STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011712	A. BUILDING: _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN MANOR	1520 EL CAMINO DRIVE PEKIN, IL 61554

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S 000	Initial Comments Annual Health Statement of Licensure violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide pressure reduction interventions, provide a skin assessment every week for four weeks after admission, obtain a treatment for a pressure ulcer upon discovery, assess and measure a pressure ulcer weekly, and provide a protein supplement for one of three residents (R39) reviewed for pressure ulcers in the sample of 27. These failures resulted in R39's stage one pressure ulcer being left untreated, resulting in the stage one pressure ulcer worsening to a stage three pressure ulcer.	S9999		

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S9999	Continued From page 2 Findings include: The National Pressure Ulcer Advisory Panel Pressure Injury Prevention Points dated 04/2016 documents, "Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury on admission and weekly for fours weeks after admission for long term care residents. Turn and reposition all individuals at risk for pressure injury, avoid positioning the individual on the body areas with the pressure injury, and reposition weak or immobile residents in the chair every hour." The facility's Pressure Injury Prevention and Treatment Protocol dated 07/2016 documents, "When a resident is admitted to the facility the following will occur: Assess the pressure injury for location, size, wound bed, drainage, odor, tunneling, wound edges, and pain. Obtain treatment. Assess and measure the pressure ulcer weekly. Stage Three Pressure Injury is a full thickness tissue skin loss with which fat is visible in the ulcer and granulation tissue is often present. A skin risk assessment (Braden Scale Pressure Sore Risk Assessment) is completed on all residents upon admission and weekly for the first four weeks after admission and quarterly thereafter. All high and moderate risk residents may have the following addressed on the care plan: Protein and/or nutritional supplements. Turning and positioning schedule, elbow/heel protectors/bridging of heels. When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: Protein Supplement will be put in place. For those residents that cannot reposition themselves, transfer self out of bed, or cannot turn themselves in bed, staff will be responsible."	S9999		

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R39's current Face Sheet documents R39 has the diagnoses of Weakness, Cognitive Deficit, Muscle Weakness, and Abnormal Posture.

R39's Braden Scale for Predicting Pressure Sore Risk dated 6-12-18, documents is a "Moderate Risk" for developing pressure ulcers and is chair fast, is unable to bear own weight which requires staff assistance into chair or wheelchair, and is unable to make frequent or significant changes independently with change and body position.

R39's Medical Record does not include a Braden Scale Pressure Risk Assessment since admission on 6-12-18.

R39's Admission Body Assessment dated 6-12-18 documents R39 has a 2.2 cm (centimeter) firm, red, non-blanchable spot on the left gluteal fold.

R39's Medical Record does not include a treatment, pressure relieving interventions, or weekly measurements of the area to the left gluteal fold from admission (6-12-18), until 8-16-18 when it had advanced to a stage three pressure ulcer.

R39's Initial Wound Evaluation and Management Summary dated 8-16-18 and signed by V14 (Wound Doctor) documents, "(R39) presents with a wound on the left buttock. Stage three pressure wound of the left buttock of at least one day in duration. Etiology: Pressure. Wound size 1.0 cm (centimeters) by 0.4 cm by 0.3 cm. Apply Calcium Alginate once daily for 30 days and foam with border apply once daily for 30 days. Importance of wound off load and compliance with local wound care discussed with rounding nurse. Risk factors: Being confined to a

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wheelchair, immobility, urinary or bowel incontinence, poor nutrition, decreased sensation around affected areas, and recent surgery/illness. Preventions of a pressure ulcer; Reposition self while in bed at least every two hours and in chair at least every hour, elevate your heels off the bed using a pillow under your lower legs, and use a pressure relieving mattress or a cushion in your chair."

R39's Physician's Orders dated 8-16-18 (date stage three pressure ulcer was identified to the left buttock) to 8-21-18 do not include orders for a protein supplement.

