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 07/29/2022

NAME OF PROVIDER OR SUPPLIER: PLEASANT MEADOWS SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 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 Complaint Investigation: 2265895/IL149480 & FRI of 6/18/2022\IL149053	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Findings 300.1210b) 300.1210d)6 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 These Requirements were NOT MET as evidenced by: Based on observation, record review and interview the facility failed to follow assessment recommendations for bed mobility and failed to ensure a care plan was updated to include known behaviors exhibited during repositioning for one of three residents (R7) reviewed for accidents in the sample list of seven residents. These failures resulted in R7 suffering nasal bone fractures when the facility failed to have two staff members present for care. Findings include: R7's Minimum Data Set (MDS) dated 5/19/22 documents R7 is severely cognitively impaired and that R7 requires extensive assistance of two people for bed mobility and transfers. R7's Care Plan does not document an intervention related to R7's preference to lay on R7's Left side with R7's head in a lowered position. R7's Physician Order Sheet (POS) dated July 1-31, 2022 documents a physician order for Rivaroxaban (anti-coagulant) 20 milligrams (mg) daily. R7's Nurse Progress Note dated 7/26/22 at 10:20 PM documents "(V22) Registered Nurse (RN) was alerted by (V21) Certified Nurse Aide (CNA) that (R7) was being provided incontinence care and was being rolled towards the wall, at the same time (R7) turned (R7's) head downwards and hit the bridge of (R7's) nose on the side rail of the bed. (R7's) nose was bleeding and there is a one centimeter (cm) skin tear on the bridge of	S9999		

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S9999	Continued From page 2	S9999		

(R7's) nose, and redness."

R7's Initial Incident Report to IDPH (Illinois Department of Public Health) dated 7/27/22 documents R7 received a "serious injury" at 10:20 PM on 7/26/22. This same IDPH report documents "Interview with (V21) Certified Nurse Aide (CNA)-(R7) had been combative since 6:00 PM. (V21) put (R7) to bed. (R7) was laying on back and reached up and grabbed (V21's) shirt. After (R7) let go, (V21) rolled (R7) on Left side and (R7) tried to roll into a ball and hit (R7's) nose on the side rail. (R7) started bleeding and (V21) got the nurse. (R7) almost always curls up when (R7) gets rolled to the Left side."

R7's Hospital Record dated 7/27/22 documents medical diagnoses of Acute Nasal Fracture and history of Atrial Fibrillation, Dementia, Current Use of Long-Term Anti-Coagulation, Cerebral Vascular Accident (CVA), Lumbar Spinal Stenosis, Alzheimer's Disease, Glaucoma and Polyneuropathy.

R7's Computed Tomography (CT) scan of Facial Bones Without Contrast report dated 7/27/22 documents "Indication: Trauma". This same report documents "Impression: There are acute comminuted fractures involving the bilateral nasal bones, nasal processes of the maxillary bones and the nasal septum."

On 7/28/22 at 1:15 PM R7 was observed with extensive dark purple/blackish bruising to both eyes and the bridge of the nose. The bruising extended down towards R7's upper cheeks on both sides of R7's face.

On 7/29/22 at 1:30 PM V2 (DON) stated " (V21) CNA repositioned (R7) without any help from

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S9999	Continued From page 3	S9999		

other staff and that most likely caused the serious injury. Other staff that were interviewed all stated (R7) always bends (R7's) head down like that and so this was common knowledge. This should have been care planned as a preference for (R7) and the staff should have been educated on it so that maybe (R7) would not have been injured. "

(B)

2 of 2 Licensure Violations

300.610a)
300.1210b)
300.1210d)1
300.1210d)3)

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

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S9999	Continued From page 4	S9999		

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Requirements were NOT MET as evidenced by:

Based on observation, record review and interview the facility failed to follow physician orders for the administration of antianxiety and pain medications and failed to ensure physician ordered narcotic pain medication was available for administration for three of three residents (R2, R4, R5) reviewed for medication errors in a sample list of seven residents. These failures resulted in R2 missing four doses of scheduled narcotic pain medication and experiencing severe pain when the medication was not available at the facility.

