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	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Rehab & Hcc	500 North Jackson Street Morrison, IL 61270

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on interview and record review the facility failed to ensure a resident's advanced directives were updated as requested for 1 of 1 resident (R18) reviewed for advanced directives in the sample of 13. The findings include: R18's profile face sheet documents he was admitted to the facility on [DATE]. The Practitioner Order for Life-Sustaining Treatment (POLST) form dated 12/16/21 shows R18 opted to be a full code. The April 2024 POS (Physician order sheet) notes R18 to be a full code. A new POLST form, undated, on the front of R18's chart shows he opted to become a DNAR (Do not attempt resuscitation). The form is signed by R18 and has no witness signature and no signature by the health care practitioner. The facility's 3/21/24 assessment for a significant change documents R18 to be cognitively intact. On 4/11/24 at 9:39 AM, R18 said they did go over all of the options with me, and I signed the paper to not do anything for me. On 4/11/24 at 8:15 AM, V3 RN (Registered Nurse) said R18 was placed on hospice, and it appears he has a DNR signed, but it is not dated and not signed by the physician so he would still be considered a full code. The form needs to be sent to the physician to be signed. On 4/11/24 at 11:31 AM, V2 DON (Director of Nursing) said on admission the nurse will have the residents fill out and sign the POLST form and will send it out for the physician to sign. The form should be signed and dated on the chart. The facility's 9/27/17 policy for advance directives documents the patient self determination act states that individuals have the right to make their own decisions and to formulate advance directives to serve as decisions when the individual is incapacitated. 3. After confirming the accuracy of provided documents with the resident/responsible party, document will be sent for appropriate signatures. No order for No Code or DNR shall be effective until the POLST form is signed by resident/responsible party and physician order is received and documented.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20042 Based on observation, interview, and record review the facility failed to ensure a resident received necessary treatment and services for her amputated leg including following up with her surgeon, obtaining a sleeve for her stump and assisting in the process to prepare and obtain a prosthetic leg for 1 of 1 resident (R26) reviewed for quality of care in the sample of 13. The findings include: On 4/9/24 at 10:45 AM, R26 was sitting in her wheelchair in her room and had a left above the knee leg amputation. R26 stated she has been at the facility for 9 months. R26 stated she came to the facility after a house fire in which she jumped out of a second story window and sustained numerous injuries' including the amputation of her leg. R26 stated she was supposed to have a sleeve for her left leg stump after surgery. R26 stated the facility said they would get her one. It took 4.5 months to get a shrinker and no one measured her for it. R26 stated she has swelling to her left leg/stump. R26 pulled her leggings down to show an elastic type covering to her leg stump that had a lot of extra material and appeared too large for her. R26 stated the shrinker was too big. R26 stated she was never measured for the shrinker and thinks the facility ordered it online. R26 stated she had numerous doctors in the hospital after the incident and doesn't know who did the amputation of her leg. R26 stated she never followed up with the surgeon after being transferred to the facility. R26 stated the staples to her stump were removed at the facility. R26 stated R26 has not been fitted for a shrinker or leg prosthesis. The hospital After Visit Summary dated 8/8/23 for R26 showed, follow up with outpatient burn & trauma clinic in 2 weeks; follow up trauma/burn for wound evaluation and staples removal. The hospital Post Acute Care Transition Document dated 8/8/23 for R26 showed her level of functioning, case management assessment, burns, wounds, external fixator, medications, all physicians to follow up with including their names and contact numbers. The document showed R26 was to follow up with the surgeon at the burn & trauma clinic in 2 weeks. The Nurses Notes for R26 showed the following: 8/8/23 - R26 was admitted to the facility with burn sites, left above the knee amputation with closure measures in place, and external fixator to bilateral hips. R26's Nurse's Notes from 8/8/23 through 4/11/24 did not show any follow up appointments with the surgeon or any fitting of a sleeve for R26's left above knee amputation. The Physician Order Sheet dated 1/1/24 for R26 showed an order on 1/24/24 for a referral to the orthopedic doctor for re-evaluation, shrinker for left residual limb and include measurements. An order dated 1/29/24 for R16 showed, referral back to surgeon for stump shrinker/prosthesis ordering and follow up post surgery. The Face Sheet dated (no date) for R26 showed medical diagnoses including stable burst fracture of T11-T12 (back) vertebra, ileus, minimally displaced fracture of the sacrum, muscle weakness, unspecified fracture of T9-T10 (back), burns of 10-19% of body surface, and acquired absence of left leg above the knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 11:55 PM, V2 DON (Director of Nursing) stated follow up appointments for residents are made by her or social services. V2 looked at the desk calendar at the nurse's desk, flipped through several months and stated she did not