

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2017
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NAME OF PROVIDER OR SUPPLIER MANOR COURT OF PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 3230 BECKER DRIVE PERU, IL 61354
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(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
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S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview, record review and observation the facility failed to provide a safe transfer from the dining room to a resident's room by not using wheelchair pedals during a transport causing a fall with a fracture for one of three residents (R1) reviewed for accidents in a sample of three. This failure resulted in R1 sustaining a fracture of the third finger on the right hand and a</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>hematoma on R1's forehead head.</p> <p>Findings include:</p> <p>On 4/2/2017 at 6:49PM, E4 Registered Nurse (RN) documented in R1's Progress Notes, "Staff propelling res (resident) in w/c (wheelchair) from dining room when res' feet dropped to the floor. Res then fell out of w/c. Res fell head first onto the floor outside of dining room. Noted to land on R (right) head then R arm then R body. Moderate amount of blood on floor under head, lacerations noted on bridge of nose and R forehead. Res complained of pain to face. Unable to move head . Pupils equal and reactive. Res was not moved. Res sent to (hospital emergency room)."</p> <p>On 4/27/2017 at 12:30PM, E4 RN stated , "I was in the dining room. I heard commotion and turned to see (R1) falling out of the wheelchair and E5, Certified Nurse Aide (CNA), standing behind (R1). (R1) had propelled herself to the dining room for supper and then (E5) started to push (R1) back to her room after supper. (R1) did not have foot pedals on her wheelchair. It is common practice here, if the residents propel themselves, they do not need foot pedals. If they need assist to be transported then they are to have foot pedals on. We cannot expect (the residents) to hold up their heavy legs for a long period of time without pedals. E5 knew this."</p> <p>On 4/27/2017 at 11:50AM, E6 CNA, who clarified she knew R1 well, stated, "(R1) propels her wheelchair so when she does that (R1's) pedals are taken off. When we are transporting her, even short distances, we need to put on the pedals. That has been our policy for a long time. (R1) is capable of picking up her feet but not for a long period of time."</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>On 4/27/2017 at 11:55AM, E3 Assistant Director of Nursing (ADON) stated, "It is common practice that residents should have foot pedals on their wheelchair when staff are pushing them down the hall, even short distances. (E5) CNA who was pushing (R1) at the time of the fall was not a new CNA. She had been employed here for about six years. (E5) was aware this is a common practice. (E5) told me that she knew she was wrong but she did not think about it and started pushing (R1) without the foot pedals on."</p> <p>R1's current Care Plan documents R1 as having a diagnosis of Dementia and as having "limited mobility and bilateral lower extremity weakness."</p> <p>On 4/27/2017 R1 has fading bruises over bilateral cheek bones and a splint on the right hand, third finger. R1 was not able to state what happened to cause these outward signs of a change in condition/injury.</p> <p>The Emergency Room reports dated 4/2/2017 document R1 had an acute fracture of the third finger on the right hand and a right frontal scalp hematoma.</p> <p>(B)</p>	S9999		