STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEKIN MANOR	1520 EL CAMINO DRIVE PEKIN, IL 61554

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop care plans for hospice services (R5 and R7) and oxygen therapy (R5 and R8) and failed to implement pressure relieving interventions (R6) for four of eight residents (R5, R6, R7, R8) reviewed for care plans on the sample list of 14. Findings include: 1. On 1/29/20, V27, R5's Physician, ordered, Hospice to evaluate and treat continuous. This order was received and verified by V28, Licensed Practical Nurse. Hospice Services for R5 began on 1/30/20 per the Resident Census Payer Change Report and Hospice Services documentation. R5's Care Plan, last reviewed/revised on 1/07/20, does not have a plan of care (Problem, Goal, Approach) for Hospice. On 3/04/20 at 2:44 PM, V24, Care Plan Coordinator and Wound Nurse, stated, No, R5 does not have a care plan for Hospice. It needs to be in the care plan. On 3/05/20 at 8:15 AM, V1, Administrator, confirmed that R5 did not have a Care Plan for Hospice. 2. On 1/09/20 V27, R7's Physician, ordered, Hospice to evaluate and treat for [MEDICAL CONDITION]. This order was received and verified by V24, Care Plan Coordinator and Wound Nurse on 1/09/20. Hospice Services for R7 began on 1/10/20 per the Resident Census Payer Change report and Hospice Services documentation. R7's Care Plan, last reviewed/revised on 12/09/19, does not have a plan of care (Problem, Goal, Approach) for Hospice. On 3/04/20 at 2:50 PM, V24, Care Plan Coordinator and Wound Nurse, stated, No, Hospice is not care planned for R7. It should be in the care plan. On 3/05/20 at 8:15 AM, V1, Administrator, confirmed that R7 did not have a Care Plan for Hospice. 3. On 2/06/20, V27, R5's Physician, ordered, Two to four liters of Oxygen via Nasal Cannula, pro re nata (PRN), for shortness of breath. This order was received and verified by V3, Licensed Practical Nurse on 2/06/20. R5's Care Plan, last reviewed/revised on 1/07/20 does not have a plan of care (Problem, Goal, Approach) for oxygen. On 3/04/20 at 2:44 PM, V24, Care Plan Coordinator and Wound Nurse, stated, No, Oxygen is not in the care plan. It should have been added when it was ordered. 4. R8's medical record documents: Diagnosis: [REDACTED]. R8's medical documents: orders, Tirtrate O2 (oxygen) for SpO2 (peripheral capillary oxygen saturation) > (greater than) 90%. Twice A Day, start date: 2/26/2019. On 3/3/2020 at 8:15 AM and 3/4/2020 at 9:45 AM, R8 was upright in wheelchair with two liters of oxygen infusing per nasal cannula . R8's medical record did not contain a care plan for oxygen therapy use. On 3/4/2020 at 2:50 PM, V24, Care Plan Coordinator, stated, (R8) does not have a care plan for oxygen use. 5. R6's care plan, with a revision date of [DATE], documents, Problem: (R6) is at increased risk for pressure injury R/T (related to) decreased mobility, generalized muscle weakness. Approach: wash clothes fitted in both hands. R6's MDS (Minimum Data Set) assessment, dated 12/3/2019, documents: impairment to upper extremities, both sides. On [DATE] at 10:00 AM, 11:45 AM, and 1:50 PM, and on 3/3/2020 at 9:45 AM, 11:00 AM, and 1:30 PM, R6 was without fitted wash clothes to bilateral hands. On 3/4/2020 at 9:50 AM, R6 was up in wheelchair and V21 (Certified Nursing Assistant) was pushing R6's chair into R6's room. R6 did not have wash clothes fitted in bilateral hands. V21 C.N.A stated, I think (R6) does need washcloths in (R6's) hands but I don't know if they have been doing that recently. The facility's policy, with a revision date of 11/28/19, titled Care Plan Policy documents, Policy: It is the policy of this facility to develop and implement a Base Line Care Plan a Comprehensive Person-Centered Care plan and conduct care plan meetings as appropriate for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 11. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. The facility's policy, dated December 2018, titled Oxygen Therapy and Safety documents, Policy: It is the policy of this facility to provide a safe environment for residents, staff and the public. Procedure: j: Address use of oxygen in Care Plan.