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 11/08/2023

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 FRI of 10/20/2023/IL166159	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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 evienced by: Based on observation, interview and record review the facility failed to provide supervision and ensure fall interventions were in place, failed to supervise/transfer a resident for safety, and failed to provide a safe transfer to prevent falls for three of three residents (R1, R2, R3) reviewed for falls on the sample list of five. Facility staff left R1 sitting on the side of the bed unsupervised and without fall interventions in place resulting in R1 falling and fracturing R1's hip. Facility staff failed to supervise and transfer R2 out of the wheelchair when R2 was falling asleep resulting in R2 falling out of the wheelchair and sustaining lacerations to R2's forehead which required nine sutures. Findings include: 1.) R1's undated Face Sheet documents R1 admitted to facility on 8/15/23. This same Face	S9999		

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S9999	Continued From page 2 Sheet documents R1 has medical diagnoses of Right Intertrochanteric Hip Fracture, Encephalopathy, Myelodysplastic Syndrome, Altered Mental Status, Overactive Bladder, Age Related Bilateral Nuclear Cataracts, Malignant Neoplasm of Prostrate, Muscle Weakness, Unsteady on Feet, Need for Assistance for Personal Care and Cognitive Communication Deficit. R1's Brief Interview for Mental Status (BIMS) dated 10/19/23 documents R1 as moderately cognitively impaired. R1's Care Plan documents R1 is at risk for falls due to weakness, unsteady gait, history of falls, Encephalopathy, altered mental status, Diabetes Mellitus Type II, bilateral cataracts, need for assistance with personal care, overactive bladder and sepsis. This same care plan documents fall interventions dated 8/16/23 which instruct staff to ensure R1's call light is within reach and encourage R1 to use it as necessary, keep needed items within reach and 8/18/23 to apply personal alarms. This same Care Plan documents a focus area dated 8/21/23 of R1 being non-compliant with using a call light and waiting for assistance with Activities of Daily Living (ADL). R1's Physician Order Sheet (POS) dated November 2023 documents a physician order starting 8/8/23 for Aspirin 81 milligrams (mg) daily and Eliquis 2.5 mg twice daily starting 10/23/23. R1's Hospital Record dated 10/20/23 documents Computerized Tomography (CT) without contrast summary as: Intertrochanteric Fracture Right Hip. This same record documents R1's admission diagnoses of fall and Right	S9999		

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S9999	Continued From page 3 Intertrochanteric Hip Fracture. This same record documents "(R1) was evaluated in the emergency room and found to have a non-displaced Right Intertrochanteric Hip Fracture. (R1) underwent surgical procedure of Intramedullary (IM) Nail on 10/20/23. (R1) will need extensive Physical Therapy (PT) and Occupational Therapy (OT) moving forward, skilled nursing facility." V3 Orthopedic Physician Progress Note dated 10/20/23 documents "82 year old white male being seen today for his Right Hip. (R1) had fallen at facility was getting into a different room when he tripped while grabbing the door. (R1) came down on his Right Hip producing a fracture." R1's Nurse Progress note dated 10/20/23 at 9:46 AM documents "Staff heard a loud noise from (R1's) room followed immediately by (R1) calling out. (R1) laying on floor in common area that adjoins the two sides of the room. (R1) laying on Left side. Prior to fall event, therapy (V5) had been in room assisting with dressing and morning Activities of Daily Living (ADL). (R1) last seen sitting on edge of bed. (R1) reports (R1) got up to use the bathroom and did so unassisted and without the use of (R1's) walker. (R1's) wheelchair was noted near (R1) but facing away from (R1) and was unlocked. Call light was not activated at the time of the fall. (R1) reports hitting back of head and Right Hip pain. (R1) stated 'I hit both sides." (R1) reports pain and limited movement to Right Lower Extremity and increased pain upon palpation. (R1) reports increased pain to Right Inner Thigh. Hospital reported at 9:40 AM that (R1) would be admitted for Right Hip Fracture.	S9999		

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R1's Final Incident Report to Illinois Department of Public Health (IDPH) dated 10/25/23 documents "(R1) stated 'I was coming around the corner in my room and reaching for the bathroom door handle. I think I wanted to go to the bathroom but not sure. I am too independent to use the call light. I was leaning to grab the door handle and my hand slipped off and lost my balance'."

