STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	**308 SOUTH SECOND STREET WALNUT, IL 61376**

(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
F 000	INITIAL COMMENTS Annual Certification Survey First Probationary Licensure	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

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WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

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F 157	Continued From page 1	F 157		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to consult the physician and failed to notify a resident's legal representative when physician prescribed medications were unavailable for consecutive doses. This failure effects one of 13 residents (R17) in the sample of 13 and one resident (R22) on the supplemental sample reviewed for medication administration.

Findings include:

1. On 4-8-15, at 9:30am, E9, LPN, stated "(R22's) last dose of Zenpep was Saturday at noon. (R22) also missed Sunday, Monday and Tuesday's doses. The medication just came in at midnight last night. Oh, and I called (R22's) doctor yesterday afternoon to let him know this resident missed all of these doses."

The electronic Medication Administration Record (eMAR) for R22, dated 4-1-15 to 4-30-15, documents that R22 did not receive one evening dose of Zenpep 10000 unit on 4-4-15 or any of the doses on 4-5-15, 4-6-15, or 4-7-15.

R22's Progress Notes, dated 4-4-15, 4-5-15, 4-6-15, 4-7-15, document "eMAR-Medication Administration Note: medication not available."

On 4-9-15, at 12:15pm, E2, Director of Nursing (DON), stated that the staff "should notify the doctor at least the next day after missed doses after calling the pharmacy first."

2. R17's Physician Order Sheet (POS), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 2	F 157		

4/9/15, documents an admission date of 3/2/15 with diagnoses, including Paralysis Agitans. R17's same POS states, "Sinemet Tablet 25-100 milligrams (mg): Give one and a half tablets by mouth in the evening related to Paralysis Agitans; Sinemet Tablet 25-100 mg: Give two tablets by mouth two times a day related to Paralysis Agitans." R17's Electronic Profile, date 4/10/15, documents Z1 (R17's spouse) as Emergency Contact and Durable Power of Attorney (POA).

R17's Electronic Medication Administration Records (eMAR), dated March 2015, documents R17 did not receive prescribed Sinemet medication on March 31, 2015 at 8:00 AM, 12:00 PM, and 5:00 PM and to refer to Progress Note. R17's eMAR, dated April 2015, documents R17 did not receive prescribed Sinemet medication on April 1, 2015 at 8:00 AM, 12:00 PM, and 5:00 PM and to refer to Progress Note.

R17's Progress Notes, dated 3/31/15, documents the following notes: "At 9:05 AM: Type: eMAR-Medication Administration Note: NA (not available); at 12:06 PM: Type: eMAR-Medication Administration Note: NA; at 5:11 PM: Type: eMAR-Medication Administration Note: n/a (not available)." R17's Progress Notes, dated 4/1/15, documents the following notes: "At 8:59 AM: Type: eMAR-Medication Administration Note: not available; at12:26 PM: Type: eMar-Medication Administration Note: not available, pharmacy contacted; at 5:31 PM: Type: eMAR-Medication Administration Note: n/a."

On 4/9/15 at 2:45 PM, Z1 (R17's POA/Spouse) stated, "I didn't know that (R17) didn't receive six doses of Sinemet."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

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F 157	Continued From page 3 On 4/10/15 at 9:40 AM, E2 (Director of Nursing) stated, "I would expect staff to notify family/POA of consecutive missed doses of medication. Especially Sinemet since that medication is significant."	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have the most recent survey results out and available for examination. This failure has the potential to affect all 49 residents in the facility. Upon entering the facility on 4/7/15 at 9:30AM and at 3:00PM, the most recent survey results were not available for examination. On 4/7/15 at 3:00PM, E2 DON (Director of Nursing), went to the central Nursing station, moved a medication cart to the side, reached up above the nursing counter, and grabbed a brown binder with black writing (not easily identifiable) from the chart rack. E2 DON stated the survey book is kept at the nurses desk but the facility	F 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

