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	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31642 Based on observation, interview and record review the facility failed to notify a family representative of a change in resident condition for one of three residents (R6) reviewed for accidents/incidents on the sample list of 17. Findings include: R6's current medical diagnoses sheet documents the following: Unspecified Dementia, Alzheimer's Disease, Repeated Falls, and Muscle Weakness. On 11/27/24 at 2:32 pm R6 was seated in a wheelchair at the nursing station. R6 had a large yellow and green colored bruise on R6's left forehead. R6's bruise was approximately the size of a silver dollar, and incorporated R6's eye lid, eyebrow and front of R6's scalp. R6 also had a small, approximately one quarter inch long by one inch wide purple and yellow bruise under her left eye. On 12/3/24 at 1:20 pm V3, Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Coordinator stated V3 saw the bruise on R6 forehead Sunday 11/24/24, when V3, LPN came in to work as a floor nurse. V3 stated she was not R6's nurse but stopped and asked what happened. V3, LPN stated Certified Nursing Assistants (unidentified) told V3, LPN R6's bruise was not from a fall and neurological assessments had been initiated on 11/21/24. V3, LPN said V3, LPN could not confirm that R6's nurse V22, Registered Nurse had notified the doctor or the family as there was no documentation in R6's chart. On 12/03/24 at 2:25 pm V2, Director of Nursing (DON) stated, We found out (V22, RN) an Agency Nurse worked that day (R6's) neuros (on paper, not in chart) were started (11/21/24). V2, DON also stated V22 did not document anything, therefore V2, DON cannot say who V22, RN contacted. 'It goes without saying that all resident incidents both the physician and family are to be notified.' On 12/04/24 at 1:25 pm V22, RN confirmed V22 was R6's nurse when R6's bruise was identified. V22, RN stated, I did not notify a family member. The facility policy ABUSE PREVENTION PROGRAM dated October 2022 documents the following: The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the (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

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	12/06/2024

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Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to resolve resident grievances of missing money. This failure affects two of five residents (R2 and R4) reviewed for missing personal belongings on the sample list of 17. Findings include: 1. The Facility Incident Report Form submitted as part of the investigation, includes R2's Minimum Data Set (MDS) dated [DATE], and therefore V1, Administrator/Abuse Prevention Coordinator was aware of R2's cognitive status. R2's MDS documents R2's Brief interview of Mental status score of 15 out of a possible 15, indicating R2 has no cognitive impairment. The facility facsimile to Illinois Department of Public Health Final (IDPH) report dated 11/06/24 documents the following: Summary: Resident (R2's) daughter (V42, POA) notified SSD (V4, Social Service Director) that resident was missing $33 on 10/28/24. The money was missing in the prior 2 (two) weeks of notifying SSD (V4). Administrator (V1, Administrator/Abuse Prevention Coordinator) was immediately notified. An investigation was immediately started. Other staff and residents were interviewed about the alleged missing money with no one having any knowledge of any resident missing any items. The facility searched the resident's room, laundry, nurse's med (medication) cart. med room and housekeeping, and did not recover the missing money. Conclusion: After staff searched the different areas of the facility. The alleged missing money was not recovered. The facility could not find the alleged missing money or confirm that the resident had money in her possession (The facility does not document residents belongings on an inventory sheets to identify what resident have in their possession) . Resident (R2) and/or POA (V42) was educated to report any missing items timely and deposit resident money in the facility resident trust fund account. There was no apparent injury/ill effect to the resident mentally and/or psychosocially. The local authorities were notified of the conclusion. Physician (unidentified). POA (R42) and Ombudsman were notified of the conclusion. There is insufficient evidence to substantiate (misappropriation) abuse. On 11/27/24 at 1:25 pm V1, Administrator/Abuse Prevention Coordinator confirmed the facility did not replace R2's missing money. V1 stated It is our choice to reimburse the residents for missing items based on the investigation findings. That is corporate protocol. On 12/05/24 at 11:44 am V34, Corporate, Director of Quality and Clinical Operation/ Registered Nurse and stated Alert and oriented residents, that have misplaced money will be reimbursed. V34 stated It is not the corporate policy, not to reimburse them. On 12/04/24 at 2:19 PM V8, Licensed Practical Nurse (LPN) stated (R2) is alert and oriented and very organized. She knows when her meds are due, she knows everything. If she said she was missing anything, I would believe her. