STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to notify a physician of a resident fall for one (R5) of three residents reviewed for falls in the sample list of 27. Findings include: R5's Admission Record dated 9/14/21 documents R5 admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Dementia, and Hemiparesis and Hemiplegia of right dominant side. R5's Minimum Data Set (MDS) dated [DATE] documents R2 has severe cognitive impairment and requires extensive assistance of one staff person for transfers. R5's Nursing Note dated 9/10/21 at 5:53 AM documents R5's roommate notified staff that R5 was on the floor. R5 was found sitting on the floor in front of the bed. R5 had an abrasion to R5's right lower back. There is no documentation that V27 (Physician) was notified of R5's fall. On 9/13/21 at 2:17 PM V3 (Assistant Director of Nursing) stated, The physician and family are to be notified of a resident's fall and documented in the medical record or incident report. V3 confirmed there is no documentation that R5's Physician (V27) was notified of R5's fall on 9/10/21. The facility's undated Fall Prevention policy documents falls will be reported to the resident's physician.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to supervise a resident (R1) with a known history of inappropriate sexual resident to resident contact, to prevent resident to resident sexual abuse. This resulted in R2 being sexually abused by R1. R1 and R2 are two of 22 residents reviewed for abuse in the sample list of 27. Staff allowed R1 unrestricted access, exposing residents (R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24) on the unit who are unable to consent to sexual interactions, to potential sexual abuse. This failure resulted in an immediate jeopardy. While the immediacy was removed on 9/15/21, the facility remains out of compliance at a severity level 2. Findings include: The facility's Abuse Investigative Summary dated 9/3/21 documents the following: On 8/27/21 R1 and R2 were discovered exhibiting sexual behavior. V13 (Certified Nursing Assistant/CNA) responded to a sounding bed alarm and called for V12's (CNA) assistance. When V12 left the nurse's station, R1 was sleeping in a recliner and R2 was sitting in the dining room. When V12 and V13 returned, R1 was in the dining room performing sexual acts on R2. R1 and R2 were separated. V18 (CNA) was on R1's and R2's unit all night, and V18 had to go to the skilled unit to assist with a resident's care. R2 was the only resident awake when V18 left the unit, a few minutes before the incident between R1 and R2 occurred. There was no documentation that R1 and R2 were supervised by staff at this time. R1 and R2 were separated and were upset with staff intervening. This summary documents, (local police) do not feel a crime was committed as no one was forced against their will to participate therefore abuse was not substantiated. R1's Admission Record dated 9/13/21 documents R1 has a diagnosis of dementia with behavioral disturbances. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. R1's Care Plan revised on 9/13/21 documents: R1 has sexual behaviors as well as physical aggression towards staff and residents. R1 had sexual behaviors towards another resident on 6/28/21, accidental physical contact with a resident on 7/5/21, physical/intimate contact with a resident 7/16/21, and physical contact with another resident on 8/27/21. R1 has a history of inappropriate sexual interactions with R2 on 6/28/21 and 7/16/21, with R7 and R9 on 6/6/21. R1's Progress Note dated 6/28/21 at 10:39 AM by V19 (Nurse Practitioner) documents: R1 was evaluated for dementia with behaviors and sexual behaviors. R1 was found to have R1's hand up another resident's shirt and fondling breasts. V19 recommended to keep distance between female residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's Admission Record dated 9/13/21 documents R2 has a diagnosis of dementia. R2's MDS dated [DATE] documents: R2 has a BIMS score of 0, indicating severe cognitive impairment. R2 has disorganized thinking. R2's Care Plan documents R2 has shown an interest in a specific male resident (R1), (R2) seeks (R1) out, and shows a romantic interest in (R1). R2's care plan includes interventions to monitor time spent with other resident (in which there is a history of intimate contact), provide reality orientation, engage in an activity that does not involve the other resident, redirect with a snack/drink, if (R1 and R2) are together, monitor their behaviors, if showing romantic physical attention towards each other attempt to separate, and assure R2's safety. On 9/13/21 at 3:46 PM V13 (CNA) stated, On 8/27/21 between 2:30-3:00 AM I (V13) heard a bed alarm sounding and went to assist the resident. I (V13) called for V12's assistance leaving R1 and R2 unsupervised. At that time R2 was sitting in a chair in the dining room and R1 was asleep in a recliner across from the dining room. When V12 and I (V13) returned to the unit R2 was sitting in a chair in the dining room with R2's pants down. R1 was on R1's knees in front of R2, and R1's face was in R2's genital area. I (V13) and V12 immediately separated R1 and R2. We try to keep one person watching R1 at all times and keep R1 and R2 separated. A lot of times I (V13) am assigned to that unit by myself, sometimes there are two CNAs. The nurse doesn't come to the unit until 4:00 AM. It is hard to keep an eye on (R1) when we are in resident rooms completing rounds. On 9/14/21 at 2:19 PM V12 (CNA) stated, I (V12) and V13 worked night shift on R1's unit on 8/26/21. Prior to R1's/R2's incident R2 was in the dining room and R1 kept trying to go into the dining room with R2. I (V12) and V13 had to keep separating R1 and R2 and tried to redirect R2 to R2's room. R2 kept returning to the dining room. R1 was combative with me (V12) and V13 when we separated R1 and R2. Sometime close to 3:00 AM V13 went to a