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	06/26/2026

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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(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. Based on observation, interview and record review, the facility failed to notify a resident's Power of Attorney/ Family Representative of a significant torso bruise. This failure affects one of three residents (R5) reviewed for injuries of unknown origin/family notification on the sample list of 31. Findings include: The facility's Incident Description report documents, 5/21/2026: Resident (R5) presents to admin (V1, Administrator/Abuse Prevention Coordinator) front office with CNA (V36, Certified Nursing Assistant). Upon dressing resident this morning, bruise noted to right breast nipple area radiating to right armpit area. Admin (V1) requests presence of DON (V2, Director of Nursing), bruising noted, and investigation completed.R5's Incident Description report also documents that V32, R5's family member/Power of Attorney (POA), was notified of R5's bruising on 5/21/26 at 9:00 a.m.R5's medical record did not document the above-described bruise. Therefore, R5's medical record also does not document that V32, R5's family member/Power of Attorney, was notified of the bruise.On 6/2/26, V2, Director of Nursing, stated the Incident Description report is an internal tool the facility uses to investigate incidents that occur in the facility. V2 stated the Incident Description report does not become part of a resident's medical record.On 6/17/26 at 3:20 p.m., V32, R5's family member/Power of Attorney, reviewed her phone records during the interview and stated R5's last fall was in April 2026 and that V32 was notified of the fall on 5/3/26. V32 also stated she was not told by the facility that her mother had pinched her breast or that she had a large bruise on 5/21/26. V32 stated, I was not notified of any bruising. I would expect them to have called. I have had to emphasize this repeatedly. I need to be informed.The facility's Notification of Resident Change in Condition Policy, dated October 1, 2019, documents the following:Policy: It is the policy of this facility to promptly notify the residents, their legal representative(s), and attending physicians of changes in the residents' health condition.Policy Specifications: To establish guidelines for assuring residents, their legal representatives, and attending physicians are informed of changes in the resident's condition.The same policy documents, 3. Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings, and care plan review. Review of high-risk clinical issues such as skin breakdown, falls, weight loss, dehydration, and others are conducted on a daily basis.The same policy also documents, 12. Resident representative(s) notifications and attempts will be made promptly and documented in the nurse's notes. In the event the licensed nurse is unable to contact the resident's representative after a reasonable time period, the Director of Nursing will be notified.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect residents from potential abuse by failing to appropriately recognize, investigate, and respond to an injury of unknown origin before concluding there were no concerns for abuse for one of three residents (R5) reviewed for bruises/injury of unknown origin, on the sample list of 31. Findings include: R5's Current Diagnoses Sheet documents the following medical diagnoses: Alzheimer's Disease Unspecified, and Unspecified Dementia with Moderate Agitation. R5's current Physician Order Sheet (POS) documents the following blood thinning medications: Eliquis (Apixaban) Oral Tablet 5 milligrams, Give 1 tablet by mouth two times a day for Atrial Fibrillation. The same POS, and Correlating Medication Administration Records and Treatment Administration Records does not document an order to monitor for bruising related to the blood thinner medication (which is standard of practice confirmed with V10, Nurse Practitioner interview below). R5's Minimum Data Set (MDS) dated [DATE] documents the following: R5 has severe cognitive impairment, has had no behaviors directed towards self or others, and no behavior of rejection of care: R5 uses a manual wheelchair with partial assistant from staff for short distance mobility and is totally dependent on staff for long distance mobility. R5 is Dependent on two or more staff to complete the following: Toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. R5 requires substantial/maximal assistance for toilet and tub transfers. R5's Care Plan dated 4/22/26 documents the following: (R5) is at risk for a psychosocial well-being problem/issue r/t (related to): diagnosis of Alzheimer's Disease and Dementia with impaired cognitive function, wears glasses to assist with vision and are labeled with name, will remain long term in the facility, at risk for exit seeking and wears a wander-guard for monitoring, moderate risk for abuse r/t dependent on others, psychiatric history, anxiety and displays behaviors, is dependent on staff to provide activities, has verbal and physical aggression towards staff other residents at times, and past history of homicidal ideations. (R5 name) will remain free from abuse. (R5) has potential/actual impairment to skin integrity. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The facilities Incident Description report dated 5/21/26 (untimed report) documents the following regarding R5: Nursing Description: Right breast/rib cage, CNA (Certified Nursing Assistant) noted during dressing that AM (witness statement documented below, confirms the bruise was identified the night before on 5/20/26, when providing a shower). DON (V2, Director of Nursing) and Wound Nurse (V7, Licensed Practical Nurse) measurements noted to be 7cm x 4 cm (assumed but not documented, length by width per standard of practice), no open area present and bruising present to right nipple, witnessed event with (V26, Registered Nurse) RN present at time of injury. Resident Description: Resident Unable to give Description Was this incident witnessed: Y (Yes) (V26, RN denies in interview below that she witnessed R5 being pinched). The same Incident Description report documents the following summary: (On) 5/21/2025 spoke with (V26, RN) nurse, (R5's) breast was pinched during transfer. No concerns for abuse. Bruising occurred during transfer. Plan of care ongoing. The same Incident Description report documents the following: (On) 5/21/2026, Investigation reflects that during transfer off (the) toilet to wheelchair, right breast pinched between toilet arm riser and wheelchairs (sic plural). (On) 5/21/2026 Resident (R5) presents to admin (V1, Administrator/Abuse Prevention Coordinator) front office with CNA (V36, Certified Nursing Assistant) upon dressing resident this morning bruise noted to right breast nipple area radiating to right armpit area. Admin (V1) requests presence DON (V2), bruising noted, and investigation completed. V26, RN's interview documented below denies the detail in the above report and confirms the injury was of unknown origin. R5's same Incident Description report documents V32 R5's Family Member Power of Attorney (POA) was notified of R5's bruising on 5/21/26 at 9:00 am. (POA denied being notified in her interview documented (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	below) On 6/17/26 at 3:20 pm V32, R5's Family Member/Power of Attorney reviewed her phone calls while being interviewed. V32 stated R5's last fall was in April and R32 was notified on 5/3/26. V32 stated she was not told by the facility that her mother had pinched her breast, or that she had a large bruise on 5/21/26. I was not notified of any bruising. I would expect them to have called. I have had to emphasize this repeatedly. I need to be informed. R5's medical record did not document the finding of the bruise on 5/20/26 or 5/21/26. There was no fall documented since 4/27/26. The fall note on 4/27/26 documents R5 fell trying to get up from a recliner chair, and R5 had no injuries from that fall. There were no incident reports or nursing notes that