STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145801	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review the facility failed to report to State Agency an allegation of potential physical abuse for three residents (R4, R7, and R8) of six residents reviewed for abuse in the sample of eight. Findings include: The facility's Abuse and Neglect of a Resident policy, last revised 11-26-19, documents 6. External Reporting of Potential Abuse: The resident's representative and the Department of Public Health shall be informed immediately. Immediately, and not to exceed, but no later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury, to the administrator of the facility and to other officials (including State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with state law. On 8-4-2020, at 11:31am, V8 Certified Nursing Assistant/CNA/Unit clerk stated that R7 told V8 that a CNA (V11) was rough with R7; V8 turned the complaint in to V3 Social Service Director/SSD. On 8-11-2020, at 11:30am, V3 SSD stated that V8 CNA had reported to V3 SSD that R7 had concerns that V11 CNA moved too fast for R7 while either putting on or taking off R7's therapeutic hose and it either caused a skin tear or a scab came off during the procedure. The facility's Corrective Action Document, dated 5-4-2020 and signed by V2 Director of Nursing/DON, documents that a resident reported V11 Certified Nursing Assistant/CNA initiated personal care while still sleeping, without providing information regarding what type of care the resident was going to receive. This document does not include the resident's name. On 8-5-2020, at 12:54pm, V2 DON confirmed the Corrective Action Document, dated 5-4-2020 was referring to R8. At this time, V2 stated R8 had said that V11 CNA came into her room, flipped the light on and the covers down without explaining the procedure. R8 also said that V11 grabbed R8 by the arm to get R8 up instead of swinging R8's feet around and out of the bed first, but no injury noted to R8's arm. On 8-4-2020, at 1:52pm, R4 states that when R4 first got to the facility a lady was really rough after R4's shoulder surgery and made R4's arm hurt worse. R4 states that R4 told a staff member about what happened. I heard they discharged her. The facility's Corrective Action Document, dated 6-10-2020 and signed by V2 DON, documents that (V11 CNA) provided care that was below our customer service standards and requirements. Two residents reported that (V11) was rushing through their care and felt she was rough when providing care for them. This document does not include the residents' names. On 8-5-2020, at 12:55pm, V2 DON confirmed the Corrective Action Document, dated 6-10-2020 was referring to R7 and R4. At this time, V2 stated that a staff nurse (V13 Licensed Practical Nurse/LPN) called V2 and asked if V2 could talk to R7. V13 LPN told V2 that R7 felt that the way V11 did cares was rough that night; R7 felt that V11 was pulling on R7 too fast. V2 heard R4 also had a complaint that when V11/CNA was transferring R4, V11 didn't do it right and R4 was worried R4 would fall. R4 told V2 DON that V11 grabbed R4's arm and R4's arm ached; that V11 was moving too fast and kind of rough, but wasn't mean. V2 stated that all findings are passed on to V1 Administrator. On 8-5-2020, at 1:35pm, V1 Administrator confirmed at this time that these allegations against V11 CNA were not reported to (State Agency).
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on interview and record review the facility failed to thoroughly investigate and document allegations of potential physical abuse for three residents (R4, R7, and R8) of six residents reviewed for abuse in the sample of eight. Findings include: The facility's Abuse and Neglect of a Resident policy, last revised 11-26-19, documents 5. Internal Investigation of Allegations: The Abuse Prevention Coordinator or designee will coordinate the initial investigation of the abuse allegation. This may include: Documented interview of the resident regarding alleged abuse. Documented interview of any witnesses to the alleged incident of abuse. Review of appropriate documentation including, but no limited to, chart review and the Preliminary Incident Investigation Form. Investigations for potential, injuries of unknown source' will include interview with associates, resident and families. This policy continues to state If an internal investigation is warranted then submit the preliminary abuse/neglect report to the state. On 8-4-2020, at 1:52pm, R4 states that when R4 first got to the facility a lady was really rough after R4's shoulder surgery and made R4's arm hurt worse. R4 states that R4 told a staff member about what happened. I heard they discharged her. The facility's Corrective Action Document, dated 5-4-2020 and signed by V2 Director of Nursing/DON, documents that a resident reported that V11 Certified Nursing Assistant/CNA initiated personal care while the resident was still sleeping and without any explanation of cares to be provided. V11 CNA was given a final warning for policy violation Conduct and Behavior - b. Failure to treat all residents, clients, customers, visitors, and fell ow employees with kindness, respect, and dignity. f. Any behavior that is deemed offensive or unsafe. This document does not include the resident's name. On 8-5-2020, at 12:54pm, V2 DON confirmed the Corrective Action Document, dated 5-4-2020 was referring to R8. V2 states at this time that R8 had said that V11 CNA grabbed R8's arm to sit R8 up. V2 continued to state there was no injury, but that V11 just didn't do the transfer right. V2 states V2 does not have any written documentation of this incident. The facility's Corrective Action Document, dated 6-10-2020 and signed by V2 DON, documents that V11 CNA was rushing through two residents' cares and felt V11 was rough when providing care for them. V11 was discharged for policy violation Conduct and Behavior - b. Failure to treat all residents, clients, customers, visitors, and fell ow employees with kindness, respect, and dignity. f. Any behavior that is deemed offensive or unsafe. And also Courtesy - All employees shall treat residents, residents' families, clients, customers, and visitors, and fell ow workers with kindness, respect, and dignity. This document does not include the residents' names. On 8-5-2020, at 12:55pm, V2 DON confirmed the Corrective Action Document, dated 6-10-2020 was referring to R7 and R4. V2 stated that a staff member reported that when V11 CNA was transferring R4, V11 didn't do it right and R4 was worried R4 would fall. V11 grabbed R4's arm and R4's arm ached. V2 also stated at this time that a staff nurse reported that R7 felt R7's care was rough that night. R7 told V2 DON that R7 felt that V11 CNA was pulling on R7 too fast. V2 states V2 does not have any written documentation of this incident. On 8-11-2020, at 8:55am, V2 DON stated that V2 did not document any formal investigation and feels that V11 CNA's behavior is a customer service issue. V2 interviewed the residents (R4, R7 and R8) and the nurse (V13 Licensed Practical Nurse/LPN) working with V11 CNA. No other staff were interviewed. On 8-5-2020, at 1:35pm, V1 Administrator states I was thinking it was more of a personnel issue and (V11 Certified Nursing Assistant/CNA) needing more training. V1 confirmed at this time there is no written reportable document for allegations against V11.

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

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.