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F 167	Continued From page 4 has a resident that takes the book so the staff puts it higher up on the desk in the chart rack. Facility Census and Condition Report, dated 4/7/15, lists 49 residents in the facility.	F 167		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to recognize and follow up on an elevated blood pressure reading for one resident (R9) of 12 residents reviewed for blood pressures in a sample of 13. Findings include: A computer generated weights and vitals summary list, dated 4/9/15, documents R9's blood pressure on 4/2/15 at 6:52PM as 209/117 while R9 was sitting and blood pressure was taken on the right arm. R9's weights and vitals summary was reviewed from 1/29/15 through the last documented entry on 4/2/15 at 6:52PM. The summary documents R9's regular blood pressure is between 124/60 and 141/60. Review of R9's progress notes, from 4/1/15 through 4/9/15, did not document notification of the doctor on R9's	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

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F 309	Continued From page 5 elevated blood pressure reading of 209/117 on 4/2/15 at 6:52PM. On 4/9/15 at 12:20PM, E2 [DON (Director of Nursing)] stated (E2) would expect staff to notify the doctor of the elevated blood pressure of 209/117 on R9. E2 DON also stated (E2) would expect staff to follow up because a blood pressure of 209/117 would be considered a change of condition for R9.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to wash hands between tasks prior to plating and serving food, failed to wear hairnets in a manner that kept all hair restrained, and failed to keep exposed pipes in the kitchen free from dirt, dust, and excessive debris buildup. These failures have the potential to affect all 49 residents living in the facility at the time of this survey. Findings include:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

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F 371	Continued From page 6 1. On 4/8/15 at 11:20 AM, E15 (Dietary Cook) stepped away from food preparation/food service area, opened a cabinet to retrieve a plastic spoon, and returned to the food preparation area to stir baked beans cooking on the range without washing hands. On the same date at 11:25 AM, E15 stepped away from food service area, grabbed a bucket filled with sanitizer and emptied the contents of the bucket in a nearby sink. E15 then walked to the three compartment sink to refill the bucket with fresh sanitizing solution. After completing this task, E15 returned to the food service area and started plating resident food without washing hands. On 4/8/15 at 11:50 AM, E17 (Dietary Manager) came into the kitchen preparation area and scooped a serving of potato salad from a bulk potato salad container to serve to a resident requesting potato salad. E17 did not wash hands immediately upon enter the kitchen, prior to serving a portion of potato salad. On 4/8/15 at 12:00 PM, E15 stated, "I should wash my hands when changing jobs in the kitchen. I should have washed my hands prior to starting to serve food." On 4/8/15 at 12:00 PM, E17 stated, "Hands should be washed prior to serving food." 2. On 4/8/15 at 11:20 AM, E16 (Dietary Aide) walked into the kitchen and E16's bangs were not secured under a hair restraint. The facility uses the [State] Food Administrative Code regulations as policy for hair restraint use which requires employees to use effective hair	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 7 restraints designed and worn to effectively keep hair from contacting food. On 4/8/15 at 12:00 PM, E17 (Dietary Manager) stated, "All hair should be covered using the hairnet or hair restraint." 3. On 4/8/15 at 12:00 PM, exposed pipes behind the range and oven had excessive dust, dirt and debris buildup. The food service holding tables are located near these pipes and room trays were being plated and placed on a rolling cart located directly next to the excessively dirty pipes. On 4/9/15 at 10:20 AM, E17 (Dietary Manager) verified that there was no policy with instructions for cleaning the pipes behind the range and oven. At this time, E17 also stated, "It is the dietary staffs responsibility to keep those pipes clean. I cannot remember the date we last cleaned the pipes because we do not have a cleaning log for the pipes. Those pipes should be kept clean because we serve food nearby, and we keep prepared/plated food and drinks close by. The Centers for Medicare and Medicaid form, 672, "Resident Census and Conditions of Residents," dated 4/7/15, documents 49 residents live in the facility.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 8	F 425		

supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure medications were available for nine (R1, R6, R10, R13, R14, R16, R17, R18, R20) of twelve residents reviewed for availability of physician prescribed medications in a sample of thirteen and one on the supplemental sample (R22).

