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	01/03/2023

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to provide showers as scheduled for one (R2) of five residents reviewed for showers in the sample list of six. Findings include: R2's Minimum Data Set, dated dated dated [DATE] documents R2's short/long term memory and recall ability is intact, and R2 requires physical assistance of at least two staff for bathing. The facility's Shower Schedule revised 12/1/22 documents R2's showers are scheduled to be given twice weekly on dayshift on Mondays and Thursdays. R2's November and December 2022 Shower Sheets provided by V2 Director of Nursing do not document that R2 received showers as scheduled during 11/4-11/8, 11/19-11/23, 12/7-12/11, and 12/16-12/21/22. On 12/29/22 at 12:04 PM R2 stated R2 has only been getting showers weekly and R2 is suppose to receive showers two times per week. On 1/3/23 at 1:21 PM V2 stated showers are scheduled to be given twice weekly. At 4:01 PM V2 stated V2 had no other documentation to provide for R2's showers.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to assess for injury/range of motion following a fall to timely identify an injury for one (R4) of three residents reviewed for falls in the sample list of six. Findings include: R4's Minimum Data Set, dated dated dated [DATE] documents has severe cognitive impairment and requires limited assistance of one for transfers and supervision for walking. R4's Nursing Note dated 12/14/2022 at 4:15 AM documents R4 was found lying on R4's right side on the floor next to R4's bed. R4 had no complaints of pain or injuries. R4's Neurological Assessment Flow Sheet initiated on 12/14/22 at 4:15 AM documents R4 was able to move all extremities between 4:15 AM on 12/14/22 and 5:00 PM on 12/15/22. R4's December 2022 Medication Administration does not document pain assessments were completed every shift. R4's Nursing Notes document: On 12/15/22 at 2:00 PM (almost 34 hours after R4's fall) V10 Licensed Practical Nurse (LPN) collected R4's urine sample via catheter insertion. R4 was reluctant to spread R4's legs, had facial grimacing, and cried when R4's right knee was touched. The physician was notified and an x-ray was ordered. On 12/15/2022 at 9:15 PM R4's x-ray results were reported to the facility and showed a right femoral neck fracture. V4 Physician was notified and R4 was transferred to the local hospital for treatment. R4's Radiology Result Report dated 12/15/22 at 8:18 PM documents a right femoral neck fracture, beneath the femoral head. R4's Hospital Notes dated 12/16/22 at 10:25 AM documents R4 presented with complaints of right hip pain after falling on 12/14/22. R4 was found to have a right hip fracture that required surgical repair. On 12/29/22 at 2:55 PM V6 Certified Nursing Assistant (CNA) provided incontinence care for R4. R4 had a dressing to R4's right hip incision. On 12/29/22 at 9:44 AM V7 CNA stated V7 worked the day after R4's fall (12/15/22). V7 stated R4 was not bearing weight during transfers, R4 was in a lot of pain, and V7 reported this to the nurse that morning. On 1/3/23 at 9:24 AM V8 CNA stated: V8 came into work at 6:00 AM on 12/14/22. That day R4 required two staff to transfer R4, and prior to R4's fall R4 was ambulatory and only needed hand held assistance. R4 seemed like R4 was in pain, but was unable to indicate where the pain was located. R4 was only able to take a few steps. V8 reported R4's change in condition to V10 Licensed Practical Nurse (LPN) on the morning of 12/14/22, and V10 said V10 was going to obtain an order for an x-ray. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/3/23 at 10:36 AM V10 LPN stated: V10 was assigned as R4's nurse from 6:00 AM until 7:15 PM on 12/14/22. V10 instructed staff to keep R4 in bed for breakfast. R4 was not smiling that day, which was unusual for R4. Night shift reported to V10 that R4 was assessed and had no injuries following R4's fall. The next day something was not right. R4 was hesitant to open R4's legs to insert a urinary catheter. V10 assessed and touched R4's legs, and R4 yelled out and cried when R4's right knee was touched. V10 notified V4 Physician and x-rays were ordered. Later that night R4's x-ray results were called to the facility and indicated R4 had a broken right hip. V10 did not assess R4 for injuries or range of motion of extremities on 12/14/22, since there was no indication of injury and night shift had assessed R4. The CNAs never reported to V10 that R4 had signs of pain/difficulty with transfers. V10 would have done a focused assessment and checked for injuries at that time. On 12/29/22 at 1:08 PM V2 Director of Nursing stated post fall pain monitoring is documented on the Medication Administration Record, and all residents have orders to assess pain level every shift. On 1/3/23 at 1:25 PM V2 stated V2 would expect the nurses to complete post fall assessments including an assessment of range of motion, and document the assessment on the Neurological Assessment Sheet. On 1/3/23 at 2:39 PM V4 Physician stated V4 would have ordered R4's x-rays sooner if the staff had reported R4's change in transfer status/pain to V4 on 12/14/22. The undated Notification of Resident Change in Condition policy documents: The licensed nurse is to use professional judgement in determining changes in condition based on assessment and findings or signs and symptoms of change which could lead to deterioration if not treated. Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings and care plan review. The facility's Falls - Clinical Protocol revised August 2008 documents: 1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematoma or other intracranial bleeding could occur up to several weeks after a fall.

