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	10/26/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 41970 Failures at this requirement required more than one deficient practice statement. A. Based on record review and interview the facility failed to ensure one resident (R2) was not subjected to sexual abuse by another resident (R3) with known sexually inappropriate behaviors. R2 who is severely cognitively impaired wandered into R3's room and was found by staff sitting on R3 with R3's hand grasping R2's breast. R2 would have experienced humiliation, fear and anxiety related to this incident if R2 was cognitively intact. This failure affected two residents (R2, R3) out of eight residents reviewed for abuse in a sample list of 13 residents. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 10/22/22, the facility remains out of compliance at a severity level two. The facility continues to monitor the effectiveness of their plan to ensure staff are assigned to monitor R3 and the effectiveness of their staff education plan for identifying and responding to potential resident sexual abuse. Findings include: R2's undated Face Sheet documents medical diagnoses of Dementia, Unsteady on Feet, COPD (Chronic Obstructive Pulmonary Disease), Weakness, and Cognitive Communication Deficit. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is severely cognitively impaired and requires extensive assistance of two staff members for bed mobility and extensive assistance of one person for transfers, dressing, eating, toileting and personal hygiene. R2's Care Plan intervention dated 3/15/22 documents (R2) will at times get agitated and wander. Staff is to redirect to (R2's) room to engage in reminiscing about the flower pictures and pictures of (R2's) family on the wall, helping take care of (R2's) stuffed animals, providing home and garden magazines to look at and provide a drink or snack. R3's undated Face Sheet documents medical diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Parkinson's Disease, Heart Failure, Major Depressive Disorder and Ataxic Gait. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. This same MDS documents R3 requires limited assistance of one person for bed mobility, transfers, walking in room and corridor, locomotion on and off unit, dressing, toileting and personal hygiene. This same MDS documents R3 uses a walker for mobility device. R3's Care Plan documents a focus area initiated 10/8/19 that documents R3 makes inappropriate sexual comments to staff, has instances of sexual acts to self, at times exposes self. This same Care Plan documents an intervention dated 5/23/22 of (R3) makes inappropriate sexual comments to staff. (R3) also has instances of sexual acts to self. (R3) at times exposes himself. R3's Nurse Progress Note dated 10/7/22 at 7:03 PM documents Power of Attorney (POA) notified of incident with inappropriate fondling of female resident (R2) under the shirt. Residents (R2, R3) were separated. POA concerned as reports (R3) has a history of verbal sexual comments. POA states that (R3) did something inappropriate to her (POA) last weekend and she is not sure what to do about it. R2's Nurse Progress Note dated 10/7/22 at 7:10 PM documents Inappropriate fondling under the shirt to (R2) that had wandered into (R3's) room. As reported per (V11) Certified Nurse Assistant (CNA), (R3) grabbed tighter when attempting to separate the residents (R2, R3). R2's Nurse Progress Note dated 10/7/22 at 7:12 PM documents Incident occurred while (R2) was wandering the unit. (R2) was found in (R3's) room with (R3's) hand under (R2's) shirt. R2's Final Incident Report to Illinois Department of Public Health (IDPH) dated 10/14/22 documents (V11) Certified Nurse Aide (CNA) reported (R2) had been given a shower and escorted to sit in common area next to window across from nurses station. (V11) left to perform personal care for other residents and a few minutes later notices that the call light was on in (R3's) room and went to see what was needed. (V11) CNA observed (R2) sitting on (R3's) bed with (R2's) back to (R3) and half on (R3's) leg. (R2 and R3) were fully clothed. (R3) had (R3's) hand under (R2's) shirt near (R2's) chest area. (V11) immediately moved to separate both residents (R2, R3) and (R3) responded '(R2) was alright there and (R2) wasn't hurting anything.' (R3) also joked about (R2) sitting on (R3's) bed and joked that (V11) CNA could sit on (R3's) bed with (R3). This same report documents Outcome of Situation: (R2) was assigned a one to one to monitor for 72 hours and thereafter moved to another unit. Staff were educated regarding monitoring confused residents and the potential for wandering. (R3) was educated to use call light to request assistance redirecting residents who accidentally enter (R3's) room and agreed to do so. (R3) also counseled regarding use of appropriate language and behavior regarding female staff and residents and indicated (R3) understood and agreed. We (facility) were not able to determine if this was intentional or an awkward accident. On 10/18/22 at 2:10 PM R3 stated I don't remember anyone coming into my room. I wouldn't mind if they did. They are welcome to come on in and have a seat and talk a spell. If you see an [AGE] year-old red head around, please send them in. I would REALLY like to talk to them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/18/22 at 3:30 PM V11 Certified Nurse Aide (CNA) stated I had just given (R2) a shower and assisted (R2) to the sitting area across from the nurses desk by the window. There were not any other staff around but (R2) will usually sit there for a little while and be ok. (R2) likes to sit there to look out the window. About 30 minutes later, the call light was ringing for (R3's) room. (R10) had put on the call light to use the bathroom. (R10) is (R3's) roommate. When I walked in (R3's) room (R2) was sitting half on (R3's) bed and half on (R3's) lap. (R2) had (R2's) back to (R3). (R3) had used his Right hand to