

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 12/24/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>35347</p> <p>Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident. This failure affects two residents (R3, R4) of six reviewed for abuse in the sample of six.</p> <p>Findings include:</p> <p>The facility Abuse Prevention Program policy (10/2022) documents: a nursing home resident has the right to be free from verbal, sexual, physical, and mental abuse, exploitation, corporal punishment, and involuntary seclusion. The same record documents: Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 ILL. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42CFR 483.13b Interpretive Guidelines).</p> <p>R4's diagnosis list (12/24/2024) documents diagnoses including: Dementia, Depression, and Muscle Weakness.</p> <p>R4's Resident Assessment (12/12/2024) documents R4 has severely impaired cognition, is completely dependent on or requires substantial staff assistance to perform activities of daily living, and uses a wheelchair for mobility.</p> <p>The Facility Incident Report Form (12/11/2024) documents on 12/3/2024 a nursing staff member (V6, Licensed Practical Nurse) was passing medications to residents in the hallway where R3 and R4 are roommates. The same record documents V6 heard an argument inside of R3 and R4's room, entered the room, and observed R3 grab R4's wheelchair followed by R3 pushing R4 away resulting in a skin tear to the arm of R4.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility incident investigation (12/3/2024) documents V6 was in the hallway outside of R3 and R4's room and observed R3 and R4 arguing back and forth and R3 kept trying to push R4 into R3/R4's room so V6 moved R4 out of R3/R4's room and shut the door. The investigation documents V6 reported R3 opened the bedroom door again and resumed trying to push R4 into R3/R4's room followed by R3 and R4 kicking each other. The investigation documents V6 then separated R3 and R4 and had returned to the medication cart to resume passing medications to residents when V5 (Certified Nurse Aide) soon approached V6 with R4 present to show V6 an arm wound caused by R3 after V6 last separated R3 and R4. V6 reported both R3 and R4 were upset and R3 admitted to causing the wound on R4's arm and said R4 was the one who started the altercation.</p> <p>On 12/24/2024 at 12:04PM, V5 (Certified Nurse Aide) reported leaving the central shower room on 12/3/2024 and seeing R4's holding R4's arm that was bleeding and asking R4 what happened to cause the injury. V5 reported R3 was located behind R4 in the hallway and stated I did that, I scratched her. V5 reported R4 cried when staff started to clean R4's injury and the wound is taking a while to heal. V5 reported every time staff change R4's shirt, R4 states hey, hey, hey.</p> <p>On 12/24/2024 at 11:50AM, V6 (Licensed Practical Nurse) reported when R3 was preparing for bedtime on 12/3/2024, R3 stated R3 would have not scratched R4 earlier in the day if R4 had not started it (the altercation).</p> <p>R4's Skin Issues assessment (12/3/2024) documents R4 sustained an arm skin tear on 12/3/2024 measuring 3.3 centimeters by 2.5 centimeters in size.</p> <p>R4's Order sheet (printed 12/24/2024) documents the following medical order (starting on 12/4/2024) for R4's arm wound sustained during R3 and R4's altercation on 12/3/2024: Clean skin tear to right arm with normal saline. Apply medicated wound dressing & cover with bordered gauze daily.</p> <p>R4's Treatment Administration Record (December, 2024) documents R4 has received the above ongoing medical treatment every day since 12/4/2024.</p>