PRINTED: 09/20/2016 FORM APPROVED OMB NO. 0938-0391

|                                |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |     | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------------|---|---|---------------------|--|--|-----|-------------------------------|--|
|                                |   | 4.000   |                     |  |  | С   |                               |  |
|                                |   | 146037  | B. WING             |  |  | 09/ | 14/2016                       |  |
| NAME OF I                      | PROVIDER OR SUPPLIER  |   |                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE  |     |                               |  |
| PLEASANT MEADOWS SENIOR LIVING |   |   |                     |  | O BOX 375 400 W WASHINGTON   |     |                               |  |
|                                |   |   |                     |  | CHRISMAN, IL 61924   |     |                               |  |
| (X4) ID<br>PREFIX<br>TAG       | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |  | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 000                          | INITIAL COMMEN  | TS  | F 0                 | 000                                    |  |     |                               |  |
|                                | Incident Report Inv   | vestigation   |                     |  |  |     |                               |  |
| F 224<br>SS=E                  |   |   | F 2                 | 224                                    |  |     |                               |  |
|                                | policies and proced<br>mistreatment, negle  | evelop and implement written<br>dures that prohibit<br>ect, and abuse of residents<br>on of resident property.  |                     |  |  |     |                               |  |
|                                | by: Based on interview failed to ensure res misappropriation of prevent intentional controlled medication 23 residents (R1, F1) | NT is not met as evidenced wand record review the facility sidents were free from fresident property by failing to diversion of residents' on by facility staff for seven of R2, R5-R9) reviewed for dabuse, in the sample of 23. |                     |  |  |     |                               |  |
|                                | The findings include  | e:  |                     |  |  |     |                               |  |
|                                | policy states misap<br>is the deliberate mi   | ed Abuse Prevention Program propriation of resident property splacement, exploitation, or ident's belongings or money t's consent.  |                     |  |  |     |                               |  |
|                                | Nurses) stated on 8 (Licensed Practical   | 0 PM, E3 (Assistant Director of 3/7/16 at 1:10 PM, E8 Nurse/LPN) stated E7 (LPN) nedications to residents that  |                     |  |  |     |                               |  |
| L ABORATOR'                    | Y DIRECTOR'S OR PROVID  | DER/SUPPLIER REPRESENTATIVE'S SIGN  | VATURE              |  | 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.

Facility ID: IL6007488

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

| AND PLAN OF CORRECTION (X |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | TIPLE CONSTRUCTION  ING   |        | COMPLETED |                            |  |  |
|---------------------------|--|---|---------------------|---|--------|-----------|----------------------------|--|--|
|                           |  | 146037  | B. WING             |   |        |           | C<br>1 <b>4/2016</b>       |  |  |
|                           | PROVIDER OR SUPPLIER   | DR LIVING   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>P O BOX 375 400 W WASHINGTON<br>CHRISMAN, IL 61924 | )DE    | ,         | 172010                     |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)   | SHOULD | BE        | (X5)<br>COMPLETION<br>DATE |  |  |
| F 224                     | don't normally take 8/8/16 and 8/9/16, a administration were concerns. E3 state administered pain r R7, R8, and R9. E3 tested negative for testing and/or denie medication.  Per Facility Investig R2, R6, and R7 sta medication. R5 wa at the time the pain being administered  On 8/10/16 and 8/1 R1, R2, R5, R6, R8 pain medication.  The Facility Inciden 8/10/16 at 2:30 PM potential drug diver State Police investic course of the investic course of the investic course of the investic course immediately ta Facility continues to investigation.  R1's Order Report States Hydrocodone milligrams every 8 I moderate pain, was R2's Order Report States Hydrocodone | pain medication. E3 stated on audits of narcotic conducted, with no issues or d 8/10/16 audits indicated E7 nedication to R1, R2, R5, R6, S stated these residents either pain medication per urine ed being given pain ative Timeline, on 8/10/16 R1, ted they had not received pain s out of the facility on 8/10/16 medication was signed as | F 2                 | 24  |        |           |                            |  |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                              |    | E CONSTRUCTION  | (X3) DATE SURVE<br>COMPLETED |         |  |
|---|---|--|------------------------------|----|---|------------------------------|---------|--|
|   |   |  | 7. BOILD                     |    |   |                              | С       |  |
|   |   | 146037   | B. WING                      |    |   | 09/                          | 14/2016 |  |
| NAME OF I   | PROVIDER OR SUPPLIER  |  |                              |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |                              |         |  |