Finding include:

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S9999	Continued From page 5 The facility policy titled 'Medication Administration Policy' effective March 2014 documents the following: "Medications not received and/or from a pharmacy and/or not administered within twenty-four (24) hours from the ordered time to be administered will be considered a medication incident." 1.) R2's undated Face Sheet documents an original admission date of 7/12/22 and a re-admission date of 7/23/22. This same Face Sheet documents medical diagnoses of Fibromyalgia, Bilateral Primary Osteoarthritis of Hip, Bilateral Primary Osteoarthritis of Knee, Scoliosis, Chronic Pain Syndrome and Morbid Obesity. R2's Electronic Medical Record (EMR) documents R2 was hospitalized from 7/15/22-7/23/22 and again on 7/28/22. R2's Minimum Data Set (MDS) dated 7/15/22 documents a Brief Interview for Mental Status Score of 15 out of 15 possible points indicating no cognitive impairment. R2's Physician Order Sheet (POS) dated July 1-31, 2022 documents Physician orders for Oxycodone Hydrochloride (Hcl) Extended Release (ER) 30 milligrams (mg) every twelve hours with a start date of 7/26/22 and Oxycodone Immediate Release (IR) 5 mg every six hours as needed for pain with a start date of 7/26/22. R2's Medication Administration Record (MAR) dated July 1-31, 2022 documents R2's Oxycodone Hcl ER 30 mg was not administered at 8:00 PM 7/26/22, at 8:00 AM and 8:00 PM 7/27/22 and at 8:00 AM 7/28/22.	S9999		

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S9999	Continued From page 6 On 7/28/22 at 12:31 PM V5 Licensed Practical Nurse (LPN) assessed R2 for pain in R2's room. R2 stated the pain is 'terrible'. V5 LPN explained to R2 that R2's Oxycodone Hydrochloride (HCL) 30 milligram (mg) tablets are not available yet but V5 does have the Oxycodone Hcl 5 mg to give. R2 stated "I do not understand what is taking so long to get my pain medication. The Nurse Practitioner (V10) told me it would not be a problem. Why can't I have my Oxycodone Hcl 30 mg?" V5 LPN informed R2 that the prescription was faxed to (V9) Physician and they (facility) are waiting for (V9) to send over the signed prescription. On 7/28/22 at 12:40 PM R2 stated "Both of my hips and knees are bone on bone which is horribly painful". R2 stated it is very difficult to move at all. R2 stated "the pain is so intense, it is like I am going through withdrawal. The Oxycodone Hcl 30 mg was scheduled and now I can only have Oxycodone Hcl 5 mg." R2 stated "They (staff) told me the doctor approved of it but they (staff) forgot to have the doctor sign the prescription so I have been without for days. I hurt all over. It is awful." On 7/28/22 at 1:30 PM V2 Director of Nurses (DON) stated R2 re-admitted from hospital on 7/23/22 with orders for Oxycodone Hydrochloride (Hcl) Extended Release (ER) 30 milligrams (mg) every twelve hours with an end date of 7/26/22 and Oxycodone Immediate Release (IR) 5 mg every six hours as needed for pain. V2 stated V10 Nurse Practitioner reviewed this order on 7/25/22 and gave order to continue both narcotic pain medications with no end date. V2 stated V20 Licensed Practical Nurse (LPN) should have asked V10 to sign the prescription while V10 was	S9999		

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S9999	Continued From page 7	S9999		

Continued From page 7

in facility but did not. V2 stated V9 Physician/Medical Director was in facility on 7/26/22 and the staff nurses again neglected to have V9 sign R2's prescription for both pain medications. V2 stated "Whenever a prescription changes, the nurses should obtain a new prescription and have the Physician or Nurse Practitioner sign the new prescription to prevent any delay in obtaining the medications and so that the resident does not have to endure needless pain or suffering. (R2) had been receiving the Oxycodone Hcl 5 mg IR but not the Oxycodone Hcl ER 30 mg." V2 confirmed R2 missed four doses of Oxycodone Hcl ER 30 mg between the evening dose on 7/26/22, both doses on 7/27/22 and the morning dose on 7/28/22.

