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S 000	Initial Comments Investigation to Facility Reported Incident of 1/10/24/IL168995	S 000		
S9999	Final Observations Statement of Licensure Violations: One of Two 300.610a) 300.1010i) 300.1210b) 300.1210d)2) 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 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B) Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on interview and record review the facility failed to obtain ordered kidney function laboratory work and failed to complete neurological exams following a fall with a head injury for one of three residents (R3) reviewed for falls. These failures resulted in R3 being admitted to the hospital for Acute Kidney Injury, Dehydration and Altered Mental Status. Findings include: The facility's Falls-Clinical Protocol policy with a revised date of August 2008 documents, "Assessment and Recognition" "2. In addition, the nurse shall assess and document/report the following: a. vital signs b. Recent injury, especially fracture or head injury c. Musculoskeletal function, observing for change in normal range of	S9999		

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motion, weight bearing, etc. (etcetera) d. Change in cognition or level of consciousness e. Neurological status." This policy also documents, "Monitoring and Follow-Up. 1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall."

The facility's undated Neurological Assessments Procedures provided by V2 Director of Nursing on 1/30/24 at 11:30 AM documents, "Neurological assessments should be performed as follows for a 72 hour period, unless otherwise ordered by the attending physician. Every 15 minutes x (times) 4, Every 1 hour x 4, Every 2 hours x 8, Every 4 hours until the 72 hour time period is complete. Notify the physician of any significant change in neurological status immediately."

1.) R3's hospital History and Physical dated 1/3/24 documents R3 was admitted to the hospital for a fall with renal and splenic hematomas. This History and Physical documents laboratory levels for the BUN (Blood Urea Nitrogen) (test for kidney function) of 23 mg/dl (milligrams/deciliter) (5-25 normal range) and Creatinine (test for kidney function) of 1.45 mg/dl (0.5-1.4 normal range).

R3's hospital after visit summary dated 1/12/24 documents to repeat the BMP (Basic Metabolic Panel) (includes BUN and Creatinine) within 5-7 days of discharge (discharge of 1/12/24).

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R3's Physician's Order documents an order for a BMP 5-7 days post hospital discharge with a start date of 1/17/24 and a stop date of 1/18/24.

R3's medical record does not contain a BMP after admission on 1/12/24.

R3's Nurse's Note dated 1/22/24 at 12:05 PM by V4 Advance Practice Registered Nurse documents that V4 called R3's Power of Attorney (POA) and reported R3's increased altered mental status, poor oral intake and headache. This note documents POA stated that R3 was not R3's self yesterday and agreed to send R3 to the Emergency Room. EMS (Emergency Medical Services) called and R3 sent to the hospital.

R3 Nurse's Note dated 1/22/24 at 9:07 PM by V10 Registered Nurse documents V10 spoke to the hospital and R3 was admitted with diagnoses including Acute Kidney Injury, Dehydration and Altered Mental Status.

On 1/30/24 at 1:34 PM, V1 Administrator confirmed R3's BMP did not get completed and V1 does not know why.

On 1/30/24 at 2:30 PM, V4 Advance Practice Registered Nurse stated if the facility would have completed R3's BMP on 1/17/24 and the values were elevated V4 would have started IV (Intravenous) fluids and that may have kept R3 from having to go to the hospital.

R3's hospital laboratory results dated 1/24/24 document a BUN of 46 (abnormal value) and a Creatinine of 1.5 (abnormal value).

2.) R3's Nurse's Notes dated 1/18/24 at 7:34 PM by V10 Registered Nurse documents at 7:15 PM

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a CNA (Certified Nursing Assistant) reported to V10 that R3 was found on the floor in front of the wheelchair laying on R3's left side. This note documents that neurological checks were initiated.

The Neurological Assessment Flow Sheet documents that neurological checks were initiated at 7:15 PM every 15 minutes x 4, then every hour x 4, then every two hours x 8 with the last one being documented at 2:00 PM on 1/19/24. The next neurological check would have been at 6:00 PM but R3 had another fall.

