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	11/15/2021

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32172 Based on interview and record review the facility failed to ensure R2 was not subjected to physical abuse by R1. R1 and R2 are two of four residents reviewed for abuse in the sample of 14. Findings include: R1's Physician Order Sheet dated 10/2021 documents R1 is diagnosed with Anxiety, Schizophrenia, and Altered Mental Status. R1's Care Plan dated 7/15/21 documents R1 exhibits behaviors of physical aggression, delusions, and paranoid behaviors. R1 was in a prior physical altercation with another resident on 6/17/21. R1's Behavior Review (Social Service) dated 7/13/21 documents R1 has problems with reoccurring delusions and physical aggression. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is moderately cognitively intact. R1's Social Service Note dated 9/30/21 documents the facility was looking for long term placement for R1 due to her behaviors, being a harm to self or others, and R1 stating she no longer wanted to live in the facility. R2's Physician Order Sheet dated 11/2021 documents R2 is diagnosed Alzheimer's Disease, Depression, Dementia without Behaviors. R2's Minimum Data Set, dated dated dated [DATE] documents R2 is severely cognitively impaired. The Incident Note dated 10/27/21 documents R1 punched R2 in the head multiple times and R1 continued to go after R2 until R1 lost her balance and stumbled back. (continued on next page)

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/9/21 at 2:00 PM V6 (Social Service Director) stated R1 started having increased paranoia, increased delusions, and felt like people were out to get her. R1 had an increase in physical aggression that began about two months prior to the incident on 10/27/21. R1 was sent to the hospital multiple times due to behaviors. V6 stated the facility began looking for alternate placement for R1 due to her increased behaviors, however no other facility would take her at the time due to the severity of her behaviors and tracheostomy. R1 was still able to communicate and could write notes and make her needs known. R1's increased behaviors/delusions/paranoia and aggression made her a risk to herself, staff, and other residents. V6 stated, We did do 1:1 (one to one) supervision with her as much as we could but didn't always have staff for that. When staff were not available for 1:1 supervision the nurses and certified nurse's assistants would have been responsible for supervising her (R1). On 11/10/21 at 11:15 AM V3 (Registered Nurse) stated she witnessed the incident on 10/27/21 between R1 and R2. V3 looked up and saw R1 get up from her chair, turn towards R2 and close fist punch R2 on the head. V3 stated R1 had been having a lot of increased agitation and physical aggression in the prior weeks before the incident. R1 had been placed on occasional 1:1 supervision but was not on 1:1 supervision at the time of the incident on 10/27/21. V3 stated R1 was at risk for self-injury and for injuring others. The facility Abuse Prevention Program Policy dated 11/22/17 documents residents have the right to be free from abuse. This includes physical abuse. The same policy documents the facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents. The same policy documents abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. The same policy documents physical abuse is the infliction of injury on a resident and includes hitting, slapping, pinching, and kicking.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35347 Based on interview and record review, the facility failed to effectively supervise R3 to prevent a traumatic fall. This failure resulted in R3 falling to the ground on R3's face and sustaining a temple laceration, temple contusion, hand fracture, and a frontal lobe brain bleed requiring emergency hospitalization and treatment. R3 is one of three residents reviewed for falls in the sample of 14. Findings include: R3's Physician Orders (11/12/2021) documents R3's diagnoses include: Dementia, Coagulation Defect, Unsteadiness on Feet, Abnormality of Gait and Mobility, Repeated Falls, Osteoarthritis of Hip, Parkinson's Disease, Abnormal Posture, and Reduced Mobility. The same record documents: Ensure proper placement and function of BED, CHAIR, and MOTION SENSOR alarms each shift for Fall Prevention. R3's Minimum Data Set (10/21/2021) documents R3 has severe cognitive impairment, requires two person physical assistance for transfers, R3 is not steady and only able to stabilize with staff assistance during transfers, and has a history of falls with injury. R3's Care Plan (11/9/2021) documents R3 is at High Risk for falls and has bed and chair alarms as a fall intervention. The facility incident report (10/25/2021) documents on 10/25/2021 V4 (Housekeeping) observed R3 stumble out of R3's room backwards into the hallway, hitting the door frame and spinning around and falling face first into the floor. The same record documents R3 sustained a laceration and hematoma (bruise) to the head, hand fracture, traumatic right frontal brain bleed, and required emergency transfer to the hospital for treatment. The facility fall investigation report (10/25/2021) documents R3 fell flat on (R3's) face during the fall on 10/25/2021. The same record documents predisposing factors for R3's fall included Confusion, Gait Imbalance, Impaired Memory, Weakness, and Ambulating without Assistance. The same record also documents R3 was seated in R3's recliner in R3's room prior to the fall after previously being out of the room with physical therapy staff. R3's hospital report (11/8/2021) documents R3 sustained a head laceration, acute brain bleed, and hand fracture from R3's fall on 10/25/2021. On 11/10/2021 at 10:29AM, V5 (Licensed Practical Nurse) reported assessing R3 after R3's fall on 10/25/2021. V5 reported R3 had a bleeding left temple laceration and contusion and was dazed and quiet after the fall. V5 reported R3 had a history of falls from R3's recliner in R3's room. V5 reported R3 was in R3's recliner prior to the fall on 10/25/2021 and R3's fall intervention of chair alarm was effective in the past and R3's alarms were always going off. V5 reported not hearing R3's alarm sounding at the time of the fall and the alarm (if operable at the time of the fall) could have helped, to an extent. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/10/2021 at 11:13AM, V3 (Registered Nurse) reported assisting R3 after R3's fall on 10/25/2021. V3 reported R3 was located on the ground in the hallway face down and was bleeding. V3 reported R3 had used bed and chair alarms in the past and I feel like they (the alarms) were (effective in preventing falls for R3). The Emergency Medical Services (EMS) report (10/25/2021) documents EMS staff found R3 laying on the floor in the facility with a laceration to R3's head. The same record documents facility Staff advised that physical therapy staff had not placed patient on an alarm after therapy and that they heard a scream and patient was on the floor. Patient is normally on an alarm due to fall risk. On 11/10/2021 at 1:44PM, V7 (Physical Therapy Assistant) reported helping R3 out of R3's chair in R3's room to go to therapy on 10/25/2021 and then returning R3 to the same chair after physical therapy. V7 stated I honestly beat myself up, I still do, when we stood up and left the room, the alarm didn't go off, when we headed out it didn't click in my brain, the alarm isn't sounding. V7 reported R3 likes to rock in his chair and V7 usually has to unplug or reset a button to shut an alarm on or off when taking a resident to therapy, but V7 reported not doing so for R3 before R3's fall on 10/25/2021. The facility Fall Prevention policy states: 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.