document V26, RN transferred R5 from the toilet and R5's breast got pinched. V2, Director of Nursing provided additional information she had not included in R5's bruise investigation or witness statement. V2, DON provided a printout of a text dated 5/21/26 at 8:43 am. The correspondence was between V2, DON and V51, CNA was regarding R5's bruise. The texts are documented as follows: V2, DON texted (R5) has significant bruising new and old to right breast and rib cage area. Are we using sit to stand on her? V51, CNA texted I reported that (bruise) last night (5/20/26) to the nurse (unidentified) when she (R5) was put in the shower. No one has informed myself (sic) that she is (requires) a (mechanical stand lift to transfer) and I have never seen one used on her. It (bruise) was on her left breast (corrected later in text to be right breast) and it was told to me when I reported it that she had a fall. V2, DON texted: Nothing was in the chart so now I have to back track V2, DON texted: Who told you it was a fall? V51, CNA texted: It (bruise) wasn't reported to me, I found out last night assisting her (R5) into the shower when I took off her shirt. I told (V20, Licensed Practical Nurse/ LPN) she (R5) had an enormous bruise on her right breast, and she (V20, LPN) told me she (R5) had a fall and they (nurses) knew (about the bruise) and I went back into the shower room. V2, DON texted: Why wasn't it (bruise) reported on day shift (5/20/26) when they put a shirt on her (R5)? V51, CNA texted: The bruise I saw was purple and turning yellow, it was huge, couldn't have been missed. Funny, I am being asked about it, when I reported it. On 6/2/26 at 11:35 am V13, CNA and this surveyor entered R5's room. R5 was lying on her back in bed. V13, asked R5 if V13 could show this surveyor her bruise. R5 was pleasantly confused, smiled and said okay. V13, CNA raised R5's shirts. R5's right breast was completely covered with a dark purple/black bruise (identified on 5/20/26). R5's bruise measured approximately the diameter of a standard soda pop can. R5 also had diffused yellow and faint green faded bruised areas under her right breast that measured approximately three inches, down the lateral aspect of her right torso and extended approximately five inches, and under her right axillary that measure approximately three inches wide and included R5's upper back. On 6/2/26 at 5:00 am V20, Licensed Practical Nurse (LPN) stated (R5) has a big bruise that is fading now for the most part. It was an injury of unknown source. At first, we (unidentified facility staff) thought it (the bruise) could be from a fall. There was nothing documented about a fall. I know they (unidentified) did an investigation, and I reported the bruise to (V10, Nurse Practitioner). It was big and was so purple it looked black. It covered one of her breasts, down to her waist, and wrapped around her back. It looked like somebody may have transferred her with the (mechanical stand lift) with the sling on too tight. Generally, the CNA's (Certified Nursing Assistants) don't use a sit to stand on her. On 6/2/26 at 6:25 am, V5, Certified Nursing Assistant (CNA) stated I know (R5) has a bruise across her chest, under her armpit and ribs. I heard it had already been reported when I saw it. I heard someone fastened the (mechanical stand lift) belt too tight. At least that is what I was told. That is what it looked like to me. Somebody else said her (R5's) breast was pinched in a transfer off the toilet. I can't imagine a bruise that bad, coming from a pinch on her wheelchair. That is just what I was told it last. On 6/2/26 at 5:35 am V16, CNA stated I do know about a resident with a seriously large bruise. (R5) has a black and blue bruise on her breast that extends all the way down her side to her hip. You could tell it was fresh. It was on my last round (resident checks) about 5:00 am (5/21/26). It was not there when I worked a few days before. It was definitely new. It wrapped around her torso from about the middle of her chest, over her (breast,) rib cage, across her stomach, under her arm, and even spread around to her back. She did not even act (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	like it hurt, but you know it had to. I reported this to (V26, Registered Nurse) and she reported it to the Administrator (V1, Administrator/Abuse Prevention Coordinator). I believe they investigated it. Nobody called me or had me write a statement. I heard later it happened from the (mechanical stand lift) during a transfer. I have never transferred her with a (mechanical stand lift), but that is what it looked like. It has faded a lot, but you can still see where it was. Her (R5's) (slang for breast) is still black, the rest of it is more yellow and faded now. On 6/2/26 at 5:55 am V21, CNA stated I do know about (R5) having a bruise. It was unbelievable. It was so dark and so big. It was in a pattern like she had on a (mechanical stand lift) sling that was too tight. (V16, CNA) and I both work over there with (R5) her, the night it was found, (V26, Registered Nurse) came and looked at it. She was going to see if maybe (R5) had a fall. I assumed she would report it to the Administrator (V1, Administrator/Abuse Prevention Coordinator) if she couldn't figure out what happened. I haven't worked over there for a while. I had not seen it (bruise) recently, until tonight. The bruise is still there but has faded a lot. On 6/5/26 at 1:30 pm V10, Nurse Practitioner (NP) said she was not notified of R5's bruises until (V2, Director of Nursing) told V10, NP later, when V10 NP came into the facility 5/21/26. V10 NP also said R5's bruises found overnight 5/21/26 were likely reported to V3, Medical Director (MD) because he was on call. V10 NP stated (V3, MD) would have provided an order to monitor the bruise as well. V10, NP said That is the standard of practice, when there are no other symptoms present. A bruise that size needs to be monitored closely for swelling, warmth, and pain. On 6/5/26 at 2:20 pm V1, Administrator/Abuse Prevention Coordinator stated V1's understanding was that V2, Director of Nursing and V7, Licensed Practical Wound Nurse had found V26, Registered Nurse witnessed R5 pinch her breast during transfer. The facility did not have to report to Illinois Department of Public Health or go any further with the investigation, that the information had been accurate and confirmed with additional information. V1 then confirmed there was no documentation in R5's medical record that documents R5's bruise, neither a recent fall nor a recent incident or a report of an improper transfer that caused R5's bruise on 5/21/26. V1, acknowledged R5's injury of unknown origin investigation should have gone on further to find supporting evidence of the cause to rule out abuse. On 6/5/26 at 3:20 pm V26, Registered Nurse (RN) reviewed the facilities Bruise/Discoloration report dated 5/21/26, regarding R5's bruise. V26 RN stated I don't know why this report says I witnessed the injury. That is not what I told (V7, Licensed Practical Wound Nurse) or the (V2, Director of Nursing) DON. The twins (V16 and V21, Certified Nursing Assistants) came and told me. I went and assessed (R5's) bruise. There was no witness to any pinch that I knew of. They (V16 and V21 CNA's) did not know what happened and neither did I. (V2, DON) asked me if (R5) could have pinched her breast during a transfer. I said she could have, but the bruise was much worse than what a pinch on her nipple would have caused. That was my expert opinion. Even though she is on blood thinners, this was a massive bruise. It covered part of her sternum, right breast, ribcage, and axillary. It was fresh and deep purple, almost black. It was an injury of unknown origin. We did not have a clue what happened to her. It looked more like a (mechanical stand lift) sling was adjusted too tight. If you put the sling on her (R5), I guarantee it would line up exactly. The CNA's and I all thought the same thing. (R5) does not use a (mechanical stand lift) stand transfer. (V2, Director of Nursing) asked me if I was aware of any recent falls. I remembered about a week prior, I saw (R5) standing in the bathroom, I intervened because I know she (R5) was on blood thinners. She was very unsteady on her feet. I assisted her right away and lowered her to the floor. It was a smooth transition with her buttocks on my leg. Once she was safe on the floor, I got two CNAs to help transfer her to bed so I could do an assessment. I checked all her skin. There was nothing on her skin at all. The bruise surely would not have been from that. Me lowering her to the floor was about a week prior to finding it. If anything, she would have a bruise on her buttocks. I did not see her pinch her nipple. I wish they would not write stuff, I did not say. V26, RN then reviewed R5's electronic medical records notes and stated, I see I did not document when I lowered (R5) to the floor. I should have documented that. Had I documented it, you could see her bruise didn't happen from me lowering her to the floor the week before the bruise (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was found. V26, RN then stated, When the Administrator (V1, Administrator/Abuse Prevention Coordinator) got here that morning (5/21/26), (V36, CNA) took (R5) up and reported the bruise as an injury of unknown origin, because that is what it was. On 6/23/26 at 2:50 pm V21, Certified Nursing Assistant (CNA) stated that she received report around 6:00 pm on 5/20/26, (the night before R5's injury of unknown origin was reported to the Administrator/Abuse Prevention Coordinator) when coming on to work the night shift. The day shift CNA (later identified as V51) had found a bruise while giving R5 a shower. V21 stated She (V51) did not say how big or how bad it was. I would have looked immediately and reported it. (R5) was asleep, in night clothes when I went in her room after shift change. It was not until 5:00 am rounds that I actually saw (R5's) bruise. It was so big. As soon as I pulled up her night shirt, it was obvious. Overnight rounds we are just changing incontinent briefs when they're soiled. At night residents don't want their blankets or clothes removed for skin assessment. We leave their covers on their upper body or I would have seen it sooner. I told (V20 and V26, Registered Nurses), they looked at it and did not know what happened. They were going to see if it was documented and report to the administrator if it was an injury of unknown reason. The facility Abuse Prevention Program policy dated October 2022 documents the following:Establishing a Resident Sensitive Environment 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 residents to concerns expressed. At least quarterly, the reported concerns from residents and families, and the facility response, will be reviewed by the facility Quality Management committee to assure that individual concerns are being addressed and to assess any patterns that might indicate needed changes in facility practices.V. Internal Reporting Requirements and Identification of AllegationsEmployees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.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 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.VII. Internal Investigation1. 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 lime.If classified as an injury of unknown source,' the person gathering facts will document the injury, the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview able. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents' right to be free from misappropriation of money and blank checks. This failure affected one of seven residents (R4) reviewed for misappropriation on the sample list of 31. Findings include:R4's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, indicating R4 has no cognitive impairment.R4's Care Plan, dated 6/9/26, documents the following:Focus: (R4) is at risk for a psychosocial well-being problem related to: low risk of abuse related to dependence on others and anxiety/fear/anger; short-term stay; diagnosis of glaucoma and wears glasses; wears hearing aids; diagnosis of anxiety; suicidal ideations with no plan to harm self; sad mood as indicated by mood assessment; self-isolates; and (R4) is capable of participating in activities of interest.Goal: (R4) will remain free from abuse.Interventions: 1. Address all complaints/concerns promptly using the grievance policy and procedure. 2. Complete a risk for abuse/neglect assessment quarterly. 3. Observe for signs and symptoms of abuse. 4. Report any signs of abuse to the Administrator, Director of Nursing, Supervisor, and follow all Illinois Department of Public Health (IDPH) and facility protocols related to reporting suspected abuse.The facility grievance log documents that V9, R4's friend and independent caregiver prior to R4's admission to the facility, filed a complaint on R4's behalf. The grievance log documents that V43, Previous Interim Administrator, and V38, Director of Clinical Services, completed an investigation regarding the alleged misappropriation of $100.00 and four blank checks on 4/9/26. The same grievance log documents R4's money and checks were reported missing sometime between March 1, 2026, and April 1, 2026. However, as documented in V31's interview below, V31, R4's family member, stated she had been visiting from Florida and placed the money and four blank checks into R4's wallet on either March 27 or March 28, 2026.The Local Police Department report, dated 6/5/26, documents R4's allegation of misappropriation of $100.00 and four blank checks was reported by the facility on 4/1/26. The report, signed by V37, Local Police Chief/Detective, documents the police department had previously instructed the facility to provide a list of individuals who had access to R4's room and personal belongings; however, the facility had not provided the requested information. The report further states, It is also usual and customary for (the facility) to provide us (police department) with the summary of their internal investigation, but that has also not been provided. It is unlikely that our investigation can go any further, particularly if (the facility) claims it to be unfounded.On 6/3/26 at 1:55 p.m., V9, R4's friend and private caregiver, was having lunch with V35, Activities Aide. During lunch, V35 stated she had heard a rumor that R13's purse had been reported missing (later confirmed to have been found) and that two male residents' wallets had also been reported missing around the same time but were later found.V9 stated, I went to the (local dollar store) for (R4). She usually had some money, and I always brought her the change. I never knew exactly how much money she had. I only knew what she gave me to run errands. I called (R4's) daughter (V31), who lives in Florida, and told her there was a rumor of theft in the building. (V31) asked me to check her mom's purse because she had left four blank checks and cash in (R4's) wallet. I told her I would check the next time I visited the facility. It was either the next day or two days later. I went to visit (R4). I told her (V31) wanted me to see if her checks and money were still in her purse, which was in the bottom drawer of her dresser. (R4) said she would appreciate me checking. Every compartment of her purse had been unzipped. Even her makeup bag was open. She had no money or checks. I immediately reported this to (V31) and to (V2, Director of Nursing).On 6/3/26 at 2:15 p.m., V35, Activities Aide, confirmed the above interview.On 6/5/26, V37, Local Police Chief/Detective, stated he initiated the investigation regarding R4's allegation of misappropriation after the facility notified law enforcement on 4/1/26. V37 stated he requested information from the facility that had still not been provided. V37 stated he had not completed his investigation because he was waiting for the facility to provide the names and (continued on next page)

