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	09/25/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on record review and interview the facility failed to ensure a resident (R1) received appropriate treatment for an infection of the heart muscle. The facility also failed to ensure the physician and Nurse Practitioner were aware of R1's infection treatment plan. Theses failures affect one (R1) of three residents reviewed for IV Medication/Infection in a sample list of three residents. These failures resulted in (R1) being hospitalized with sepsis and subsequently expiring due to R1's worsening infection. These failures resulted in Immediate Jeopardy. The Immediate Jeopardy began on [DATE] at 6:42PM when R1's antibiotic intravenous treatment was changed for Enterococcus with Endocarditis without physician coordination of R1's Infectious Disease plan when discharged from the hospital ([DATE]). V1, Administrator, was notified of the Immediate Jeopardy on [DATE] at 11:09 AM. The surveyor confirmed by interview and record review the Immediate Jeopardy was removed on [DATE] at 2:30PM but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of continuing audits, education, and initiation of plan of correction. Findings include: R1's Progress Note dated [DATE] at 6:42PM documents R1 was admitted to the facility following hospitalization (as documented on R1's Post Acute Care Transition Document dated [DATE]) for Sepsis secondary to cellulitis, Bacteremia with Enterococcus with Endocarditis, Atrial Fibrillation with Rapid Ventricular Response (RVR), RVR likely triggered from Sepsis, Sepsis on admission with Tachycardia, Leukocytosis. Blood Cultures Positive for Enterococcus. Repeat Blood Cultures Positive for Gram Positive Cocci in Chains. Repeat Blood Cultures Negative. Percutaneous Intravenous Central Catheter (PICC) line placed on day of discharge. Infectious Disease consult recommended six weeks of Intravenous Vancomycin. Further Infectious Disease recommendations as mentioned in discharge instructions for lab orders and monitoring. Cardiology consulted Transesophageal Echocardiogram showed Mitral Vegetation. Discharge to (the facility) with six weeks of Intravenous Vancomycin. R1's Progress Note dated [DATE] documents V10, Licensed Practical Nurse (LPN) entered the correct hospital discharge order for Vancomycin 1000 Milligrams by IV Route every 48 hours for 40 days. in R1's electronic medical record. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility order report for R1 dated [DATE] documents CBC with diff, CMP, Vanco trough (goal ,d+[DATE]) weekly **Fax results to (Fax#) Attn: (infectious disease specialist) one time a day every Mon for Vanco administration until [DATE], there was no documentation provided that reports were faxed as ordered Monday, [DATE]. R1's Post Acute Care Transition Document was uploaded to R1's electronic medical record on [DATE]. On [DATE] at 11:46AM V1 Administrator verified This document and other transfer information arrived with the resident via ambulance and were given to the admitting nurse. On [DATE] at 10:00AM V11, Registered nurse (RN) confirmed Pharmacy notified V11, Registered nurse (RN) R1's Vancomycin was changed to 1000 Milligrams every 24 hours on [DATE]. V11 confirmed V11 was instructed by pharmacy to change the Vancomycin order from every 48 hours to every 24 hours 1,000 Milligrams Per PICC line. V11 stated I don't change anything with a Vancomycin order unless Pharmacy or the Nurse Practitioner give me an order, V6, Nurse Practitioner signed the order. No lab was drawn and there is no rationale documented to justify the change. On [DATE] at 11:15AM V9 Registered Pharmacist (IV service) stated I believe the change in the Vancomycin order for (R1) was not done by pharmacy intentionally. The only trough (antibiotic dose testing) and kidney function test the pharmacy had at the time the order was changed was the hospital trough which was 16 ug/mL(micrograms per milliliter) and Creatinine was within normal limits so there was no rationale for the order to be changed. R1 Medication administration record for June and [DATE] documents R1 received the 1000 Milligram dose of Vancomycin daily [DATE], [DATE], [DATE] and [DATE]. A Vancomycin trough, Complete Blood Count, and Comprehensive Metabolic Panel was obtained prior to the administration of the [DATE] dose of Vancomycin. The lab reported a panic level of Vancomycin at 37.4 and a Creatinine of 3.9, and a Glomerular Filtration Rate of 12% which the lab report documents indicate Kidney Failure. Following