directly hold on to (R2's) Right breast. (R2) did not have on a bra or undershirt and (R2's) shirt was loose. (R3) smiled and told me that I was being a 'killjoy' by attempting to remove (R2) from the situation. (R3) did not want to let go of (R2's) breast. (R3) then said 'if you are going to take (R2) away from me then you have to take (R2's) place in the bed'. V11 stated (R3) has had these behaviors before. The last time (R3) walked down the hall to another resident's room, stood in the doorway and began masturbating in front of another resident. I do not remember who the other resident was. She (unknown resident) was in her room on another hall from what (R3) lived on. (R3) is able to use a walker independently to get around the room and up and down the halls. I don't know what we will do with him because he keeps doing this. V11 stated R2 exhibited a flat affect and no response while R3 was grasping R2's breast. R2 is cognitively impaired and non-interviewable and no family or friends were available to offer an opinion of how this incident would have affected R2. On 10/19/22 at 1:55 PM V19 Social Service Director (SSD) stated (R3) has made inappropriate comments to female staff but not to any other residents that I am aware of. (R2) did like to walk down (R3's) hallway. (R2) would gravitate towards that hall so we (facility) thought moving (R2) off the unit completely would be best. (R3) has already been established with (V36) Psychologist. (R3) was already on Prozac to help reduce (R3's) sexual urges. We (facility) should have sent (R3) out to the emergency room for an evaluation that day. Next time we (facility) will. On 10/19/22 at 2:20 PM V36 Psychologist stated I have been seeing (R3) for the last three years at this facility. I am not surprised to hear that (R3) has had inappropriate sexual behaviors. This is typical of (R3). I have not been made aware of any instances of other residents being involved. (R3) has complained of loneliness due to the death of (R3's) wife. (R3) is escalating in (R3's) behaviors. (R3) has moved from comments to groping to now grabbing. (R3) is progressing in sexually aggressive behaviors. (R3) asked me to get (R3) a laptop. I don't think that is a sound idea though because (R3) will use it for pornography. (R3) should be monitored closely if (R3) comes out of (R3's) room. An Immediate Jeopardy situation was identified on 10/22/22. V1 Administrator was notified of the Immediate jeopardy on 10/22/22 at 10:17 AM. The Immediate Jeopardy was identified to have begun on 10/7/22 when the facility failed to ensure one (R2) resident was not subjected to sexual assault from another resident (R3). The surveyor confirmed through observation, interview and record review the facility took the following actions to remove the Immediate Jeopardy: 1. R2 was provided a head-to-toe assessment and moved to a closed hallway on 10/22/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. R3 was moved to a separate (from R2) unit on 10/21/22. V38 scheduler confirmed responsibility for assigning staff to monitor R3 when R3 is out of R3's room and confirmed that staff will be assigned to monitor R3 on a one to one basis when R3 is out of R3's room. 3. The Director of Nurses confirmed staff were trained regarding monitoring R3 when R3 is out of R3's room on 10/21/22 and a copy of the inservice sign in sheet was provided. 4. The Social Service Director confirmed all residents were reviewed for being predisposed to perpetrating sexual abuse on 10/22/22. 5. The Medical Director was notified of incident by the Director of Nurses on 10/7/22. V45 Nurse Practitioner evaluated R3 on 10/25/22 and V45 is consulting with V46 Medical Director concerning management of R3's behaviors. 6. V1 Administrator confirmed that training regarding identifying and responding to potential sexual abuse was initiated on 10/22/22 for staff and administration and training will continue until all staff have been trained. 7. V1 confirmed that the Administrator or designee will audit each new admission for potential of sexual abuse for 3 months. Any issues will be addressed immediately. 8. V1 confirmed that the Quality Assurance Committee will monitor the facility's performance to ensure that corrections are achieved. B. Based on record review and interview the facility failed to ensure residents were not subjected to mental and physical abuse by staff when staff threw food around residents and used a syringe to spray residents with water during a meal for seven of eight residents (R1, R2, R4, R8, R9, R11, R12) reviewed for abuse on the sample of 13 residents. This failure resulted in psychosocial harm to R1, R2, R4, R8 and R9 who were intentionally sprayed in the face with water by staff and expressed anger and anxiety during the abuse by crying and screaming at staff to stop throwing food and water. Findings include: R1's undated Face Sheet documents medical diagnoses of Parkinson's Disease and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring supervision with eating. R2's undated Face Sheet documents medical diagnoses of Dementia, Unsteady on Feet and Cognitive Communication Deficit. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is severely cognitively impaired. This same MDS documents R2 requires extensive assistance of one person for eating. R4's undated Face Sheet documents medical diagnoses of medical diagnoses of Cerebral Palsy, Mild Intellectual Disabilities, Facial Weakness, Dementia, Feeding Difficulties and Chronic Pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Minimum Data Set (MDS) dated [DATE] documents R4 as moderately cognitively impaired. This same MDS documents R4 as requiring limited assistance of one person for eating. R4's Care Plan documents an intervention dated 8/18/22 (R4) is at risk for abuse related to being dependent on others, anxiety/fear/anger and depression. R8's undated Face Sheet documents medical diagnoses of Alzheimer's Disease, Cognitive Communication Deficit, Frontal Lobe and Executive Function Deficit, Dementia and [NAME] Matter Disease. R8's Minimum Data Set (MDS) dated [DATE] documents R8 as severely cognitively impaired. This same MDS documents R8 requires extensive assistance of one person for eating. R9's undated Face Sheet documents medical diagnoses of Dementia, Macular Degeneration and Conductive Hearing Loss. R9's Minimum Data Set (MDS) dated [DATE] documents R9 as moderately cognitively impaired. This same MDS documents R9 as requiring total assistance of one person for eating. R11's undated Face Sheet documents medical diagnoses of Alzheimer's Disease, Dementia with Behavioral Disturbance. R11's Minimum Data Set (MDS) dated [DATE] documents R11 as severely cognitively impaired. This same MDS documents R11 requires extensive assistance of one person for eating. R12's undated Face Sheet documents medical diagnoses of Spondylosis with Myelopathy of Cervical Region, Feeding Difficulties, Hemiplegia and Hemiparesis Following Cerebrovascular Disease Affecting Left Non-Dominant Side, and Left-Hand Contracture. R12's Minimum Data Set (MDS) dated [DATE] documents R12 as severely cognitively impaired. This same MDS documents R12 requires extensive assistance of one person for eating. R1's Initial Incident Report to Illinois Department of Public Health (IDPH) dated 10/13/22 documents (V1) Abuse Coordinator was notified by (RN) that two Certified Nurse Aides (CNA) were throwing peas and squirting each other with water at mealtime and residents at the table were hit by the food and splashed with water. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/19/22 at 1:30 PM R7 stated I saw the whole mess. It was a supper meal on a Wednesday. There were two Certified Nurse Aides (CNA's) (V3, V4) sitting at a table of residents on the far end of the dining room. I sit at the Queen's table in the middle of the dining room. That end of the dining room was so loud, we (residents) could not hear anything. It was obnoxious. Then I saw (V3 and V4) CNA's throwing food at five different residents. One of the CNA's (V3) had a Styrofoam cup of water and some kind of medical syringe. (V3) would fill the syringe with water and point it at those residents and squirt them in the face. Those residents were (R1, R2, R4, R8 and R9). (R1) yelled at (V3) saying 'I am going to kick you're a** if you (V3) squirt me again!' and 'Come closer so I can kick you're a**.' There were residents crying, screaming and yelling for (V3, V4) to stop. They all have the Alzheimer's and don't know what is going on. There is a special place in hell for people that hurt those kinds of people. It made me so mad. I started yelling at those two (V3, V4) to cut it out. I had to yell really loud for them to hear me because they (V3, V4) were being so loud. They (V3, V4) still didn't stop so I started to push myself over there to tell them to stop throwing food and squirting water at people who cannot defend themselves. At that time, (V6) CNA walked over to me and told me to stay put. (V6) yelled at (V3, V4) and walked over to the table where (V3, V4) were sitting. (V6) CNA told them to knock it off and they (V3, V4) finally did. It was awful. I felt so bad for those ladies (R1, R2, R4, R8, R9). They did not deserve to be treated like that. I hope they (facility) fired those a*******. They (V3, V4) aren't brave enough to pick on somebody who has their mind about them. On 10/19/22 at 11:30 AM V4 Certified Nurse Aide (CNA) stated (V3) CNA and I were sitting at a table in the dining room assisting residents with supper meal. (R1) was sitting at the table right next to ours (V3, V4). (V3) CNA took a plunger like the kind they (nurses) use to fill up a urinary catheter balloon out of (V3) pocket and squirted (R1) twice. (V3) squirted (R1) in the cheek and second time in (R1's) shoulder. The water didn't just hit (R1) in two spots but (V3) actually squirted (R1) two separate times. I was assisting another resident eating supper. I don't remember who that was. We (facility) had peas for supper that night. I scooped up the peas with the spoon and they (peas) fell off the spoon so I picked them up off table and tossed them over my shoulder behind me. Then (V3) took the peas off (V3's) spoon and tossed them in the air. That is when I told (V3) to stop throwing food around. (V3) stopped at that point. (V7) Licensed Practical Nurse (LPN) took me in the medication room right before I left at 6:00 PM. (V7) asked me what happened and I told her everything then I left for the day. The next day at the end of my shift, (V8) pulled me into a front office and questioned me about this incident. (V1) came in a few minutes later and suspended me. I haven't been back to work since. On 10/19/22 at 11:50 AM V6 Certified Nurse Aide (CNA) stated I remember that day. It was awful. It was so chaotic. I was on the other side of the dining room assisting residents with supper meal. The area where (R1) was sitting was so loud. Several residents complained it was too loud to eat so I went over to (R1's) table. (V3) CNA had a plunger (V3) kept dipping into a cup of water and filling it up. (V3) squirted water at R1, R2, R4, R8 and R9. I saw (V3) keep filling up the plunger with water and I saw (V3) squirt all those residents. I yelled at (V3) to stop. (R1) yelled, screamed and cussed at (V3). (R1) yelled 'I am going to kick your (V3) a**. You (V3) have no right to squirt me with water. Come over here so I can kick you're a**'. I had to stay with (R1) for a while because (R1) is a high fall risk and (R1) kept trying to get up to get to (V3). (V3) was laughing but (V3) stopped after we (staff) were all yelling at (V3) to stop. (R7) also yelled at (V3) to stop. (R7) is alert and oriented. (R7) could tell how bad it was that day. It was awful. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/22 at 10:00 AM V30 (R8) Power of Attorney (POA) stated (R8) has had Dementia for a very long time. Prior to (R8's) Dementia, (R8) would take very good care of herself. (R8) would dress well, wear make-up, you know, just look nice every day. (R8) always took pride in how (R8) looked. I am sure (R8) would be appalled at having food thrown and water squirted at (R8). (R8) would have been very mad about that if (R8) were in her right mind. On 10/20/22 at 1:30 PM V25 (R9's) Power of Attorney (POA) stated (R9) is in the end stages of Dementia. If (R9) had her right mind, (R9) would never appreciate having food thrown at her or water squirted at (R9). (R9) has always been on the stricter side and did not have much of a sense of humor. (R9) would have been very upset by this. (R9) would have told those staff (V3, V4) to stop that behavior immediately. On 10/20/22 at 12:35 PM V1 stated I was informed on 10/12/22 evening about 8:00 PM-9:00 PM of (V3, V4) two Certified Nurse Aides (CNA) throwing food and squirting water at residents including (R1) and others. I did not know who the other residents were until further into the investigation. I didn't ask who they were. I was just so shocked. On 10/20/22 at 3:15 PM V1 Administrator stated There are many types of abuse. I have done many educations on the types of abuse and what to do and who to report to with all my staff. The nurse (V7) Licensed Practical Nurse (LPN) contacted me about 8:00-9:00 PM the evening of 10/12/22. The date on the Initial and Final Reports to Illinois Department of Public Health (IDPH) are not accurate. This incident involving (R1, R2, R4, R8, R9, R11 and R12) did in fact happen at 5:00 PM 10/12/22. (V7) told me that (R1) had been hit with food and squirted with water by (V3 and V4) Certified Nurse Aides (CNA's). To be honest, I just could not believe the staff would do something like this. On 10/25/22 at 11:10 AM V45 Nurse Practitioner (NP) stated All residents have the right to dignity and respect. Throwing any kind of food and squirting water at residents is unacceptable. That is not treating them with the respect and dignity they (residents) deserve. That is abuse. It is discouraging to think this behavior happened at all but hopefully the facility will not allow that again. The undated facility policy titled 'Abuse Prevention Program-Policy' documents the following: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. 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. Definitions: Abuse means 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. Sexual abuse is non-consensual sexual contact of any type with a resident. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by a licensee, employee or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This includes, but is not limited to, harassing a resident, mocking, insulting, or ridiculing, yelling or hovering over a resident, with the intent to intimidate; threats of deprivation; and isolation.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41970 Based on record review and interview the facility failed to implement their Abuse Prevention Program policy by failing to assess residents after an allegation of abuse and by failing to protect residents from the alleged perpetrators during the abuse investigation for seven of eight residents (R1, R2, R4, R8, R9, R11 and R12) reviewed for abuse in a sample list of 13 residents. Findings include: The Initial Incident Report to Illinois Department of Public Health (IDPH) dated 10/13/22 documents (V1) Abuse Coordinator was notified by (V7) Licensed Practical Nurse (LPN) that two Certified Nurse Aides (CNA) were throwing peas and squirting each other with water at meal time and residents at the table were hit by the food and splashed with water. On 10/20/22 at 3:15 PM V1 Administrator stated This incident involving (R1, R2, R4, R8, R9, R11 and R12) did happen at 5:00 PM 10/12/22. (V7 Licensed Practical Nurse) told me that (R1) had been hit with food and squirted with water by (V3 and V4) Certified Nurse Aides (CNA's). V1 stated The Initial Report sent to Illinois Department of Public Health (IDPH) should have read the date of occurrence was 10/12/22. (V7) told me that (R1) had been hit with food and squirted with water by (V3 and V4) Certified Nurse Aides (CNA's). To be honest, I just could not believe the staff would do something like this. I did not instruct (V7) to have (V3 or V4) to go home. I was just shocked. Looking back, I would do things differently. I came in the next morning (10/13/22) and interviewed staff and other alert and oriented residents. V1 also stated We (facility) have not completed any assessments for (R2, R4, R8, R9, R11, or R12) because initially I was not made aware that anything might have happened to them. I knew there were other residents but was so shocked that staff would even do this I did not ask who the other resident's were. V1 stated (R1's) assessment was completed but not directly after the incident on 10/12/22. On 12/20/22 at 12:35 PM V1 stated After reviewing (V3, V4) CNA timecard reports, they both (V3, V4) stayed longer than they (V3, V4) should have. V3 CNA was scheduled and worked from 2:05 PM-10:02 PM on 10/12/22 and V4 CNA worked 5:48 AM-6:07 PM on 10/12/22 and 5:50 AM-2:30 PM on 10/13/22. I should not have allowed either (V3, V4) to work. I did not instruct (V7) to send (V3 and V4) home pending investigation. V1 confirmed the facility Abuse Prevention Training Program policy documents staff should be sent home pending investigation of incident. On 10/24/22 V2 Director of Nurses confirmed R1, R2, R4, R8, R9, R11 and R12 were not assessed directly after the incident on 10/12/22. The undated facility policy titled 'Abuse Prevention Training Program' documents the following: Documentation in the resident's chart should reflect the resident's physical and emotional status as well as any medical and nursing interventions implemented. The policy also states The facility will remove any alleged perpetrator of abuse or neglect from any further contact with residents pending an investigation. If the alleged perpetrator is an employee, the employee will be sent home and/or advised not to return to work until further notice.

