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	07/29/2022

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41970 Based on record review and interview the facility failed to investigate a discrepancy in a Narcotic medication timely for one (R4) resident of three residents reviewed for medication errors in a sample list of seven residents. Findings include: The undated facility policy titled 'The Medication and Treatment Incident Reporting Policy' documents the following: Medication and treatment incidents will be promptly investigated to determine if the incident could be an 'unusual occurrence', and therefore reportable to Illinois Department of Public Health (IDPH). R4's Physician Order Sheet (POS) dated July 1-31, 2022 documents a physician order for Hydrocodone-Acetaminophen (Norco) 10-325 milligrams (mg) three times per day. This same POS documents R4's medical diagnosis of Chronic Pain Syndrome. R4's Medication Incident Report dated 7/22/22 documents (R4) received a Norco at 2:00 PM and additional dose at 4:00 PM. This same report documents V15 Licensed Practical Nurse (LPN)/Nurse Manager was notified of the narcotic discrepancy on 7/22/22 at 7:24 PM. On 7/29/22 at 1:40 PM V2 Director of Nurses (DON) stated there was a discrepancy in Narcotics that was first noted on 7/22/22 due to (R4) receiving two Hydrocodone-Acetaminophen 10-325 milligram (mg) pills. V2 stated this discrepancy was not realized until later that same shift on 7/22/22. V2 stated this narcotic discrepancy was reported to V15 Licensed Practical Nurse (LPN)/Nurse Manager and (V2) on 7/22/22. V2 stated I did not investigate this narcotic medication error until 7/29/22. The investigation should have been done the same day. V2 stated the facility was at risk of further narcotic medication errors due to lack of investigating and educating nurses to the root cause of the original problem.

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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, record review and interview the facility failed to follow assessment recommendations for bed mobility and failed to ensure a care plan was updated to include known behaviors exhibited during repositioning for one of three residents (R7) reviewed for accidents in the sample list of seven residents. These failures resulted in R7 suffering nasal bone fractures when the facility failed to have two staff members present for care. Findings include: R7's Minimum Data Set (MDS) dated [DATE] documents R7 is severely cognitively impaired and that R7 requires extensive assistance of two people for bed mobility and transfers. R7's Care Plan does not document an intervention related to R7's preference to lay on R7's Left side with R7's head in a lowered position. R7's Physician Order Sheet (POS) dated July 1-31, 2022 documents a physician order for Rivaroxaban (anti-coagulant) 20 milligrams (mg) daily. R7's Nurse Progress Note dated 7/26/22 at 10:20 PM documents (V22) Registered Nurse (RN) was alerted by (V21) Certified Nurse Aide (CNA) that (R7) was being provided incontinence care and was being rolled towards the wall, at the same time (R7) turned (R7's) head downwards and hit the bridge of (R7's) nose on the side rail of the bed. (R7's) nose was bleeding and there is a one centimeter (cm) skin tear on the bridge of (R7's) nose, and redness. R7's Initial Incident Report to IDPH (Illinois Department of Public Health) dated 7/27/22 documents R7 received a serious injury at 10:20 PM on 7/26/22. This same IDPH report documents Interview with (V21) Certified Nurse Aide (CNA)-(R7) had been combative since 6:00 PM. (V21) put (R7) to bed. (R7) was laying on back and reached up and grabbed (V21's) shirt. After (R7) let go, (V21) rolled (R7) on Left side and (R7) tried to roll into a ball and hit (R7's) nose on the side rail. (R7) started bleeding and (V21) got the nurse. (R7) almost always curls up when (R7) gets rolled to the Left side. R7's Hospital Record dated 7/27/22 documents medical diagnoses of Acute Nasal Fracture and history of Atrial Fibrillation, Dementia, Current Use of Long-Term Anti-Coagulation, Cerebral Vascular Accident (CVA), Lumbar Spinal Stenosis, Alzheimer's Disease, Glaucoma and Polyneuropathy. R7's Computed Tomography (CT) scan of Facial Bones Without Contrast report dated 7/27/22 documents Indication: Trauma. This same report documents Impression: There are acute comminuted fractures involving the bilateral nasal bones, nasal processes of the maxillary bones and the nasal septum. On 7/28/22 at 1:15 PM R7 was observed with extensive dark purple/blackish bruising to both eyes and the bridge of the nose. The bruising extended down towards R7's upper cheeks on both sides of R7's face. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/29/22 at 1:30 PM V2 (DON) stated (V21) CNA repositioned (R7) without any help from other staff and that most likely caused the serious injury. Other staff that were interviewed all stated (R7) always bends (R7's) head down like that and so this was common knowledge. This should have been care planned as a preference for (R7) and the staff should have been educated on it so that maybe (R7) would not have been injured.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, record review and interview the facility failed to follow physician orders for the administration of antianxiety and pain medications and failed to ensure physician ordered narcotic pain medication was available for administration for three of three residents (R2, R4, R5) reviewed for medication errors in a sample list of seven residents. These failures resulted in R2 missing four doses of scheduled narcotic pain medication and experiencing severe pain when the medication was not available at the facility. Finding include: The facility policy titled 'Medication Administration Policy' effective March 2014 documents the following: Medications not received and/or from a pharmacy and/or not administered within twenty-four (24) hours from the ordered time to be administered will be considered a medication incident. 1.) R2's undated Face Sheet documents an original admitted [DATE] and a re-admitted [DATE]. This same Face Sheet documents medical diagnoses of Fibromyalgia, Bilateral Primary Osteoarthritis of Hip, Bilateral Primary Osteoarthritis of Knee, Scoliosis, Chronic Pain Syndrome and Morbid Obesity. R2's Electronic Medical Record (EMR) documents R2 was hospitalized from 7/15/22-7/23/22 and again on 7/28/22. R2's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status Score of 15 out of 15 possible points indicating no cognitive impairment. R2's Physician Order Sheet (POS) dated July 1-31, 2022 documents Physician orders for Oxycodone Hydrochloride (Hcl) Extended Release (ER) 30 milligrams (mg) every twelve hours with a start date of 7/26/22 and Oxycodone Immediate Release (IR) 5 mg every six hours as needed for pain with a start date of 7/26/22. R2's Medication Administration Record (MAR) dated July 1-31, 2022 documents R2's Oxycodone Hcl ER 30 mg was not administered at 8:00 PM 7/26/22, at 8:00 AM and 8:00 PM 7/27/22 and at 8:00 AM 7/28/22. On 7/28/22 at 12:31 PM V5 Licensed Practical Nurse (LPN) assessed R2 for pain in R2's room. R2 stated the pain is 'terrible'. V5 LPN explained to R2 that R2's Oxycodone Hydrochloride (HCL) 30 milligram (mg) tablets are not available yet but V5 does have the Oxycodone Hcl 5 mg to give. R2 stated I do not understand what is taking so long to get my pain medication. The Nurse Practitioner (V10) told me it would not be a problem. Why can't I have my Oxycodone Hcl 30 mg? V5 LPN informed R2 that the prescription was faxed to (V9) Physician and they (facility) are waiting for (V9) to send over the signed prescription. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 7/28/22 at 12:40 PM R2 stated Both of my hips and knees are bone on bone which is horribly painful. R2 stated it is very difficult to move at all. R2 stated the pain is so intense, it is like I am going through withdrawal. The Oxycodone Hcl 30 mg was scheduled and now I can only have Oxycodone Hcl 5 mg. R2 stated They (staff) told me the doctor approved of it but they (staff) forgot to have the doctor sign the prescription so I have been without for days. I hurt all over. It is awful. On 7/28/22 at 1:30 PM V2 Director of Nurses (DON) stated R2 readmitted from hospital on 7/23/22 with orders for Oxycodone Hydrochloride (Hcl) Extended Release (ER) 30 milligrams (mg) every twelve hours with an end date of 7/26/22 and Oxycodone Immediate Release (IR) 5 mg every six hours as needed for pain. V2 stated V10 Nurse Practitioner reviewed this order on 7/25/22 and gave order to continue both narcotic pain medications with