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 1:40 pm R2 was seated on the side of her bed. R2 stated I don't want to make waves. It is not a big deal. I had four, five-dollar bills and three ones ($23). My daughter (V42) gave me a ten-dollar bill for a haircut (confirmed in family interview below). Whoever got it knows they did it. It would be really nice, to get it back, but I understand they don't give missing money back. They think I may have just lost it. I know someone else helped themselves. I love everybody here. I would not want to accuse anybody. On 12/06/24 at 11:30 am, V42, R2's Family Member/Power of Attorney stated I reported my mother (R2) had money missing. The nurse (unidentified) I (V42) reported it to was short, with dark hair and glasses. That nurse (unidentified) said my mother was not the only resident missing money. I had given her (R2) ten dollars to get her hair cut. She had several dollars already. She is reliable and can tell you exactly what she had. I did not hear anything from the facility for about three or four days. They never found it. I thought they would give her back what money she was missing. My mother would never complain. She is always very sweet and does not want to get anyone in trouble. She has not had anything else come up missing. 2. The Facility Incident Report Form submitted as part of the investigation, includes R4's Minimum Data Set (MDS) dated [DATE], therefore V1, Administrator/ Abuse Prevention Coordinator was aware of R4's cognitive status. R4's MDS documents R4's Brief interview of Mental status score as 15 out of a possible 15, indicating R4 has no cognitive impairment. The facility facsimile to Illinois Department of Public Health Final report dated 11/12/24 documents the following Summary: Resident (R4) notified SSD on 11/4/2024 that she was missing a butterfly necklace, car/house keys and $25 in cash. The resident kept her personal belongings in her room instead of being in a lock box. Administrator (V1, Administrator/Abuse prevention Coordinator) was immediately notified of the allegation, and an investigation was immediately started. Resident was interviewed by staff and couldn't remember when she had last seen the missing items or where she kept the missing items. Resident stated the $25 was kept in an envelope in her room and couldn't remember when she had last seen the envelope. Other staff and residents were interviewed with no one having any knowledge of any resident missing items. The facility searched the resident's room, laundry. nurse's med cart, med room and housekeeping and did not recover the missing money. Staff found in the resident's room the missing butterfly necklace and the keys. Conclusion: After staff searched different areas of the resident room and/or facility, the alleged missing money was not recovered but the necklace and keys were located in the resident's room. The facility couldn't confirm that the resident had money in her possession or her room. Resident was educated to deposit any money in the resident trust fund account or lock any money in her personal lock box. There was no apparent injury/ill effect to the resident mentally and/or psychosocially. The local authorities were notified of the conclusion. Physician. POA and Ombudsman were notified of the conclusion. (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 11:00 am R4 said R4 had a gold necklace and a blue necklace that went missing from her room. I also have my keys back. R4 stated it just reappeared on her table one day. R4 stated R4 also had $25 dollars missing from her room. R4 stated I had a $20 dollar bill and a $5 dollar bill sitting on the bedside table. I was waiting to go to Therapy and when I came back from Therapy, it was gone. There is a resident that rolls around in her (R6) wheelchair and steals things from people's rooms (could not confirm during survey). (R6) doesn't know what she is doing. I caught (R6) in my room a couple of weeks ago. I was in my room and (R6) wheeled herself in and took my cellular phone off of my bedside table. Well, I said, 'No! Put that back! Get out of here!'. I had to take my phone back from (R6) and then she left. I have told the staff about these things but (R6) keeps doing it. I have gotten everything back but the cash. I suppose it is just gone. I was going to use that money to buy some Christmas presents. Now I don't know what I will do. On 11/27/24 at 1:25 pm V1, Administrator/Abuse Prevention Coordinator confirmed the facility did not replace R4's missing money. V1 stated It is our choice to reimburse the residents for missing items based on the investigation findings. That is corporate protocol. On 12/05/24 at 11:44 am V34, Corporate, Director of Quality and Clinical Operation/ Registered Nurse and stated Alert and oriented residents, that have misplaced money will be reimbursed. V34 stated It is not the corporate policy, not to reimburse them. The facility pamphlet titled 'Illinois Long-Term Care Ombudsman Program Resident Rights' for people in Long-Term Care Facilities' revised 11/18 documents a resident has the right to make their own choices. The facility must treat the resident with dignity and respect You have the right to complain to your facility and to get a prompt response. Your personal property rights You have the right to keep and wear your own clothing. You may keep and use your own property. You have the right to expect your facility to have a safe place where you can keep small valuables which you can get to daily. Your facility must try to keep your property from being lost or stolen. (The facility does not document residents belongings on an inventory sheets to identify.) If your property is missing, the facility must try to find it. The facility ABUSE PREVENTION PROGRAM dated October 2022 documents the following: POLICY IV. Establishing a Resident Sensitive Environment (continued on next page)