2.) R4's Physician Order Sheet (POS) dated July 1-31, 2022 documents a physician order for Hydrocodone-Acetaminophen (Norco) 10-325 milligrams (mg) three times per day. This same POS documents R4's medical diagnosis of Chronic Pain Syndrome.

R4's Medication Incident Report dated 7/22/22 documents "(R4) received a Norco at 2:00 PM and additional dose at 4:00 PM." This same report documents V15 Licensed Practical Nurse (LPN)/Nurse Manager was notified of a narcotic discrepancy on 7/22/22 at 7:24 PM.

R4's Medication Detail Report dated July 1-31, 2022 documents R4 was administered Norco at 3:54 PM on 7/22/22.

R4's Narcotic Count Sheet dated 7/22/22 documents V13 Registered Nurse (RN) administered Norco at 2:00 PM and V14 Licensed Practical Nurse (LPN) administered Norco at 4:00 PM on 7/22/22.

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S9999	Continued From page 8	S9999		

On 7/29/22 at 1:35 PM V2 Director of Nurses (DON) stated R4 received an extra dose of Hydrocodone-Acetaminophen (Norco) 10-325 milligrams (mg) on 7/22/22. V2 stated the day shift nurse V13 Registered Nurse (RN) gave the 2:00 PM scheduled dose of Norco, signed the medication out as given on the Narcotic Count Sheet but did not sign the Electronic Medical Record (EMR). V2 stated V14 Licensed Practical Nurse (LPN) was the oncoming second shift nurse on 7/22/22 who counted the narcotics with V13 RN. V2 DON stated the count was correct and verified by both nurses. V2 stated V14 LPN gave this same narcotic pain medication again because the Medication Administration Record (MAR) showed that it had not been given at 2:00 PM and was late. V2 stated V14 LPN gave the medication at 3:54 PM on 7/22/22. V2 stated this medication error was reported to V15 LPN/Nurse Manager on call at 7:24 PM 7/22/22. V2 stated administering additional doses of narcotic medications could have very detrimental effects on residents. V2 stated "this error could cause obvious effects like sleepiness, but it could also cause more serious effects of respiratory and cardiac issues."

3.) R5's Physician Order Sheet (POS) dated June 1-30, 2022 documents a Physician order for Ativan 1 milligram (mg) two times daily for Anxiety.

R5's Medication Incident Report dated 6/30/22 documents "(R5) received 1 milligram (mg) of Ativan instead of the prescribed dose of 0.5 mg."

R5's Care Plan dated 4/16/21 documents R5 has impaired thought processes and instructs staff to Administer medications as ordered.

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S9999	Continued From page 9 R5's Nurse Progress note dated 6/30/22 at 8:40 PM documents "During shift count noted discrepancy in amount of Lorazepam remaining in card and what was signed out as given. (R5) had 30 Lorazepam in card and 29 documented as remaining. Upon looking it was noted that another resident (R1) was short 1 tab of Lorazepam. One mg of dose of Lorazepam that was given to (R5) was from wrong card. (R5's) dose is 0.5 mg." On 7/29/22 at 1:45 PM V2 Director of Nurses (DON) stated R5 was given the wrong dose of Ativan. (V23) Licensed Practical Nurse (LPN) had inadvertently administered R5 a 1 milligram (mg) Ativan from (R1) another resident's card sitting just in front of (R5's) card of Ativan in the narcotic drawer of the medication cart. V2 stated (V23) made an error. V2 stated "whenever a nurse administers a medication, the nurse should verify the correct medication and dose are given to the correct resident at the correct time." V2 stated "This medication error did not cause (R5) any negative problems but certainly could have caused increased sedation, confusion or problems with eating due to being overly sedated." (B)	S9999		