Findings include:

The facility's Medication Administration policy, dated 1-11-10, documents "Missed doses of medication...In such cases, the facility will notify the contracted back up pharmacy or resident family for provision to the facility."

On 4-9-15, at 11:10am, E12, Licensed Practical Nurse (LPN), stated "(We) have a hard time getting medications sometimes with this pharmacy."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 9	F 425		

On 4-9-15, at 12:15pm, E2, Director of Nursing (DON), stated "(the pharmacy) should be called for each missing medication, if no medication available then call the back-up pharmacy."

1. On 4-7-15, at 12:10pm, during medication administration, R22 did not receive a Zenpep Delayed Release 10000 unit capsule as ordered.

On 4-7-15, at 12:10pm, E9, Licensed Practical Nurse (LPN), stated that R22 will not be getting R22's Zenpep due to medication not being available.

R22's Physician Order Statement (POS), dated 4-1-15, documents that R22 is to receive "Zenpep capsule Delayed Release Particles 10000 unit three times a day for Acute Pancreatitis."

On 4-8-15, at 9:30am, E9, LPN, stated "(R22's) last dose of Zenpep was Saturday at noon. (R22) also missed Sunday, Monday and Tuesday's doses. The medication just came in at midnight last night."

The electronic Medication Administration Record (eMAR) for R22, dated 4-1-15 to 4-30-15, documents that R22 did not receive one evening dose of Zenpep 10000 unit on 4-4-15 nor any of the doses on 4-5-15, 4-6-15, or 4-7-15.

R22's Progress Notes, dated 4-4-15, 4-5-15, 4-6-15, 4-7-15, document "eMAR-Medication Administration Note: medication not available."

2. R18's POS, dated 4-1-15, documents the order "Norco tablet 5-325mg (Hyrocodone-Acetaminophen) give one tablet orally two times a day for Unspecified Arthropathy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 10	F 425		

multiple sites and Generalized Osteoarthrosis."

The eMAR for R18, dated 1-1-15 to 1-31-15, documents that R18 did not receive any doses of Norco 5-325mg on 1-18-15, 1-19-15, and 1-20-15.

R18's Progress Notes, dated 1-18-15, 1-19-15, 1-20-15, document "eMAR-Medication Administration Note: medication not available."

3. R6's POS, dated 4-1-15, documents the orders "Depakote Sprinkles Capsule 125mg give two capsules by mouth in the evening related to Dementia; Ativan tablet(Lorazepam) give 0.25 mg by mouth every 12 hours for anxiety related to Dementia; Metamucil Powder 28.3% give 15cc (cubic centimeters) by mouth with meals; Aricept tablet 5mg (Donepezil HCL) give one tablet by mouth at bedtime related to Dementia."

The eMAR for R6, documents on 12-28-15, R6 did not receive any dose of Depakote; on 1-7-15, R6 did not receive the evening dose of Ativan; R6 did not receive Metamucil on 1-16-15 with evening meal nor on 2-18-15 with breakfast or evening meals, and on 3-12-15 R6 did not receive any dose of Aricept.

R6's Progress Notes, dated 12-28-15, 1-7-15, 1-16-15, 2-18-15, and 3-12-15, document "eMAR-Medication Administration Note: medication not available."

4. R10's POS, dated 4-1-15, documents the orders "Lumigan Solution 0.01% (Bimatoprost) instill one drop in both eyes at bedtime related to Glaucoma; Multivital-M Tablet (Multiple Vitamins-Minerals) give one table by mouth in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 11	F 425		

morning related to Mineral Deficiency."