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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** 40385 Based on observation, interview, and record review the facility failed to provide supervision and toileting assistance for one (R6) of three residents reviewed for falls. This failure resulted in R6 falling and sustaining a right hip fracture, right orbital (eye socket) fracture, and right wrist fracture. The facility also failed to implement post fall interventions for one (R6) of three residents reviewed for falls in the sample list of six. Findings include: R6's Diagnosis List dated 1/3/23 documents R6 has Dementia. R6's Minimum Data Set, dated dated dated [DATE] documents: R6 has a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. R6 requires limited assistance of one staff person for transfers, walking, dressing, and toileting. R6 uses a walker, is not steady, and only able to stabilize balance with staff assistance when turning around, moving on/off the toilet, and for surface to surface transfers. R6's Care Plan dated 11/7/22 documents R6 is at risk for falls related to confusion, gait/balance problems, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Osteoporosis, overactive bladder, and reflux disease. R6's care planned fall interventions do not include the use of an alarming device. R6's Nursing Notes document the following: On 12/15/22 at 12:46 PM R6 had an unwitnessed fall in a resident room. R6 was found lying on the floor holding R6's head. R6 had a laceration to R6's right eye, right face 5 cm (centimeters) long by 1.27 cm wide by 0.3 cm deep, right wrist, and right forearm 3.5 cm long by 1 cm wide by 0.1 cm deep. R6's right wrist was flaccid (limp). R6's right eye was swollen shut and R6 was unable to open R6's eye. This nurse (V10 Licensed Practical Nurse) applied pressure with ABD (abdominal) pads to orbital socket to stop hemorrhaging. R6 was transported by ambulance to the emergency room . Contributing factors include R6 was not using R6's cane/walker as instructed and R6 has diagnoses of Dementia and an unsteady gait. R6's undated Fall Investigation documents the following: R6's fall occurred in another resident room. V11 Certified Nursing Assistant (CNA) saw R6 in the bathroom approximately 3 minutes prior to the fall. V11 thought R6 was trying to put on different pants because resident's (R6's) pants were in the bathroom. R6 requires limited assistance of one person for activities of daily living and transfers. Root Cause: it is probable resident (R6) was attempting to dress without assistance resulting in (R6) becoming off balance and falling. Based on investigation, it is probable that resident (R6) took herself to the bathroom and took off her pants. Resident (R6) had a different pair of pants around her ankle upon staff assessment. R6 was transferred to the emergency room and diagnosed with a right hip, wrist, and orbital bone fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's Hospital emergency room Note dated 12/15/22 at 1:32 PM documents R6 had an unwitnessed fall at the nursing home and presented with right eye bruising/bleeding, right hip pain, right facial injuries, and fractured right wrist. R6's right wrist x-ray and right hip x-ray dated 12/15/22 document There is an acute dorsally impacted fracture distal metaphysis of the radius. There is an acute avulsion fracture styloid process distal ulna. Right hip x-ray shows a fracture in the subcaptial region extending to the mid cervical region medially. Acute pathology is right wrist fracture and right hip fracture. R6's head/facial bone Computed Tomography scan dated 12/15/22 documents Right orbital rim fracture. On 12/29/22 at 10:52 AM R6 was lying in bed on a motion sensor bed alarm. R6 had a cast to R6's right forearm and bruising/scabbed area to R6's right check. R6 did not remember falling and was unable to recall details of R6's fall. At 11:15 AM V12 and V6 CNAs used a gait belt and transferred R6 from the wheelchair into the shower chair. R6 had dark blue bruising to R6's right side and lower back/hip. At 1:51 PM R6 was sitting in a recliner in R6's room. R6 did not have a motion sensor alarm in R6's recliner. On 12/29/22 at 1:54 PM V12 CNA stated V12 was not sure who transferred R6 into the recliner. V12 confirmed R6's recliner did not have a motion sensor alarm. I put one (alarm) in (R6's) chair this morning and (R6) uses it (alarm) in bed. We have a binder at the desk that tells us fall interventions/alarms. On 12/29/22 at 1:57 PM the fall intervention binder did not contain information regarding R6's fall interventions. V9 Licensed Practical Nurse (LPN) confirmed the binder did not contain fall interventions for R6. V9 stated V9 was not sure if R6 uses motion sensor alarms and V9 would have to look up the information. V9 reviewed R6's Physician Orders and stated there is no order for R6 to have an alarm. There would