see any appointments related to R26's left leg stump. V2 was shown the order in R26's chart dated 1/29/24 and she stated she was not aware of the order. V2 stated she did not know anything about the sleeve/shrinker for R16's stump. V2 stated it would be important to have measurements for the shrinker and have the rights size so R26 can get a prosthesis. V2 stated R26 is waiting for a leg prosthesis and wants one. On 4/10/24 at 3:05 PM, V6 (Social Services) stated she was not aware of the order on 1/24/24 for R24. V6 stated V2 should be going through the orders to make sure they are done. V6 stated she wasn't here at the facility when this order was received and did not start until 2/5/24. V6 stated she doesn't know anything about the shrinker or where it came from. V6 stated she talked to R26 who said she thought someone ordered it off the internet and no one measured her for it. V6 stated she was by an outside clinic that R26 needs to be measured for a sock to shrink the stump and it is important so she can get a prosthesis. On 4/11/24 at 8:35 AM, V3 RN (Registered Nurse) stated, the end goal is to shrink that (stump) and reduce the swelling so R26 can have a prosthetic. I don't know about any follow ups for R26's stump. I don't know what doctor was managing the stump. The NP (Nurse Practitioner) wrote an order and wanted her to go somewhere. The previous process (for appointments) was if we get an order for a referral, we give it to soc services, and they make the appointment. If the doctor writes an order it is supposed to be followed. The standard of care would be to follow up with the surgeon after a leg amputation. On 4/11/23 at 2:00 PM, V1 (Administrator) stated the facility did not have a policy for quality of care, post surgical care, or current standards of practice related to the care of a resident after an amputation. The only policy the facility had for following physician orders was a policy of Conformance with Physician Medication Orders (9/27/17).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview, and record review the facility failed to ensure pressure injury interventions were in place as ordered and failed to identify a pressure injury prior to the injury becoming a stage 2 pressure injury for 2 of 5 residents (R5, R4) reviewed for pressure injuries in the sample of 13. The findings include: 1. R5's profile face sheet documents she was admitted to the facility on [DATE]. The facility's annual assessment of 1/10/24 documents R5 to be cognitively intact. The same document shows she is at risk for pressure injuries and had one or more unhealed pressure injuries. The 12/14/23 wound evaluation and management summary report shows an initial evaluation of a stage 2 pressure wound to the sacrum of greater than 4 days in duration. The wound measured 2.9 cm (centimeters) in length, 0.3 cm (width) and 0.2 cm (depth). The nursing progress notes were reviewed and no not show a report or initial identification of any open pressure areas. R5's December 2023 treatment record does not show any skin checks ordered or completed. She had a new order for ointment to the sacrum dated 12/14/23, the same day she was seen by the wound physician. R5's care plan of 8/15/2019 documents she was a moderate risk for skin breakdown and needs a weekly skin check with documentation. On 4/11/24 at 10:32 AM, V3 RN (Registered Nurse) said skin checks depend on the resident, (R5) should have a skin check weekly. V3 said R5 is incontinent so her skin would be checked when performing incontinence care, and her pressure injury should have been identified earlier. Wounds should not be found at a stage two, ideally, they are found at a stage one and get a treatment in place to prevent it from progressing. All of the wound details should be in the nursing progress notes when the injury is found, and the assessment. On 4/11/24 at 11:25 AM, V2 DON (Director of Nursing) said pressure injuries should be found prior to becoming a stage 2. Some residents have skin checks daily and some are scheduled weekly. R5's bottom would have been looked at during care and should have been identified sooner. Nurses should fill out the skin assessment and notify the physician to get treatment orders. All of that information would be in the nursing progress notes. A copy of the assessment and wound treatment is then forwarded to me for evaluation. 20042 2. On 4/9/24 at 10:06 AM, R4 was in his room in a wheelchair that did not have any pressure relieving device in the chair. On 4/9/24 at 2:13 PM, R4 was up in his wheelchair propelling himself down the hall. R4 went to the nurse's station to tell V3 RN (Registered Nurse) that he needed medicine for his cold. R4 did not have any pressure relieving device in his chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 2:18 PM, V3 RN stated, R4 is supposed to have a pressure relief cushion in his chair and confirmed there wasn't one in his chair. V3 stated that V3 asked hospice for a cushion and thought they brought one. R4 stated he did not have a cushion for his wheelchair. There wasn't a cushion for R4's chair in his room. On 4/11/24 at 10:23 AM, V2 DON (Director of Nursing) stated for a resident with pressure ulcer(s) they should have offloading of the wound, treatment orders, wound treatments done, and the wound doctor following the resident. V2 stated having a pressure relief cushion to the chair is important to relieve pressure so the wound doesn't get any worse. The Wound Care Provider's Note dated 4/8/24 for R4 showed, stage 2 pressure wound to the left medial buttock partial thickness - hydrocolloid sheet (thin) apply three times per week for 23 days; skin prep apply three times per week for 23 