The eMAR for R10, documents on 1-2-15 and 2-19-15, R10 did not receive any Lumigan Solution eye drops; on 3-13-15 and 3-14-15, R10 did not receive any dose of Multiple Vitamin-Minerals.

R10's Progress Notes, dated 1-2-15, 2-19-15, 3-13-15 and 3-14-15, document "eMAR-Medication Administration Note: medication not available."

5. The POS/Physicians Order Sheet for R16, dated 4/2/15, documents the following orders for R16: "Aspirin 81mg/milligrams by mouth in the morning related to Chronic Ischemic Heart Disease; Benefiber Powder give 10cc (cubic centimeters) by mouth in the morning related to Constipation; Cholecalciferol 2000 units by the mouth in the morning related to muscle weakness; Cyanocobalamin 500 mcg (micrograms) by mouth in the morning related to muscle weakness; Ferrous Sulfate 65mg by mouth in the morning related to Anemia; Folic Acid 1mg by mouth in the morning related to Ischemic Heart Disease; Glimepiride 2mg by mouth two times a day related to Diabetes; Humalog Solution Inject 8units (if blood sugar over than 120 subcutaneously with meals related to Diabetes; Lisinopril 2.5mg by mouth in the morning related to Ischemic Heart Disease; MetFormin HCl 500mg by mouth two times a day related to Diabetes; Oxybutynin 5mg by mouth two times a day related to Chronic Kidney Disease; Plavix 75mg by mouth in the morning related to Chronic Ischemic Heart Disease.

The eMAR/electronic Medication Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 12	F 425		

Record for R16, dated 4/3/15 documents R16 did not receive any of the above physician ordered medications at 8:00am and did not receive the 4:00 pm dose of Glimeperide, MetFormin or Oxybutynin.

The Progress Notes for R16, dated 4/3/15 documents "eMAR Note: no/supply."

6. The POS/Physicians Order Sheet for R20, dated 3/7/15, documents R20 to receive Levofloxacin 500mg/milligrams by mouth in the morning related to UTI/Urinary Tract Infection. The POS, dated 3/19/15, documents R20 to receive Rifampin 300mg twice daily x(times) 10 days related to UTI. The POS, dated 3/29/15, documents R20 to receive Bactrim DS 800-160mg twice daily x 10 days related to UTI.

The eMAR/electronic Medication Administration Record for R20, dated 3/7/15 documents R20 did not receive the physician ordered Levofloxacin. The eMAR, dated 3/19/15 documents R20 did not not receive the physician ordered Rifampin. The eMAR, dated 3/29/15 documents R20 did not receive the physician ordered Bactrim DS.

The Progress Notes for R20, dated 3/7/15, 3/19/15 and 3/29/15, documents "eMAR Note: Not available."

7. R17's POS, dated 4/9/15, documents an admission date of 3/2/15 with the following diagnoses: Aftercare involving Internal Fixation Device, Closed Fracture of Shaft of Fibula with Tibia, Paralysis Agitans, Abnormality of Gait, Muscular Wasting and Disuse Atrophy, Essential Hypertension, Depressive Disorder, Osteoporosis, Hypertrophy Prostate without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 13	F 425		

obstruction, Urinary Frequency, Constipation, Hyperlipidemia and Iron Deficiency Anemia.