| PLEASANT MEADOWS SENIOR LIVING                      |   |  | P O BOX 375 400 W WASHINGTON |    |   |                              |         |  |
|   |   |  |                              | C  | HRISMAN, IL 61924   |                              |         |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |                              | X  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | SHOULD BE C                  |         |  |
| F 224   | Continued From pa   | _  | F 2                          | 24 |   |                              |         |  |
|   | R5's Order Report Summary, dated 9/14/16, states Hydrocodone-Acetaminophen 5-325 milligrams every 6 hours by mouth as needed for pain, was ordered on 6/4/16.  R6's Order Report Summary, dated 9/14/16, states Tramadol 50 milligrams every 6 hours by mouth as needed for pain, was ordered on 11/4/15. |  |                              |    |   |                              |         |  |
|   |   |  |                              |    |   |                              |         |  |
|   | states Hydrocodon   |  |                              |    |   |                              |         |  |
|   | states Tramadol 50  | Summary, dated 9/14/16,<br>milligrams 4 times a day by<br>or pain, was ordered on                              |                              |    |   |                              |         |  |
|   | states Hydrocodon<br>milligrams every 6   |  | F 2                          | 26 |   |                              |         |  |
|   | policies and proced<br>mistreatment, negle  | evelop and implement written<br>dures that prohibit<br>ect, and abuse of residents<br>on of resident property. |                              |    |   |                              |         |  |
|   | This REQUIREMEN   | NT is not met as evidenced   |                              |    |   |                              |         |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X: |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '                |    | CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C |                            |  |  |
|---|---|---|--------------------|----|---|------------------------------|----------------------------|--|--|
|   |   | 146037  | B. WING            |    |   |                              | 14/2016                    |  |  |
|   | NAME OF PROVIDER OR SUPPLIER  PLEASANT MEADOWS SENIOR LIVING  |   |                    | PC | REET ADDRESS, CITY, STATE, ZIP CODE  D BOX 375 400 W WASHINGTON  IRISMAN, IL 61924                                | 1 00/                        | 1 1/2010                   |  |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE                           | (X5)<br>COMPLETION<br>DATE |  |  |
| F 226   | by: Based on interview failed to operational policy by failing to president property the residents' controlled seven of 23 resider for narcotic control 23.  The findings include The facility's undate policy states the face neglect, or abuse of misappropriation of deliberate misplace use of resident's be resident's consent.  On 9/14/16 at 12:00 Nurses) stated on 8 (Licensed Practical gave a lot of pain medication to R1, FE3 stated these residented being given Per Facility Investig R2, R6, and R7 state medication. R5 was at the time the pain being administered On 8/10/16 and 8/1 | w and record review the facility lize their abuse prevention prevent misappropriation of prough intentional diversion of dimedication by facility staff for ints (R1, R2, R5-R9) reviewed and abuse, in the sample of and abuse, in the sample of etc.  Bed Abuse Prevention Program cility prohibits mistreatment, if its residents. Abuse includes resident property, which is the ement, exploitation, or wrongful elongings or money without the property of States (Assistant Director of States) and the property of the states are detailed by the states of | F 2                | 26 |   |                              |                            |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '     |  | E CONSTRUCTION  | L  |                            |  |  |  |
|--|--|--|---------|--|---|----|----------------------------|--|--|--|
|  |  | 146037   | B. WING |  |   |    | C<br>1 <b>4/2016</b>       |  |  |  |
| NAME OF PROVIDER OR SUPPLIER  PLEASANT MEADOWS SENIOR LIVING |  |  |         | STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 375 400 W WASHINGTON |   |    |                            |  |  |  |
|  |  |  | ID      |  | HRISMAN, IL 61924   |    |                            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |         | Х  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |  |  |  |
| F 226  | Continued From papain medication.  |  | F 2     | 26   |   |    |                            |  |  |  |
| F 431<br>SS=E  | 8/10/16 at 2:30 PM potential drug diver State Police Specia State Police investic course of the invest Nurse/LPN) confes was immediately ta Facility continues to investigation. 483.60(b), (d), (e) LABEL/STORE DR  The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliate records are in order | at Report Form for event on states investigation of sion was initiated. Z1 (Illinois al Agent) was notified and gation began. During the tigation E7 (Licensed Practical sed to stealing the drugs. E7 ken off the staff roster. To cooperate with Z1's DRUG RECORDS, UGS & BIOLOGICALS and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically | F 4     | .31  |   |    |                            |  |  |  |