be an order if (R6) was suppose to have one. On 1/3/23 at 10:18 AM V11 CNA stated: V11 was walking with R6 to the dining room (on 12/15/22). R6 told V11 that R6 needed to go to the bathroom. V11 told R6 to go ahead and go to the bathroom, and V11 would return later. V11 went to assist another employee with a resident transfer, and upon return R6 was found on the floor near the closet of another resident's room. V11 had last seen R6 sitting on the toilet in the adjoining bathroom of that room a few minutes prior. R6 was found to have on different pants that did not belong to R6. R6's walker was in the bathroom and not in the resident room near R6. V11 does not work R6's hall much, but R6 was pretty independent with toileting. The post fall intervention was not to leave residents in the bathroom by themselves. R6's fall probably could have been prevented if someone was in the bathroom assisting R6. R6 gets confused and mixed up. R6 was in the closet getting clothes to change into, because R6 was incontinent. On 1/3/23 at 10:45 AM V10 LPN stated V10 heard a scream and found R6 lying face down in another resident room. R6 was bleeding, R6's orbital socket had a big gash and R6's right wrist was limp. V10 supported R6's wrist with R6's fingers. R6 was unable to open R6's right eye due to swelling and a hematoma. Prior to the fall R6 was confused, had an unsteady gait, and required assistance of one staff person for transfers, ambulation, and toileting. R6 was not safe to be left in the bathroom by herself due to R6's confusion. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/3/23 at 1:25 PM V2 Director of Nursing stated R6 should have a motion sensor alarm in use when R6 is sitting in the recliner in R6's room. This information should be updated on R6's care plan and included in the binder at the nurse's station. V2 stated through investigation it is probable that R6 was attempting to pull up R6's pants that R6 had obtained from the room and fell . V12 stated V11 had witnessed R6 in the bathroom approximately 3 minutes prior to the fall, and staff should assisted R6 since R6 required one assist for activities of daily living. On 1/3/23 at 2:39 PM V4 Physician confirmed R6's injuries are consistent with a fall. The facility's Falls - Clinical Protocol revised August 2008 documents: Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide routine and thorough urinary catheter care and ensure urinary catheter drainage bag and tubing off of the floor for three (R1, R2, R3) of three residents reviewed for urinary catheters in the sample list of six. Findings include: 1.) R1's Brief Interview for Mental Status dated 12/21/22 documents R1 is cognitively intact. R1's Physician's Orders dated 12/29/22 documents an order for urinary catheter care to be completed every shift and to ensure the urinary drainage bag is kept off of the floor. There is no documentation in R1's electronic medical record that the Certified Nursing Assistants (CNAs) provide catheter care every shift prior to 12/29/22. R1's Nursing Notes document R1 admitted to the facility on [DATE] with a urinary catheter. R1's Baseline Care Plan dated 12/27/22 does not document R1's urinary catheter. On 12/29/22 at 9:51 AM R1's urinary catheter drainage bag on R1's wheelchair contained dark yellow urine. R1 stated the staff provide urinary catheter care/cleaning about every other day. On 12/29/22 at 2:02 PM V13 Registered Nurse and V14 CNA entered R1's room to provide catheter care. R1 transferred from the wheelchair to the bed with the use of a wheeled walker. R1's urinary catheter drainage bag was hooked onto R1's wheeled walker, and R1's urinary catheter drainage tubing was dragging the floor when R1 walked to the bed. V14 used a wash cloth to wash, rinse, and dry R1's urinary meatus and approximately 1 inch of the top side of R1's urinary catheter, near insertion. V14 did not wrap the washcloth around the catheter to clean all sides or clean past 1 inch from insertion. R1 used the wheeled walker to transfer back into the wheelchair, and R1's catheter drainage tubing was dragging the floor. On 12/29/22 at 2:17 PM V14 confirmed V14 did not clean R1's urinary catheter tubing correctly, and urinary drainage bags/tubing are to be kept off of the floor. On 12/29/22 at 2:39 PM V2 Director of Nursing stated: Catheter care is done every shift by the CNAs. Both the CNAs and nurses are to document that catheter care is performed. CNAs are to document catheter care every shift under the tasks section of the resident's electronic medical record. V2 expects staff to wrap the urinary catheter with the washcloth and clean downward from insertion site during catheter care, and urinary drainage bags/tubing are to be kept off of the floor. 