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide and maintain pressure relieving boots for one (R4) of three residents reviewed for pressure relieving boots in a sample of 14. Findings: The policy Pressure Ulcer Informational Acknowledgement, dated 2/23/18, states, All residents admitted to this facility are assessed for the risk of skin breakdown. Interventions to prevent the development of pressure injuries are implemented for resident's assessed as moderate or high risk. The 2/25/20 Minimum Data Set, Section M, states that R4 is at risk of developing Pressure Ulcers/Injuries. The document Wound Evaluation and Management Summary, dated 1/31/19, states, R4 has an unstageable deep tissue Injury of the left, distal, medial foot of at least seven days duration. There is exudate. Prior healing wound has improved and requires confirmation of current clinical status and evaluation with preventive recommendations to prevent recurrence, signed by V25, Wound Physician. The document Wound Evaluation and Management Summary, dated 10/18/18, states, R4 has an unstageable deep tissue injury of the left, distal, medial foot of at least eight days duration. There is no exudate. There is no indication of pain associated with this condition, signed by V25, Wound Physician. On 7/29/19, V27, R4's Physician order [REDACTED]. This was received and verified by R29, Licensed Practical Nurse. R4 did not have pressure relieving boots on R4's feet when observed on 3/02/20 - 3/04/20. R4 is unable to verbalize when she has last worn the pressure relieving boots. V26, R4's Health Power of Attorney, confirmed that R4 did not have the pressure relieving boots on her feet on 3/02/20 at 12:00 PM. V26 could not remember seeing the pressure relieving boots on R4's feet. V7, Registered Nurse, confirmed that R4 was not wearing the pressure relieving boots on R4's feet on 3/03/19 at 2:20 PM. V7 could not find the pressure relieving boots in R4's room. V7 also confirmed that the pressure releasing boots were not on R4's feet on 3/04/20 at 10:30 AM. On 3/04/20 at 2:44 PM, R24, Wound and Care Plan Coordinator, stated, that R4 does not have any pressure ulcers at this time, but R4 did have pressure ulcers on her feet that are healed. The order for the pressure relieving boots is an active order. V24 states, I talked with V7, Registered Nurse, about R4's pressure relieving boots. R7 said that a previously employed nurse told the staff that since the pressure ulcers on R4's feet had healed that R4 no longer needed to wear the pressure relieving boots. It's been months since R4 has worn the pressure relieving boots. The pressure relieving boots protect the feet, are very soft and were helpful in the healing process. They are also a preventative measure against getting pressure ulcers. The pressure relieving boots should have been put on R4 since the physician ordered them.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer narcotic pain medication as ordered

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 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) by the physician for one of four residents (R9) reviewed for medication administration on the sample list of 14. This failure resulted in (R9) experiencing inadequate pain control. Findings include: V9's medical record documents, Orders: Buprenorphine HCl ([MEDICATION NAME]) - Schedule III (narcotic, pain medication) tablet, sublingual; amt (amount) 2 mg (milligrams); sublingual, twice a day at 7:00 AM - 10:00 AM and 7:00 PM - 10:00 PM. Diagnosis: [REDACTED]. On 3/3/2020 at 8:40 AM, V9, Licensed Practical Nurse (LPN), placed Buprenorphine 2 mg (milligram) tablet in a medication cup and added applesauce to the medication cup. V9, LPN, then administered the Buprenorphine 2 mg tablet with the applesauce to R9. V9 swallowed the medication/ applesauce immediately after administration. Buprenorphine package insert, with a revision date of February 2018, documents, Method of Administration (Buprenorphine) must be administered whole. Do not cut, chew, or swallow (Buprenorphine). Advise patients not to eat or drink anything until the tablet is completely dissolved. (Buprenorphine) should be placed under the tongue until it is dissolved. The patients should continue to hold the tablets under the tongue until they dissolve; swallowing the tablets reduces the bioavailability of the drug. On 3/3/2020 at 10:25 AM, V9, Licensed Practical Nurse, confirmed R9 did not place Buprenorphine 2mg (milligram) under tongue (sublingual) for administration. V9, LPN, stated R9 swallowed all medications (including Buprenorphine) whole in applesauce this morning. On 3/3/2020 at 2:15 PM, V17, Pharmacist, stated, Buprenorphine's package insert states, sublingual tablet should be placed under the tongue until dissolved (can take up to 10 minutes to fully dissolve; should not be chewed