface to surface transfers.

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F 689	Continued From page 14	F 689		

An 8/24/21 intervention showed extensive assistance of two with gait belt or total mechanical lift for transfers.
R23's 9/13/21 continence care plan showed antibiotic therapy for infection to left hip surgical site. R23's physician order sheet showed a 9/13/21 order for antibiotics every six hours for 10 days.

The facility's 11/10/18 Fall Prevention Policy showed the purpose of the policy was to provide for resident safety and to minimize injuries related to falls. Appropriate interventions will be implemented for residents determined to be at high risk.

The facility's 10/30/08 Mechanical Lift Policy showed the mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel.
2. The September 2021 POS shows R21 was admitted on 5/7/20. The 5/18/20 care plan documented R21 to have impaired physical mobility and was to be transferred using 2 staff and a gait belt for all transfers.

On 9/15/21 at 9:00 AM, V8 and V9 CNA's (Certified Nursing Assistants) assisted R21 to her room to place her in bed. V8 placed a gait belt around R21's waist, with staff on both sides, V8 placed her arm under R21's left under arm and with her right hand grabbed the waist band of R21's pants and pulled R21 out of her wheelchair. R21 was not able to bear weight during the transfer and she was moved from her wheelchair to the bed with only her toes sliding across the floor. After the transfer, V9 said R21 really does

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F 689	Continued From page 15 not stand, but she has always been a gait belt transfer. A facility safety poster about safe transfers reads "Can't bear weight for five seconds or more? Get a Lift! Safer transfers for residents are safer transfers for caregivers." 3. On 9/15/21 at 9:18 AM, V5 and V8 placed a gait belt around R8's waist. V8 pulled up under R8's arm and with her right hand, she grabbed the back of R8's pants and pulled her up out of the wheelchair. On 9/15/21 at 12:41 PM, V2 DON (Director of Nursing) said the gait belt is used to assist them to transfer a resident, not to completely lift them. Staff should never be using the waist band of the pants or under the arm to lift a resident. R21 should be a mechanical lift if she does not bear weight during a transfer. The facility's 12/17/12 policy for transfer belt/ gait belts documents 7. Monitor the resident during transfers for C. Inability to participate in transfer. D. Anything that is not normal for the way the resident usually transfers. 8. Report any changes in resident's performance during transfers to the charge nurse.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		9/17/21

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F 690	Continued From page 16 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident's urinary drainage bag was not placed on the floor, failed to ensure a resident's catheter tubing was not positioned in a manner to impede drainage, and failed to provide incontinence care for four hours to an incontinent resident for two of three residents (R10, R1) reviewed for catheters and incontinence care in the sample of 12.	F 690	F690 Services Bowel/Incontinence, Catheter, UTI CFR9s) 483.25(e)(1-3) 483.21(3)(1)Incontinence – the facility must ensure that resident who is incontinent of bladder and bowel on admission receives services and assistance to maintenance unless his or her clinical condition is or becomes such	

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F 690	Continued From page 17 The findings include: 1. On 09/14/21 at 01:43 PM, V6 Certified Nursing Assistant (CNA) and V7 CNA prepared R10 for transfer from the chair to bed. R10 was in her chair with the urinary catheter tubing beneath her left thigh. The urine in the tubing was light yellow with moderate purulent sediment. During the transfer using a mechanical stand lift, V6 removed the catheter drainage bag from hanging on the lift and tossed it on the floor towards R10's bed. The dignity bag's opening was on the bottom allowing the catheter bag to be in direct contact with the floor. R10 was transferred into the bed and positioned on the left side with the catheter tubing beneath the left upper leg (laying directly on the tubing). On 9/15/21 at 12:26 PM, V2 Director of Nursing (DON) said urinary drainage bags should not be tossed on the floor for infection control. A resident's drainage tubing could become kinked and not allow the bladder to drain properly if there's pressure on the tubing. Both of these things could increase a resident's risk for a urinary tract infection (UTI). R10's 5/25/19 continence care plan showed to keep catheter tubing free of kinks. R10's 7/12/21 facility assessment showed R10 was dependent for bed mobility, dressing, toilet use, personal hygiene, and bathing. This assessment showed R10 required extensive assistance for transfers, had an indwelling catheter, and ostomy. R10's September 2021 physician order sheet (POS) showed a history of urinary tract infection	F 690	that continence is not possible to maintain. 1. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice; A) Director of Nursing in-serviced nursing staff on Incontinence care and Catheter Care. (Attachment A) 2. 2 of 3 residents have the potential to be affected by the alleged deficient practice; however, due to the implementation of 1a-b the alleged deficient practice will not reoccur. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A) Director of Nursing will monitor for compliance during daily QA rounds. 4. The following Quality Assurance Plans have been implemented to ensure the alleged deficient practice does not recur A) The Quality Assurance team will monitor compliance through the internal Quality Assurance process. Completion Date: 9/17/21	