days; limit sitting to 60 minutes, off load wound, turn side to side in bed every 1-2 hours if able, reposition per facility protocol. The Physician Order Sheet dated 4/1/24 for R4 showed medical diagnoses including falls, hypertension, chronic obstructive pulmonary disease, restless leg syndrome, dementia, coronary artery disease with coronary artery bypass graft, chronic kidney disease, atrial fibrillation, iron deficiency, celiac disease, chronic back pain, and compression fracture. The Care Plan Dated 2/19/24 for R4 showed, Risk for impaired skin integrity. Educate resident/representative about proper skin care to prevent skin breakdown. The care plan did not show R4 has a stage 2 pressure ulcer or interventions in place for offloading and repositioning every 1-2 hours if able. The facility's Decubitus Care/Pressure Areas policy (1/2018) showed, when a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 20042 Based on observation, interview, and record review the facility failed to ensure a catheter had a secure device in place, the drainage bag was kept off the bed, and the catheter tubing was cleaned in a manner to prevent contamination for 1 of 1 resident (R17) reviewed for catheters in the sample of 13. The findings include: On 4/10/24 at 2:23 PM, R17 was laying on her back in bed with her catheter drainage bag attached to the lower bed frame of her bed. R17 did not have a device in place to secure the catheter tubing. V9 CNA (Certified Nursing Assistant) and V10 CNA put on gowns and gloves and went into R17's room to provide catheter care. V9 took a wet washcloth, cleaned R17's groin, and discarded the washcloth. V9 took another wet washcloth, wiped R17's vaginal area and then wiped straight down the catheter tubing. V9 placed the drainage bag on R17's bed when V9 and V10 were repositioning R17 in bed. V9 and V10 stated they were not aware that the catheter drainage bag could not lay on the resident's bed. V9 stated she should have gotten a clean washcloth to wipe down R17's catheter tubing. V9 stated she washed R17's vaginal area and then went straight down the catheter tubing. On 4/11/24 at 10:23 AM, V2 DON (Director of Nursing) stated, the catheter drainage bag should never be on the bed for infection control. Staff are supposed to fold the washcloth a different direction before moving to a new area or cleaning the catheter tubing to avoid contamination. I put one (catheter tubing secure device) on R17 not to long ago because I noticed her tubing was pulling. I put it on to prevent the catheter from coming out. A day or two later I noticed the secure device was not on and I asked who took it off, but no one could tell me who did it. I noticed her tubing tugs so R17 should have one on. The Physician Orders dated 4/1/24 for R17 showed medical diagnoses including neurogenic bladder, mass of adrenal gland, expressive aphasia, history of cerebral vascular accident with right sided weakness, sleep apnea, pulmonary hypertension, peripheral neuropathy, hypertension, deep venous thrombosis, diabetes mellitus, diverticulosis, coronary artery disease, atrial fibrillation, and arthritis. The Care Plan dated 4/3/24 for R17 showed she is on an antibiotic related to a wound infection to her coccyx (pressure ulcer). She has a catheter. Catheter care every shift and change every week; 18 French 30 ml (catheter/balloon size) were the only catheter interventions listed. The facility's Catheter Care policy (12/8/10) showed, 7. Wash the catheter tubing from the opening of the urethra outward 4 inches or farther if needed. Do not pull on catheter. The policy did not state to use a clean washcloth or to turn an existing washcloth prior to cleaning the tubing. The facility's Catheterizations, Catheter Insertion policy (2/2018) showed, 7. Secure the catheter to the thigh and attach drainage collection unit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35175 Based on observation, interview, and record review, the facility failed to ensure the facility water system was tested for Legionella and failed to ensure water was not sedentary in an unoccupied area of the facility. This failure had the potential to affect all 28 facility residents. The findings include: The facility's 4/9/24 application for Medicare and Medicaid form showed there were 28 residents in the facility. On 04/10/24 at 11:02 AM, V4 Maintenance said weekly he flushes toilets and runs water for 2-3 minutes on anything that has a faucet on the south hall. V4 said he was unsure if a water system assessment had been done to identify potential problem areas that may be conducive to water borne pathogen growth. V4 said he did not know the last time water testing for Legionella was done if ever. Testing results and a policy were requested. V4 said V5 Business Office Manager (BOM) was his supervisor. At 11:21 AM, V5 said she thought the facility was last tested for Legionella in 2019. V5 said she would check with the city since they do some testing. This surveyor requested a copy of the facility's Legionella test results. At 11:37 AM, V5 said she was told by the city that they only test for chlorine and fluoride. They do not do Legionella testing. V5 said she had no evidence Legionella testing was ever done at the facility. V5 said there's only one shower room being used. The whirlpool down the north hall was not used because it needs repairs. It hasn't been used in the six years she had been there. V5 said they use the room to toilet residents but don't use the tub. At 11:57 AM, V5 said there were no logs to show any flushing or water temperature checks were done on the south hall. V5 said V4 wrote in a notebook that he ran water in all sinks and toilets on 3/22/24 and 