R17's POS, dated 4/9/15, states orders as follows "Aspirin Tablet: Give 325 mg by mouth in the morning related to Essential Hypertension; Aspirin Tablet: Give 81 mg by mouth in the morning related to Essential Hypertension; Calcium - Vitamin D Tablet 600-200 mg/unit: Give one tablet by mouth in the morning related to Osteoporosis; Catapres patch weekly 0.1 mg/24 hours: Apply one patch transdermally in the morning every Tuesday related to Essential Hypertension; Colace Capsule 100 mg: Give one capsule by mouth two times a day related to Constipation; Ditropan Tablet Extended Release 24 hour 5 mg: Give one tablet orally at bedtime related to Urinary Frequency; Divalproex Sodium Extended Release Tablet 500 mg: Give 500 mg by mouth at bedtime related to Paralysis Agitans; Entacapone Tablet 200 mg: Give 200 mg by mouth at bedtime related to Paralysis Agitans; Fergon Tablet 240 mg: Give one tablet by mouth in the morning related to Iron Deficiency Anemia; Flomax Capsule 0.4 mg: Give one capsule by mouth at bedtime related to Hypertrophy Prostate; Fludrocortisone Acetate Tablet 0.1 mg: Give one tablet by mouth at bedtime related to Essential Hypertension; Imipramine Hydrochloride 50 mg: Give 100 mg by mouth at bedtime related to Depressive Disorder; Iron Tablet: Give 27 mg by mouth in the morning related to Aftercare Involving Internal Fixation Device; Lisinopril Tablet 20 mg: Give 20 mg by mouth at bedtime related to Essential Hypertension; Multivitamin Capsule: Give one tablet by mouth in the morning for multivitamin; Simvastatin Tablet 80 mg: Give 80 mg by mouth at bedtime related to Hyperlipidemia; Sinemet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 14	F 425		

25-100 mg: Give one and a half tablets by mouth in the evening related to Paralysis Agitans; Sinemet 25-100 mg: Give two tablets by mouth two times a day related to Paralysis Agitans; Zoloft Tablet 100 mg: Give 100 mg by mouth at bedtime related to Depressive Disorder.

On 3/2/15, R17's eMAR documents R17 did not receiving bedtime doses of Diavalproex, Flomax, Fludrocortisone Acetate, Imipramine Hydrochloride, Lisinopril, Simvastatin, Zoloft, Sinemet, Colace, and Entacapone.

R17's Progress Notes, dated 3/2/15, documents the medications were not available.

On 3/3/15, R17's eMAR documents R17 did not receive the following medications: Aspirin, Calcium - Vitamin D Tablet, Catapres patch, Flomax, Iron Tablet, Lisinopril, Multivitamin, Zoloft, and both doses of Colace.

R17's Progress Notes, dated 3/3/15, documents the medications were not available.

On 3/8/15, R17's eMAR documents R17 did not receive morning doses of Calcium - Vitamin D Tablet, Fergon, Multivitamin, and Colace.

R17's Progress Notes, dated 3/8/15, documents the medications were not available.

On 3/25/15 and 3/26/15, R17's eMAR documents R17 did not receive bedtime dose of Ditropan.

R17's Progress Notes, dated 3/25/15 and 3/26/15, documents the medication was not available due to "no supply."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 15	F 425		

On 3/31/15 and 4/1/15, R17's eMAR documents R17 did not receive six consecutive doses of Sinemet.

R17's Progress Notes, dated 3/31/15 and 4/1/15, documents the medication was not available.

R17's eMAR documents that on 4/3/15 R17 did not receive morning dose of Aspirin, and on 4/7/15 R17 did not receive weekly Catapres patch.

R17's Progress Notes on 4/3/15 and 4/7/15 documents both medication were not available.

On 4/9/15 at 12:35 PM, E2 (DON) stated, "If (R17) medications are not documented as being given on the eMAR or in Progress Notes, then the medication was not given. My belief is: no documentation; task not complete."

8. R14's POS, dated 4/9/15, documents a diagnosis of Depressive disorder with an order for "Wellbutrin 75 milligrams (mg): Give 75 mg by mouth
two times a day related to Depressive Disorder.

R14's eMar, dated 3/2015, documents that on 3/5/15 at 8:00 PM and 3/12/15 at 8:00 AM, R14 did not receive prescribed Wellbutrin medication.

R14's Progress Notes, dated 3/5/15 at 8:16 PM and 3/12/15 at 9:25 AM, documents the medication was not available.