resident's room to respond to a bed alarm. V13 called for my (V12) assistance and I (V12) left R1 and R2 to assist V13. When I (V12) and V13 returned from providing resident care, R1 and R2 were in the dining room. R2 was sitting with R2's pants pulled down. R1 was kneeling in front of R2, and R1 was licking R2's genital area. I (V12) and V13 immediately separated R1 and R2. R1 and R2 like to kiss and hug each other, and we try to watch them and keep them separated. We try to have three CNAs on the unit but that doesn't always happen. V12 confirmed there were no other staff on the unit to monitor R1 and R2 when V12 and V13 left them unattended. On 9/14/21 at 9:15 AM V1 (Administrator) stated, The facility has been trying to staff three employees on R1's/R2's unit, with the intention of having one employee supervising the residents on the unit. V13 called me about 3:15 AM on 8/27/21 to report R1's/R2's incident that happened around 3:00 AM. V18, V13, and V12 (CNAs) were assigned to R1's/R2's unit. V18 had left the unit to assist with a resident's care on the skilled unit. V13 responded to a resident's bed alarm. V13 called for V12's assistance. At that time R1 was asleep in the recliner near the entrance to the unit, and R2 was in the dining room. When V12 and V13 returned, R2 was sitting in the dining room with R2's pants pulled down. R1 was kneeling in front of R2 and was kissing R2's thighs. Staff have been trained to call the other unit to have staff come assist or monitor the unit. Residents with a diagnosis of dementia do not have the ability to consent to sexual activity. V1 confirmed all residents on (R1's/R2's) unit have cognitive impairment. The facility's Daily Census dated 8/27/21 documents 22 residents (R1, R2, and R5-R24) reside on R1's/R2's unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Facility Assessment updated on 8/19/21 documents: This unit (R1's/R2's unit) is where our residents live that are suffering from Dementia or Alzheimer's and are still able to participate in programming for this condition, or are an elopement risk and cannot be placed outside of a locked unit. The staff of this unit undergo additional training for Dementia/Alzheimer's disease to ensure that they are equipped for the behaviors and occurrences on this unit. An Immediate Jeopardy was identified on 9/15/21. The Immediate Jeopardy was identified to have begun on 8/27/21 when R1 and R2 were left unsupervised, resulting in R1 engaging in inappropriate sexual behavior with R2. Staff allowed R1 and R2 unrestricted access to each other and all residents on the unit (R1, R2, and R5-R24) who are unable to consent to sexual interactions, exposing them to potential abuse. Residents remain at risk until R1 and R2 are provided supervision and behavioral services to meet their needs. On 9/15/21 at 10:23 AM V1 (Administrator) was notified of the Immediate Jeopardy situation. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. V1 (Administrator) and V28 (Certified Nurse Aide Scheduler) confirmed by interview and provided documentation that a one-on-one care giver was assigned to R1 to be present at R1's side at all times from 9/15/21 at 6:00 PM until R1 was discharged to a behavioral facility on 9/16/21 at 4:17 PM. V31 (CNA), V35 (CNA), V36 (CNA), and V38 (Restorative Aide) confirmed they provided one on one care for R1 on 9/15/21 and 9/16/21. 2. V1 (Administrator) provided documentation of a physician order and instructions on the Medication Administration Record for R2 to have frequent monitoring beginning on 9/15/21 and documentation of staff education for R2 to have frequent monitoring on 9/15/21 and 9/16/21. Staff interviews confirmed that staff are aware that R2 needs frequent monitoring to ensure R2 is having appropriate interactions with other residents. 3. V1 (Administrator) provided documentation of a schedule for management staff assigned to verify that R1 has one on one care at all times while at the facility. 4. On 9/20/21 R1 was not observed at the facility, and R2 was observed to have frequent staff monitoring. 5. V1 (Administrator) provided documentation and confirmed by interview that V1 reviewed the facility Abuse Policy with V39 (Corporate Consultant) on 9/15/21 and that all staff attended an in-service regarding abuse prevention, recognition and reporting including sexual abuse on 9/15/21 and 9/16/21. 6. V1 (Administrator) confirmed by interview that R1 will not return to the facility after treatment at the behavioral facility. R1's Medical Record and an interview with V30 (Social Services Director) confirmed that discharge planning is in progress for R1 and that the facility is planning for R1 to be admitted to another facility after being discharged from the behavioral facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to operationalize their Abuse Prevention Program by failing to prevent resident to resident sexual abuse and failed to develop an abuse policy that directs staff to assess a resident following an allegation of physical and sexual abuse. This failure affects two (R1, R2) of 22 residents reviewed for abuse in the sample list of 27. Findings include: The facility's Abuse Prevention Program with an effective date of 7/22/17 documents the following: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual or physical abuse; corporal punishment; and involuntary seclusion. This policy defines abuse as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This policy defines sexual abuse as non-consensual sexual contact of any type with a resident. The facility's Abuse Prevention Training Program with an effective date of 7/22/17 documents: Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, a nurse shall complete a full assessment of the resident for other bruises, laceration, or pain. Documentation in the resident's chart should reflect the resident's physical and emotional status as well as any medical and nursing