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	146037	A. Building B. Wing	06/26/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact information of staff who cared for R4 after V31 returned to Florida and before 4/1/26, when the missing money and checks were discovered.V37 stated, I understand from (R4's) daughter (V31) that she visited during the last week of March (March 27 or 28, 2026, according to V31's interview below) and placed money and checks in (R4's) wallet. (R4's) daughter immediately stopped payment on the checks. The daughter had no concerns about (V9), the friend and previous caregiver, or the ladies from church who routinely visit (R4). My interviews also found them to be credible. At this point, the facility employees need to be interviewed. One of them would be the likely perpetrator.On 6/17/26 at 2:40 p.m., V1, Administrator/Abuse Prevention Coordinator, stated the investigation into R4's allegation of misappropriation, reported on 4/1/26, had been completed before V1 began working at the facility on 4/6/26. V1 stated she received a notification in the facility's electronic system on her first day of employment indicating the final IDPH report was due. V1 stated she submitted the final report that same day. V1 confirmed neither R4 nor V31 had been notified of the results of the investigation completed by V43, Previous Interim Administrator.On 6/23/26 at 11:50 a.m., R23, R4's friend, stated, R4 and I have known each other for years. I come here to visit her regularly. I remember several months ago R4 told me someone had taken money from her purse while she was sleeping one night. She always had her own money. I have seen her give money to our church when our friends visit. R4 is sharp and honest. If she said she had a certain amount of money, I believe her. She is almost [AGE] years old, but she is reliable. No one ever interviewed me about it. I would have told them the same thing. I probably would have remembered more details if I had been asked at the time.On 6/23/26 at 12:25 p.m., R4 confirmed R23 visits her regularly in her room. R4 stated, R23 and I have been friends for years. We went to church together. (R23) has her own money. She would never take anything from me. R4 also stated, It really bothers me that I cannot figure out who stole from me. I was hoping the facility and police could figure this out.The facility's Abuse Prevention Program policy, dated October 2022, documents the following:Establishing a Resident-Sensitive Environment 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.Concern Identification and Follow-up Resident and family concerns will be documented, reviewed, addressed, and responded to using the facility's grievance procedures. Residents and families will receive a timely response, and concerns will be reviewed by the Quality Management Committee at least quarterly.Internal InvestigationAll incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment, or misappropriation of resident property occurred, was alleged, or was suspected.Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation.Investigation Procedures: 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. Written statements, medical records, and other pertinent documents will be reviewed. Residents to whom the accused regularly provided care, and employees with whom the accused regularly worked, will also be interviewed.The facility's Filing Grievances/Complaints policy, revised December 2004, documents: 7. The resident, or person filing the grievance on behalf of the resident, will be informed of the findings of the investigation and the actions to be taken to correct any identified problems. Such notification will be made orally by the Administrator, or designee, within five working days of the filing of the grievance. A written summary will also be provided to the resident, and a copy will be maintained in the business office.Should the resident not be satisfied with the results of the investigation or the recommended actions, the resident may file a written complaint with the local Ombudsman Program or the State Survey and Certification Agency.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to operationalize their abuse prevention policy by failing to inform a resident and resident's family representative of a misappropriation, investigation results. This failure affected one of seven residents (R4) reviewed for misappropriation on the sample list of 31.Findings include:The facility's Abuse Prevention Program policy, dated October 2022, documents the following:IV. Establishing a Resident-Sensitive EnvironmentThis 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 through 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 to the resident or family regarding concerns expressed. At least quarterly, reported concerns from residents and families, along with the facility's responses, will be reviewed by the Quality Management Committee to ensure individual concerns are addressed and to identify any patterns indicating the need for changes in facility practices.The same Abuse Prevention Program policy documents the following:Informing the Resident's Representative. The resident or the resident's representative will be informed of the conclusions of the investigation.The facility's investigation regarding R4's allegation of misappropriation, dated 4/7/26, documents the following Final Summary/Conclusion:Based on the investigation, the cash and four blank checks were determined to be missing but remain unaccounted for. The resident's POA (V31, Family Member/Power of Attorney) contacted the bank and canceled the checks so they could not be used.There is no documentation in the 4/7/26 investigation report indicating that R4 or V31, R4's Power of Attorney/Daughter, was informed of the investigation's conclusions after the facility completed the investigation on 4/7/26 and submitted its final report to the Illinois Department of Public Health (IDPH).The Local Police Department report, dated 6/5/26, documents that R4's allegation of misappropriation of one hundred dollars and four blank checks was reported by the facility on 4/1/26. The report, signed by V37, Local Police Chief/Detective, documents that the police department had previously instructed the facility to provide a list of individuals who had access to R4's room and personal belongings; however, the facility had not provided the requested information. The report further states:It is also usual and customary for (the facility) to provide us (police department) with the summary of their internal investigation, but that has also not been provided. It is unlikely that our investigation can go any further, particularly if (the facility) claims it to be unfounded.R4's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, indicating R4 has no cognitive impairment.On 6/2/26 at 1:15 p.m., R4 stated she had been missing approximately one hundred dollars and four blank checks since V31, Family Member/Power of Attorney, visited at the end of March. R4 stated, I wish the directors in this nursing home would have identified who did this. I would rest a lot easier. I have heard nothing about the investigation.On 6/3/26 at 10:50 a.m., V31, R4's Power of Attorney/Family Member, confirmed R4 had approximately one hundred dollars in her wallet on March 27 or March 28, 2026, which was discovered missing on 4/1/26. V31 stated neither she nor R4 had been informed of the results of the facility's investigation.On 6/16/26 at 4:00 p.m., V38, Director of Clinical Services, stated he spoke with R4's daughter (V31) when the allegation of misappropriation was reported on 4/1/26. V38 stated he submitted the initial report to IDPH but did not complete the investigation. V38 stated V43, Previous Interim Administrator, completed the investigation and that he did not know whether V43 informed R4 or V31 of the investigation's conclusions.On 6/17/26 at 2:40 p.m., V1, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator/Abuse Prevention Coordinator, stated the investigation into R4's allegation of misappropriation had been completed before V1 began working at the facility on 4/6/26. V1 stated she received a notification through the facility's electronic system on her first day indicating the final IDPH report was due and submitted the report that same day. V1 confirmed neither she nor anyone else had notified R4 or V31 of the conclusions of the investigation completed by the previous administrator.