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	146037	A. Building B. Wing	10/26/2022

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41970 Based on record review and interview the facility failed to ensure allegations of abuse were reported to the administrator within two hours for eight of eight residents (R1, R2, R3, R4, R8, R9, R11, R12) reviewed for abuse in a sample list of 13 residents. Findings include: 1.) R3's undated Face sheet documents medical diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Parkinson's Disease, Heart Failure, Major Depressive Disorder and Ataxic Gait. On 10/18/22 at 3:30 PM V11 Certified Nurse Aide (CNA) stated that sometime last summer (2022) V11 witnessed R3 walk down the hall to another resident's room and stand in the doorway and begin masturbating in front of another (unknown) resident. V11 stated V11 does not remember who the other resident was. V11 stated she (unknown resident) was in her room on another hall different from R3's hall. V11 stated (R3) is able to use a walker independently to get around the room and up and down the halls. On 10/21/22 at 9:50 AM V11 Certified Nurse Aide (CNA) confirmed V11 did not report R3 masturbating in a female resident's (unknown) doorway to V1 Abuse Coordinator. On 10/26/22 at 10:30 AM V1 stated V1 was unaware of R3 masturbating in a female (unknown) resident's doorway. V1 stated I will get this one reported to Illinois Department of Public Health (IDPH). On 10/19/22 at 1:55 PM V19 Social Service Director stated (R3) does not have any documented history of inappropriate sexual behaviors with other residents. (R3) has made inappropriate comments to female staff but not to any other residents that I am aware of. (R3) was already on Prozac to help reduce (R3)'s sexual urges. On 10/23/22 at 1:40 PM V19 stated if R3 walked into a residents room and masturbated in the doorway, then that should have been reported to the administrator. 2. The Initial Incident Report to Illinois Department of Public Health (IDPH) dated 10/13/22 documents (V1) Abuse Coordinator was notified by (V7) Licensed Practical Nurse (LPN) that two Certified Nurse Aides (CNA) were throwing peas and squirting each other with water at meal time and residents at the table were hit by the food and splashed with water. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/20/22 at 3:15 PM V1 Administrator stated This incident involving (R1, R2, R4, R8, R9, R11 and R12) did happen at 5:00 PM 10/12/22. (V7 Licensed Practical Nurse) told me that (R1) had been hit with food and squirted with water by (V3 and V4) Certified Nurse Aides (CNA's). V1 stated The nurse (V7) Licensed Practical Nurse (LPN) contacted me about 8:00-9:00 PM the evening of 10/12/22. The Initial Report sent to Illinois Department of Public Health (IDPH) should have read the date of occurrence was 10/12/22. (V7) told me that (R1) had been hit with food and squirted with water by (V3 and V4) Certified Nurse Aides. To be honest, I just could not believe the staff would do something like this. I did not instruct (V7) to have (V3 or V4) to go home. I was just shocked. Looking back, I would do things differently. I came in the next morning (10/13/22) and interviewed staff and other alert and oriented residents. The staff involved (V3, V4) and the nurse (V7) should have all reported this to me as the Abuse Coordinator as soon as it happened. Unfortunately they (V3, V4, V7) did not. (V7) waited a few hours and V3 and V4 did not report this at all. It was only when I questioned them (V3, V4) that I was told what had happened. The undated facility policy titled 'Abuse Prevention Training Program' documents the following: Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.

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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** 32853 Based on observation, interview and record review the facility failed to follow a Physician's Order to use an adaptive cup with a lid to prevent spills, failed to supervise residents drinking hot liquids, and failed to assess residents for safe handling of hot liquids for two of three residents (R6,R4) reviewed for accidents in the sample list of 13 residents. These failures resulted in R4 and R6 suffering second degree burns when they spilled hot coffee, supplied by the facility, on themselves. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 10/24/22, the facility remains out of compliance at severity level 2 as the facility continues to monitor the effectiveness of the re-education of direct care staff related to hot liquid management for residents. Findings include: The facility's Precautions for Handling Hot Beverages policy dated 2020 documents, Staff will monitor, serve, and hold hot beverages in a safe manner to prevent potential burns. Additional precautions may be implemented: a. Assessing and identifying those individuals served who are at high risk for burning themselves with hot beverages. b. Ensuring staff monitor the identified high-risk resident(s) during meal times and/or when hot beverages are served. c. Utilizing specialized spill proof lids and cups for those individuals identified as high risk for spillage and potential for burning. 1.) R6's Face Sheet documents diagnoses including Dementia without Behavioral Disturbances, Need for Assistance with Personal Care, Facial Weakness, Cognitive Communication Deficit, Muscle Weakness (Generalized) and Dysphagia, Oral Phase. R6's Order Summary Report dated 10/19/22 documents an order for a regular diet, pureed texture add fortified foods three times a day with meals for diet with a start date 7/14/21. R6's care Plan dated 9/27/21 document R6 has an ADL (Activities of Daily Living) for eating with interventions to provide food, utensils, and drinks of preference. Placing items within R6's reach, open cartons and cut up food as needed, provide verbal/visual cues and physical prompts as needed. Staff to provide physical assistance as needed. R6's Minimum Data Set (MDS) dated [DATE] documents R6 is severely cognitively impaired and requires extensive physical assistance of one staff for eating. R6's medical record does not document an assessment for safe handling of hot liquids until 10/19/22. R6's Hot Liquids Risk Screed dated 10/19/22 documents that R6 should have hot liquids cooled before handling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Occupational Therapy Evaluation