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	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 40385 Based on interview and record review the facility failed to obtain consents for psychotropic medication use for two (R8, R37) of five residents reviewed for unnecessary medications in the sample list of 46. Findings include: The facility's Psychotropic Medication Policy revised November 2017 documents Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. Side effects of medications shall be described during the informed consent process. 1.) R8's October 2024 Medication Administration Record documents R8 received Depakote (anticonvulsant/mood stabilizer) Delayed Release 500 milligrams by mouth four times daily since 7/12/24. R8's Psychiatry Note dated 9/5/24 at 3:23 PM documents R8 receives Depakote for Bipolar Disorder. There is no documented consent for Depakote in R8's electronic medical record. On 10/30/24 at 1:05 PM V10 Restorative Nurse/Registered Nurse confirmed all of R8's psychotropic medication consents were provided, and there was no consent for Depakote. V10 was asked about assessing for R8's Depakote use. V10 stated R8 has a psychiatric diagnosis and seizure disorder, so it is a dual medication treatment. 35347 2.) R37's Physician Orders (printed 10/31/2024) and Medication Administration Record (October, 2024) document R37 receives the psychotropic medications trazodone hydrochloride (50 milligrams, half a tab by mouth, each day at bedtime) and fluoxetine hydrochloride (60 milligrams by mouth once a day). On 10/30/2024 at 1:15PM, R37's electronic medical record (undated) did not document R37's informed consents for trazodone and fluoxetine use. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 11:00AM, V1 (Administrator) was asked if the facility had obtained R37's consent for the above medications. V1 replied being uncertain if consents were obtained. V1 did not provide any records documenting R37's consent for the above medications prior to the conclusion of the survey on 10/31/2024.

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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 - 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** 37813 Based on observation, interview and record review the facility failed to protect the resident's right to be free of misappropriation of money and personal property for four of five residents (R13, R130, R25 and R46) reviewed for misappropriation in a sample list of 40 residents. Failing to prevent the misappropriation of R13's commemorative coin set, which is not replaceable, resulted in R13 being tearful and experiencing feelings of sadness and loss due to the sentimental value of the coins. Findings Include: The facility Abuse Prevention Program dated October 2022 documents this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent. 1. R13's Care Plan updated 10/27/24 documents: (R13) has an alteration in neurological status related to: Major Depressive Disorder Recurrent, Agoraphobia, Anxiety, and PTSD (Posttraumatic Shock Disorder). R13's Minimum Data Set (MDS) dated [DATE] documents R13 is cognitively intact. On 10/29/24 at 9:00AM R13 was seated in a wheelchair in R13's room with a family member visiting. R57 (R13's) roommate was in bed in the room. R13 stated I can talk to you in front of my roommate and my (family member) I trust them. I had $100.00 and eight double struck commemorative coins taken from my lock box. It had to be staff because they might have known I was keeping my key beside my bed in my pencil box. It is bad enough I lost the money, but I used to carve the casts and strike the coins. Those I had here were in silver and bronze. I am losing my sight and my fingers don't work well because I have neuropathy. Those coins meant a lot to me. I kept them here because I like to look at them and remember what I used to do. I can't remember the exact date, but my (family member) can tell you. I reported it to (V1) Administrator and (V29), Social Services. They did not offer to call the police, but I wish they had. R13 looked upset and bit his bottom lip as he talked. Tears started to well up in R13's eyes. V33, R13's family member stated (R13) had the coins and his $100.00 on the evening of 10/16/24. I saw them. I came back on 10/17/24 and he did not have them. R57 stated I did not see (R13's) coins that day before, but I have seen that (R13) had the coins he made. On 10/29/24 at 11:00AM V1, Administrator stated there is really no documented investigation. I do not believe the money has been returned to (R13). (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	2.) The facility's Grievance Log for the three months prior to the survey documents R130 withdrew money from the bank on 9/1/24 and stored it in her purse. On 9/2/24 (R130) noticed money was missing around noon. (R130) was interviewed and family confirms money was withdrawn from the bank. Facility will replace the money. R130's MDS dated [DATE] documents R130 is cognitively intact. R130's Progress Note documents R130 was discharged home with home care services 10/28/24. On 9/30/24 R130 stated I took $140.00 out of the bank and put it in my purse. I went to therapy and when I came back I was going to address cards to my family and put in the money but the money was gone. I never got the money back. I told (V34) Care Plan Nurse the money was missing. I never heard anything so I just thought I would still be getting it. I have been sick and that was quite a bit of money to me. Now that I am home, I will be a little short at the end of the month and it was for my family. I save that up. You know I think whoever took it must really need it, but I would have just given it to them if they asked. On 10/30/24 at 12:00PM V34 verified R130's account of the allegation. V34 stated I really thought (R130) had the money replaced. on 10/30/24 at 12:15PM V29, Social Service also verified R130's account of the allegation. V29 also stated she was under the impression R130 was reimbursed for this loss. 50993 3.) The facility's grievance log dated 10/25/2024 documents: R25 reported to manager (V10 Restorative Registered Nurse) that (R25) had money missing. V29 SSD (Social Service Director) followed up and R25 explained that last week (R25) had $100 missing and then on October 22nd (R25) had another $20 missing. He stated the money was in his wallet in his top drawer. V29 reported R25's missing money to V1 Administrator to follow up. R25's MDS (Minimum Data Set) dated 8/19/24 documents R25 is alert and oriented. On 10/27/24 at 9:58 AM, R25 stated I have had money missing twice. R25 explained, two weeks ago R25 had $170 in cash in R25's wallet, which was in the top drawer of R25's nightstand. R25 left his room to attend therapy, leaving the wallet in the nightstand drawer, and upon returning to R25's room, R25 found that the $100 bill was gone leaving $70 in the wallet. R25 stated he reported the theft to the unidentified Certified Nurses Assistant (CNA) and Registered Nurse (RN), but doesn't remember who it was. R25 stated again on 10/23/24, R25 had money stolen. R25 explained that R25 left the facility for a physicians appointment and while en route, realized he had forgotten his wallet. Upon returning to the facility, R25 noticed that the top drawer of the nightstand was open a couple inches and another $20 was missing, leaving $50 in the wallet. R25 reported this theft to the unidentified RN on duty. R25 stated that V29 SSD informed R25 that four to five people have been hit in the last couple of weeks and that the facility is looking into the thefts. On 10/28/24 at 10:39 AM, V29 SSD confirmed that R25 had reported having money stolen but that V29 was not made aware of the allegation until 10/25/24 On 10/28/24 at 10:45 AM, V1 Administrator confirmed V1 was aware of R25's missing/stolen money. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 11:29AM, V10 Restorative Registered Nurse stated R25's missing money was reported to her by V6 Certified Nurses Assistant (CNA) on 10/23/24. V10 explained that V10 reported the missing/stolen money to V1 Administrator and V2 Director of Nursing (DON) on 10/24/24. On 10/28/24 at 11:40 AM, V6 CNA stated R25 came to the nurses' station and stated loudly this is the second time someone stole from me! On 10/30/24 at 10:00 AM, V25 LPN (Licensed Practical Nurse) stated V25 is familiar with R25 and has seen cash in a money clip on R25's wallet. On 10/30/24 at 10:10 AM, R25 stated R25 had been given the money by his family explaining his son or daughter will bring him cash whenever he needs it. 4.) The facility's grievance log dated 10/25/24 documents R46 had money stolen on 10/1/24. On 10/27/24 at 9:50 AM, R46 stated R46 had cash stolen from R46 during a room move. R46 explained R46 had $100 in cash in R46's dresser drawer and after moving rooms, the $100 was missing. R46 stated an unidentified housekeeper saw the cash in R46's drawer while assisting R46 with the room move. R46's MDS (Minimum Data Set) dated 9/11/24 documents R46 is alert and oriented. R46's ongoing Census Sheet documents R46 changed rooms on 10/01/24. On 10/28/24 at 10:39 AM, V29 SSD confirmed R46 reported having money stolen and reported it to V29 on 10/25/24. V29 reported that V29 completed a Grievance Form and that V1 Administrator was handling the investigation. On 10/28/24 at 10:45 AM, V1 Administrator confirmed V1 was made aware of R46 having money stolen and that the facility was handling it internally. On 10/28/24 at 11:40 AM, V6 CNA (Certified Nursing Assistant) stated on 10/23/24, R46 reported to V6 that R46 had money stolen. On 10/29/24 at 11:40 AM, V16 LPN (Licensed Practical Nurse) stated R46 reported to V16 that R46 had money stolen from him. On 10/30/24 at 10:15 AM, R46 stated that R46 gets cash out of the ATM (Automated Teller Machine) using a debit card from his Social Security Card, therefore he does not have any bank statements.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to have a physician's order and care plan for restraint use for one (R8) of two residents reviewed for restraints in the sample list of 46. Findings include: The facility's Physical Restraint Policy dated February 2014 documents A physician order for a restraint will be valid for thirty (30) days. After 30 days, the Restraint Observation must be completed to determine if the restraint is required further. Physician orders for restraint shall be complete and specifically define the type, reason, duration, and justification for use. Residents who are restrained will be temporarily released from the restraint at least every two (2) hours and more often as necessary such as for ADL (Activities of Daily Living) care, activities, and meals. The care plan will reflect specific circumstances and medical symptoms for restraint use and time frames. The resident's response to the use of the restraint and goals identified in the plan of care will be documented at least quarterly and with significant change in condition. Documentation will reflect attempts towards restraint reduction and least restrictive restraint utilization. On 10/27/24 at 8:30 AM and 11:50 AM R8 was sitting in a wheelchair near the nurse's station with a lap cushion threaded through the armrests of the wheelchair. From 10:18-10:23 AM R8 was sitting at a dining room table eating, and the lap cushion was in place. At 11:50 AM R8 stated the lap cushion is used because R8 likes to lean forward and it gives R8 something to lean on. On 10/27/24 at 12:03 PM V9 Certified Nursing Assistant (CNA) stated R8 is unable to remove the lap cushion herself. V9 asked R8 to remove the lap cushion. R8 attempted, but was unable to release the lap cushion from R8's wheelchair. V8 CNA stated R8 has had falls within the last few weeks and the lap cushion was one of the fall interventions. On 10/28/24 at 9:21 AM R8 was near the nurse's station, in her wheelchair with the lap cushion in place. At 10:38 AM R8 was sitting at the dining room table eating, with the lap cushion in place. From 11:13 AM - 11:39 AM R8 was sitting near the nurses' station with the lap cushion in place. R8's ongoing diagnoses list includes Dementia, Anxiety Disorder, Conversion Disorder with Seizures/Convulsions, Post Traumatic Stress Disorder, and Bipolar Disorder. R8's Minimum Data Set (MDS) dated [DATE] documents R8 is cognitively intact, requires substantial/maximal staff assistance for transfers and toileting, and is occasionally incontinent of urine. R8's Restraint Evaluation and Consent dated 10/8/24 documents an evaluation for the lap cushion and lists this device as both an enabler and a restraint for R8. This evaluation documents unsteady gait, frequent falls, and attempts to self transfer with inability to do so safely, are the reasons the restraint is used. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's October 2024 Physician Orders do not include an order for the lap cushion restraint and how often it should be released. R8's Care Plan dated 5/20/24 documents R8 is at risk for falls and includes an intervention dated 10/8/24 (lap cushion) restraint/enabler to help assist (R8) in upright position while in w/c (wheelchair), to help avoid leaning forward in w/c. R8's Care Plan does not include a problem, goals, and interventions for R8's lap cushion restraint. On 10/29/24 at 9:42 AM V2 Director of Nursing stated a lap cushion would be considered a restraint if the resident is unable to release on command and there should be a physician's order for use. V2 stated R8's lap cushion is included in R8's care plan as a fall intervention. V2 confirmed the care plan should have problem, goals, and interventions to address R8's restraint use and reduction plan.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on observation, interview, and record review the facility failed to immediately report allegations of misappropriation to the facility's administrator and failed to report allegations of misappropriation to the State Agency (SA) and law enforcement for four residents (R13,R130,R25,R46) of five residents reviewed for misappropriation in a sample list of 46 residents. These failures have the potential to affect all 73 residents residing in the facility. Findings Include: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Abuse Prevention Program policy dated October 2022 documents Employees are required to report any incident, allegations 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. Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the Administrator or person designated to act in the Administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the Administrator or a designee shall initiate an incident investigation. Any allegations 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 that two hours of 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. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the Administrator or designee, shall notify the Department of Public Health's Regional Office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the Administrator and is being investigated. The report shall include the following information: name, age, diagnosis and mental status of the resident allegedly abused or whose property was misappropriated; type of abuse; date, time, location and circumstances of the alleged incident; any obvious injuries or complaints of injury; steps the facility has taken to protect the residents. This report shall be made immediately. The facility shall also contact local law enforcement authorities. If there is a reasonable suspicion that a crime has been committed that results in serious bodily harm, a report shall be made to local law enforcement and IDPH (Illinois Department of Public Health) immediately. If there is a reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury, then a report to local law enforcement as soon as possible but within 24 hours of when the suspicion was formed. Then within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including the steps the facility has taken in response to the allegation, will be sent to IDPH. This final investigation report shall contain the following: name, age, diagnosis and mental status of the resident allegedly abused or from whom property was misappropriated; the original allegation; a summary of facts determined during the process of the investigation, review of medical record and interview of witnesses; conclusion of the investigation based on known facts; the police report, if applicable; if the allegation is determined to be valid and the perpetrator is an employee, a separate sheet listing the employee's name, address, phone number, title, date of hire, copies of previous disciplinary actions, and current employment status (still working, suspended or terminated). 1. R13's Care Plan updated 10/27/24 documents: (R13) has an alteration in neurological status related to: Major Depressive Disorder Recurrent, Agoraphobia, Anxiety, and PTSD (Posttraumatic Shock Disorder). R13's Minimum Data Set (MDS) dated [DATE] documents R13 is cognitively intact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/29/24 at 9:00AM R13 was seated in a wheelchair in R13's room with a family member visiting. R57 (R13's) roommate is in bed in the room. R13 stated I can talk to you in front of my roommate and my (family member) I trust them. I had $100.00 and eight double struck commemorative coins taken from my lock box. It had to be staff because they might have known I was keeping my key beside my bed in my pencil box. It is bad enough I lost the money, but I used to carve the casts and strike the coins. Those I had here were in silver and bronze. I am losing my sight and my fingers don't work well because I have neuropathy. Those coins meant a lot to me. I kept them here because I like to look at them and remember what I used to do. I can't remember the exact date, but my (family member) can tell you. I reported it to (V1) Administrator and (V29), Social Services. They did not offer to call the police, but I wish they had R13 looked upset and bit his bottom lip as he talked. Tears started to well up in R13's eyes. V33, R13's family member stated (R13) had the coins and his $100.00 on the evening of 10/16/24. I saw them. I came back on 10/17/24 and he did not have them. R57 stated I did not see (R13's) coins that day before, but I have seen that (R13) had the coins he made. On 10/29/24 at 11:00AM V1, Administrator stated there is really no documented investigation. I am aware that allegations of misappropriation are to be reported to the SA and if there is a reasonable suspicion of a crime to the police. I do not believe the money has been returned to (R13). At that time, V1 verified the facility did not report R13's allegation of misappropriation to the SA or the police. 2. The facility's Grievance Log for the three months prior to the survey documents R130 withdrew money from the bank on 9/1/24 and stored it in her purse. On 9/2/24 (R130) noticed money was missing around noon. (R130) was interviewed and family confirms money was withdrawn from the bank. Facility will replace the money. R130's MDS dated [DATE] documents R130 is cognitively intact. R130 is documented in a progress note as being discharged home with home care services 10/28/24. On 9/30/24 R130 stated I took $140.00 out of the bank and put it in my purse. I went to therapy and when I came back I was going to address cards to my family and put in the money but the money was gone. I never got the money back. I told (V34) Care Plan Nurse the money was missing. I never heard anything so I just thought I would still be getting it. I have been sick and that was quite a bit of money to me. Now that I am home, I will be a little short at the end of the month and it was for my family. I save that up. You know I think whoever took it must really need it, but I would have just given it to them if they asked. On 10/30/24 at 12:00PM V34 verified R130's account of the allegation. V34 stated I really thought (R130) had the money replaced. On 10/30/24 at 12:15PM V29, Social Service also verified R130's account of the allegation. V29 also stated she was under the impression R130 was reimbursed for this loss. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/29/24 at 11:00AM V1, Administrator stated there is really no documented investigation. I am aware that allegations of misappropriation are to be reported to the SA and if there is a reasonable suspicion of a crime to the police. I do not believe the money has been returned to (R130). V1 verified this incident was not reported to the State Agency or the police. 50993 3.) On 10/27/24 at 9:58 AM, R25 stated R25 had money stolen on two separate occasions in the last month totaling $120. R25 reported the theft to an unknown Certified Nurses Assistant (CNA) and an unknown Registered Nurse (RN) upon discovery of each occurrence. R25 stated that on 10/25/24, V29 Social Services Director (SSD) informed R25 that four to five other residents have also reported theft. On 10/28/24 at 10:39 AM, V29 stated R25's stolen money was reported to V29 on 10/25/24. V29 stated V29 completed the Grievance Form on 10/25/24 and reported the allegation to V1 Administrator. On 10/28/24 at 10:45 AM, V1 Administrator stated the Corporate Office's direction was to handle the allegation internally with the Grievance process. V1 reported nothing has been submitted to IDPH (Illinois Department of Public Health) or the police, the facility is just handling it internally. On 10/28/24 at 11:29AM, V10 Restorative RN (Registered Nurse) stated R25's missing money was reported to V10 by V6 Certified Nurses Assistant (CNA) on 10/23/24. V10 interviewed R25 about the missing money and then reported the allegation to V1 Administrator and V2 Director of Nursing (DON) the following morning. On 10/28/24 at 12:21 PM, V10 Restorative RN stated I could have called V1 or V2 immediately, but V10 did not feel like it was needed or an emergency. 4.) On 10/27/24 at 9:50 AM, R46 stated $100 in cash was stolen from R46's dresser drawer, after moving rooms on 10/01/24. On 10/28/24 at 10:39 AM, V29 SSD (Social Service Director) stated the theft of R46's money was reported to V29 on 10/25/24. V29 explained V29 completed the Grievance Form on 10/25/24 and reported the allegation to V1 Administrator. On 10/28/24 at 10:45 AM, V1 Administrator reported nothing has been submitted to IDPH (Illinois Department of Public Health) or the police, due to the facility handling the allegation internally. On 10/29/24 at 11:40 AM, V16 (LPN) stated R46 reported to her that R46 had money stolen out of R46's dresser. V16 explained V16 immediately reported it to V2 (DON) who was the Administrator at the time. On 10/29/24 at 11:49 AM, V2 (DON) stated V2 does not remember V16 (LPN) ever reporting the incident to V2 (DON), but should have reported it immediately. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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	146037	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on observation, interview, and record review the facility failed to investigate allegations of misappropriation of money and personal property and implement corrective action to prevent further incidents of misappropriation for four residents (R13,R130,R25,R46) of five residents reviewed for misappropriation in a sample list of 46 residents. These failures have the potential to affect all 73 residents residing in the facility. Findings Include: The facility Abuse Prevention Program policy dated October 2022 documents all incidents or allegations of abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, that was alleged or suspected will be documented and result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. The person in charge of the investigation will update the Administrator or person designated in the Administrator's absence during the progress of the investigation. The Administrator or designee will keep the resident or resident representative informed of the progress of the investigation. The investigator will report the conclusion of the investigation in writing to the Administrator or designee within five working days of the reported incident. 1. R13's Care Plan updated 10/27/24 documents: (R13) has an alteration in neurological status related to: Major Depressive Disorder Recurrent, Agoraphobia, Anxiety, and PTSD (Posttraumatic Shock Disorder). R13's Minimum Data Set (MDS) dated [DATE] documents R13 is cognitively intact. On 10/29/24 at 9:00AM R13 was seated in a wheelchair in R13's room with a family member visiting. R57 (R13's) roommate was in bed in the room. R13 stated I can talk to you in front of my roommate and my (family member) I trust them. I had $100.00 and eight double struck commemorative coins taken from my lock box. V33, R13's family member stated (R13) had the coins and his $100.00 on the evening of 10/16/24. I saw them. I came back on 10/17/24 and he did not have them. R57 stated I did not see (R13's) coins that day before, but I have seen that (R13) had the coins he made. On 10/29/24 at 11:00AM V1, Administrator stated I was instructed to treat this as a grievance. So, there is really no documented investigation. I do not believe the money has been returned to (R13). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The facility's Grievance Log for the three months prior to the survey documents R130 withdrew money from the bank on 9/1/24 and stored it in her purse. On 9/2/24 (R130) noticed money was missing around noon. (R130) was interviewed and family confirms money was withdrawn from the bank. Facility will replace the money. R130's MDS dated [DATE] documents R130 is cognitively intact. R130 is documented in a progress note as being discharged home with home care services 10/28/24. On 9/30/24 R130 stated I took $140.00 out of the bank and put it in my purse. I went to therapy and when I came back I was going to address cards to my family and put in the money but the money was gone. After numerous requests over the coarse of two days, documentation of an investigation or follow-up were not provided by the facility for R130's allegation of misappropriation. On 10/30/24 at 12:15PM V29, Social Service also verified R130's account of the allegation. V29 also stated she was under the impression R130 was reimbursed for this loss. 50993 3.) On 10/27/24 at 9:58 AM, R25 stated R25 had money stolen on two separate occasions in the last month totaling $120. R25 reported the theft to an unknown Certified Nurses Assistant (CNA) and an unknown Registered Nurse (RN). R25 stated that on 10/25/24, V29 Social Services Director (SSD) informed R25 that four to five other residents have also reported theft. On 10/28/24 at 10:39 AM, V29 stated R25's stolen money was reported to V29 on 10/25/24. V29 stated V29 completed the Grievance Form on 10/25/24 and reported the allegation to V1 Administrator and V1 is handling the investigation. V29 also stated, we are waiting to hear back from Corporate on what to do. On 10/28/24 at 10:45 AM, V1 Administrator stated the Corporate Office's direction was to handle it internally with the Grievance process and the facility will be refunding the residents money. V1 reported nothing has been submitted to IDPH (Illinois Department of Public Health) or the police, the facility is just handling it internally. V1 stated V29 should have done the investigation, and confirmed V29 has not investigated the incident. 4.) On 10/27/24 at 9:50 AM, R46 stated $100 in cash was stolen from R46's dresser drawer, after moving rooms on 10/01/24. At this time, R46 stated no one from administration has followed up with R46 regarding the theft. R46's ongoing Census Sheet documents R46 changed rooms on 10/01/24. On 10/28/24 at 10:39 AM, V29 SSD (Social Service Director) stated the theft of R46's money was reported to V29 on 10/25/24. V29 explained V29 completed the Grievance Form on 10/25/24 and reported the allegation to V1 Administrator. V29 explained, V1 was handling the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/28/24 at 10:45 AM, V1 Administrator stated the Corporate Office's direction was to handle it internally with the Grievance process and the facility will be refunding the residents money. V1 Administrator reports nothing has been submitted to IDPH (Illinois Department of Public Health) or the police, due to the facility is handling it internally. V1 stated V29 should have done the investigation, and confirmed V1 has not investigated the incident. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 32853 Based on interview and record review the facility failed to develop a comprehensive care plan for weight loss for one of 19 residents (R66) reviewed for care plans in the sample list of 46. Findings include: The Facility's Care Plan policy with a revised date of August, 2007 documents, Our facility develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. R66's Care Plan dated 5/7/24 documents a diagnosis of Alzheimer's Disease. This Care Plan documents to encourage adequate nutrition and to offer small, frequent feedings. R66's weight record documents on 5/28/24 R66 weighed 143.2 pounds and on 9/2/24 R66 weighed 118 pounds. That is a 17.6% weight loss in a little over three months. V19 Dietician documents on 6/15/24 that R66 has had weight loss and recommended adding 60 cc (cubic centimeters) of (nutritional supplement) two times a day. V19 then documents on 9/13/24 that R66 has had continued weight loss and recommended increasing (nutritional supplement) to 90 cc two times a day. R66's Care Plan does not document the significant weight loss that has been ongoing since June, 2024. On 10/30/24 at 2:00 PM, V34 Care Plan Coordinator confirmed R66's weight loss is not on the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35347 Based on observation, interview, and record review the facility failed to provide fingernail care, bathing, and timely toileting/incontinence cares for five (R11, R30, R37, R131, R230) of 19 residents reviewed for Activities of Daily Living (ADLs) in the sample list of 46 residents. Findings include: 1. The facility Resident Council Group Concern Form (September, 2024) documents a group council complaint of facility staff not providing timely nursing care to residents. The facility grievance log (July and September, 2024) documents complaints of facility staff not answering call lights promptly, not providing showers timely, and not providing toileting care timely to residents. R37's diagnosis list (printed 10/29/2024) documents R37's diagnoses include: Need For Assistance With Personal Care, Reduced Mobility, Unsteadiness on Feet, and Osteoarthritis Of Hip. R37's quarterly assessment (8/14/2024) documents R37 is occasionally incontinent of bladder and requires substantial/maximal staff assistance for toileting hygiene. R37's Care Plan (8/7/2024) documents R37 has a toileting self-care deficit, requires extensive staff assistance for toileting, and staff are to provide physical toileting assistance as-needed to R37. On 10/27/2024 at 9:45AM, R37 reported facility staff do not answer call lights promptly and R37 waits a long time sometimes for staff to come help R37 with toileting care. A bedside commode was present in R37's room and R37 reported transferring onto the commode independently but requiring staff assistance with care after using the commode. R37 reported R37's legs get numb sitting on the commode waiting for staff for assistance for perineal care and to transfer back off of the commode. 2. R11's diagnosis list (printed 10/29/2024) documents R11's diagnoses include: Reduced Mobility, Need For Assistance With Personal Care, and Weakness. R11's quarterly assessment (9/20/2024) documents R11 is occasionally incontinent of bowel and is completely dependent on staff assistance for toileting hygiene. R11's Care Plan (10/27/2024) documents R11 has a toileting self-care deficit, requires extensive staff assistance for toileting, and staff are to provide physical toileting assistance as-needed to R11. On 10/27/2024 at 9:50AM, R11 reported waiting a long time for staff to respond to call lights sometimes. R11 reported waiting over 30 minutes for staff to respond to R11's call light when R11 needs toileting assistance and R11 has had to get used to it and the facility doesn't have enough staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/2024 at 10:45AM, V20 (Certified Nurse Aide) reported both R11 and R37 are cognitively intact. V20 reported the facility is appropriately staffed unless they have staff call offs and we (facility staff) try to apologize (to residents when staff are unable to answer call lights timely). V20 reported having 16 residents to provide care for during V20's shift on 10/29/2024. The facility Call Light System policy (undated) documents facility staff will respond promptly when call lights are activated. 37813 3. R230's Minimum Data Set (MDS) dated [DATE] documents R230 was admitted to the facility 10/16/24. This MDS documents R230 is severely cognitively impaired. R230's Care Plan initiated 10/16/24 does not include documentation of R230's shower or bath routine. On 10/27/24 at 12:17 PM V37 R230's family member stated (R230) has been (at the facility) almost two weeks and has not gotten a shower. At home R230 was used to getting showers on Sundays, Wednesdays, and Fridays. Family was told resident would only get two showers weekly and scheduled for Tuesday and Friday. R230's Shower and bath task on R230's electronic medical record does not document a bath or shower since R230's admission. 32853 4. R30's diagnoses list documents diagnoses including Cerebral Infarction, Metabolic Encephalopathy, Malignant Melanoma of Scalp and Neck, Other Reduced Mobility and Need for Assistance with Personal Care. R30's Care Plan dated 5/6/24 documents R30 has an ADL (Activities of Daily Living) self care deficiency with an intervention for staff to provide physical assistance as needed. R30's Minimum Data Set (MDS) dated [DATE] documents R30 is severely cognitively impaired and has impairment of both sides of the upper and lower extremities. This MDS documents that R30 is fully dependent on staff for bathing. On 10/29/24 at 10:55 AM the resident shower list posted at the skilled side nurses station documents R30 is scheduled to receive showers on Tuesday and Friday nights. On 10/29/24 at 11:00 AM, V12 Wound Nurse provided shower sheets for R30 and confirmed that the last documented shower sheet they have for R30 is dated 10/9/24 and V12 confirmed R30 was discharged to the hospital on 10/25/24. According to R30's shower documentation, R30 went 16 days without a shower. 5. R131's Care Plan dated 10/8/24 documents diagnoses including Dementia, Generalized Anxiety Disorder, Depression and Exudative Age Related Macular Degeneration of the Right Eye. This Care Plan does not document any ADL requirements for R131. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R131's MDS dated [DATE] documents R131 has moderately impaired cognition and documents R131 is dependent on staff for showers and personal hygiene. On 10/29/24 at 11:00 AM, V12 provided one shower sheet for R131 dated 10/12/24 and stated she could not find anymore for R131. On 10/30/24 the facility provided another shower sheet for R131 dated 10/24/24 documenting R131 was given a bed bath on this date. According to R131's shower sheets, R131 went 12 days between being bathed. On 10/27/24 at 8:38 AM, R131 was sitting in her wheelchair near the nurse's station. R131's fingernails were extending beyond her fingers approximately an 1/8 inch and there was black and brown debris caked underneath her fingernails. On 10/28/24 at 2:21 PM, V13 Physical Therapy Staff assisted R131 into bed. R131 still has brown and black debris caked underneath her fingernails. On 10/29/24 at 12:00 PM, V2 Director of Nursing stated that cleaning under resident's fingernails is the responsibility of the Certified Nursing Assistants and sometimes the Activity Department does them on special nail days. The facility's Shower/Tub Bath policy with a revised date of August 2002 documents, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32853 Based on observation, interview and record review the facility failed to ensure wound dressing changes were completed as ordered by the Physician for one of one resident (R59) reviewed for skin conditions in the sample list of 46. Findings include: R59's diagnosis list documents diagnoses including Congestive Heart Failure, Need for Assistance with Personal Care, Cellulitis of Right Lower Limb, Morbid Obesity and Mild Intellectual Disabilities. R59's Nurse's Notes dated 10/18/24 by V12 Wound Nurse documents R59 has bilateral lower leg edema and has an open area on her right lower leg measuring 2 cm (centimeters) x (by) 2 cm with some blood tinged drainage,and that the area is tender to touch. V12 documents that the Nurse Practitioner was notified and R59 was started on an antibiotic for cellulitis and a treatment order was obtained to clean the wound and apply a calcium alginate dressing and cover with a bordered foam dressing daily. R59's Treatment Administration Record dated 10/1/24-10/31/24 documents the order for the treatment to the right lower extremity to clean with normal saline, apply the calcium alginate dressing and cover with bordered foam dressing every evening, but did not start until 10/21/24, three days after the wound was found. On 10/27/24 at 9:18 AM, R59 was laying in bed and had a dressing on her right lower leg and the dressing was dated 10/18/24 and this dressing looked dirty and worn. R59's Nurse's Notes document the wound was identified on 10/18/24 and a dressing was applied but was never changed again until on or after 10/27/24, at least nine days later. On 10/29/24 at 12:58 PM, V12 Wound Nurse confirmed that she found the wound on 10/18/24 and contacted the Nurse Practitioner and applied the dressing. V12 stated that she got busy and forgot to put the order in the computer. V12 stated that the wound should have been cleaned and dressed daily after 10/18/24.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to complete weekly pressure ulcer assessments, implement treatment orders timely, administer treatments as ordered, maintain wound dressings, accurately complete skin and wound assessments, and implement interventions to prevent the development and worsening of pressure ulcers for four (R8, R32, R52, R44) of four residents reviewed for pressure ulcers in the sample list of 46. These failures resulted in R8 developing stage three pressure ulcer and R32 developing an unstageable pressure ulcer. Findings include: The facility's Measurement of Alterations in Skin Integrity policy dated January 2017 documents wound type, stage, measurements and characteristics should be assessed and documented upon identification and weekly thereafter, record refusal of treatment or pressure relieving interventions and the resident's care plan should also reflect this. The facility's Braden- Pressure Risk Assessment Tool policy dated January 2017 documents the Braden scale determines pressure ulcer risk and this assessment should be completed upon admission, then weekly for the first month, and then at least quarterly and with changes in condition. This policy documents appropriate individualized interventions should be implemented and documented on the resident's care plan. The facility's Pressure/Skin Breakdown- Clinical Protocol dated January 2017 documents to determine a resident's significant risk factors for developing pressure ulcers, such as immobility, recent weight loss, and a history of pressure ulcers; assess skin condition, pain, mobility, treatments, support surfaces, and diagnoses; and the physician will give orders for wound care including pressure redistribution surfaces. The facility's Prevention of Pressure Wounds policy dated January 2017 documents pressure injuries are usually due to sitting in the same position for an extended period of time causing increased pressure, decreased circulation, and subsequent tissue destruction; and can also be related to irritating substances on the skin such as urine and feces. This policy documents there should be a system or procedure in place to assure assessments are completed timely, changes in condition are identified, evaluated, reported to the physician, and addressed. This policy documents preventative measures include repositioning at least every two hours, determining if a special mattress is needed, use of pressure relieving cushions for chairs, avoiding donut shaped or waffle cushions, routinely assessing skin condition, using moisture barrier creams, using pillows to float heels when in bed, immediately reporting any signs of pressure injuries, administering vitamins and supplements per physician's orders, and having the dietitian assess nutrition and make recommendations. 1.) R8's Minimum Data Set (MDS) dated [DATE] documents R8 is cognitively intact, requires partial/moderate staff assistance for rolling in bed, requires substantial/maximal staff assistance for transfers, and is occasionally incontinent of urine. R8's Braden assessment dated [DATE] (after R8's pressure ulcers developed) document R8 is low risk. The last Braden Assessment recorded for R8 was on 10/13/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R8's Care Plan dated 5/26/23 documents R8 is at risk for impaired skin integrity, and includes interventions to apply barrier cream three times daily as needed, Braden Assessments weekly for four weeks then quarterly, and to encourage good nutrition and hydration to promote healthier skin. There is no documentation that R8 refuses turning/repositioning. This care plan has not been updated to include R8's pressure ulcers or any new pressure relieving interventions after 5/26/23. R8's Physician Order dated 6/19/23 May use Pressure relieving mattress and/or cushion on w/c (wheelchair) if Needed. There is no documentation that R8 requires a pressure relieving cushion in R8's wheelchair. R8's ongoing weight log documents R8 had a significant weight loss between August 2024 and September 2024, and continued weight loss as of 10/30/24. R8's October 2024 Treatment Administration Record (TAR) documents an order dated 10/6/24 to cleanse right buttock wound with wound cleanser, apply collagen and bordered foam every shift for Stage Two pressure ulcer, and an order dated 10/10/24-10/28/24 to clean right buttock wound, apply Santyl, apply Calcium Alginate, and cover with a bordered foam dressing daily. This TAR documents to complete skin assessments on Mondays and Thursdays, and inaccurately documents R8's skin as intact and without wounds 10/7-10/14/24. This TAR documents to apply barrier cream to the left buttock three times daily as of 10/7/24, and there is no documentation that barrier cream was applied prior to 10/7/24. R8's Nursing Note dated 10/6/24 at 12:12 AM documents R8 had a new Stage Two Pressure Ulcer to the right buttock, the Wound Nurse (V12) was notified, the area was cleansed, Collagen was applied, and the wound was covered with a bordered foam dressing. There is no documentation of wound characteristics and measurements prior to evaluation by V7 Wound Physician on 10/7/24. R8's Wound Care Telemedicine Follow Up Evaluation dated 10/7/24, recorded by V7, documents R8 has a Group 1 mattress and a foam cushion in R8's chair. This note documents R8 has a right buttock Stage Three Pressure Wound of greater than three days duration that measured 1.5 centimeters (cm) long by 1.7 cm wide by 0.2 cm deep and had 90% slough (dead cells). This note includes recommendations to off-load wound, reposition per facility protocol, Group 2 Mattress (air mattress), Multivitamin once daily, Vitamin C 500 milligrams (mg) twice daily, Zinc Sulphate 220 mg once daily for 14 days. There is no documentation in R8's medical record that the recommended vitamins were implemented. R8's Wound Care Telemedicine Follow Up Evaluation dated 10/18/24 documents R8's right buttock wound resolved and R8 had a left hip Stage Three Pressure Wound of greater than two days duration that measured 1.3 cm by 1 cm by 0.2 cm and had 50% slough. This note documents R8 now has a Group 2 mattress as of today (11 days after V7's order) and recommends to off-load wound and repositioning. R8's Wound Care Telemedicine Follow Up Evaluation dated 10/25/24 documents R8's left hip Stage Three Pressure Wound measured 1.2 x 1 x 0.2 cm, and R8's right buttock Stage Three Pressure Wound reopened over three days ago and measured 2.0 x 2.0 x 0.3 cm. There is no documentation in R8's medical record that R8 has been evaluated by a dietitian since March 2024, prior to R8's weight loss and wounds. (continued on next page)

