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 _____	C 04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS CHR VILLAGE	**P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 5 E2, DON, (Director of Nurses) confirmed on 4/6/12 at 2:30 PM R3's daughter Z1 told her what the emergency room nurse stated about 5 nitro-dur patches being left on R3. The Mylan Pharmaceutical package insert for Nitroglycerin Transdermal Patches reflects the following information on overdosage: Hemodynamic Effects: "The ill effects of nitroglycerin overdose are generally the result of nitroglycerin's capacity to induce vasodilation, venous pooling, reduced cardiac output and hypotension. These hemodynamic changes may have protean manifestations, including increased intracranial pressure, with any or all of persistent throbbing headache, confusion and moderate fever; vertigo, palpitations, visual disturbances, nausea and vomiting (possibly with colic and even bloody diarrhea); syncope(especially in the upright position); air hunger and dyspnea, later followed by reduced ventilatory effort; diaphoresis, with the skin either flushed or cold and clammy, heart block and bradycardia; paralysis; coma; seizures; and death."	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a)	F9999		

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F9999	Continued From page 6 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: Section 300.1210d)6) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on record review and interview the facility failed to provide supervision for R3 while sitting in a wheelchair which resulted in R3 falling from the	F9999		

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F9999	Continued From page 7	F9999		

wheelchair and sustaining a subdural hematoma. The facility failed to ensure the fall prevention interventions for R5 (alarm & bolsters) were working appropriately and applied correctly which resulted in R5 having three falls. R3 and R5 are two residents reviewed for falls in a sample of 5.

Findings include:

1. The Physician's Order Sheet dated March 2012 for R3 lists the following diagnoses: Congestive Heart Failure, Dysphagia Oral Phase and Altered Mental Status. The MDS (Minimum Data Set) dated 3/19/12 states that R3 is moderately impaired in cognitive skills for daily decision making and requires extensive assistance with two plus (persons) physical assist for all transfers. R3's balance is not steady and is only able to be stabilized with human assistance.

The facility's Fall Assessments dated 2/17/12 and 3/14/12 for R3 reflects that R3 is at High Risk for falls.

The facility's Fall Investigation Conclusion report dated 3/19/12 in the section titled "Incident Description" for R3 states "(R3) was sitting up in the wheelchair next to the nurses station. When a loud thump was heard and (R3) was observed laying on floor, wheelchair tipped on her.(R3) was laying more on right side with right arm under her and blood present under forehead....."

On 4/6/12 at 10:45 AM E5, CNA (Certified Nursing Assistant) stated that (R3) was confused that day and was trying to get out of bed so she helped E5, CNA get (R3) up and put into a wheelchair. E5 continued to state R3 was placed

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F9999	Continued From page 8	F9999		

at the far east corner of the nurses station. E5 stated R3 did not have any type of safety belt or alarms on the wheelchair and that R3 was sitting on her own in the wheelchair.

On 4/6/12 at 9:30 AM E6, RN (Registered Nurse) stated "No I did not have visual view of (R3) when they placed her at the end of the nurses station. I heard a thump and found (R3) on the floor with the wheelchair on top of her. We sent (R3) to the hospital for evaluation."

The Hospital Report dated 3/21/12 titled " Finalized Diagnostic Report" "CT (Computerized Tomography) Without Contrast" states under the section titled "Impression" reads "Head CT on (R3) shows stable appearance of the right parietal extra-axial hemorrhage, probably a subdural hematoma."

2. The Facility's "Investigation Conclusion Report" on a fall dated 1/14/12 for R5 states Resident (R5) was observed on floor at bedside at 7:45 a.m. The report also reflects that there was an alarm in place at this time but the alarm did not sound. The interventions listed for implementation are "Staff to have resident up for the day at 7:30 a. m., bed et (and) chair alarm in place. Continue bladder wheel to establish toileting pattern".

The facility's "Investigation Conclusion Report" on a fall dated 3/2/12 for R5 states Resident (R5) was observed in a sitting position on floor mat at bedside at 5:30 a.m. The report also reflects that there was no alarm present. The interventions listed for implementation are "Medication

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F9999	Continued From page 9 Review, Low Bed and a Body Pillow". The Facility's "Investigation Conclusion Report" on a fall dated 3/3/12 for R5 states the staff was alerted by a sounding alarm and R5 was observed on right side lying position on floor mat. The report also reflects that the Bolsters were not on correctly. The interventions listed for implementation are "Bolsters for safety d/t (due to) decreased safety awareness. Low bed at all times". On 4/5/12 at 2:15 p.m. E3 (Assistant Director of Nursing) confirmed that Bolsters were implemented for R5 at the time of the 3/2/12 fall as a nursing intervention. E3 and E2 (Director of Nursing) both at this time on 4/5/12 acknowledged that the alarm on R5's bed, had it been working, may have prevented the 1/14/12 fall. Also acknowledged by E2 and E3 was, had the Bolsters been on R5's bed correctly, the 3/3/12 fall may have been prevented. (B)	F9999		