interventions implemented. If the resident complains of physical injuries or if resident harm is suspected, the resident's healthcare provider with prescriptive authority is contacted for further instructions. This policy does not document to assess the resident for injuries following abuse allegations. The facility's Abuse Investigative Summary dated 9/3/21 documents the following: On 8/27/21 R1 and R2 were discovered exhibiting sexual behavior. V13 (Certified Nursing Assistant/CNA) responded to a sounding bed alarm and called for V12's (CNA) assistance. When V12 left the nurse's station, R1 was sleeping in a recliner and R2 was sitting in the dining room. When V12 and V13 returned, R1 was in the dining room performing sexual acts on R2. R1 and R2 were separated. V18 (CNA) was on R1's and R2's unit all night, and V18 had to go to the skilled unit to assist with a resident's care. R2 was the only resident awake when V18 left the unit, a few minutes before the incident between R1 and R2 occurred. There was no documentation that R1 and R2 were supervised by staff at this time, or that R2 was assessed for injuries. R1's Admission Record dated 9/13/21 documents R1 has a diagnosis of dementia with behavioral disturbances. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. R1's Care Plan revised on 9/13/21 documents: R1 has sexual behaviors as well as physical aggression towards staff and residents. R1 had sexual behaviors towards another resident on 6.28.21, accidental physical contact with a resident on 7.5.21, physical/intimate contact with a resident 7.16.21, and physical contact with another resident on 8.27.21. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 has a history of inappropriate sexual interactions with R2 on 6/28/21 and 7/16/21, and with R7 and R9 on 6/6/21. R1's Progress Note dated 6/28/21 at 10:39 AM by V19 (Nurse Practitioner) documents: R1 was evaluated for dementia with behaviors and sexual behaviors. R1 was found to have R1's hand up another resident's shirt and fondling breasts. V19 recommended to keep distance between female residents. R2's Admission Record dated 9/13/21 documents R2 has a diagnosis of dementia. R2's MDS dated [DATE] documents: R2 has a BIMS score of 0, indicating severe cognitive impairment. R2 has disorganized thinking. R2's Care Plan documents R2 has shown an interest in a specific male resident (R1), (R2) seeks (R1) out, and shows a romantic interest in (R1). R2's care plan includes interventions to monitor time spent with other resident (in which there is a history of intimate contact), provide reality orientation, engage in an activity that does not involve the other resident, redirect with a snack/drink, if (R1 and R2) are together, monitor their behaviors, if showing romantic physical attention towards each other attempt to separate, and assure R2's safety. On 9/13/21 at 3:46 PM V13 (CNA) stated, On 8/27/21 between 2:30-3:00 AM I (V13) heard a bed alarm sounding and went to assist the resident. I (V13) called for V12's assistance, leaving R1 and R2 unsupervised. At that time R2 was sitting in a chair in the dining room and R1 was asleep in a recliner across from the dining room. When V12 and I (V13) returned, R2 was sitting in a chair in the dining room with R2's pants down. R1 was on R1's knees in front of R2, and R1's face was in R2's genital area. I (V13) and V12 immediately separated R1 and R2. We try to keep one person watching R1 at all times and keep R1 and R2 separated. A lot of times I (V13) am assigned to that unit by myself, sometimes there are two CNAs. The nurse doesn't come to the unit until 4:00 AM. It is hard to keep an eye on (R1) when we are in resident rooms completing rounds. On 9/14/21 at 2:19 PM V12 (CNA) stated, I (V12) and V13 worked night shift on R1's unit on 8/26/21. Prior to R1's/R2's incident R2 was in the dining room and R1 kept trying to go into the dining room with R2. I (V12) and V13 had to keep separating R1 and R2 and tried to redirect R2 to R2's room. R2 kept returning to the dining room. R1 was combative with me (V12) and V13 when we separated R1 and R2. Sometime close to 3:00 AM V13 went to a resident's room to respond to a bed alarm. V13 called for my (V12's) assistance and I (V12) left R1 and R2 to assist V13. When I (V12) and V13 returned from providing resident care, R1 and R2 were in the dining room. R2 was sitting with R2's pants pulled down. R1 was kneeling in front of R2, and R1 was licking R2's genital area. I (V12) and V13 immediately separated R1 and R2. R1 and R2 like to kiss and hug each other, and we try to watch them and keep them separated. We try to have three CNAs on the unit but that doesn't always happen. V12 confirmed there were no other staff on the unit to monitor R1 and R2 when V12 and V13 left them unattended. On 9/14/21 at 2:09 PM V23 (Agency Registered Nurse) stated: V23 worked night shift on 8/26/21 and was the nurse assigned to the skilled unit and R1's/R2's unit. The staff did not call V23 to report the incident between R1 and R2, they called V1 (Administrator). V23 did not find out about the incident until after V1 arrived at the facility that morning. V23 did not complete an assessment of R2 after the incident with R1. V23 stated V23 assumed V1 was handling the investigation for the incident. (continued on next page)

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	146037	A. Building B. Wing	09/27/2021