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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. Based on observations interviews and record review the facility failed to report an injury of unknown origin to the State Agency for one of three residents (R5) reviewed for bruises/injury of unknown origin/reporting on the sample list of 31. Findings include: The facility's Incident Description report, dated 5/21/26, documents the following, (On) 5/21/2026 Resident (R5) presents to admin (V1, Administrator/Abuse Prevention Coordinator) front office with CNA (V36, Certified Nursing Assistant). Upon dressing resident this morning, bruise noted to right breast nipple area radiating to right armpit area. Admin (V1) requests presence of DON (V2, Director of Nursing), bruising noted, and investigation completed.On 6/5/26 at 2:20 p.m., V1, Administrator/Abuse Prevention Coordinator, stated V1's understanding was that V2, Director of Nursing, and V7, Wound Licensed Practical Nurse, had determined that V26, Registered Nurse, witnessed R5 pinch her breast during a transfer. V1 stated the facility would not have had to report the incident to the Illinois Department of Public Health (IDPH) or continue the investigation if that information had been accurate (V26, RN denied witnessing R5 pinch her breast during the transfer, as documented below) and confirmed by additional evidence.V1 then confirmed there was no documentation in R5's medical record of the bruise, a recent fall, or an incident involving an improper transfer that could explain the cause of R5's bruise identified on 5/21/26. V1 acknowledged the investigation into R5's bruise, an injury of unknown origin, should have continued to obtain supporting evidence to determine the cause, rule out abuse, and report the allegation to IDPH while additional information was being obtained.On 6/23/26 at 2:50 p.m., V21, Certified Nursing Assistant (CNA), confirmed the details of V26's interview, documented below.On 6/5/26 at 3:20 p.m., V26, Registered Nurse (RN), reviewed the facility's Incident Description report dated 5/21/26 regarding R5's bruise. V26 stated she did not witness R5 pinch her breast or sustain the bruise. V26 stated V16 and V21, Certified Nursing Assistants, informed her of the bruise. V26 stated, The bruise was an injury of unknown origin. We did not have a clue what happened to her. It looked more like a mechanical stand lift sling was adjusted too tight. If you put the sling on her (R5), I guarantee it would line up exactly.The facility's Abuse Prevention Program policy, dated October 2022, documents the following: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; andThe 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 because of the number of injuries observed at one particular point in time or the incidence of injuries over time.Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interviews and record review, the facility failed to recognize and thoroughly investigate an injury of unknown origin one of three residents (R5) reviewed for bruises/injury of unknown origin, on the sample list of 31. Findings include: The facilities Incident Description report dated 5/21/26 (untimed report) documents the following regarding R5: Nursing Description: Right breast/rib cage CNA (Certified Nursing Assistant) noted during dressing that AM (witness statement documented below, confirms the bruise was identified the night before on 5/20/26, when providing a shower). (The) DON (V2, Director of Nursing) and Wound Nurse (V7, Licensed Practical Nurse) measurements noted to be 7cm x 4 cm (assumed but not documented, length by width per standard of practice), no open area present and bruising present to right nipple, witnessed event with (V26, Registered Nurse) RN present at time of injury. Resident Description: Resident Unable to give Description. Was this incident witnessed: Y (Yes) (V26, RN denies in interview below that she witnessed R5 being pinched). The same Incident Description report documents the following summary: (On) 5/21/2025 spoke with (V26, RN) nurse, (R5's) breast was pinched during transfer. No concerns for abuse. Bruising occurred during transfer. Plan of care ongoing. The same Incident Description report documents the following: (On) 5/21/2026. Investigation reflects that during transfer off (the) toilet to wheelchair right breast pinched between toilet arm riser and wheelchairs (sic plural). (On) 5/21/2026 Resident (R5) presents to admin (V1, Administrator/Abuse Prevention Coordinator) front office with CNA (V36, Certified Nursing Assistant) upon dressing resident this morning bruise noted to right breast nipple area radiating to right armpit area. Admin (V1) requests presence of DON (V2), bruising noted, and investigation completed. R5's medical record did not document R5's bruise or any falls or incidents to determine the cause of R5's bruise. Therefore there was no record review to support the investigation conclusion documented above. On 6/2/26 at 5:35 am V16, CNA confirmed the details of V26's interview documented below. On 6/5/26 at 2:20 pm V1, Administrator/Abuse Prevention Coordinator stated V1's understanding was that V2, Director of Nursing and V7, Licensed Practical Wound Nurse had found V26, Registered Nurse witnessed R5 pinch her breast during transfer. The facility did not have to report, to Illinois Department of Public Health or go any further with the investigation, had the information been accurate and confirmed with additional information. V1 then confirmed there was no documentation in R5's medical record that documents R5's bruise, a recent fall, or a recent incident report of an improper transfer, that explained the cause of R5's bruise on 5/21/26. V1, acknowledged R5's bruise/injury of unknown origin investigation, should have gone on further to find supporting evidence of the cause, so as to rule out abuse. On 6/23/26 at 2:50 pm V21, CNA confirmed the details of V26, interview documented below. On 6/5/26 at 3:20 pm V26, Registered Nurse (RN) reviewed the above facilities report dated 5/21/26, regarding R5's bruise. V26 RN stated I don't know why this report says I witnessed the injury. That is not what I told (V7, Wound Licensed Practical Nurse) or the (V2, Director of Nursing) DON. The twins (V16 and V21, Certified Nursing Assistants) came and told me. I went and assessed (R5's) bruise. There was no witness to any pinch that I knew of. They (V16 and V21 CNA's) did not know what happened and neither did I. (V2, DON) asked me if (R5) could have pinched her breast during a transfer. I said she could have, but the bruise was much worse than what a pinch on her nipple would have caused. That was my expert opinion. Even though she is on blood thinners, this was a massive bruise. It covered part of her sternum, right breast, ribcage, and axillary. It was fresh and deep purple, almost black. It was an injury of unknown origin. We did not have a clue what happened to her. It looked more like a (mechanical stand lift) sling was adjusted too tight. If you put the sling on her (R5), I guarantee it would line up exactly. The CNA's and I all thought the same thing. (R5) does not use a (mechanical stand lift) stand transfer. (V2, Director of Nursing) asked me if I was aware of any recent falls. I remembered about a week prior, I saw (R5) standing in the bathroom, I intervened because I know she (R5) was on blood thinners. She was very unsteady on her feet. I assisted her right away and lowered (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her to the floor. It was a smooth transition with her buttocks on my leg. Once she was safe on the floor, I got two CNAs to help transfer her to bed so I could do an assessment. I checked all her skin. There was nothing on her skin at all. The bruise surely would not have been from that. Me lowering her (R5) to the floor was about a week prior to finding it. If anything, she would have a bruise on her buttocks. I did not see her pinch her nipple. I wish they would not write stuff, I did not say. V26, RN then reviewed R5's electronic medical record notes and stated. I see I did not document when I lowered (R5) to the floor. I should have documented that. Had I documented it, you could see her bruise didn't happen from me lowering her to the floor the week before the bruise was found. The facility Abuse Prevention Program policy dated October 2022 documents the following: 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 lime.

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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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess residents for risk of entrapment from a bedrail and failed to calibrate an alternating air flow mattress setting for a resident's weight. These failures resulted in R12's mattress becoming overinflated which caused R12 to fall into the bedrail and to the floor. During the fall R12's arm became entrapped in the bedrail and R12 was unable to reposition R12's head and neck away from the bedrail which resulted in neck and sternum injuries. These failures affect eleven of eleven residents (R4, R6, R7, R10, R12, R13, R27, R28, R29, R30, and R31) reviewed for side rails and accidents on the sample list of 31.The Immediate Jeopardy began on 03/05/26, when the facility added bed siderails and a low air loss mattress to R12's bed, without completing a side rail assessment for safe use. V1 Administrator was notified of the Immediate Jeopardy on 6/17/26 at 12:10 pm. The surveyor confirmed by observation, interview and record review the Immediate Jeopardy was removed on 6/18/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include:1. According to the United States Consumer Product Safety Commission's current official website: cpsc.gov, There are risk involved in using adult portable rails, however, including injuries from falls, or entrapment, or death by asphyxiation from head, neck, or chest entrapment. In fact, CPSC (Consumer Product Safety Commission) data show that 90 percent of injuries associated with adult portable bed rails are from entrapment of the head, chest and neck.R12's Current Diagnoses Sheet documents the following: Unspecified Dementia Unspecified Severity with Agitation, Osteoarthritis Unspecified Site, Age-Related Osteoporosis with Current Pathological Fracture Left Femur (History of), Subsequent Encounter for Aftercare with Routine Healing, Muscle Weakness (Generalized), Unsteadiness on Feet, Need for Assistance, and Abnormalities of Gait and Mobility,R12's Minimum Data Set (MDS) dated [DATE] documents R12 has severe cognitive impairment and is totally dependent on physical staff assistance with all activities of daily living which include bed mobility and transfers.R12's Fall Risk assessment dated [DATE] is completed. The score is not identified on the 3/9/26 assessment. The corresponding 3/9/26 Fall Risk Assessment list in R12's electronic medical record documents R12 had a score of 18, which indicates R12 was at high risk for falls due to a score greater than 10. R12's Care Plan dated 5/26/26 documents R12 requires a full body mechanical lift for transfers. R12's same Care Plan documents on 3/5/26 the following interventions were implemented: Bed Mobility: Inform (R12) about the plan and clarify what is expected of her. Use both verbal and visual cues, instructing her to use her enabler bars to assist with rolling from side to side and completing bed mobility tasks safely. (R12) depends on staff to help her reposition every two hours and as needed to relieve pressure and ensure her comfort. She (R12) uses a low-air-loss mattress for precautionary measures, with the dial set to the third position. Date Initiated: 03/05/2026There is no documentation in R12's medical record that R12 has had a side rail assessment to determine R12's risk for entrapment/safety.R12's Nursing Note dated 5/15/2026 at 2:16 am documents the following: Note Text: Resident (R12) was found by CNA (V27, Certified Nursing Assistant) sitting on floor with her (R12's) face and arm by the side rail. Resident (R12) was assessed. Bruising noted to left and right side of neck and right breast/sternal area. Three small abrasions/tears noted to left side of neck and one small abrasion/tear noted to right side. Resident A&O x1 (alert and oriented to self only). VS WNL (vital signs within normal limits). Resident was assisted back to bed, and call light within reach. Fall mat placed. NP (V10, Nurse Practitioner) and DON (V2, Director of Nursing) notified.R12's Nursing Note: dated 5/15/26 at 2:44 am documents R12's personal bed alarm did not sound when R12 fell from her bed.R12's Fall investigation report dated 5/15/26 at 1:45 am documents the following: Predisposing factors: Fall (continued on next page)

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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.