or swallowed (swallowing tablets before dissolved reduces bioavailability). If the bioavailability is reduced it can affect a patients pain control. On 3/3/2020 at 2:40 PM, R9 stated, I took all of my medications this morning whole in applesauce and swallowed them. I am in severe pain today, I would rate it a 20 on a scale of 10. My pain is not under control. I had to take my afternoon pain medication early. R9's Medication Administration Record [REDACTED]. On 3/03/2020 at 1:30 PM, R9's (MAR) documents by V18 (Assistant Director of Nursing), Early administration: Resident request. Comment: Res (resident) rated pain 10/10 wanted pain med early. R9's medical record documents on 2/27/2020 at 3:37 PM, Resident admitted to (facility). Resident is alert and oriented x 4. Admitting DX (diagnosis) include: increased weakness and [DIAGNOSES REDACTED]. On 3/3/2020 at 3:20 PM, V16 (R9's Physician) stated, I expect medications to be given the way it is ordered. The facility's policy, with a revision date of February 2004, titled Medication Administration documents, Objective: 1. to provide the resident with those medications deemed necessary by the physician to improve and/or stabilize specified [DIAGNOSES REDACTED]. All medications must be administered to the resident in the manner and method prescribed by the physician.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document the administration of physician ordered medication for five of eight residents (R1, R2, R6, R5 and R11) reviewed for medication administration on the sample list of 14. Findings include: 1. R1's medical record documents: Orders: Albuteral Sulfate solution for nebulization; 2.5 mg (milligrams) /3 mL (milliliters) (0.083 %); amt: 3 ml; inhalation, three times a day at 5:00 AM, 12:00 PM, and 08:00 PM, start date: [DATE]. R1's Medication Administration Records (MAR) does not document the administration of Albuteral Sulfate solution 2.5 mg/3 ml on 2/7/2020 at 12:00 PM. 2. R2's medical record documents: Orders: [MEDICATION NAME] tablet (pain medication); 50 mg; amount 1; oral, three times a day at 7:00 AM - 10:00 AM, 11:00 AM - 2:00 PM, and 3:00 PM - 6:00 PM, start date: 8/26/2019. R2's (MAR's) does not document the administration of [MEDICATION NAME] 50 mg on 12/28/19 at 7:00 AM - 10:00 AM, 11:00 AM- 2:00 PM. R2's medical record documents: Orders: [MEDICATION NAME] Concentrate (pain medication) 100 mg/ 5ml, amount to administer: 0.25 ml, oral, three times a day at 7:00 AM- 10:00 AM, 11:00 AM - 2:00 PM and 7:00 PM - 10:00 PM, start date: 2/3/2020, stop date: [DATE]. R2's (MAR's) do not document the administration of [MEDICATION NAME] Concentrate 0.25 ml on 2/3/2020 at 11:00 AM - 2:00 PM. R2's medical record documents: Orders: [MEDICATION NAME] Concentrate 100 mg/ 5 ml, amount to administer: 0.25 ml, oral, every two hours at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM. R2's (MAR's) does not document the administration of [MEDICATION NAME] Concentrate 0.25 ml on 2/23/2020 at 10:00 AM. 3. R6's medical record documents: Orders: [MEDICATION NAME] (narcotic) 0.5 MG (one half tablet) oral twice a day at 7:00 AM-10:00 AM and 7:00 PM - 10:00 PM, start date: 10/30/19 and [MEDICATION NAME] ([MEDICATION NAME]-[MEDICATION NAME]) (narcotic - pain medication) 5 - 325 MG, one tablet three times a day at 7:00 AM - 10:00 AM, 3:00 PM - 6:00 PM, and 7:00 PM to 10:00 PM. R6's (MAR's) does not document the administration of [MEDICATION NAME] 0.5 MG tablet on 2/22/2020 at 7:00 AM- 10:00 AM, and [MEDICATION NAME] 5 - 325 MG tablet on 2/22/2020 at 7:00 AM - 10:00 AM. 4. Medications on R5's physician's orders [REDACTED]. R5's Medication Administration Record [REDACTED]. 5. Medications on R11's physician's orders [REDACTED]. R11's Medication Administration Record [REDACTED]. On 3/4/2020 at 2:30 PM, V2, Director of Nursing, verifed R1, R2, R6, R5 and R11 MAR's do not document the administration of physician ordered medications and stated, Nurses are expected to sign medications out on the Medication Administration Records after the administration per facility policy. The facility's policy, with a revision date of February 2004, titled Medication Administration documents, Objective: To provide the resident with those medications deemed necessary by the physician to improve and/or stabilize specified [DIAGNOSES REDACTED]. Documentation of meds given will be done in a consistent manner by the nurse placing her initials in the appropriate space on the MAR. Documentation on the MAR indicated [REDACTED].