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	146037	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/27/24 at 8:30 AM and 11:58 AM R8 was sitting in a wheelchair near the nurses' station with a soft lap cushion looped through the armrests of R8's chair. at 10:18 AM R8 was sitting in a wheelchair in the dining room. At 11:58 AM R8 was sitting in her wheelchair. R8 stated R8 has wounds on R8's bottom, but was unsure how long the wounds had been there or how often treatments are administered. On 10/28/24 at 9:21 AM R8 was sitting in a wheelchair by the nurses' station. At 10:38 AM R8 was sitting in a wheelchair in the dining room. At 11:13 AM staff transported R8 in a wheelchair from the dining room to the 100 hall nurses' station. Continuous observations were made from 11:13 AM until 11:39 AM of R8 sitting in a wheelchair near the nurses' station. The lap cushion remained in place during all of these observations. On 10/28/24 12:02 PM V4 and V6 Certified Nursing Assistants (CNAs) transferred R8 from her wheelchair into bed. There was a foam horseshoe shaped cushion, that was approximately one inch thick, in R8's wheelchair. R8 was incontinent of urine and V6 provided incontinence cares. R8 had open pink wounds to the right buttock and left hip that were not covered with dressings. V6 stated V6 had not provided any cares for R8 yet today and was unsure how long the wounds were without dressings. V6 stated V6 will notify the nurse so the wounds can be covered. On 10/28/24 at 12:16 PM V3 Licensed Practical Nurse stated R8's wounds started with the right buttock that was a thin layer of skin that had sheered off, and then a few days later the left hip wound developed. V3 entered R8's room, administered R8's pressure ulcer treatment, and used pillows to position R8 on her right side before leaving the room. V3 stated no staff had reported that R8's dressings came off, prior to V6. On 10/28/24 at 2:34 PM V11 CNA stated V11 R8 was transferred out of bed around 7:30 AM and V11 provided no other transfer or toileting cares for R8 prior to leaving at 10:00 AM. V11 stated V4 was the only other CNA working on R8's hall at that time. On 10/28/24 at 3:04 PM V4 CNA stated V4 did not provide any cares for R8 besides the transfer observed at 12:02 PM. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 3:23 PM V12 Wound Nurse stated V12 has been the facility's wound nurse for approximately three weeks. V12 stated V12 has not yet updated resident care plans to include wounds, but they should be updated to reflect wounds and new interventions. V12 stated V12 and V7 Wound Physician complete weekly wound assessments which are documented in the assessment section of the resident's electronic medical record (EMR) or in V7's notes. V12 stated there can't be a delay in starting treatment, and the nurses should notify the physician and document an assessment of the wound when found. V12 confirmed Braden assessments are documented in the assessments section of the EMR, and should be done on admission, then weekly for four weeks, and then quarterly. V12 stated residents at high risk for pressure ulcers should have weight monitored weekly, placed on a turning and repositioning schedule, and skin checks more than weekly. V12 stated turning/repositioning should be documented on the care plan and in tasks in the EMR. V12 stated residents with wounds should be referred to the dietitian. At 4:00 PM V12 Wound Nurse stated V12 rounds with V7 Wound Physician, and V12 is responsible for entering V7's orders/recommendations. V12 stated R8 used to walk and then recently declined requiring total assistance for cares. V12 stated staff should reposition R8 at least every two hours and offload pressure from R8's wounds. V12 stated That is way too long for (R8) to be in her wheelchair, when told R8 had not been repositioned from 7:30 AM until 12:00 PM. V12 stated R8's air mattress was installed on 10/18/24. V12 stated V12 was unsure when R8's wheelchair cushion was implemented. V12 was unaware of V7's recommendations for Vitamin C, Zinc and Multivitamin, and confirmed these recommendations were never implemented. On 10/29/24 at 12:18 V12 confirmed V12 had not notified the dietitian of residents with wounds, and confirmed all of V7's wound notes were uploaded into R32's electronic medical record. On 10/30/24 at 11:05 AM V12 stated V12 was unable to determine the type and brand of R8's cushion, so the cushion was replaced today. On 10/29/24 at 11:57 AM V2 Director of Nursing stated V2 used to oversee wounds until June 2024. V2 stated the wound nurse is responsible for sending a wound list to the dietitian. On 10/29/24 at 12:34 PM V19 Registered Dietitian stated R8's last nutritional assessment was completed in March 2024. V19 stated the facility does not notify or request for V19 to evaluate residents with wounds. V19 stated V19 runs reports to determine which residents need to be evaluated, but there is no report that identifies wounds. V19 stated V19 has to ask staff to determine if residents have wounds. V19 stated no one had requested to evaluate R8's nutritional status and V19 was unaware that R8 had developed pressure ulcers. V19 stated if V19 had evaluated R8, V19 would have recommended Zinc, Vitamin C, a multivitamin, and liquid protein; and possibly would have recommended a nutritional supplement if R8 had lost weight, but R8 does not have a documented weight for October. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 from 1:00 PM-1:15 PM V7 stated V7 has been the facility's wound physician for the last few months and V7 conducts her visits virtually, not in person. V7 stated Prealbumin is ordered to evaluate nutrition and protein levels and should be implemented by the next month's laboratory draw. V7 stated vitamins aid with wound healing and should be implemented by the next day. V7 stated Group 1 mattresses are foam mattresses that are good for up to Stage Two Pressure Ulcers and a Group 2 mattress is a low air loss mattress used for Stage Three Pressure Ulcers and higher, or if the resident has a low Body Mass Index. V7 stated residents at high risk for pressure ulcers should have preventative interventions implemented based on the facility's protocol, which generally includes frequent repositioning and offloading and use of pressure relieving surfaces. V7 stated V7 avoids using horseshoe or donut cushions since they cause skin to spread and can cause wounds to worsen. V7 stated generally foam cushions with approximately three inch thickness are used. V7 stated there was a period of time where the facility didn't have a wound nurse due to staffing issues; V7 worked closely with V2 when V2 was the Assistant Director of Nursing, but then V2 changed positions and there were several weeks where no one was assessing wounds. V7 confirmed not implementing pressure relieving interventions, physician recommendations, nutritional evaluations, wound and skin assessments/monitoring, and treatments timely and as ordered, can contribute to the development and worsening of pressure ulcers. 2.) R32's MDS dated [DATE] is inaccurate and documents R32 did not have pressure ulcers. R32's MDS dated [DATE] documents the following: R32 has sever cognitive impairment, R32 requires supervision/touch assistance from staff for bed mobility, and partial/moderate staff assistance with transfers. R32 is occasionally incontinent of urine and requires dependence on staff for toileting hygiene. R32 had an unplanned significant weight loss within the last six months. R32 has two facility acquired pressure ulcers, one stage three and one unstageable. R32's Braden assessment dated [DATE] documents R32 scored low risk for developing pressure ulcers. There are no other documented Braden Assessments in R32's medical record until 10/8/24, after R32 developed unstageable and stage three pressure ulcers. R32's Care Plan dated 7/9/24 documents R32 has potential for impaired skin integrity and includes interventions to apply barrier cream three times daily as needed, Braden scale weekly for four weeks then quarterly, encourage good nutrition and hydration, follow physician's orders for treatment. This care plan has not been updated to include R32's pressure ulcers or any new pressure relieving interventions after 7/9/24. There is no documentation that R32 refuses pressure relieving interventions. R32's Physician's Order dated 7/11/24 documents to give Pro Stat (protein supplement) 30 milliliters once daily. R32's Physician Order dated 7/9/24 documents to apply pressure relieving boots or offload heels when in bed. R32's Physician Order dated 7/31/24 documents air mattress to bed. R32's Physician Order dated 7/12/24 documents May use pressure relieving mattress and/or cushion on w/c if Needed. There is no documentation that barrier cream, air mattress, or wheelchair cushion was applied prior to these orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R32's Admission Evaluation dated 7/3/24 documents R32 admitted with a Stage Two Pressure Ulcer of sacrum/coccyx. There is no documentation that a treatment order was initiated for this wound until 7/9/24 and there are no documented assessments of this wound until 7/31/24 when the wound had deteriorated to a Stage Three. There is no documentation that R32 admitted with any foot wounds. R32's Shower Sheet dated 7/7/24 documents R32 had a blister to the left heel and left big toe. There are no documented measurements or wound descriptions, and no documentation that the physician was notified and a treatment was initiated prior to 7/9/24. R32's Nursing Note dated 7/9/2024 at 12:34 PM documents R32 had a blister to the left heel that measured 3.5 cm by 7 cm, a skin protectant and dry dressing was applied, R32's buttocks was red/excoriated with no open areas. An antifungal cream and zinc oxide cream was applied. R32's Nursing Note dated 8/4/2024 at 5:29 PM documents R32's coccyx had a 6 cm by 3 cm maroon spot with a small open area. Triple antibiotic ointment and a bordered foam dressing was applied and education was provided on timely depend changes and cream application. R32's Registered Dietitian Note dated 8/29/24 at 8:07 AM documents R32's weight has decreased over the past month and there were no new interventions. This note does not document that the dietitian was aware of R32's stage three pressure ulcers and there is no documentation that R32 was evaluated by a dietitian in September. There are no weekly wound assessments in R32's EMR prior to October 2024, besides V7's assessments on 7/31/24, 8/9/24, 8/15/24, 9/5/24, and 9/12/24. R32's Wound Care Telemedicine Initial Evaluation dated 7/31/24, recorded by V7, documents R32's unstageable Deep Tissue Injury of the Left Heel measured 6.9 cm by 4.4 cm and no measurable depth. and R32's Stage Three Pressure Ulcer of the coccyx measured 1.9 cm by 1 cm by 1.2 cm. V7 recommended to off-load wound, reposition per facility protocol, float heels in bed, pressure relieving boot, dietitian consult, and Prealbumin level. There is no documentation that R32's Prealbumin level was obtained as recommended and V7 documents Prealbumin results pending on V7's Evaluations from July-October 2024. R32's Wound Care Telemedicine Evaluation dated 10/25/24 documents R32's unstageable heel ulcer measured 1.0 x 0.7 x 0.2 cm, the wound was macerated (moisture related damage), and the treatment was changed to Calcium Alginate with bordered foam dressing applied three times weekly. R32's Stage Three Pressure Ulcer of the coccyx measured 1.0 x 0.5 x 0.5 cm. R32's August and September 2024 TAR documents R32's left heel treatment scheduled three times per week was not administered three times in August and five times in September. R32's daily coccyx treatment was not administered eight times in August and eight times in September. On 10/27/24 at 11:44 AM R32 stated R32 has sores on her feet/heel and her bottom that R32 did not admit with. R32 was lying in bed on her back and was not wearing heel protectors. R32's heels were in direct contact with R32's air mattress. R32's wheelchair pressure relieving cushion decompressed with applied hand pressure and the wheelchair seat could be felt through the cushion, indicating the cushion was not fully inflated with air. On 10/27/24 at V8 CNA stated V8 was unsure if R32 has any foot wounds, but R32 has a wound on R32's bottom. V8 stated R32 wears pressure relieving boots at night. V8 tested R32's wheelchair cushion with hand pressure and confirmed the cushion decompressed. V8 stated I believe that is how it (cushion) is suppose to be. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 9:03 AM R32 was sitting in her wheelchair in her room. At 11:20 AM staff brought R32 to her room and R32 was still in her wheelchair. R32 remained sitting in her wheelchair in her room until 11:45 AM when V4 CNA transferred R32 onto the toilet. At 11:54 AM V5 CNA responded to R32's bathroom call light. V5 confirmed R32's wheelchair cushion was not fully inflated by testing it with applied hand pressure. V5 stated that is how much it has been inflated since R32 started using it. V5 transferred R32 off of the toilet and into R32's wheelchair containing the cushion. On 10/28/24 at 11:59 AM V4 stated V4 transferred R32 out of bed and into her wheelchair between 8:00 AM and 9:00 AM. At 12:01 PM V4 and V5 transferred R32 into the stationary chair in R32's room and the chair did not contain a pressure relieving cushion. At 12:31 PM and 1:20 PM R32 was still sitting in the stationary chair. On 10/28/24 at 12:31 PM V3 Licensed Practical Nurse stated V3 already completed R32's heel treatment earlier this morning and V3 had applied a medicated honey treatment. V3 stated V3 wasn't aware that R3's heel treatment had changed to calcium alginate, so V3 will need to do R32's heel treatment again. At 1:36 PM V3 stated skin assessments are documented on the Medication Administration Records, the nurse documents if skin is intact, or if there is a wound or new wound. V3 stated there should be wound descriptions in the progress notes. V3 confirmed CNAs should use the care plan to determine pressure relieving interventions. V3 entered R32's room, transferred R32 from the stationary chair into bed, and administered R32's left heel and coccyx wound treatments. R32's stationary chair did not contain a pressure relieving cushion. R32's left outer heel had a small superficial wound and there was a deep marble sized wound to R32's coccyx. V3 raised the head of R32's bed, applied R32's covers, and left R32 lying on her back with the head of the bed elevated approximately 45 degrees (causing pressure to R32's coccyx). V3 did not offer or encourage R32 to off-load pressure from her coccyx and lay on her side prior to leaving R32's room. On 10/28/24 at 1:57 PM V3 confirmed V3 did not offer or encourage R32 to lay on her side prior to leaving the room. V3 stated V3 just didn't think of it (off-loading), and confirmed off-loading pressure from the coccyx would aide in wound healing. On 10/28/24 at 3:23 PM V12 Wound Nurse stated R32's wounds are pressure related and interventions include repositioning, off-loading, and pressure relieving boots. V12 confirmed R32 requires staff assistance to reposition or off-load, R32 should be repositioned at least every two hours and pillows should be used to off-load coccyx and heel pressure, unless pressure relieving boots are in place. V12 stated R32 should use a pressure relieving cushion in the wheelchair and stationary chair in her room. V12 confirmed R32's wheelchair cushion should be inflated and you should not be able to feel the seat of the wheelchair when pressure is applied V12 stated the CNAs should be checking that. V12 confirmed nurses should look at the TAR for treatment orders prior to administration and treatment administrations are documented on the TAR. V12 confirmed a blister is a stage two pressure ulcer and not implementing pressure ulcer interventions could contribute to a decline in wounds. V12 confirmed R32 admitted with a stage two pressure ulcer of the sacrum, there is no documentation of left heel wound on admission, and there are no assessments or measurements of this wound prior to being seen by V7. V12 confirmed there are no documented Braden Assessments in R32's EMR after 7/3/24 until 10/8/24. V12 stated a Braden score of 15 is considered high risk and that was R32's score on admission. V12 confirmed Prealbumin was never ordered for R32 and V12 stated she will follow up on this. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 9:38 AM V34 MDS Coordinator reviewed R32's admission and nursing notes and MDS, and confirmed R32's July MDS does not accurately reflect R32's skin status at that time. V34 stated V34 was told by staff at that time that R32 did not have any wounds, the wound nurse is suppose to enter wounds into the wound rounds tracking system, but there was no information entered for R32 at that time. V34 stated V34 consulted with corporate and will need to submit a modification for this MDS. V34 stated the wound nurse is responsible for adding wounds and new interventions on the care plan, and pressure relieving boots are documented in physician orders and on the care plan. On 10/29/24 at 12:34 PM V19 Registered Dietitian stated R32 was evaluated in July and August with no new recommendations, but V19 was not aware that R32's wounds had declined when R32 was evaluated in August. V19 stated if V32 was aware, V19 may have increased liquid protein to be given twice daily. V19 stated R32 should have been evaluated again in September, but V19 does not see where that was done. The manufacturer's instructions for R32's pressure relieving cushion dated 5/3/24 documents to inflate air until all of the air cells feel firm, remove the hand pump,allow air to escape from the valve until the air deflation is no longer felt or heard, and then close the inflation valve. Perform a hand check to evaluate sufficient air between the person and the base of the cushion, and adjust as needed. 37813 3.) R44's Minimum Data Set (MDS) dated [DATE] documents R44 is at risk for pressure ulcers and was admitted with no pressure ulcers. R44's Wound Care Telemedicine initial evaluation dated 10/18/24 by V7, Wound Physician documents R44 developed a facility acquired Stage III Pressure Ulcer of greater than 10 days duration on the coccyx measuring 1.6 cm (centimeters) by 1.0 cm by 0.3 cm deep. At that time V7 ordered the following wound dressing: Calcium Alginate with silver covered with gauze island dressing with border. R44's Treatment Administration Record documents this treatment was initiated. R44's Wound Care Telemedicine Follow-up evaluation dated 10/25/24 by V7, Wound Physician documents the wound has increased in size to 3.0 cm (centimeters) by 1.5 cm by 0.5 cm deep. At that time V7 ordered the following wound dressing: medicated honey Calcium Alginate with silver covered with gauze island dressing with border. R44's Treatment Administration Record documents this treatment was not initiated. The treatment ordered 10/18/24 was continued. On 10/29/24 at 1:00PM V12 Licensed Practical Nurse (wound Nurse) applied R44's treatment. V12 removed the old dressing, removed gloves, performed hand hygiene, cleansed R44's wound with normal saline, removed gloves, performed hand hygiene, applied calcium alginate with silver to clean wound bed and covered with a bordered foam dressing. V12 did not apply medicated honey to wound as ordered. When asked why she did not apply the medicated honey V12 stated I don't think that is ordered on the TAR. At this time it was observed R44 had a new Stage III pressure ulcer on her left ischium approximately the size of a quarter. There is no documentation R44 has been evaluated by a dietitian for the facility acquired pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 12:34PM V19 Registered Dietitian stated, When a resident develops a facility acquired pressure ulcer, the facility should reach out to me and I should evaluate and make recommendations to enhance healing. This facility does not do so. I usually pick up on issues like this when I do the periodic visits. I have not evaluated (R44). 4.) R52's Minimum Data Set (MDS) dated [DATE] documents R52 is at risk for pressure ulcers and was admitted with no pressure ulcers. R52's Treatment Administration Record (TAR) for October 2024 documents a new treatment dated 10/26/24 for Clean area to left buttock with normal saline. Apply calcium alginate to wound bed & cover with gauze foam daily every day shift for wound care. On 10/29/24 at 10:00 AM V12 Licensed Practical Nurse (wound Nurse) stated (R52) developed a new facility acquired Stage II pressure ulcer 10/25/24. We are treating it. On 10/29/24 at 1:15PM V12 Licensed Practical Nurse (wound Nurse) applied R52's treatment. V12 removed the old dressing, removed gloves, performed hand hygiene, cleansed R52's wound with normal saline, removed gloves, performed hand hygiene, applied calcium alginate with silver to clean wound bed and covered with a bordered foam dressing. At this time V12 verified R52's wound is now a Stage III because it has visible slough of tissue. V12 also verified R52 has developed an additional dime sized stage III pressure ulcer to her right buttock. R52 was sitting in the bed with the head elevated to sitting position. R52's bed did not have a pressure relieving mattress in place. There is no documentation R52 has been evaluated by a dietitian for the facility acquired pressure ulcers. On 10/29/24 at 12:34PM V19 Registered Dietitian stated, When a resident develops a facility acquired pressure ulcer, the facility should reach out to me and I should evaluate and make recommendations to enhance healing. This facility does not do so. I usually pick up on issues like this when I do the periodic visits. I have not evaluated (R52). There is no documentation to support R52 has been evaluated by the wound care Physician. On 10/29/24 at 1:15PM V12 verified this.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32853 Based on observation, interview and record review the facility failed to ensure that the environment was free from hazards for seven of seven residents (R21, R53, R29, R39, R16, R61, R66) reviewed for safety and supervision in the sample list of 46. Findings include: The facility's Storage and Medications policy dated 10/27/14 documents, The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. On 10/28/24 at 9:05 AM, there were two weekly pill organizers sitting on the entry way table, unattended and accessible to other residents. There were 28 days for the pills to be placed in. There were at least 27 unidentified pills visible in the cases. This table is at the front entry of the building which leads to the 100 hall and leads to the chapel/dining room area. On 10/28/24 at 9:10 AM, V2 Director of Nursing confirmed the pill organizers were sitting on the table and stated that the resident whose name is on the pill containers is not a long term care resident, but a resident of the attached assisted living facility. At this same time, V15 Certified Nursing Assistant/Receptionist stated that she thought that the pharmacy dropped them off there and stated that is what they always do with his pills. V2 stated that the medications should not be left there and V2 removed the pill containers. On 10/30/24 at 11:06 AM, V1 Administrator provided a list of residents that are independently ambulatory in the vicinity of the entry table that the medications were left on. This list documents R21, R53, R29, R39, R16, R61 and R66 are all able to move independently around the facility and would have access to the medications that were left on the entry table.

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to monitor weights and implement nutritional interventions for significant weight loss for four (R8, R52, R25, R44) of five residents reviewed for nutrition in the sample list of 46. These failures resulted in ongoing weight loss following a significant weight loss for R8, R52, R25, and R44. Findings include: The facility's Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol dated August 2008 documents to assess for recent weight loss and the physician will review for possible causes of weight loss with the nursing staff and/or dietitian before ordering interventions. This policy documents the physician and/or designee will authorize appropriate interventions as indicated, reconsider dietary restrictions and altered diet consistency, and consider diagnostic testing. The facility's Routine Nutritional Documentation and assessment dated 2020 documents residents are assessed and monitored for nutrition in accordance with the Minimum Data Set (MDS) schedule, and residents who are considered with nutritional risk or concerns are referred to the Registered Dietitian for a comprehensive nutritional assessment. This policy documents the Dining Services Manager and Registered Dietitian will document quarterly progress notes for observations, progress of nutritional goals, and nutritional care information. 1.) R8's MDS dated [DATE] documents R8 is cognitively intact, R8's weight was 156 pounds (lb), and R8 had no significant weight loss within the last six months. The last documented nutritional assessment in R8's medical record is dated as 3/2/24 and there is no documentation that R8's significant weight loss in September was evaluated by a dietitian. R8's ongoing weight log documents R8's weight as follows: 4/4/24 150.4 lbs, 7/1/24 156.4 lbs, 8/2/24 156 lbs, 9/2/24 146 lbs (6.41% loss in one month), and 10/30/24 143 lbs (8.3% loss in three months). There were no documented weights in R8's medical record after 9/2/24 until 10/30/24. R8's Care Plan dated 5/26/23 documents R8 has a nutritional problem related to abnormal weight loss and interventions include to provide supplements as ordered, dietitian to evaluate and make dietary changes as needed. This care plan does not document any nutritional interventions were developed/implemented after 5/26/23 to address R8's significant weight loss. R8's active October 2024 physician's orders documents R8's diet as Regular/Mechanical Soft. There are no documented orders for nutritional supplements. R8's Wound Care Telemedicine Follow Up Evaluation dated 10/25/24 documents R8 has stage three pressure ulcers to the right buttock and left hip. On 10/27/24 at 10:23 AM R8 was in the dining room eating. R8's meal consisted of waffles, banana, and sausage, and did not include any nutritional supplements. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 10/29/24 at 12:34 PM V19 Registered Dietitian stated R8 was due for an annual nutritional evaluation in June 2024, but one was not done because the electronic software program did not trigger for one to be done with R8's annual MDS. V19 stated R8's last nutritional assessment was completed in March 2024. V19 stated no one had requested to evaluate R8's nutritional status and V19 was unaware that R8 had developed pressure ulcers. V19 stated residents with wounds should be evaluated by the dietitian monthly. If V19 had evaluated R8, V19 would have recommended Zinc, Vitamin C, a multivitamin, liquid protein. V19 stated V19 possibly would have recommended a nutritional supplement if R8 had lost weight, but R8 does not have a documented weight for October. On 10/29/24 at 2:00 PM V2 Director of Nursing stated weights are recorded under the weight section of the resident's electronic medical record. R8's weight was requested to be obtained at this time. On 10/30/24 at 11:02 AM V10 Restorative Nurse/Registered Nurse stated R8's weight today was 143 lbs. 37813 2.) R44's weight flow sheet documents on 05/12/2024, (R44) weighed 125.8 lbs. On 10/04/2024, R44 weighed 101.2 pounds which is a 19.55 % Loss. R44's Wound Care Telemedicine initial evaluation dated 10/18/24 by V7, Wound Physician documents R44 developed a facility acquired Stage III Pressure Ulcer of greater than 10 days duration on the coccyx. 10/29/24 12:39 PM V19 Registered Dietitian stated The facility does not reach out to me when a resident has a wound or a significant weight loss. Yes I should be notified of a significant weight loss and/or a wound and I should evaluate these residents. V19 verified V19 has not evaluated R44. 3.) R52's weight flow sheet documents on 09/03/2024, R52 weighed 131.2 lbs. on 10/15/2024, R52 weighed 123.6 pounds which is a 5.79 % loss. R52's Treatment Administration Record (TAR) for October 2024 documents a new treatment dated 10/26/24 for Clean area to left buttock with normal saline. Apply calcium alginate to wound bed & cover with gauze foam daily every day shift for wound care. On 10/29/24 at 10:00 AM V12 Licensed Practical Nurse (wound Nurse) stated (R52) developed a new facility acquired Stage II pressure ulcer on 10/25/24. We are treating it. 10/29/24 12:39 PM V19 Registered Dietitian stated The facility does not reach out to me when a resident has a wound or a significant weight loss. Yes I should be notified of a significant weight loss and/or a wound and I should evaluate these residents. V19 verified V19 has not evaluated R52. 