R3's Nurse's Note dated 1/19/24 at 6:00 PM by V13 Licensed Practical Nurse documents they heard a loud noise and the CNA ran to R3's room and R3 had fallen and hit R3's head. R3 had a laceration to the left side of R3's head and was bleeding. EMS (Emergency Medical Service) was called and they took R3 to the Emergency Room.

R3's Nurse's Note dated 1/19/24 at 8:45 PM by V13 documents V13 spoke to the hospital nurse and they stated that R3 had 5 staples placed to the left side of R3's head.

R3's Nurse's Note dated 1/19/24 at 11:00 PM by V14 Registered Nurse documents R3 returned from the hospital at 10:15 PM and neurological checks were within normal limits.

R3's Neurological Assessment Flow Sheet documents the neurological checks (neuros) were restarted at 10:30 PM and then another at 1:00 AM on 1/20/24 then one more at 5:00 AM.

R3's Nurses Notes document that R3 returned to the facility on 1/19/24 at 10:15 PM which was 4 1/4 hours after the second fall. R3 should have

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resumed the neuros with one remaining one hour check left and then eight remaining two hours checks and then the four hour checks to get to the 72 hours.

R3's Neurological Assessment Flow Sheet only documents three checks being completed after R3 returned from the hospital and only one of those checks were completed at the appropriate time.

On 1/30/24 at 11:08 AM, V4 Advance Practice Registered Nurse stated that V4 was under the understanding that the nurses were completing the neurological exams on R3 when R3 came back from the fall on 1/19/24. V4 stated that V4 expects them to pick up the neurological exams when R3 returned at the time frame R3 returned at. V4 stated that V4 examined R3 on 1/22/24 because nursing staff requested due to a change in condition and V4 sent R3 to the hospital for altered mental status.

On 1/30/24 at 11:41 AM, V8 Licensed Practical Nurse stated that on 1/21/24 R3 wasn't chewing food well but R3 did not have any bottom teeth so V8 downgraded R3's diet to mechanical soft. V8 stated that R3 would get tired after receiving the Parkinson's Disease medication and that was normal for R3.

On 1/30/24 at 11:53 AM, V10 Registered Nurse stated that on 1/22/24 V10 gave R3 the morning medications and R3 took them fine but after breakfast V10 noticed a decline in R3's condition and notified the Nurse Practitioner and V4 Advance Practice Registered Nurse examined R3 and sent R3 to the hospital.

(B)

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300.610a)
300.1210a)
300.1210b)5)
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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest

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practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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

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and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to implement fall prevention interventions to prevent falls for three of three residents (R2, R3, R4) reviewed for falls in the sample list of five. These failures resulted in R2 and R3 falling and suffering head lacerations that required staples at the emergency room.

Findings include:

The facility's Falls - Clinical Protocol policy with a revised date of August 2008 documents, "As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling."

The facility's Falls and Fall Risk, Managing policy with a revised date of August 2008 documents, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."

The facility's undated Gait Belt Policy & Procedure documents, "It is the policy of this facility that gait belts are utilized on all residents requiring physical assistance with transfer unless contraindicated. The gait belt will be utilized for any resident that has been assessed to need a mechanical lift or stand by assist for safe transfer ability."

1.) R2's Order Summary Report documents

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diagnoses including Radiculopathy Lumbar Region, Other Malaise, Low Back Pain, Weakness, Morbid Obesity, Other Intervertebral Disc Degeneration Lumbar Region, Discitis Lumbar Region, Muscle Weakness, Unsteadiness on Feet and Difficulty in Walking. This Order Summary Report documents an order for Apixaban (anticoagulant) 5 mg (milligrams) twice a day with a start date of 10/4/23.

R2's Care Plan dated 10/5/23 documents R2 is at risk for falls related to gait/balance problems, unaware of safety needs, Pain, Incontinence, Obesity, Depression, limited/decreased mobility, Osteoarthritis and Restless Leg Syndrome with an intervention to maintain a clear pathway in the room and free of obstacles. This Care Plan does not document how R2's transfers or ambulates.