9. R1's POS, dated 4/9/15, documents a diagnosis of Chronic Pain with an order for "Norco Tablet 5-325 milligrams (mg): Give one tablet by mouth four times a day related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 425	Continued From page 16 Chronic Pain." R1's eMar, dated 3/2015, documents that on 3/5/15, R1 did not receive prescribed Norco medication on 3/5/15 at 12:00 PM and to refer to Progress Note. R1's Progress Note, dated 3/5/15, documents the following note: "At 11:56 PM: Type: eMar-Medication Administration Note: medication not available from pharmacy." 10.) R13's MAR (Medication Administration Record), dated 9/1/14 through 9/30/14, documents R13's "Zyprexa Tablet 15MG (Olanzapine) give 7.5mg orally in the morning related to Dementia" and "Zyprexa Tablet 15MG (Olanzapine) give 7.5mg orally at bedtime related to Dementia." On 9/4/14, R13's MAR documents R13 did not receive Zyprexa at 8AM or 8PM, and documents "code 7=refer to Progress Notes." R13's Progress Notes dated 4/9/15, documents on 9/4/14 at 9:41AM "unavailable" and 9/4/14 at 7:10PM "no/supply. " R13's (POS) Physician Order Sheet dated 9/1/14 through 9/30/14, documents R13 has the diagnoses of Dementia (unspecified, with behavior disturbance), and Alzheimers.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 441	Continued From page 17	F 441		

safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 441	Continued From page 18	F 441		

cross-contamination during incontinence care for three (R6, R10, and R14) of four residents reviewed for infection control in a sample of 13.

Findings include:

The facility policy Glove Use, dated 3-1-10, documents "Non-sterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident. Wash hands after removing gloves. Disposable (single-use) gloves should be replaced as soon as practical when contaminated..."

The "Incontinent Care" policy, revised 8/27/12, documents "Using a clean part of the wash cloth, cleanse downward from front to back or top to bottom...Remove gloves and complete hand hygiene...Front to back or top to bottom motion is to keep stool or rectal contamination away from urinary meatus. This will decrease the chance of a urinary tract infection."

1. On 4-7-15, at 1:20pm, E6 and E7, Certified Nursing Assistants (CNA), provided incontinence care for R6. E6, Certified Nursing Assistant (CNA) cleansed stool from R6's back side then with the same contaminated gloves touched the bath basin, mechanical lift, and R6's arm. During R6's incontinence care, E7, CNA, was handed the contaminated wash cloth. With the same contaminated gloves, E7 touched the linen bag, R6's belt, bed linens, bed positioning controller, and R6's body.

On 4-7-15, at 1:42pm, E6, CNA, stated that E6 should have "changed gloves after cleaning dirty area before moving to next area...I forgot and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 441	Continued From page 19 skipped a step." 2. On 4-8-15, at 10:30am, E8, CNA, without gloves, transferred R10 to bedside commode then removed R10's urine saturated incontinence pad. On 4-8-15, at 11:00am, E8, CNA, stated "I should have never touched the incontinence pad without gloves on." 3. On 4/8/15 at 2:35 P.M., E10 (CNA) and E11 (CNA) performed incontinence care on R14. E10 wiped R14's groins with a wet washcloth. Using the same area of the washcloth, E10 wiped R14's perineal area starting at the back and wiping towards the front. E10 then removed gloves. Without washing hands prior, E10 reached into E10's pocket, pulled out a new pair of gloves, and then placed gloves on. E10 wiped R14's groins and then wiped R14's perineal area starting at the back and wiping towards the front. E10, again, removed gloves, reached into E10's pocket for a new pair of gloves without washing hands prior. E10 then wiped R14's rectal area. E10 removed gloves, and then reached into E10's pocket for a new pair of gloves, without washing hands prior. On 4/8/15 at 2:55 P.M. E10 stated, "I should have washed my hands before changing gloves each time. Also, I normally would have wiped front to back."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 514	Continued From page 20	F 514		

standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to transcribe physician ordered medications for two of 13 residents (R9 and R16) reviewed for physician prescribed medications in the sample of 13.

