STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007488	A. BUILDING: _____ B. WING _____	C 12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS SENIOR LIVING	400 WEST WASHINGTON CHRISMAN, IL 61924

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2069438/IL129152	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review and interview the facility failed to prevent a fall and failed to ensure the safety of a medically compromised resident by not developing and implementing an individualized baseline care plan with specific targeted interventions to prevent falls for R4. The failure resulted in a fall for R4 who sustained an intertrochanteric fracture of the right hip. R4 is one of three residents reviewed for falls. Findings include: R4's Electronic Medical Record documents R4	S9999		

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S9999	Continued From page 2 admitted on 6/5/20 and discharged on 6/8/20. R4's Physician Order Sheet documents diagnoses of: Muscle Weakness, History of Falls, Thoracic (#9) Compression Fracture and Urinary Tract Infection. R4's Minimum Data Set dated 6/8/20 documents R4 as being independent in self-care and mobility prior to facility stay and requiring extensive assistance of two staff for transfers during stay. R4's Electronic Medical Record does not document a baseline Care Plan initiated. R4's Care Plan documents a focus area of falls with a fall intervention initiated on 6/6/20 of 15-minute checks. There was no intervention on this same Care Plan for R4's fall the morning of 6/7/20. Nurse Progress Notes dated 6/6/20 at 10:54 AM document R4 is "constantly up and down from bed to chair." These same Nurse Progress Notes dated 6/6/20 at 1:36 PM document R4 fell and received a skin tear to Left Elbow; 6/7/20 at 6:02 AM documents R4 had a fall with no injury; and documents another unwitnessed fall for R4 on 6/7/20 at 10:00 PM. The Nurse Progress Note dated 6/7/20 at 10:00 PM documents "(R4) is able to move legs but not completely stretched out. Upon rising, (R4) would not stand up straight and kept crossing right leg/ankle over left foot." Staff assisted R4 from floor position to wheelchair and again from wheelchair to bed without completing full assessment after fall. Nurse Progress Note documents R4 attempted to cross right leg/ankle over left foot with both transfers. This same progress note documents "R4 is unable to express self and very difficult to know if there is a problem or not." This same Nurse Progress Note documents a temporary fall	S9999		

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S9999	Continued From page 3 intervention after R4's 6/7/20 at 10:00 PM fall of placing R4 closer to nurses' station. R4's Diagnostic X-Ray obtained on 6/7/20 documents result of Acute Right Intertrochanteric Fracture of the Right Hip with varus deformity. On 12/4/20 at 2:35 PM V7 (Nurse Practitioner/NP) stated facility was aware that R4 had history of falling and was being admitted with a Thoracic Vertebrae (#9) Compression fracture which required R4 to wear a back brace, and a urinary tract infection which made R4 confused. V7 stated facility should have placed R4 on alarms, frequent checks and placed closer to the nurses' station from the time of admission. V7 stated R4 should have been more closely monitored by staff. V7 stated any new admission should require closer monitoring initially to check mobility status. V7 stated R4's Thoracic (#9) Compression Fracture put R4 at higher risk for injury. V7 stated facility may have prevented R4 from a fall with major injury if facility more closely monitored R4. On 12/4/20 at 3:45 PM V1 (Administrator) stated the facility did not create a baseline care plan for R4. V1 stated every resident should have a baseline care plan to allow staff information specific to resident and to be able to provide adequate care. V1 stated facility should have monitored R4 more closely to possibly prevent falls. (B)	S9999		