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	10/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent resident elopement by failing to ensure an exit door was alarmed/monitored to prevent residents from exiting unnoticed and failed to develop and implement a care plan for a resident at risk for elopement for one of three residents (R1) reviewed for elopement on a sample list of five. These failures resulted in R1, a cognitively impaired resident at risk for falls, leaving the facility unsupervised in a wheelchair in the dark. R1 was found three tenths of a mile from the facility in the middle of a country road near railroad tracks by a local citizen who alerted facility staff of R1's location. Findings include:The immediate jeopardy began on 9/05/25 at approximately 9:00 p.m. when R1 left the facility in a wheelchair unnoticed, after staff disable the door alarm, and traveled unsupervised down a country road approximately three tenths of a mile away from the facility. V1, Administrator was notified of the Immediate Jeopardy on 9/25/25 at 3:20PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 9/25/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. R1's admission Record dated 9/23/25 documents R1 admitted to facility 8/28/2019. The admission Record documents R1's medical diagnoses include Congestive Heart Failure with presence of Cardiac Pacemaker, Age-Related Cognitive Decline, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, Abnormalities of Gait and Mobility, Lack of Coordination, Parkinson's Disease Without Dyskinesia, Need for Assistance with Personal Care, Unsteadiness on Feet, and Insomnia.R1's Minimum Data Set (MDS) Section C dated 8/15/25 documents R1 has moderate cognitive impairment.R1's Elopement Risk assessment dated [DATE] identifies R1 at risk for elopement.R1's undated Care Plan documents R1 has confusion and a cognitive communication deficit, R1 is high risk for falls, has a history of falls with major injury, and staff have observed R1 turning off safety alarms. The Care Plan documents R1 has psychosocial well-being issues with reported feelings of isolation, has diagnoses of Major Depressive disorder and Insomnia, is at moderate risk for abuse related to dependence on others, displays inappropriate behaviors, has impaired cognitive function, and has suicidal ideations. R1's undated Care Plan documents Elopement risk was added on 9/6/25 by V4 Social Services Director (SSD) with a goal of R1 will not leave the facility without being escorted by family or staff. The Nurse Practitioner Visit Note dated 8/20/25 documents R1 is a high fall risk, impulsive, needs safety reminders and lists diagnoses of confusional arousals and Altered Mental Status (AMS).R1's Nursing Progress Notes dated 8/26/25 document R1 was found unresponsive with decreased respirations.R1's Physician Visit Note dated 8/27/25 documents R1 had a transient unresponsive episode with bradypnea (abnormally slow breathing) and pallor, which resolved spontaneously. The Note documents to continue to monitor neurological and cardiopulmonary status closely, including level of consciousness, respiratory rate, and skin color, and maintain fall and safety precautions, especially during toileting and transfers.The Psychiatric Nurse Practitioner Visit Notes dated 8/29/25, document R1 reports feeling more depressed for one week. The Notes document staff suspect it could be due to family and staff talking to him about his behaviors. His appetite and sleep are so-so. Reports ongoing suicidal ideations. When asked if he had a plan, he stated That's my business, not yours. When educated on notifying staff of any worsening thoughts or development of plan, he stated I told you it's my business. If I want to do it, I'll figure it out somehow. The Notes document R1 denies homicidal ideations or audio-visual hallucinations and staff are aware of his statements and will continue to monitor closely.R1's Psychiatry Visit Notes dated 9/15/25 document staff reported R1 has new behavior of exit seeking with multiple attempts over previous week and R1 confirmed to practitioner that he would continue to exit seek as he does not want to be at facility.On 9/23/25 at 11:41 AM, V6, R1's friend, stated that on Friday night of 9/5/25, he received a phone call from the facility stating they believed R1 had gotten out of the facility and someone in the community had called reporting they had seen him. V6 could not recall the exact time of the call but stated it was dark outside and he was already in bed. V6 stated that approximately an hour after he received the first call, R1 called from facility stating he was back. V6 stated that R1 stated to V6, R1 had to go home to feed the dog, and he didn't want to be in the facility anymore. V6 stated R1's residence prior to living at the facility was an apartment approximately 45 miles north that was right behind the railroad tracks. V6 stated R1 has stated to V6 previously that he would just follow the tracks home. V6 stated R1 knew the exit code because it had been posted on the door for years. V6 stated staff (Unknown) told him where R1 had been found indicating