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	146037	A. Building B. Wing	12/06/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* This facility desires to prevent abuse, neglect, exploitation, mistreatment, deprivation of goods and services by staff and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Concern Identification and Follow-up: Resident and family concerns will be documented, reviewed, addressed, and responded to using the facility's concern identification or grievance procedures. Residents and families will be informed of the facility's concern identification or grievance procedures. An essential element of customer satisfaction is a timely response back to the family or resident to concerns expressed.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to recognize and report a facial bruise of unknown origin to the Abuse Prevention Coordinator for one of three residents (R6) reviewed for incident/accidents on the sample list of 17. Findings include: R6's Current Diagnoses list documents the following:Repeated Falls, Difficulty Walking, Muscle Weakness, Generalized, Alzheimer's Disease and Unspecified Dementia, Unspecified Severity. R6's Minimum Data Set (MDS) dated [DATE] documents R6's Brief Interview of Mental Status score as 00 (zero) out of a possible 15, indicating severe cognitive impairment. The same MDS documents R6 uses a wheel chair for mobility and has not had any wandering behaviors or behaviors directed towards self or others. On 11/27/24 at 2:32 pm R6 was seated in a wheelchair at the nursing station. R6 had a large yellow and green colored bruise on R6's left forehead. R6's bruise was approximately the size of a silver dollar, and incorporated R6's eye lid, eyebrow and the front of R6's scalp back approximately one inch back from R6's hairline. R6 also had a small, approximately one quarter inch long long by one inch wide light purple with yellow edged bruise under her left eye. V12, Wound Nurse stated she believed R6's left forehead bruise was from a fall. R6's Handwritten Neurological Flow Sheet was started 11/21/24 at 2:45 pm. There was no documentation to identify why neurological assessments were being recorded. There was no documentation on the facility incident /accident log that R6 had a fall. There was no documentation in R6's medical record of a fall or incident that caused R6's forehead bruise. On 12/03/24 at 12:00 pm V15, Registered Nurse (RN)/Restorative Nurse Manager/Fall Investigations stated R6's did not fall. If R6 had a fell V15, RN would have been the one to investigate. V15, RN stated she did not know anything about R6's bruised forehead until the neuros came across her desk this morning. I found out (R6's) bruise was reported to (V1, Administrator) in a group email as a possible injury of unknown origin from (V3, LPN). On 12/3/24 at 1:20 pm V3 Licensed Practical Nurse (LPN) /Minimum Data Set Coordinator stated she saw the bruise on R6 forehead Sunday when she was a float nurse, 11/24/24. V3 stated she was not R6's nurse. V3, LPN said V3, LPN stopped as she was passing through that unit and saw R6's left forehead bruise. Two CNA's (unidentified) said (V22, Agency Registered Nurse) was the nurse when (R6's) forehead bruise was found (11/21/24). They said (R6's) bruise was not from a fall. They (unidentified CNA's) said (V22) had done a head-to-toe assessment and started neuros. Since neuros had already been initiated, I (V3) thought (V1) had already been notified by (V22) of the injury to (R6's) forehead/eye because it was not from a fall. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 1:35 V1, Administrator/Abuse Prevention Coordinator was in his office with V17, Regional Director of Operations office. V1 stated staff did not report R6's forehead bruise to V1, Administrator/Abuse Prevention Coordinator, until he got a group email 11/27/24 from V3. There was not anything mentioned of the size or location of the bruise. The DON (V2, Director of Nursing) was copied on the email (11/27/24) as was (V12, Licensed Practical Nurse) the wound nurse. There was nothing mentioned of the size or face bruise. V1 said V1 believed V2, DON was checking into the bruise and would let V1 know if there was anything suspicious. V1 heard nothing from V2, DON of a concern. He would have investigated the bruise as an injury of unknown origin, and reported to Illinois Department of Public Health. V17, Regional Director of Operations stated, The facility is expected to follow the facility policy and report immediately to the Administrator, if there is a suspicious bruise of unknown origin. The