50993 4.) R25's ongoing weight logs document R25's weight as 229.6 pounds on 08/01/24 and 216 pounds on 09/02/24, demonstrating a 5.92% weight loss in one month. This log documents R25's October 2024 weight as 215.4 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	R25's Nursing Progress Notes dated 9/1/24 - 9/30/24 does not document that V35 R25's Nurse Practitioner or V19 RD (Registered Dietician) were notified of R25's significant weight loss. R25's September and October 2024 Physician Order Sheets do not document any new orders for nutritional supplements following R25's significant weight loss. On 10/29/24 at 11:10 AM, V2 DON (Director of Nursing) stated V2 was unaware of R25's weight loss. V2 stated the expectation is that V19 RD (Registered Dietitian) would report the weight loss to nursing services with their recommendations. On 10/29/24 at 12:31 PM, V19 RD stated that the weight loss from 08/01/24 through 09/02/24 would be considered a significant weight loss. V19 explained the facility should have reached out to V19 so that V19 could have evaluated R25's weight loss and ordered nutritional supplements due to R25's weight loss but the facility does not do that.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50993 Based on observation, interview and record review the facility failed to date and secure oxygen tubing, humidification bottle, and nebulizer tubing for one of three residents (R25) reviewed for oxygen on the sample list of 46. Findings include: R25's Care Plan updated 12/4/24, documents R25 is to receive nebulizer and oxygen therapies as ordered. R25's Physician Order Sheet dated 9/20/24 documents an order for oxygen per nasal cannula to maintain an oxygen saturation of 90% or above at bedtime. On 10/27/24 at 8:22 AM, R25's oxygen tubing (nasal cannula) was uncovered and draped over the knob of the oxygen concentrator with the nasal prongs of the nasal cannula on R25's floor. The tubing and humidifier bottle were not dated. At this time, a nebulizer machine sitting on R25's dresser had an uncovered nebulizer mask, reservoir and tubing connected to the nebulizer machine that was also not dated. On 10/27/24 at 8:44 AM, R25 was sitting on the side of R25's bed receiving oxygen via the tubing/nasal cannula that had been on the floor previously. On 10/27/24 at 9:58 AM, R25's undated oxygen tubing was lying on the floor beside the oxygen concentrator, uncovered. On 10/28/24 at 10:24 AM, R25's oxygen tubing/nasal cannula was uncovered and lying on the floor beside the oxygen concentrator, and the humidifier bottle remained undated. R25 stated R25 used the oxygen that morning and that staff does not date the tubing or humidification bottle when it is changed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37813 Based on interview and record review the facility failed to regularly assess for the use of psychotropic medications for four (R1, R44, R8, R46) of five residents reviewed for psychotropic medication use in a sample list of 46 residents. Findings include: The facility's policy Psychotropic Medication Policy updated 11/2017 states Psychotropic medication shall not be prescribed without informed consent of the resident, the resident's guardian, or other authorized representative. Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increasing dosages or combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Side effects of the medication will be described during the informed consent process. 1.) R1's Medication Administration Record for October 2024 includes the following current physician's orders for psychotropic medication: R1's Medication Administration Record for October 2024 includes the following current physician's orders for psychotropic medication: Lorazepam (Antianxiety) 0.5 Mg (milligrams) every eight hours as needed. Quetiapine (Antipsychotic) 50 mg every morning and 75 MG every evening. Fluoxitine (antidepressant) 40 Mg daily. Buspar (antianxiety). R1's electronic medical record documents the most recent assessment for R1's quitapine and buspar were dated 5/2/24. There are no assessments documented for R1's Lorazepam or Fluoxitine. There are no informed consents for the current increased dosages of Quitapine and Fluoxatine and no consent for R1's Lorazepam. On 10/30/24 at 10:00AM V2, Director of Nursing confirmed the R1's informed consents and Assessments for psychotropic medications are either missing or out dated as described above. 2.) R44's Medication Administration Record for October 2024 includes the following current physician's orders for psychotropic medication: Lorazapam (antianxiety) 0.5 Mg every eight hours as needed. Zoloft (antidepressant) 25 Mg daily. Zyprexa (antipsychotic) 10 Mg daily and 5 Mg at night. Trazadone (antidepressant) 25 Mg. at night. R44's electronic medical record documents the most recent assessment for R1's Zyprexa was 1/26/24 and no documented assessment for R44's Lorazepam, Zoloft, and Trazadone On 10/30/24 at 10:00AM V2, Director of Nursing confirmed that R44's informed consents and Assessments for psychotropic medications are either missing or out dated as described above. 50993 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) R46's Physician Order Sheet dated October 2024 documents an order for the following medications: Amitriptyline (antidepressant) 25mg (milligram) at bedtime, Lorazepam (antianxiety) 1mg every eight hours as needed, Bupropion (antidepressant) 300mg extended release daily, and Sertraline (antidepressant) 100mg twice daily. R46's Medical Record does not contain a current Psychotropic Medication Assessment. The most recent one is dated 12/8/23. On 10/30/24 at 1:05 pm, V10 Restorative Registered Nurse stated the facility completes Psychotropic Medication Assessments every six months, not quarterly as their policy states they will be done, and confirmed that R46 did not have a Psychotropic Medication Assessment completed since 12/8/23. 40385 4.) R8's ongoing diagnoses list documents primary diagnosis of Dementia (9/27/22), Anxiety Disorder (2/13/19), Major Depressive Disorder (10/24/18), Conversion Disorder with Seizures/Convulsions (6/27/23), Post Traumatic Stress Disorder (6/27/23), and Bipolar Disorder (6/27/23). R8's October 2024 Medication Administration Record documents R8 received Duloxetine Hydrochloride (antidepressant) 60 milligrams (mg) one capsule by mouth once daily for Major Depressive Disorder Oral Capsule since 5/14/24, Abilify (antipsychotic) 2.5 mg by moth twice daily for mood disorder since 8/15/24, and Depakote (anticonvulsant/mood stabilizer) Delayed Release 500 mg by mouth four times daily since 7/12/24. R8's Psychiatry Note dated 9/5/24 at 3:23 PM documents R8 receives Depakote 500 mg four times daily for Bipolar Disorder. R8's (Behavioral Center) Progress Note dated 8/13/24 documents R8 was seen for evaluation of medication. This note documents R8's tremors are unchanged with addition of Cogentin, there are concerns of antipsychotic induced parkinsonism, and Abilify dosage was decreased at this time. This note documents if tremors are not improved, will plan to change medications. The last documented Abnormal Involuntary Movement Scale (AIMS) evaluation in R32's medical record, was completed on 7/15/24 with a score of two due to minimal facial expression and lips/mouth movements. R8's Psychotropic Medication Reviews dated 1/19/24 and 5/2/24 do not document an assessment for the use of Depakote and what targeted behaviors this medication is used to treat. There are no other documented Psychotropic Medication Reviews in R8's medical record after 5/2/24. 10/30/24 at 11:02 AM V10 Restorative/Registered Nurse stated psychotropic medication assessments are completed by the Director of Nursing or (Psychiatry Services), which are done on admission, quarterly, and with any medication/dosage changes. V10 stated AIMS are done as the same frequency as the psychotropic medication assessments, and are documented in the assessments tab of the resident's electronic medical record. On 10/30/24 at 1:05 PM V10 confirmed all of R8's AIMS and psychotropic medication assessments within the last year were provided. V10 was asked about assessing for R8's Depakote use. V10 stated R8 has a psychiatric diagnosis and seizure disorder, so it is dual medication treatment. V10 stated the facility only completes psychotropic medication assessments every six months.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32853 Based on observation, interview and record review the facility failed to administer medications according to Physician's Orders for one of four residents (R75) reviewed for medication administration in the sample list of 46. This failure resulted in two medication errors out of 33 opportunities resulting in a 6.06% error rate. Findings include: The facility's undated Medication Administration Policy documents, Drugs will be administered in accordance with orders of licensed medical practitioners in this State. Medications shall be administered within one (1) hour of the medication schedule unless specifically ordered otherwise (see Medication Administration Schedule). R75's Medication Administration Record dated 10/1/24-10/31/24 documents orders for Metoprolol Tartrate 25 mg (milligrams) give 0.5 tablet twice a day at 8:00 AM and at 5:00 PM and an order for Vitamin D give 50 mcg (micrograms) every day. On 10/27/24 at 12:41 PM, V14 Licensed Practical Nurse gave R75 one Metoprolol 25 mg half a tablet (12.5 mg), over 4 1/2 hours late. V14 also administered R75 Vitamin D3 5,000 units one tablet. R75 should have received only 2,000 units (50mcg). On 10/27/24 at 1:50 PM, V14 confirmed that the Metoprolol for R75 was scheduled for 8:00 AM and it was given late. V14 stated it was given late due to the computers going down this morning. V14 also confirmed that she gave the wrong dose of Vitamin D to R75. V14 stated that she must have looked at the mcg not units.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35347 Based on observation and interview, the facility failed to serve palatable resident meals. This failure affects one resident (R37) of 10 reviewed for food palatability in the sample list of 46. Findings include: On 10/27/2024 at 9:45AM, R37 reported eating meals in R37's room and receiving cold food. On 10/29/2024 at 11:08AM, meal trays arrived in the 200 hallway and staff immediately began serving the trays to residents. All resident meals were served on ceramic plates. R37 received a meal tray of biscuits and sausage gravy. R37's food items measured 95 degrees Fahrenheit by Illinois Department of Public Health thermometer. R37 reported R37's food was not warm and R37 would like R37's meals to be warmer. On 10/29/2024 at 3:00PM, V28 (Cook) reported meals provided to residents eating in their rooms may not be arriving hot because hall trays are assembled in the main kitchen and placed onto a cart that is transported to the adjacent dining room where a drink station is located where staff then have to prepare each resident drink for each tray before taking the cart to the hall to serve the meals to residents. V28 reported thinking if the drinks were prepared separately on the halls, resident hall tray meals could likely be served more quickly and arrive warmer.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37813 Based on interview and record review the facility failed to prevent, investigate, and implement systemic interventions to address allegations of misappropriation. This failure affects four (R13, R25, R46, R130) residents and has the potential to affect all 73 residents who reside at the facility. Findings include: The facility's Midnight Census Report dated 10/26/24 documents 73 residents reside at the facility. The facility Abuse Prevention Program dated October 2022 documents all incidents or allegations of abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, that was alleged or suspected will be documented and result in an investigation. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. The person in charge of the investigation will update the Administrator or person designated in the Administrator's absence during the progress of the investigation. The Administrator or designee will keep the resident or resident representative informed of the progress of the investigation. The investigator will report the conclusion of the investigation in writing to the Administrator or designee within five working days of the reported incident. On 10/29/24 at 9:00AM R13 was seated in wheelchair in room with family member visiting. R13 stated I had $100.00 and eight double struck commemorative coins taken from my lock box. It had to be staff because they might have known I was keeping my key beside my bed in my pencil box. It is bad enough I lost the money, but I used to carve the casts and strike the coins. The facility's Grievance Log for the three months prior to the survey documents R130 withdrew money from the bank on 9/1/24 and stored it in her purse. On 9/2/24 (R130) noticed money was missing around noon. (R130) was interviewed and family confirms money was withdrawn from the bank. Facility will replace the money. The facility's grievance log dated 10/25/2024 documents: R25 reported to manager (V10 Restorative Registered Nurse) that (R25) had money missing. V29 SSD (Social Service Director) followed up and R25 explained that last week (R25) had $100 missing and then on October 22nd (R25) had another $20 missing. He stated the money was in his wallet in his top drawer. V29 reported R25's missing money to V1 Administrator to follow up. On 10/27/24 at 9:50 AM, R46 stated R46 had cash stolen from R46 during a room move. R46 explained R46 had $100 in cash in R46's dresser drawer and after moving rooms, the $100 was missing. R46 stated an unidentified housekeeper seen the cash in R46's drawer while assisting R46 with the room move. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/29/24 at 11:00AM V1, Administrator stated there are really no documented investigations. I am aware that allegations of misappropriation are to be reported to the state agency and if there is a reasonable suspicion of a crime to the police. I do not believe the money has been returned. I was instructed by corporate to treat these like grievances and I followed those instructions. No documented investigations were provided by the facility. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 50993 Based on interview and record review, the facility failed to develop, implement, and maintain an effective, comprehensive, data-driven Quality Assurance Performance Improvement Program that demonstrates systematic identification of problematic areas within the facility along with reporting, investigation, and analysis of those areas to prevent adverse outcomes to the residents. This failure affects seven (R13, R25, R46, R130, R8, R44, and R52) residents and has the potential to affect all 73 residents who reside at the facility. Findings Include: The facility's ongoing Grievance Log dated September - October 2024 documents misappropriation of money for R13, R25, R46, and R130. Ongoing weight Logs for R8, R25, R44, and R52 document these residents have had a significant weight loss between August 2024 and September 2024, with no assessments completed by V19 RD (Registered Dietitian) or nutritional interventions implemented to try to prevent further weight loss. On 10/30/24 at 11:21 AM, V1 Administrator stated V1 has only been employed by the facility for three weeks, therefore has not attended any QAPI meetings but stated the facility conducts monthly and quarterly meetings. V1 stated V1 was aware of R13, R25, and R46 having money missing however V1 was instructed by Corporate to handle it internally by logging the misappropriation of money on the Grievance Log. V1 stated V1 did not investigate or report the allegations of misappropriation of money and has not implemented any changes to prevent further incidents of misappropriation of money. V1 also stated V1 did not identify the ongoing incidents of misappropriation of money and the facility's lack of response to all of the misappropriation of resident money as a system failure. On 10/31/24 at 9:25 AM, V2 Director of Nursing/Former Administrator stated the facility meets monthly for QAPI and has identified problems with Wounds and Laboratory Services but those are the only concern areas that has been identified. On 10/29/24 at 11:10 AM, V2 stated that for significant weight losses, the facility relies on V19 to alert nursing services with recommendations when V19 identifies a significant weight loss. On 10/29/24 at 12:31 PM, V19 RD stated the facility should be the one notifying V19 when a significant weight loss is identified so that the resident can be evaluated and interventions can be implemented, but they don't do that. (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

