STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047969	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN MANOR	1520 EL CAMINO DRIVE , PEKIN, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2524469/IL192683	S0000		
S9999	Final Observations Statement of Licensure ~~Violations~~ 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)4)A) 300.1220b)3) 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. Section 300.1010 Medical Care Policies	S9999		

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

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S9999	Continued from page 1 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	S9999		

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S9999	Continued from page 2 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These regulations were not met as evidence by: Based on observation, interview, and record review the facility failed to develop and implement pressure relieving interventions to prevent pressure ulcer development, conduct a pressure ulcer risk assessment once a week for four weeks after admission and then quarterly thereafter, update pressure ulcer care plans with pressure relieving interventions, and failed to provide a treatment as ordered by the physician for three of three residents (R1, R2, and R3) reviewed for facility acquired pressure ulcers in the sample of four. These failures resulted in R1 developing a stage four full thickness pressure ulcer to the medial heel that required surgical debridement, R2 developing an infected, painful stage four pressure ulcer to the left lateral ankle that required surgical debridement, and R2 developing a painful stage four pressure ulcer to the right lateral heel that required surgical debridement. Findings include: The facility's Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol dated 10-24-22 documents "Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury or pressure ulcer that might develop. Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure injury will present as an open ulcer. The appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure	S9999		

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S9999	Continued from page 3 in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Principles: 1. A skin assessment (Braden Scale Pressure Ulcer Risk Assessment) is completed on all residents upon admission and weekly for the first four weeks after admission, quarterly, and whenever there is a change in the resident's condition. 2. An individualized plan of care will be developed for the resident following the guidelines of the assessment. 3. All high and moderate risk residents will be assessed for the needs of the items below. If the intervention is initiated, it will be added to the care plan. A. Special mattress and wheelchair cushions. B. PROMS (Passive Range of Motions). C. Protein and/or Nutritional Supplements. D. Turning and positioning schedule. E. Skin Checks. F. Elbow/heel protectors/bridging of heels. 6. When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: A. Assess the pressure injury for location, size, wound bed, drainage, odor, tunneling, undermining or sinus tract, wound edges/surrounding tissues, and pain at site. B. Determine the injury's current stage of development: Stage One Pressure Injury: Non-blanchable erythema of intact skin. Stage Two Pressure Ulcer: Partial thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not viable. Granulation (new tissue) tissue, slough (dead tissue in wounds), and eschar (black or brown hardened layer of dead tissue that forms over a wound) are not present. Stage Three Pressure Ulcer: Full thickness loss of skin, in which subcutaneous fat is visible in the ulcer and granulation tissues are epibole (rolled wound edges) are often present. Slough and or/eschar may be visible but does not obscure the depth of tissue loss. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/pressure injury. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage with the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (dry, adherent, intact without erythema or fluctuance) should only be removed after careful consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration due to damage of underlying soft tissue, this area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or	S9999		

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S9999	Continued from page 4 cooler as compared to adjacent tissue, This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. C. Notify the physician of the above assessment and obtain orders for treatment of pressure ulcer/injury. If pressure ulcer/injury is showing no improvement, Physician will be notified so change of treatment may be obtained, E. Care plan will be established for treatment of existing pressure ulcers/injuries. G. For pressure ulcer with drainage the physician will be notified, and culture obtained if ordered. Pressure Injury and Treatment Protocol: H. Weekly measurements will be conducted and entered in the chart under wound management. J. Turning and repositioning assistance will be given to those residents that are unable to reposition themselves. K. Special devices will be used to relieve pressure, L. All treatment and charting of pressure ulcers/injuries will be done by licensed staff." 1. R1's Face Sheet documents R1 is an 83-year-old admitted to the facility on 12/18/23 with the diagnoses Muscle Weakness, Lack of Coordination, Cognitive Communication Deficit, and Vascular Dementia. R1's MDS (Minimum Data Set) Assessment dated 3/19/25 documents R1 is severely cognitively impaired, requires moderate assistance with personal hygiene and rolling left to right, is at risk for developing pressure ulcers, has one stage four facility acquired pressure ulcer, and is not on a turning and repositioning program. R1's current Physician's Order Sheets dated 5/26/25 through 6/26/25 document, "Start Date: 6/17/25 Stage four pressure wound of right lateral ankle cleanse with wound cleanser, pat dry, apply hydrogel to would bed, cover with abdominal pad and kerlix (rolled gauze). Change dressing daily and as needed for impaired dressing integrity." R1's Braden Scale for Predicting Pressure Sore Risk Assessment dated 12/26/24 documents a score of "16" indicating R1 was at risk of development of pressure ulcers. This same Braden Scale documents R1 was chairfast, was slightly limited in mobility, and required minimum staff assistance in moving to prevent friction and shearing." R1's Medical Record dated 6/27/24 through 6/27/25 does	S9999		

