Illinois Department of Public Health

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 ______	R-C 06/18/2024

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 First Complaint Revisit to Survey date 5/23/24, Complaint #2463664/IL172973	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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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 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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

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These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide adequate supervision and implement effective fall interventions for a resident (R4) at high risk for falls. The facility also failed to assess, provide a safe transfer post fall, complete a fall investigation and Neurological Assessments for another resident (R6). These failures affect two (R4, R6) residents out of five residents reviewed for falls in a sample list of five residents. These failures resulted in R4 falling and sustaining Bilateral Subacute Subdural Hematomas.

Findings include:

1.) R4's undated Medical Diagnosis List documents R4's medical diagnoses as Diabetes Mellitus Type II, Chronic Congestive Heart Failure, Kidney Failure, Persistent Atrial Fibrillation, Muscle Weakness, Abnormalities of Gait and Mobility, Dementia, Unsteady on Feet and History of Falling.

R4's Minimum Data Set (MDS) dated 4/24/24 documents R4 as severely cognitively impaired. This same MDS documents R4 requires maximum assistance for toileting, bathing, dressing, personal hygiene and transfers.

R4's Care Plan intervention dated 1/24/24 instructs staff to ensure R4 is wearing proper footwear when ambulating or transferring, intervention dated 5/20/24 documents R4 is to have a chair alarm to personal chair and intervention dated 6/7/24 documents R4 is to have a (wheelchair lap cushion) to wheelchair.

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S9999	Continued From page 3 R4's Physician Order Sheet (POS) dated May 2024 documents a physician order starting 4/5/24 and ending 6/3/24 for Apixaban 2.5 milligrams (mg) daily (anticoagulant). This same POS documents a physician order for Aspirin 81 mg daily starting 6/3/24. R4's Computerized Tomography (CT) of the head without contrast dated 6/3/24 documents "Impression: Subacute to Chronic Bilateral Subdural Hemorrhage measure nine millimeters (mm) on the Right side and four mm on the Left side." R4's undated fall investigation documents R4 had an unwitnessed fall at 4:00 AM on 6/3/24 when attempting to ambulate to the bathroom. This report documents "(R4) was given a shower at 10:00 PM and assisted into bed. (R4) was observed sleeping at approximately 2:00 AM." This same report documents "(V18) Agency Licensed Practical Nurse (LPN) noted a Hematoma to the back of (R4's) head and sent (R4) to the emergency department per policy. Imaging in the emergency department revealed a Subacute to Chronic Subdural Hematoma. (R4's) last Computerized Tomography (CT) scan was on April 4, 2024, hospital stated it is new since this scan. (R4) received Vitamin K and Kcentra at the hospital. A medication review was done in the hospital. Eliquis was discontinued and (R4) was started on Zyprexa every bedtime. Root Cause: Loss of balance due to attempting to go to the bathroom without the use of assistive device." R4's Final Incident Report to the State Agency dated 6/7/24 documents R4 fell at the facility on 6/3/24 at 4:00 AM resulting in Bilateral Subacute Subdural Hematoma's. This same report	S9999		

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documents R4 was assisted to bed at 10:00 PM on the evening of 6/2/24 and then observed sleeping in his bed at 2:00 AM. This same report documents "(R4's) bed alarm was sounding and (R7) the resident sharing the conjoining bathroom with (R4) called out for staff assistance. The closest staff member was providing care to another resident at the time. The staff member ensured the resident she was caring for was safe and responded. Staff noted (R4) was sitting on the floor in front of the bathroom against his roommates wheelchair. (R4) was attempting to ambulate to the bathroom without his assistive device and (R4) lost his balance. The nurse on duty observed what she thought was a Hematoma forming on the back of (R4's) head and sent (R4) to the emergency department for additional evaluation. Imaging in the emergency department revealed Bilateral Subacute on Chronic Subdural Hematoma's. (R4) was treated with Vitamin K and Kcentra in the emergency department and returned to the facility after being monitored in observation.

R4's Hospital Record dated 6/3/24 documents R4's chief complaint as a fall. This same record documents "Status post multiple ground level falls while anticoagulant on Eliquis with Bilateral Subdural Hematoma's, the Right measuring nine millimeters (mm) and the Left measuring four mm in greatest thickness. (R4) is no longer a candidate to receive full dose anticoagulation due to his fall frequency. Will wait 72 hours and start baby Aspirin for secondary Stroke prophylaxis." This same hospital record documents "Inpatient Diagnosis: Subdural Hematoma onset 6/3/24. Small purplish discoloration bruising of the Left Periorbital area without bony tenderness to the Zygomatic Arch or Orbital Rim. Various stages of healing of superficial abrasions are seen as well.

