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 04/14/2022

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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S 000	Initial Comments Complaint Investigation: 2262635/IL145406	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 3001210c) 300.120d)5 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were NOT met as evidenced by: Based on record review and interview the facility failed to implement a baseline care plan for skin breakdown prevention, failed to complete assessments and wound treatments and failed to follow up on dietician recommended wound supplements for one of three residents (R1) reviewed for pressure sores in the sample of 13 residents. These failures resulted in the worsening of R1's stage three and unstageable pressure sores. Findings include:	S9999		

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S9999	Continued From page 2	S9999		

The facility policy titled 'Prevention of Pressure Ulcers' revised 2008 documents the following: "Review the resident's Care Plan to review for any special needs of the resident. The following are additional clinical conditions, treatments and abnormal lab values that indicate a resident is at risk for Pressure Ulcers: Impaired/decreased mobility and decreased functional ability, co-morbid conditions such as Diabetes Mellitus, Drugs such as steroids that may affect wound healing and Exposure of skin to urinary and fecal incontinence. The following will be necessary when providing preventative skin care: Pressure Risk Assessment Form and Intervention Preventative measures such as: use a draw sheet to assist in moving from side to side and up in the bed, skin to skin contact needs to be avoided by placement of pillows, folded sheets or clothing and change position every two hours as needed.

R1's undated Face Sheet documents an admission date of 8/14/21 and diagnoses of Parkinson's Disease, Diabetes Mellitus Type II, Acute Kidney Failure, Reduced Mobility, History of Urinary Tract Infections (UTI), Need for Assistance with Personal Care, Hypertension, Feeding Difficulties, Long Term Use of Insulin, and Idiopathic Gout.

R1's Minimum Data Set (MDS) dated 8/30/21 documents a Brief Interview for Mental Status (BIMS) score of 15 out of possible 15 points which indicates no cognitive impairment. This same MDS documents R1 as requiring two person extensive assistance with bed mobility, transfers and toileting.

R1's Clinical Admission Evaluation dated 8/14/21

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S9999	Continued From page 3 documents "reddened buttocks". R1's Baseline Care Plan does not document Pressure Ulcer interventions. R1's Initial Wound Evaluation and Management Summary dated 8/20/21 documents a sacral wound initial visit by Wound Physician (V6). This same summary documents R1's Sacral wound as partial thickness with light clear pink drainage. R1's Electronic Medical Record (EMR) documents a hospital stay from 8/20/21-8/24/21. R1's EMR does not document a skin/wound assessment for R1 upon return from hospital stay on 8/24/21. R1's Wound Evaluation and Management Summary dated 8/27/21 documents R1's Sacral Pressure Ulcer as Stage 3 as deteriorated due to larger size. This same Summary documents R1's Left Medial Buttock wound and Left Lateral Buttock wounds as new wounds. V6 Wound Physician ordered Therahoney sheet covered with bordered foam dressing daily for 30 days. R1's Treatment Administration Record (TAR) dated August 1-31, 2021 documents R1's Physician prescribed wound treatments were not signed off on 8/29/21 and 8/31/21. R1's Nutritional Assessment completed by V7 Registered Dietician (RD) dated 8/31/21 documents "recommend Prostat 30 milliliters (ml) daily and Arginaid one packet daily for wound support." R1's Medication Administration Record (MAR) dated August 1-31, 2021 and September 1-30, 2021 does not document Physician orders for	S9999		

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S9999	Continued From page 4 Prostat and Arginaid wound supplements. R1's Wound Evaluation and Management Summary dated 9/3/21 documents R1's sacrum wound as stage 3 with no change, R1's Left Medial Buttock Unstageable Pressure Ulcer as deteriorated due to infection and larger size; and Left Lateral Buttock Unstageable Pressure Ulcer deteriorated due to infection and larger size. V6 Wound Physician ordered Doxycycline and probiotic and ¼ strength bleach solution, gauze and dressing daily for all three wounds. On 9/6/21 at 9:45 PM V21 Licensed Practical Nurse (LPN) documented "Five small areas noted to Left Buttock, Wound Physician (V6) aware and treatment in place. Areas continue with greenish slough to wound bed with redness noted around wounds. Small shearing area noted to Sacrum. (R1) complained of burning sensation to Left Buttock during treatment." On 4/12/22 at 3:00 PM V5 Nurse Practitioner stated "Normally the Registered Dietician will make recommendations based on nutritional status of the resident. The recommendations for (R1) from the Registered Dietician were never received. We have no record of that." On 4/13/22 at 2:00 PM V7 Registered Dietician stated 'With my corporation, the expectation would be to recommend any dietary changes based on resident nutritional needs and give those recommendations to the facility, usually the DON (Director of Nursing) or ADON (Assistant Director of Nurses) and they get the Physician to sign, and then those orders get added to the system." On 4/8/21 at 3:00 PM V1 Administrator stated	S9999		

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S9999	Continued From page 5	S9999		

(R1) "was very compliant. She (R1) was very sweet and would do anything the staff asked of her (R1). I (V1) would not see how the wounds would have gotten any worse. We (facility) do not have any documentation that (R1)'s wounds were unavoidable. She (R1) admitted as a short term resident for therapy. She (R1) was supposed to return home. The pressure wounds (R1) had were obtained at this facility and also worsened at this facility. "

On 4/8/21 at 3:05 PM V3 Assistant Director of Nurses (ADON) stated (R1) admitted to facility after a hospital stay for knee surgery and a Urinary Tract Infection (UTI). V3 stated "the purpose of (R1) stay was short term rehabilitation. We (facility) do not have any documentation that shows that (R1) pressure wounds were unavoidable, by all accounts (R1) should not have had any pressure wounds and they certainly should not have gotten worse. (R1) went out to the hospital from 8/20/22-8/24/22. When (R1) came back from that hospital stay (R1) did not have had a complete skin and wound assessment completed. We (facility) do not have any documentation for that."

On 4/12/21 at 3:00 PM V5 Nurse Practitioner stated "did not personally lay eyes on wounds of (R1). My (V5) admission assessment was based on the documentation from the hospital discharge records on 8/14/21. Staff should enter orders when they are received. This facility does have a (V6) Wound Physician who makes rounds on Friday afternoons with a facility nurse. Sometimes the hardcopy of (V6) orders are not received until two days after (V6) makes rounds. If a resident such as (R1) has multiple comorbidities, uncontrollable high blood sugars and is on a steroid for (R1) Gout flare up then

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S9999	Continued From page 6 (R1) would be high risk for those wounds to worsen. Those wound orders should have been put in the same day they were received. If there is a delay, the wound could get worse or could get infected." V5 Nurse Practitioner stated "wounds need to be addressed and treated to have optimal healing potential and that any delay in wound care could mean that the wound could deteriorate and possibly cause infection in the wound." On 4/13/22 at 10:55 AM (V4) Medical Director/PCP stated 'We (facility) failed this resident (R1). This facility has gotten much better at notifying the providers of areas of care that need addressed but obviously we dropped the ball for this person (R1). The facility staff are being re-educated on documentation and importance of providing timely interventions. She (R1) was very compromised with all of her medical conditions. She had acute hyperglycemic episodes, uncontrolled Diabetes Mellitus and Gout flare up. The Prednisone was ordered to help regulate the Gout, but that also can elevate blood sugars and deter wounds from healing. She (R1) had many chronic conditions that could contribute to the formation and worsening of her wounds, but this facility also did not treat these wounds as they should have. I can't say 100% that her wounds were preventable due to all of her other conditions and especially the Diabetes. The facility has had some major communication and documentation errors in this case and they are working on those." (B)	S9999		