STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLEASANT MEADOWS SENIOR LIVING	**400 WEST WASHINGTON CHRISMAN, IL 61924**

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

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accommodate the communication needs of one of three residents (R2) reviewed for communication on the sample list of nine. Findings include: On 8/2/20 at 7:45 AM, V12 (R2's Family Member) stated the facility's cordless phone was broke for seven months, the facility got a new phone and they don't know how to work it. V12 stated the facility staff have tried using their personal cell phones but R2 cannot hear well on the cell phones and the staff do not allow privacy when the staff use their phones. V12 stated the facility staff will put it on speaker and stay in the room. V12 stated R2 and V12 don't get to talk now. V12 stated they cannot visit in person so the phone is the only way V12 gets to talk to R2. R2's care plan with a revision date of 4/2/20 documents R2 has [DIAGNOSES REDACTED]. R2's care plan with a revision date of 3/12/20 documents R2 is at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID-19 precautions. This care plan includes an intervention to provide alternative methods of communications with family/visitors. On 8/5/20 at 9:11 AM, V2 (Director of Nursing) stated there have been issues with the cordless phone. It has been at least since March since it has worked. V2 stated V12 told me R2 was having a hard time hearing. V2 stated they tried to put the phone on speaker. V2 stated R2 does have a roommate so phone calls may not be private. V2 stated there is not a private place in the building to hold a phone call. V2 stated R2 cannot do the outside visits because R2 is intolerant of the heat.
F 0686 **Level of harm** - Minimal harm or potential for 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** Based on interview and record review the facility failed to follow a Wound Physician's recommendation to consult with the Registered Dietitian and failed to implement a protein supplement as recommended by the dietitian for one of three residents (R2) reviewed for pressure ulcers. The facility also failed to ensure the physician and family were notified of newly developed/decline in pressure ulcers in a timely manner and failed to initiate measures to prevent worsening/development of pressure ulcers for one (R1) of three residents reviewed for pressure ulcers on the sample of nine. Findings include: 1. R2's Wound physician progress notes [REDACTED]. This note documents R2 as having a stage three pressure ulcer to the sacrum. R2's medical record did not contain a wound consult by the dietitian until 7/21/20. R2's Dietitian Recommendation written by V13 (Dietitian) dated 7/21/20 documents a recommendation to begin Prostat (protein supplement) 30 milliliters for increased protein needs related to skin integrity. R2's medical record does not document the administration of Prostat 30 milliliters until 8/4/20. On 8/4/20 at 11:10 AM, V14 (Assistant Director of Nursing) confirmed V13 did not complete a wound consult until 7/21/20 and the recommendation for Prostat was not started until 8/4/20. On 8/5/20 at 10:16 AM, V13 stated the Prostat was recommended because it provides extra protein, Vitamin C, and Zinc. V13 stated R2 had a wound so I wanted to start it for wound healing. Prostat would help with R2's protein needs and wound healing. V16 did not assess R2's wound needs until 7/21/20. 2. R1's Task List documents Staff to re-position (R2) q (every) 2h (hours) and PRN (as needed) in order to relieve pressure and optimize tissue circulation. This list documents staff are to provide extensive physical assistance to reposition R1. The documentation for completion of repositioning 7/7/20 to 7/16/20 does not document R1 was repositioned every two hours. R1's Documentation Survey Reports dated 8/5/20 for May 2020, June 2020 and July 2020 do not document R1 was repositioned every two hours. The area to document that R1 was turned every two hours during the shift have multiple single entries for each shift, where turning every two hours was documented only a few hours in to the shift, prior to the turning happening for these months with no additional documentation to support the every two hour turning for R1. R1's Progress Notes dated 5/27/2020 document R1 was found to have an open area of 3 centimeters (cm) by 4 cm on R1's posterior left upper thigh. There is no documentation V16 (Wound Physician) or R1's family were notified at this time. R1's Progress notes dated 5/29/2020 document V16 observed the pressure ulcer and ordered to apply barrier cream every shift. R1's Wound Physician notes dated 5/29/20 document R1's assessment by V16. These notes do not document any pressure ulcers present to the left ischium. R1's Progress Notes dated 6/1/2020 at 9:51pm document R1 has a blister on left heel, skin prep applied, blue bootie on. There is no documentation R1's family or V16 were notified. Progress Notes on 6/13/2020 at 11:33am document R1 remains on an antibiotic