

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 12/17/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the right to be free from verbal abuse of one (R1) resident from another resident (R2) out of four residents reviewed for abuse in a sample list of eight residents. Findings include:R1's Electronic Medical Record (EMR) documents medical diagnoses as Legal Blindness, Lack of Coordination, Disorders of Muscles, Dementia and Anxiety. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 requires maximum assistance with bed mobility and is dependent on staff for bathing, toileting, dressing, personal hygiene and transfers. R2's MDS dated [DATE] documents R2 as severely cognitively impaired. This same MDS documents R2 requires moderate assistance with transfers and supervision with walking up to 50 feet. R2's Psychiatric Evaluation dated 10/21/25 documents R2 was admitted to a psychiatric hospital after threatening to kill his roommate (R1). This same report documents R2 stated he would act on his verbal threats to kill someone if they made him made enough because he had been trained in the military on how to kill someone. R1 and R2's Final Report to the State Agency dated 10/24/25 documents R2 was making verbally aggressive and threatening comments to his roommate R1 on 10/20/25. This same report documents R2 told staff if staff did not 'shut him up' (R1), then R2 would 'kill the son of a b****'. This same report documents R2 continued to threaten and scream at staff as they were separating R2 from R1. This same report documents V26 CNA witnessed R2 threatening R1 directly as V26 was separating R2 from R1. On 12/9/25 at 2:40 PM R2 was walking independently in his room, came to the hallway and returned into his room. On 12/17/25 at 2:00 PM R1 was laying in a reclined wheelchair yelling out 'help me' repeatedly. V25 CNA walked over to R1 to assist R1. R1 stated he did not need anything and continued to yell out 'help me'. V25 CNA stated R1 continually yells out with no purpose or need. V25 CNA stated R1 does not yell at any one person but just 'yells out all the time'. On 12/10/25 at 10:30 AM V2 Director of Nursing (DON) stated R2 is known to have verbal outbursts towards other residents and can be verbally and physically aggressive towards staff. V2 DON stated V2 and V9 SSD both witnessed an incident last week where R2 lifted his cane in an attempt to hit V2 and V9 with it. V2 DON stated R2 was went to the emergency room for Homicidal Ideations where he was then sent to a psychiatric facility. V2 DON stated R2 has not had any further behaviors since his medication changes and return to the facility on [DATE]. The facility policy titled Abuse Prevention Program dated October 2022 documents Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident. The term willful in the definition of abuse means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent cross contamination during wound care of one (R2) residents Right Ankle Arterial wounds out of three residents reviewed for wound care in a sample list of eight residents. Findings include:R2's MDS dated [DATE] documents R2 as severely cognitively impaired. This same MDS documents R2 requires moderate assistance with transfers and supervision with walking up to 50 feet. R2's Care Plan intervention dated 8/21/25 instructs staff to provide treatment to areas as ordered. R2's Physician Order Sheet (POS) dated December 2025 documents a physician order starting 11/26/25 to Clean R2's Right Ankle Arterial wound with wound cleanser, apply barrier ointment to the surrounding wound, apply Vaseline soaked gauze to the open wounds and cover with absorbent pad and gauze wrap daily and as needed. The facility daily staffing sheets show contract nurses were scheduled as R2's nurses from 10/16/25-10/20/25. R2's Hospital Record dated 10/20/25 documents R2 does have localized Right Lower Extremity wrap and when unwrapped the hospital staff noted Erythema and Cellulitic appearance to lower leg. This same record documents there was localized maggots on wound when unwrapped with the appearance that it had not been changed in some time as the gauze was adhered to the skin and difficult to remove with sterile water. Adult Protective [NAME] (APS) was contacted due to maggots found on lower extremity cellulitic wound. On 12/9/25 at 12:25 PM V5 Registered Nurse (RN) stated R2 was seen in the emergency room initially for a resident to resident altercation that occurred at the facility. V5 stated upon completing a skin check on R2 V5 and V6 Nurse Practitioner (NP) found that R2 had an open wound on his ankle. V5 stated there was a dressing on R2's ankle that was very dry and hard to remove due it stuck to R2's skin. V5 stated R2's dressing was not labeled/dated. V5 stated when V5 removed R1's dressing there were multiple maggots crawling on R2's wound and inside of the dressing. V5 RN stated R2's open ankle wound had a large amount of slough and was very red with minimal drainage. V5 RN stated R2 was started on an antibiotic for his ankle wound prior to R2 being sent to a psychiatric facility to address his behaviors. On 12/11/25 at 11:30 AM V10 Licensed Practical Nurse (LPN) completed wound care for R2's Right Lower Extremity Arterial wounds. R2 has three separate open areas each the size of a baseball. R2's open Arterial wounds were all red with moderate drainage and red periwounds. V10 LPN used the same piece of gauze to cleanse all three of R2's Arterial wounds. V10 LPN wiped R2's Arterial wounds dry by rubbing the same piece of dry gauze over each wound, periwounds and around the dry skin around R2's entire Right Ankle/Foot. R2's prior dressing was not dated/initialed. On 12/11/25 at 12:20 PM V11 Registered Nurse (RN) and V10 Licensed Practical Nurse (LPN) both stated the nurses who work directly for the facility do the dressing changes for R2 as ordered but the contracted nurses do not do the treatments. V11 RN stated she works part time she will change R2's dressing as ordered, then be off work for three to four days and return to see her same dressing on R2's Ankle. V10 LPN stated R2 will allow her to complete his dressing change and also sees her own dressing on R2's ankle two to three days after she has been off and then returns to work. Both V10 LPN and V11 RN stated the facility is aware of this and they are told that V21 Wound LPN will return soon and be able to monitor dressing changes. V21 RN stated she does not want to get the facility 'in trouble' but believes the residents 'deserve better care' than what the contracted nurses are providing. V21 RN stated the contracted nurses should be held accountable for signing off treatments as being done when they are not doing them. On 12/17/25 at 11:00 AM V2 Director of Nurses (DON) stated R2 has an Arterial wound on his Right Ankle. V2 DON stated V21 Wound Nurse/LPN is on leave so V2 DON has been overseeing the wound program in V21's absence. V2 DON stated she does not observe the resident wounds/dressings. V2 DON stated the last time V2 DON visualized R2's Right Ankle wounds was two weeks prior to R2 being sent to the emergency room. V2 DON stated My nurses are adults and know to do the dressings. I shouldn't have to follow them around. V2 DON stated she reviews the Treatment Administration Record (TAR) to see that the wound treatments are signed off but does not have a system in place to ensure the dressings are being completed and/or the dressings are being dated or monitored. V2 DON stated there is no audit system in place for wound dressings. V2 DON stated the facility utilizes 'a lot' of contract nurses. V2 DON confirmed R2 was seen by V17 Wound NP on 10/26/25 and from 10/16/25-10/20/25 was assigned all contract nurses. V2 DON confirmed R2's treatment was signed off as being completed on 10/20/25 prior to R2 being sent to the emergency room where he had to have his dressing soaked off due to adherence to his skin. On 12/17/25 at 1:00 PM V1 Administrator stated the facility</p>		