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/21 at 9:15 AM V1 (Administrator) stated, The facility has been trying to staff three employees on R1's/R2's unit, with the intention of having one employee supervising the residents on the unit. V18, V13, and V12 (CNAs) were assigned to R1's/R2's unit. V18 had left the unit to assist with a resident's care on the skilled unit. V13 responded to a resident's bed alarm. V13 called for V12's assistance. At that time R1 was asleep in the recliner near the entrance to the unit, and R2 was in the dining room. When V12 and V13 returned, R2 was sitting in the dining room with R2's pants pulled down. R1 was kneeling in front of R2 and was kissing R2's thighs. Staff have been trained to call the other unit to have staff come assist or monitor the unit. Residents with a diagnosis of dementia do not have the ability to consent to sexual activity. On 9/14/21 at 2:28 PM V1 (Administrator) stated the nurses should complete an assessment of the resident after a physical or sexual abuse allegation. V23 was the nurse working the night of R1's/R2's incident. V1 assumed V23 completed an assessment of R2, since V23 was aware of the incident before V1 arrived at the facility. On 9/14/21 at 4:00 PM V1 confirmed there is no documentation that R2 was assessed for injuries following the incident with R1 on 8/27/21. On 9/15/21 at 10:23 AM V1 confirmed the facility's policy instructs staff to complete an assessment of resident for injuries of unknown origin or when there are physical injuries but does not instruct staff to assess the resident for injuries following allegations of physical or sexual abuse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31680 Based on observation, interview and record review the facility failed to: develop and implement fall interventions for self-transfers for a resident, complete post fall neurological assessments after a resident's unwitnessed fall, ensure thorough fall investigations were completed and ensure resident fall interventions were implemented. This failure affects three of three residents (R3, R4, R5) reviewed for falls on the sample list of 27 residents. R3 was known to be at high risk for falls, required staff assistance for ambulation, had incontinence care needs, and was at risk for life threatening complications including hemorrhage and internal bleeding due to receiving antiplatelet medication. R3 fell , suffered a subdural hematoma, and died after staff failed to develop and implement fall interventions for self-transfers. R4 fell and suffered a fractured arm after staff failed to ensure a motion sensor alarm was present in R4's room. The Facility's failure to develop and implement fall interventions, complete assessments, and ensure thorough fall investigations for residents resulted in an Immediate Jeopardy. While the immediacy was removed on [DATE], the facility remains out of compliance at a severity level 2. Findings include: 1. The Facility Clinical Admission Evaluation dated [DATE] documents R3 has some confusion, disorganized thinking, and short-term memory loss and that R3 is continent of bowel and incontinent of urine. The Admission Evaluation documents R3 has an unsteady gait and poor balance. The Fall Risk assessment dated [DATE] documents R3 is at high risk for falls. The Hospital Discharge Summary dated [DATE] documents R3 has a diagnosis of Cognitive Decline and Impairment and that R3 has had recent falls at home. The Discharge Summary documents R3 has speech difficulty and gait impairment and that R3 was brought to the Emergency Department by R3's family due to concerns related to worsening cognitive decline and ability to care for R3's self at home. The Nurse's Note dated [DATE] documents R3 was admitted to the facility on that date from the hospital. The Physician Order Sheet dated [DATE]-[DATE] documents R3 has diagnoses of Dementia, Anxiety Disorder, Parkinson's Disease, Overactive Bladder, Retention of Urine and Repeated Falls. The Physician Order Sheet also documents an order for R3 to have Plavix (antiplatelet) 75 milligrams in the morning for a history of Transient Ischemic Attack and Cerebral Infarction. The undated Plavix Prescribing Information sheet states Plavix increases the risk of bleeding. R3's Baseline Care Plan dated [DATE] documents R3 is unsafe with independent transfers, has poor standing balance and should transfer with staff assistance and a gait belt. The Baseline Care Plan documents R3 needs staff assistance for walking, locomotion, dressing, hygiene, and toilet use. The Baseline Care Plan does not document that R3 self-transfers or include interventions to address self-transferring. The Baseline Care Plan does not document a plan for toileting or incontinence care for R3. (continued on next page)

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	146037	A. Building B. Wing	09/27/2021

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan dated [DATE] documents R3 is at high risk for falls due to deconditioning and gait and balance problems and documents the following fall interventions: Be sure R3's call light is within reach and encourage R3 to use it for assist and as needed; Ensure R3 is wearing proper footwear when ambulating or mobilizing in wheelchair; Follow facility fall protocol; R3 needs activities that minimize the potential for falls while providing diversion and distraction; Keep furniture in locked position; Keep needed items (water, etc.) in reach; R3 needs a safe environment; Maintain a clear pathway in room. R3's care plan does not document that R3 self-transfers or include interventions to address self-transferring. R3's Care Plan dated [DATE] does not address a plan for toileting or incontinence care for R3. The Fall Incident Description dated [DATE] documents, (R3) was found on the floor in (R3's) bathroom. (R3) had apparently taken (R3's self) in to use the toilet. (R3's) dementia gives (R3) poor safety awareness. There was feces and urine in (R3's) depends and on the outside of them. (R3) apparently felt an urgency to use the bathroom and did not use the call light or wait for assistance. Nurse Practitioner (V19) was first to respond and noted a laceration approx. (approximately) one inch on the back of (R3's) head. First aid immediately performed to control the bleeding. Vitals taken. Nurse Practitioner ordered to send to ER (emergency room) for an evaluation. The Fall Summary of Events dated [DATE] documents, Nurse Practitioner (V19) entered room at 2:45 PM (on [DATE]) to do an initial assessment and to meet (R3) and discovered (R3) on the floor in the bathroom. (R3) was laying at a diagonal on the floor with (R3's) head bleeding. There was feces and urine all over the floor as well as smeared on the toilet paper dispenser and the wall above it. There was feces and urine on the inside and outside of (R3's) (brief). (Brief was) pulled down. The Fall Summary of Events, Staff Interviews and Fall Timeline dated [DATE] for R3's [DATE] fall and the Fall Incident Description dated [DATE] do not document when R3 was last toileted or received incontinence care before being found on the floor in the bathroom. R3's Bowel and Bladder Continence Records dated [DATE] do not document R3 was toileted or received incontinence care during the day or evening shifts on [DATE]. The Hospital Discharge Summary dated [DATE] documents R3 was admitted to the hospital on [DATE] after falling at the facility and a Computed Tomography of R3's brain showed a large subdural hematoma. The Discharge Summary dated [DATE] documents Although patient's (R3) code status is DNR (Do Not Resuscitate), family requested intubation. Neurologic status continued to deteriorate. The Discharge Summary documents R3 died at the hospital on [DATE]. On [DATE] at 2:15 pm V6 (Certified Nursing Assistant/CNA) stated on [DATE] R3 was up and down and up and down by R3's self. V6 stated V6 observed R3 standing by the bed in R3's room a couple of times and found the urinal with urine in it on the night table, which was not located within arm's reach of the bed. V6 stated V6 guessed R3 got out of bed, used the urinal, and then got back in bed. V6 stated the evening of [DATE] V6 assisted R3 to the chair and R3 was weak and unsteady. V6 stated later that evening V6 found R3 back in bed. V6 stated R3 had the call light in the chair, but R3 did not use it to call for assist to get back in the bed. V6 stated V6 reported to the (unknown) nurse that R3 was getting up and down by R3's self. On [DATE] at 12:55 PM V5 (CNA) stated R3 was incontinent at times and they also took R3 to the bathroom. V5 stated V5 remembers walking by R3's room and seeing R3 standing in R3's room unassisted. V5 stated V5 assisted R3 to walk to the bathroom and R3 was unsteady. (continued on next page)

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	146037	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:20 pm V7 (CNA) stated V7 was assigned to R3's unit on [DATE] for the 6:00 am to 2:00 PM shift. V7 stated in the morning V7 observed R3 in the bed. V7 stated V7 spoke with R3 between breakfast and lunch and at that time R3 was in the doorway of R3's room in the wheelchair and R3 wanted an incontinence brief and ice water. V7 stated V7 picked up R3's lunch tray around 12:30 pm and R3 was back in the bed. V7 stated V7 assumed R3 was transferring R3's self. V7 stated V7 did not see R3 on [DATE] after picking up R3's lunch tray. V7 stated V7 did not transfer R3 during the shift, and V7 did not take R3 to the bathroom or check R3's incontinence brief during the shift. On [DATE] at 5:30 pm V9 (Registered Nurse/RN/Assistant Director of Nursing/ADON) stated V9 was R3's nurse for the 6:00 am to 2:00 PM shift on [DATE]. V9 stated V9 checked on R3 when the CNA (V7) was picking up R3's lunch tray between 12:30 and 1:00 pm. V9 stated at that time R3 was lying in bed. V9 stated V9 did not transfer R3 or take R3 to the bathroom during V9's shift. V9 stated V9 did not ask R3 if R3 needed to use the bathroom during V9's shift. V9 stated V9 did not know R3 was getting up by R3's self. On [DATE] at 8:45 am V8 (Licensed Practical Nurse/LPN) stated V8 relieved another nurse (V9) at 2:00 PM on [DATE]. V8 stated V8 did not see R3 during the shift until R3 was found on the floor in the bathroom by V19 (Nurse Practitioner). V8 stated when V8 arrived R3 was on the floor in the bathroom under the sink, and R3 had a head wound that was bleeding. V8 stated R3 had been incontinent of bowel and bladder. V8 stated R3 was not supposed to be up by R3's self. V8 stated R3 had fallen prior to being admitted to the facility, and R3 was a high fall risk. V8 stated V8 did not know R3 was getting up without assist. On [DATE] at 11:25 am V3 (Assistant Director of Nursing/ADON) stated V3 initiated R3's Care Plan with the standard facility fall interventions. V3 stated after the fall assessment was completed, staff should have implemented fall interventions appropriate for R3. V3 stated V3 did not know R3 was self-transferring until R3 fell on [DATE]. V3 stated if V3 had known R3 was self-transferring, V3 would have placed (bed and chair) alarms to alert staff R3 was getting up. V3 stated R3 was a high fall risk and had a bedside sitter at the hospital before being admitted to the facility. V3 also stated staff should have been providing incontinence care for R3 and toileting R3. V3 confirmed R3's fall investigation and medical record do not document when R3 was last toileted or received incontinence care before R3 was found on the floor in the bathroom. V3 stated the nurses should have included this information in their documentation. On [DATE] at 1:30 pm V19 (Nurse Practitioner) stated on [DATE], V19 was going to see R3 as a new admit and found R3 on the floor in the restroom. V19 stated R3 had a laceration on R3's head. V19 stated R3 suffered the head injury when R3 fell . V19 stated V19's concern and fear was that R3 was on Plavix and had had a brain bleed. V19 stated emergency responders arranged for R3 to be flown by helicopter to the hospital. V19 stated later the nursing home staff told V19 that R3 died at the hospital. V19 stated R3 had cognitive impairment and tried to get up independently, but R3 was not capable of being up independently. V19 stated V19 would expect facility staff to have interventions in place to prevent falls. On [DATE] at 4:40 pm V29 (Physician) stated V29 reviewed R3's hospital record and stated, The fall is the culprit. V29 stated according to the medical record the subdural hematoma resulted from the fall and the subdural hematoma caused R3's death. (continued on next page)