for wound to buttocks and that the wound is deep and green slough noted. There is no documentation the family was notified of R1's wound drainage. R1's Wound Physician notes dated 6/5/2020 document R1 has an unstageable pressure ulcer (due to necrosis) of the left ischium with moderate serous exudate. These notes document this pressure ulcer measures 7 cm Length (L) x 5cm Width (W) x 0.1cm Depth (D). R1's Wound Physician notes dated 6/12/2020 document R1's left ischium pressure ulcer has deteriorated with 40% thick devitalized necrotic tissue. R1's Wound Physician notes dated 6/19/2020 document R1 has a Stage II pressure ulcer to the left distal lateral foot. These notes document R1's unstageable pressure ulcer to the left ischium has deteriorated with moderate serous exudate measuring 6cm x 4.5cm x 1.5cm with muscle and subcutaneous tissues evident. These notes also document R1's left distal lateral foot pressure ulcer with measurements of 1.5cm x 1cm x immeasurable. R1's Progress Notes dated 6/18/2020 at 1:36pm document R1's antibiotic continues for wound infection and ESBL of urine and that R1's urine is contained in brief. 6/19/2020 at 11:37am R1 on Bactrim DS (Double Strength) (Antibiotic) for ESBL of wound to the left hip and that R1 remains on contact precautions. 6/25/20 at 1:59pm, R1 remains incontinent of urine, contained in brief. There is no documentation a urine specimen was ever collected. There is no documentation in R1's medical records that the facility contacted V16 regarding cross contamination of R1's urine and left ischium pressure ulcer. R1's Progress Notes dated 7/10/2020 document a wound culture was obtained and a [DEVICE] (vac) device was placed to R1's left ischium. These notes document a urinary catheter was inserted at this time to prevent urine flowing in and around wound vac. These notes also document V16 gave orders for insertion of (urinary) catheter to promote wound healing. R1's Wound Physician notes dated 7/10/2020 document R1's unstageable pressure ulcer to the left ischium has deteriorated due to undermining deeper. There is no documentation family was notified of this deterioration at this time. On 8/5/2020 at 3:40pm, V2 (Director of Nursing/DON) stated V2 would expect the facility to notify the physician and family as soon as possible. V2 stated the facility is expected to chart physician and family notification in the resident's progress notes. At this time V2 stated R1 had not had a urinalysis or urine culture documenting R1 has a urinary tract infection as documented in R1's progress notes, that the infection was of R1's left ischium wound. The facility's Pressure Wound Treatment policy dated January 2017 documents pressure injury treatment requires a comprehensive approach including maximizing the potential for healing.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on interview and record review, the facility failed to implement facility identified post fall interventions for two of three residents (R1, R5) reviewed for falls on the sample of nine. Findings include: 1. R1's Face Sheet dated 8/3/2020 document R1's [DIAGNOSES REDACTED]. R1's Fall Investigation dated 4/29/2020 at 6:00pm documents R1 was at the nurse's station with unidentified staff when another unidentified resident yelled. V18 (Nurse) stood up and witnessed R1 on the floor with R1's left arm under R1's left side of R1's body. The intervention for the fall was to educate staff on wheelchair positioning. There is no documentation the education on wheelchair positioning was provided. On 8/5/2020 at 3:40pm, V17 (Fall Coordinator) stated V17 could not remember what was said education wise or what staff were educated. V17 had only educated staff working that evening of R1's fall. V17 stated V17 did not educate any other staff who provide care for R1 and did not document education was provided. V17 was unable to recall what was included in the education V17 stated V17 provided. 2. R5's Face Sheet dated 8/4/2020 documents R5 has a history of repeated falls with [DIAGNOSES REDACTED]. R5's Care Plans dated 7/20/2020 document R5 is at risk for falls and R5 is to be on 15 minute checks during resting hours. R5's Fall Investigations of repeated falls dated below document the following: R5's Fall Investigation dated 3/4/2020 at 4:30am documents R5 was found with pants off in the common area. R5's brief and pants were found soiled and draped over the walker in the bathroom. The documented root cause is incontinence and ambulating without assist. The investigation documents the intervention of 15 minute checks. There is no documentation of the 15 minute checks in R5's medical record. R5's Fall Investigation dated 3/10/20 at 6:10am documents R5 was found on the bathroom floor. The investigation documents the root cause of this fall as R5 got out of bed without assistance with intervention to place a bed alarm. There is no documentation in R5's medical records for 15 minute checks. On 8/5/2020 at 3:40pm, V17 stated R5 was resting at this time and should have been checked on every 15 minutes