F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a five percent (5%) or lower medication error rate. There were four medication errors out of 35 medication opportunities resulting in a 11% medication error rate. This failure affected three out of four residents (R8, R9, and R10) reviewed for medication administration on the sample list of 14. Findings include: 1. R8's physician orders [REDACTED]. On 3/3/2020 at 8:15 AM, V8, Registered Nurse (RN), administered [MEDICATION NAME] Allergy Relief spray to R8's bilateral nostrils. V8 did not have R8 blow nose prior to the administration of [MEDICATION NAME]. [MEDICATION NAME] Allergy Relief ([MEDICATION NAME] propionate) package insert documents, Using your [MEDICATION NAME] propionate nasal spray: Step 1: Blow your nose to clear your nostrils. On 3/3/2020 at 10:30 AM, V8 (RN) confirmed R8 did not blow nose right before the administration of physician ordered [MEDICATION NAME] Nasal Spray. 2. V9's physician orders [REDACTED]. Start date: 2/27/2020. On 3/3/2020 at 8:40 AM, V9, (Licensed Practical Nurse) LPN, administered Buprenorphine 2 mg to R9 whole in applesauce by spoon. R9 then swallowed the applesauce and medications. On 3/3/2020 at 10:25 AM, V9, LPN, confirmed R9 did not place Buprenorphine 2mg under tongue (sublingual) for administration. V9, LPN, stated, R9 took all medications whole in applesauce. Buprenorphine package insert, with a revision date of February 2018 documents, Method of Administration (Buprenorphine) must be administered whole. Do not cut, chew, or swallow (Buprenorphine). Advise patients not to eat or drink anything until the tablet is completely dissolved. (Buprenorphine) should be placed under the tongue until it is dissolved. The patients should continue to hold the tablets under the tongue until they dissolve; swallowing the tablets reduces the bioavailability of the drug. 3. R10's physician orders [REDACTED]. On 3/3/2020 at 8:50 AM, V9, LPN, shook R10's [MEDICATION NAME] inhaler for 5 seconds, handed R10 the [MEDICATION NAME] inhaler, and stood at R10's side. R10 then self administered one puff, took a deep break in, breathed out, and self administered another puff, breathed in and breathed out. After the administration, V9, LPN, retrieved the inhaler from R10 and placed the inhaler back into the medication cart. R10 did not shake the [MEDICATION NAME] inhaler in between puff administration, and R10 did not rinse R10 mouth with water and spit water out after the administration of [MEDICATION NAME]. [MEDICATION NAME] ([MEDICATION NAME]-[MEDICATION NAME]) package insert documents, using your [MEDICATION NAME]-[MEDICATION NAME] inhaler: 6. Shake inhaler well for 5 seconds. 7. Breathe our fully, Hold inhaler up to your mouth, close your lips around it. 8. Breathe in deeply and slowly through your mouth, press down firmly and fully on the top of the counter, inhaler to release the medicine. 9. Continue to breath in and hold your breath for about 10 seconds, before you breathe out release your finger from the top of the counter. 10. Shake the inhaler again for 5 seconds and repeat steps 7 to 9. 12. After you finish taking [MEDICATION NAME]-[MEDICATION NAME] (2 puffs) rinse your mouth with water. Spit out the water. Do not swallow it. On 3/3/2020 at 10:25 AM, V9, LPN, stated, R10 did not shake inhaler for 5 seconds between puff administration and R10 did not swish water around in mouth and spit out after the administration of the [MEDICATION NAME] inhaler. 4. R10's physician order [REDACTED]. On 3/3/2020 at 9:00 AM, V9, LPN,

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F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) stated, We are out of the One-A-Day Womens Vitamin for R10. R10's MAR indicated [REDACTED]. The facility's policy, with a revision date of February 2004, titled Medication Administration documents, Objective: to provide the resident with those medications deemed necessary by the physician to improve and/ or stabilize specified [DIAGNOSES REDACTED].