group email mentioned above, dated 11/27/24, written by V3, LPN, does not document V1 was being notified of an injury of unknown origin. The email documents R6's had a bruise identified the previous Thursday. The email also documents V3 is looking into the nurse schedule to identify the nurse and have that nurse start a risk management note on R6. The email notification does not identify the extent or location of R6's left forehead bruise. On 12/03/24 at 1:50 pm V17, Regional Director of Operations stated R6's facial bruise is being investigated, and IDPH will be notified now (12/03/24) that V1, Administrator/Abuse Prevention Coordinator is aware of the extent of R6's bruise. On 12/03/24 at 2:00 V16, Agency Registered Nurse (RN) stated V22, Agency RN was the nurse when R6's forehead bruise was identified. (R6's) forehead bruise was maroon when I saw it. I got it in report from her (V22, RN), that (R6) was on neuro (neurological) checks (assessment). I asked if she (R6) had a fall. (V22, RN) said 'no'. (V22, RN) said she had no idea what happened, and started neuros. I figured this had already been reported to the Administrator (V1, Administrator/ Abuse Prevention Coordinator), since (V22) did not know how it (forehead bruise) happened. I was not told if the doctor (unidentified) or the family (unidentified) were notified. I just assumed they were. That is usually what we do. On 12/03/24 at 2:25 pm V2, Director of Nursing (DON) stated V2, DON was notified on 11/27/24 by an email. He looked at R6's forehead bruise then. He did not measure R6's bruise and did not document his observation. V2, DON also stated We found out (V22, RN) an Agency Nurse worked that day the neuros were started (11/21/24). She did not document anything, therefor I can't say who she contacted. It goes without saying that all resident incidents both the physician and family are to be notified. I will call her to do a late note, and I will do a late entry too. V2 stated (R6) wanders around, in her wheelchair. She wanders the halls, into other resident rooms and is sometimes seen bending forward to pick things off the floor. She also goes through the doors on her own, and may have bumped her head on one of the doors. The incident was not witnessed (nor did V2, DON obtain witness statement to make his conclusion), but that is the most likely root cause. I did not consider it an injury of unknown origin since I believe that to be the root cause. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at 1:25 pm V22, Agency Registered Nurse returned phone calls and stated I was working a long shift that day. I forgot to document. It was (V11) CNA that came to me and said (R6) had been in restorative (therapy). (V35) Nurse Practitioner said start neuros (neurological assessment) and I had already planned to do that. I assessed vitals and neuros, all were good. I did a skin check. I did not notify a family member. I did tell (V12, Licensed Practical Nurse) the Wound Nurse about the bruise. I told her (V12), (R6) had a bruise on her head, and I don't know how she (R6) got it. I was asking the CNA's (unidentified) if she fell . No one saw what happened. No one saw her fall. I did not measure (R6's) bruise. I know that I should have done that and notify the family. V22 also stated I don't do in-services at the facility. I am Agency. I live two hours away. I did not know to tell the Administrator (V1, Administrator/Abuse prevention Coordinator). The facility facsimile to Illinois Department of Public Health (IDPH) dated 12/03/24 (twelve days after bruise was identified 11/21/24) documents the following: Resident (R6) was observed by LPN (V3, Licensed Practical Nurse) to have a bruise on L (left) side of forehead on 11/27/24 at 10:29 am. Upon investigating the incident by LPN (V3), she (V3) discovered that Neuro (neurological assessment) checks were initiated by staff nurse (V22, Agency Registered Nurse) on 11/21/24 at 1445 (2:45 pm) on resident (R6). Investigation continues. IDPH, Physician, Resident Representative were notified of the incident. Final report will be completed within 5 working days. The facility policy ABUSE PREVENTION PROGRAM dated October 2022 documents the following: VII. Internal Investigation 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: * The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and * The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If classified as an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting and investigating abuse will be followed. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 31642 Based on observation, interview and record review the facility failed to follow physician orders and prevent cross contamination during wound care treatment administration. These failures affected one of three residents (R1) reviewed for accidents/skin impairment on the sample list of 17. Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status score of 05 (five), out of a possible 15, indicating R1 has severe cognitive impairment. R1's Skin/Issue note completed 11/13/2024 at 6:02 pm documented by V12, Facility Wound Licensed Practical Nurse documents the following: R1's Front right thigh. Issue type: Burn. Full thickness burn. Wound acquired in-house. Exact date:11/05/2024. The same Skin /Issue note documents R1's burn measured: Length (cm):4 Width (cm): 4 Depth (cm): 0.1. R1's right thigh burn is documented as having Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements (blisters that opened). R1's same Skin/Issue report documents: Front left thigh. Issue type: Burn. Full thickness burn. Wound acquired in-house. Exact date:11/05/2024. R1's same Skin issue report note documents R1's left thigh burns has the following measurement: Length (cm): 5.5 Width (cm): 6 Depth (cm): Exudate type: Serous: clear watery fluid, which is separated from solid elements. R1's skin issue report note documents: Skin Issues Note: Saw wound doctor today. Treatment for silver sulfadiazine 1% cream. R1's Physician Order Sheet dated November 2024 documents the following: Clean areas to left & right thighs with normal saline. Apply silver sulfadiazine 1% cream & cover with (name brand-thick layered cotton dressing) pad every shift. May use thin layer of Triple antibiotic ointment until silver sulfadiazine 1% cream is delivered, every shift for wound care.-Start Date 11/14/2024 at 2300 (11:00 pm). On 11/27/24 at 2:10 pm V12 LPN, Wound Nurse, set up supplies on the wound cart positioned just outside R1's room. V12, and V14 entered R1's room, used hand sanitizer and donned gloves. V12 had removed the gloves she donned from her uniform pocket. V12 pulled back R1's blanket and assisted R1 to a back lying position. R1 stated the areas are not painful just tender when touched, as V12, palpitated R1's bilateral upper inner thigh burns with the contaminated gloves used to pull back R1's blanket and position R1. V14 measured R1's left thigh blistered area. R1's left thigh blister had an opened area that was moist and red and measured .3 centimeters (cm) long (L) by .1 cm wide (W) at approximately nine o'clock position, of her burn. New granulated tissue was noted over the original burned area of 19 cm L by 11 cm W. The blistered area of R1's right inner thigh (measured 9 centimeters (cm) long (L) by 9.5 cm wide (W) had new granulated thin, fragile skin and had no open area. V14 confirmed R1's left thigh blistered was still tacking an open. V14 then directed V12 to complete the physician ordered Silvadene one percent cream treatment. (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	12/06/2024

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V12 then removed V12's soiled gloves, used hand sanitizer and left R1's room. R12 brought the jar of Silvadene medicated burn cream into the room. V12 donned gloves she had removed from her uniform pocket, and pulled back the blanket to complete R1's upper inner thigh burn treatment. V12 reached into the Silvadene with the presumed soiled gloves from her pocket. V12 used her right index finger to reach into the Silvadene cream jar. V12 applied Silvadene cream with her soiled gloved, right index finger. V12 applied Silvedene cream R1's left opened blister. V12 did not wash R1's burn wounds before applying the Silvadene cream With the same soiled glove and same right index finger, V12 went on to apply the Silvadene cream to the right burn wound area of R1's right thigh. V12 did not clean the right burn wound before applying the cream. V12, removed her gloves, pulled the covers up over residents legs and confirmed V12 was done with R1's treatment. V12 did not cover R1's burns with the name brand - thick layered cotton pad as provider ordered. On 11/27/24 at 2:30 pm V14, Wound Nurse Practitioner and V12, Wound Licensed Practical Nurse both confirmed hand hygiene and donning new gloves are necessary after touching contaminated objects. V12 and V14 both confirmed R1's wound treatments are to be completed wearing clean gloves. Both acknowledged V12 should not have been pulled gloves out of V12's pocket further cross contaminating gloves. Both V12 and V14 acknowledged that wound cleaning should be completed before the treatment cream is applied and treatments are to be completed as physician ordered. Both V12 and V14 confirmed the failure to use an applicator instead of the finger, as well as completing both wound treatment with the same index finger should , is cross contamination of the wounds. V14 also stated the wound treatment should have been done separately to prevent cross contamination. V12 stated I was really nervous; I know better and usually do better. The facility policy Wound Care dated as revised October 2010 documents the following: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation, 1. Verify that there is a physician's order for this procedure. The same policy documents: Steps in the Procedure 1. Use disposable cloth {paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. (continued on next page)

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	146037	A. Building B. Wing	12/06/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. 8. Pour liquid solutions directly on gauze sponges on their (sic) papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11. Place one (I) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 12. Remove dry gauze. Apply treatments as indicated. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. Be certain all clean items are on clean field.