these lab values one more dose of 1000 milligrams of Vancomycin was administered prior to discontinuing on [DATE] by V6, Nurse Practitioner. V6 then ordered Clindamycin 150 Milligrams three times daily for 10 days for cellulitis. On [DATE] at 2:00PM V6 (NP) stated (R1) was admitted after (R1) was hospitalized for Sepsis due to Cellulitis. I wasn't aware there was an admitting diagnosis of Bacterial Endocarditis. On [DATE] at 1:42PM V13, Medical Director stated I was not aware that (R1) had Endocarditis. I thought the Clindamycin was appropriate because I believed (R1) was being treated for cellulitis. Had I been aware of the Endocarditis and the abnormal trough and kidney function I would have had (R1) sent out to the hospital. R1's Progress Note dated [DATE] at 1:04PM documents R1 experienced nausea and vomiting and had felt unwell since the prior day and was sent out to the hospital. R1 was admitted with Sepsis. R1 was treated until R1 expired on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Hospital Admission record dated [DATE] by emergency room Physician documents (R1) presents to Emergency Department with recurrence of presentation that (R1) was hospitalized last month at (other hospital) for. Patient (has) Recurrent Cellulitis Leading to Sepsis, Infectious Endocarditis, with recurrent Atrial Fibrillation with RVR. Was supposed to be discharged with six weeks Intravenous Vancomycin. Patient (does) not have PICC line in currently. This same record documents R1 had a [NAME] Blood Count of 25.8 (normal reference range 4XXX,d+[DATE].00) and Lactic Acid 3.2 (normal reference range 0XXX,d+[DATE]. 0). On [DATE] at 2:53PM V7, Infectious Disease Physician (from the hospital) R1 was admitted to on [DATE] stated The lack of care for (R1) at (the facility) caused (R1) to be rehospitalized with Sepsis from Endocarditis. Ultimately (R1) had a stroke in my opinion from a bit of vegetation that broke off from (R1's) heart and traveled to (R1's) brain. I believe the lack of appropriate care at (the facility) hastened (R1's) death. (R1's) Endocarditis was caused by enterococcus. Enterococcus is not even susceptible to the clindamycin they put (R1) on at (the facility). R1's death certificate dated [DATE] lists R1's cause of death as Acute Onset Chronic Respiratory Failure Metabolic Toxic Encephalopathy secondary to Recent Endocarditis with Enterococcus Faecalis Valve Endocarditis. The Facility Assessment last reviewed [DATE] states Infection Prevention: 24-hour Communication Report is reviewed and if any concerns it is addressed. An Infection Control/Preventionist (ICP) all aspects of prevention and infection control including policy and plan development, recording, and staff training. All new orders are checked a daily and if an antibiotic is ordered an infection verification form is completed to see if the signs and symptoms met criteria. Then resident is placed on log with appropriate information and plotted on facility floor plan to track and watch for trending. If any trends are identified staff, visitors, families, and residents are given education as appropriate. The ICP reports weekly to the NHSN database all COVID related information, performs weekly resident and staff COVID testing, and keeps a log of call-ins with signs and symptoms from all employees and consults with local public health officials to ensure the highest level of infection control is received. The Immediate Jeopardy that began on [DATE] at 6:42PM was removed on [DATE] at 2:30PM when the facility took the following actions to remove the immediacy: 1. The corrective action(s) taken for the resident(s) found to have been affected by the deficient practice: R1 did not return to the facility. 2. The corrective action(s) for other resident(s) having the potential to be affected by the same deficient practice: All residents on IV antibiotics have the potential to be affected by this practice. R2 has the potential to be affected by the same deficient practice. All ancillary orders necessary for the care and maintenance of R2's access port were reviewed for accuracy. This was completed on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON confirmed R2's antibiotic orders were correct with the prescribing MD on [DATE]. 