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have complete and readily accessible medical records for three of eight residents (R1, R7 and R11) reviewed for medical records on the sample list of 14. Findings include: The facility's policy, with a revision date of September 2014, titled Medical Records documents, Area: Medical Records. Policy: It is the policy of the facility that an active or inactive record shall be kept for each resident as outlined. This record shall be kept current, dated, signed, complete, legible, and available at all times to the personnel of the facility and any other entities as needed. Purpose: H) Resident Documents - These documents should be placed in the appropriate heading and labeled and dated to be easily identified. 10. Hospice, a: any hospice documentation. 1. R1's progress notes documents on 1/03/2020 at 8:38 AM, (R1) was admitted to this facility this evening from (local hospital). (R1) will be a (hospice) resident. R1's progress notes documents on [DATE]20 12:58 PM, At 10:30 am res (resident) noted to have no respirations or pulse. Verified by second nurse. Family at bedside at time of death. (hospice) notified at 10:38 am. R1's electronic health medical records (EHMR) contained one form titled (hospice) dated 1/14/2020, signed by V23 (Physician) with admission hospice orders. R1's EHMR did not contain any further documentation regarding the plan of care and cares that were provided to R1 from [DATE] to [DATE]20 by R1's hospice provider. On 3/3/2020 at 10:35 AM, V7, Registered Nurse, stated, Hospice will give us papers if they are going to change an order and we enter them into the computer system and then give the paper copy to medical records to be scanned in. We do not get paper copies of what cares they have done when they are here. Hospice is not able to document in the residents EHMR. On 3/4/2020 at 10:45 AM, V1, Administrator, provided multiple typed medical record documents for R1 from the hospice provider, dated [DATE] to [DATE]20. These forms documented hospice's initial visit summary, routine visit summary's, team care plan, and clinical notes. On 3/4/2020 at 10:45 AM, V1, Administrator, stated, These are the notes from the hospice provider, we had some of these but not all of these documents. None of these documents had been scanned into R1's EHMR. 2. R7's chart review on 3/03/20 showed that the medical record did not include Hospice documentation. On 1/09/20, V27, R7's Physician, wrote the order for Hospice to evaluate and treat R7 for [MEDICAL CONDITION], unspecified. R7 has received Hospice Services since 1/10/20 per Hospice Services Care Plan. On 3/04/20 at 9:00 AM, V1, Administrator, stated that hard copies were not available at the facility and that V1 had requested and received the Hospice documentation from Hospice Services. This included progress notes written by nurses, certified nursing assistants, a Chaplin, case manager, and social worker. R7's Hospice evaluation, assessment and acceptance was on 1/10/20. Hospice visited R7 twice a week until it changed to daily on 2/28/20, when R7's condition changed to the transition period. 3. R11's chart review on 3/04/20 showed that the medical record did not include Hospice documentation. On 10/22/19 V27, R11's Physician, wrote the order for Hospice to evaluate and treat R11 for Unspecified systolic (congestive) heart failure. R11 was accepted into Hospice Services since 10/30/19 per the Hospice Team Care Plan. On 3/04/20 at 9:00 AM, V1, Administrator, stated that R11's hard copy Hospice documentation was not available at the facility until 3/04/20, when V1 requested and received the Hospice Service documentation. This included the Hospice Care Plan and progress notes written by nurses, certified nursing assistants, a Chaplin, case manager, and social worker. These documents were first dated on 10/30/19 after Hospice evaluation, assessment had accepted R11 into their services.