3/28/24. On 04/10/24 at 12:34 PM, there was a large therapeutic bathtub with a lift system in a common bathroom near the north nurse's station. There was a continual slow dripping of water from an opening on the right side (facing the faucet) of the tub. There was a long brown stained area which followed the dripping water down the side of the tub. Staff were observed toileting residents in the room. The room door was wide open when not in use. The entire south end of the facility was unoccupied, and a second large therapeutic soaking tub was located near the south nurse's station. On 04/11/24 at 08:34 AM, V1 Administrator said ASHRAE (the American Society of Heating, Refrigerating and Air Conditioning Engineers) has the standard to ensure the water systems are clear and safe. I know that Legionella testing must be done from ASHRAE. I am unsure what the facility policy is regarding Legionella testing or the industry standard. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/11/24 at 11:06 AM, V4 said he was aware the north tub had a stained area due to consistent dripping of water from the faucet of the unused whirlpool tub. V4 said the south hall had been unoccupied since 2018-2019. V4 said the whirlpool soaker tub on the south hall was inoperable so he doesn't run the water in it when he comes to flush toilets down there. This surveyor accompanied V4 to the south hall tub room. V4 turned on the faucet in the tub and water did come from it. The facility's 5/24/23 Legionella Environmental Assessment Form completed by a Corporate Administrator showed there were no hot tubs, whirlpool or hydrotherapy spas on the premises. This assessment showed it was very important to measure and document the current physical and chemical characteristics of the potable water, as this can help determine whether conditions are likely to support Legionella growth. A sampling strategy and procedure are suggested along with a flow sheet to record results to track the results. The flowsheet was marked N/A (not applicable). (There was no evidence the facility utilized this sampling procedure). This assessment, Appendix C applied to hot tubs, whirlpool and hydrotherapy spas and was marked N/A although there were two such tubs in the facility. No maintenance disinfecting or monitoring of the tubs was evident. There was no evidence the facility followed the recommendations to prevent Legionella in the tubs as evidenced by the lack of monitoring. This assessment showed it should be performed by an epidemiologist or environmental health specialist. The facility's 8/10/18 Legionella Management Procedure showed the Corporate Maintenance Director will ensure all staff are kept fully informed of developments in Legislation and good practices relating to the management of Legionella, ensure approved contractors are available to undertake surveys/risk assessments upon (?), to ensure surveys are undertaken as and when this procedure dictates (?). Total Viable Cell Counts (Dip Slides) shall be taken during each risk assessment. If and when Legionella water samples are required, the samples should be sent away to an independent accredited laboratory for analysis within 48 hours. The facility's undated Legionella Policy and Procedure showed to ensure water cannot stagnate anywhere in the system. The facility's water temperature logs did not include any rooms on the unoccupied south hall or either facility tub directly. The Illinois Compiled Statutes (210 ILCS 45/3-206.06) Sec. 3-206.06 showed Testing for Legionella bacteria. A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests shall be made available to the Department upon request. a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. (Section 3-206.06 of the Act) b) The policy shall be based on the ASHRAE Guideline Managing the Risk of Legionellosis Associated with Building Water Systems and the Centers for Disease Control and Prevention's Toolkit for Controlling Legionella in Common Sources of Exposure. The policy shall include, at a minimum:1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system; 2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and 3) A system to document the results of testing and corrective actions taken. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Any and all facility testing results for Legionella was requested numerous times and none was received.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 35175 Based on interview and record review, the facility failed to have a certified Infection Preventionist. This failure could affect all 28 facility residents. The findings include: The facility's 4/9/24 application for Medicare and Medicaid form showed there were 28 residents in the facility. On 04/10/24 at 10:05 AM, V2 Director of Nursing (DON) said she has been at the facility since January 29, 2024. V2 said she is the facility's Infection Preventionist (IP). V2 said she did not have IP certification. On 04/11/24 at 08:34 AM, V1 Administrator said I am aware it is required to have a certified infection preventionist in the facility. V1 said V2 is trying to get through the course but is not currently certified. It's important to have a certified IP. We need to make sure the residents are safe and protected from infection. The facility's 3/3/23 Infection Preventionist Job Description showed qualifications: must have completed specialty training in infection prevention and control through accredited continuing education such as Centers for Disease Control and Prevention (CDC) or APIC (consulting firm) Infection Preventionist. The facility's QAPI (quality assurance performance improvement) team roster identified V2 as the facility Infection Preventionist.