dated 10/12/22 documents the reason for referral is due to increase in spillage and documents R6's current level is moderate assistance (hands on assist, lifts, holds or supports). This Evaluation documents R6 is referred for Occupational Therapy visits five times a week for four weeks. R6's Nurse's Notes dated 10/6/22 at 7:47 PM by V26 Licensed Practical Nurse (LPN) documents that it was reported to V26 that R6 had spilled coffee on R6's self, noted reddened area on right thigh with blisters, small, reddened area on right abdomen with no blisters and another area on the left inner thigh with small blisters and POA (Power of Attorney) and Physician notified. R6's Nurse's Notes dated 10/6/22 at 8:44 PM by V26 documents the area on the right inner thigh measures 24cm (centimeters) x (by) 6cm with several blisters, the on call Physician notified and ordered to give Tylenol for pain and have the wound nurse follow up with R6 in the morning. This note documents the area on the inner thigh measures 5cm x 2cm with two small blisters and the area on the abdomen measures 2cm x 3cm with no blisters noted. R6's Investigation dated 10/6/22 documents R6 was sitting at the dining room table with R6's coffee cup in front of R6 and did not have a good grip on the cup causing R6 to drop and spill the cup into R6's lap. V27 Certified Nursing Assistant (CNA) witnessed the incident and responded immediately. V27 attempted to soak up the coffee with napkins. V27 started to take R6 back to the nurse's station and V28 CNA intercepted and took R6 the rest of the way to the nurse's station. V9 Wound Nurse assessed, and the areas were only red at that time with no blisters. The investigation documents that the evening shift noticed blisters develop and notified the Physician and POA. On 10/18/22 at 11:45 AM, V10 Wound Physician was evaluating R6's burns. V9 Wound Nurse was assisting V10. R6's left thigh wound was red but the skin was not open. The right inner thigh wound was large, approximately 9 to 10 cm (centimeters) long and approximately 1 to 1/2 cm wide with approximately 0.1 cm depth, the skin was open, the wound bed was red with yellow slough and looked red and inflamed around the edges. R6's wound area on the top of the right thigh was large, approximately 9 to 10 cm long and 1 to 2 cm wide and necrotic, blackish red scabbed over the entire wound. V10 stated R6's burns were second degree burns from a coffee spill and V10 stated V10 is ordering antibiotics for R6 as the burns appear infected. On 10/18/22 at 11:55 AM, V2 Director of Nursing stated R6 dropped R6's coffee cup on R6's lap and there was no staff sitting at the table with R6. V2 stated that staff was sitting at the table next to R6 when R6 spilled R6's coffee and burnt R6's self. V2 stated that V2 inserviced staff regarding serving hot beverages. On 10/18/22 at 12:10 PM, V9 Wound Nurse stated that V9 sent a picture of the burns to V10 to get a stage and a treatment order. V9 confirmed V10 stated R6's burns were second degree burns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/18/22 at 12:24 PM, V29 Dietary Manager dispensed a cup of coffee from the coffee maker in the dining room and checked the temperature with a dial thermometer which read 152 degrees Fahrenheit (F.). The same cup of coffee was checked with a digital thermometer and read 154 degrees F. V29 stated the temperature should be between 160 degrees and 171 degrees F. to serve to the residents. V29 stated that they now take the temperature of the coffee before each meal and if it is above 170 degrees F. they are supposed to add ice to the coffee before giving it to the residents. V29 stated that they did not previously keep a log of the coffee temperatures, but they started a log on 10/13/22. V29 also stated that they ordered lids for the coffee cups, and they just came in and started using them today. V29 stated that V29 called the coffee machine company after R6's burn and they came in to see if the coffee temperature could be turned down, but it could not be turned any lower. The coffee temperature log dated 10/13/22 through 10/18/22 documents the highest temperature as 160 degrees F. on several days. On 10/19/22 at 11:20, V15 Certified Occupational Therapy Assistant stated that R6 would not be safe drinking hot liquids independently as that is the reason they are putting R6 on therapy. On 10/20/22 at 11:29 AM, V2 stated R6 should have had staff sitting at the table with R6 at the time of the burn incident because R6 had beverages in front of R6. On 10/21/22 at 1:31 PM, V27 CNA stated on 10/6/22 that V27 was taking residents to the dining room and R6 was sitting at the table without drinks when V27 went to get another resident. V27 stated when V27 returned to the dining room someone had given R6 a cup of coffee. V27 stated V27 looked at R6 and R6 was trying to pick up the cup and couldn't get R6's fingers through the handle and dropped the hot coffee on R6's lap. V27 stated that V27 ran to R6 and lifted R6's slacks away from R6's skin and the slacks were hot to touch. V27 stated V27 yelled for help and another staff member assisted V27 to wipe up the hot coffee and the other staff member took R6 back to the nurse's station for the nurse to assess R6. V27 stated that the residents at the feeding assisted table are not suppose to have their drinks until staff is with them. V27 stated that R6 doesn't hold onto things very well. 2.) R4's Face Sheet documents diagnoses including Diabetes Mellitus, Mild Intellectual Disabilities, Cerebral Palsy, Dysphagia Oral Phase, Dysphagia Oropharyngeal Phase and Hydrocephalus. R4's Order Summary Report dated 10/19/22 documents an order for a regular diet, pureed texture, honey consistency, orange/red adaptive cups with matching lids with a start date of 7/8/22. R4's Care Plan dated 1/31/19 documents R4 has an ADL (Activities of Daily Living) self-care deficit in eating with interventions to provide food/fluids as ordered and utensils placing items within reach, staff to open cartons and cut up food as needed, provide verbal/visual cues and physical prompts as needed for R4 to self-feed as R4 is able/willing, staff to provide physical assistance as needed. R4's Minimum Data Set (MDS) dated [DATE] documents R4 has moderately impaired cognition and R4 requires limited physical assistance of one staff member for eating. R4's medical record does not document an assessment for safe handling of