3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: IT confirmed on [DATE] that the facility contracted Medical Director and Nurse Practitioner have remote access to Point Click Care and Point Click Care Connect. IV antibiotic orders for all current residents were reviewed for accuracy by Infection Preventions to include indication, dosage, access type and location, and all necessary ancillary orders. Any identified discrepancies were brought to the attention of the MD/NP. This was completed on [DATE]. All new admission discharge notes will be reviewed during the AM clinical meeting by Medical Records or designee, the DON or designee, and the MDS coordinator or designee the following business day. All discrepancies will be reported to the MD/NP. Any pharmacy recommended antibiotic dosage changes, discontinuation of antibiotic treatment prior to end date ordered by the facility's contracted MD or NP, or initiation of another antibiotic in lieu of the facility's contracted MD's or NP's prescribed antibiotic treatment will first be approved by the prescribing physician. The DON, Nurse Practitioner, and the Infection Preventionist were educated by the Administrator on how to view new or changed antibiotic orders on the clinical dashboard in Point Click Care. This was completed on [DATE]. Corporate Consultant educated DON on medication and treatment reconciliation for admissions/readmissions. This was completed on [DATE]. 4. To ensure the deficient practice does not reoccur, the corrective actions(s) will be monitored by: The DON or designee will audit all new admission/readmissions to ensure that all orders and diagnoses have been accurately transcribed. This audit will be completed the next business day after each admission/readmission and will be an ongoing review. Any identified issues will be immediately corrected. Infection Preventionist or designee will review the Point Click Care dashboard daily for any new antibiotic orders to ensure that the antibiotic therapy is appropriate. Any changes to existing antibiotic orders or discrepancies will be reported to the MD/NP immediately to ensure that they are aware of the change and notified of the discrepancy. This will be an ongoing review. The QAPI Committee will monitor results for compliance. 5. Completion date systemic changes will be completed: [DATE] The facility removal plan was submitted [DATE] reviewed, revised and accepted [DATE].

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on observation, interview and record review the facility failed to provide residents intravenous therapy consistent with professional standards of practice. The facility failed to complete residents intravenous (IV) dressing changes, monitor document required measurements, specify type of intravenous (IV) access device (R1, R2 peripheral central venous catheter, and R3 implantable venous access device) including anatomical location of the residents device with an IV care plan for specific interventions. The facility also failed to obtain orders for residents IV dressing changes, device flushes, need to monitor for signs and symptoms of infection and infiltration. These failures affected three of three residents (R1, R2 and R3) reviewed for intravenous medication administration on the sample list of three. Findings include 1.) R1's progress note dated 6/26/24 at 6:42PM documents R1 was admitted to the facility following hospitalization (as documented on R1's Post Acute Care Transition Document dated 6/26/24) for Sepsis secondary to cellulitis, Bacteremia with Enterococcus with Endocarditis, Atrial Fibrillation with Rapid Ventricular Response (RVR), RVR likely triggered from Sepsis, Sepsis on admission with Tachycardia, Leukocytosis. Blood Cultures Positive for Enterococcus. Repeat Blood Cultures Positive for Gram Positive Cocci in Chains. Repeat Blood Cultures Negative. Percutaneous Intravenous Central Catheter (PICC) line placed on day of discharge. Infectious Disease consult recommended six weeks of Intravenous Vancomycin. Further Infectious Disease recommendations as mentioned in discharge instructions for lab orders and monitoring. Cardiology consulted Transesophageal Echocardiogram showed Mitral Vegetation. Discharge to (the facility) with six weeks of Intravenous Vancomycin. There is no documentation in R1's electronic medical record to indicate care of R1's PICC line (monitored or assessed for length of line, circumference of arm, or signs and symptoms of infection/infiltration). R1's PICC Line maintenance is not included on R1's care Plan. On 9/19/24 at 2:00PM V1, Administrator stated I see in our system where the nursing staff could have added parameters for the PICC Line and failed to do so. 31642 2.) R2's Diagnoses Sheet dated 9/5/24 on admission to the facility documents the following: Encounter For Other Orthopedic Aftercare, Unspecified Fracture Of Shaft of Right Tibia, Subsequent Encounter for Closed Fracture With Routine Healing and Diabetes Type II Without Complications. On 9/19/24 at 3:05 pm V2, Director of Nursing submitted the following: R2's TRAVEL CARD the identifies the type of IV (intravenous access) R2 has. The card documents the following: Always carry your Xcel PICC with PASV Valve Technology Travel Card with you. This card has important information about your catheter that healthcare providers will need to care for you. The travel card then documents the length of the PICC line on the insertion date of 8/22/24 was 46 centimeters. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 Physician Order Summary (POS) sheet dated September 2024 documents the following: Vancomycin (antibiotic) HCl in NaCl Intravenous Solution 1.5-0.9 GM/250ML-% (Vancomycin) HCl-Sodium Chloride, Use 1.5 gram intravenously in the morning for infection until 10/01/2024. The same POS does not document the type of IV access R2 has, the location of R2's IV site, IV flush order to be administered, monitoring for infiltration and/or infection, measuring the catheter from the insertion site nor need for sterile dressing changes to maintain access site. R2's corresponding September 1-30, 2024 Medication Administrator Record (MAR) and Treatment Administration Record (TAR) do not document an IV flush was administered 9/6/24- 9/10/24 (R2 was in the hospital 9/11/24) and 9/12/24 in conjunction with the antibiotic Vancomycin IV administered on those days. There are no dressing changes, monitoring or measurement documented. R2's Corresponding Nurses Notes do not documents the IV services were provided. R2's Care Plan Care Plan dated 9/11/24 documents under the care are focused of skin/admitted with a surgical incision and is on IV medication. The care plan does not document type of intravenous access, location of IV for the administration of IV antibiotics, IV flush information, dressing changes, nor measurements for R2's PICC IV access. 3.) R3's current diagnoses sheet documents the following: Hemiplegia Unspecified Affecting Right Dominant Side and Diabetes Mellitus II and Acquired Absence of Other Toe(s) Unspecified Side. R3's (distant hospital) Wound Clinic note dated 8/28/24 documents R3 was started on IV antibiotics post toe amputations. R3 was started on Cubicin and Invanz (Invanz was discontinued 9/3/24). There is no documented type of IV access documented. R3's POS sheet dated September 2024 documents the following: Cubicin (antibiotic medication) Intravenous Solution Reconstituted 500 MG (Daptomycin) Use 300 mg (milligrams) intravenously in the morning for gangrene for 4 Weeks-Start Date 08/28/2024. R3's same POS does not document the type of IV access R3, the locations of R3's IV site, an IV flush order to be administered, monitoring for infiltration and infection replace the Huber needle to port catheter or indicated the IV dressing should be changed to maintain the sterile access IV port site. R3's Minimum Data Set, dated dated dated [DATE] documents R3 has a Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment. On 9/18/24 at 2:05 pm R3 lifts left foot which had a coban wrap (self-adherent elastic wrap that sticks only to itself) over the left foot and ankle. R3 stated This is what I get my antibiotic for. A bad infection they are trying to get rid of. I am diabetic and I may have to have part of my leg removed (amputated) because I don't have enough circulation in my leg. I get my iv medications here (R3 pulls collar of shirt over to reveal an IV port on her right chest). There is no date on the transparent IV dressing. R3 stated The dressing has not been changed since she has started the antibiotic (8/28/24). R3's September MAR and TAR does not indicate type of R3's IV access, the anatomical location of R3's IV site, an IV flush order to be administered, monitoring for infiltration and infection, replace the Huber needle to port catheter nor indicated the IV dressing should be changed to maintain the sterile access IV port site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Care Plan documents last updated 8/19/24 was not updated to include R3's IV site monitoring for infection, dressing changes and care. On 9/18/24 at 1:20 pm V1 Administrator /Registered Nurse and V6, Nurse Practitioner together reviewed the electronic medical records for R2 and R3. Neither could find the information to confirm IV location or monitoring IV site, dressing changes or flush orders. Nothing on POS, Care Plan, TAR or MAR. V6 stated R2 and R3's IV sites should be identified. V1 and V6 were sure, off