	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONS	STRUCTION	(X3) DATE S COMPLE	ETED
		14G099	B. WIN	G			C 7/2012
NAME OF P	ROVIDER OR SUPPLIER MANOR			P.O.BOX	RESS, CITY, STATE, ZIP CODE 303, 901 OGLESBY ROAD BURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF EACH CORRECTIVE ACTION S OSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 331	been no meeting w to discuss the need R4's meals, R4 con Diet with Ground M been made to R4's There has been no developed to addre dietary needs since	on has been done, there has ith the Interdisciplinary Team I for additional monitoring of a mo	W 3				
***************************************	Licensure Violation 350.620a) 350.1210 350.1230b)6)7) 350.3240a)		Woo				
	a) The facility shall procedures governifacility which shall be involvement of the shall be available to public. These writte	have written policies and ing all services provided by the performulated with the administrator. The policies of the staff, residents and the en policies shall be followed in y and shall be reviewed at					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILE	DING			c
		14G099	B. WING	G			7/2012
NAME OF P	ROVIDER OR SUPPLIER MANOR		S	P.O	ET ADDRESS, CITY, STATE, ZIP CODE D.BOX 303, 901 OGLESBY ROAD RRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999		ge 17 ovide all services necessary to lent in good physical health.	W999	99			
	services, in accorda shall include, but ar The DON shall part 6) Development of resident to provide the total habilitation 7) Modification of the	pe provided with nursing ance with their needs, which he not limited to, the following: icipate in: a written plan for each for nursing services as part of					
		ee, administrator, employee or nall not abuse or neglect a					
	These regulations v	vere not met as evidenced by:					
	review the facility fa evaluation,monitoring physician orders for in 1 individual, who and required surger A second individual	ration, interview and record ailed to provide nursing and compliance with 2 individuals, which resulted is below ideal body weight by for a bowel obstruction (R2). (R3) required manual mpaction at the hospital. The					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		14G099	B. WI	NG _			C 7/2012
NAME OF P	ROVIDER OR SUPPLIER			Р	REET ADDRESS, CITY, STATE, ZIP CODE 2.O.BOX 303, 901 OGLESBY ROAD JARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	A) Provide necessal bowel movements in been recently diagrand/or fecal impaction of the fecal by the physician for 1 ideal body weight (C) Provide a nutrition the physician for 1 ideal body weight (C) Accurately monimindividual, who received bowel obstruction as weight (R2). E) Address a weight (R2) and notify the weight loss in 1 weight los	ary monitoring of individual's for 2 individuals, who have losed with bowel obstruction ions requiring manual removal on (R2 and R3). Ives in the time frame as sician for 2 individuals, who is Fecal Impaction (R2, R3). In the supplement as ordered by individual, who is below his R2). It is tor the nutritional status for 1 ently underwent surgery for and is below his ideal body It loss of 11 pounds in 1 week physician of a documented ek for (R2) In the plan to address a Dehydration, Weight loss and	W9	999			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		NG	COMPLE	TED
		14G099	B. WIN	NG _			7/ 2012
NAME OF P	ROVIDER OR SUPPLIER				P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	SHOULD BE COMPLÉ	
W9999	Continued From pa	ge 19	W99	999	9		
	b) Monitor R2 and F administer laxatives	R3's bowel movements and as ordered.					
	dated 03-01-12, R2	2's Individual Program Plan 2 functions at a severe level of R2 is dependent on staff for living.					
	12-07-11, R2 was to complaints of, "Coff 4." After an evaluate with diagnosis' that obstruction, Fecal III	"History and Physical" dated aken to the local hospital for fee ground emesis x (times) tion in the emergency room included: Small- bowel mpaction, Dilated stomach bintestinal Bleeding, R4 was pital on 12/07/12.					
	12/10/11 states, "The significant fecal imperimental (Computerized Axial)	Il Tomography) scan and on ion. The patient had a fecal					
		ocedure Report" dated t R2 also had a small bowel 11.					
	On 12/21/11, R2 wa	as readmitted to the facility.					