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Quality Assurance Improvement Plan dated 10/1/18 documents the purpose of QAPI (Quality Assurance Performance Improvement) in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers, and other partners so that we may realize our vision to set the standard in nursing and rehabilitative care; to provide excellent quality resident care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the resident cost effectively while maintaining good resident outcomes and perceptions of care. To do this, all employees will participate in ongoing QAPI efforts which supports our mission to be a recognized leader in clinical quality and customer satisfaction in the market we serve. This facility uses QAPI to make decisions and guide our day to day functions. QAPI includes all employees, all departments and all services provided. QAPI focuses on systems and processes to identify system gaps rather than blaming individuals. Our organization supports PI (Performance Improvement) by encouraging our employees to support each other as well as being accountable for their own professional performance and practice. Our organization has a culture that encourages, rather than punishes those who identify errors or system breakdowns. Our facility has a PI Program which systematically monitors, analyzes and improves it's performance to improve resident outcomes. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50993 Based on interview and record review the facility failed to take actions aimed at performance improvement, implement those actions, measure its success and track performance. This failure has the potential to affect all 73 residents residing in the facility. Findings include: The facility's Quality Assurance Improvement Plan dated 10/1/18 documents, the purpose of QAPI (Quality Assurance Performance Improvement) in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers, and other partners so that we may realize our vision to set the standard in nursing and rehabilitative care; to provide excellent quality resident care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the resident cost effectively while maintaining good resident outcomes and perceptions of care. To do this, all employees will participate in ongoing QAPI efforts which supports our mission to be a recognized leader in clinical quality and customer satisfaction in the market we serve. This facility uses QAPI to make decisions and guide our day to day functions. QAPI includes all employees, all departments and all services provided. QAPI focuses on systems and processes to identify system gaps rather than blaming individuals. Our organization supports PI (Performance Improvement) by encouraging our employees to support each other as well as being accountable for their own professional performance and practice. Our organization has a culture that encourages, rather than punishes those who identify errors or system breakdowns. Our facility has a PI Program which systematically monitors, analyzes and improves its performance to improve resident outcomes. On 10/31/24 at 9:25 AM, V2 Director of Nursing/Former Administrator stated the facility meets monthly for QAPI and has identified problems with Wounds and Laboratory Services but those are the only concern areas that have been identified. V2 also stated V2 has developed PIP's (Performance Improvement Projects) for both areas of concern however has not implemented any steps for improvement or followed up on the areas of concern because V2 hasn't had time due to state (surveyors are) always in the building. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 50993 Based on interview and record review, the facility failed to hold quarterly Quality Assurance Performance Improvement meetings with all required attendees. This failure has the potential to affect all 73 residents who reside at the facility. Findings Include: The facility's Quality Assurance Performance Improvement (QAPI) sign in sheets dated 10/9/24 does not contain V39 (Former DON (Director of Nursing)/Infection Preventionist) signature as attending the meeting. The QAPI sign in dated 7/26/24 does not include V39 or V40's Medical Director signature as attending the meeting. The QAPI sign in dated 4/10/24 does not contain V40's signature as attending the meeting. On 10/30/24 at 11:21 AM, V1 Administrator stated V1 has only been employed at the facility for three weeks therefore has not attended a Quality Assurance Performance Improvement (QAPI) meeting. At this time, V24 Medical Records stated V24 takes the minutes for the meetings and explained that the last quarterly meeting was held on 10/9/24. V24 confirmed that V39 and V40 were not always at the meetings, their attendance was hit or miss. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35347 Failures at this level required more than one deficient practice statement. A. Based on interview and record review, the facility failed to develop a water management plan that included the required risk assessment, control measures, and testing protocols to reduce the risk of growth of Legionella and other pathogens in the facility's water system. This failure has the potential to affect all 73 residents in the facility. B. Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBPs) and provide hygienic wound care for three (R8, R32, R69) of five residents reviewed for EBP in the sample list of 46. Findings include: a. On 10/31/2024 at 11:00AM, the facility water management plan (undated) failed to document the required facility water system risk assessment where Legionella and other pathogens could grow and spread in the facility water system. The plan did not identify any specific testing protocols, acceptable ranges for control measures, or any corrective actions when control limits are not maintained to reduce the risk of waterborne pathogens in the facility water system. The plan's facility water distribution system diagram did not identify control points for known areas of elevated risk such as stagnation, low/zero disinfectant levels, or other conditions for bacteria to spread. On 10/31/2024 at 11:10AM, V27 (Maintenance Supervisor) reported the facility water management plan did not identify any waterborne infection control measures, control limits, or corrective actions to reduce waterborne infection risk in the facility. V27 reported no residential areas of the facility water distribution system, except the rehab unit, are served by a recirculating water supply. V27 denied the facility had any written protocols for flushing areas of the facility water system after boil orders or when fixtures remain unused for extended periods of time. The facility Long-Term Care Facility Application for Medicare and Medicaid (10/27/2024) documents 73 residents reside in the facility. 40385 b1.) The facility's Enhanced Barrier Precautions policy dated 4/1/24 documents EBP are used to prevent the transmission of multidrug-resistant organisms and are indicated to be used during high contact activities for residents with chronic wounds or indwelling medical devices. High contact care includes dressing, bathing, transfers, incontinence and hygiene cares, changing linens, medical device care, and wound care. This policy documents to post signage on the resident's room door or wall outside of the room to to indicate precautions and required Personal Protective Equipment (PPE) needed during listed high contact care; and ensure gowns and gloves are available immediately outside of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Wound Care policy dated October 2010 documents the following steps when providing wound care: apply gloves, remove the wound dressing, pull glove over the dressing and discard, perform hand hygiene, apply gloves, cleanse the wound, administer treatment as ordered, remove gloves and perform hand hygiene. R8's Wound Care Telemedicine Follow Up Evaluation dated 10/7/24 documents R8 has a Stage Three Pressure Ulcer of the right buttock. R8's active October 2024 Physician Orders do not document an order for EBP. R8's Care Plan with review date 9/19/24 does not document EBP. On 10/28/24 at 12:02 PM V4 and V6 Certified Nursing Assistants (CNAs) transferred R8 from the wheelchair into bed. V4 and V6 were not wearing gloves or gowns during R8's transfer. V6 provided R8's incontinence cares and was not wearing a gown. R8 had two open wounds, one to the right buttock and one to the left hip. There was no signage posted on R8's room door to indicate R8 was on EBP. On 10/28/24 at 12:16 PM V3 Licensed Practical Nurse (LPN) entered R8's room to administer R8's pressure ulcer treatments. V3 was not wearing a gown. V3 performed hand hygiene and applied gloves. V3 cleansed R8's left hip wound and then the right buttock wound. V3 applied Santyl, Calcium Alginate, and a bordered foam dressing to the left hip wound, then applied Collagen and bordered dressing to the right buttock wound. V3 did not change gloves during R8's pressure ulcer treatments. On 10/29/24 at 2:10 PM there was no EBP signage posted on R8's room door. b2.) R32's Nursing Note dated 7/9/2024 at 12:34 PM documents R32 had a blister to the left heel that measured 3.5 cm by 7 cm, and a skin protectant and dry dressing was applied. R32's Nursing Note dated 8/4/2024 at 5:29 PM documents R32's coccyx had a 6 cm by 3 cm maroon spot with a small open area. R32's active October 2024 Physician Orders do not document an order for EBP. R32's Care Plan with review date 8/2/24 does not document EBP. On 10/28/24 at 11:45 AM V4 CNA transferred R32 from the wheelchair onto the toilet in R32's bathroom. V4 was not wearing a gown or gloves during this transfer. There was a sign on R32's door indicating R32 was on EBP and to wear gown and gloves during high contact care, which included transfers and toileting assistance. There was no cart containing Personal Protective Equipment (PPE) outside of R32's doorway. On 10/28/24 at 11:54 AM V5 CNA answered R32's bathroom call light. V5 transferred R32 off of the toilet and into the wheelchair. V5 was not wearing a gown for R32's cares. AT 11:59 AM V4 and V5 entered R32's room without applying a gown and transferred R32 into the stationary chair in R32's room. On 10/28/24 at 1:36 PM V3 LPN entered R32's room to administer R32's wound treatments. V3 applied gloves, removed the dressing to R32's left heel, and transferred R32 into bed. R32 had a superficial wound to the left outer heel. V3 did not change gloves prior to cleansing and administering R32's wound treatments. V3 cleansed the wound, applied Calcium Alginate, and covered with a bordered foam dressing. Using the same gloves, V3 applied skin protectant wipe to R32's right great toe. V3 then removed R32's coccyx dressing, cleansed the wound, applied Calcium Alginate, and covered with a bordered foam dressing. The wound was deep and approximately marble size. V3 did not change gloves or wear a gown during R32's transfer and wound treatments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/28/24 at 1:57 PM V3 and V4 stated they weren't aware that gown should be worn for high contact cares for R32 and R8. Both confirmed there was an EBP sign on R32's door, but not on R8's door. V3 and V4 stated they didn't think about EBP since there isn't a PPE cart outside of the rooms. V3 stated EBP may be something we need additional training on. On 10/29/24 at 2:00 PM V2 Director of Nursing stated nurses should perform hand hygiene and apply gloves prior to wound treatment administration, and change gloves and perform hand hygiene after removing a dressing and when cleaning and applying a new dressing. V2 stated staff were educated on EBP during a recent all staff in-service. V2 confirmed staff should wear gown and gloves during high contact care for residents on EBP for wounds. V2 confirmed an EBP sign should be posted on the resident's room door. 50993 b3.) On 10/27/24 at 9:01 AM, R69's room door had a sign which read, Enhanced Barrier Precautions and there was a supply cart outside of R69's room that contained Personal Protective Equipment including gowns, mask, and gloves. R69's Physician Order Sheet dated 10/24/24 documents an order for surgical wound care; to clean the incision site with Normal Saline, pat dry, cover with dry gauze, and secure with tape. On 10/28/24 at 1:20 PM, V22 Licensed Practical Nurse (LPN) gathered supplies consisting of clean 4 inch by 4 inch gauze, two thick absorbent gauze dressings, pre-filled 10ml (milliliter) Normal Saline syringe, and silk tape for R69's surgical wound dressing change to left above the knee amputation surgical site. V22 entered R69's room without a gown on and donned gloves without performing hand hygiene prior. V22 removed R69's old dressing and placed the old dressing on R69's footrest of the recliner on top of R69's blanket. V22 did not perform hand hygiene or change gloves after removing the old dressing. V22 then cleansed the surgical wound with Normal Saline and gauze, and placed two thick absorbent gauze dressing to wound, securing the dressing with silk tape while wearing the same gloves. V22 then discarded the dressing supplies into R69's trash can and removed gloves but did not perform hand hygiene after removing the gloves. On 10/28/24 at 1:50 PM, V22 (LPN) stated she should have changed her gloves and performed hand hygiene after removing the old dressing. V22 stated she has had no training on Enhanced Barrier Precautions from the facility since hire and was not aware she should be wearing a gown. V22 confirmed R69 had an Enhanced Barrier Precautions sign hanging on R69's room door and stated, I (V22) didn't notice it until the surveyor pointed it out to V22. On 10/28/24 at 1:35 PM, V12 Wound Licensed Practical Nurse stated V12 would expect any nurse while performing wound care to change gloves and perform hand hygiene after removing an old dressing. V12 stated any resident that has a urinary catheter, feeding tube, or certain wound treatments should be on Enhanced Barrier Precautions and staff should wear gown and gloves when providing direct care for residents. V12 stated there has been a lack of education in the facility on Enhanced Barrier Precautions for V12 and the nursing staff as a whole. R69's Physician Order Sheet dated 10/24/24 documents an order for a urinary catheter. This Physician Order Sheet does not contain an order for Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/28/24 at 1:32 PM, V22 Licensed Practical Nurse (LPN) and V23 Certified Nursing Assistant (CNA) entered R69's room for urinary catheter care. V22 performed hand hygiene and donned gloves but no gown. Catheter care was performed by V22 using clean technique. V22 LPN handed V23 CNA R69's urinary catheter bag to assist with application of new incontinent brief, V23 had gloves on but no gown.