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	alarm. R12's same Fall investigation report also documents the following: (V27, / CNA): resident (R12) slid off side of bed, unwitnessed found resident on floor with head resting on guardrail. Intervention/Root Cause: low air loss mattress /appears resident rolls out of bed -- bed is in lowest position/floor (air mattress) position set to 340 lbs. (pounds) - resident weighs 96 lbs. Intervention: air mattress at correct settings, restorative programs updated, PT/OT eval (Physical Therapy/ Occupational Therapy evaluation).R12's same Fall investigation report documented above does not document the side rail involvement was identified as part of the root cause related to R12's injuries and therefor does not include an intervention.R12's Bruise assessment Wound report, with pictures only documents one measurement and location. R12's bruise assessment documents the location of the bruise being measured was on R12's chin. The measurements were recorded as 10.0 centimeters (cm) length, 7.0 cm width and 0.10 cm depth. The pictures of the bruise were of R12's neck and spanned over the center and both sides of R12's neck. There was no picture of R12's sternum. The same wound report documents skin intact though R12 had skin tears on the bilateral neck (noted in the nurses note above). The skin tears were not measured. The same wound report does not describe the color of the bruise and surrounding tissue for swelling, redness or signs of infection in accordance with standard of practice.R12's Physical Therapy - PT Evaluation & Plan of Treatment dated 5/18/26 (three days post fall) directs staff to remove R12's bed siderails and also documents the following: Current Referral Reason for Referral/Current Illness: Pt (Patient R12) is a (specific stated age) referred to skilled PT following a recent fall w/o (without) ER (Emergency Room) visit w/ (with) acute injuries. Pt was found sitting on the floor w/ (with) her face and arm by the side rail, bruising noted to L and R (left and right) side of neck and R (right) breast sternal area, 3 small abrasions/tears noted to L (left) side of neck and one small abrasion/tear noted to R (right) side. She (R12) presents to therapy with contractures on BLE (bilateral lower extremities), 2 assist dep (dependent) for bed mobility, (full body mechanical lift) for transfers, bed/chair bound, total dep (dependence) for all ADLs (Activities of Daily Living), nonverbal, ongoing agitation and confusion, but no acute behavioral disturbances or distress. Pt's fall prevention measures include a bed alarm, a low bed precaution, a bedside floor mat to cushion, and a body pillow. Therapy recommends removal of pt's bed rail at this time due to pt's cognitive decline/ confusion and poor safety awareness. Pt is also in good restorative program for passive rom (Range of Motion), dressing/bathing/ grooming and feeding. DC (discharge) skilled PT (Physical Therapy) at this time as pt (patient R12) is functioning at baseline w/o (without) any significant decline.On 6/3/26 at 1:30 pm V2, Director of Nursing (DON) and this surveyor walked to the nurse's station. R12 was seated in a geriatric wheeled chair, and was confused. R12 had three pencil eraser sized light white scar-like areas on her neck. Surrounding the scar like areas on R12's neck was a faded yellow bruise area approximately two inches wide going down approximately two inches down the center of 12's neck. There was a red dry skin patch noted on R12's chin. A full visual assessment was not conducted at this time due to resident's cognitive status and the resident was seated in a common area. V2, DON confirmed R12's scar-like areas are healed skin tears and the discolorations are faded bruises from when R12 fell on 5/15/26. V2, DON reviewed the details of R12's 5/15/26 fall out of bed. V2, DON stated the facility does not complete a side rail assessment to determine the residents' risk of entrapment and does not consider a consent is needed for side rail use when the side rail is an enabler not a restraint. As V2, DON reviewed R12's Fall investigation, V2, DON stated (R12) would have been bounced around like she (R12) was in a bounce house, because the air mattress had been hyperinflated for a person weighing 340 pounds, and (R12) only weighs 96 pounds. V2, DON then stated I have educated the CNAs. They were hyperinflating (R12's) mattress when they changed her (R12). It creates a firmer surface to change (provide incontinence care) and reposition her (R12). We have put a stop to that. Only the nurses can change the setting (on the air mattress inflation).On 6/3/26 at 3:42 pm V27, Certified Nursing Assistant (CNA) stated when he (V27, CNA) found R12 seated on the floor next to R12's low bed, R12's right arm was stuck in the right-side rail. R12's arm was protruding from the inside of the bed, (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	through the right siderail opening. R12's hand was suspended over the floor, and outside the bed rail. R12's buttocks were on the floor. R12's back was against the bed, R12's neck and head were leaning at an angle, and up against the side rail. V27, CNA stated (R12) couldn't move her head and neck, because her arm was caught in the side rail. It (arm caught in the side rail) was holding her in that position up against the side rail. V27, CNA also said R12 had skin tears on both sides of her neck, and bluish colored bruising to her neck and chest. I am not sure how long she was stuck. It was my first round of bed checks. I came in to work that night at 10:00 pm. I had been in her (R12's) room to get a bedpan to her roommate (R15) about 1:00 am. (R12) could have fallen any time after I (V27, CNA) provided the bed pan to her (R12's) roommate (R15), and when I found her around 1:45 am to 2:00 am. Her bed alarm was not turned on or I would have known right away that she fell. I really don't know how long she was on the floor like that. One of the nurses (unidentified) came and said the air mattress was turned too high (hyperinflated) causing (R12) to be pushed into the side rail. V27, CNA also stated (R12) is dependent on staff for repositioning in bed and does not use the side rail for repositioning.On 6/4/26 at 12:55 pm V36, Certified Nursing Assistant (CNA) stated (R12's) bruises I saw a couple days after she fell out of her (R12) bed. They said she (R12) rolled out of bed because her (R12's) air mattress was turned too high. She (R12) did have side rails, but I have never seen her use them. She (R12) has Dementia and doesn't understand even simple directions. She (R12) can't roll on her own that's why they think the air mattress shifted and rolled her off the bed that is all I heard about the fall. When I first saw a band aid on (R12's) chin, I (V36 CNA) also saw, all around her neck, she had a big green and faded yellow bruises. She had a fading bruise in the middle of her chest, too.On 6/5/26 at 8:20 am V3, Medical Director (MD) confirmed R12 is cognitively impaired and totally dependent on staff. V3, MD acknowledged R12's fall from a hyperinflated air mattress, a bed with side rails that were not properly assessed for safety to prevent entrapment, and a bed alarm that did not activate are all the issues of concern. V3, MD was non-committal to identify the potential risk for serious injury or death when R12's side rails were in use with an air mattress and without a side rail entrapment assessment. 