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 _____	R 03/16/2023

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 First revisit to Annual Health Survey of 1/13/2023 & First revisit to FRI of 12/14/2022/IL154726	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.12310d)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. These Requirements were not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to supervise a resident (R100) with a history of multiple falls and failed to implement therapeutic interventions to reduce the risk of falls. This failure resulted in R100 falling while unsupervised and sustaining a left hip fracture. R100 is one of three residents reviewed for falls in the sample of seven. Findings include: R100's Diagnosis Sheet includes the following diagnoses: History of Falls, Syncope and Collapse, Reduced Mobility, Dementia without Behaviors and Glaucoma. R100's Minimum Data Base (MDS) dated 2/10/23 documents R100 as being Severely Cognitively Impaired. This same MDS documents that R100 requires one person physical assist with transferring, walking in the corridor (hall) and toileting. The facility's Fall Log (current) documents the following falls in the facility since R100's admission date of 9/5/22: 1. 9/5/22 at 7:41 am - ambulating unassisted 2. 10/4/22 at 5:15 am - ambulating unassisted 3. 2/11/23 at 2:41 pm - ambulating unassisted 4. 2/18/23 at 12:05 am - ambulating unassisted 5. 2/25/23 at 11:11 am - ambulating unassisted 6. 3/3/23 at 1:30 am - ambulating unassisted For purposes of this survey the last four above falls were reviewed for root cause and post-fall interventions. The Incident Report dated Saturday, 2/11/23 documents that R100 fell in the dining room and	S9999		

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S9999	Continued From page 2 stated "I felt tired and my legs giving away." R100 hit R100's head and neuro checks were completed. The facility determined that R100 was dizzy and fell, implementing the post-fall intervention of a restorative program of "walk to dine" with a wheelchair to follow R100 to and from the dining room. The Incident Report dated Saturday, 2/18/23 documents R100 falling in R100's room and determined the root cause as "ambulating without assistance" and was transferred to the hospital Emergency Room due to hitting R100's head and R100 complaining of head and neck pain. There were no findings at the hospital for trauma. A bed alarm was implemented. The Incident Report dated Saturday, 2/25/23 documents that R100 was found in the hallway on the floor on R100's back and R100 complained of severe left hip pain. On assessment it was noted there was external rotation of the left leg. An ambulance was called and R100 was transported to the Emergency Room (ER). This fall was unwitnessed. A statement by V4 Certified Nursing Assistant documents that V4 had seen R100 approximately 5 to 10 minutes prior to the fall standing in the hallway with another resident, unsupervised and unassisted. There was no documentation or confirmation that R100's bed alarm was in place or sounding. ER Notes dated 2/25/23 document the following: "(R100) arrived to ED (Emergency Department) by ambulance from (facility). (R100) arrives with complaints of left groin pain after a fall; complaints of left hip pain with movement. (R100) also hit (R100's) head with the fall per EMS (Emergency Medical Service) and arrives on	S9999		

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S9999	Continued From page 3 backboard with c-collar (cervical collar) in place. (R100) has advanced dementia. (R100) had a ground level fall at the (facility) today and complains of left hip plain. (R100) does not remember the fall. No family at bedside." Hospital X-Rays of "Hip per 2-3 views w/pelvis (with pelvis) unilateral left" document the following: Findings: "Bones: Displaced impacted subcapital fracture neck of femur on the left side with about 1 cm (centimeter) displacement of the distal fracture fragment medially." R100 was returned to the facility post-operatively (Status Post Hip Surgery) on 2/27/23 per facility Progress Notes. On 3/3/23 a facility Incident Report documents that R100 fell in R100's room while self toileting and fell to the floor on the left post-operative side and complained of severe pain. R100 was again sent to the ER for evaluation. R100 did not return to the facility. On 3/15/23 at 2:00 pm, V2 Director of Nursing stated when R100 first came to the facility physical therapy was involved, but R100 had plateaued, so R100 was discharged from therapy. V2 confirmed this was in September of 2022 (5 months ago) and R100 had not had any physical therapy since until it was ordered when returning with the fractured hip on 2/27/23. V2 confirmed that the bed alarm put on R100's bed was at the request of R100's family because R100 was not safe to be up unassisted while ambulating.	S9999		

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S9999	Continued From page 4 On 3/16/23 at 12:05 pm, V1 Administrator confirmed that the facility should have put therapeutic fall interventions in place. V1 confirmed that physical therapy should have been consulted on the use of an assistive device, such as a walker, to aide in R100's ambulation. V1 stated the facility was aware that there would be a problem with R100 ambulating unassisted and falling. On 3/16/23 at 1:36 pm, V11, Family Member of R100 stated V11 spoke to the facility several times and told the facility that R100 could not walk unassisted. V11 stated "they just let (R100) get up and fall, they should have had (R100) in some kind of program so that (R100) could use a walker or they should have been with (R100) when (R100) was up walking. (R100) is not returning there." (A)	S9999		