On 11/7/23 at 11:30 AM R1 was sitting up in highback wheelchair at community dining room table. No pressure alarm in place.

On 11/7/23 at 2:40 PM R1 was laying in bed. R1's call light was laying on floor under R1's bed out of reach of R1.

On 11/8/23 at 10:40 AM R1 was sitting in a highback wheelchair at the community dining table. R1's chair alarm was in place with alarm cord hanging from the back of the seat of the wheelchair not plugged in to anything.

On 11/7/23 at 11:35 AM V4 RN stated the morning R1 fell, V4 was called into R1's room to assess R1. V4 stated R1 was laying on his Left side facing away from the door. V4 RN stated the staff all heard the crash and went running into R1's room. R5 (R1's wife) was present but not in R1's room. V4 RN stated R1's injury was obvious upon assessment. V4 RN stated R1 did not have personal alarms in place at time of fall.

On 11/7/23 at 11:36 AM V9 Certified Nurse Aide (CNA) stated "I am (R1's) CNA everyday. (R1) has days where he is alert and oriented and other days that he is really confused. (R1) does need some help getting up and walking. (R1) was walking a long way with therapy but now he just

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uses his wheelchair since his hip got broken. (R1) was supposed to be wearing bed and chair alarms. They (facility) started that after (R1's) first fall a long time ago. (R1) has a habit of trying to get up by himself. There are some days (R1) is stronger and can do that and others that he is much weaker and not oriented that he needs a lot more help. (R1) was supposed to use one assist, gait belt and a walker before this last fall (10/20). The space between (R1's) bed and the wall was not big enough for (R1) to use his walker or wheelchair. (R1's) bed was (adjacent) directly up against his wife's bed. (R1's) wife needed room for her wheelchair to fit on her side of the bed so (R1's) side was way too narrow for any of his equipment to fit in there."

On 11/7/23 at 11:45 AM V5 Occupational Therapy Assistant (OTA) stated "I work with (R1) several days a week. It was our (V5, R1) normal routine from me to help (R1) out of bed, get dressed and complete his morning Activities of Daily Living (ADL's). The morning (R1) fell I was working with him as normal. (R1) had urinated all over the bed so I was trying to get that cleaned up. I helped (R1) get dressed. (R1) was fully dressed and wearing no skid socks. I remember unclipping (R1's) call light from (R1's) bed linens and placing it over the footboard of (R1's) bed. This would have been out of reach. (R1) did not have any alarms on his bed. I grabbed up all of the soiled linen and left (R1) sitting on the side of his bare mattress. I left (R1) alone like that to take his dirty linens over across the unit to the soiled utility room. I was gone for one to two minutes at the most. I did not make sure (R1's) call light was in reach and did not put the bed alarm on the bed. I didn't even know (R1) used a bed alarm. I never saw one in (R1's) room. The space between (R1's) bed and wall was not nearly big enough to

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leave (R1's) walker. (R1's) wife was also a resident here (facility). (R1's) wife is not able to stand or walk so she needed extra space on her side of the bed to fit all of her equipment. There just wasn't enough room in there. We (staff) would leave (R1's) walker and wheelchair at the end of (R1's) bed because of the space issue. (R1) has times he is more confused and more weak due to his blood transfusions. (R1) gets blood transfusions regularly for his Cancer. (R1) was progressing quite well in therapy before this last fall and now I am not sure he will be going back home."

On 11/7/23 at 2:20 PM R5 (R1's) spouse stated "We (R1, R5) have never had any kind of alarms on our beds. I have never heard any kind of alarm going off. As much as (R1) tries to get up on his own, I would have heard something like that."

On 11/8/23 at 10:30 AM V14 Director of Rehabilitation Services stated "(R1's) cognition fluctuated. (R1) would have good days and other days he would struggle more. (R1) did not have much safety awareness. (R1) was non-compliant with recommendations. (V5) OTA should not have left (R1) alone without a call light or any way to reach out for help. The linens could have waited. (V5) should have completed (R1's) therapy, gotten (R1) positioned safely and then removed the linens."

On 11/8/23 at 10:50 AM V15 Licensed Practical Nurse (LPN) stated "(R1) is not always alert and oriented and he was a high fall risk even before his fall. The alarms were put in place after (R1's) first fall back in August, 2023. If I were to guess, I would go by whatever (R1's) careplan says and it says (R1) is supposed to have personal alarms.