R39's Minimum Data Set (MDS) Section G Functional Status dated 6-19-18, documents R39 is unable to ambulate and requires assistance of one staff for personal hygiene, toileting, transfers, bed mobility, and transfers. This same MDS Cognitive Patterns Section C documents R39 is cognitively intact.

R39's Pressure Ulcer Care Plan dated 8-18-18 documents R39 has a stage three pressure ulcer to the left buttock with the following intervention: Assist resident with turning and re-positioning.

On 08/19/18 at 09:42 AM and 2:50 PM, R39 was sitting up in the wheelchair with direct pressure to the left buttock pressure ulcer. R39 stated, "I have had a sore on my bottom for about one week. I think the sore is from sitting up too long in my wheelchair. The staff does not really ask me to lay down off of the sore."

On 08/20/18 at 8:45 AM, 10:30 AM, 12:00 PM, and 01:45 PM, R39 was sitting up in the wheelchair with direct pressure to the left buttock pressure ulcer.

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On 08/20/18 at 01:46 PM, V9 (Licensed Practical Nurse/LPN) provided wound care to R39's left buttock pressure ulcer. R39's left buttock pressure ulcer had a beefy red center with a white tissue surrounding and was draining a moderate amount or yellowish/pink drainage. V9 measured the wound being 2 cm (centimeters) by 1 cm by 0.5 cm depth.

On 08/20/18 at 01:50 PM, V8 (CNA/Certified Nursing Assistant) stated, "(V10/CNA) and myself are taking care of (R39) today. I am not sure what time (R39) got up today. I have not re-positioned (R39) out of the wheelchair or offered (R39) to lay down today. I am not sure if (R39) is to be re-positioned. I don't work with (R39) enough to know if (R39) needs re-positioned. I have not asked (R39) to lay down today. (R39) has been in the wheelchair since this morning."

On 08/20/18 at 01:52 PM, V9 (Licensed Practical Nurse) stated, "(R39) needs to be laid down off of the pressure ulcer, or the pressure ulcer will worsen, or R39 will develop additional pressure ulcers. (R39) has been up in the wheelchair since sometime this morning around breakfast. I have never known of (R39) refusing to lay down or re-position."

On 08/20/18 at 02:07 PM, V10 (CNA) stated, "I got (R39) up in the wheelchair around 7:15 AM today. I have not asked (R39) to lay down since 7:15 AM this morning. (R39) has been up in the wheelchair since 7:15 AM."

On 08/21/18 at 11:19 AM, V3 (Assistant Director Of Nursing/ADON) stated, "A Braden Skin Assessment is suppose to be done on admission

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and then weekly for the first four weeks. (R39) only had a Braden Skin Assessment done on admission dated 6-12-18. (R39) has not had a Braden Skin Assessment done since admission. (R39's) Stage three pressure ulcer was caused from pressure to the left buttock and could have been prevented had the Braden Skin Assessment been done and pressure relieved. (R39's) pressure ulcer should have been treated before it progressed to a stage three. (R39's Spouse) found the pressure ulcer on 8-16-18 and reported the wound to the nurse. (R39) should be turned and re-positioned every two hours out of the wheelchair. A dietician has not assessed (R39's) pressure ulcer and nutritional risks yet."

On 08/21/18 at 02:08 PM, V14 (Wound Doctor) stated, "(R39's) wound to the left buttock was due to pressure from sitting in the wheelchair too long. (R39) should be laid down to bed after every meal and at least every two hours, and (R39) should be positioned to the right side to keep pressure off of the wound. Pressure was the only contributing factor to the pressure ulcer development."