	from the local hospidocumentation state a dysphagia treatmentation" R2's medischarge include B	Discharge Summary Report" ital dated 12/21/11, es, "He will be discharged with ent" " monitor his bowel edications at the time of bisacodyl suppository 10 ed if no bowel movement in					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		14G099	B. WI				C 7/2012
	ROVIDER OR SUPPLIER		'	Р	REET ADDRESS, CITY, STATE, ZIP CODE CO.BOX 303, 901 OGLESBY ROAD IARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	two days and Mirala R2's "Discharge Su hospital continues trisk and dietary inst Magic cup, Liquids straw. Feed patient Documentation on Report" also states follow-up includes: pneumonia, Status post-op and bowel R2's "BM (bowel mage for R2 on 01-30, 01 A laxative was chare 02-03-12, the 5 the movement. There having a bowel moved a bowel movement. There is administered laxative physician. On 03-25 no bowel movement laxative was charted day of no bowel movement laxative was charted ay of no bowel movement and laxative was orders. Per review of the hodated 12-21-11, R2	mmary Report" from the local o say that R2 is an aspiration ructions include: "Puree diet, by spoon, no sippie cup or ." R2's "Discharge Summary that issues to be addressed at Status of the persistent right of hydration and Status of	W9:	999			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		14G099	B. WI	NG			C 7/2012
	PROVIDER OR SUPPLIER			Р	REET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	cc to be provided for dinner. Per observations may training center, the facility for R2's glasses of chocolat juice. There was reduring the noon medical during the noon of the facility for his may were the only liquid. Per observation of at 4:50 PM. R2 record chocolate milk. The plasses and was the milk to mix the milk to mix the milk to mix the milk to R2. No Ensure evening meal. On 04-18-12 at 9:40 Supervisor) was inthe had not received the and evening meal of the she did not have the R2's tray and that no ordering it. E12 conknow when it would be removed the facility of the fac	ade on 04-17-12, at the local liquids that were provided by lunch consisted of 2 half e milk and 1 half glass of the Ensure provided for him hal. Ith Z2 (Direct Support Person /17/12 at as she was feeding e facility sent R2's liquids from eal and the juice and milk is sent. Ithe evening meal on 04-17-05 elived 2 glasses, both half full The chocolate mix that had a had settled to the bottom of is very visible. Staff did not stir chocolate flavor before giving e Plus was sent with the O AM, E12 (Dietary Assistant erviewed and asked why R2 e Ensure Plus with his noon on 04-17-12. E 12 said that e Ensure Plus to send out on ursing was in charge of titinued to say that she did not	W9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		14G099	B. WII	NG			C 7/2012
	ROVIDER OR SUPPLIER			Р	REET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	responsibility to ord During interview with 04-18-12 at 9:05 a.l know anything about Plus. Per review of R2's of 01-10-12, and complication of R2's idea. Per review of R2's idea. Per interview of R2's idea. There is no evidence. There is no evidence.	er it when it was needed. th E1 (Administrator) on m., E1 said that she didn't ut the ordering of the Ensure dietary assessment dated pleted by E3 (Registered al body weight is 100 pounds. Medication Administration in place to weight R2 one aday. The weekly weights for recorded as: ads ads ads ads ace that the facility re-weighed acy when his weight increased k (from 03-11 to 03-18-12). be that the physician was	W9	999			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G099	B. WII				C 7/2012
NAME OF P	ROVIDER OR SUPPLIER		•	Р	REET ADDRESS, CITY, STATE, ZIP CODE .O.BOX 303, 901 OGLESBY ROAD IARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	she was not aware documented for R2 The surveyor asked in place for staff guloss was document facility policy was to an accurate weight the gain or loss was R2 had been reweig was not aware of R asked if the physicitime, E2 said "No, I notify the doctor." R2's meal intake sh 2012 was reviewed amounts of food an noon and dinner medocumented althou had not yet been see Additional documer intake sheet review shows that on 04-1 meal and took 600 although this documbefore 04-18-12. Per review of R2's I dated 03-01-12, the recent diagnosis of interventions to ensbasis, no interventio of the Fecal impact	that a weight loss had been d E2 if the facility had a policy idance if a large weight gain or ed. E1 and E2 said that the reweigh the resident to insure and to notify the physician if accurate. E2 was asked if ghed either time. E2 said she 2 being reweighed. When an had been notified either was not aware so I did not not eet for the month of April on 04-17-12, at 9:30 AM. The d liquids consumed for the eal for 04-17-12 were already gh the noon and dinner meal	W9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		14G099	B. WI	NG			C 7/2012