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F 690	Continued From page 18	F 690		

(UTI).

2. On 9/14/21 observations were made of R1 in her chair from 9:20 AM-1:00 PM. R1 was not toileted or checked and changed during this time frame. At lunchtime, V7 said she was taking a break and V6 said she'll take the residents to the dining room. V6 brought R1 from the nurses' station area to the dining room. After lunch, V6 was questioned as to why R1 had not been toileted or checked and changed for at least four hours. V6 and V7 transferred R1 from her chair to bed. The back of R1's pants were wet with urine. V6 and V7 performed incontinence care for R1. V6 and V7 cleaned the front groin area and did not clean the posterior buttock area. A clean incontinence brief was placed on R1.

On 9/14/21, V6 Certified Nursing Assistant said "we usually toilet R1 on the way to the dining room before lunch. We must've missed her today".

On 9/15/21 at 12:26 PM, V2 Director of Nursing (DON) said residents should be toileted or checked every two hours to prevent skin breakdown.

R1's 6/10/21 facility assessment showed resident is rarely/never understood. This assessment showed R1 was dependent for bed mobility, transfer, locomotion, dressing, eating, toilet use, and personal hygiene. The assessment showed R1 was frequently incontinent of bowel and bladder.

R1's 4/26/21 Continence care plan showed to toilet and/or change padding and give proper

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F 690	Continued From page 19 hygiene before/after meals and prn (as needed) for incontinence. R1's face sheet showed diagnosis of dementia and need for assistance with personal care. The facility's 12/17 Perineal Cleansing Policy showed the policy purpose was to eliminate odor; to prevent irritation or infection and to enhance resident's self-esteem.11. Wash peri-anal area thoroughly with each stroke beginning at the base of the labia and extending up over the buttocks.	F 690		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure Registered Nurse (RN) coverage for 8 hours a day, 7 days a week. This applies to all 27 residents in the facility. The findings include:	F 727	F727 RN 7days/week, Full time DON 483.35(b) (1)-(3) Registered Nurse The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. 1. The corrective action for the alleged deficient practice has been achieved by	9/17/21

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F 727	Continued From page 20 The facility census and conditions of resident's form 672 dated 9/14/21 shows there are 27 residents in the facility. The facility's Nurse schedule for September 1-30, 2021 shows no RN scheduled for September 4, 5, 11, 12, 18, 19, 25 and 26 2021. (All were week-end shifts.) On 9/15/21 at 8:51 AM, V2 Director of Nursing (DON) said she has a posting for RN's but has not had any applicants for the open RN position. V2 said she works Monday through Friday. On 9/16/21 at 8:53 AM, V12 Administrator said they have been trying to hire some RNs to work in the facility, but no one has applied. V12 said if they had more RN's they could accept a higher acuity of residents. V12 said they have no policy for RN staffing.	F 727	the following: A. The facility will continue to actively recruit an RN.(Attachment A) B. All residents are screened prior to admission to ensure all needs can be met with current staff. No residents have been put at risk at any time. 2. All residents have the potential to be affected by the alleged deficient practice, however, due to the implementation of 1A, the alleged deficient practice will not reoccur. 3. Upon review of the facility's systemic measures, no changes were required to ensure the alleged deficient practice does not recur. 4. The following Quality Assurance Programs have been implemented to ensure the alleged deficient practice does not recur: A. The Quality Assurance team will monitor compliance through the internal Quality Assurance process.. Completion Date: 9/17/2021 This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission	

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F 727	Continued From page 21	F 727	that the Facility violated any federal or state regulation or failed to follow any applicable standard of care.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		9/17/21