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Small Abrasion Right Parietal Posterior Scalp. Critical care time was performed to assess and manage the high probability of imminent, life-threatening deterioration that could result in multi-organ failure."

On 6/14/24 at 11:25 AM R4 was sitting in his wheelchair next to the nurses station. R4's (wheelchair lap cusion) was sitting on the floor next to R4. R4 was not wearing non-skid socks and did not have a pressure alarm in his wheelchair. No staff were present.

On 6/14/24 at 11:30 AM V5 Certified Nurse Aide (CNA) stated R4 was assisted out of bed earlier in the morning by night shift staff. V5 stated R4 is supposed to wear non-skid socks and have a pressure alarm in his wheelchair. V5 CNA stated "(R4) is a very high fall risk and he should always have his fall interventions in place. Otherwise, (R4) could very easily fall again. (R4) doesn't realize he could get hurt. I checked (R4's) careplan that is in the new folder at the desk and it says (R4) is supposed to have the pressure alarm when he is up in his personal chair. That would be his wheelchair so (R4) should have the pressure alarm on. It looks like the careplan they gave us is not up to date."

On 6/14/24 at 1:00 PM V11 Nurse Practitioner (NP) stated R4 is a very high fall risk. V11 stated R4 has fallen multiple times and received several serious injuries while at facility. V11 NP stated "(R4) obtained a large Hematoma and extensive bruising from his 5/5/24 fall. I had ordered X-Rays for that fall that were negative but since the Telehealth Physician did not send (R4) to the hospital a Computerized Tomography (CT) scan was never completed. The last CT that was completed per (R4's) Hospital records was 4/4/24

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with no abnormalities noted. The next CT (R4) had completed was after his fall on 6/3/24 which reported subacute to chronic bilateral Subdural Hematoma. This means (R4) had a chronic Subdural Hematoma from a previous head injury and now a new acute Subdural Hematoma from his fall on 6/3/24. Since (R4) has not had any other head injuries the chronic Subdural Hematoma would be from his fall at the facility on 5/5/24 and now another one on 6/3/24 while under their (facility) care. Those two falls (5/5/24 and 6/3/24) were very similar. The staff should be monitoring (R4) much more closely than what they were." V11 confirmed R4's injury was from the fall on 6/3/24.

On 6/14/24 at 1:38 PM V13 Agency Registered Nurse (RN) stated V13 is R4's nurse today (6/14/24). V13 stated "(R4) has had several falls and some with head injuries. I am an agency nurse but I work at this facility every week or so. (R4) has had a major decline in his functioning in the past few weeks because of his head injuries. (R4) was up walking with a walker and now he is bound to a wheelchair. (R4) still tries to stand and should definitely have all of his fall interventions in place. The staff should be watching (R4) like a "hawk" due to his poor safety awareness and history of falls with injuries. I will make sure (R4) gets those fall interventions in place."

On 6/15/24 at 9:25 PM V17 Certified Nurse Aide (CNA) stated V17 was assisting another resident at the tine of R4's unwitnessed fall on 6/3/24. V17 stated "I heard another resident (R7) hollering out so I went to investigate. I never heard (R6's) alarm sounding until I got to his room. (R7) told me (R6) had fallen. (R7) and (R6) live on different halls but share a bathroom.

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(R6) was sitting on his buttocks next to (R7's) wheelchair in R6's room in between (R6's) bed and bathroom. V17 stated R6 had hit his head on the arm of the wheelchair. V17 stated V17 was told in the shift to shift report at 10:00 PM on 6/2/24 that R6 had been 'up and down all evening and had been trying to get up out of his wheelchair and bed multiple times'. V17 stated "I usually assist (R6) to the toilet every two hours but that night he was sleeping. I didn't want to wake him up. I wanted to just leave him be so (R6) wouldn't be wanting to be up and down again. (R6) takes a lot of attention when he is awake. I didn't wake (R6) up because I was afraid he would fall. "

On 6/17/24 at 5:20 AM V18 Agency Licensed Practical Nurse (LPN) stated R4 had an unwitnessed fall at 4:00 AM the morning of 6/3/24. V18 stated R4 is a high fall risk resident who requires the staff's attention when he is awake. V18 stated "That night I remember (R4) slept a lot. I thought the staff were taking (R4) to the bathroom every two hours. I did not realize it was six hours between staff toileting (R6). (R6) should be checked and changed every two hours around the clock. I hate that some residents would have their sleep disrupted but if the alternative is falling, then we (staff) are to get that resident up."