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S9999	Continued from page 5 not include any quarterly Braden Scale Pressure Risk Assessments except for the one completed on 12/26/24. R1's Wound Evaluation and Management Summary dated 3/12/24 and signed by V14 (Wound Physician) documents, "Stage four pressure wound of the right medial heel full thickness. Etiology: Pressure. Stage four. Duration: Less than 62 days. Wound Size: 5.0 cm (centimeters) by 5.3 cm by not measurable depth. Exudate: Moderate serosanguinous (pinkish drainage). Slough: 40 % (percent). Granulation tissue: 60 %. General Recommendations: Off-load wound, reposition per facility protocol, float heels in bed, and prevalon (heel floating cushioned) boots. Surgical Excisional Debridement procedure to remove necrotic tissue and establish the margins of viable tissue. R1's current Pressure Ulcer Care Plan does not include the interventions to ensure R1 is wearing heel pressure relieving boots and did not include pressure relieving interventions to prevent pressure to the heels prior to the development of R1's right medial heel pressure ulcer. On 6/26/25 from 11:00 AM through 11:45 AM R1 was sitting up in her wheelchair. R1 did not have heel protecting boots on, or a dressing covering the right outer heel wound. On 6/26/25 at 1:00 PM V16 (Wound Nurse) stated, "I do not know why (R1) did not have a dressing on her right heel." On 6/27/25 at 9:35 AM R1 was lying on a low air-loss mattress. R1's heels were lying directly on the bed. R1 did not have pressure relieving heel boots on, or her heels off-loaded as ordered by the physician. R1's right foot was facing outward, putting pressure directly on the right ankle pressure wound. During this time, V17 (CNA/Certified Nursing Assistant) verified he did not know R1 was supposed to wear heel protector boots. On 6/27/25 at 9:30 AM V2 (DON/Director of Nursing) performed the wound treatment to R1's right outer heel. R1's right outer heel was covered in 40 percent slough and was approximately five cm round.	S9999		

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S9999	Continued from page 6 On 6/27/25 at 12:00 PM V2 (DON) stated, "(R1) has only had one Braden Scale Pressure Risk Assessment done within the last year. (R1) should have had Braden Scale Pressure Risk Assessments done quarterly. (R1's) pressure relieving heel boots are not on the care plan and (R1) did not have any pressure relieving interventions to the heels prior to the development of the pressure ulcer to the right heel. (R1's) wound to the right medial heel was caused by pressure. (V17/CNA) is new to taking care of (R1) and is probably not aware that (R1) needs a heel boot on." 2. R2's Face Sheet documents R2 is a 97-year-old admitted to the facility on 5/28/24 with the diagnoses of Fracture of the Right Humerus, Osteoarthritis, Chronic Diastolic Congestive Heart Failure, Reduced Mobility, Stiffness of the Left Ankle, Left Knee and Right Ankle, Chronic Kidney Disease Stage Three, and Hypertension. R2's MDS Assessment dated 6/2/25 documents R2 is cognitively intact, is dependent on staff for personal hygiene, rolling side to side, and transfers, is at risk of developing pressure ulcers, has one facility acquired stage three pressure ulcer, has one stage four facility acquired pressure ulcer, and is not on a turning/repositioning program. R2's current Physician's Order Sheets dated 5/26/25 through 6/26/25 document, "Start Date: 5/6/25 Stage four pressure ulcer wound of left lateral ankle cleanse with wound cleanser, pat dry, apply xeroform (petroleum gauze) to wound bed, cover with abdominal pad, and warp with kerlix once daily. Start Date: 6/14/25 Stage three pressure wound of right lateral heel cleanse with wound cleanser, pat dry, apply xeroform, cover with abdominal pad, wrap with kerlix and secure with tape daily and as needed." R2's Treatment Administration Record dated 6/1/25 through 6/27/25 documents R2's treatments to the right lateral heel pressure ulcer and left lateral ankle were not performed on 6/20/25. R2's Braden Scale for Predicting Pressure Sore Risk Assessment dated 6/24/25 documents a score of "14" indicating R2 is at moderate risk of development of pressure ulcers. This same Braden Scale documents R2 is	S9999		

