STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W 000	INITIAL COMMENTS INCIDENT REPORT INVESTIGATION INCIDENT OF 04/25/12 - IL 57798	W 000		
W9999	FINAL OBSERVATIONS Licensure Violations: 350.620a) 350.1210 350.1220j) 350.1230b)7) 350.1610e)1) 350.3240a)b) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's	W9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 1 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. 350.1230 b)7) Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. 350.1610 e) 1) Resident Record Requirements e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. 350.3240 a) b) Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 2 administrator. (Section 3-610 of the Act) These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure that individuals are provided with nursing services in accordance with their needs for 1 of 1 individual (R2) hospitalized on 04/25/12 with a displaced fracture (fracture in which the two ends of the broken bone are separated from one another) of his femoral (thigh) bone and a fracture of his right hip as evidenced by: 1) Direct support staff neglected to implement the facility's policy and procedures on Abuse/Neglect reporting when they failed to promptly notify nursing personnel after hearing a popping sound when transferring R2 on 04/11/12; and 2) Nursing staff failed to implement interventions identified within R2's medical care plan to be free of fractures and to ensure the prevention of delay in treatment and further injury when they neglected to: a) document concerns expressed by direct support staff regarding R2's right leg from 04/14 -04/22/12; b) document that they had assessed R2's leg; and c) notify the physician of direct support staff's concerns regarding changes noted to R2's leg. Findings include: 1) The facility's direct support staff failed to implement the facility's policy and procedures on Abuse/Neglect when they neglected to promptly notify nursing personnel after hearing a popping	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 3 sound when transferring R2 on 04/11/12. The facility's policy regarding abuse, neglect and or mistreatment dated 09/09/11 defines Neglect as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. More specifically, a failure in a long term care facility to provide adequate medical or personal care or maintenance, which results in a physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition... Other examples of neglect include failure to report when a client falls, bumps their feet or other injuries; failure to report changes in a client's condition..." In review of the facsimile report submitted to the Illinois Department of Public Health on 04/26/12, this report states, "Regarding: Client Injury Involving Client: R2 DOB (Date of Birth) 06/16/43 Adm. (Admit) Date: 04/12/12 This fax is to inform you/your agency that on April 25th, 2012 R1 was taken to ... hospital ... due to discoloration and swelling of the right leg (upper thigh/knee area). An assessment and x-ray were obtained an a preliminary report received. The report identifies: 1) Deformity of the femoral neck due to fracture 2) Oblique displaced fracture (fracture in which two ends of the broken bone are separated from one another) of the distal third of the femur 3) Soft tissue swelling of the region of the right hip and femur 4) Foreshortening due to a fracture of the right hip. R1 was admitted to the hospital for possible	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 4	W9999		

further treatment/assessment. R1's guardian OSG (Office of State Guardian - Z1) has been notified of R1's status. An investigation has been initiated with it's conclusion (to be) forwarded to your agency upon it's completion..."

The facility's final investigation dated 05/02/12 concludes that R2 sustained injury to his leg on 04/11/12 when E3 (DSP - Direct Support Person) and E21 (DSP in training) were scheduled to assist R2 with his bath on 04/11/12 as confirmed per the bathing sheet record.

This investigation (dated 05/02/12) contains E3's undated Written Statement which states, "On 04/ 11 /12 E21 (DSP in training) and I went to get R2 for a bath... we turned him over on his side to put gait belt around him. Laid him on his back to lock the gait belt. After that I (E3) went to lift him up... E21 went for his legs. She tried to cradle his legs to lift him up, but when we tried we heard a pop. We laid him back down. We looked him over to see if we hurt him. We did not tell the nurse. It looked like his legs might have gotten caught in between her and the bed. His legs are odd shaped so it might have been a little hard to lift... We were both scared and did not tell the nurse. We should have, but we did not."