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S9999	Continued From page 7 So that means to me as a nurse that the bed and chair alarms should be in place. We (staff) are supposed to follow those fall interventions. I will make sure (R1's) chair alarm gets plugged in. It doesn't do any good otherwise." On 11/8/23 at 3:00 PM V17 Nurse Practitioner stated R1 is not always alert and oriented. V17 stated R1's cognition fluctuates based on his medical condition and need for blood transfusions. V17 stated the facility caused R1's Right Intertrochanteric Fracture by not having the fall interventions in place to prevent R1's fall. 2.) R2's undated Face Sheet documents an admission date of 9/20/23. This same Face Sheet documents R2's medical diagnoses of Cerebral Infarction, Chronic Systolic Heart Failure, Dementia, Anemia, Weakness, Osteoarthritis of Left Shoulder, Muscle Weakness, Unsteady on Feet, Need for Assistance with Personal Care, Insomnia and History of Falling. R2's Minimum Data Set (MDS) documents R2 as cognitively intact. Requires extensive two assist for transfers, extensive one assist for bed mobility, dressing, toileting and personal hygiene. R2's Nurse Progress Note dated 11/1/23 at 9:06 AM documents "(R2) was sitting at the desk and fell forward out of the wheelchair. (R2) was leaning over in wheelchair and rocking. (R2) had been reminded to sit up prior to this. (R2) fell hitting head on floor. (R2) has two lacerations to forehead; three centimeters (cm) on the Left Forehead and 2 cm x 2 cm mid forehead near hair line." R2's Hospital Record dated 11/1/23 documents	S9999		

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S9999	Continued From page 8 R2 was seen in emergency room for a fall at facility. This same record documents "(R2) to emergency room from facility with chief complaint of fall out of her wheelchair this morning resulting in a head injury. (R2) is noted to have two lacerations to her forehead with bleeding controlled." R2's Final Report to the State Agency dated 11/7/23 documents R2's fall at the facility on 11/1/23 and R2 receiving two lacerations that required nine sutures total to the left forehead. On 11/7/23 at 11:18 AM R2's left forehead had two separate areas with multiple sutures. R2's left forehead laceration's were dry with a small amount of redness. On 11/8/23 at 10:30 AM R2 was sitting in the wheelchair in front of the nurses desk. V4 Registered Nurse (RN) was standing with V4's back to R2 behind the opposite side of nurses desk. R2 was sitting in a slumped over position with R2's eyes closed. R2 Appeared to be sleeping with R2's head resting on the right side of R2's wheelchair. On 11/7/23 at 11:10 AM V7 Certified Nurse Aide (CNA) stated "(R2) will start to lean forward and rock in her wheelchair when she starts to get tired. (R2) likes to sit at the nurses station but she will lay down sometimes when she gets tired also. That day (R2) fell, (R2) was sitting in front of the nurses desk. (R2) had been rocking back and forth for a while that morning. The only staff present was (V16) Licensed Practical Nurse (LPN) who was sitting behind the nurses desk. You can't see the residents from that point because the nurses desk is too tall and solid. No one had asked (R2) if she wanted to lay down.	S9999		

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(R2) might have wanted to but no one asked. (V16) did tell (R2) to sit up a couple of times but didn't ask (R2) if she wanted to lay down. (R2) rocked herself to sleep that day and fell out of the wheelchair. I think (R2) got a bunch of stitches from her fall."

On 11/7/23 at 11:20 AM R2 stated "I don't remember falling but I do remember being taken to the hospital and had to get these things (pointing to forehead sutures). Let me tell you, that hurt! I was out here (next to nurses station) by myself and must have fallen or something because the next thing I know I was being sent to the emergency room."

On 11/8/23 at 2:15 PM V16 Licensed Practical Nurse (LPN) stated R2 was known to rock herself to sleep in her wheelchair prior to R2 falling on 11/1/23. V16 LPN stated R2 was rocking in her wheelchair prior to her falling out of wheelchair. V16 LPN stated "I gently nudged (R2) to wake her up. (R2) does that all the time. I have had to wake (R2) up in her wheelchair hundreds of times. I didn't ask (R2) if she wanted to lay down or sit in her recliner in her room. I just nudged her and then sat down at the nurses desk. I couldn't see (R2) from the desk. I just heard a big thud sound when (R2) hit the floor. I should have had the staff lay (R2) down."