hot liquids until 10/18/22. R4's Hot Liquids Risk Screen dated 10/18/22 documents that R4 should have hot liquids cooled before handling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Speech Therapy Discharge Instructions dated 8/1/22 documents Drinks in adaptive cups/lids. R4's Nurse's Notes dated 10/13/22 at 7:10 PM documents R4 burnt self with coffee. R4's Investigation dated 10/13/22 documents V13 Certified Nursing Assistant (CNA) prepared coffee for R4 and gave it to R4. When R4 went to take a drink R4 missed R4's mouth and poured the coffee on R4's self. R4 was taken back to R4's room and clothing was removed from R4. Physician and R4's Power of Attorney (POA) were notified. Treatment orders were obtained and implemented. On 10/18/22 at 12:10 PM, V10 Wound Physician stated that R4's burn on R4's chest is a second degree burn from spilling hot coffee on R4's self. On 10/19/22 at 9:46 AM, R4 stated that on 10/13/22 R4 was drinking coffee and it went all over R4 and R4's clothes. R4 stated that R4 missed R4's mouth. R4 stated it burned and R4 hollered out. R4 stated staff brought R4 to R4's room and put a bandage on the burn. R4 stated that it hurts if it is touched. On 10/19/22 at 9:53 AM, V2 Director of Nursing stated when R4 spilled R4's coffee and burnt R4's self, there were no staff directly at the table with R4. V2 stated staff were passing out drinks in the dining room. V2 stated that R4 sits at an assisted feeding table because R4 needs additional assistance. V2 stated that staff were inserviced regarding serving hot liquids the day before R4 was burnt. On 10/19/22 at 11:32 AM, V13 Certified Nursing Assistant (CNA) stated that V13 got R4's coffee for R4. V13 stated that V13 put coffee in a regular cup, added the thickener to it and added several pieces of ice to the coffee then set it on the table in front of R4. V13 stated that V13 continued to pass out drinks to other residents when V13 heard R4 scream out. V13 stated V13 and the nurse V23 (Registered Nurse) immediately went to R4 and wiped up the coffee then took R4 to R4's room and removed R4's clothing and put a nightgown on R4. V13 stated that R4 wanted to eat supper so they brought R4 out by the nurse's station so R4 could eat supper. On 10/20/22 at 12:59 PM, V23 stated that V23 was passing medications in the dining room when V23 heard R4 holler. V23 stated that V23 immediately went to R4 and saw that R4 had spilled something on R4 so V23 started wiping it off and realized it was coffee because it was hot. V23 stated that they took R4 back to R4's room and removed R4's clothing and tried to put a cold washcloth on the area but R4 yelled and didn't want V23 to touch it. V23 stated that they put clothing on R4 and R4 wanted to eat so they brought R4 out to the nurse's station to eat. V23 stated that V23 notified the Physician and the POA. V23 stated that this happened at the supper meal and V23 left that day at 6:00 PM. On 10/20/22 at 1:20 PM, V24 Licensed Practical Nurse (LPN) stated that V24 was working on 10/13/22 when R4 spilled the coffee on R4's self. V24 stated that V24 assisted the nurse with notifications and received an order to apply a petroleum-based dressing to the burn and cover with a dry dressing and V24 stated V24 applied the dressing to R4 on 10/13/22. V24 stated that R4 did not complain of any pain that evening but V24 stated R4 receives scheduled pain medication. V10's Wound documentation dated 10/18/22 documents a burn wound to the chest with partial thickness measuring 9cm (centimeters) x (by) 12cm with light serous exudate. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/18/22 at 12:10 PM, R4's wound dressing was removed by V9 Wound Nurse. The area was large, approximately 10 cm x 10 cm and the skin was red and there were some areas of yellow slough. At that time V10 removed the slough with a cotton swab and R4 was yelling out as V10 touched the burn. After V10 removed the skin V10 measured the area then V10 applied the dressing to the open wound. On 10/20/22 at 11:11 AM, V18 Speech Therapist stated that V18 discharged R4 from Speech Therapy in July, 2022. V18 stated that R4 was supposed to have a cup with a lid because R4 needed to protect R4's airway and needed spill control. V18 stated that R4 would have liquid running down R4's face when R4 drank out of a regular cup. V18 stated that V18 would expect staff to follow those recommendations. V18 stated that V18's recommendations got sent to the Physician's and the Physician writes an order for those recommendations. On 10/20/22 at 11:29 AM, V2 DON (Director of Nursing) stated that R4 was supposed to and is still supposed to have staff at the table with R4 when R4 is in the dining room. V2 stated that there was no staff directly at the table with R4 when R4 spilled R4's coffee on R4 and burnt R4's self. V2 stated that they have so many residents that have to be fed that they don't all fit at one table, so staff must go back and forth to the tables. V2 stated that R4 should have had a staff member at R4's table at that time because R4 had beverages. V2 stated that V2 was aware that R4 should have had an adaptive cup with a lid and did not have it at the time of the spill with the burn. V2 stated that the kitchen did not have the cups out and available so V13 used a regular coffee cup. V2 stated V13 should have spoken to the kitchen staff and gotten a cup with a lid for R4. An Immediate Jeopardy situation was identified on 10/21/22. The Immediate Jeopardy was identified to have begun on 10/6/22 when R6 sustained second degree burns to R6's inner thighs as a result of mishandling a hot liquid beverage served by the facility. On 10/21/22 at 8:58 AM, V1 Administrator was notified of the Immediate Jeopardy situation. The surveyor confirmed through observation, interview and record review the facility took the following actions to remove the Immediate Jeopardy: 1.) R4 had a 'Hot Liquid Risk Screen Assesment' completed on 10/18/22. R4's Care Plan has been updated. R4 was evaluated by OT (Occupational Therapy) who made recommendations. R6 had a 'Hot Liquid Risk Screen Assesment' completed on 10/12/22. R6's Care Plan has been updated. R6 was evaluated to OT who made recommendations. Completed by Occupational Therapy. 2.) No new residents have been identified to have been affected. Completed by Director of Nursing and Occupational Therapy on 10/25/22. 