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	146037	A. Building B. Wing	09/27/2021

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	146037	A. Building B. Wing	09/27/2021

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:00 am V24 (RN) stated when R4 fell on [DATE], R4 broke R4's arm. V24 stated R4 fell in R4's room. V24 stated R4 would not stay in the chair or call for help. V24 stated the CNA staff found R4 on the floor and alerted V24. V24 stated initially R4 complained of left arm pain and then after they assisted R4 off the floor, R4 stated R4 had no pain. V24 stated over the next few days R4 complained of arm pain and was not using R4's arm, so a portable x-ray was obtained which indicated R4 had a fractured arm. V24 stated V24 was not aware R4 should have had a motion sensor in R4's room. V24 stated no alarm was sounding to alert staff R4 was up in R4's room. V24 stated R4 could propel R4's self quickly in the wheelchair, and R4 would go to R4's room. V22's (LPN) Nurse's Note dated [DATE] documents observed (R4) sitting on the floor by nightstand; noted hematoma right forehead and two skin tears left thumb; movement of all ext (extremities) WNL (within normal limits); skin tears on thumb cleansed et (and) bandage applied; Ice pack to hematoma. The Post Fall Evaluation dated [DATE] states on [DATE] R4 fell in R4's room. The Evaluation documents no alarm was sounding. The Fall Report dated [DATE] documents the root cause of R4's fall was that R4 was attempting to transfer and ambulate without staff assist. The Fall Report dated [DATE] does not document an alarm was sounding when R4 was found on the floor. On [DATE] at 9:30 am V22 (LPN) stated on [DATE] R4 got up out of bed and was found sitting on the floor leaning on the night table. V22 stated R4's roommate (R25) turned on the call light to alert staff that R4 had fallen. V22 stated R4 suffered a hematoma to R4's forehead when R4 fell . V22 stated R4 frequently gets up by R4's self. V22 stated an alarm was not in use when R4 fell on [DATE]. On [DATE] at 2:40 PM R4 was seated in a wheelchair at the nurse's station with a cast on R4's left arm and bruises to R4's right forehead and cheek. On [DATE] at 11:25 am V3 (Assistant Director of Nursing/ADON) stated residents should be toileted upon rising, before and after meals and at bedtime. V3 confirmed R4's [DATE] fall investigation and medical record do not document when R4 was toileted or received incontinence care on [DATE]. V3 stated the nurses should include this information in their documentation. On [DATE] at 10:45 am V3 (ADON) stated if R4 is taking R4's self back to R4's room, the motion sensor alarm should be on in R4's room at all times. V3 stated the intervention for R4 to have a motion sensor in R4's room to alert staff when R4 is up was implemented in [DATE]. V3 confirmed R4 should have had the motion sensor on in R4's room when R4 fell on [DATE], [DATE] and [DATE]. On [DATE] at 10:45 am R4's room was observed with V3. At that time no motion sensor was present in R4's room. V3 stated the motion sensor box should be on R4's night table and the alarm box should be at the nurses station. V3 located the motion sensor box and alarm box at the nurse's station. On [DATE] at 1:15 PM V8 (LPN/R4's nurse) stated V8 did not know R4 was supposed to have a motion sensor alarm in R4's room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:30 pm V19 (Nurse Practitioner) stated R4 has had multiple falls at the facility, and R4 fractured R4's arm during one of the falls. V19 stated R4 has cognitive impairment and tries to get up independently. V19 stated V19 would expect facility staff to have interventions in place to prevent falls. 40385 3. R5's Admission Record dated [DATE] documents R5 admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Dementia, and Hemiparesis and Hemiplegia of right dominant side. R5's MDS dated [DATE] documents R5 has severe cognitive impairment and requires extensive assistance of one staff person for transfers. R5's Care Plan revised on [DATE] documents R5 is at risk for falls. R5's care plan includes interventions to ensure call light is within reach, encourage participation in activities, ensure appropriate footwear is worn, physical therapy to evaluate and treat, ensure items are within reach, and follow the facility's fall protocol. There are no documented post fall interventions after [DATE]. R5's Fall Report dated [DATE] at 3:45 AM documents: R5 was found lying on the floor without injuries, and R5 stated R5 needed to use the bathroom. R5's Fall Report dated [DATE] at 4:00 PM documents R5 was heard yelling for help and was found in an unidentified resident room lying on R5's left side. R5 had a 2 cm (centimeter) by 0.2 cm laceration above R5's left eyebrow, and 2 cm by 2 cm scrape to R5's left knee. R5's Post Fall Worksheet dated [DATE] documents an intervention to add chair alarm. R5's Nursing Note dated [DATE] at 5:53 AM documents R5's roommate notified staff that R5 was on the floor. R5 was sitting in front of the bed. R5 had an abrasion to R5's right lower back. There is no documentation that an alarm was in use or sounding at the time of R5's fall. There is no documentation that a post fall investigation was completed to identify the root cause of R5's falls or that post fall interventions were implemented. There are no documented post fall neurological assessments completed for R5 after [DATE] at 9:45 AM. On [DATE] at 1:46 PM R5 was sitting in a wheelchair in the dining room. There was no alarm observed on R5's wheelchair. On [DATE] at 3:39 PM V25 (Human Resources) was pushing R5 in a wheelchair onto R5's unit. R5's wheelchair