

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  Pleasant Meadows Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  400 West Washington 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058</b></p> <p>Based on observation, interview, and record review, the facility failed to conduct pressure ulcer risk assessments (R1, R5, R6), failed to obtain treatment orders for identified pressure ulcers (R5, R6), failed to complete pressure ulcer monitoring (R5, R6), and failed to complete pressure ulcer treatments according to physician orders (R5, R6). These failures affect three residents (R1, R5, and R6) out of three reviewed for pressure ulcer services on the sample of six. These failures resulted in R5 developing a worsening stage 3 pressure ulcer.</p> <p>Findings include:</p> <p>The facility's policy Braden Pressure Risk Assessment Tool dated [DATE], documents each resident should be assessed for risk of developing pressure ulcers on admission, weekly for the first month, at least quarterly, and with any significant change in condition, utilizing the Braden scale assessment form.</p> <p>The facility policy Measurement of Alterations in Skin Integrity dated [DATE], documents all skin alterations, wounds, and ulcers will be measured weekly and the results documented in the clinical record. This policy describes the stages of pressure ulcers, instructs staff to assign a stage to the ulcer, document a description of the ulcer, measure the ulcer, measure or describe the depth of the ulcer, and to describe any drainage or odors.</p> <p>1. R5's Assessments dated [DATE] document this was the most recent date located in R5's medical record for facility staff assessing R5's risk for developing pressure ulcers utilizing the Braden scale pressure ulcer risk assessment tool.</p> <p>On [DATE] at 1:15 PM, V1, Administrator, stated, I know we have a more recent Bradens than over a year ago, I completed a whole house sweep of every resident for a Braden back in April, but even that still puts us over a quarter behind. V1, Administrator, provided a more recent Braden assessment dated [DATE] which rated R5 as at risk.</p> <p>R5's Care Plan documents a focus area of R5's risk for impaired skin integrity with a nursing intervention listed as Braden scale weekly x 4 weeks then quarterly, initiated [DATE].</p> <p>R5's Nurses Note dated [DATE] documents a notation of an open pressure ulcer located on R5's left buttock measuring 2 centimeters (cm) by 1.5 cm.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R5's Nurses Note dated [DATE] documents R5's dressing change for the left buttock was unable to be completed because R5 was sitting in a chair.</p> <p>R5's Nurses Note dated [DATE] documents R5's dressing change for the left buttock was completed by the wound nurse. There was no documentation of measurements nor a description of this ulcer.</p> <p>R5's Nurses Note dated [DATE] documents R5's dressing change for R5's wounds was completed by the hospice nurse and also documented an open ulcer located on R5's coccyx measuring 2 cm by 1.5 cm. There was no mention of the left buttock ulcer, and no description of either ulcer.</p> <p>R5's Nurses Note dated [DATE] documents completion of wound rounds with the wound physician, the physician ordered to continue the current treatments, and that R5 had no open areas.</p> <p>R5's Nurses Note dated [DATE] documents R5 had open wounds with dressings in place. There was no documented location, measurements, nor descriptions of the open wounds.</p> <p>R5's Nurses Note dated [DATE] documents the presence R5's left buttock ulcer. There was no documented measurements nor description of this ulcer, nor any mention of R5's coccyx open ulcer.</p> <p>R5's Treatment Administration Record dated for [DATE] documents a treatment order for R5's coccyx ulcer was not obtained or implemented until [DATE]. This record documents R5's treatment for the coccyx ulcer was not completed according to the physician orders on [DATE] and [DATE] on day shift. This same record documents R5's coccyx treatment was discontinued and changed to the evening shift on [DATE]. This same record documents R5's left buttock treatment order had been continuously in R5's treatment record from [DATE] through the current date ([DATE]), disputing the documentation on [DATE] that R5 had no open areas during the wound rounds. This record documents R5's treatment for the left buttock was not completed according to physician orders on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. This same record documents the treatment for R5's left buttock was likewise discontinued [DATE] and changed to the evening shift.</p> <p>R5's Treatment Administration Record dated for [DATE] documents R5's treatment for the open ulcer on R5's coccyx was not completed on [DATE]. This record documents the treatment order for R5's coccyx was revised [DATE] and implemented to begin [DATE].</p> <p>On [DATE] at 1:15 PM, V1. Administrator, stated, We know we have some things to work on and improve. We have not been consistent in doing our weekly measurements. Part of the issue is we had a wound company who stopped serving our facility back in February (2024), then the new practitioner is only providing us their service when they can squeeze us into their schedule, and they aren't actually coming onsite, they are doing their visits by telehealth (virtual visits over the computer). V1 continued, We did designate one of our nurses as the wound nurse, but her training has been delayed because we had needs for her to work the floor (in direct care).</p> <p>On [DATE] at 1:15 PM, V2, Director of Nursing, stated, We also have had to use agency nurses which do not necessarily know the residents well and are not diligent about signing treatments in the record. We also have cross over of shifts like some nurses might work 12 hours shifts and some work 8 hour shifts, so there is some confusion about which nurse is going to do the treatments when they are set up as day shift or evening shift.