3.) R3's undated Face Sheet documents R3 admitted to facility on 8/16/21. This same Face Sheet documents medical diagnoses of Dementia, Unsteady on Feet, Need for Assistance with Personal Care, Reduced Mobility, Muscle Weakness, Anterograde Amnesia and Heart Failure.

R3's Minimum Data Set (MDS) dated 8/17/23

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documents R3 is cognitively intact. This same MDS documents R3 requires extensive assistance of one person for transfers.

R3's Care Plan documents a fall intervention dated 4/23/21 for staff to provide proprioception (correction) of posterior lean.

R3's Nurse Progress Note dated 10/28/23 at 10:34 AM documents "(V7) Certified Nurse Aide (CNA) was walking (R3) to wheelchair when another resident (R4) came into room. (R3) turned to set in chair and fell backwards to the floor. (V7) CNA attempted to catch (R3). (R3) fell onto Right Hip and hit head on chair. (R3) complained of pain in Right Hip/Pelvis area."

R3's Hospital Record dated 10/28/23 documents R3 was seen in the emergency room due to a fall at facility. This same record documents R3's discharge diagnoses of Closed Head Injury, Pain in Right Lower Limb, Strain of Neck Muscle and Fall.

R3's undated Fall Investigation documents R3's fall on 10/28/23 as being witnessed by (V7) Certified Nurse Aide (CNA). This same report documents "(R3) turned to sit down in her wheelchair and (R4) entered the room and began touching her blanket. (R3) became upset by (R4) touching her blanket and this caused her anxiety. It is probable that (R3) became fixated on (R4) touching her blanket and became off balance resulting in her fall. (V7) attempted to catch (R3) as she fell and was unable to do so."

On 11/7/23 at 10:45 AM R3 stated "I was sitting in my recliner and (V7) Certified Nurse Aide (CNA) was standing in front of me. I was trying to stand up when I saw (R4) walking right into my room.

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S9999	Continued From page 11 (V7) was looking at (R4), telling (R4) to leave when (R4) came over to my wheelchair and tried to grab my sweater from the back of my wheelchair. My wheelchair was sitting on my Left side in front of my roommate's chair by her bed. When I saw (R4) try to grab my sweater, I reached over to get a hold of it before (R4) took off with it. That is when I fell. I fell straight back. (V7) CNA could not have done anything to stop me because she was standing in front of me. I hit my head and hurt my hip. I had to go to the hospital emergency room and be checked out by the doctor. They (hospital) did a bunch of tests and sent me back. As soon as I got back I made sure my sweater was still there." On 11/7/23 at 11:00 AM V7 Certified Nurse Aide (CNA) stated "I was the CNA helping (R3) the day she fell. I went into (R3's) room to get her up to go to an activity. (R3) was sitting in her recliner by her bed. (R3's) ex-roommate's highback chair that stayed in the room was sitting so close to R3's recliner on (R3's) Left side that there was no room for the wheelchair. I had to angle the wheelchair in front of (R3's) ex-roommates chair. I was standing in front of (R3) kind of on her Right side. There just wasn't enough room in there to set things up right. We (staff) just have to make do sometimes. (R3) stood and at the same time (R4) came into (R3's) room and tried to touch (R3's) sweater that was laying over the back of (R3's) wheelchair. (R3) started to grab at her sweater and that is when she lost her balance and fell. If I had been on (R3's) Left side, I would have been able to try to catch her. It is hard to catch someone when they fall back and you are in front of them. I felt so bad. I am glad (R3) did not get hurt anymore than she did. Next time, I will definitely just move the other chair so I can be positioned better."	S9999		

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 11/08/2023

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
S9999	Continued From page 12 On 11/8/23 at 2:40 PM V18 Medical Director stated the facility should follow the resident's care plan in order to try to reduce accidents and/or falls from happening. V18 confirmed R1's fall interventions were not in place on 10/20/23 which resulted in his fall that caused his Right Intertrochanteric Fracture. V18 Medical Director stated staff should address the needs of the residents such as R2 falling out of the wheelchair before it happens. V18 Medical Director agreed staff should have positioned themselves/furniture better to avoid R3's fall. V18 Medical Director stated "I can't say much in support of the facility with these kinds of preventable incidents. I will say they (facility) are working towards providing adequate care for the residents but it looks like they are not there yet." (A)	S9999		