3.) Seating chart has been made for all residents. Staff members are being assigned to speficic tables for residents who require feeding assistance. All residents have been assessed with 'Hot Liquids Risk Screen' Assessment and triggered residents are being evaluated by OT. Triggered residents were screened by therapy staff on 10/25/22. 10 residents were identified to need an OT evaluation. Seven of these 10 OT evaluations were completed 10/25/22 and the other three are supposed to be completed during supper meal on 10/26/22. Staff inservicing has been started and remains in progress. Staff are observing residents during meal times. Completed by Director of Nursing and Occupational Therapy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4.) DON has assigned mealtime audits to be completed by the floor nurses for every meal. These audits have been intiated (10/24/22) and are in progress. Quality Assurance (QA) Committee will monitor the facility performance at next QA meeting on 11/9/22. 5.) All residents identified to be at high risk for mishandling hot liquids were restricted from independently handling hot liquids until they could be assessed for safety in doing so. Completed on 10/24/22 by Administrator.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on record review, observation and interview the facility failed to develop and implement effective targeted interventions to ensure residents with Dementia do not wander into other residents rooms for two (R2, R13) residents out of two residents reviewed for Dementia services in a sample list of 13 residents. Findings include: 1.) R2's undated Face Sheet documents medical diagnoses of Dementia, Unsteady on Feet, COPD (Chronic Obstructive Pulmonary Disease), Weakness and Cognitive Communication Deficit. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is severely cognitively impaired. This same MDS documents R2 requires extensive assistance of two for bed mobility and extensive assistance of one person for transfers, dressing, eating, toileting and personal hygiene. R2's Nurse Progress Note dated 10/7/22 at 7:12 PM documents Incident occurred while (R2) was wandering the unit. (R2) was found in (R3's) room with (R3's) hand under (R2's) shirt. R2's Care Plan intervention dated 3/15/22 documents (R2) gets agitated and wanders. Staff is to redirect (R2) to (R2's) room to engage in reminiscing about the flower pictures and pictures of (R2's) family on the wall, helping take care of (R2's) stuffed animals, providing home and garden magazines to look at and provide a drink and snack. On 10/20/22 at 11:15 AM V32 and V33 Certified Nurse Aides (CNA's) were sitting at the nurses desk. V32 and V33 CNA's were both looking down towards laps and typing on cellular phones for three minutes continuously without looking around to monitor residents. Multiple residents were sitting in their wheelchairs and stationary chairs around the nurses station. R2 was sitting in a stationary chair holding R2's helmet in R2's lap. R2 stood up from chair, walked towards hallway and then returned to chair while V32 and V33 CNA's were using their cellular phones. V32 and V33 CNA's did not assist R2. On 10/20/22 at 11:18 AM V32 Certified Nurse Aide (CNA) looked up from desk and stated 'oh, you scared me. I didn't know anyone was there.' On 10/20/22 at 1:50 PM V34 Certified Nurse Aide (CNA) stated (R2) is very busy. (R2) was moved over to this unit because (R2) was abused by another resident (R3) on another hall so they (facility) moved (R2) over here. (R2) wanders everywhere. (R2) wanders in and out of other resident rooms. We (staff) just caught (R2) this morning walking down the hall with another resident's picture frame. (R2) had been in another resident's room with no one watching. (R2) gets away from us sometimes. (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	10/26/2022

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/20/22 at 2:00 PM V35 Activity Director (AD) stated I was bringing in another resident from smoking and saw (R2) walking down the hall with a picture frame in (R2's) hands. The picture belonged to another resident. (R2) had taken it out of the other resident's room. I couldn't just stop what I was doing so I took the smoker back to their room and then came back to (R2). (R2) was already down the hall a few more rooms. I returned the picture to the rightful owner then came back again to check on (R2). This took a few minutes. (R2) was pushing an empty wheelchair down the hall. (R2) was almost at the end of the long hall that leads into the dining room. No staff were around at that time. They (staff) must have been occupied helping other residents. It was just me and (R2). I turned (R2) around and left (R2) to continue walking down the hall. 2.) R13's undated Face Sheet documents medical diagnoses of Vascular Dementia, Cognitive Communication Deficit, Bilateral Open Angle Glaucoma, Syncope and Collapse. R13's Minimum Data Set (MDS) dated [DATE] documents R13 as severely cognitively impaired. This same MDS documents R13 requires supervision with walking on and off unit. On 10/20/22 at 3:00 PM V11 Certified Nurse Aide (CNA) was observed removing R13 from R3's room. R3 has recently shown sexually aggressive behavior towards another resident (R2). V11 escorted R13 out of R3's room back into hallway and left R13 in hallway to continue to wander independently. On 10/21/22 at 9:50 AM V11 Certified Nurse Aide (CNA) stated I had to get (R13) out of (R3's) room yesterday afternoon about 3:00 PM. (R13) wanders everywhere. (R13) is really nice and easy to redirect. We (staff) just go get (R13) out of people's rooms. (R13) will go with anyone willingly. I don't think anything happened between (R13 and R3). I saw (R13) walk into (R3's) room and went and got (R13) directly. V11 stated (R2) also wanders everywhere. We (staff) would have to constantly pull (R2) out of other people rooms. V11 stated (R2) does not know what (R2) is doing at all. There are times when staff are all busy and then we (staff) have to go find (R2) because (R2) has wandered off. On 10/21/22 at 1:40 PM V19 Social Service Director (SSD) stated the residents who wander are supposed to be monitored by the staff. V19 SSD stated the staff are supposed to follow the Dementia careplans for residents who wander around all day. V19 stated when the staff does not follow the Care Plan, then the resident is at higher risk of something bad happening like what happened with (R2).