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	146037	A. Building B. Wing	12/06/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to provide adequate assistance and supervision during dining and failed to serve a hot beverage at a safe temperature. This failure resulted in R1 suffering a preventable, second degree burn to her bilateral upper legs. R1 is one of three residents reviewed for incident/accidents on the sample list of 17. Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status score of 05 (five), out of a possible 15, indicating R1 has severe cognitive impairment. R1's Same MDS documents: Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. R1 is Coded as follows: A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Eating is documented as 02. Substantial/maximal assistance - 'Helper does MORE THAN HALF' the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. R1's incident investigation witness statements, submitted to the Illinois Department of Public Health reportable injury form documents: (V23) LPN (Licensed Practical Nurse), (dated) 11/5/2024 at 1050 am: Reporting staff member. Reported to DON (V2, Director of Nursing) that resident (R1) had taken another resident's (unidentified) hot chocolate and had spilled it onto her (R1) lap. Resident (R1) was taken to her room, disrobed, and a head-to-toe assessment was performed by the nurse. Noted some light pink areas to bilateral thighs. Nurse reports resident denied pain and showed no s/s (signs /symptoms) of distress. The same incident investigation documents the following: (V21, Certified Nursing Assistant) CNA, (dated) 11/5/2024 at 1200 pm: I was the one that made the hot chocolate. I put the three ice cubes in it- because of the burn last summer (unidentified resident) - and set it down. I had my back (R1 unassisted, unsupervised) to her (R1) but I heard it spill and (R1) made a surprised noise. I turned around and she (R1) had spilled it (hot chocolate) onto her lap. I pulled her dress away from her '[lap]' to limit contact of the hot chocolate on her skin. We (V21, and unidentified assistant) got her (R1) to her room and got her undressed. The nurse (V23) then came in and checked her out. (R1) didn't seem to be in any pain but just seemed upset that she got hot chocolate on her dress. R1's N Adv - Skin Issues dated 11/6/2024 at 3:54 pm documents the following: (continued on next page)

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	146037	A. Building B. Wing	12/06/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Skin Issues: Skin Issue: #001: New skin Issue. Location: Front right thigh. Additional location information: anterior Issue type: Burn. Superficial burn (downgraded to 'Full Thickness' burn. 11/13/24 report below). Wound acquired in-house. Exact date: 11/05/2024 Signs and symptoms of infection: None. Painful: No. Staged by: N/A. Length (cm): 19 Width (cm): 11 Depth (cm): 0 Undermining: No. Tunneling: No. Epithelial: 100%. Exudate amount: None. Odor after cleansing: None. Surrounding tissue: Normal in color. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Cleansing solution: Water. Other primary dressing: skin prep (protective wound treatment) Secondary dressing: No secondary dressing applied. Modalities: None. Other additional care: cups with lids & staff monitor at meal times. Skin Issues Note: Wound doctor (V14, Wound Nurse Practitioner) saw today. Treatment changed to skin prep daily. Skin issue education: Signs and symptoms of infection. Skin issue education: Treatment of skin issue. Skin issue education: Care of skin issue(s). Skin issue notification: Wound nurse. Skin issue notification: Provider. Skin issue notification: Family. Completed Clinical Suggestions. R1's Nurse Progress Note dated 11/07/24 at 1:10 pm documents the following: Note Text: NP (V14, Nurse Practitioner) in the building to see resident (R1) and assess areas to bilat (bilateral) inner thighs. New order received for Medihoney (medicated topical treatment) BID (twice a day) to bilat (bilateral) inner thighs for 10 days and monitor for s/s (signs/symptoms) of infection and pain and to report to NP (V14)/MD (unidentified physician) if noted. R1's Skin/Issue note completed 11/13/2024 at 6:02 pm documented by V12, Facility Wound Licensed Practical Nurse documents R1's Front right thigh. Issue type: Burn. Full thickness burn. Wound acquired in-house. Exact date:11/05/2024. The same Skin /Issue note documents R1's burn measure Length (cm):4 Width (cm): 4 Depth (cm): 0.1. R1's right thigh burn is documented as having Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements (blisters that opened). R1's same Skin/Issue report documents: Front left thigh. Issue type: