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 11/15/2021

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 Investigation of: Facility Reported Incident of 10-25-21/IL140026	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to effectively supervise R3 to prevent a traumatic fall. This failure resulted in R3 falling to the ground on R3's face and sustaining a temple laceration, temple contusion, hand fracture, and a frontal lobe brain bleed requiring emergency hospitalization and treatment. R3 is one of three residents reviewed for falls in the sample of 14. Findings include: R3's Physician Orders (11/12/2021) documents R3's diagnoses include: Dementia, Coagulation Defect, Unsteadiness on Feet, Abnormality of Gait and Mobility, Repeated Falls, Osteoarthritis of Hip, Parkinson's Disease, Abnormal Posture, and Reduced Mobility. The same record	S9999		

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S9999	Continued From page 2 documents: Ensure proper placement and function of BED, CHAIR, and MOTION SENSOR alarms each shift for Fall Prevention. R3's Minimum Data Set (10/21/2021) documents R3 has severe cognitive impairment, requires two person physical assistance for transfers, R3 is not steady and only able to stabilize with staff assistance during transfers, and has a history of falls with injury. R3's Care Plan (11/9/2021) documents R3 is at High Risk for falls and has bed and chair alarms as a fall intervention. The facility incident report (10/25/2021) documents on 10/25/2021 V4 (Housekeeping) observed R3 stumble out of R3's room backwards into the hallway, hitting the door frame and spinning around and falling face first into the floor. The same record documents R3 sustained a laceration and hematoma (bruise) to the head, hand fracture, traumatic right frontal brain bleed, and required emergency transfer to the hospital for treatment. The facility fall investigation report (10/25/2021) documents R3 "fell flat on (R3's) face" during the fall on 10/25/2021. The same record documents predisposing factors for R3's fall included Confusion, Gait Imbalance, Impaired Memory, Weakness, and Ambulating without Assistance. The same record also documents R3 was seated in R3's recliner in R3's room prior to the fall after previously being out of the room with physical therapy staff. R3's hospital report (11/8/2021) documents R3 sustained a head laceration, acute brain bleed, and hand fracture from R3's fall on 10/25/2021.	S9999		

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S9999	Continued From page 3 On 11/10/2021 at 10:29AM, V5 (Licensed Practical Nurse) reported assessing R3 after R3's fall on 10/25/2021. V5 reported R3 had a bleeding left temple laceration and contusion and was dazed and quiet after the fall. V5 reported R3 had a history of falls from R3's recliner in R3's room. V5 reported R3 was in R3's recliner prior to the fall on 10/25/2021 and R3's fall intervention of chair alarm was effective in the past and R3's alarms "were always going off." V5 reported not hearing R3's alarm sounding at the time of the fall and "the alarm (if operable at the time of the fall) could have helped, to an extent." On 11/10/2021 at 11:13AM, V3 (Registered Nurse) reported assisting R3 after R3's fall on 10/25/2021. V3 reported R3 was located on the ground in the hallway face down and was bleeding. V3 reported R3 had used bed and chair alarms in the past and "I feel like they (the alarms) were (effective in preventing falls for R3)." The Emergency Medical Services (EMS) report (10/25/2021) documents EMS staff found R3 laying on the floor in the facility with a laceration to R3's head. The same record documents facility "Staff advised that physical therapy staff had not placed patient on an alarm after therapy and that they heard a scream and patient was on the floor. Patient is normally on an alarm due to fall risk." On 11/10/2021 at 1:44PM, V7 (Physical Therapy Assistant) reported helping R3 out of R3's chair in R3's room to go to therapy on 10/25/2021 and then returning R3 to the same chair after physical therapy. V7 stated "I honestly beat myself up, I still do, when we stood up and left the room, the alarm didn't go off, when we headed out it didn't	S9999		

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S9999	Continued From page 4 click in my brain, the alarm isn't sounding." V7 reported R3 likes to rock in his chair and V7 usually has to unplug or reset a button to shut an alarm on or off when taking a resident to therapy, but V7 reported not doing so for R3 before R3's fall on 10/25/2021. The facility Fall Prevention policy states: "It is the policy to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs." (A)	S9999		