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
	IL6007512	A. BUILDING: ____ B. WING ____	01/31/2024

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

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)5) 300.1220b)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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 02/16/24

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

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b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements were not met as evidenced by:

Based on interview, observation and record review, the facility failed to perform skin risk assessments, implement additional pressure relieving interventions after a change in condition, and identify a pressure ulcer prior to its status worsening to a Stage III for one of three residents (R9) reviewed for pressure ulcers in the sample of 38. This failure resulted in R9's pressure ulcer worseing without new interventions implemented.

Findings Include:

The facility's Pressure Injury Prevention policy (revised 01/10/24) documents the following: "The community must ensure that : A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent

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infection, and prevent new ulcers from developing." This policy also documents, "Each resident is formally assessed for risk of developing pressure injuries using the Braden Scale completed upon admission, quarterly, significant changes, and after developing pressure injury. " This same policy documents, "Inspect the skin when performing or assisting with personal cares or ADLs (activities of daily living.); Evaluating condition of skin (skin color, moisture, temperature, integrity, and turgor) at least weekly, or more often if indicated, such as when the resident is using a medical device that may cause pressure." This policy also documents, "Care Plan documentation: Care Plan will be revised quarterly and as needed."

R9's medical record documents R9 was admitted to the facility on 06/27/23 with a Stage III pressure ulcer present on her sacrum, and physician orders are in place for daily wound care and dressing changes to R9's sacral wound.. This same medical record documents R9 developed a Stage III pressure ulcer on the right side of her lower thoracic area (middle back) on 08/22/23.

R9's current Physician's Orders document the following Physician's Order for R9's lower thoracic pressure ulcer: "Lower back - cleanse with wound cleaner, pat dry, cover with bordered gauze every night shift every Tuesday, Thursday, and Saturday."

R9's Braden Scale for Predicting Pressure Sore Risk Assessment (dated 06/28/23) documents a score of 17, indicating R9 is at risk for pressure ulcer development. R9's next Braden Scale for Predicting Pressure Sore Risk Assessment was not completed until 12/01/23 and also documents a score of 17, indicating R9 is at risk for pressure

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ulcer development.

R9's monthly Treatment Administration Record (dated 07/2023 - 01/2024) documents R9 has received weekly skin checks during this time frame. R9's Treatment Administration Record (dated August 2023) documents R9 received a skin check on the following days: 08/01/23, 08/08/23, 08/15/23, 08/22/23 and 08/29/23.

R9's Wound Evaluation (dated 08/22/23) documents a Stage III pressure ulcer (full-thickness skin loss) measuring 2.5 cm (centimeters) by 2.5 cm by 0.1 cm with the presence of slough tissue was discovered on the right side of R9's lower thoracic area. According to the Pressure Ulcer Prevention & Prevention Treatment Clinical Practice Guideline, "Slough tissue: Soft, moist, devitalized (avascular) tissue. It may be white, yellow, tan or green, and it may be loose or firmly adherent." (www.npuap.org).

R9's care plan documents, "(R9) has actual impairment to skin integrity of both ankles and sacrum. All were present on admission. This current care plan has no mention of R9's current right lower thoracic area Stage III pressure ulcer, or R9's risk for skin impairment.

On 01/31/24 at 09:55 AM, R9 was lying in bed covered with a blanket watching television. R9 smiled and stated she would be getting her shower soon, "I am going to get my hair washed today." V4 (Care Plan/Minimum Data Set Coordinator/Wound Nurse) entered R9's room to provide wound care to R9's pressure ulcers. V4 removed the current dressing in place to R9's right lower thoracic area, and an oval-shaped red, open area approximately 3 cm (centimeters) by 2 cm was present with areas of eschar (brown

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scabbed) tissue present ". V4 cleansed R9's pressure ulcer with wound cleanser and applied a new dressing.

On 01/31/24 at 11:00 AM, V4 (Care Plan Coordinator/Wound Nurse) stated that R9's Braden Scale Assessments were not completed quarterly as directed by the facility's Pressure Ulcer Prevention policy. V4 stated R9 had a change in condition around the time her pressure ulcer developed and was admitted under the care of hospice services shortly after. V4 verified no Braden Scale Assessment was completed at that time. V4 also confirmed that no additional pressure relieving interventions were implemented at the time of R9's decline. V4 then stated that R9 should have been considered a high risk for pressure ulcer development, since R9 had a Stage III pressure ulcer on her sacrum upon admission. V4 stated that R9 should have been receiving daily skin checks, and the development of R9's right lower thoracic area pressure ulcer that had progressed to Stage III upon discovery could have been avoided or discovered before progressing to a Stage III if daily skin checks were being completed, "Someone should have seen it while (R9) was receiving daily cares." V4 also confirmed that R9's current care plan had no mention of R9's lower thoracic area pressure ulcer.

(B)