STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145801	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Luther Home	505 College Avenue Ottawa, IL 61350

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 33760 Based on interview and record review the facility failed to notify a resident's representative of a change on resident's anti depressant medication to 1 of 5 residents (R2) reviewed for notification of change in the sample of 5. Findings include: R2's electronic face sheet printed last 5/7/25 show R2 has diagnoses of dementia and major depressive disorder. The face sheet show V14 (R2's Daughter) is R2's power of attorney (POA). On 5/7/25 at 12PM, V14 said R2's antidepressant medication's dose (Zoloft) was decreased without the facility notifying her. V14 said when she came back from vacation last March 2025, she noticed R2 was being tearful and emotional. V14 said she requested a copy of R2's medication record and found out that R2's dose of Zoloft was decreased from 75 milligrams (mg) to 50 mg. V14 said she did not consent to the dose change. V14 said she informed V4 that she would have not given permission of R2's antidepressant dose decreased. R2's electronic medical record (EMAR) documents that from 12/24 to 1/22/25, R2 was on Zoloft 75 mg. On 1/23/25, R2 was put on Zoloft 50 mg which V14 said she did not consent to. R2 was on 50 mg of Zoloft from 1/23/25 to 3/21/25 (almost 3 months). On 3/22/25, R2 was put back to 75 mg per V14's request. On 4/9/25 and up to present, R2 was now on 100 mg which V14 have also consented. R2's Psychotropic Consent form documents that on 5/31/23 to 3/18/25, R2 was on 75 mg of Zoloft. The form show that V14 signed the consent. On 4/9/25, R2's Zoloft was increased to 100 mg (50 mg in AM and 50 mg in PM) which V14 also consented. The psychotropic form did not show that R2 was put on 50 mg from from 1/23/25 to 3/21/25. The psychotropic form also did not show that V14 consented to the decrease of R2's 50 mg dose. On 5/7/25 at 1:06 PM, V4 (Resource Nurse) said when there is a change of resident's medication, the POA should be notified of the medication changes and a consent should be obtained from the resident or resident's representative.