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:35 PM, facilitated by V10, Licensed Practical Nurse, and V2, Director of Nursing, R5's coccyx ulcer was observed to be approximately (visually estimated but confirmed by V10 and V2) 3.5 cm long by 0.5 cm wide and apparently stage 3 with full thickness skin loss and subcutaneous (fat) tissue exposed. This open ulcer was surrounded by an area of non-blanchable redness (stage 1 with tissue damage already occurred) approximately (again confirmed with V2 and V10) 7 cm long by 6 cm wide.</p> <p>On [DATE] at 2:35 PM, V10 stated, When this ulcer first started it was open stage 3 like this, it remained stable for a few weeks, then it worsened and has been like that for the past several weeks.</p> <p>On [DATE] at 3:25 PM, V1, Administrator, stated, The treatment orders have to be obtained faster than that (from [DATE] until [DATE]). I would expect a nurse to at least put a dry gauze dressing in place when they first notice an open area, then turn it over to inform the physician to obtain a more targeted treatment.</p> <p>2. R6's Assessments dated [DATE] document this was the most recent date located in R6's medical record for facility staff assessing R6's risk for developing pressure ulcers utilizing the Braden scale pressure ulcer risk assessment tool.</p> <p>On [DATE] at 1:15 pm, V1, Administrator, provided a more recent Braden assessment dated [DATE] which rated R6 as very limited risk.</p> <p>R6's Care Plan documents a focus area that R6 is at risk for altered skin integrity and potential for pressure ulcers with nursing interventions including Braden scale quarterly, implemented [DATE].</p> <p>R6's Nurses Notes dated [DATE] document R6 developed an open pressure ulcer on the left shoulder which measured 1 cm by 1 cm. There was no depth measurement, nor a description of this open area. This same Nurses Note documents R6 also developed a second open pressure ulcer on the left hip measuring 1 cm by 0.5 cm. There was likewise no depth measurement or description of this second open ulcer.</p> <p>R6's Nurses Notes dated [DATE] document a second notation of R6's two open areas. This note documented the open ulcer on R6's left shoulder measured 2 cm by 1.4 cm, indicating this area had grown in size since [DATE]. There was no depth measurement nor description for R6's open ulcer on the shoulder. This note documented the open ulcer on R6's left hip measured 0.5 cm by 0.5 cm with no documented depth measurement nor description. There were no additional measurements nor descriptions between [DATE] and [DATE].</p> <p>R6's historical Physician Order Sheet and Treatment Administration Record for [DATE] document there was not a treatment order obtained from R6's physician to treat the two open ulcers until [DATE], at which time the orders for treatment indicated R6's open ulcers were on the right shoulder and right hip.</p> <p>On [DATE] at 2:35 PM, V2, Director of Nursing, stated, The ulcers are actually on (R6's) right hip and right shoulder. (Staff) must have been looking at (R6) and documented what side the ulcers were related to their own left not the residents left.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R6's Nurses Notes dated [DATE] documented the presence of R6's two open ulcers but no measurements or description. There were no additional measurements or descriptions between the note on [DATE] and [DATE].</p> <p>R6's Treatment Administration Record dated for [DATE] documents the treatment for the pressure ulcer on R6's right shoulder was not completed according to the physician orders on [DATE] for the day shift. This same treatment order was documented as discontinued on [DATE] and changed to the evening shift. This same treatment record documents R6's treatment for the right hip was not completed on [DATE] and [DATE] for the day shift. This right hip treatment was likewise discontinued [DATE] and changed to the evening shift.</p> <p>On [DATE] at 2:35 PM, facilitated by V10, Licensed Practical Nurse/ Wound Care Nurse, and V2, Director of Nursing, R6's pressure ulcer of the right shoulder was observed to be a stage 2 (partial skin thickness) with surrounding healing scar tissue, and likewise the right hip pressure ulcer on R6 was a stage 2 with surrounding healing scar tissue.</p> <p>On [DATE] at 1:35 PM, V10 stated, Those are definitely stage 2, partial skin layers. They used to be larger but they have been healing. They have always been stage 2.</p> <p>On [DATE] at 3:25 PM, V1, Administrator, stated, The treatment orders have to be obtained faster than that (from [DATE] until [DATE]). I would expect a nurse to at least put a dry gauze dressing in place when they first notice an open area, then turn it over to inform the physician to obtain a more targeted treatment.</p> <p>3. R1's Minimum Data Set List and Census Details document R1 was discharged deceased from the facility [DATE].</p> <p>R1's Assessments dated [DATE] documents this was the most recent pressure ulcer risk assessments utilizing the Braden scale pressure ulcer risk assessment tool conducted by facility staff located in R1's medical record.</p> <p>On [DATE] at 1:15 PM, V1, Administrator, provided a more recent Braden assessment dated [DATE], rating R1 as high risk for pressure ulcers.</p> <p>R1's Nurses Note dated [DATE] documents a notation of a sore located on R1's left ankle with a measurement of 7 cm long by 6 cm wide, along with an area of redness on R1's right heel. A subsequent nurses note on this same date documented the presence of redness on R1's gluteal area (buttock) and coccyx.</p> <p>On [DATE] at 9:55 AM, V1, Administrator (former direct care registered nurse at the facility), stated, I did see (R1's) ulcer on the ankle. I did see that the nurse (V5, Registered Nurse) documented the area on (R1's) ankle was 7 cm by 6 cm, but I think he was measuring the entire area, but the hole in the skin was only about this big. V1 held up his fingers to indicate approximately 0.75 cm diameter. V1 further stated, I would stage that ulcer at stage 2.</p>		