E2 (Facility's Investigating Designee) was interviewed on 05/10/12 at 4:00 P.M. and stated that during the facility's investigation it was concluded that E3 (DSP) and E21 (DSP in training) neglected to report R2's leg popping on 04/11/12. E2 stated that E3 had been trained to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 5 report all incidents and changes in the resident's condition at the time of hire and on a continuing basis. During this interview, E2 also confirmed that E21 is presently in training and also should have reported the incident, but failed to do so. E2 provided the surveyor with a copy of E3's most current training record for Abuse/Neglect reporting. Review of the In-Service Education Report dated 02/23/12 regarding Abuse/Neglect and Resident Rights confirmed that E3 had participated in this inservice and has been trained on the facility's policy to report all incidents and changes in the individual's condition. As based on the facility's conclusion and as confirmed per interview with E2 (Facility's Investigating Designee) on 05/10/12, E3 (DSP) failed to implement the facility's policy on Abuse/Neglect when she neglected to report to nursing staff the incident of R2's leg popping during a transfer with E21 (DSP in training) on 04/11/12. 2) The facility's nursing staff failed to implement interventions within R2's medical care plan by neglecting to document concerns expressed by direct support staff regarding R2's right leg from 04/14 -04/22/12, neglecting to document that they had assessed R2's leg, and neglecting to notify the physician of direct support staff's concerns regarding changes noted to R2's leg. In reviewing R2's clinical record a Nurses' Admission Assessment dated 04/10/12 identifies that R2 had no abnormalities to his right leg at the	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 6 time of his admission to the facility. This assessment depicts that R2 has a G-tube (gastronomy tube), that half of his left big toenail is black and that he has a very small area in the center of his upper buttock cheeks. R2's Care Plan dated 04/16/12 identifies that he has, "Potential Problem/Risk for injury related to developmental factors (Spastic Quadriplegia)." Outcomes within this plan states that he will remain free from injury including fractures and that staff will identify signs or symptoms of injury to prevent delay in treatment and to prevent any further injury. Interventions within this plan includes: "Assess, document and report any s/s (signs or symptoms) of fracture (loss of power of movement, pain, with acute tenderness over the suspected site, swelling and bruising, deformity, unnatural mobility and crepitus (grating cracking or popping sounds and sensations experienced under the skin joints)." These interventions also identify that nursing staff should consult with the primary physician and/or with the orthopedic physician on an as needed basis. The facility's final investigation dated 05/02/12 identifies that after E3 (DSP) and E21 (DSP in training) heard R2's leg pop on 04/11/12, direct support staff reported to nursing staff on 04/14, 04/15, 04/18, 04/23 and 04/25/12 about the appearance of R2's right leg and their concern(s) that something was wrong, without action by nursing personnel. The Nurse's Notes from 04/12/12 - 04/22/12 does	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 7 not identify that nursing documented any concerns expressed by staff regarding R2's right leg, nor did nursing document that they had assessed R2's legs. In review of the Written Statements that are contained within the facility's investigation dated 05/02/12, it is noted that E6, E7, E12, E13, E14, E18, E20, E24 and E26 (Direct Support Staff/DSP) all reported to the nurse(s) on duty about their concern(s) regarding the appearance of R2's right leg. Examples of these statements include: E18's (DSP)Written Statement dated 04/26/12 states, "It was about a couple weeks ago E13 (DSP) and E12 (DSP) was B&Bing and putting R2's clothing on when I walked in and they asked me for my opinion on his leg. It keep cracking and popping. By his hip it was up more maybe swollen and in the middle of his top part of leg in was bent downward. I got the night shift nurse (E19/LPN) and she felt his leg and said everything was ok to get him up and that what we did. This was when he was only here for a couple days." E12's (DSP) Written Statement dated 04/14/12 states, "E13 (DSP) and I (E12) were about to begin our b&b (bowel and bladder) get up on R2 at around 6 P.M. I then noticed that his leg and knee did not look normal. We stopped and notified my supervisor (E14) and the night shift nurse (E15/LPN-Licensed Practical Nurse). E15/LPN assessed him and called in a 2nd nurse	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 8 (E16). They said his leg looked normal so we continued with his get up." E14's (DSP) Written Statement dated 04/26/12 states, "E12(DSP) came to me about 5:45 pm on April 14th and said he thought R2's leg might be broken. So I went in to look at it and it was caved in on the right leg. I went and got his nurse (E15/LPN). She (E15) said she wasn't sure so she went to get E16 (LPN). When she (E15) left to get her (E16), I went to tell E20 (DSP) what was going on. He (E20) had me start filling out a injury report. I filled it half way out and went to check and see what E16 (LPN) said. E12 and E13 (DSPs) told me she said it was fine. I (E14/DSP) came back and told E20 (DSP), he told me not to worry about the injury report so I threw it away." E13's (DSP) Written Statement dated 04/26/12 states, "While assisting R2 on the 14th of April I noticed his leg looked deformed so I go E17 (DSP) and asked her if his leg looked like that when he first got here and she didn't know and she went and got E16 (LPN) and two other nurses (unidentified) and they looked at this leg and said it was fine but while me and E12 (DSP) was assisting him his leg was extremely flexible and I asked R2 if his leg hurt and he said yes and shook his head but while the nurses was looking at his leg he made no faces, we put him in his chair like we were told to and someone told me E3 (DSP) and someone else was getting him up on a day before and they heard a POP and didn't say anything and I didn't notice any discoloration or swelling."	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 9	W9999		

When reviewing R2's nursing notes for 04/14 - 04/15/12, no documentation has been completed be nursing staff identifying that direct care staff had notified them regarding their concerns about his (R2's) right leg. No documentation has been completed by nursing staff on these dates identifying that they completed an assessment on R2's right leg and documented this/these assessment(s) as based on staff's reports.

E15's (LPN) written statement dated 04/30/12 states, "On the evening of 04/15/12, early in the shift, DSP (unidentified) called me to resident's room. They stated, "his leg looked funny." The DSPs were getting ready to get him out of bed. There was an abnormal angle to the R (right) leg above the knee. I called the other nurses to ask if they had seen it before. E16 and E11 came to look (none of us had seen him before). We examined his leg. There was no sign of any tenderness. No discoloration was noted. The DSPs were told they could go ahead and get him up."