the top of their heads, what type or location R2 and R3's IV site was. V1 and V6 stated this information for both residents should be included and the antibiotic orders are to document the type of the infection that is being treated should also be on the mar. The specific type of IV monitoring should be on the Treatment sheet. If either access site is an IV PICC line they facility nurses should be measuring the circumference of the residents arm and the length of the catheter to ensure placement remains intact. V6 stated I was just getting ready to change the monitoring to every shift instead of every 24 hours for both (R2 and R3), I did not realize until now that the nurses have not been monitoring the IV sites. There is nothing on the MAR or TAR. V1 then stated the care plans for both R2 and R3 should reflect the residents current IV status with detailed monitoring for sign and symptoms of infiltration and infection. I am not sure why the care plans and orders are incomplete. On 9/19/24 at 12:55 pm V14, Licensed Practical Nurse/Care Plan Coordinator confirmed interventions for R2 and R3 were not complete on the care plan. Under skin she documented IV antibiotic for infections but failed to document location, specific IV type frequency of monitoring. V14 stated that that information is usually on the POS / MAR and TAR. She did not know and had not been told to put interventions for the actual IV category only that the IV antibiotics are part of the interventions for the wounds. On 9/19/24 at 2:45 pm V19, Registered Nurse stated she administered R3's antibiotic via Right Subclavian Intravenous Port today, after changing the Huber needle, which should have been changed weekly. V19 stated she changed the IV port dressing but could not say if there was a date on the dressing. She has not changed it since R3 was started on IV antibiotics. V19 stated V19 completed normal saline flush before and after administering the antibiotic. The flush was 10 cc normal saline each time. All of these things should have been on the MAR to confirm the care was being provided. They have been added today. V19, RN also stated R2's had a PICC line to her left upper arm. Her orders will be updated when she returns from the hospital. We can't enter anything because she is not actively in the facility so all orders have been d/c at this point. The facility policy Medication Ordering, Receiving and Storage dated as effective May 2015 documents the following: PHYSICIAN IV ORDERS Policy The purpose of this policy is to provide guidelines for IV medication orders to be consistent with principles of safe and effective order writing so that all prescribed medications are administered safely and accurately. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	General Guidelines 3. Each facility, in conjunction with the Consultant Pharmacist, (name of pharmacy) Pharmacists and the Medical Director, shall identify and approve appropriate order writing practices and related policies. They shall also approve any modifications to the list of approved abbreviations. 4. Physicians shall provide timely, accurate, and complete orders. 5.Verbal or Telephone Orders in the facility: a. Verbal or telephone orders shall be given in an emergency situation or when the Attending Physician is not immediately available to write or sign the order.; b. Verbal or telephone orders shall always be based on actual conversations with the prescribing practitioner or on approved written protocols.; c. Verbal or telephone orders shall be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. Documentation on the physician's order sheet shall include 'v.o.' (verbal order) or 't. o.' (telephone order).; d. Documentation shall include the instructions from the Physician, date, time and the signature and title of the person transcribing the information. Procedure 1. Order for IV medication shall be verified by the Nurse prior to administering a new medication or solution. 2. The Nurse shall verify medication orders with the Physician when there is a question regarding it. Any dose or order that appears inappropriate considering the resident's age, allergy history, condition or diagnosis shall be verified with the Attending Physician. 3. Orders for infusion or IV medications should include the following elements: a. Resident name., b. Date ordered., c. Name of medication., d. Name of base solution, as appropriate for IV medication orders., e. Strength of medication, where indicated., f. Dosage., g. Route of administration, including type of IV line., h. Time, frequency or rate of IV administration., i. Quantity or duration/length of therapy., j. Diagnosis or indication for use., k. Physician and/or Prescriber name., l. Signature of Nurse noting order., 4. Additional resident information the Nurse should have on hand includes: a. allergies; b. age; c. height and weight; and; d. pertinent laboratory results. 