On 8/22/18 at 2:55 p.m., V3 (ADON) stated, "(R39) was admitted on 6/12/18 with a stage one pressure ulcer. The admission assessment wasn't marked as being a pressure ulcer, however the description of a non-blanchable area is a stage one pressure ulcer. It was not until 8/16/18 that they (facility staff) obtained a treatment order for the pressure ulcer, and it is now a stage three. Nothing was done with the stage one pressure ulcer when (R39) was admitted until 8/16/18."
(B)

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300.610a)

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300.1210b)
300.3220f)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

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S9999	Continued From page 8 resident. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to monitor and establish control of severe pain following a fall with suspected fracture for one of 16 residents (R69) reviewed for accidents in the sample of 27. These failures resulted in R69 experiencing uncontrolled severe pain for over 20 hours before receiving treatment/surgical repair for a left hip fracture. Based on interview and record review, the facility failed to obtain an x-ray in a timely manner following a fall with suspected fracture for one of 16 residents (R69) reviewed for accidents in the sample of 27. This failure resulted in R69 waiting 19 hours to have an x-ray completed and receive emergency care/surgical intervention for a fracture of the left hip. Findings include: The facility's Pain Management policy, dated 9/2010, documents, "The facility is dedicated to the philosophy that all residents should be as free of pain as possible, through a combination of medical intervention and functional therapy." The policy also documents, "Purpose: To identify resident experiencing pain to establish control of pain to the resident's satisfaction and to relieve related symptoms. Residents will be monitored until pain is resolved or is under control and periodically thereafter." The facility's Emergencies policy, dated 4/3/18, documents, "Immediate care of the Resident:	S9999		

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Falls: Check for any apparent dislocation or possible fracture. If any signs of this are noted, stabilize resident until ambulance arrives." The policy also documents, "Acute Trauma: Fractures: Immobilize the joint above and below the fracture. Elevate extremity. Apply Ice. Notify doctor. Transport to hospital. Notify family."

R69's Progress notes, dated 7/14/18 at 6:58 a.m., document, "At 9:57 pm certified nursing assistants alerted this nurse that R69 was on floor in bathroom. Upon arrival, R69 was noted to be on her knees leaning over toilet while playing with the toilet water. Weight noted on left knee. R69 denied pain at that time and just wanted to be picked up off of the floor. R69 did complain of usual back pain prior to fall, however, res began to complain of left hip and left upper leg pain at 11:10 pm. R69 refusing to straighten out her left leg due to pain. No rotation noted. Unable to assess if there is shortening due to her position. Upon attempt to straighten out R69's left lower extremity, R69 screamed out in pain and moved back to bent position. R69 did not sleep at all throughout the night and continued to complain of pain. X-ray ordered at 11:27 pm for left hip and left femur to rule out injuries. As needed Tylenol administered between scheduled Norco doses."

R69's Radiology Order, dated 7/13/18 at 11:27 p.m., documents an order was obtained to x-ray R69's left hip and femur for pain.

R69's Progress notes, dated 7/14/18, 3:42 p.m., documents, "R69 complains of pain upon moving left leg."

R69's Progress notes, dated 07/14/2018 06:17 PM, document, "Mobile x-ray here x-rays completed."

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R69's Radiology Report, dated 7/14/18, documents, "There is an impacted acute or subacute subcapital fracture of the left hip with varus alignment at the hip. Conclusion: Fracture of the hip."

R69's Progress notes, dated 07/14/2018 08:30 PM, document, "Hip X-Ray results = Left hip/pelvis-There is no prior study available for comparison. There is narrowing of the hip compartment consistent with osteoarthritis. There is an impacted acute or subacute subcapital fracture of the hip with varus alignment at the hip. Conclusion: Fracture of the hip. 8:45 pm V3 (Assistant Director of Nursing) on call notified. 8:50 pm Power of Attorney notified of fall and x-ray results. Agreed to send to emergency room for evaluation and treatment. Message left for return call from doctor calling services. 911 notified of need for transport. "

