	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDIEN	<u></u>		A. BUILDING:				
		IL6009567	B. WING		01/0	) 8/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
GARDENVIEW MANOR			TLIN TILTON E, IL 61834	N ROAD			
(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 SHOULD  CROSS-REFERENCED TO THE APPROLEMENCY)	D BE	(X5) COMPLETE DATE	
S9999	Final Observations		S9999				
	Licensure Violations 300.610a 300.1010h) 300.1210d)5 300.3240a  Section 300.610 Rea) The facility shall procedures governifacility. The written policies of nursing and other policies shall compliments and dated minutes of any accident, injuresident's condition safety or welfare of limited to, the prese decubitus ulcers or percent or more with facility shall obtain a of care for the care injury or change in condification.	esident Care Policies have written policies and ng all services provided by the policies and procedures shall Resident Care Policy ng of at least the dvisory physician or the mmittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually locumented by written, signed of the meeting.  Iedical Care Policies notify the resident's physician ry, or significant change in a that threatens the health, a resident, including, but not nce of incipient or manifest a weight loss or gain of five nin a period of 30 days. The and record the physician's plan or treatment of such accident, condition at the time of					
	Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest						

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/26/15

If continuation sheet 1 of 6

A Hachment A "Statement of Licensure VIOLATIONS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURVEY COMPLETED  C  O1/08/2015  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  14792 CATLIN TILTON ROAD  DANVILLE, IL 61834  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 1  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.  d) Pursuant to subsection (a), general nursing	IIIIIOIS L	repartment of Public	пеаш				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  14792 CATLIN TILTON ROAD  DANVILLE, IL 61834   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 1  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.			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
NAME OF PROVIDER OR SUPPLIER  GARDENVIEW MANOR  14792 CATLIN TILTON ROAD DANVILLE, IL 61834   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 1 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.	IL6009567		IL6009567	B. WING		I .	
GARDENVIEW MANOR  14792 CATLIN TILTON ROAD DANVILLE, IL 61834   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 1  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.				000000000000000000000000000000000000000	OTATE 710 000E	J	
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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.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:  5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.  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 are not met as evidenced by:  Based on observation, interview and record review, the facility failed to do admission and weekly skin risk assessments for newly admitted residents, implement interventions to prevent the development of pressure ulcers, and notify physician in timely manner for treatment orders for two of three residents (R1 and R2) reviewed	\$9999	practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the red) Pursuant to subscare shall include, a and shall be practic seven-day-a-week left of a regular program pressure sores, head breakdown shall be seven-day-a-week left enters the facility with develop pressure sores were unavoid pressure sores shall services to promote and prevent new pressure sores and prevent new pressure of a facility shresident.  These Requirement by:  Based on observation weekly skin risk assoresidents, implement development of prephysician in timely rephysician in timely resident in timely response to the resident of the resident of prephysician in timely resident of the resident of prephysician in timely resident in timel	I, mental, and psychological sident, in accordance with apprehensive resident care properly supervised nursing care shall be provided to each estotal nursing and personal esident.  Dection (a), general nursing at a minimum, the following ed on a 24-hour, basis:  In to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who estout pressure sores does not be unless the individual's imonstrates that the pressure able. A resident having all receive treatment and eshealing, prevent infection, essure sores from developing.  Described and Neglect ese, administrator, employee or neall not abuse or neglect a start are not met as evidenced and the interview and record esiled to do admission and esessments for newly admitted and interventions to prevent the ssure ulcers, and notify manner for treatment orders	S9999			

Illinois Department of Public Health

STATE FORM 6899 IY0K11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		C	
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NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
GARDE	VIEW MANOR		TLIN TILTON E, IL 61834	ROAD		
	A. U. U. J. A.		L, IL 01034			;
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
		ne developement of multiple ure ulcers for R1 and R2.	SECULO DA Constitucione de la constitución de la co			The state of the s
	documents that R1 Retardation, Parkins	Physical dated 11/28/14 has Diagnoses of Mental son's, and Prostate Cancer. the facility on 12-4-14. R1's	,			
	MDS (Minimum Dat 1-1-15 documents to assist of two staff for hygiene, and total as	ta Set) dated 12-11-14 and hat R1 requires extensive or bed mobility and personal ssist of two for transfers. The o documents that R1 is always				
	no skin issues. Prog R1 documents the fi there was a 4.0 x 2. area to right gluteal. shearingSDTI (sus 2.5 x 2.5 x 0.1 cm o coccyxalso right harearight lateral ar	ed 12-9-14 for R1 document gress Notes dated 1/2/15 for ollowing: "Upon assessment 5 x 0.1 cm (centimeter) openlooks similar to spect deep tissue injury)A pen sheared area to eel 3.0 x 4.0 cm black nkle 3.0 x 2.0 cm SDTIleft ark black discolored area."				
	the following pressu acquired: 1/1/15 Cod 1-2-15 Left Lateral A determine (UTD), 1- 0.1, 1-2-15 Right Lateral	g dated 1-4-15 documents re ulcers, stages, and dates ccyx 2.5 x 2.5 x 0.1 stage 2, ankle 3.0 x 2.0 x unable to 1-15 Right Gluteal 4.0 x 2.5 x teral Ankle 3.0 x 2.0 x UTD, x 1.0 x UTD, and 1-2-15 x UTD.				
	which included: turn	ocuments no wound ts were ordered until 1/3/15 and reposition every two				

