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 _____	C 06/11/2015

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	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 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: 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:	S9999		

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S9999	Continued From page 1	S9999		

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

These requirements were not met as evidenced by:
Based on record review and interview, the facility failed to utilize foot pedals on a wheelchair to prevent resident injury for one of one residents (R1) reviewed for a fracture, in a sample of four and failed to ensure residents were monitored by staff during toileting and investigate a resident fall, for one of two residents (R2) reviewed for falls, in a sample of four. This failure resulted in R1's right foot getting caught under a wheelchair, causing a right femur fracture.

Findings include:

1. The Electronic Medical Record documents that R1 was admitted to the facility on 8/06/14 with diagnoses of History of Personal Falls, Muscle Weakness, Gait Abnormality and Osteopenia.

On 5/19/15, Progress Notes document R1 complained of left knee pain and R1's "(foot)..had got caught under the wheelchair while it was moving." A Radiology Report, dated 5/19/15 documents an X-ray of left knee was obtained.

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S9999	Continued From page 2 On 5/25/15, a Radiology Report documents left knee medial fracture concyle fracture around a total knee arthroplasty component....difficult to appreciate if a new fracture or callous formation of old fracture. On 5/20/15, the Physician's Order Sheet documents R1 was now non-weight bearing on the left lower extremity and was to utilize a mechanical lift for all transfers. On 5/21/15, Progress Notes document E3 (Certified Nurse Aide/CNA) was pushing R1 in wheelchair down the hallway, when R1 lowered his right foot to the floor causing his right foot to be pulled under the chair. Progress Notes document an x-ray of the right knee was ordered, due to R1's complaint of pain. A Radiology Report of the right knee, dated 5/21/15, documents R1 sustained an acute right femoral sopracondylar fracture. On 6/10/15 at 1:05 p.m., E3 (CNA) stated (E3) was assisting R1 on 5/21/15, by pushing him in his wheelchair with the left leg elevated on a pillow on a foot pedal. E3 stated that there was not a pedal placed on the right side of wheelchair at that time. E3 confirmed that R1 dropped his right foot while (E3) was pushing the wheelchair, pulling the right foot underneath. E3 stated (E3) was not fully aware of circumstances of R1's incident on 5/19/15, in which R1's left foot was caught under the wheelchair. E3 stated, "had I been aware of incident, I would have put a pedal on right side of (R1's) wheelchair." On 6/11/15 at 9:45 a.m., E2 (Director of Nurses) stated if a resident is known to have problems with their feet dropping to floor while being pushed in a wheelchair, it would be better to have pedals on the wheelchair. At 11:45 a.m., E2 stated all staff were inserviced on 5/27/15	S9999		

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regarding the need to place foot pedals on a wheelchair, when a resident is being pushed by staff to ensure resident safety.

An Inservice Education/Meeting Report, dated 5/27/15, document staff were reminded that "Residents who cannot propel themselves in their wheelchairs need to have foot pedals placed on their wheelchairs before being escorted. Residents who are determined to be independent in propelling themselves in their wheelchairs need to complete task independently. If the independent resident asks for assistance, then foot pedals are to be placed before assisting the resident."

2. The Electronic Medical Record Admission Summary documents R2 was admitted to the facility on 12/23/13 with the diagnoses of Dementia, Abnormal Gait, Lack of Coordination and Muscle Weakness.

Minimum Data Set, dated 3/31/15, documents R2 requires the extensive assist of one staff while toileting. The current Plan of Care, dated 3/31/15, documents R2 is high risk for falls, related to weakness, cognitive impairment, Psychiatric Medication use, anxiety and requiring staff assistance to transfer. The Plan of Care also identifies R2 as being "non-complaint with transferring at times."

An "Event" in the Electronic Medical Record, dated 5/27/15, documents, "Resident reported that she fell back onto the toilet in attempt to self-transfer to the wheelchair. Resident has a 5 cm (centimeter) round bruise on the left hip." The Electronic Medical Record did not contain documented evidence of an investigation into R2's 5/27/15 fall.

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S9999	Continued From page 4 On 6/10/15 at 2:34 p.m., E2 (Director of Nursing) stated the facility did not consider the 5/27/15 incident involving R2 an "actual fall." E2 stated R2 had informed staff that R2 had "partially stood up", in attempt to transfer self back to the wheelchair, and then "went back down onto the toilet seat, causing her hip to bruise." E2 stated the fall was unwitnessed, because staff were "going back and forth between residents and left (R2) alone on the toilet." E2 stated she had no documented statements or written investigation regarding the fall, other than the identification of the left hip bruise. According to E2, R2's current Plan of Care did not document any new fall prevention interventions after the 5/27/15 incident since it wasn't treated as a fall. The facility policy, titled "Accident and Incident Report", documents in the event of an accident involving a resident, staff are required to document on "Form-137 (Resident Accident & Incident Reports), as well as in the Nurses Notes." (B)	S9999		