did not contain an alarm. On [DATE] at 2:38 PM V14 (CNA) stated R5 does not utilize an alarming device in the wheelchair or bed. On [DATE] at 2:17 PM V3 (ADON) stated: V3 is responsible for completing post fall investigations and updating the care plan with post fall interventions. V3 has not completed post fall investigations for R5's falls on [DATE], [DATE], and [DATE]. V3 confirmed R5's care plan has not been updated with post fall interventions for R5's falls. After R5's fall on [DATE], V26 (LPN) requested an alarm be implemented for R5. V3 provided an alarm for R5, and R5 should have an alarm in the bed and wheelchair. V3 stated, On [DATE] R5's fall occurred around 3:00 AM, so we initiated toileting assistance scheduled between 2:30 and 3:00 AM. V3 wasn't aware of R5's fall on [DATE] since an incident report had not been completed for R5's fall. V3 stated, If a fall is not witnessed, then neurological assessments must be completed according to the facility policy. V3 confirmed that R5's fall on [DATE] was unwitnessed. (continued on next page)

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	146037	A. Building B. Wing	09/27/2021

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:29 PM V1 (Administrator) provided R5's neurological assessment flow sheet for R5's fall on [DATE]. V1 confirmed the flow sheet does not document neurological assessments were completed after [DATE] at 9:45 AM. The facility's undated Fall Prevention policy documents: It is the policy to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this facility are analyzed and trended through the QA (Quality Assurance) process to maintain a safe environment. Clinically appropriate interventions will be put into place to reduce the risk for falls and/or to prevent recurrence of falls. The interdisciplinary team will review and modify the fall risk prevention plan at a minimum of quarterly, after each fall, and as clinically indicated. Interventions for the fall prevention plan will be modified following the interdisciplinary review and changes will be made to the plan of care. This policy documents neurological assessments will be completed per protocol for unwitnessed falls and documented in the medical record, incident/accident reports will be completed for tracking and trending and an investigation will be completed with a documented summary. The facility's undated Neurological Assessment protocol documents: Neurological assessments should be performed as follows for a 72-hour period, unless otherwise ordered by the attending physician. This protocol documents to complete post fall neurological assessments every 15 minutes for 4 times, every hour for 4 times, every two hours for 8 times, and then every four hours until 72 hours has been completed. The facility's undated Fall Prevention policy documents, It is the policy to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this facility are analyzed and trended through the QA (Quality Assurance) process to maintain a safe environment. Clinically appropriate interventions will be put into place to reduce the risk for falls and/or to prevent recurrence of falls. An Immediate Jeopardy was identified on [DATE]. The Immediate Jeopardy was identified to have begun on [DATE] when facility failed to implement interventions to prevent falls for R4. On [DATE] at 2:40 pm V1 (Administrator) was notified on the Immediate Jeopardy. The surveyor confirmed through observation, interview and record review that the facility took the following actions to remove the immediate jeopardy: 1. On [DATE] Nursing staff received instruction through a text message to complete training on assessing residents for fall risk upon admission, including resident specific interventions on the baseline care plan, completing the post fall assessment and implementing post fall interventions. 2. On [DATE] all staff received instruction through a text message to complete training on the use of a yellow star sign on resident's doors to indicate they are at high risk of falling. 3. On [DATE] and [DATE] audits were conducted for all residents identified as being at high risk for falls to ensure resident specific interventions are in place and falling star signs were placed the resident room doors and name plates. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On [DATE] and [DATE] audits were completed by V2 (Director of Nursing) to ensure newly admitted residents and readmitted residents were assessed for fall risk and interventions were in place. 5. On [DATE] R5's fall care plan was reviewed and updated by V3 (Assistant Director of Nursing) and fall interventions were in place for R5.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to have sufficient nursing staff to supervise residents and prevent resident to resident sexual abuse of R1 by R2, two of 22 residents reviewed for abuse in the sample list of 27. This failure has the potential to affect all 22 residents (R1, R2, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24) who reside on R1's unit. Findings include: The facility's Facility Assessment updated 8/19/21 documents a daily staffing breakdown for a census of 90 that includes 17 nurse assistants/helping hands and 8 direct care licensed nurses. This assessment documents This unit (R1's/R2's unit) is where our residents live that are suffering from Dementia or Alzheimer's and are still able to participate in programming for this condition, or are an elopement risk and cannot be placed outside of a locked unit. The staff of this unit undergo additional training for Dementia/Alzheimer's disease to ensure that they are equipped for the behaviors and occurrences on this unit. The facility's Daily Census dated 8/27/21 documents 22 residents (R1, R2, and R5-R24) reside on R1's/R2's unit. The facility's census dated 8/26/21 and 8/27/21 documents the facility had a census of 88 residents. The facility's hall assignments and employee