2. R4, R6, R7, R10, R13, R27, R28, R29, R30, and R31's medical records do not include side rail assessments.On 6/23/26 between 12:15 pm and 1:15 pm, V2, Director of Nursing (DON) and V7, Licensed Practical Nurse (LPN)/Wound Nurse went from resident room to resident room with this surveyor. R4, R6, R7, R10, R13, R27, R28, R29, R30, and R31 all had air mattresses and bed siderails on their beds.During the same observations noted above, V2 DON and V7, LPN confirmed the facility had not completed side rail assessments prior to originally installing side rails for R4, R6, R7, R10, R13, R27, R28, R29, R30, and R31, for risk of entrapment and safety.The facility policy Proper Use of Beds and Bed Mobility Systems- effective 04/25/15 documents the following: PurposeThe purpose of these guidelines is to ensure the safe use of all beds and bed mobility systems as resident mobility aids.DefinitionMobility Systems are defined as any mechanical, material or equipment attachment devices that are used to assist and increase the resident's functional status with ADLs (Activities of Daily Living) as determined by the interdisciplinary team. All such devices must be in compliance with state and federal guidelines. Mobility Systems include, but are not limited to, trapeze, Halos, side rails, and poles. The facility presented an initial abatement plan to remove the immediacy on 6/17/26 at 3:53 pm. The survey team reviewed the abatement plan. The abatement required revisions to remove the immediacy.The facility presented a first update to the abatement plan to remove the immediacy on 6/18/26 at 11:59 am. The survey team reviewed the first updated abatement plan. The abatement required revisions to remove the immediacy.The facility presented a second update to the abatement plan to remove the immediacy on 6/18/26 at 1:21 pm. The survey team reviewed the second update to the original abatement plan and accepted the abatement plan on 6/18/26 at 1:57 pm.The Immediate Jeopardy that began on 3/05/25 and was removed on 6/18/26 when the facility took the following actions to remove the immediacy.1. R12 received a new low bed on 5/15/26 with side rails removed on 5/18/2026.2. R12's alternating air flow mattress was adjusted to the correct setting air mattress inflation level to the manufacturer's recommended settings and (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	verified proper functioning on 5/15/2026.3. V3, Medical Director, V10, Nurse Practitioner and V34, R12's Family Member were notified of the incident and care plan revisions were completed by V1, Administrator and V2, Director of Nursing on 5/15/2026.4. R12 was assessed for injury, entrapment risk, pain, skin impairment, and psychosocial effects by V2, Director of Nursing and V7, Wound/ Licensed Practical Nurse. Completed on 6/17/26.5. R12's Care Plan was updated to reflect current interventions which include a low bed, Physical and Occupational Therapy evaluation, Neurological checks and updated low air mattress setting to appropriate to weight. Completed by V2, Director of Nursing and V46, Minimum Data Set Coordinator /Care Plan Coordinator on 5/15/26.6. A facility wide audit was conducted regarding air flow mattresses by V2, Director of Nursing and completed on 5/15/26.7. A facility wide audit was conducted on side rails completed by V2, Director of Nursing and V7, Wound/Licensed Practical Nurse on 6/17/26.8. R4, R6, R7, R10, R12 (side rails removed post assessment), R13, R27, R28, R29, R30, and R31, were assessed for bed safety and risk for entrapment and care plans were updated as needed. Completed by V2, Director of Nursing and V7, Wound/Licensed Practical Nurse and V46, Care Plan/Minimum Data Set Coordinator on 6/18/26.9. Training was provided to V1, Administrator and V2, Director of Nursing on the policy dated 4/25/15 titled; Proper Use of Beds and Bed Mobility Systems completed by V38, Director of Clinical Services on 6/17/26.10. Training was provided by V2 DON/designee to Nurse Managers (MDS, IP and Fall/Restorative nurses), Housekeeping/Laundry Supervisor and Interim Maintenance Director on 6/18/26 on assessing the risk of entrapment before bed rails are placed on residents' bed and on Bed Rail Use and Bed Inspection. Initiated 6/18/26 and ongoing.11. V2 DON updated orders for resident's (R4, R6, R7, R10, R12, R13, R27, R28, R29, R30, and R31) Electronic Medication Administration Record with air flow mattresses to check every shift for accurate settings. Completed by V2, Director of Nursing on 6/17/26.12. V2 DON/designee provided training to nurses on ensuring assessments are completed for bed rails on admission, quarterly and/or change in condition to ensure resident safe utilization. The DON/designee called all nurses and provided verbal education. Don/designee will provide an Inservice to all new nurses prior to first shift worked. Initiated by V2, Director of Nursing on 6/17/26 and ongoing.13. V2, Director of Nursing and V44, Licensed Practical Nurse/Fall Nurse will audit: five residents with bed rails twice weekly for four weeks to verify completion of bed rail assessments and care plan accuracy, five residents with air flow mattresses twice weekly for four weeks to verify proper mattress settings based on manufacturer's guidelines. Initiated on 6/17/26. Audit findings will be reviewed through the facility Quality Assurance and Performance Improvement (QAPI) Committee.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain complete and accurate medical records for three residents (R2, R5, and R20) out of four reviewed for safety/medical records on the sample list of 31. Findings include: 1. R5's Current Medical Diagnoses Sheet documents the following diagnoses: Alzheimer's Disease, Unspecified, and Unspecified Dementia with Moderate Agitation.R5's Minimum Data Set (MDS), dated [DATE], documents that R5 has severe cognitive impairment, a history of falls, and is dependent on staff for assistance with all activities of daily living.The facility's Incident Description report, dated 5/21/26 (untimed), inaccurately documents that R5's right breast and rib cage bruises were identified on 5/21/26.According to the witness text message documented below, V51, Certified Nursing Assistant (CNA), identified R5's right breast and rib bruise on 5/20/26.The facility's Incident Description report, dated 5/21/26, failed to document a complete assessment of R5's bruise. Standard nursing practice requires documentation of the bruise's color, warmth, swelling, and pain.The facility's report also measured R5's bruise without identifying the orientation of the measurements. The report documents, DON (V2, Director of Nursing) and Wound Nurse (V7, Licensed Practical Nurse) measurements noted to be 7 cm x 4 cm (assumed but not documented as length by width), no open area present and bruising present to right nipple, witnessed event with (V26, Registered Nurse) RN