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
	IL6007488	A. BUILDING: ______ B. WING ______	C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS SENIOR LIVING	**400 WEST WASHINGTON CHRISMAN, IL 61924**

(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) COMPLETE DATE
S 000	Initial Comments	S 000		

Complaint Investigation

2061241/IL120204

S9999	Final Observations	S9999		

Statement of Licensure Violations

300.1210b)
300.1210d)6)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed prevent falls by failing to implement a fall intervention (R1) and provide a safe transfer (R2) for two of three residents (R1, R2) reviewed for resident injury on the sample of three. This failure resulted in R1 requiring emergency services for lacerations to the right forehead, bridge of nose, right inner elbow, right knee and right shoulder and in R1 sustaining fractured nasal bones.

Findings include:

1. On 2/18/20 at 1:40 PM, R1 was sitting in R1's wheelchair in the hallway. R1 had bruising covering the forehead, bridge of nose, and cheek bones. R1 had a nose laceration and forehead laceration.

R1's Incident report dated 9/16/19 at 9:00 PM, documents V13 (Certified Nursing Assistant/CNA) was pushing R1 in wheelchair down the hallway to R1's room, R1 dropped feet to floor and R1's feet went under chair causing R1 to fall forwards onto floor. This report documents an intervention to have wheelchair pedals on the wheelchair when R1 is in the wheelchair. R1's Care Plan documents a 10/1/19 intervention for "Foot pedals to be on wheelchair when (R1) is in wheelchair."

R1's Incident report dated 2/12/20 at 4:25 PM documents R1 flung self out of wheelchair, landing on face. Injuries noted and sent to the

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emergency room.

On 2/18/20 at 11:35 AM, V5 (CNA) stated that at dinner time, V5 was taking residents down to the dining room. V5 stated V5 was pushing R1 in the wheelchair and R1 went forward out of the chair. V5 stated V5 is not sure if the wheelchair pedals were on R1's wheelchair. On 2/18/20 at 11:45 AM, V3 (Licensed Practical Nurse/LPN) stated V3 was heading out to the dining room with the medication cart. V3 stated V3 turned around and R1 had fallen out of the wheel chair. V3 stated R1's foot pedals were not on the wheelchair. V3 stated V3 sent R1 out to the hospital due to hematoma to her forehead, laceration to the bridge of nose, hematoma to the right shoulder, skin tear to the right inner elbow, and an abrasion to the right knee.

On 2/18/20 at 1:08 PM, V9 (Fall Coordinator) stated V9 investigated R1's 2/12/20 fall. V9 stated V5 was just beginning to push R1 down the hall and then R1 fell out of the wheelchair. V9 stated the wheelchair pedals were not on R1's wheelchair. V9 told V5 that the wheelchair pedals were not on.

On 2/19/20 at 11:12 AM, V2 (Director of Nursing) stated the intervention of the wheel chair pedals was put into place after the fall on 9/16/19. V2 stated R1 would drop R1's feet to the floor causing R1 to fall forward when being pushed in the wheel chair. V2 stated when R1 was being pushed the wheel chair pedals should be in place to prevent R1 from falling forward out of the chair. V2 stated when investigating R1's 2/12/20 fall it was determined that R1's wheelchair pedals were not in place.

R1's emergency room notes dated 2/12/20

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documents under Chief Complaint, "(R1) was sitting in wheelchair and had a witnessed fall out of (R1's) wheelchair hitting (R1's) right side of (R1's) forehead and bridge of (R1's) nose from (R1's) glasses, right (inner elbow) lacerations and right knee and shoulder." These notes also document under Diagnoses, "fractured nasal bones - Onset: 2/12/2020." These notes contain a radiology report dated 2/12/20 that documents, "right nasal bone fracture."

On 2/19/20 at 12:01 PM, V14 (Hospital Radiologist) stated the fracture to R1's nose was an acute fracture caused by R1's 2/12/20 fall.

2. On 2/18/20 at 10:05 am, R2 was observed to have a left below knee amputation. On 2/18/20 at 10:05 am, R2 was asked about previous falls. R2 stated that R2 was "dropped by a little gal in the shower a little while ago. V4 (Certified Nursing Assistant/CNA) needed another person and V4 just couldn't transfer me. I hit my head in the shower and it really hurt."

On 2/18/20 at 11:43 am, V3 (Licensed Practical Nurse/LPN) stated V4 came and got V3 and she found R2 sitting on the floor of the shower. V3 also said V3 educated the staff after the fall that a gait belt had to be used when transferring R2. V3 confirmed no gait belt was used on the R2 at the time of the fall (1/11/20).

On 2/18/20 at 12:20 pm, V4 stated when R2 fell on 1/11/20, V4 failed to use a gait belt, failed to ensure that the wheel chair was locked before transferring R2, and failed to have non-slip footwear on R2 for transfer.

On 2/18/20 at 12:45 pm, V2 (Director of Nursing/DON) stated R2 fell on 1/11/20. V2

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S9999	Continued From page 4 reported that V2 would expect that staff would use a gait belt, expected that they would lock wheelchair wheels and expected that they would put non-slip footwear on residents before transferring them. R2's fall documentation form dated 1/11/20 at 10:45 am, documents that R2 was in the shower room transferring from wheelchair to shower chair with V4. R2 lost R2's balance and was assisted to the floor but hit R2's head. R2 verbalized needing more assistance to transfer. R2's Care plan dated 10/8/19 documents, "Apply gait belt and provide verbal/visual cues as needed (i.e. push up from bed/chair to stand and reach back before sitting) for safe transfer technique. Ensure that (R2) is wearing appropriate footwear when ambulating or mobilizing in wheelchair." (B)	S9999		