

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145598</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEMINARY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2345 NORTH SEMINARY STREET</b> <b>GALESBURG, IL 61401</b>		
(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	F 000			
F 246 SS=D	<p>Original Complaint Investigation #1526823/IL82153</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accommodate a residents right to smoke cigarettes for one of three residents (R1) reviewed for improper nursing care in the sample of three.</p> <p>Findings include:</p> <p>A Smoking Policy dated 7/2012, documents "In order to protect the health and safety of our residents, staff, and visitors, it is a policy of this facility that there will be no smoking inside the facility by residents, staff, or visitors. Areas are designated outside of the facility for smoking. When a resident chooses to smoke outside the facility in the designated smoking area, smoking by residents classified as not responsible shall be prohibited, except when under direct supervision."</p> <p>A Progress Note dated 10/29/15, documents "informed (R1) and (R1's daughter) that (R1) will</p>	F 246			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145598</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEMINARY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2345 NORTH SEMINARY STREET</b> <b>GALESBURG, IL 61401</b>		
(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 246	Continued From page 1  no longer be allowed to smoke as facility policies are not being followed. Discussed with (R1's daughter) the decision to find other placement for (R1).  On 12/21/15 at 9:18 a.m., Z3 (R1's family member) stated R1 is no longer allowed to smoke cigarettes at the facility unless a family member is there to take R1 outside. Z1 stated R1 has never harmed herself smoking and is not a risk to hurt others when smoking. Z3 stated R1's smoking privilege was taken away because R1 was not putting "cigarette butts" in the ashtray.  On 12/22/15 at 1:45 p.m., E1 (Administrator) stated R1's smoking privileges were taken away because R1 "was not following the rules." E1 stated "(R1) was flicking cigarette butts on the ground and not always turning cigarettes back in to the nurse when coming inside." E1 stated R1 has never smoked inside the building. E1 stated R1 has never been burned when smoking or placed anyone at risk. E1 stated at one point R1 was provided staff supervision while smoking but that is no longer happening. E1 stated "(the facility) is not going to do that. (R1) will need to find a new facility." E1 stated there are no documented rules for resident smoking.  On 12/22/15 at 11:30 a.m., R1 stated "I'm not very happy" about no being able to smoke when I want to. R1 stated R1 can smoke independently but the facility will not allow it.	F 246			
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	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145598</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEMINARY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2345 NORTH SEMINARY STREET</b> <b>GALESBURG, IL 61401</b>		
(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 309	<p>Continued From page 2</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide timely interventions for a shoulder injury for one of three residents (R1) reviewed for improper nursing care in the sample of three.</p> <p>Findings include:</p> <p>A current computer generated face sheet, documents R1 was admitted on 12/6/08 and has diagnoses which include, Spinal Stenosis, Major Depressive Disorder, Anxiety Disorder, and Osteoporosis.</p> <p>On 12/22/15 at 11:30 a.m., R1 was lying in bed with a sling supporting R1's right arm. R1's right shoulder had noted deformity.</p> <p>A Progress Note dated 11/12/15 at 8:35 a.m., documents R1 fell to the floor attempting to transfer self from wheelchair to bed independently without locking wheelchair brakes. No injuries were noted.</p> <p>A Progress Noted dated 11/15/15 at 12:02 p.m., documents R1's daughter reported that R1 has had increased pain in right shoulder since R1 fell on 11/12/15. "Upon asking (R1) if (R1) had increased or abnormal pain from fall, (R1) denied</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145598</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEMINARY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2345 NORTH SEMINARY STREET</b> <b>GALESBURG, IL 61401</b>		
(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 309	<p>Continued From page 3</p> <p>new pain from fall but does state that pain has been worse." A Progress Note dated 11/15/15 at 12:30 p.m., documents R1 experienced pain when performing range of motion.</p> <p>Progress Notes dated 11/16/15 through 12/14/15, do not document any further information regarding R1's right shoulder pain.</p> <p>A Progress Note dated 12/14/15 at 1:49 p.m., documents a physician order was received for right shoulder X-ray due to R1 "continuing to (complain of) pain to (right) shoulder."</p> <p>A Radiology Report dated 12/15/15, documents R1 had a right anterior shoulder dislocation. On 12/15/15 at 10:15 a.m., R1's physician was notified of right shoulder dislocation and new orders were received to refer R1 to an Orthopedic specialist.</p> <p>A Progress Note dated 12/18/15, Z4 (R1's Orthopedic Specialist) documents R1 has a "chronic dislocation of right shoulder."</p> <p>On 12/22/15 at 12:54 p.m., Z4 stated R1's "chronic" shoulder dislocation is potentially more than a few weeks old." Z4 stated the dislocation would have been caused by trauma such as a fall. "I don't know exactly how old the dislocation is, there is no way to tell." Z4 also stated R1's right shoulder had noted deformity and "did not look or act like a normal shoulder." Z4 stated R1's shoulder dislocation could have been from R1's fall on 11/12/15.</p> <p>On 12/21/15 at 9:18 a.m., Z3 (R1's family member) stated R1's right shoulder had been hurting since early November. Z3 stated I</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145598</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEMINARY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2345 NORTH SEMINARY STREET</b> <b>GALESBURG, IL 61401</b>		
(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 309	Continued From page 4 reported it to multiple nurses and nothing was done about it. Z3 stated Z3 went to the facility "and had to throw a fit" to finally get something done on 12/14/15. Z3 stated on 12/14/15, E1 "tried to tell me it (R1's right shoulder) had already been looked at there was nothing wrong with it. Z3 stated E1 was not correct and an x-ray had not been done.	F 309			