R2's Minimum Data Set (MDS) dated 12/20/23 documents R2 requires partial/moderate assistance for moving from a sitting position to a standing position, transferring from a chair to the bed or wheelchair and to walk 10 feet. Partial/moderate assistance is documented as the helper lifts, holds or supports the trunk or limbs. This MDS documents R2 has moderately impaired cognition with a BIMS (Brief Interview for Mental Status) of 11/15.

The facility's Detailed Incident Summary dated 1/16/24 completed by V2 Director of Nursing documents on 1/10/24 at 1:00 AM, R2 turned on the call light for assistance to ambulate to the bathroom. V3 Certified Nursing Assistant assisted R2 with the walker and began ambulating to the bathroom. R2 requested V3 move a trash can. V3 bent down, picked up the trash can and turned to set it down when V3 heard R2's walker rattle. V3 was unable to catch R2 before R2 fell. The nurse

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on duty assessed R2 and R2 had a laceration on the back of the head. R2 was sent to the emergency room.

R2's Emergency Room note dated 1/10/24 documents Patient Discharge Instruction which documents 6 staples, discharge diagnoses of a Fall - Primary and Laceration of Head - Primary. R2's Computed Tomography (CT) scans dated 1/10/24 document no acute fractures. R2's CT of the head dated 1/10/24 at 1:53 AM documents "Clinical History/Indication for exam" as pain - 92 year old female in Emergency Room (ER) after a fall hitting the back of (R2's) head, laceration to the back of the head. This ER report documents R2 received Fentanyl (narcotic pain reliever) IV (Intravenous) push of 50 mcg (micrograms) at 2:30 AM, Fentanyl 25 mcg IV push at 2:45 AM and Fentanyl 25 mcg IV push at 4:10 AM. This ER report documents wound care type - laceration to posterior head measuring 6 cm (centimeters) long by 0.5 cm wide by 0.25 cm deep. This report documents observed behaviors of R2 as grimacing, guarding, moaning and restraint to movement.

On 1/29/24 at 1:04 PM, V3 Certified Nursing Assistant (CNA) stated that on 1/10/24 V3 answered R2's call light. V3 stated R2 needed to go to the bathroom so V3 moved the bedside table and assisted R2 to stand with the walker in front of R2. V3 stated R2 requested V3 move a trash can out of the way and V3 stated V3 bent over to move it and as V3 turned around R2 was falling to the floor. V3 stated that V3 got assistance from the nurse and sat R2 up and saw blood and the nurse called EMS (Emergency Medical Services) and they transferred R2 to the hospital. V3 confirmed V3 did not use a gait belt on R2 during the transfer and did not keep hands

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on R2 the entire time.

On 1/29/24 at 1:29 PM, V2 Director of Nursing stated that V3 did not use a gait belt when transferring R2 but should have used a gait belt.

On 1/30/24 at 8:55 AM, R2 stated that R2 was getting out of bed and the next thing R2 knew was R2 fell and hit the bottom part of the bed frame with the back of R2's head. R2 stated that R2 has right sided neck pain now after the fall.

On 1/30/24 at 9:29 AM, V6 Physical Therapy Assistant/Director of Rehab stated that at the time of the fall on 1/10/24 that R2 would have required the assistance of one staff member. V6 confirmed that assistance should have been with a gait belt and hands on R2 for transfers.

On 1/30/24 at 10:33 AM, V7 CNA/RNA (Restorative Nursing Assistant) and V5 CNA applied a gait belt to R2 while R2 was in the wheelchair and they both assisted R2 with hands on the gait belt to shuffle R2's feet over to the recliner and R2 sat down. V7 and V5 removed the gait belt and gave R2 the call light cord.

On 1/30/24 at 11:08 AM, V4 Advanced Practice Registered Nurse confirmed that R2's fall on 1/10/24 caused the laceration to the back of R2's head and required an Emergency Room visit for 6 staples to close the wound.