E6's (DSP) Written Statement dated 04/27/12 states, "On 04/18/12, E23 (DSP) told E7 (DSP) that R2's right upper leg looked like it was broken... When I (E6) got to the room, E23 (DSP) said that he thought R2's right leg looked like a broken femur and it had some warmth to it. E23 said he told the nurse (E26) and she said it was okay his leg looks like that has since he came here... Then on 04/23/12 E23 (DSP) said that E15 (LPN), E11 (LPN) and E16 (LPN) had all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 10 looked at it then. I then told E23 he should write it on report concerns since he reported it to nurse and myself (E6). Then on 04/23/12 E23 had E7 (LPN) and I (E6) look at R2's leg again because it was yellow. Upon assessment of R2's leg I noticed that it was also yellow on both of his ankles. E23 said he told E8 (Assistant Director of Nursing/ADON) already about the yellow on the upper right leg. I told E23 go ahead and write the ankle down for having yellow on them as well and I went to let E8 (ADON) know. When I spoke with E8, she said she was making note of the discoloration and going to let day shift decide what to do." The Nurse's Notes from 04/12/12 -04/22/12 does not identify that nursing staff documented that they had assessed R2's legs, nor did they notify the physician of staff's concerns. R2's Care Plan dated 04/16/12 identifies that nursing staff are to, "Assess, document and report any s/s (signs or symptoms) of fracture (loss of power of movement, pain, with acute tenderness over the suspected site, swelling and bruising, deformity, unnatural mobility and crepitus" and consult with the physician on an as needed basis. R2's Nurse's Notes dated 04/23/12 states, "It was reported to the nurse (E25/LPN) that resident's (R2's) right thigh and both ankles are yellow tint in appearance. Upon assessment, I (E25) verified this. Skin is warm and dry to the touch with no open areas. Will continue to monitor."	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 11 After the 04/23/12 entry, there is no further entries made in R2's Nurse's Notes regarding monitoring of the condition of R2's right leg until 04/25/12 when nursing documented, "DSP (unidentified) reported res. (resident R2) leg "not looking rite" upon assessment this nurse was unable to decide. E28 (DON - Director of Nursing) and E29 (RSD - Resident Services Director) notified. N.O. (New Orders) Send to ... ER (Emergency Room) for tx (treatment) et (and) eval (evaluation) r/t (related to) swollen leg. At 7:00 P.M. on 04/25/12 nursing staff documented, "Resident (R2) admitted with dx (diagnosis) of complete comminuted and displaced fracture of the distal shaft of the R (right) femur." The Diagnostic Imaging reports dated 04/25/12 identifies that R2 not only sustained a fracture to his right femur but also sustained a fracture to his right hip. The first Diagnostic Report states, "Right Femur, Two views of the right femur demonstrates a complete comminuted and displaced fracture of the distal shaft of the right femur and there is a foreshortening due to a fracture of the hip. Marked soft tissue swelling is present." The second Diagnostic Imaging reports dated 04/25/12 states, "There is a deformity of the femoral neck due to a fracture and there is an oblique displaced fracture of the distal third of the femur with soft tissue swelling of the region of the right hip and the femur." In review of the facility's final investigation dated 05/02/12, it was concluded that R2 did not receive	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 12 medical treatment until 04/25/12 which was fourteen days after direct support staff (E3) and E21 (DSP in training) heard his leg pop while they were transferring him on 04/11/12. E2 (Facility's Investigating Designee) was interviewed on 05/10/12 at 4:00 P.M. and stated that during the facility's investigation it was concluded that nursing staff failed to document concerns and document their assessment(s) regarding R2's right leg. E2 stated, "When we began investigating we had direct care staff telling us that they had told the nurse on duty, but when we checked nursing documentation there was nothing documented by nursing staff." During this interview, R2's medical care plan dated 04/16/12 was reviewed with E2. When the section stating that nursing staff are to, "Assess, document and report any s/s (signs or symptoms) of fracture (loss of power of movement, pain, with acute tenderness over the suspected site, swelling and bruising, deformity, unnatural mobility and crepitus" was reviewed with E2, she confirmed that nursing staff did not implement R2's care plan as written by stating, "No." When E2 was asked if R2 remained, "free from injury including fractures and if nursing staff had documented that they had assessed R2 for signs or symptoms of injury to prevent delay in treatment and to prevent any further injury" as identified within his care plan, she stated, "No." E2 also confirmed that nursing staff did not contact the physician (E9) regarding direct care staff's concerns and/or the changes in appearance of R2's right leg until fourteen days after E3 (DSP) and E21 (DSP in training) heard R2's leg pop while transferring him	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	C 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD CENTRALIA, IL 62801**

(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
W9999	Continued From page 13 on 04/11/12. (A)	W9999		