NAME OF P	ROVIDER OR SUPPLIER		•	Р	REET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	has not developed address R2's diagn Impaction or Weight B) Per review of R3 sheet, sheet he is a functions at a Proforetardation. R3 is on tube for nourishment dependent on staff. During the daily state at 4:00 PM, E1 (Activated R3 had been the dialysis unit became and becoming lether E2 (Director of Nursmight have a boweld Per interview with Esaid that R3 had be hospital because the dialysis unit. On 04-19-12 this sure hospitals intensive the hospital record. R3 included Hypotensia. The local hospital's dated 04-17-12, R3 disimpaction becaute for the first review of The forms of treatment.	E2 (Director of Nursing) on M., E2 stated that the facility or implemented a plan to osis of Dehydration, Fecal at loss. B's current physician order a 63 year old male that and level of Mental dependent on a gastric feeding and activities of daily living. The meeting held on 04-17-12 definitions are to a local hospital from the sause of a low blood pressure argic while receiving dialysis.	W99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	COMPLE	TED
		14G099	B. WIN	۱G _			C 7/2012
NAME OF P	ROVIDER OR SUPPLIER			F	REET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946	33,11	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	frames were marked January 1, 2, 3, and 17. January 26, 27 February 1, 2, 3, 4, March 2, 3, 4 and 5. April 1, 3, 4 and 5. There was no evide laxative for any of the R3's Bowel Movement indicate that a laxate March 1, but did nor results and was not documentation to it administered to R3 Documentation on I elimination record of and cannot be identificated in the facility policy (not laxative on the 3rd is movement. There was no evide policy was followed	d April 2012 the following time d as no bowel movement: 4 4, January 12, 13, 14, 15, 16, 28, 29, 30, 31. 5, 6, 7, 8, 9, and 10. March 14, 15 and 16 Ince that R3 received a ne dates listed. In the dimination records ive was given the night of the produce any documented repeated. There is no dentify what type of laxative on 03-01-12. R3's Bowel Movement lated 04-02-12 is scribbled tified as a "O" for no bowel other letter to indicate R3 did ment. E2, on 04-18-12 at 9:00 AM., of produced) is to give a night without a bowel ence provided that the facility's when R2 and R3 were a multiple subsequent days	W99	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		14G099	B. WII	NG			C 7/2012
	ROVIDER OR SUPPLIER		•	Р	REET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD MARRISBURG, IL 62946		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	2) Based on Intervifacility failed to ensideveloped to reduce choking episodes for ground meat diet armeat, with the Heim to free the "chunk of the the the the "chunk of the the the "chunk of the the the the "chunk of the	iews and record review the ure that systems were ethe possibility of further or 1 individual who requires a nd choked on a "chunk of alich maneuver being required of meat." (R4) cility's current physician's (12 through 04/30/12, R4 is a who functions at a Moderate ardation. R4's current continues to say that R4 is anical Soft Diet with Ground as Inventory for Client and CAP) dated 02/06/12, R4 equivalency of 1 year and 7 essment dated 02/13/12, es that R4 is edentulous. vice Plan (ISP) dated 02/08/12 eating program. R4's eating (14) will chew her food 4 times nother bite with 1 verbal cue es facility's Incident Report cumentation states, "During as eating and got choked on filled her mouth too full. was successfully performed. consumer had recovered by personnel examined	W9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		14G099	B. WING			C 7/2012
	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
(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 SHOOL CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	(DSP) on 04/12/12 she had just left the when she heard so because R4 was chreturned to the roor went limp. E10 con blue - trying to talk. removed the food of (DSP) was doing the said that R4 choked sandwich. E10 state Per interview with E on 04/17/12 at 2:05 the dining room and when she heard so choking. E14 said to room and R4 was "blue." E14 continue Heimlich Maneuver meat came up. What type of supervision don't think she is suffer." During interview with E at 10:20 a.m., E3 stated that to R4's eating progron 03/30/12. Per interview with E at 10:20 a.m., E1 stocking, staff were bites of food to ens	th E10, Direct Support Person at 4:00 p.m., E10 said that a room where R4 was eating meone yell, "Call 911" noking. E10 said that she mand R4 was choking and tinued to say, "She (R4) was "E10 said that she (E10) but of R4's mouth while E17 he Heimlich Maneuver. E10 don barbecue meat from a ed, "(R4) took too big of bite." E14 (Licensed Practical Nurse) of p.m., E14 said that R4 was in that she (E14) was in the hall meone yell that R4 was hat she went into the dining Slumped over and kind of ed to say that she (E14) did the en and a quarter size "Chunk" of en asked if R4 was on any during meals, E14 said, "I apposed to have staff with the E3 (Qualified Mental sional) on 04/17/12 at 3:45 to there has been no changes ram since the choking incident e1 (Administrator) on 04/25/12 tated that, at the time of R4's to monitor her (R4's) first few ure that she did not take too ontinued to say that after R4	W999	99		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 05/17/2012		
		14G099						
NAME OF PROVIDER OR SUPPLIER TURNER MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W9999	choked, she was no swallowing evaluati been no meeting w to discuss the need R4's meals, R4 con Diet with Ground M been made to R4's There has been no developed to addre dietary needs since	of seen by the physician, no on has been done, there has ith the Interdisciplinary Team I for additional monitoring of tinues on a Mechanical Soft eat and that no changes have	W9	999				