Burn. Full thickness burn. Wound acquired in-house. Exact date:11/05/2024. R1's same Skin issue report note documents R1's left thigh burns has the following measurement: Length (cm): 5.5 Width (cm): 6 Depth (cm): Exudate type: Serous: clear watery fluid, which is separated from solid elements. R1's skin issue report note documents: Skin Issues Note: Saw wound doctor (was seen by V14, Wound Nurse Practitioner) today. Treatment for silver sulfadiazine 1% cream. On 11/27/24 at 1:37 pm V14, Wound Nurse Practitioner (consulting, wound care private company) stated V14 has seen R1 for her burns three times on 11/6, 11/13, and 11/20 and will be assessing R1's burns again today. V14 stated, The hot chocolate (R1) spilled on her thighs was obviously too hot to be served. Therefore, R1's burns could have been prevented. (R1) is cognitively impaired, requires assistance at meals. Staff are responsible to serve liquids at a safe temperature. (continued on next page)

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	146037	A. Building B. Wing	12/06/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	V14 also stated On my first observation (11/6/24) of (R1's) burns were large, intact blisters (second degree). The blister area on her right thigh measured 9 centimeters (cm) long (L), by 9.5 cm wide (W). The blisters on her (R1's) left leg measures 19 cm L by 11 cm W. There was no depth measured because the blisters were intact. We were trying to keep the blisters intact as long as possible. I ordered skin prep. The blistered areas were difficult to maintain intact since she would be wearing clothes. When I came in on the thirteenth (11/13/24) the blisters had opened. I changed the treatment order to Silvadene to promote healing and decrease the discomfort. On the 20th (11/20/24) The Silvadene treatment was successful as evidenced by the decrease in measurement. On her (R1) left thigh 1.0 cm L by 3 cm W and Superficial depth.1 cm. (R1's) right thigh burn measured 2.5 cm L by 1.5 cm W, .1 cm D. I continued the Silvadene treatment. On 12/3/24 at 10:15 am V7, Dietary Manager stated, I was not here when (R1) spilled hot chocolate in her lap. I was on vacation. The first I heard of it was when that other surveyor was here last week. I tested the temperature of the water and coffee that day. The other surveyor was with me. The coffee and water temps (temperatures) were high, 166 degrees and 168 degrees (Fahrenheit) if I remember correctly. V7 then stated (R1) had grabbed (R6's) hot chocolate, as I understand it was the situation that day. V7 then went out to the resident main dining room. The main dining room was full of residents eating. V7 opened the spigot on the right side coffee dispenser and poured coffee into a cup. The coffee was steaming. V7 measured the coffee dispensed at 160 degrees Fahrenheit. Both surveyor and V7 took a drink of the coffee. This surveyor's mouth experienced an uncomfortable, hot tingling sensation. This surveyor had to pause before swallowing the coffee. V7 also sampled a cup of coffee from the right side coffee dispenser. V7 stated I like my coffee very hot, but this is very, very, hot. V7 also stated Hot beverages should be served, at most 120 - 130 degrees, though brewing temperature is 165. V7 then opened the spigot on the left side coffee dispenser and poured into a cup. V7 measured the coffee as 159 degrees Fahrenheit. V8, Certified Nursing Assistant (CNA) came over to the coffee/water dispenser and poured a cup water and placed a tea bag in a cup. V8 CNA stated she was preparing the tea for R11. V7 then measured the temperature of R11's tea . R11's tea measured which measure 160 degrees Fahrenheit. V8, CNA walked away with the R11's tea and served it steaming to R11 at a table adjacent to the coffee/water dispensers. V7 then stated Staff are supposed to add a couple of ice cubes when serving residents hot drinks. They should all know that. Surveyor asked R11 if her tea was too hot. R11 stated Yes, but I don't drink it until after I eat. It is always served real hot, but the tea steeps well when it is hot. On 12/3/24 at 11:12 am V43, Maintenance Director stated, We do not have a policy (for water temperatures). We do not have a mixing valve to turn the water supply temperature down on the coffee maker. I can tell you; we have to keep the resident bathroom and showers temperatures adjusted to 110 degrees (Fahrenheit) or less. That is straight from the state regulations, so a resident skin does not get burned. On 12/3/24 at 10:40 am V21, CNA stated that served the hot chocolate at R1's table the day R1 got burned. V21 also stated I am usually careful to put ice in the residents' hot drinks (beverages) because we had a resident (unidentified) last summer that got burnt on coffee. I am almost positive I put ice in that hot chocolate. I was surprised it was still hot enough to cause (R1's) legs to burn like that. It was though. I should have put more ice in it because it was still too hot, apparently. (continued on next page)