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to follow their influenza (flu) vaccination policy for five (R1, R8, R32, R63, R66) of five residents reviewed for immunizations in the sample list of 46. This failure has the potential to affect all 73 residents residing in the facility. The facility also failed to track and offer pneumococcal vaccinations to ensure residents are up to date for three (R32, R63, R66) of five residents reviewed for immunizations in the sample list of 46. Findings include: The facility's Vaccination of Residents policy dated August 2008 documents: Because long-term care residents are prone to developing serious complications when they contract the flu, all residents will be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident has already been vaccinate. The influenza vaccine will be available to all residents between October 1st and March 31st of each year. Residents admitted during this time period will be offered the vaccine within five (5) days after admission, unless medically contraindicated or the resident has already been vaccinated. Prior to the vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the influenza vaccinations. Provision of such education shall be documented in the resident's medical record. Before receiving the Pneumovax, the resident or legal representative shall receive education regarding the benefits and potential side effects of the pneumococcal vaccine. Contraindications for Pneumovax are: c. Previous vaccination; d. Pregnancy or lactation; and e. Chemotherapy or other immunosuppressive therapy. If vaccinations are refused, the refusal shall be documented in the resident's medical record. If the resident receives a vaccination, at least the following information shall be documented in the resident's medical record: a. Site of administration; b. Date of administration; c. Lot number of the vaccine (located on the vial); d. Expiration date (located on the vial); e. Name of person administering the vaccine. 1. On 10/29/24 at 11:52 AM V2 Director of Nursing/Infection Preventionist stated the facility has not yet offered residents this year's influenza vaccine. V2 stated the facility is currently working on getting a contracted company to schedule a flu clinic, and one has not been scheduled yet. V2 stated the facility contacted one company on 10/22/24, but they had no availability. V2 stated vaccine information should be documented in the immunization section of the residents electronic medical record (EMR). On 10/30/24 at 9:30 AM V2 was unavailable. V1 Administrator stated immunization consents are uploaded into the resident's EMR. AT 10:25 AM V1 confirmed the facility had not attempted to order the 2024 influenza vaccine from their pharmacy or contacted the Local Health Department for 2024 flu vaccine administration. V10 Restorative Nurse stated we are in the process of scheduling a flu clinic and the 2024 flu vaccine consent forms have not been sent out yet, that is done once the clinic is scheduled. V10 stated everyone is eligible for the flu vaccine unless they have an allergy, and that would be documented on the consent form. V10 stated no residents are up to date with the 2024 flu vaccine and the facility gave the 2023 flu vaccines in December. V1 and V10 confirmed vaccine education is documented on the consents as well as declination to be vaccinated. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Informed Consent for Vaccinations documents a copy of the Centers for Disease Control and Prevention (CDC) Information Statement is provided to describe the vaccine's risks and benefits. This consent form documents possible side effects, the vaccine is offered annually prior to the influenza season, and a section to indicate the vaccine is requested or declined. There is no documented 2024 flu vaccine consent form, or documentation that the vaccine has been given, in R8's, R32's, R63's, R66's, and R1's EMRs. R32's Minimum Data Set (MDS) dated [DATE] documents R32 admitted to the facility on [DATE], R32's diagnoses include Hypertension and Coronary Artery Disease. R32's Physician Order dated 7/12/24 documents May administer Influenza Vaccine annually (Unless contraindicated). Record in Immunization Tab. R63's ongoing Diagnoses List documents R63 is over age 65 and diagnoses include morbid obesity, Carotid Artery Syndrome, and history of COVID-19. R63's Physician Order dated 4/12/24 documents May Administer Influenza Vaccine Annually if resident/representative gives consent. R66's ongoing Diagnoses List documents R66 is over age 65 and diagnoses include acute and chronic respiratory failure, history of COVID-19, and congestive heart failure. R8's MDS dated [DATE] documents R8's diagnoses include a history of COVID-19, Hypertension, and Hyperlipidemia. On 10/30/24 at 12:42 PM V1 provided a paper with vaccine information for R8, R32, R63, R66, and R1, that documents the following: R1 received flu vaccine on 12/6/23. R32 received flu vaccine on 11/10/23. R8 received flu vaccine on 12/6/23. There is no historical flu vaccine information for R63 and R66. This vaccine will be offered during the 2024 clinic. The CDC's Preventing Seasonal Flu dated 8/26/24 documents the following: The best way to reduce risk of influenza and associated complications is to get a yearly influenza vaccination; and everyone age six months and over, especially those at high risk, should ideally be vaccinated annually by the end of October. People over age 65 and those with chronic respiratory conditions, heart conditions, and diabetes are at higher risk for serious flu complications. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility. 2.) R32's MDS dated [DATE] documents R32's pneumococcal vaccination is not up to date, and this vaccine was not offered due to not being eligible. R32's Physician Order dated 7/12/24 documents May administer Prevnar13 or Pneumovax 23 pneumonia vaccine as indicated (not current or status unknown) per CDC recommendations with physician's order. Document in Immunization Tab. There is no documentation in R32's EMR of pneumococcal vaccination history and there is no documentation that the pneumococcal vaccine was offered to R32 after admitting to the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R63's Physician Order dated 4/12/24 documents May administer Prevnar 13 or Pneumovax 23, pneumonia vaccine, as indicated (not current or status unknown) per CDC recommendations with physician's order. Document in Immunization tab. R63's MDS dated [DATE] documents R63's pneumococcal vaccination is not up to date, this vaccine was not offered due to not being eligible. R63's EMR does not document R63's pneumococcal vaccine history and there is no documentation that the pneumococcal vaccine was offered to R63. R66's EMR does not document R66's pneumococcal vaccination history or that this vaccine was offered to R66. R66's MDS dated [DATE] documents R66's pneumococcal vaccination is not up to date, this vaccine was not given due to being ineligible. On 10/29/24 at 2:00 PM V2 Director of Nursing stated pneumonia vaccines should be offered upon admission and annually. V2 thought the vaccine consent form is uploaded into the miscellaneous section of the resident's EMR, and V2 stated this form documents the vaccine is offered and if it was offered or declined. On 10/30/24 at 9:30 AM V1 Administrator stated immunization consents are uploaded into the resident's EMR. AT 10:25 AM V1 and V10 confirmed vaccine education is documented on the consents as well as the right to decline. V10 stated the pneumonia vaccine is only given once after age 65, unless the resident does not have a spleen then it is given more often. At this time pneumonia vaccine information was requested for R32, R66 and R63. On 10/30/24 at 12:42 PM V1 provided a paper with vaccine information for R8, R32, R63, R66, and R1, that documents the following flu information: R32, R63, and R66 have no documented pneumococcal vaccination on file and this vaccine will be offered and consent form provided during the 2024 flu clinic. The facility failed to provide documentation that the pneumonia vaccine was offered to R32, R63 and R66. The CDC's Pneumococcal Vaccine Timing for Adults dated 3/15/23 documents for people over age 65 with no prior pneumococcal vaccinations, give either PCV 20 (pneumococcal conjugate vaccine) or PCV15 followed by PPSV 23 (pneumococcal polysaccharide vaccine) a year or more later.

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	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. 40385 Based on interview and record review the facility failed to follow its Compliance and Ethics program by failing to have a committee that meets on a quarterly basis. This failure has the potential to affect all 73 residents residing in the facility. Findings include: The facility's Compliance Policies and Procedures dated 10/29/17 documents the organization is required to have written compliance and ethics standards including policies and procedures to reduce the prospect of criminal, civil, and administrative violations, management staff appointed to oversee compliance, steps to achieve compliance through monitoring and audits, reporting systems for reporting wrongful conduct within the facility, enforcement of standards through disciplinary action, and a response system after non-compliance is detected. This policy documents the facility's compliance committee meets at least quarterly and this committee includes, but is not limited to the facility's Administrator (who is the Compliance Liaison); the Director of Nursing (DON), Social Services Director (SSD) or Psychiatric Rehabilitation Director; The Director of Admissions; The Minimum Data Set Coordinator; and the Corporate Compliance Officer. On 10/31/24 at 9:44 AM V2 DON was unsure of the facility's Compliance and Ethics Program or committee. V2 stated V2 was the facility's administrator in July, August, and September 2024 and became DON in October 2024. V2 stated V2 thought compliance was reviewed during the facility's Quality Assurance meetings. V2 confirmed V2 did not attend separate Compliance and Ethics committee meetings. V2 stated the administrator is the compliance officer, as they have to ensure compliance with state and federal regulations. V2 stated there is hotline telephone number for people to call and report concerns with compliance. On 10/31/24 at V29 SSD stated V29 has been the SSD since March 2024 and V29 was unsure of the facility's Compliance and Ethics Program or committee. V29 stated the facility has not had Compliance and Ethics committee meetings. V29 stated concerns are just reported to V29, and then V29 files a grievance so the concern can be followed up on. The facility's Quality Assurance meeting minutes for meetings dated 1/10/24, 4/10/24, 7/26/24, and 10/9/24 do not mention the facility's Compliance and Ethics Program or committee. The Long-Term Care Facility Application for Medicare and Medicaid dated 10/27/24 documents 73 residents reside in the facility.

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	10/31/2024

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 35347 Based on interview and record review, the facility failed to prevent the potential for a fire hazard by failing to maintain facility laundry dryers in a safe operating condition. This failure has the potential to affect all 73 residents in the facility. Findings include: On 10/30/2024 at 1:25PM, the facility laundry dryers and surrounding floors, walls, ductwork, electric motors, and utility conduits were covered in lint appearing 0.25-1 in thickness. The entire floor area behind the dryers was covered with heavy accumulations of lint completely obscuring the floor surface below. The lint covered all portions of the rear dryer cabinets and also the electric motor casings of the dryers. The exterior sheet metal surfaces of the dryers were hot to the touch. V36 (Laundry Aide) was present and viewed the area behind the dryers and was asked if V36 thought the lint accumulations were a fire hazard. V36 stated to me, it would be. V36 reported the facility maintenance staff are supposed to clean the area behind the dryers, but V36 was unsure how often maintenance staff cleaned the area. On 10/30/2024 at 2:26PM, V38 (Laundry Manager) viewed the lint accumulations behind the dryers and was asked if V38 thought the dryer area was a fire hazard and V38 replied yes, it is. V38 reported facility maintenance staff are supposed to clean the area weekly, but V38 was unsure when staff last cleaned the area. V38 reported the facility management asked the maintenance staff two or three weeks ago to clean the area, but the cleaning never happened. The facility Long-Term Care Facility Application for Medicare and Medicaid (10/27/2024) documents 73 residents reside in the facility.