2.) R3's Care Plan dated 1/15/24 documents R3 was admitted to the facility on 1/12/24 with diagnoses including Parkinson's Disease, Anxiety Disorder, Sleep Disorder, Orthostatic Hypotension, Weakness, Difficulty in Walking, History of Falling, Unspecified Dementia, Other Spondylosis with Radiculopathy Thoracic Region

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and Low Back Pain. This Care Plan documents R3 is at risk for falls related to gait/balance problems, Pain, Restless Leg Syndrome, Type 2 Diabetes, History of Falls, Unsteady Gait, Low Back Pain and Parkinson's disease dated 1/15/2024 with an intervention of a bed alarm and a chair alarm dated 1/18/24 and
ensure that R3 is wearing appropriate footwear when transferring, ambulating or mobilizing in the wheelchair dated 1/15/2024.

R3's MDS dated 1/19/24 documents R3 requires partial/moderate assistance for moving from a sitting position to a standing position, transferring from a chair to the bed or wheelchair and to walk 10 feet. Partial/moderate assistance is documented as the helper lifts, holds or supports the trunk or limbs. This MDS documents R3 has severe cognitive impairment.

R3's Incident Investigation for 1/19/24 at 6:00 PM documents R3 had a prior fall on 1/18/24. This report documents a Summary of events/situation as the CNA entered R3's room and positioned R3 on the edge of the bed to eat R3's dinner with the tray in front of R3 and feet on the floor. This CNA exited the room. Approximately 15 to 20 minutes later another CNA heard a crash and responded to R3's room. R3 was bleeding from the left side of R3's head. Pressure was applied and EMS was called. This report documents that in the Emergency Room R3 had a laceration to the left side of the head closed with 5 staples. A CT scan was completed at that time and was clear. R3 returned to the facility. This Investigation includes a statement from V12 CNA which documents when V12 last saw R3 sitting on the edge of the bed that R3 had regular socks on.

R3 Nurse's Note dated 1/19/24 at 6:00 PM by

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 01/30/2024

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
S9999	Continued From page 13	S9999		

V13 Licensed Practical Nurse documents when V13 first saw R3 on the floor R3 was in a T-shirt and an incontinence brief with no pants on and no socks on R3's feet (barefoot).

On 1/30/24 at 11:24 AM, V2 Director of Nursing stated that there was a conflict in stories that R3 did have socks on when R3 fell but they immediately implemented that R3 was to have gripper socks on at all times after this fall. V2 confirmed that R3 is not currently in the facility as R3 had to return to the hospital on 1/22/24.

3.) R4's Care Plan with an updated date of 1/3/24 documents diagnoses including Unspecified Dementia, Weakness, Adjustment Disorder, Unspecified Convulsions, History of falls, history of falls with fractures, Unsteadiness on Feet, Age Related Osteoporosis and Repeated Falls. This Care Plan documents R4 is at risk for falls related to a history of a fall with fracture of the right femur with right hemiarthroplasty, Dementia, A-Fib (Atrial Fibrillation) and Seizure Disorder. This Care Plan documents interventions of a bed and chair alarm due to decreased safety awareness and impulsivity with an initiated date of 4/20/2023 and a non slip mat to the recliner dated 9/22/22.

On 1/30/24 at 8:47 AM, R4 was in the recliner in R4's room sleeping with the walker sitting in front of R4. There was no alarm on the recliner. There was a pressure alarm pad with the alarm box on the wheelchair sitting by the door but not on the recliner.

On 1/30/24 at 9:18 AM, R4 was still in the recliner in R4's room with no alarm on the recliner. R4 is awake sitting in the recliner.

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S9999	Continued From page 14 On 1/30/24 at 9:19 AM, V5 CNA stated that R4 is supposed to have the alarm in the recliner but she hasn't gotten it moved to the recliner yet. At this time V5 had R4 stand up with the walker and V5 moved the alarm from the wheelchair to the recliner. The non slip pad remained in the wheelchair and it did not get moved to the recliner. (B)	S9999		