no end date. V2 stated V20 Licensed Practical Nurse (LPN) should have asked V10 to sign the prescription while V10 was in facility but did not. V2 stated V9 Physician/Medical Director was in facility on 7/26/22 and the staff nurses again neglected to have V9 sign R2's prescription for both pain medications. V2 stated Whenever a prescription changes, the nurses should obtain a new prescription and have the Physician or Nurse Practitioner sign the new prescription to prevent any delay in obtaining the medications and so that the resident does not have to endure needless pain or suffering. (R2) had been receiving the Oxycodone Hcl 5 mg IR but not the Oxycodone Hcl ER 30 mg. V2 confirmed R2 missed four doses of Oxycodone Hcl ER 30 mg between the evening dose on 7/26/22, both doses on 7/27/22 and the morning dose on 7/28/22. 2.) R4's Physician Order Sheet (POS) dated July 1-31, 2022 documents a physician order for Hydrocodone-Acetaminophen (Norco) 10-325 milligrams (mg) three times per day. This same POS documents R4's medical diagnosis of Chronic Pain Syndrome. R4's Medication Incident Report dated 7/22/22 documents (R4) received a Norco at 2:00 PM and additional dose at 4:00 PM. This same report documents V15 Licensed Practical Nurse (LPN)/Nurse Manager was notified of a narcotic discrepancy on 7/22/22 at 7:24 PM. R4's Medication Detail Report dated July 1-31, 2022 documents R4 was administered Norco at 3:54 PM on 7/22/22. R4's Narcotic Count Sheet dated 7/22/22 documents V13 Registered Nurse (RN) administered Norco at 2:00 PM and V14 Licensed Practical Nurse (LPN) administered Norco at 4:00 PM on 7/22/22. On 7/29/22 at 1:35 PM V2 Director of Nurses (DON) stated R4 received an extra dose of Hydrocodone-Acetaminophen (Norco) 10-325 milligrams (mg) on 7/22/22. V2 stated the day shift nurse V13 Registered Nurse (RN) gave the 2:00 PM scheduled dose of Norco, signed the medication out as given on the Narcotic Count Sheet but did not sign the Electronic Medical Record (EMR). V2 stated V14 Licensed Practical Nurse (LPN) was the oncoming second shift nurse on 7/22/22 who counted the narcotics with V13 RN. V2 DON stated the count was correct and verified by both nurses. V2 stated V14 LPN gave this same narcotic pain medication again because the Medication Administration Record (MAR) showed that it had not been given at 2:00 PM and was late. V2 stated V14 LPN gave the medication at 3:54 PM on 7/22/22. V2 stated this medication error was reported to V15 LPN/Nurse Manager on call at 7:24 PM 7/22/22. V2 stated administering additional doses of narcotic medications could have very detrimental effects on residents. V2 stated this error could cause obvious effects like sleepiness, but it could also cause more serious effects of respiratory and cardiac issues. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	3.) R5's Physician Order Sheet (POS) dated June 1-30, 2022 documents a Physician order for Ativan 1 milligram (mg) two times daily for Anxiety. R5's Medication Incident Report dated 6/30/22 documents (R5) received 1 milligram (mg) of Ativan instead of the prescribed dose of 0.5 mg. R5's Care Plan dated 4/16/21 documents R5 has impaired thought processes and instructs staff to Administer medications as ordered. R5's Nurse Progress note dated 6/30/22 at 8:40 PM documents During shift count noted discrepancy in amount of Lorazepam remaining in card and what was signed out as given. (R5) had 30 Lorazepam in card and 29 documented as remaining. Upon looking it was noted that another resident (R1) was short 1 tab of Lorazepam. One mg of dose of Lorazepam that was given to (R5) was from wrong card. (R5's) dose is 0.5 mg. On 7/29/22 at 1:45 PM V2 Director of Nurses (DON) stated R5 was given the wrong dose of Ativan. (V23) Licensed Practical Nurse (LPN) had inadvertently administered R5 a 1 milligram (mg) Ativan from (R1) another resident's card sitting just in front of (R5's) card of Ativan in the narcotic drawer of the medication cart. V2 stated (V23) made an error. V2 stated whenever a nurse administers a medication, the nurse should verify the correct medication and dose are given to the correct resident at the correct time. V2 stated This medication error did not cause (R5) any negative problems but certainly could have caused increased sedation, confusion or problems with eating due to being overly sedated.