Findings include:

1. The face Sheet for R16 documents that R16 was admitted to the facility on 4/2/15.

A local hospital "Medication Discharge Report," dated 4/2/15, documents that a printed prescription for "pantoprazole (Protonix 40 mg/milligrams oral delayed release tablet) 1 TAB, by mouth, once a day."

A local hospital prescription for R16, dated 4/2/15, documents R16 to receive "Protonix 40 mg oral delayed release tablet, 1 tab orally daily."

EGD/Esophagogastroduodenoscopy (diagnostic procedure that allows the physician to diagnose and treat problems in the upper gastrointestinal tract) report, dated 4/2/15, documents R16 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 514	Continued From page 21	F 514		

"very mild gastritis".

The MAR/Medication Administration Record, dated 4/1/15 through 4/30/15 does not list Protonix as a medication for R16 since admission.

The facility Progress Notes, dated 4/8/15, documents R12/LPN (Licensed Practical Nurse) received a physicians order to discontinue R16's Protonix due to "no diagnosis to support use."

On 4/9/15 at 11:45 am, E 12/LPN confirmed that R16 had a prescription for Protonix, dated 4/2/15 and that the Protonix was included on the local hospital "Medication Discharge Report" for R12 to begin on admission to the facility. E12 stated the Protonix order was not processed on admission and was probably just overlooked. E12 also stated (E12) called R16's primary care physician and received the order to discontinue R16's Protonix use on 4/8/15 after (E12) was informed that the medication had not been processed upon admission.

On 4/9/15 at 12:15 pm, E2 DON/Director of Nursing stated (E2) not processing a physicians order is consider a medication error and would be treated as such. E2 also stated a medication error report would follow the Protonix not being processed.

2. R9's Medication Review Report, dated 4/9/15 at 11:51AM, documents R9 as taking "Zoloft Tablet 50MG (milligram) (Sertraline HCL) Give 50mg by mouth in the morning...Order Date 4/7/15....and Start Date 4/8/15." R9's Psychotropic Medication Consent form dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146063	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT MANOR	308 SOUTH SECOND STREET WALNUT, IL 61376

(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
F 514	Continued From page 22	F 514		

4/8/15, documents verbal consent for Zoloft 50mg daily from Z1 (R9's Power of Attorney) by E12 LPN (Licensed Practical Nurse).

R9's MAR (Medication Administration Record), dated 4/1/15 through 4/30/15, documents R9 was administered Zoloft 50MG at 8AM on 4/8/15; and on 4/9/15 at 8AM, Zoloft 50MG was documented as refer to Progress Notes. R9's Progress Notes, dated 4/9/15 at 11:52AM, documents on 4/9/15 at 9:56AM eMAR (electronic Medication Administration Record) as "na" by E14 LPN.

On 4/9/15 at 12:55PM, E14 (LPN), stated (E14) was unable to find R9's Zoloft for 4/9/15 at 8AM; and the documentation in the eMAR of "na" means the medication is "not available."

On 4/9/15 at 11:10AM, E12 (LPN), stated (E12) obtained verbal consent for R9's Zoloft from Z1 (R9's Power of Attorney). E12 (LPN) also stated, the facility pharmacy never sent the drug last night (4/8/15) so the Zoloft has not been started yet on R9.

On 4/9/15 at 1:35PM, E12 (LPN), stated R9 did not have an order for Zoloft 50MG, and that it was entered on the wrong chart for R23. E12 (LPN) also stated, the MAR for R9 on 4/8/15 that documents R9 was administered Zoloft 50MG at 8AM was an error in documentation by E9 (LPN) because the medication is unavailable. E12 (LPN) also stated (E12) doesn't know how the MAR's are monitored for accuracy.