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	146037	A. Building B. Wing	12/06/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's policy title Precautions for Handling Hot Beverages Guideline: Staff will monitor, serve and hold hot beverages in a safe manner to prevent potential burns. Procedure: It is recommended that the temperature of the equipment be set at the lowest possible temperature for adequate brewing; anticipated to be in the range of 160-170 degrees Fahrenheit. The serving temperature should be approximately 10 - 15 degrees less than the brewing temperature. 4. Additional precautions: a- Assessing and identifying those individuals served who are at high risk for burning themselves with hot beverages. b- Ensuring staff monitor the identified high-risk resident during meal times and/or when hot beverages are served.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31642 Based on observation, interview and record review the facility repeatedly failed to maintain complete and accurate medical record for one of eight residents (R6) reviewed for medical records on the sample list of 17. Findings include: R6's current medical diagnoses sheet documents the following: Unspecified Dementia, Alzheimer's Disease, Repeated Falls, and Muscle Weakness. On 11/27/24 at 2:32 pm R6 was seated in a wheelchair at the nursing station. R6 had a large yellow and green colored bruise on R6's left forehead. R6's bruise was approximately the size of a silver dollar, and incorporated R6's eye lid, eyebrow and the front of R6's scalp. R6 also had a small, approximately one quarter inch long by one inch wide purple and yellow bruise under her left eye. There was no documented measurement of R6's bruise. There was no progress note documented on R6's chart to identify the cause of R6's left forehead bruise. There was no incident or accident on the facility log for R6 in November or December 2024. There was no documentation that vital signs were completed. There was no documentation that the physician, family or the Administrator were notified. On 12/3/24 at 1:20 pm V3 LPN /Minimum Data Set Coordinator stated she saw the bruise on R6 forehead Sunday when she was a float nurse can't remember which day but believes it was 11/24/24 (three days after neurological assessment was started). V3 stated she was not R6's nurses. V3 stopped when as she was passing through that unit and saw R6's left forehead bruise. Since there is nothing documented, in the chart, (paper neurological assessments were not in R6's medical records.) I don't know if (V22, Agency RN) notified the doctor or the family. R6's Progress Note signed by V35, Nurse Practitioner, dated 12/04/24, was not added to R6's chart until 12/04/24 (fourteen days after R6's bruise was identified. R6's Nurse Practitioner Progress Note documents the following: CHIEF COMPLAINT - Bruising to the left side of the forehead without known trauma. History of Present Illness: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 11/21, nursing staff noticed bruising to the left side of forehead during morning rounds in a resident with dementia. - Bruising appears yellow light bluish in color on the left side of forehead. - No reported or witnessed falls by staff. Resident consistently denies any falls, head injuries, or trauma when questioned. - Denies headache, dizziness, blurred vision, nausea, vomiting, or chest pain. - Remains alert and oriented times 2 to 3, answering most questions appropriately. - Neurologically intact with no extremity deformities noted. - Unable to independently lift self from fallen position to seated position in wheelchair or bed. - Self-propels in wheelchair, suggesting possible unreported contact with an object. - Not currently on any blood thinners. - Staff has initiated neurological monitoring per protocol since discovery of bruising. On 12/03/24 at 2:25 pm V2, Director of Nursing (DON) stated V2, DON was notified on 11/27/24 (six days after neurological assessments were initiated) by an email. V2, DON said V2, DON looked at the bruise then, and did not measure R6's bruise. V2 also stated V2, DON did not document his observation. If it was not documented, it looks like it wasn't done. I did it and should have made a note. On 12/04/24 at 1:25 pm V22, Agency Registered Nurse and stated she was working a long shift on 11/21/24 and forgot to document R6's left forehead bruise.