and documented. R5's Fall Investigation dated 3/12/20 7:50pm documents R5 was found in another unidentified resident's bathroom on the floor. This investigation documents the toilet had bowel movement in the toilet. R5's pants were down. The intervention documented in this investigation was to continue with frequent checks for toileting and physical and occupational therapy to evaluate and treat for strengthening and balance. The root cause is documented as toileting self and lost balance. R1's medical records do not document frequent checks for toileting. On 8/5/2020 at 3:40pm, V17 stated frequent checks for toileting would be at least every two hours. On 8/5/2020 at 4:00pm, the facility was unable to provide documentation that post fall interventions were implemented for R5. The facility's undated Fall Prevention policy documents the facility will provide each resident with interventions to prevent falls. This policy documents the interdisciplinary team will review and modify the fall risk prevention plan after each fall and changes will be made to the resident's plan of care. This policy also documents clinically appropriate interventions will be put in to place to reduce the risk of and/or prevent reoccurrence of falls.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a protein supplement to meet the nutritional needs of one of three residents (R2) reviewed for pressure ulcers on the sample list of nine. Findings include: R2's Dietitian Recommendation written by V13 (Dietitian) dated 7/21/20 documents a recommendation to begin Prostat (protein supplement) 30 milliliters for increased protein needs related to skin integrity. This recommendation documents R2's [MEDICATION NAME] was 1.8. R2's laboratory report dated 6/10/20 documents an [MEDICATION NAME] result of 1.8. This report documents R2's result of 1.8 as low. R2's medical record does not document that R2 received any Prostat from 7/21/20 through 8/3/20. R2's Medication Administration Record [REDACTED]. On 8/5/20 at 10:16 AM, V13 stated the Prostat was recommended because it provides extra protein, Vitamin C, and Zinc. V13 stated R2 had a wound so I wanted to start it for wound healing. V13 stated Prostat can help bring up the [MEDICATION NAME]. V13 stated Prostat would help with R2's protein needs and wound healing.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to correctly process a written order for an anticoagulant for one of three residents (R2) reviewed for anticoagulants on the sample list of 9. Findings include: R2's physician order [REDACTED]. Give 1 tablet by mouth in the evening every Saturday and Sunday. R2's physician order [REDACTED]. Give 1 tablet by mouth in the evening every Monday, Tuesday, Wednesday, Thursday, and Friday. R2's Medication Administration Record [REDACTED]. R2's progress note dated 2/18/2020 at 5:09 PM documents order noted to cont [MEDICATION NAME] 3 mg M-F (Monday through Friday), decreased [MEDICATION NAME] to 1 mg (on Saturday and Sunday). R2's Medication Administration documents that the [MEDICATION NAME] 2 mg was decreased to 1 mg on 2/18/20. R2's Medication Administration Record [REDACTED]. R2's Medication Administration Record [REDACTED]. On 8/4/20 at 2:35 PM, V9 (Nurse Practitioner) stated V9 manages R2's anticoagulant therapy. V9 stated on 2/25/20, V9 gave an order to continue R2's current [MEDICATION NAME] dose. V9 stated R2's order should have been [MEDICATION NAME] 1 mg on Saturday and Sunday and 3 milligrams on Monday through Friday. On 8/4/20 at 4:05 PM, V2 (Director of Nursing) stated the [MEDICATION NAME] order was processed wrong on R2's Medication Administration Record. V2 stated the 2/26/20 order for [MEDICATION NAME] 3 mg every day was an error.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the correct anticoagulant dose for one of three residents (R2) reviewed for anticoagulant therapy on the sample list of nine. Findings include: R2's physician orders [REDACTED]. R2's Medication Administration Record [REDACTED]. R2's MAR indicated [REDACTED]. R2's February 2020 MAR indicated [REDACTED]. R2's March 2020 MAR indicated [REDACTED]. On 8/4/20 at 2:35 PM, V9 (Nurse Practitioner) stated V9 manages R2's anticoagulant therapy. V9 stated on 2/25/20, R2's INR (international normalized ratio) was 2.01. V9 stated V9 gave an order to continue R2's current [MEDICATION NAME] dose and recheck INR on 3/10/20. V9 stated R2 should have received [MEDICATION NAME] 1 mg on Saturday and Sunday and 3 milligrams on Monday through Friday. V9 stated on 3/10/20 R2's INR had jumped to 6. V9 stated V9 had called and questioned the facility as to why it had jumped from 2 to 6. V9 stated It would make sense that R2's INR went up to 6 if she got double the dose of [MEDICATION NAME] from 2/26/20 through 3/3/20. R2's laboratory report dated 3/10/20 documents R2's INR was 6.5. This report documents that R2's INR was critically high. On 8/5/20 at 8:18 AM, V2 (Director of Nursing) confirmed that R2 received the wrong amount of [MEDICATION NAME] on 2/26/20, 2/27/20, 2/28/20, 2/29/20, 3/1/20, and 3/3/20.