5. Orders 'To Keep Open' (TKO) or 'Keep Vein Open (KVO) will not be accepted without a specific rate from the Physician. 6. Stat orders should be communicated from the facility to the pharmacy immediately upon receipt from the Physician. Stat infusion medications and supplies will be delivered to the facility within a timely manner whether during the pharmacy's regular business hours or after hours/emergency times. 7. Orders for flushing protocols should also be written at the time of IV medication order writing if not already present in the resident's medical record. The facility policy OVERVIEW OF IV THERAPY Effective date May 2015 documents the following: OVERVIEW: TYPES OF VASCULAR ACCESS DEVICES and includes ten types of venous access catheter and the specific directions with each type of catheter care required to maintain resident safety and maintain intravenous catheter patency. This same policy also directs staff regarding the Peripherally Inserted Central Catheter (PICC) as follows: (9) Upper arm circumference should be measured on admission and weekly to monitor for infiltration. (10) External catheter length should be monitored on admission, and weekly to monitor for outward migration of the catheter. (11) No blood pressures or phlebotomy should be done on arm that contains PICC. (12) Anchor catheter to skin to prevent accidental removal while changing clothes. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Care Plan dated as revised August 2007 documents the following: Policy Statement Our facility develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Policy Interpretation and Implementation: 1. An Interdisciplinary Assessment Team, in coordination with the resident and his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident. 2. The comprehensive care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care;

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on Record Review and Interview the facility failed to provide an effective Infection prevention and control program. This failure has the potential to affect all 76 residents who reside at the facility. Findings Include: The facility's census dated [DATE] documents 76 residents reside at the facility. The facility's policy Infection Prevention and Control and Stewardship Program last reviewed [DATE] states Policy: To comply with system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement. To comply with the core elements of antibiotic stewardship to reduce the unnecessary use of antibiotics. The facility has established an infection control program which addresses all phases of the organization's operation to reduce and prevent the risk of nosocomial infections in residents and healthcare workers. The designated Infection Control Employee and Quality Assurance Committee is responsible for monitoring the effectiveness of the program and continually improving the outcomes. The committee shall consider and approve as appropriate all written recommendations for policy and procedure revisions. All infection Control policies and procedure will be reviewed annually (this policy was last documented as reviewed [DATE]) by the Quality Assurance Committee and revised as needed. Department Heads are responsible for assuring personnel are made aware of all revisions and respective policies and procedures. The infection tracking for July and [DATE] provided by the facility does not quantify the infection numbers for specific sites or analyze the location to identify possible clusters of residents infection. There is no documentation to indicate the Infection Control team met or made recommendations regarding Infection Control. R1's Progress Note dated [DATE] at 6:42PM documents R1 was admitted to the facility following hospitalization (as documented on R1's Post Acute Care Transition Document dated [DATE]) for Sepsis secondary to cellulitis, Bacteremia with Enterococcus with Endocarditis, Blood Cultures Positive for Enterococcus. Repeat Blood Cultures Positive for Gram Positive Cocci in Chains. Repeat Blood Cultures Negative. Percutaneous Intravenous Central Catheter (PICC) line placed on day of discharge. Infectious Disease consult recommended six weeks of Intravenous Vancomycin. Further Infectious