present at time of injury.As documented in V26's interview below, V26, Registered Nurse (RN), did not witness the event.The same Incident Description report documents the following summary: (On) 5/21/2025 spoke with (V26, RN) nurse, (R5's) breast was pinched during transfer. No concerns for abuse. Bruising occurred during transfer. Plan of care ongoing.On 6/5/26 at 3:20 p.m., V26, Registered Nurse (RN), reviewed R5's Incident Description report dated 5/21/26. V26 stated, I don't know why this report says I witnessed the injury. That is not what I told (V7, Wound Licensed Practical Nurse) or the (V2, Director of Nursing) DON. V26 further stated she had lowered R5 to the floor approximately one week before the bruises were discovered. V26 acknowledged she did not document lowering R5 to the floor or complete documentation of a post-event skin assessment.The same Incident Description report documents that V32, R5's family member/Power of Attorney (POA), was notified of R5's bruising on 5/21/26 at 9:00 a.m.On 6/17/26 at 3:20 p.m., V32, R5's family member/Power of Attorney, stated, I was not notified of any bruising. I would expect them to have called. I have had to emphasize this repeatedly. I need to be informed.There is no documentation in R5's medical record that the bruise was identified on 5/20/26 or 5/21/26. There is also no documentation that V26 transferred R5 from the toilet or that R5 pinched her breast during the transfer.V2, Director of Nursing (DON), provided a printout of text messages dated 5/21/26 at 8:43 a.m. The correspondence between V2 and V51, Certified Nursing Assistant (CNA), concerned R5's bruise.The text messages document the following:V2 texted, (R5) has significant bruising, new and old, to right breast and rib cage area. Are we using sit to stand on her?V51 replied, I reported that (R5's bruise) last night (5/20/26) to the nurse (unidentified) when she (R5) was put in the shower. No one has informed myself (sic) that she requires a mechanical stand lift for transfers, and I have never seen one used on her. It (bruise) was on her left breast (later corrected to right breast), and I was told when I reported it that she had a fall.On 6/2/26 at 5:00 a.m., V20, Licensed Practical Nurse (LPN), stated, (R5) has a big bruise that is fading now, for the most part. It was an injury of unknown source. At first, we thought it could be from a fall. There was nothing documented about a fall.There is no documented physician order, treatment order, or nursing documentation indicating R5's bruise was monitored.On 6/5/26 at 1:30 p.m., V10, Nurse Practitioner, stated she expected facility nurses to follow the standard of practice when assessing a bruise. V10 stated, A bruise that size needs to be monitored closely for swelling, warmth, and pain.On 6/5/26 at 2:20 p.m., V1, Administrator/Abuse Prevention Coordinator, confirmed there was no documentation in (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's medical record of the bruise, a recent fall, a recent incident, or an improper transfer that could explain the cause of R5's bruise identified on 5/20/26 or 5/21/26.2. R2's Care Plan, dated 11/20/24, documents that R2 exhibits exit-seeking behavior.R2's Elopement Risk Assessment, dated 3/6/26, documents that R2 is at risk for elopement.The facility investigation, provided by V1 and dated 5/1/26, documents that R2 exited the facility, entered a staff member's automobile, and was resistant to leaving the automobile and returning to the building.R2's comprehensive medical record contains no documentation regarding R2's exit from the building on 5/1/26 or notification of R2's family or physician.On 6/5/26 at 2:20 p.m., V1, Administrator, stated R2's exit from the building on 5/1/26 was not documented in R2's electronic medical record and should have been. V1 stated the elopement was documented in the facility's risk management section and confirmed surveyors do not have access to that portion of the electronic record. V1 further stated an investigation had been conducted regarding the incident.On 6/16/26 at 10:44 a.m., V1 confirmed R2's exit from the building on 5/1/26 had not been documented in the medical record. Only the second exit incident, which occurred on 5/2/26, was documented. V1 further stated no investigation was conducted regarding the 5/2/26 exit because Activity staff accompanied R2 during that incident.The facility's Charting and Documentation policy, dated 2006, documents that all observations and incidents must be documented in the resident's clinical record, including the date, time, and notification of the family and physician.3. R2's Physician Order Sheet, dated 6/17/26, directs nursing staff to monitor R2's Wanderguard (electronic monitoring device) each shift to ensure it is in place on R2's right ankle.R2's Treatment Administration Record (TAR) for May 2026 and June 2026 through 6/17/26 documents nursing staff electronically initialed that the Wanderguard was checked and remained on R2's right ankle. The June 2026 TAR also documents the order was rewritten on 6/2/26 to include the Wanderguard identification number while continuing to direct staff to monitor the device on R2's right ankle.On 6/16/26 at 10:53 a.m., R2 was observed lying in bed with the Wanderguard on the left ankle.On 6/23/26 at 3:53 p.m., R2 was seated in the dining room with the Wanderguard on the left ankle. V29, Certified Nursing Assistant, observed and confirmed the Wanderguard was on R2's left ankle.4. R2's Physician Order Sheet, dated 6/17/26, directs nursing staff to monitor R2's Wanderguard each shift to ensure it is in place on R2's right ankle.R2's Treatment Administration Record for May 2026 documents nursing staff failed to electronically document Wanderguard monitoring on six occasions: day shift on 5/5/26; day and evening shifts on 5/6/26; and evening shifts on 5/22/26, 5/24/26, and 5/27/26.R2's Treatment Administration Record for June 2026, through 6/16/26, documents nursing staff failed to electronically document Wanderguard monitoring on four occasions: night shift on 6/4/26; day and evening shifts on 6/10/26; and evening shift on 6/15/26.The facility's Charting and Documentation policy, dated 2006, requires all observations to be documented in the resident's clinical record, including the date, time, and the care provider's name and title.5. R20's Physician Order Sheet, dated 6/17/26, directs nursing staff to monitor R20's Wanderguard (electronic monitoring device) every shift to ensure it is in place on R20's left ankle.R20's Treatment Administration Record for June 2026 documents nursing staff electronically initialed that the Wanderguard was checked and remained on R20's left ankle.The facility's undated List of Residents Utilizing a Wanderguard documents R20's Wanderguard is to be placed on the left ankle.On 6/16/26 at 1:47 p.m., R20 was observed seated in a recliner in her room with the Wanderguard on her right ankle. At 3:20 p.m., R20 confirmed the Wanderguard was on her right ankle.On 6/24/26 at 11:56 a.m., V52, Licensed Practical Nurse, while conducting a function check of R20's Wanderguard, observed and confirmed the Wanderguard was on R20's right ankle.