Illinois D	epartment of Public	Health			FORM	IAPPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		IL6012470	B. WING		01/	09/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PITTSFIE	LD MANOR		/RY STREET ELD, IL 6236:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Revisit to Annual H	ealth Survey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610 a) 300.1010 h) 300.1210 b) 300.1220 b)7)					
	a) The facility procedures governing facility. The written be formulated by a Committee consisting administrator, the a medical advisory co of nursing and other policies shall comp The written policies the facility and shall	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	h) The facility physician of any ac change in a resider health, safety or we but not limited to, th manifest decubitus of five percent or m The facility shall ob plan of care for the	Medical Care Policies shall notify the resident's cident, injury, or significant at's condition that threatens the elfare of a resident, including, ne presence of incipient or ulcers or a weight loss or gain fore within a period of 30 days. tain and record the physician's care or treatment of such change in condition at the time				
	tment of Public Health / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE
Electron	ically Signed					01/09/25
ATE FOR	N		6899	TPZ12	lf continu	ation sheet 1

		Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		IL6012470 B. WING			R 01/09/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
PITTSFIE	ELD MANOR		RY STREET			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
S9999	Continued From pa	ge 1	S9999			
	Nursing and Persor b) The facility s care and services to practicable physical well-being of the res each resident's com plan. Adequate and care and personal of resident to meet the care needs of the res Section 300.1220 S Services b) The DON sl nursing services of 7) Coordin	shall provide the necessary o attain or maintain the highes l, mental, and psychological sident, in accordance with nprehensive resident care properly supervised nursing care shall be provided to each total nursing and personal				
	Based on interview failed to notify the D level for 1 of 3 resid quality of care in the resulted in R32 bein blood sugar of 703 Findings include: R32's Face Sheet,	s are not met as evidenced by and record review, the facility octor of a high blood glucose lents (R32) reviewed for a sample of 20. This failure ng sent to the hospital, had a and required an insulin drip.				
	Diabetes mellitus. R32's Physician Ord documents, "(blood	ders, dated 2/23/24, glucose monitor) as needed s needed) 1, PRN 2, PRN 3."				

ITPZ12

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R		
		IL6012470	B. WING		01/	09/2025
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
PITTSFI	ELD MANOR		IRY STREET			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
S9999	Continued From page 2		S9999			
	 Continued From page 2 R32's Nurses Note, dated 01/02/2025 08:37 PM, documents, "Received call back from on-call provider regarding residents blood glucose. This nurse spoke with (V55, Nurse Practitioner) and she gave 1x order for 4 units of NovoLog and to send blood glucose logs to MD (Medical Doctor) so he can review them. This nurse administered 1x dose of 4 units of Novolog." R32's Nurses Note, dated 01/03/2025 04:55 AM, documents, "Resting states she is not feeling well and has had one loose stool. Vitals obtained 104/50, 16, 98.0, 99% RA (room air), 76. No other complaints of nausea or emesis noted. BS (blood sugar) remains elevated at 469 this AM. Fax sent to MD." R32's Nurses Note, dated 01/03/2025 08:30 AM, documents, "Send to ED (Emergency Department)/(V56 Nurse Practitioner)/telephone/resident BS (blood sugar) measured hi on glucometer, hands cool to touch, 		r			
	and resident had lat 138/74 80 98% on r A&0 (alert and orier Message left for PC return call to facility Technicians) transp ambulance. Report Department) and no dose of Basaglar ar (medication) sheet,	rge emesis. VS (vital signs) oom air. temp 97.8. Resident ntated) x 3. 911 notified. DA (Power of Attorney) to . EMT's (Emergency Medical orted resident/gurney to called to ED (Emergency otified resident had morning nd NovoLog. Face sheet, med signed DNR (Do Not and Bed hold policy sent with				
	documents, "RN (H	dated 01/03/2025 12:56 PM, ospital Registered Nurse) being admitted with DBK (sic pacidosis) "				

ITPZ12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012470				`́сом	E SURVEY PLETED R 09/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE	•	
PITTSFI	ELD MANOR		ELD, IL 62363			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
\$9999	R32's Nurses Note, documents, "(Hosp resident and stated residents blood sug admission. Stated v Friday at 4 pm." R32's hospital dicha 1/3/25, documents and initially had a b Emergency Room. On 1/9/25 at 12:16 was questioned why sugar of 464 instea stated, "(R32) is a b really high and then sugar was high. I ca an order for 4 unit co out because I thoug infection too, but the here. The doctor too how she is doing in On 1/9/25 at 2:30 P stated the nurse sh and let the Doctor k still high, instead of Doctor. The policy Change dated 12/02, docum promptly notify the n representative, and in the resident's cor nurse will notify the when: b. There is a	dated 01/05/2025 09:04 AM, ital) RN called report on on 1/3/25 (Thursday) ar was over 600 upon vas on an insulin drip until arge summary, admit date of R32 was admitted with DKA lood sugar of 703 in the PM, V20, Registered Nurse, y she faxed the doctor a blood d of the calling the doctor. V20 prittle diabetic she can get drop fast. At 7 PM (R32's) alled the on call doctor and got of insulin. I wanted to send her yht she had a urinary tract e doctor wanted to keep her ld me to watch her and see			.,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6012470	B. WING			R 09/2025
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PITTSFIE	LD MANOR		VRY STREET ELD, IL 62363			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 4	S9999			
	(A)					