

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

PRINTED: 02/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>146108</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANOR COURT OF PEORIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6900 NORTH STALWORTH</b> <b>PEORIA, IL 61615</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 314 SS=D	<p>Original investigation of complaint 1320930/IL62006</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to assist one of five sampled residents (R1) off of a bedpan for over two hours.</p> <p>Findings include:</p> <p>On 3/14/13 at 10:20 A.M. Z1 (R1's daughter) stated that on the evening of 3/2/13 R1 had called Z1 and told her that no one would answer R1's call light. Z1 stated that she then went to the facility and arrived there at 12:45 A.M. R1 was in pain and found to be on a bedpan. Z1 said that after talking to staff, Z1 found out that R1 had been on the bedpan since 10:25 P.M. This was 2 hours and 20 minutes. Z1 said that when they took R1 off the bedpan, R1 had a new open area on her buttocks. Z1 stated that R1 was transferred to another facility on 3/5/13.</p>	F 314		4/12/13	

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.

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F 314	<p>Continued From page 1</p> <p>On 3/29/13 at 11:10 A.M. E4 (Certified Nurse's Aide) confirmed that on 3/2/13 R1 was placed on the bed pan at 10:25 P.M.. E4 stated that second shift staff passed on the information to third shift staff at 10:30 P.M., but third shift must have forgotten to take R1 off the bedpan.</p> <p>Nursing Admission form from facility R1 was transferred to on 3/5/13 notes a four centimeter by 1 centimeter open area on R1's buttocks.</p> <p>On 3/14/13 at 2:05 P.M. Z2 (Licensed Practical Nurse) at facility R1 was transferred to, stated that the open wound on R1's buttocks looks as if it was caused by a bedpan.</p> <p>On 3/14/13 at 2:15 P.M. R1 stated that on the night of 3/2/13 she remembers being left on the bedpan for a long time. R1 remembered being in a lot of pain and calling her daughter for help. R1 stated that she called her daughter because the staff would not answer her call light.</p>	F 314			