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S9999	Continued from page 7 chairfast, is very limited in mobility, and requires moderate to maximum assistance in moving to prevent friction and shearing." R2's Medical Record dated 5/28/24 through 6/27/25 does not include any Braden Scale Pressure Risk Assessments weekly times four weeks after admission, or quarterly except for the one assessment dated 6/24/25. R2's Wound Evaluation and Management Summary dated 4/22/25 and signed by V14 (Wound Physician) documents, "Stage four pressure wound of the left lateral ankle full thickness. Etiology: Pressure. Stage four. Duration: Less than one day. Wound Size: 0.9 cm by 1.5 cm by non-measurable cm. Exudate: Moderate serosanguinous. Slough: 80%. Granulation tissue: 20%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, elevate legs, and float heels in bed. Specific to visit recommendations: Pressure off-loading boot-prevalon." R2's Wound Evaluation and Management Summary dated 5/6/25 and signed by V14 (Wound Physician) documents, "Stage four pressure wound of the left lateral ankle full thickness. Etiology: Pressure. Stage four. Duration: Less than 15 days. Wound Size: 1.3 cm by 1.3 cm by non-measurable cm. Exudate: Moderate sero-sanguinous. Slough: 80%. Granulation tissue: 20%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Deep swab technique of stage four pressure wound of left lateral ankle demonstrates MRSA (Methicillin-Resistant Staphylococcus Aureus) and Proteus Mirabilis on 5/6/25. Start Bactrim DS (Double Strength) BID (twice daily) for 14 days. Probiotics daily for 30 days. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. Stage three pressure wound of the right lateral heel full thickness. Etiology: Pressure. Stage: Three. Duration: Less than one day. Wound Size: 2.0 cm by 1.5 cm by 0.4 cm. Exudate: Light serosanguinous. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Secondary dressing abdominal pad once daily and as needed. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in	S9999		

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S9999	Continued from page 8 bed, elevate legs, and float heels in bed. Specific to visit recommendations: Pressure off-loading boot-prevalon." R2's Wound Evaluation and Management Summary dated 6/26/25 and signed by V14 (Wound Physician) documents, "Stage four pressure wound of the left lateral ankle full thickness. Etiology: Pressure. Stage four. Duration: Less than 66 days. Wound Size: 0.8 cm by 0.5 cm by 0.3 cm. Exudate: Moderate sero-sanguinous. Slough: 30%. Granulation tissue: 70%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Sharp selective debridement procedure to remove biofilm and remove devitalized epidermis and/or dermis. Stage four pressure wound of the right lateral heel full thickness. Etiology: Pressure. Stage: four. Duration: Less than 52 days. Wound Size: 1.2 cm by 0.8 cm by non-measurable depth cm. Exudate: Moderate Serous. Slough: 100%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Secondary dressing abdominal pad once daily and as needed. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, elevate legs, and float heels in bed. Specific to visit recommendations: Pressure off-loading boot-prevalon. Low air-loss mattress." R2's current Pressure Ulcer Care Plan does not include the interventions to ensure R2's low air-loss bed and did not include pressure relieving interventions to prevent pressure to the heels/ankles prior to the development of R2's right lateral heel and left lateral ankle pressure ulcers. On 6/27/25 at 9:48 AM V2 (DON) performed wound treatments to R2's left lateral ankle and R2's right lateral heel. R2's left lateral ankle wound was approximately 1.3 cm round and covered in 80 percent slough. R2's right lateral heel was approximately 2.0 cm by 1.5 cm with a slight depth and red in color. On 6/27/25 at 12:15 PM V2 (DON) stated, "(R2) did not get the Braden Pressure Ulcer Risk Assessments done weekly for four weeks after admission or quarterly. The only Braden Pressure Ulcer Risk Assessment (R2) had done was on 6/24/25. (R2's) treatments to the left lateral ankle and right lateral heel were not done as	S9999		

