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 09/25/2024

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 Complaint Investigation: #2467372/IL177984	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1)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 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.	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 10/10/24

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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 record review and interview the facility failed to ensure a resident (R1) received appropriate treatment for an infection of the heart muscle. The facility also failed to ensure the physician and Nurse Practitioner were aware of R1's infection treatment plan. Theses failures affect one (R1) of three residents reviewed for IV Medication/Infection in a sample list of three residents. These failures resulted in (R1) being hospitalized with sepsis and subsequently expiring due to R1's worsening infection.

Findings include:

R1's Progress Note dated 6/26/24 at 6:42PM documents R1 was admitted to the facility following hospitalization (as documented on R1's Post Acute Care Transition Document dated 6/26/24) for "Sepsis secondary to cellulitis,

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S9999	Continued From page 2 Bacteremia with Enterococcus with Endocarditis, Atrial Fibrillation with Rapid Ventricular Response (RVR), RVR likely triggered from Sepsis, Sepsis on admission with Tachycardia, Leukocytosis. Blood Cultures Positive for Enterococcus. Repeat Blood Cultures Positive for Gram Positive Cocci in Chains. Repeat Blood Cultures Negative. Percutaneous Intravenous Central Catheter (PICC) line placed on day of discharge. Infectious Disease consult recommended six weeks of Intravenous Vancomycin. Further Infectious Disease recommendations as mentioned in discharge instructions for lab orders and monitoring. Cardiology consulted Transesophageal Echocardiogram showed Mitral Vegetation. Discharge to (the facility) with six weeks of Intravenous Vancomycin." R1's Progress Note dated 6/26/24 documents V10, Licensed Practical Nurse (LPN) entered the correct hospital discharge order for "Vancomycin 1000 Milligrams by IV Route every 48 hours for 40 days." in R1's electronic medical record. The facility order report for R1 dated 7/1/24 documents CBC with diff, CMP, Vanco trough (goal 10-20) weekly **Fax results to (Fax#) Attn: (infectious disease specialist) one time a day every Mon for Vanco administration until 8/7/24, there was no documentation provided that reports were faxed as ordered Monday, 7/1/24. R1's Post Acute Care Transition Document was uploaded to R1's electronic medical record on 7/1/24. On 9/20/24 at 11:46AM V1 Administrator verified This document and other transfer information arrived with the resident via ambulance and were given to the admitting nurse. On 9/18/24 at 10:00AM V11, Registered nurse	S9999		

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(RN) confirmed Pharmacy notified V11, Registered nurse (RN) R1's Vancomycin was changed to 1000 Milligrams every 24 hours on 6/27/24. V11 confirmed V11 was instructed by pharmacy to change the Vancomycin order from every 48 hours to every 24 hours 1,000 Milligrams Per PICC line. V11 stated "I don't change anything with a Vancomycin order unless Pharmacy or the Nurse Practitioner give me an order," V6, Nurse Practitioner signed the order. No lab was drawn and there is no rationale documented to justify the change.

On 9/18/24 at 11:15AM V9 Registered Pharmacist (IV service) stated "I believe the change in the Vancomycin order for (R1) was not done by pharmacy intentionally. The only trough (antibiotic dose testing) and kidney function test the pharmacy had at the time the order was changed was the hospital trough which was 16 ug/mL(micrograms per milliliter) and Creatinine was within normal limits so there was no rationale for the order to be changed."

R1 Medication administration record for June and July 2024 documents R1 received the 1000 Milligram dose of Vancomycin daily 6/28/24, 6/29/24, 6/30/24 and 7/1/24. A Vancomycin trough, Complete Blood Count, and Comprehensive Metabolic Panel was obtained prior to the administration of the 7/1/24 dose of Vancomycin. The lab reported a panic level of Vancomycin at 37.4 and a Creatinine of 3.9, and a Glomerular Filtration Rate of 12% which the lab report documents indicate "Kidney Failure." Following these lab values one more dose of 1000 milligrams of Vancomycin was administered prior to discontinuing on 7/2/24 by V6, Nurse Practitioner. V6 then ordered Clindamycin 150 Milligrams three times daily for 10 days "for

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cellulitis."

On 9/17/24 at 2:00PM V6 (NP) stated "(R1) was admitted after (R1) was hospitalized for Sepsis due to Cellulitis. I wasn't aware there was an admitting diagnosis of Bacterial Endocarditis."

On 9/18/24 at 1:42PM V13, Medical Director stated "I was not aware that (R1) had Endocarditis. I thought the Clindamycin was appropriate because I believed (R1) was being treated for cellulitis. Had I been aware of the Endocarditis and the abnormal trough and kidney function I would have had (R1) sent out to the hospital."

R1's Progress Note dated 7/20/24 at 1:04PM documents R1 experienced nausea and vomiting and had felt unwell since the prior day and was sent out to the hospital. R1 was admitted with Sepsis. R1 was treated until R1 expired on 8/13/23.

R1's Hospital Admission record dated 7/20/24 by Emergency Room Physician documents "(R1) presents to Emergency Department with recurrence of presentation that (R1) was hospitalized last month at (other hospital) for. Patient (has) Recurrent Cellulitis Leading to Sepsis, Infectious Endocarditis, with recurrent Atrial Fibrillation with RVR. Was supposed to be discharged with six weeks Intravenous Vancomycin. Patient (does) not have PICC line in currently." This same record documents R1 had a White Blood Count of 25.8 (normal reference range 4.00-11.00) and Lactic Acid 3.2 (normal reference range 0.5-2.0).

On 9/20/24 at 2:53PM V7, Infectious Disease Physician (from the hospital) R1 was admitted to

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on 7/20/24 stated "The lack of care for (R1) at (the facility) caused (R1) to be rehospitalized with Sepsis from Endocarditis. Ultimately (R1) had a stroke in my opinion from a bit of vegetation that broke off from (R1's) heart and traveled to (R1's) brain. I believe the lack of appropriate care at (the facility) hastened (R1's) death. (R1's) Endocarditis was caused by enterococcus. Enterococcus is not even susceptible to the clindamycin they put (R1) on at (the facility)."

R1's death certificate dated 8/19/24 lists R1's cause of death as "Acute Onset Chronic Respiratory Failure Metabolic Toxic Encephalopathy secondary to Recent Endocarditis with Enterococcus Faecalis Valve Endocarditis."

The Facility Assessment last reviewed June 2024 states "Infection Prevention: "24-hour Communication Report is reviewed and if any concerns it is addressed. An Infection Control/Preventionist (ICP) all aspects of prevention and infection control including policy and plan development, recording, and staff training. All new orders are checked a daily and if an antibiotic is ordered an infection verification form is completed to see if the signs and symptoms met criteria. Then resident is placed on log with appropriate information and plotted on facility floor plan to track and watch for trending. If any trends are identified staff, visitors, families, and residents are given education as appropriate. The ICP reports weekly to the NHSN database all COVID related information, performs weekly resident and staff COVID testing, and keeps a log of call-ins with signs and symptoms from all employees and consults with local public health officials to ensure the highest level of infection control is received."

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