Disease recommendations as mentioned in discharge instructions for lab orders and monitoring. Cardiology consulted Transesophageal Echocardiogram showed Mitral Vegetation. Discharge to (the facility) with six weeks of Intravenous Vancomycin. R1's Post Acute Care Transition Document was uploaded to R1's electronic medical record on [DATE]. On [DATE] at 11:46AM V1 Administrator verified This document and other transfer information arrived with the resident via ambulance and were given to the admitting nurse. R1's Progress Note dated [DATE] documents V10, Licensed Practical Nurse (LPN) entered the correct hospital discharge order for Vancomycin 1000 Milligrams by IV Route every 48 hours for 40 days. in R1's electronic medical record. (continued on next page)

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	09/25/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:00AM V11, Registered nurse (RN) confirmed Pharmacy notified V11, Registered nurse (RN) R1's Vancomycin was changed to 1000 Milligrams every 24 hours. V11 confirmed V11 was instructed by pharmacy to change the Vancomycin order from every 48 hours to every 24 hours 1,000 Milligrams Per PICC line. V11 stated I don't change anything with a Vancomycin order unless Pharmacy or the Nurse Practitioner giver me an order, V6, Nurse Practitioner signed the order. No lab was drawn and there is no rationale documented to justify the change. On [DATE] at 11:15AM V9 Registered Pharmacist (IV service) stated I believe the change in the Vancomycin order for (R1) was not done by pharmacy intentionally. The only trough and kidney function test the pharmacy had at the time the order was changed was the hospital trough which was 16 and Creatinine was within normal limits so there was no rationale for the order to be changed. R1 Medication administration record for June and [DATE] documents R1 received the 1000 Milligram dose of Vancomycin [DATE], [DATE], [DATE],[DATE], and [DATE]. A Vancomycin trough, Complete Blood Count, and Comprehensive Metabolic Panel was obtained prior to the [DATE] dose of Vancomycin. The lab reported a panic level of Vancomycin at 37.4 and a Creatinine of 3.9, and a Glomerular Filtration Rate of 12% which the lab report documents indicate Kidney Failure. Following these lab values one more dose of 1000 milligrams of Vancomycin was administered Prior to discontinuing on [DATE] by V6, Nurse Practitioner. V6 then ordered Clindamycin 150 Milligrams three times daily for 10 days for cellulitis. On [DATE] at 2:00PM V6 stated (R1) was admitted after (R1) was hospitalized for Sepsis due to Cellulitis. I wasn't aware there was an admitting diagnosis of Bacterial Endocarditis. On [DATE] at 1:42PM V13, Medical Director stated I was not aware that (R1) had Endocarditis. I thought the Clindamycin was appropriate because I believed (R1) was being treated for cellulitis. Had I been aware of the Endocarditis and the abnormal trough and kidney function I would have had (R1) sent out to the hospital. R1's Progress Note dated [DATE] at 1:04PM documents R1 experienced nausea and vomiting and had felt unwell since the prior day and was sent out to the hospital. R1 was admitted with Sepsis. R1 was treated until R1 expired on [DATE]. R1's death certificate dated [DATE] lists R1's cause of death as Acute Onset Chronic Respiratory Failure Metabolic Toxic Encephalopathy secondary to Recent Endocarditis with Enterococcus Faecalis Valve Endocarditis. On [DATE] at 2:53PM V7, Infectious Disease Physician from the hospital R1 was admitted to [DATE] stated The lack of care for (R1) at (the facility) caused (R1) to be rehospitalized with Sepsis from Endocarditis. Ultimately (R1) had a stroke in my opinion from a bit of vegetation that broke off from (R1's) heart and traveled to (R1's) brain. I believe the lack of appropriate care at (the facility) hastened (R1's) death. (R1's) Endocarditis was caused by enterococcus. Enterococcus is not even susceptible to the clindamycin they put (R1) on at (the facility). There is no documentation to support the infection Control Commitee met to evaluate R1's infection status of make recommendations to treat R1's infection at any time during R1's stay at the facility. On [DATE] at 11:00AM V1, Administrator stated the former DON who was on maternity leave and then resigned had been the Infection Preventionist. A new DON was hired at the beginning of August. A new Infection Preventionist is starting soon. V1 stated he was the Infection Preventionist prior to taking the Administrator position and is a certified Infection Preventionist.