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.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 33760 Based on interview and record review the facility failed to notify a resolution of a grievance to 1 of 5 residents (R2) reviewed for grievances in the sample of 5. Findings include: On 5/6/25 at 1:30 PM, V14 (R2's POA and daughter) said on 4/16/25 while she was at the facility, she sent an electronic communication (text) with V4 (Resource Nurse) letting her know that she wanted to file a grievance regarding R2. V14 said she arrived at R2's room close to 10AM last 4/16/25. Upon opening R2's door, R2's room was with strong urine odor. R2 was in bed, soaked and wet with urine, R2 had not been gotten up and had not eaten her breakfast. V14 said she wanted V4 to come to R2's room and see what was going on. V14 said she saw V4 in the elevator and said to V4, I hope you are figuring out what happened this morning (with R2) and get back to me. V14 said she had not heard from V4 or any staff from the facility regarding the findings of her grievance regarding R2's issue, it's almost a month now. On 5/6/25 at 10:30 AM, V4 (Resource Nurse) said on 4/16/25 around 10AM, she received a text from V14 (R2's daughter) that she needed her to go to 2nd floor. V14 said V4 sounded upset about R2's care. V4 said when she was at the 2nd floor elevator, she saw V14 and R2. V14 was loud, yelling you need to find out what happened! V4 said she asked V14 if they can discuss in private and to refrain from yelling. V4 said another family member of R2 also called the facility to follow up since R2's POA (V14) was upset of what happened with R2 earlier (R2 was not up for breakfast and R2 was soaked and wet) . V4 said she informed the family member that they are looking into the situation and will educate staff. V4 confirmed that up to this time, she had not spoken to V4 regarding the grievance last 4/16/25. V4 said within 24 hours there should be an update to the grievance resolution. On 5/7/25 at 10:05 AM, V6 (Social Service) said on 4/16/25 she witnessed how V14 was so upset about R2's care. V6 said she filled out R2's grievance form but she did not notify V4 of the facility's response or findings to R2's grievance. R2's grievance/concern form dated 4/16/25 under concern show, Incontinence Care which was signed off by V6 (Social Service) and V1 Administrator. Under Response: (Family member) stated that POA is stressed and wanted to follow up (with)-nurse supervisor, explained all steps to resolve complaint to team members. The grievance response did not include that V14 who is R2's POA was informed of the result of the investigation and resolution of the grievance. On 5/7/25 at 10:15 AM, V1 said they will get hold of V4 (R2's POA) today to give an update of the grievance resolution. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Grievance Resolution dated 7/25/24 show, all grievances and complaints filed by a resident/her representative, family member will be investigated and corrective actions will be taken to resolve the grievance. 7. The resident, or person acting on behalf of the resident will be informed of the findings of the investigation as well as the corrective actions recommended within 7 working days of the filing of the grievance or complaint.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on interview and record review the facility failed to provide incontinence care to a resident that need extensive assist with Activities of daily living (ADL) to 1 of 5 residents (R2) reviewed for incontinence care in the sample of 5. Findings include: R2's facility assessment dated [DATE] show R2 is frequently incontinent of urine and need assist with toileting and transfers. On 5/6/25 at 12:30 PM, V14 (R2's daughter) said last 4/16/25 she arrived at the facility almost 10AM. R2's room was permeating with strong urine odor. R2 was still in bed, she was soaked and wet. R2 was trying to get up from bed, her foot was already dangling at the side of the bed. V14 said she was very upset, R2 was not toileted. On 5/7/25 at 2:30 PM, V16 (Certified Nursing Assistant-CNA) said she was R2's CNA the night shift from 4/15/25 going to 4/16/25. R2 went to bed at 11:30 PM. V16 said at around 2:30 AM, she went to R2's room and offered R2 to be toileted but R2 refused. At 7AM, V16 said she did not go and check on R2 again but gave report to V7 (day CNA). V16 said the last time R2 was toileted was at 11:30 PM (4/15/25) when R2 was put to bed. On 5/6/25 at 11:16 AM, V7 (CNA) said on 4/16/25 she came in at 5AM, she was R2's CNA on day shift. V7 said the night shift CNA (V16) gave report that R2 was fine. V7 said she peeked in R2's room at around 6:30ish that morning, R2 was asleep. V7 said she did not check on R2 if she was wet and did not asked R2 if she needed to go to the bathroom. At 7:30 AM, she went again to R2's room, I just opened the door and peeked, [R2] was still asleep. Again, V7 said she did not go and check if R2 was wet and did not offer for R2 to use the bathroom. V7 said at 8:45 AM, she saw the nurse coming out from R2's room so V7 said she did not go to R2's room. V7 said she went on break around 9:15-9:30 AM. V7 said by the time she got back to the floor, R2's daughter (V14) was in R2's room, V14 was very upset that R2 was soaked and wet. On 5/6/25 at 11:54 AM, V8 (CNA) said on 4/16/25 at around 10AM, R2's call light was on. V8 said she went to R2's room, V14, R2's daughter was in the room, R2 was in the bathroom, V14 was very upset, she said R2 was still in bed when she arrived, R2 was soaked and wet with urine. On 5/7/25 at 2:45 PM, V2 (Director of Nursing) said all residents including R2 should be checked and change to keep them dry and prevent skin breakdown. R2's careplan dated 2/24/25 documents R2 has occasional bladder incontinence r/t Confusion, Dementia, Impaired Mobility, will remain free from skin breakdown due to incontinence and brief use. With intervention to include: Approach resident in a manner of lets go to the restroom or lets get changes instead of asking do you need to be changed?

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 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 imaging performed in the ER that showed a C1 fracture. R1's face sheet shows he is an [AGE] year-old male with diagnoses including Alzheimer's, vascular dementia, type 2 diabetes, muscle weakness and hypertension. R1's Fall Risk assessment dated [DATE] 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 .