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	04/21/2023

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 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** 31642 Based on observation, interview, and record review, the facility failed to maintain a resident walkway free of obstacles and provide ambulation assistance, and failed to ensure a mobility device was within a resident's reach for two of three residents (R2 and R3) reviewed for falls on the sample of three residents. These failures resulted in R3 suffering a fractured wrist and R2 suffering a head laceration that required sutures. Findings include: 1.) R3's Medical Diagnoses Sheet last updated 4/21/23 documents diagnoses of Fractured Right Radius, Weakness, Unsteadiness on Feet, History of Falling, Fractured Right Femur, Dementia, Psychotic Disturbance and Anxiety. R3's Minimum Data Set (MDS) date 4/6/23 (nine days prior to fall 4/15/23) documents the following: R3 has a Brief Interview of Mental Status score of nine out of a possible score of 15, indicating moderate cognitive impairment. R3's same MDS documents R3 has had one fall with major injury since admission 10/08/21. The same MDS documents R3 is ambulatory with limited physical staff assistance of one, uses a walker, is not steady walking and requires physical staff assistance to stabilize during ambulation. R3's Illinois Department of Public Health, Long-Term Care Facility and IDD-Serious Injury and Communicable Disease Report dated 4/15/23 at 7:23 am documents a fall investigation as follows: (R3) was sent to the hospital. 'Incident Description' diagnosis (diagnoses), right wrist fracture, (and) hematoma to left shoulder. The same report includes an attachment sheet of interviews as follows: Interview with (V9, Registered Nurse) - got a call over intercom and resident (R3) was rolled over on (R3's) back on (the) floor. Assessed her (R3). Big skin tear on hand. Left leg bothering her (R3). Worried about head. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing Note (included with this witness statement): Resident was walking to the dining room with her walker, going to breakfast, when she fell forward on her face. Noted skin tear to left hand, blood coming from her (R3's) mouth, redness to (R3's) forehead, pain to left hip and left arm. Vitals (blood pressure) 185/92 (high), pulse 72, (temperature) 97.8 (degrees Fahrenheit), spo2 (blood oxygen level) 99 percent. (V3, Medical Director/ Physician), notified and (verbal order) to send out to hospital. (V11, R3's Family Member), notified of fall and sent to (community hospital). Interview with (V5, Certified Nursing Assistant)- last saw her (R3) walking up the main hall in front of the office (around corner from the chapel/activity room), right before she (R3) fell . She was using her walker and had both hands on it (the walker). Interview with (R3), - stated she (R3) does not remember falling and does not remember much anymore and that it is frustrating to her at times. Resident (R3) reported to the nurse (unidentified) at the time of the fall that she tripped and fell forward. The same Report attachment, documents the following: Staff reported that they think resident's (R3's) walker may have gotten caught on the activity table. Staff also reported that resident's shoes are slick. POA (V11, Family Member) contacted and agreeable to bringing resident in new shoes. R3's Hospital report dated 4/15/23 documents Chief Complaint, fall. Patient is here via ems (Emergency Medical Service) from (long-term care facility) after patient (R3) had a fall today. Patient was walking to (the) dining room and fell forward onto face. Patient (R3) has voiced complaints of pain to bil (bilateral) hip and patient has a wound to left hand. Patient has no visible injuries to her face. Patient is alert and oriented x 3. Acuity (Urgent). The same hospital report includes an X-ray report documenting R3 has a fracture at the distal radial metaphysis at the right wrist. On 4/20/23 at 5:30 pm V5, Certified Nursing Assistant (CNA) stated she worked, and had seen R3 just before and right after the fall 4/15/23. The fall itself was not witnessed. V5 confirmed her witness statement and added: I saw (R3) walking in the hall with her walker, by the front office that leads into the chapel and the dining room. She had on shoes, glasses were on and both hands on her (R3) walker, when I saw her. I was going through the dining room, over to skilled unit. I heard (V8, Office Manager) say on the overhead page that a nurse was needed in the dining room. I knew what that meant. (V9, Registered Nurse/RN) was already heading that way, and over by (R3) as I responded. (R3) was laying on her back. V5 stated We noticed (R3) had a big skin tear on her left hand. V5 stated (R3) told us she did not know what exactly happen. She said she knew she went over the top of the walker. (R3) is very confused at her baseline. We all saw the puzzle table was the cause of her (R3's) fall. The table stuck out a couple feet and blocked part of the dining room doorway. R3's walker was up against the table. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/20/23 at 5:50 pm V5, CNA walked over to the dining room entrance, at the edge of the chapel/activity room. There was a large table approximately three to four feet deep by five feet wide in this area and approximately 18 inches of the table protruded out into the walkway of the dining room doorway. V5, CNA stated This is where we have most all the activities. This is where (R3) fell . You can see the table is angled and sticks out too far. It blocks part of the doorway. This is the way residents go from (R3's) unit to the dining room. V5, CNA also stated Myself (V5, CNA), and (V9, RN) both think (R3's) walker struck the table corner because this table was so far out. Just like it is now. We mentioned that to (V2, Director of Nursing). She (V2) said it was a good idea to move the table, but she would have to talk to activities (Activity Department) first. Here it (the table) still sets, several days after the (R3's) fall (4/15/23). It had to be the table because (R3) went over the top of her walker. She had slip on shoes, so it would not be laces that caused (R3) to trip. V5 also stated They (unidentified) put an alarm on her dining chair. That will alert us when she gets up. That won't change the real issue. The puzzle table needs to be moved. On 4/20/23 at 6:20 pm V8, Office Manager stated I heard (R3) scream as she fell . I saw her immediately on the floor and her walker up against to table. It was obvious the walker ran into the table and caused the fall. That is my opinion. I can't be sure, but that is what it looked like. I called for a nurse on the intercom. (V9, Registered Nurse) and a couple (CNA's) were with (R3) when I rounded the corner to come back and help with what I could. On 4/20/23 at 6:40 pm V2, stated I was aware, the staff that responded to (R3) when she fell at the dining room entrance thought the table was the problem. I have moved it up against the wall now. I don't know where to put it yet. I could have done that (moved the table from the walkway) the same day (R3) fell . I don't know why I didn't. I focused on her shoes and asked her family to bring in new ones. Both the table and the slippery shoes were likely the cause of the fall. I realize that now. On 4/21/23 at 2:10 pm, V3, Physician/ Medical Director stated R3's wrist fracture was due to the impact of the fall and the fracture was not pathological in nature. V3 stated Wrists do not spontaneously fracture, hips can. V3 also stated If the facility identified an activity table was blocking part of the doorway, a likely intervention would be to move the table that played a part in the fall. It does not take a rocket scientist to figure that out. 2.) R2's Diagnoses Sheet documents diagnoses of Acute Respiratory Failure, Reduced Mobility, Need for Assistance with Personal Care, Localized Edema, Visual Disturbances, Cerebral Infarction, Orthostatic Hypotension, History of Falling and Repeated Falls. R2's Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status score as 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents R2 uses a walker and a wheelchair for mobility, requires extensive physical staff assistance with toileting and is not able to stabilize during ambulation without staff assistance. The same MDS documents R2 is continent of bowel and occasionally incontinent of urine. R2's Care Plan dated 4/3/23 documents; (R2) needs a safe environment with: clutter free, adequate, glare-free light, a working and reachable call light, (and) personal items within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Illinois Department of Public Health notification Long-Term Care Facility and IDD-Serious Injury and Communicable Disease Report documents R2's fall occurred on 4/8/23 at 11:35 pm. The Report includes the following attachment (R2) Fall investigation, (R2) stated he was trying to get to the bathroom to pee and have a bowel movement. Had diarrhea and was afraid was going to make a mess. Stated he could not remember if he turned call light on or not, but was wearing glasses and had non-slip socks on, but did not use his walker or wheelchair.' R2's Hospital report dated 4/9/23 documents Chief Complaint, fall. Pt (Patient R2) to ER (emergency room) from (long term care facility) via (local) EMS (Emergency Medical Service) with c/o (complaint of) unwitnessed fall and positive loss of consciousness. Pt (R2) reports he was attempting to hurry to the restroom and did not make it in time and accidentally slipped in his own stool on the floor, falling head first onto the floor. Pt (R2) is on eliquis (blood thinner) and did hit his head. Pt (R2) reports pain all over but reports the most pain is in his R (right) forearm/wrist and rates pain 10/10. Pt is noted to have deformity to the R wrist/forearm as well as swelling/bruising. EMS splinted R arm prior to arrival. Pt has bruise to L (left) upper arm. Pt has laceration and bruising above R eye and abrasion/bruising