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S9999	Continued from page 9 ordered on 6/20/25. (R2's) wounds to the left lateral ankle and right later heel were caused by pressure. (R2) did not have pressure relieving interventions to the heels or ankles prior to developing the pressure ulcers. (R2's) care plan does not include (R2's) low air-loss mattress." 3. R3's Face Sheet documents R3 is a 92-year-old admitted to the facility on 3/25/25 with the diagnoses of a Fracture to the Right Femur, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Major Depressive Disorder, Chronic Pain, Hypertension, Cognitive Communicative Deficit, and Hearing Loss. R3's Admission Braden Scale for Predicting Pressure Sore Risk Assessment dated 3/25/25 documents a score of "16" indicating R3 was at risk of development of pressure ulcers. This same Braden Scale documents R3 was chairfast, had no limitations in mobility, 3 and required moderate to maximum assistance in moving to prevent friction and shearing. R3's Admission MDS Assessment dated 4/1/25 documents R3 was significantly cognitively impaired, was dependent on staff for turning left to right, personal hygiene, and transferring to the chair. This same MDS documents R3 was at risk for developing pressure ulcers, had no pressure ulcers upon admission, and was not on a turning/repositioning program. R3's Significant Change MDS Assessment dated 4/25/25 documents R3 is severely cognitively impaired, is dependent on staff for turning left to right, personal hygiene, and transferring to the chair. This same MDS documents R3 was at risk of developing pressures, had no pressure ulcers as of 4/25/25, and was not on a turning/repositioning program as of 4/25/25. R3's Medical Record dated 3/25/25 through 6/27/25 does not include any Braden Scale Pressure Risk Assessments weekly times four weeks after admission, or after a change in condition except for the one assessment dated 3/25/25. R3's Progress Notes dated 6/14/25 at 4:59 AM and signed by V15 (LPN/Licensed Practical Nurse) document, "Two cm open area noted to right ischium. Area cleansed and hydrocolloid applied."	S9999		

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S9999	Continued from page 10 R3's current Physician's Order Sheets dated 5/26/25 through 6/26/25 document, "Start Date: 6/14/25 apply hydrocolloid to right ischium every three days and as needed." R3's Treatment Administration Records dated 6/14/25 through 6/26/25 document R3 did not get a treatment performed as scheduled to the right ischium on 6/20/25. R3's Initial Wound Evaluation and Management Summary dated 6/19/25 and signed by V14 (Wound Physician) documents, "Stage two pressure wound of the right ischium partial thickness. Etiology: Pressure. Stage two. Duration: Less than one day. Wound Size: 1.0 cm by 0.7 cm by 0.1 cm. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, and float heels in bed. Low air loss mattress. Dressing Treatment Plan: Hydrocolloid three times per week and as needed if saturated, soiled, or dislodged." R3's Wound Evaluation and Management Summary dated 6/26/25 and signed by V14 (Wound Physician) documents, "Stage two pressure wound of the right ischium partial thickness. Etiology: Pressure. Stage two. Duration: Less than eight days. Wound Size: 1.0 cm by 0.7 cm by 0.1 cm. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, and float heels in bed. Low air loss mattress. Dressing Treatment Plan: Hydrocolloid three times per week and as needed if saturated, soiled, or dislodged." R3's Care Plan dated 3/25/25 through 6/26/25 does not include the physician ordered pressure relieving interventions to provide a low air-loss mattress, off-load pressure to the wound, or float R3's heels while in bed. On 6/26/25 V2 (Director of Nursing) stated, "(R3) has had no other Braden Scale Pressure Sore Risk Assessments since admission 3/25/25 and should have had a Braden Pressure Risk Assessment done weekly after admission and after a change of condition. On 6/26/25 from 11:35 AM through 2:00 PM and 6/27/25 at 9:15 AM R3 was lying in bed on her back, on a regular	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047969	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN MANOR	1520 EL CAMINO DRIVE , PEKIN, Illinois, 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) COMPLETION DATE
S9999	Continued from page 11 mattress (not low air-loss as ordered by the physician). R3's heels were lying directly on the bed. R3 did not have heel protection boots on, or her heels off-loaded as ordered by the physician. On 6/27/25 at 9:15 AM V2 (Director of Nursing/DON)) performed the wound treatment to R3's right ischium. When removing the hydrocolloid dressing, R3 was moaning and saying ouch. The right ischium wound was approximately 1 cm round pink with reddened skin surrounding the wound. During this time V2 stated, "I do not know if (R3's) heels should be off-loaded or if (R3) is supposed to have a low air-loss mattress or heel boots. I will have to look at (R3's) orders." On 6/27/25 at 12:30 PM V16 (Wound Nurse) stated, "I did not get (R3) a low air-loss mattress or pressure relieving boots. I do rounds with (V14) and have never looked at (V14's) recommendations. I will make sure I look now. (R3's) air-loss mattress and pressure relieving boots never got added to (R3's) care plan. The staff should always make sure (R3's) pressure is off (R3's) ischium wound and heels." On 6/27/25 at 10:30 AM V14 (Wound Physician) stated the facility should always off-load R3's heels to prevent pressure to the heels and the facility should have contacted hospice to order a low air-loss mattress and prevalon boots for the resident. R3's wound to the right ischium was caused from pressure. R1 and R3's wounds were caused from pressure according to my notes. V14 verified R1, R2, and R3 should have had pressure relieving interventions tried prior to development of pressure ulcers to prevent their (R1, R2, and R3's) pressure ulcers from developing. (B)	S9999		