|  | labeled in accordar<br>professional princip<br>appropriate access  | als used in the facility must be ace with currently accepted alles, and include the ory and cautionary e expiration date when  |         |  |   |    |                            |  |  |  |
|  | facility must store a locked compartmen  | State and Federal laws, the III drugs and biologicals in hts under proper temperature to only authorized personnel to keys.  |         |  |   |    |                            |  |  |  |
|  | The facility must pro  | ovide separately locked,   |         |  |   |    |                            |  |  |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                |     | E CONSTRUCTION  |          | E SURVEY<br>IPLETED        |
|--------------------------|---|---|--------------------|-----|---|----------|----------------------------|
|                          |   | 146037  | B. WING            |     |   |          | C<br><b>14/2016</b>        |
|                          | PROVIDER OR SUPPLIER  | DR LIVING   |                    | Р   | TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 375 400 W WASHINGTON HRISMAN, IL 61924                               | <u> </u> | 11/2010                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE |
| F 431                    | controlled drugs lis<br>Comprehensive Dr<br>Control Act of 1976<br>abuse, except whe<br>package drug distri   | d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the hinimal and a missing dose can   | F 4                | 131 |   |          |                            |
|                          | by: Based on interview failed to ensure inv was completed bet medication keys be 13 residents (R7, F  | NT is not met as evidenced v and record review, the facility entory of controlled medication ween nurses prior to controlled sing rendered. This applies to 112-R23) reviewed for narcotic ole of 23. The findings include:   |                    |     |   |          |                            |
|                          | 9/13/16, states the R7 receives Norco receives Morphine receives Fentanyl f needed for pain. R for pain. R15 recei R16 receives Tramadol receives Fentanyl f needed for pain. R needed for pain. R needed for pain. R21 receives Morphine R23 receives Morp for pain. | as needed for pain. R12 as needed for pain. R13 or pain and Tramadol as 14 receives Norco as needed ves Norco as needed for pain. adol as needed for pain. R17 as needed for pain. R18 or pain and Tramadol as 19 receives Tramadol as 20 receives Norco as needed ves Fentanyl for pain. R22 and Norco as needed for pain. hine and Tramadol as needed |                    |     |   |          |                            |
|                          | R7 and R12-23 res facility.   | ide on the skilled unit of the  |                    |     |   |          |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |         |                              | LE CONSTRUCTION  |            | E SURVEY<br>PLETED         |  |  |  |
|---|---|--|---------|------------------------------|--|------------|----------------------------|--|--|--|
|   |   |  |         |                              |  | С          |                            |  |  |  |
|   |   | 146037   | B. WING |                              |  | 09/14/2016 |                            |  |  |  |
| NAME OF I   | PROVIDER OR SUPPLIER  |  |         |                              | STREET ADDRESS, CITY, STATE, ZIP CODE  |            |                            |  |  |  |
| PLEASANT MEADOWS SENIOR LIVING                      |   |  |         | P O BOX 375 400 W WASHINGTON |  |            |                            |  |  |  |
|   |   |  |         | (                            | CHRISMAN, IL 61924   |            |                            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |         | Χ                            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE         | (X5)<br>COMPLETION<br>DATE |  |  |  |
| F 431   | November 2015-De  | igative Timeline dated ecember 2015 states on  | F       | 131                          |  |            |                            |  |  |  |
|   | 11/29/15 at 8:00 PM, E5 (Registered Nurse/RN) gave E6 (RN) the medication keys to the skilled unit though no narcotic/controlled medication count was completed.  On 9/13/16 at 1:30 PM, E4 (RN/Former Director of Nurses) stated she did not know why E5 and E6 did not complete a narcotic/controlled medication count. E4 stated a narcotic/controlled medication count should be complete when nurses nurses exchange medication keys.  On 9/13/16 at 2:20 PM, E2 (Director of Nurses) stated narcotic/controlled medication count should be completed between nurses prior to medication key exchange. |  |         |                              |  |            |                            |  |  |  |
|   |   |  |         |                              |  |            |                            |  |  |  |
|   |   |  |         |                              |  |            |                            |  |  |  |
|   | E5 and E6 where u   | ınavailable for interview.   |         |                              |  |            |                            |  |  |  |
|   | Receipt, Storage, F<br>policy, revised 11/2<br>inventory of all con-  | olled Substance Medication<br>Handling and Record Control<br>1/12, states conduct an<br>trolled medications at each<br>en keys are rendered. |         |                              |  |            |                            |  |  |  |
|   |   |  |         |                              |  |            |                            |  |  |  |