under R eye. Pt is also noted to have been bleeding from L side of head (parietal region)/bleeding controlled at this time. Pt denies chest pain. Pt has no other complaints at this time. The same Hospital report documents R2 has soft tissue swelling to the right elbow on X-ray and that R2 received three sutures to a forehead laceration. On 4/20/23 at 4:35 pm V4, Certified Nursing Assistant (CNA) stated R2's fall 4/8/23 was not witnessed. V4, CNA confirmed V4, CNA was the staff member that responded first when R2 fell . V4 stated (R2) fell on his left side, on his bathroom floor. It is strange that he had the right side of his head lacerated. I saw him last, at shift change maybe 9:30 or 10 pm. I round on everybody before I start my shift. He (R2) was laying down sleeping in bed. His (1/8) grab bar rails were up. He uses them for positioning. I had to go around the bed side table, in his room to see him. His wheelchair was not next to his bed. It was not within his reach. It (wheelchair) was up against his closet, several feet from his bed. I am not good with measurement. It might have been three, four, or more feet away. I am not for sure. He knows what is going on. He has no confusion. He can tell you how far away it was. I know from working other places the residents' walkers and wheelchairs are supposed to be by their bed. We were taught, if we move it away from their reach, it's considered restraining the resident in bed. I make sure call lights are within reach and all the residents are breathing, as I do rounds (checking on residents) at the beginning of the shift. I should have moved his wheelchair. I don't know why I didn't when I did my first round. (R2) was sleeping in bed evening shift. I was working part of evening shift too. I helped answer call lights on that unit, that evening. He (R2) was not my resident, until I started at 10:00 pm. I worked the whole unit, three halls with (V15) CNA. (R2) had his fall on my shift. He told me he did not have time to get to his (R2)wheelchair across the room. He had to go to the bathroom, quick. He is always continent of bowel. He was afraid he was going to mess in his pants. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/20/23 at 6:12 pm R2 was seated on the side of the bed. R2 had an (approximate) two inch wide laceration with stitches above the right eyebrow. R2 stated The fall I had in the bathroom (4/8/23) occurred because my (R2's) wheelchair was over there, up against the closet. R2 points to the far-left corner of his bedroom. The corner built-in closet was at an angle, approximately eight feet to the left, from the foot of R2's bed. R2 then points to the right and stated That bathroom door is about the same distance (at an angle, approximately eight feet from the head of the bed). I had to go immediately, or I would have been very embarrassed for the CNA's to clean me up. I made it to the bathroom okay. I lost my balance and fell inside the bathroom before I could make it to the toilet. Had my wheelchair been closer, I would have used it. I didn't have time to go the one direction, get the wheelchair then come back to the bathroom. I didn't have time to put on the call light and wait. It was emergent that I go right away, before I made a big mess for staff to clean up. That would have been terribly embarrassing. On 4/20/23 at 6:40 pm V2, Director of Nursing stated I was not aware that (R2's) wheel chair was being placed across the room instead of by his bed. I will be doing education with the staff. It should always be within the resident reach. On 4/21/23 at 2:10 pm, V3, Physician/ Medical Director stated he was informed of R2's fall and sent R2 out to the hospital. V3 also stated It is a given that mobility devices should always be within a residents reach. The facility Falls - Clinical Protocol dated as revised August 2008 documents the following: Assessment and Recognition 1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. a. Staff will ask the resident and the caregiver or family about a history of falling. b. The staff and physician should document in the medical record a history of one or more recent falls (for example, within 90 days). c. While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause. 2. In addition, the nurse shall assess and document/report the following: a. Vital signs b. Recent injury, especially fracture or head injury c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc. d. Change in cognition or level of consciousness e. Neurological status, Pain (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	g. Frequency and number of falls since last physician visit h. Precipitating factors, details on how fall occurred i. All current medications, especially those associated with dizziness or lethargy j. All active diagnose 3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, and illnesses affecting the central nervous system and blood pressure. The same protocol documents the following: Treatment/ Management 1. 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.