Illinois Department of Public Health

heels when in bed, apply skin prep to darkened

IIIINOIS L	repartment of Public	nealui	,		·	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6009567	B. WING		1	)8/2015
NAME OF	PROVIDER OR SUPPLIER		DDECC CITY	STATE, ZIP CODE		
NAIVIE OF	PROVIDER OR SUPPLIER		TLIN TILTOI			
GARDE	IVIEW MANOR		E, IL 61834	Y ROAD		
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S9999	Continued From pa	ge 3	S9999			
		nkles and heels, and er cream every shift to the right				
	E2 Director of Nursi	m E1 Administrator (Adm) and ing (DON) both stated that R1 es when he was discharged 1/5/15.				
	Nurse (LPN) stated issues until a few daall of our mattress	pm E3 Licensed Practical, "(R1) didn't have any skin ays before he was discharged are pressure reducing but if was on an air mattress, he				
	stated, "(R1) was no returned to work on areas on heels, butt	m E4 Registered Nurse (RN) of on an air mattresswhen I 1/4/15 (R1) had several open locks, scrotum, ankles(R1) and squirm in bed and chair but position himself."				
	Assistant (CNA) sta (R1) to bed his botto	m E5 Certified Nursing ted, "on 1/2/15 when I put om was really broken down, I reported it to (E3)I hadn't or to that."			To control to the con	
	left side, at the Hosp had been admitted to these wounds" point explained that R1 have right gluteal fold and "gluteal fold is 5 x 3 coccyx is a small state eschar area to his left 100% slough covered	m R1 was laying in bed on his bital. Z3 LPN stated that R1 o them on 1/6/15 and had "all ting to his lower body. Z3 ad just had his dressings to I coccyx done but stated, cm with nectrotic tissue and age 1." R1 had a 3 x 3 cm of theel and 0.75 cm open ad wound to the left lateral m circular eschar area on				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED  C 01/08/2015	
		IL6009567	B. WING		1		
	PROVIDER OR SUPPLIER	STREET AL 14792 CA	DDRESS, CITY, S ATLIN TILTON E, IL 61834				
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\$9999	right lateral ankle, a mid foot, a 1.5 x 2. lateral distal foot, a to the right heel.  No Braden Skin As chart or provided by the chart of the char	a 1 cm eschar area to lateral 0 cm eschar area to the right and a 2 x 4 cm fluid filled blister assessment was found in R1's by the facility.  There was ekly skin assessment cues the nurses that the done, they just didn't do what					

Illinois D	epartment of Public	Health			FORM	APPROVED
AND DUAN OF CORRECTION INTERCATION NUMBERS		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6009567	B. WING		01/0	)8/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GARDENVIEW MANOR		TLIN TILTOI E, IL 61834	N ROAD			
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S9999	Continued From pa	ge 5	S9999			
		also noted, right hip has a 2. 0				
	An admission Braden Scale Assessment dated 12-8-14 was completed and showed R2 as being at moderate risk for skin breakdown. No further Assessments were found in R2's chart or provided by the facility.					
	The Wound Tracking dated 1-4-15 documents that R2 has the following pressure ulcers, stages, and the dates acquired: 8-7-14 right medial ankle 2.0 x 2.0 unstageable, 12-31-14 left heel 4.0 x 3.0 x UTD, and 12-31-14 right heel 1.0 x 1.0 x 0 stage 1.					
	The Physician Current Orders printed 1-8-15 documents that R2 did not have any treatments ordered for the pressure ulcers that R2 had since 8-7-14 on right medial ankle since returning from the hospital on 12-6-14 until 12-24-14. The new pressure ulcers that developed on 12-31-14 on R2's right and left heel didn't have any treatments ordered until 1-3-15.					

STATE FORM