STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND I ENVOI CONTINUENTON		A. BUILDING:				
		IL6015887	B. WING		05/1) 4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MANOR	COURT OF PERU		KER DRIVE			
		PERU, IL	61354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210b) 300.1210d)6) 300.2040b) 300.2040e) 300.2040g) 300.3240a)					
	Section 300.610 Re	esident 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 0 Nursing and Person	General Requirements for nal Care				
	and services to atta practicable physica well-being of the re each resident's con plan. Adequate and care and personal of resident to meet the	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident. Restorative measures				

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

05/27/15

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
W 0045007		B. WING		C 05/14/2015			
NAME OF I		IL6015887			05/1	4/2015	
	PROVIDER OR SUPPLIER		KER DRIVE	STATE, ZIP CODE			
MANOR	COURT OF PERU	PERU, IL					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	shall include, at a m procedures:	ninimum, the following					
	Section 300.1210 G Nursing and Persor	General Requirements for nal Care					
	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:						
	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 300.2040 D	Diet Orders					
	medical record, for whether the resider	write a diet order, in the each resident indicating It is to have a general or a e diet shall be served as					
	Section 300.2040 D	Diet Orders					
	physician as part of clinical condition, to substances in the d increase certain sul potassium), or to pr	t means a diet ordered by the a treatment for a disease or eliminate or decrease certain liet (e.g., sodium) or to ostances in the diet (e.g., rovide food in a form that the eat (e.g., mechanically altered					

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
					С		
		IL6015887	B. WING			4/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
MANOR	COURT OF PERU	3230 BEC PERU, IL	KER DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 2	S9999				
	therapeutic diets shift separate menus a specific diet, diet in type, in a form easi available in a conversal section 300.3240 A a) An owner, licens	ariations of prescribed hall be available in the kitchen. are not planned for each formation for each specific by understood by staff, shall be enient location in the kitchen.					
	by: Based on interview failed to serve food resident's needs an Orders for a mechathree residents (R2 sample of three. The choking on a piece having to be transpand admitted with foobstruction. Findings include: The facility's incider Agency, dated 5/2/had a choking episor This same notification to have increased residency.	and record review, the facility in a form to meet the did the resident's Physician unically altered diet for one of reviewed for diet orders in a his failure resulted in R2 of cut up chicken nugget and orted to the local area hospital oreign body airway at notification to the State 15, documents on 5/1/15, R2 ode during the evening meal. on documents that R2 started espiratory distress at 4:00 AM ation to the local area hospital					

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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	
		IL6015887	B. WING			C 14/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MANOR	COURT OF PERU	3230 BEC PERU, IL	KER DRIVE 61354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	and admitted relate obstruction.	d to a foreign body airway				
	AM, states, "Reside elevated to approxil 'Nurse, nurse' with Barking quality note 160/90. Assistance Oxygen titrated to fo saturation with peripaturation: 85% on time to transport to on 6 L oxygen with will not tolerate."	ess Note, dated 5/2/15 at 4:25 ent in bed with head of bed mately 45 degrees. Calls for labored respirations of 40. ed. Vital Signs: 98.4, 100, 40, e provided to sit up at bedside. our liters (L) with little effect on oheral capillary oxygen 4 L oxygen. 911 called at this emergency room. Resident non rebreather attempted but bital History and Physical				
	The local area hospital History and Physical Examination, dated 5/2/15, states, "History of Present Illness: The patient had some dinner yesterday and as per nursing home facility the patient was brought in early morning today to be evaluated since the patient was having a lot of shortness of breath. In the Emergency Room it was noted that the patient actually had a chicken nugget which was taken out by forceps. The patient saturation was in the low 80's at the time of admission."					
	dated 5/7/15 states with upper airway o nugget removed by Room by the Emerg white blood cell cou Upon discharge nor started on Levequir Zosyn antibiotics fo	bital Discharge Summary, , "(This patient) was admitted bstruction. (R2) had a chicken forceps in the Emergency gency Room physician. (R2's) ant on admission was 27,000. rmal at 10,000 (patient was n, Flagyl, and Intravenous r post-obstructive pneumonia."				
	R2's Physician Orde	er Sheet/POS on 5/1/15 I Soft Diet."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
W 0045007		B. WING		C 05/14/2015			
		IL6015887			05/1	4/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S KER DRIVE	STATE, ZIP CODE			
MANOR	COURT OF PERU	PERU, IL					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 4	S9999				
	(Dietary Manager), facility supper meal soft diet order was sauce. The facility's Diet M	preadsheet provided by E5 undated, documents the for 5/1/15 for the mechanical ground chicken nuggets with					
	that for the Mechanical Soft Diet, meat should be ground and served with gravy or sauce. The facility's witness investigation statement, dated 5/4/15, from E8 (Certified Nurse Assistant/CNA), who was involved with meal assistance for R2 on 5/1/15, states, "(E8) knows (R2) has a mechanical soft diet order. (E8) was cutting up the chicken nuggets when the alarm on another resident was sounding. (E8) stopped cutting up the chicken and went to attend to the other resident." The facility's witness investigation statement, dated 5/4/15, from E7 (CNA), also involved with meal preparation for R2, states, "(E7) knows that (R2) is a mechanical soft diet(E7) served the meal and the kitchen was not notified of the lack of mechanical soft foods."						
	(on) a mechanical s the tuna sandwich, chicken nuggets. I meat is usually grou	PM, E7 (CNA) stated, "(R2) is soft diet. When (R2) didn't like (E8) told me to get (R2) usually feed (R2) and (R2's) unded up. I thought that if it gh, it would count as					
	On 5/12/15 at 11:55 am, E5 (Dietary Manager) stated, "On 5/1/15, the chicken nugget was the entree and tuna salad sandwiches were the substitution meal. Usually the residents with a						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
7.11.2 7.2 11.0 1.0 00 11.120 11.0 11			A. BUILDING:		С	
IL6015887		B. WING		05/14/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MANOR	COURT OF PERU		KER DRIVE			
		PERU, IL				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	mechanical soft die because the ground my cook didn't mechanicals for this unisalad sandwich, (R (R2's) chicken nuggmechanically altere Nursing Assistant (Soft Diet Order, the been ground/mechanical sandwich sauce because On 5/13/15 at 1:25 stated, "I would've to be grounded/mechanical discharge spneumonia could bincident." On 5/13/15 at 12:08 Dietitian/RD) stated mechanical soft die meat with sauce and be cut into small pie On 5/12/15 at 3:00 Pathologist/SLP) st mechanical soft die sauce and/or gravy soft diet order beca Technically, (R2's)	et order prefer the tuna d chicken nuggets are dry, so chanically alter any chicken t. Since (R2) refused the tuna 2) was given chicken nuggets. gets for that meal were not ed, just cut by the Certified CNA). For the Mechanical echicken nuggets should've anically altered and served et they are dry." PM, Z1 (R2's Physician) expected the chicken nuggets chanically altered. Yes, the summary of post-obstructive e related to the choking B PM, Z2 (Registered d, "It is this facility's policy that et orders will be served ground ad/or gravy. Meat cannot just exes." PM, E11 (Speech Language eated, "In this facility, et orders are ground meat with the choking risk. The served ground meat with the conders are ground meat wit	S9999			
	(B)					

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