

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2022
NAME OF PROVIDER OR SUPPLIER Pleasant Meadows Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on record review and interview the facility failed to provide supervision (R1) and remove an accident hazard (R3) to prevent falls for two of three residents reviewed for falls on the sample of 12 residents. Failing to supervise R1 resulted in R1 falling and suffering a laceration to R1's head when R1 pulled a linen cart over on top of R1.</p> <p>Findings include:</p> <p>1. R1's undated Face Sheet documents diagnoses of Alzheimer's Disease, Dementia, Repeated Falls and Muscle Weakness.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents cognitive decision making skills as severely impaired. This same MDS documents R1 as requiring extensive assistance of one person for transfers, dressing, toileting, personal hygiene and bed mobility and one person assist for walking in corridors.</p> <p>R1's Physician Order Sheet (POS) dated February 1-28, 2022 documents a physician order to walk to dine and restroom dated 9/21/21.</p> <p>R1's Initial Fall Report to Illinois Department of Public Health (IDPH) dated 2/3/22 documents R1 fell on [DATE] receiving physical harm or injury.</p> <p>R1's Nurse Progress Note dated 2/3/22 at 12:05 PM V26 Licensed Practical Nurse (LPN) documented this nurse (V26) was at the medication cart, the cnas (Certified Nurse Aides) were in the dining room feeding residents lunch when heard a thump. (R1) was laying flat on (R1's) back with the linen cart on top of (R1). With the assistance of staff (V27 and V28 CNA's), the linen cart was removed from on top of (R1), upon assessment, eyes were open, pupils reactive, but did not respond to verbal or physical stimuli. (V26) immediately called 911.</p> <p>On 2/7/22 at 11:00 AM V2 Director of Nurses stated (R1) was eating lunch in the dining room on the dementia unit. (R1) was finished eating so (R1) got up from table and walked out to commons area. V26 Licensed Practical Nurse (LPN) was at the medication cart with (V26's) back to (R1). (V26) stated (V26) heard a loud thump and turned to see (R1) on the floor with the linen cart laying on top of (R1). There were other staff in the dining room but did not witness (R1) fall. (V28) Certified Nurse Aide (CNA) and (V27) CNA were both in the dining room and saw (R1) walk out but did not witness (R1) fall. V2 stated the staff should monitor residents on the dementia unit.</p> <p>(continued on next page)</p>

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/7/22 at 11:10 AM V3 Assistant Director of Nurses (ADON) stated (R1) normally walks independently about dementia unit with supervision from staff. V3 stated this fall was reported to the Illinois Department of Public Health (IDPH) on 2/3/22. V3 stated (R1) received serious injury as a result of this fall. (R1) ended up with two staples in the back of (R1's) head. (V3) think that is very serious.</p> <p>On 2/8/22 at 11:30 AM V26 Licensed Practical Nurse (LPN) stated (V26) was at the medication cart with (V26) back to the residents. (V26) heard a loud thump sound. (V26) turned around and saw (R1) laying on floor with entire linen cart laying on top of (R1). The staff immediately ran over to help (R1). (V26) did not hear anything prior to the thump sound. (R1) was pretty dazed for three or four minutes. It took a few minutes for (R1) to come around. (V26) called 911. V26 stated (V26) think (R1) must have lost balance and tried to pull at the linen cart to steady herself (R1) ending up pulling it on top of (R1). (V27 and V28) CNA's were not supervising (R1) at that time because (R1) had left the dining room. All of our (facility) residents need supervision that is why they (residents) are here.</p> <p>On 2/8/22 at 11:45 AM V28 Certified Nurse Aide (CNA) stated (V27) and (V28) were in the dining room cleaning tables after lunch. (R1) had already left. (V28) did not see (R1) fall. All the residents back here (dementia unit) need supervision. I (V28) feel bad for (R1). (R1) hasn't walked right since. Before (R1's) fall (R1) walked a lot more. Now it seems really hard for (R1) to get around.</p> <p>2. R3's undated Face Sheet documents diagnoses of Alzheimer's Disease, History of Falling, Dementia, Cognitive Communication Deficit and Abnormalities of Gait and Mobility.</p> <p>R3's Care Plan intervention dated 9/28/17 documents to maintain a clear pathway free of obstacles.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of 4 out of 15 possible points indicating severely impaired cognitive impairment. This same MDS documents R3 as requiring extensive assistance of one person for locomotion on unit.</p> <p>R3's Nurse Progress Note dated 2/7/22 at 9:45 AM V32 Registered Nurse (RN) documented Therapist (V10) was pushing (R3) in wheelchair over vacuum cord, which tipped (R3) forward and onto the floor.</p> <p>On 2/8/22 at 2:00 PM V10 Physical Therapy Assistant (PTA) stated The first thing (V10) should have done is not touch (R3) because (R3) is not even on therapy. We (therapists) are not supposed to help those that are not on our case load. (R3) wheeled herself (R3) into another resident's room on the dementia unit. (V10) was in the next room and heard something. (V10) was just trying to help (R3) out of the other room. The housekeeper was vacuuming the common area just outside the resident rooms. (V10) tried to push (R3) in the wheelchair over the vacuum cord. (R3) must have not been sitting back in (R3) wheelchair. (R3) fell forward out on to floor directly landing on (R3) head. (V10) stated it (fall) happened when (V10) was trying to maneuver the wheelchair over the vacuum cord. Next time (V10) will just unplug the cord or take another route. (V10) am lucky (R3) did not get seriously injured. (V10) will never do that again. (V10) do not know what I (V10) was thinking. (V10) am a therapist. (V10) am trained in safe transfers and transports! V10 PTA stated this fall was completely avoidable. (V10) should have not tried to push R3 over the vacuum cord which caused R3 to fall. (V10) was only trying to help (R3) because I (V10) couldn't find any staff to assist.</p>		