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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. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident's medical record included an elopement event for one of three residents (R1) reviewed for elopement in the sample list of five. R1's admission Record dated 9/23/25 documents R1 admitted to facility 8/28/2019. The admission Record documents R1's medical diagnoses include Congestive Heart Failure with presence of Cardiac Pacemaker, Age-Related Cognitive Decline, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, Abnormalities of Gait and Mobility, Lack of Coordination, Parkinson's Disease Without Dyskinesia, Need for Assistance with Personal Care, Unsteadiness on Feet, and Insomnia.R1's Minimum Data Sheet (MDS) Section C dated 8/15/25 documents R1 has moderate cognitive impairment.R1's undated Care Plan documents R1 has confusion and a cognitive communication deficit, R1 is high risk for falls, has a history of falls with major injury, and staff have observed R1 turning off safety alarms. The Care Plan documents R1 has psychosocial well-being issues with reported feelings of isolation, has diagnoses of Major Depressive Disorder, and Insomnia, is at moderate risk for abuse related to dependence on others, displays inappropriate behaviors, has impaired cognitive function, and has suicidal ideations.On 9/23/25 at 11:41 AM, V6, R1's friend, stated that on that Friday night of 9/5/25, he received a phone call from the facility stating that they believed R1 had gotten out of the facility and that someone in the community had called reporting they had seen him. V6 could not recall the exact time of the call but stated it was dark outside and he was already in bed. V6 stated that approximately an hour after he received the first call, R1 called from the facility stating he was back. R1 stated to V6 that he had to go home to feed the dog and that he didn't want to be in facility anymore. V6 stated R1's residence prior to living at the facility was an apartment approximately 45 miles north that was right behind the railroad tracks. V6 stated R1 has stated to V6 previously that he would just follow the tracks home. V6 stated R1 knew the exit code because it had been posted on the door for years. V6 stated staff (Unkown) told him where R1 had been found indicating R1 had to travel over uneven, bumpy, railroad tracks to get to the location R1 was found. V6 stated if R1 fell out of the wheelchair he would not have the strength to pull himself back in. R1's medical record does not document notification to V6 on 9/5/25.The Facility Investigation File dated 9/6/25 includes one written statement from V14 RN. V14's undated written statement documents that at 9:55PM she received a call from a local town resident stating she had observed someone in a wheelchair in the road near her home that she believed was a resident of the facility. A head count was initiated and R1 was found to be missing. The statement documents R1 was last seen heading toward the front hallway in a wheelchair around 9:00 pm. The statement documents upon R1's return, no injury was found, and a wander guard was placed on R1's right ankle. The statement documents notifications were made to V1 Administrator, V16 Supervisor, and V6 R1's Representative.R1's undated Care Plan documents Elopement risk was added on 9/6/25 by V4 Social Services Director (SSD) with a goal of R1 will not leave facility without being escorted by family or staff. R1's Physican Order Sheet dated 9/23/25 documents a new order for monitoring wander guard functioning started on 9/8/25.R1's Psychiatry Visit Notes dated 9/15/25 document staff reported R1 has new behavior of exit seeking with multiple attempts over previous week and R1 confirmed to practitioner that he would continue to exit seek as he does not want to be at facility.R1's medical record does not document any incident on the night of 9/5/25. On 9/24/25 at 3:20 PM V2 Director of Nurses, stated she was not aware there was no documentation for R1 on the event on 9/5/25. The Facility Medical Record Policy, undated documents physicians, nursing staff, and other healthcare professionals are responsible for making timely and accurate entries. Nursing documentation shall include notations of incidents including notification to medical doctor and resident representative.The Facility policy titled Accidents & Incidents dated 6/1/2007 documents staff must document in the clinical record a descriptive summary of an incident and any associated interventions including resident response to interventions, as well as complete incident report by end of shift.