timecards for 8/26/21 were reviewed. There were no Helping Hand employees who worked on 8/26/21. On 8/26/21 a total of 15.5 Certified Nursing Assistants (CNAs) and 8 licensed nurses worked. Three CNAs were assigned to R1's unit for night shift on 8/26/21. The facility's Abuse Investigative Summary dated 9/3/21 documents the following: On 8/27/21 R1 and R2 were discovered exhibiting sexual behavior. V13 (Certified Nursing Assistant/CNA) responded to a sounding bed alarm and called for V12's (CNA) assistance. When V12 left the nurse's station, R1 was sleeping in a recliner and R2 was sitting in the dining room. When V12 and V13 returned, R1 was in the dining room performing sexual acts on R2. R1 and R2 were separated. V18 (CNA) was on R1's and R2's unit all night, and V18 had to go to the skilled unit to assist with a resident's care. R2 was the only resident awake when V18 left the unit, a few minutes before the incident between R1 and R2 occurred. There was no documentation that R1 and R2 were supervised by staff at this time. R1's Admission Record dated 9/13/21 documents R1 has a diagnosis of dementia with behavioral disturbances. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. R1's Care Plan revised on 9/13/21 documents: R1 has sexual behaviors as well as physical aggression towards staff and residents. R1 had sexual behaviors towards another resident on 6/28/21, accidental physical contact with a resident on 7/5/21, physical/intimate contact with a resident 7/16/21, and physical contact with another resident on 8/27/21. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1 has a history of inappropriate sexual interactions with R2 on 6/28/21 and 7/16/21, with R7 and R9 on 6/6/21. R1's Progress Note dated 6/28/21 at 10:39 AM by V19 (Nurse Practitioner) documents: R1 was evaluated for dementia with behaviors and sexual behaviors. R1 was found to have R1's hand up another resident's shirt and fondling breasts. V19 recommended to keep distance between female residents. R2's Admission Record dated 9/13/21 documents R2 has a diagnosis of dementia. R2's MDS dated [DATE] documents: R2 has a BIMS score of 0, indicating severe cognitive impairment. R2 has disorganized thinking. R2's Care Plan documents R2 has shown an interest in a specific male resident (R1), (R2) seeks (R1) out, and shows a romantic interest in (R1). R2's care plan includes interventions to monitor time spent with other resident (in which there is a history of intimate contact), provide reality orientation, engage in an activity that does not involve the other resident, redirect with a snack/drink, if (R1 and R2) are together, monitor their behaviors, if showing romantic physical attention towards each other attempt to separate, and assure R2's safety. On 9/13/21 at 3:46 PM V13 (CNA) stated, On 8/27/21 between 2:30-3:00 AM I (V13) heard a bed alarm sounding and went to assist the resident. I (V13) called for V12's assistance leaving R1 and R2 unsupervised. At that time R2 was sitting in a chair in the dining room and R1 was asleep in a recliner across from the dining room. When V12 and I (V13) returned to the unit R2 was sitting in a chair in the dining room with R2's pants down. R1 was on R1's knees in front of R2, and R1's face was in R2's genital area. I (V13) and V12 immediately separated R1 and R2. We try to keep one person watching R1 at all times and keep R1 and R2 separated. A lot of times I (V13) am assigned to that unit by myself, sometimes there are two CNAs. The nurse doesn't come to the unit until 4:00 AM. It is hard to keep an eye on (R1) when we are in resident rooms completing rounds. On 9/14/21 at 2:19 PM V12 (CNA) stated, I (V12) and V13 worked night shift on R1's unit on 8/26/21. Prior to R1's/R2's incident R2 was in the dining room and R1 kept trying to go into the dining room with R2. I (V12) and V13 had to keep separating R1 and R2 and tried to redirect R2 to R2's room. R2 kept returning to the dining room. R1 was combative with me (V12) and V13 when we separated R1 and R2. Sometime close to 3:00 AM V13 went to a resident's room to respond to a bed alarm. V13 called for my (V12) assistance and I (V12) left R1 and R2 to assist V13. When I (V12) and V13 returned from providing resident care, R1 and R2 were in the dining room. R2 was sitting with R2's pants pulled down. R1 was kneeling in front of R2, and R1 was licking R2's genital area. I (V12) and V13 immediately separated R1 and R2. R1 and R2 like to kiss and hug each other, and we try to watch them and keep them separated. We try to have three CNAs on the unit but that doesn't always happen. V12 confirmed there were no other staff on the unit to monitor R1 and R2 when V12 and V13 left them unattended. On 9/14/21 at 9:15 AM V1 (Administrator) stated, The facility has been trying to staff three employees on R1's/R2's unit, with the intention of having one employee supervising the residents on the unit. V13 called me about 3:15 AM on 8/27/21 to report R1's/R2's incident that happened around 3:00 AM. V18, V13, and V12 (CNAs) were assigned to R1's/R2's unit. V18 had left the unit to assist with a resident's care on the skilled unit. V13 responded to a resident's bed alarm. V13 called for V12's assistance. At that time R1 was asleep in the recliner near the entrance to the unit, and R2 was in the dining room. When V12 and V13 returned, R2 was sitting in the dining room with R2's pants pulled down. R1 was kneeling in front of R2 and was kissing R2's thighs. Staff have been trained to call the other unit to have staff come assist or monitor the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/21 at 2:40 PM V28 (Scheduler) confirmed there were no Helping Hand employees who worked on 8/26/21 and the hall assignment sheet for 8/26/21 accurately documents all of the nurses and CNAs who worked. On 9/15/21 at 3:00 PM V28 stated V18, V13, and V12 (CNAs) were assigned to work on R1's unit on night shift on 8/26/21.