R69's Medications Administration History, dated 7/1-7/31/18, documents that on 7/13/18's pain assessment severe pain to R69's left lower extremity was documented, and on 7/14/18's pain assessment pain at the level of a "9" all over was documented. The Medication Administration History also documents that R69 received a scheduled Fentanyl 12 mcg (microgram)/hr (hour) patch on 7/13/18, from the time of the fall to being sent to the emergency room two scheduled doses of Norco (hydrocodone-acetaminophen) 10-325 mg (milligrams) one tablet were administered, and two doses of as needed Tylenol 650 mg were administered on 7/13/18 at 11:04 p.m. and 7/14/18 at 7:23 a.m. The as needed dose at 11:04 p.m. was administered for general pain, and the 7:23 a.m. dose was administered for pain at the level of a "9" all over. Both as needed

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doses document the as needed results of the medication were not effective.

R69's Progress notes, dated 07/15/2018 at 11:26 AM, document, "Called local hospital R69 admitted, she will have surgery tomorrow for left hip fracture. "

R69's Serious Injury Incident Report, dated 7/18/18, documents, "On 7/13/18 at approximately 9:57 p.m., R69 dementia resident who is one assist transfer attempted to self toilet was noted on her knees in her bathroom. During Initial Assessment, R69 had no complain of pain and wanting to go back to bed and was assisted by staff. Doctor notified, and left message for Power of Attorney. During another assessment around 11:00 p.m., R69 started to have complaint of pain to left hip region and documented limited ROM. X-ray order per standing orders. Results noted left fracture acute/subacute subcaptial region. POA answered and notified and doctor notified of X-ray results. R69 sent to hospital where she was admitted and had surgery scheduled for 7/16/18."

R69's Emergency Report, dated 7/14/18, documents, "Hip Injury Pain. Complaint injury. Onset 16 hours ago at the nursing home.

R69's Operative Report, dated 7/16/18, documents, "Pre-operative diagnosis: left femoral neck fracture. Procedure: Left hip hemiathroplasty."

On 08/21/18 09:26 AM, V23 (Licensed Practical Nurse) stated, "If we order a stat x-ray they are here immediately but otherwise it just depends on how busy they are. With (R69) falling and having concerns of a possible broken hip it should have

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been a stat x-ray."

On 8/22/18 at 1:15 p.m., V23 stated, "I came in that morning (7/14/18) and the nurse told me that R69 had a fall the previous night. Then, we got her up for lunch because she wanted out of bed. She would complain when her left leg was moved. She was up in her wheel chair/ and she was toileted by staff. If we suspect a fracture after a fall it just depends if we send them out or not. I wasn't aware that the policy said if fracture is suspected to send to emergency room."

On 8/22/18 at 1:30 p.m., V21 (Certified Nursing Assistant) stated, "(R69) was complaining of pain more (7/14/18) than usual especially when (R69) was moved."

On 8/22/18 at 1:30 p.m., V26 (Certified Nursing Assistant) stated, "(R69) was in a lot of pain that next morning (7/14/18) with any kind of movement. We got her up for breakfast and lunch. We were also taking her to the restroom. She was a two person gaitbelt stand pivot transfer. She was babying and favoring that left leg. She would grab and guard her left hip saying 'oh oh' when we would move her."

On 08/22/18 at 09:15 AM, V2 (Director of Nursing) stated, "If R69's X-ray was ordered at 11:27 pm it should have been a stat X-ray that should be done within 4 hours especially with the increased pain. They should not have waited that long we could have sent her in to the emergency room for pain relief."

On 08/21/18 at 09:49 AM, V19 (R69's Nurse Practitioner) stated, "If the facility got the order to x-ray (R69's) hip around 11:00 pm I would have expected them to get the x-ray done within the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011712	A. BUILDING: _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN MANOR	1520 EL CAMINO DRIVE PEKIN, IL 61554

(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) COMPLETE DATE
S9999	Continued From page 13 hour not at 6:00 pm the following night especially with it actually being fractured. (R69) had to have been in pain." (B)	S9999		