2.) R6's undated Face Sheet documents R6 medical diagnoses as Dementia, Cerebral Infarction, Reduced Mobility, Abnormalities of Gait and Mobility, Intervertebral Disc Degeneration Lumbar Region, Macular Degeneration, Osteoarthritis, Muscle Weakness, Cervical Disc Degeneration, Need for Assistance with Personal Care and Unsteady on Feet.

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R6's Minimum Data Set (MDS) dated 4/10/24 documents R6 as severely cognitively impaired. This same MDS documents R6 requires maximum assistance (helper does more than half the effort) for bathing, dressing, bed mobility, personal hygiene and transfers.

R6's Care Plan intervention dated 2/8/24 documents R6 requires two staff for transfers and is weight bearing as tolerated.

R6's Physician Order Sheet (POS) dated June 2024 documents a physician order stating 5/18/2024 for Aspirin 81 milligrams (mg) daily.

R6's Fall Risk Evaluation dated 2/20/24 documents R6 as a high risk for falls.

R6's Nurse Practitioner Progress Note dated 6/10/24 at 2:32 PM documents "(R6) is being seen today related to recent multiple falls. (R6) has apparently fallen from her chair. (R6) would benefit from a different chair, low adjustable back, dumped or cushion are different options for safety."

The facility was unable to provide Neurological Assessments and Fall investigation for R6's unwitnessed fall on 6/14/24.

On 6/14/24 at 11: 39 AM R6 was sitting next to her wheelchair at the end of a resident hallway. R6's pressure alarm was sounding with no staff present.

On 6/14/24 at 11:43 AM V8 Certified Nurse Aide (CNA) attempted to lift R6 without using a gait belt back into her wheelchair by putting her arms underneath R6's underarms (face to face). V8 CNA was able to lift R6 up off of the floor two

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inches and then sat R6 back down on the floor. V7 Certified Nurse Aide (CNA) then applied a gait belt to R6's waist and assisted V8 CNA to assist R6 back up into her wheelchair. V7 CNA nor V8 CNA called for a nurse to assess R6 prior to lifting R6 back into her wheelchair. V7 CNA and V8 CNA then assisted R6 to her bed. V7 CNA called for R6's nurse to assess R6 after R6 was assisted to bed.

On 6/14/24 at 11:55 AM V1 Administrator stated R6 is care planned for putting herself on the floor but if the staff do not witness R6 doing that then the incident should be considered an unwitnessed fall. V1 Administrator state R6's nurse should have been called to assess R6 prior to the staff assisting her off of the floor.

On 6/14/24 at 12:05 PM V10 Registered Nurse (RN) stated V10 was not notified of R6 sitting on the floor in the hallway. V10 RN stated "I am (R6's) nurse today. The staff called me to assess (R6) after they (V7, V8) put her to bed. They (staff) should have called me prior to that. (R6) was assessed and had no injury but (V7, V8) did not know that when they were transferring her from the floor to her wheelchair."

The facility policy titled 'Falls-Clinical Protocol' revised May 2024 documents a Fall Risk Assessment shall be completed on admission, quarterly, after a fall and as clinically indicated. In addition, the nurse shall assess and document/report the following: Vital signs, recent injury, musculoskeletal function, change in condition, neurological status, pain frequency/number of falls since last Physician visit, precipitating factors, details on how the fall occurred, all current medications and all active diagnoses. The staff will evaluate and documents

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S9999	Continued From page 10 falls that occur while the individual is in the facility; for example, when and where they happen;, any observations of the events, etc. Falls should be identified as witnessed or unwitnessed events. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. 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. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If a resident has an unwitnessed fall or hits their head initiate Neurological checks. If a resident has an unwitnessed fall or hits their head and is on anticoagulation medications then send the resident to the emergency room for an evaluation. (B)	S9999		