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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>146037 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>08/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Pleasant Meadows Senior Living |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>400 West Washington<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32172</p> <p>Based on interview and record review the facility failed to protect the residents' right to be free from verbal abuse by another resident. This failure affected two of four residents (R5, R6) reviewed for abuse in the sample of nine.</p> <p>Findings Include:</p> <p>The facility's Abuse Prevention Program dated October 2022 documents the facility affirms the right of it's residents to be free from abuse or mistreatment. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident.</p> <p>The Abuse Investigation Summary dated 7/19/24 documents R5 and R6 were in a verbal altercation in their shared room. R5 began calling the staff name and telling them to get the F*** (expletive) out of his room or he would shoot them. His roommate (R6) then came out of the bathroom and R5 started to yell at R6 and told him to get the F*** (expletive) out of the his room or he would shoot him. R6 responded by telling R5 that he would kick his a** (expletive).</p> <p>R5's Medical Diagnoses sheet dated August 2024 documents R5 is diagnosed with Anxiety and Unspecified Symptoms and Signs involving Cognitive Function and Awareness.</p> <p>R5's Minimum Data Set (MDS) dated [DATE] documents R5 is severely cognitively impaired.</p> <p>R5's Care Plan dated 7/19/24 documents R5 is at moderate risk for abuse related to his dependency on others, Dementia, and Anxiety.</p> <p>R6's Medical Diagnoses sheet dated August 2024 documents R6 is diagnosed with Parkinson's Disease and Depression.</p> <p>R6's Minimum Data Set (MDS) dated [DATE] documents R6 is moderately cognitively impaired. R6 could not recall details of the verbal altercation.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R6's Care Plan dated 9/27/23 documents R6 is at low risk for abuse related to depression however does have a history of resident to resident inappropriate sexual behavior.</p> <p>On 8/2/24 at 10:28 AM V9 Licensed Practical Nurse (LPN) stated R5 does get loud and curses often when he is upset. He is very confused and can get agitated.</p> <p>On 8/6/24 at 4:37 PM V20 Certified Nurses Assistant (CNA) stated R5's alarm was going off and she entered his room. R5 told her to get the F*** (expletive) out of his room. R6 came out of the bathroom and R5 told him to get the F*** (expletive) out and if he didn't he (R5) would get his gun and blow R6's head off. R6 then responded by saying he would like to see him try and he will get his a** (expletive) kicked.</p> <p>On 8/2/24 at 2:51 PM V1 Administrator confirmed the verbal abuse and physical threat of violence between R5 and R6 did occur.</p> |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32172</p> <p>Based on interview and record review the facility failed to protect the resident's right to be free from abuse by failing to prevent misappropriation of a resident's physician prescribed medication. This failure affected one of three residents (R3) reviewed for abuse in the sample of nine.</p> <p>Findings Include:</p> <p>The Abuse Prevention Program dated October 2022 documents the term Abuse can include misappropriation of resident property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>The Incident Report for the incident of 7/22/24 documents R3's Semaglutide Injectable medication could not be found.</p> <p>R3's Physician Order Sheet dated July 2024 documents R3 is diagnosed with Diabetes. R3 is also prescribed Solution Pen-Injector 4 Milligrams/3 Milliliters (Semaglutide) - Inject 1 Milligram subcutaneous, once every Sunday related to Diabetes Mellitus. This medication order started on 7/15/24.</p> <p>R3's Minimum Data Set, dated dated dated [DATE] documents R3 is cognitively intact.</p> <p>R3's Care Plan dated 7/16/24 documents R3 is at moderate risk for abuse related to dependence on others, Depression, and chronic complaints of Pain and Anxiety.</p> <p>On 8/2/24 at 12:35 PM R3 stated her family brought in her Semaglutide medication from home. R3 stated one full box or one months supply was brought in and stored in the facility's refrigerator. R3 stated this is the box that went missing. R3 stated V6 Licensed Practical Nurse (LPN) was to administer the first dose from the new box on 7/21/24 but realized the medication was no longer in the refrigerator. R3 stated the facility completed an investigation and determined her medication was missing but could not determine who took the medication or where it had gone. R3 confirmed the facility replaced the missing medication which cost almost \$1200 out of pocket.</p> <p>On 8/2/24 at 11:43 AM V6 LPN stated she placed R3's Semaglutide medication in the medication room refrigerator on 7/15/24. V6 stated on 7/21/24 she was supposed to give R3 her ordered dose of Semaglutide. V6 stated she went to get the new unopened box from the refrigerator and it was no longer there. She looked for it and could not find it anywhere. V6 reported the missing medication to V1 Administrator.</p> <p>On 8/2/24 at 2:51 PM V1 Administrator confirmed the misappropriation occurred. R3's Semaglutide medication did go missing and after a thorough investigation the facility could not determine who took the medication.</p> |  |  |