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F 880	Continued From page 22 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement COVID-19 infection control measures for a newly admitted resident. The facility failed to handle soiled materials in a manner to prevent cross contamination. This failure has the potential to	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 483.80 Infection Control. The facility must establish and maintain an infection prevention and control program designed	

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F 880	Continued From page 23 affect all 27 residents residing in the facility. The findings include: 1. The facility's 9/14/21 Facility Census and condition report (672) documents there are 27 residents residing in the facility. The September POS (Physician's order sheet) shows R76 was admitted to the facility on 9/13/21 with multiple diagnoses, including dementia. On 9/14/21 at 10:21 AM, V3 LPN (Licensed Practical Nurse) said R76 was admitted the day before from home and had not been vaccinated for COVID-19. V3 said as a new admit R76 should be on isolation and confined to her room. There should be PPE (personal protective equipment) outside the room. V3 said staff should be wearing gowns, gloves, and masks. V3 said PPE was not available by R76's door. On 9/14/21 at 10:15 AM, R76 was observed in her room, no isolation signs were observed on her door. There were no gowns, gloves, or masks outside the room. R76 was observed wandering in and out of the room and down the hallway. Staff in the facility were wearing surgical masks and no eye protection. On 9/14/21 at 10:25 AM, V2 DON (Director of Nursing) said she had put up the isolation signs on the door but took them down when the resident would not stay in the room. On 9/14/21 at 12:35 PM, V7 CNA (Certified Nursing Assistant) was observed in R76's room with her surgical mask pulled under her chin while talking to R76. During interview, V7 pulled her	F 880	to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 483.80(a) Infection prevention and control program. 1. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice; a) Staff has been inserviced on Covid 19 Control Measures (Attachment A) b) Staff has been inserviced on Proper linen handling (Attachment B) 2. All may have the potential of being affected by the alleged deficient practice. However, due to the implementation of (1 a-b), the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: a) The DON will monitor during daily QA rounds. b) New Admits/Readmits will be discussed in daily QA mtg to ensure appropriate level of care is provided. 4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. BUILDING _____ B. WING _____	09/16/2021

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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F 880	Continued From page 24 mask back down to speak with this surveyor. On 9/15/21 at 8:30 AM, contact isolation and droplet precaution signs were observed on R76's door. No PPE including gowns, gloves, masks were available at the room for staff. The sign for droplet precautions shows "everyone must make sure their eyes, nose, and mouth are fully covered before room entry". On 9/15/21 at 8:40 AM, V2 said she expect the staff to wear a gown, gloves, N95 mask and eye protection when entering a room with contact and droplet isolation. The facility's 9/1/21 policy for COVID-19 control measures: Newly Admitted or Readmitted Residents 3. New admissions are to be placed in a private room and placed on Contact/Droplet Precautions (quarantine), regardless of their vaccination status. Residents are to remain in a private room under observation for 14 days. 2. On 9/15/21 after lunch, V6 Certified Nursing Assistant (CNA) and V7 CNA transferred R1 from her chair to bed. The back of R1's pants were wet with urine. While performing incontinence care, V7 threw the soiled wet washcloths and urine saturated incontinence brief on the floor. On 9/15/21 at 12:26 PM, V2 Director of Nursing (DON) said soiled linens and incontinence briefs should not be thrown on the floor. They should be put into bags for infection control. R1's 6/10/21 facility assessment showed resident is rarely/never understood. This assessment showed R1 was dependent for bed mobility, transfer, locomotion, dressing, eating, toilet use,	F 880	a) The Quality Assurance team will monitor compliance through the internal Quality Assurance process. .	

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F 880	Continued From page 25	F 880		

and personal hygiene. The assessment showed R1 was frequently incontinent of bowel and bladder.

The facility's 12/7/18 Laundry/Linen Handling Policy showed the policy purpose is to limit transmission of pathogenic microorganisms in contaminated linen. 1. Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. 2. All soiled linen should be bagged.

The facility's 12/17 Perineal Cleansing Policy showed the policy purpose was to eliminate odor; to prevent irritation or infection and to enhance resident's self-esteem. 7. Place soiled items in plastic bag. 12. Place soiled items in plastic bag.