2.) R2's Minimum Data Set (MDS) dated [DATE] documents: R2's short term memory, long term memory, and recall ability are intact. R2 requires extensive assistance of two staff for toileting assistance and has a urinary catheter. R2's Response History for Catheter Care dated 12/29/22 does not document that catheter care was consistently provided by the CNAs three times daily/every shift between 11/30/22 and 12/27/22. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's December 2022 Infection Control Log documents R2 had a Urinary Tract Infection on 12/3/22. On 12/29/22 at 12:04 PM R2 stated R2 has a urinary catheter since April 2022 and the staff do not perform routine catheter care/cleaning. R2 stated R2 recently had Urinary Tract Infections. 3.) R3's MDS dated [DATE] documents R3 is cognitively intact. R3's Physician's Orders dated 12/29/22 document an order to administer catheter care every shift and to keep the urinary drainage bag off of the floor. R3's Response History for Toileting/Catheter Care dated 12/29/22 does not document that catheter care was performed every shift between 11/30/22 and 12/29/22. On 12/29/22 at 9:26 AM and 10:51 AM R3 was lying in bed. R3's urinary catheter drainage bag was lying directly on the floor and contained clear yellow urine. On 12/29/22 at 9:26 AM R3 stated CNAs provide urinary catheter care/cleaning a couple times per week. The facility's Catheter Care, Urinary policy revised September 2005 documents: Be sure the catheter tubing and drainage bag are kept off the floor. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. Record catheter care in the resident's medical record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to complete routine pain assessments for one (R4) of five residents reviewed for pain in the sample list of six. Findings include: R4's Diagnoses List dated 1/3/23 documents R4 has Alzheimer's Disease. R4's Care Plan dated as revised 12/29/22 documents R4 has the potential for altered comfort related to right femur fracture. This care plan includes interventions to assess R4's pain using the 1-10 pain scale or similar tool, document pain characteristics including location/intensity/frequency/duration/aggravating and alleviating factors, monitor nonverbal expressions of pain, and administer medications as ordered. R4's Nursing Notes document: On 12/14/2022 at 4:15 AM R4 was found lying on R4's right side on the floor next to R4's bed. On 12/15/22 at 2:00 PM V10 Licensed Practical Nurse (LPN) collected R4's urine sample via urinary catheter insertion. R4 was reluctant to spread R4's legs, had facial grimacing, and cried when R4's right knee was touched. The physician was notified and an x-ray was ordered. On 12/15/2022 at 9:15 PM R4's x-ray results showed right femoral neck fracture. V4 Physician was notified and R4 was transferred to the local hospital. R4 readmitted to the facility on [DATE] following right hip surgical repair. R4's Physician's Orders dated 1/3/23 do not include orders for pain assessments every shift. R4's December 2022 Medication Administration (MAR) documents Norco (pain medication) 5/325 milligrams (mg) one tablet every 6 hours as needed for pain and Tylenol 650 mg every 6 hours as needed for pain were initiated on 12/19/22. R4's December 2022 and January 2023 MARs document Tylenol was not administered and Norco was only administered one time on 1/3/23. These MARs do not document that R4's pain is routinely assessed. R4's Response History report (completed by Certified Nursing Assistants) dated 1/3/23 documents R4 complained of pain on 12/19, 12/20, 12/21, 12/22, 12/23, 12/25, and 12/28/22. On 12/29/22 at 2:55 PM V6 Certified Nursing Assistant (CNA) provided incontinence care for R4. R4 had a dressing to R4's right hip incision. On 1/3/23 at 11:08 AM V6 and V8 CNAs transferred R4 from the bed to the wheelchair. R4 made verbal sounds, facial grimacing, and R4's legs were shaking. V8 stated: The only time R4 appears to be in pain is during transfers and V8 reports to the nurse. R4 was given pain medication earlier, prior to the transfer. On 12/29/22 at 9:44 AM V7 CNA stated R6 worked the day after R4's fall (12/15/22). R4 was in a lot of pain, was not bearing weight during transfer and V7 reported this to the nurse. On 1/3/23 at 9:24 AM V8 CNA stated: V8 came into work at 6:00 AM on 12/14/22. R4 seemed like R4 was in pain, but was unable to indicate where the pain was located. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/29/22 at 1:08 PM V2 Director of Nursing stated post fall pain monitoring is documented on the Medication Administration Record, and all residents have orders to assess pain level every shift. On 1/3/23 at 1:25 PM V2 stated a pain scale on the MAR is used to document the resident's score/rate of pain. At 3:10 PM V2 confirmed R4 does not have an order for pain assessments or that pain assessments are routinely documented on R4's MAR. The facility's Pain Assessment policy revised August 2008 documents pain will be assessed and documented regularly using the facility's pain assessment tool.