STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to answer a call light timely to provide timely incontinence cares and dressing, failed to maintain a resident's dignity for one of four residents (R4) reviewed for resident rights in the sample of four. Findings include: The facility's Resident Rights policy dated 11/28/17 documents, the resident has a right to a dignified existence, self-determination, and communication with and access to persona and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her qualify of life, recognizing each residents' individuality. The facility must protect and promote the rights of the resident. The facility's Call Light Policy dated 01/20024 documents, Answer a call light promptly. Listen to resident's request. Do not make him/her feel that you are too busy to help. Respond to request. Offer further assistance before leaving resident's room. R4's current Care Plan documents R4 needs one assistance of staff for incontinence cares. On 6/27/25 at 10:30 AM R4 was lying in bed. During this time R4 had on an adult brief and a gown that was soiled with feces and the feces was running down both of R4's legs and up R4's stomach. R4's call light was on. R4 stated, I have been waiting for someone to clean me up for over a half an hour. I had to go to the bathroom, and no one answered my call light in time. I am sorry. This is embarrassing. Over two hours ago I turned on my call light. I wanted to get up out of bed and get dressed for the day. (V20/CNA/Certified Nursing Assistant) came in earlier, shut off my call light, and said she would be back. (V20) never returned. I have a brace to my right knee and cannot get dressed or get up on my own. On 6/27/25 at 10:45 AM V20 (CNA) stated, I was passing hall trays earlier this morning when (R4) wanted to get up. I did not have time to get (R4) up at that time, so I did turn off (R4's) call light. On 6/27/25 at 12:15 PM V2 (Director of Nursing) stated R4 should not have had to lay in her own stool and R4's call light should have been answered quicker.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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 observation, interview, and record review the facility failed to develop and implement pressure relieving interventions to prevent pressure ulcer development, conduct a pressure ulcer risk assessment once a week for four weeks after admission and then quarterly thereafter, update pressure ulcer care plans with pressure relieving interventions, and failed to provide a treatment as ordered by the physician for three of three residents (R1, R2, and R3) reviewed for facility acquired pressure ulcers in the sample of four. These failures resulted in R1 developing a stage four full thickness pressure ulcer to the medial heel that required surgical debridement, R2 developing an infected, painful stage four pressure ulcer to the left lateral ankle that required surgical debridement, and R2 developing a painful stage four pressure ulcer to the right lateral heel that required surgical debridement. Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol dated 10-24-22 documents Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury or pressure ulcer that might develop. Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure injury will present as an open ulcer. The appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Principles: 1. A skin assessment (Braden Scale Pressure Ulcer Risk Assessment) is completed on all residents upon admission and weekly for the first four weeks after admission, quarterly, and whenever there is a change in the resident's condition. 2. An individualized plan of care will be developed for the resident following the guidelines of the assessment. 3. All high and moderate risk residents will be assessed for the needs of the items below. If the intervention is initiated, it will be added to the care plan. A. Special mattress and wheelchair cushions. B. PROMS (Passive Range of Motions). C. Protein and/or Nutritional Supplements. D. Turning and positioning schedule. E. Skin Checks. F. Elbow/heel protectors/bridging of heels. 6. When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: A. Assess the pressure injury for location, size, wound bed, drainage, odor, tunneling, undermining or sinus tract, wound edges/surrounding tissues, and pain at site. B. Determine the injury's current stage of development: Stage One Pressure Injury: Non-blanchable erythema of intact skin. Stage Two Pressure Ulcer: Partial thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not viable. Granulation (new tissue) tissue, slough (dead tissue in wounds), and eschar (black or brown hardened layer of dead tissue that forms over a wound) are not present. Stage Three Pressure Ulcer: Full thickness loss of skin, in which subcutaneous fat is visible in the ulcer and granulation tissues are epibole (rolled wound edges) are often present. Slough and or/eschar may be visible but does not obscure the depth of tissue loss. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/pressure injury. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage with the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (dry, adherent, intact without erythema or fluctuance) should only be removed after careful consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration due to damage of underlying soft tissue, this area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue, This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. C. Notify the physician of the above assessment and obtain orders for treatment of pressure ulcer/injury. If pressure ulcer/injury is showing no improvement, Physician will be notified so change of treatment may be obtained, E. Care plan will be established for treatment of existing pressure ulcers/injuries. G. For pressure ulcer with drainage the physician will be notified, and culture obtained if ordered. Pressure Injury and Treatment Protocol: H. Weekly measurements will be conducted and entered in the chart under wound management. J. Turning and repositioning assistance will be given to those residents that are unable to reposition themselves. K. Special devices will be used to relieve pressure, L. All treatment and charting of pressure ulcers/injuries will be done by licensed staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	1. R1's Face Sheet documents R1 is an [AGE] year-old admitted to the facility on [DATE] with the diagnoses Muscle Weakness, Lack of Coordination, Cognitive Communication Deficit, and Vascular Dementia. R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired, requires moderate assistance with personal hygiene and rolling left to right, is at risk for developing pressure ulcers, has one stage four facility acquired pressure ulcer, and is not on a turning and repositioning program. R1's current Physician's Order Sheets dated 5/26/25 through 6/26/25 document, Start Date: 6/17/25 Stage four pressure wound of right lateral ankle cleanse with wound cleanser, pat dry, apply hydrogel to would bed, cover with abdominal pad and kerlix (rolled gauze). Change dressing daily and as needed for impaired dressing integrity. R1's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] documents a score of 16 indicating R1 was at risk of development of pressure ulcers. This same Braden Scale documents R1 was chairfast, was slightly limited in mobility, and required minimum staff assistance in moving to prevent friction and shearing. R1's Medical Record dated 6/27/24 through 6/27/25 does not include any quarterly Braden Scale Pressure Risk Assessments except for the one completed on 12/26/24. R1's Wound Evaluation and Management Summary dated 3/12/24 and signed by V14 (Wound Physician) documents, Stage four pressure wound of the right medial heel full thickness. Etiology: Pressure. Stage four. Duration: Less than 62 days. Wound Size: 5.0 cm (centimeters) by 5.3 cm by not measurable depth. Exudate: Moderate serosanguinous (pinkish drainage). Slough: 40 % (percent). Granulation tissue: 60 %. General Recommendations: Off-load wound, reposition per facility protocol, float heels in bed, and prevalon (heel floating cushioned) boots. Surgical Excisional Debridement procedure to remove necrotic tissue and establish the margins of viable tissue. R1's current Pressure Ulcer Care Plan does not include the interventions to ensure R1 is wearing heel pressure relieving boots and did not include pressure relieving interventions to prevent pressure to the heels prior to the development of R1's right medial heel pressure ulcer. On 6/26/25 from 11:00 AM through 11:45 AM R1 was sitting up in her wheelchair. R1 did not have heel protecting boots on, or a dressing covering the right outer heel wound. On 6/26/25 at 1:00 PM V16 (Wound Nurse) stated, I do not know why (R1) did not have a dressing on her right heel. On 6/27/25 at 9:35 AM R1 was lying on a low air-loss mattress. R1's heels were lying directly on the bed. R1 did not have pressure relieving heel boots on, or her heels off-loaded as ordered by the physician. R1's right foot was facing outward, putting pressure directly on the right ankle pressure wound. During this time, V17 (CNA/Certified Nursing Assistant) verified he did not know R1 was supposed to wear heel protector boots. On 6/27/25 at 9:30 AM V2 (DON/Director of Nursing) performed the wound treatment to R1's right outer heel. R1's right outer heel was covered in 40 percent slough and was approximately five cm round. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/27/25 at 12:00 PM V2 (DON) stated, (R1) has only had one Braden Scale Pressure Risk Assessment done within the last year. (R1) should have had Braden Scale Pressure Risk Assessments done quarterly. (R1's) pressure relieving heel boots are not on the care plan and (R1) did not have any pressure relieving interventions to the heels prior to the development of the pressure ulcer to the right heel. (R1's) wound to the right medial heel was caused by pressure. (V17/CNA) is new to taking care of (R1) and is probably not aware that (R1) needs a heel boot on. 2. R2's Face Sheet documents R2 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Fracture of the Right Humerus, Osteoarthritis, Chronic Diastolic Congestive Heart Failure, Reduced Mobility, Stiffness of the Left Ankle, Left Knee and Right Ankle, Chronic Kidney Disease Stage Three, and Hypertension. R2's MDS assessment dated [DATE] documents R2 is cognitively intact, is dependent on staff for personal hygiene, rolling side to side, and transfers, is at risk of developing pressure ulcers, has one facility acquired stage three pressure ulcer, has one stage four facility acquired pressure ulcer, and is not on a turning/repositioning program. R2's current Physician's Order Sheets dated 5/26/25 through 6/26/25 document, Start Date: 5/6/25 Stage four pressure ulcer wound of left lateral ankle cleanse with wound cleanser, pat dry, apply xeroform (petroleum gauze) to wound bed, cover with abdominal pad, and [NAME] with kerlix once daily. Start Date: 6/14/25 Stage three pressure wound of right lateral heel cleanse with wound cleanser, pat dry, apply xeroform, cover with abdominal pad, wrap with kerlix and secure with tape daily and as needed. R2's Treatment Administration Record dated 6/1/25 through 6/27/25 documents R2's treatments to the right lateral heel pressure ulcer and left lateral ankle were not performed on 6/20/25. R2's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] documents a score of 14 indicating R2 is at moderate risk of development of pressure ulcers. This same Braden Scale documents R2 is chairfast, is very limited in mobility, and requires moderate to maximum assistance in moving to prevent friction and shearing. R2's Medical Record dated 5/28/24 through 6/27/25 does not include any Braden Scale Pressure Risk Assessments weekly times four weeks after admission, or quarterly except for the one assessment dated [DATE]. R2's Wound Evaluation and Management Summary dated 4/22/25 and signed by V14 (Wound Physician) documents, Stage four pressure wound of the left lateral ankle full thickness. Etiology: Pressure. Stage four. Duration: Less than one day. Wound Size: 0.9 cm by 1.5 cm by non-measurable cm. Exudate: Moderate serosanguinous. Slough: 80%. Granulation tissue: 20%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, elevate legs, and float heels in bed. Specific to visit recommendations: Pressure off-loading boot-prevalon. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's Wound Evaluation and Management Summary dated 5/6/25 and signed by V14 (Wound Physician) documents, Stage four pressure wound of the left lateral ankle full thickness. Etiology: Pressure. Stage four. Duration: Less than 15 days. Wound Size: 1.3 cm by 1.3 cm by non-measurable cm. Exudate: Moderate sero-sanguinous. Slough: 80%. Granulation tissue: 20%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Deep swab technique of stage four pressure wound of left lateral ankle demonstrates MRSA (Methicillin-Resistant Staphylococcus Aureus) and Proteus Mirabilis on 5/6/25. Start Bactrim DS (Double Strength) BID (twice daily) for 14 days. Probiotics daily for 30 days. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. Stage three pressure wound of the right lateral heel full thickness. Etiology: Pressure. Stage: Three. Duration: Less than one day. Wound Size: 2.0 cm by 1.5 cm by 0.4 cm. Exudate: Light serosanguinous. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Secondary dressing abdominal pad once daily and as needed. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, elevate legs, and float heels in bed. Specific to visit recommendations: Pressure off-loading boot-prevalon. R2's Wound Evaluation and Management Summary dated 6/26/25 and signed by V14 (Wound Physician) documents, Stage four pressure wound of the left lateral ankle full thickness. Etiology: Pressure. Stage four. Duration: Less than 66 days. Wound Size: 0.8 cm by 0.5 cm by 0.3 cm. Exudate: Moderate sero-sanguinous. Slough: 30%. Granulation tissue: 70%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Sharp selective debridement procedure to remove biofilm and remove devitalized epidermis and/or dermis. Stage four pressure wound of the right lateral heel full thickness. Etiology: Pressure. Stage: four. Duration: Less than 52 days. Wound Size: 1.2 cm by 0.8 cm by non-measurable depth cm. Exudate: Moderate Serous. Slough: 100%. Dressing Treatment Plan: Xeroform gauze apply once daily as needed if saturated, soiled, or dislodged. Secondary dressing abdominal pad once daily and as needed. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, elevate legs, and float heels in bed. Specific to visit recommendations: Pressure off-loading boot-prevalon. Low air-loss mattress. R2's current Pressure Ulcer Care Plan does not include the interventions to ensure R2's low air-loss bed and did not include pressure relieving interventions to prevent pressure to the heels/ankles prior to the development of R2's right lateral heel and left lateral ankle pressure ulcers. On 6/27/25 at 9:48 AM V2 (DON) performed wound treatments to R2's left lateral ankle and R2's right lateral heel. R2's left lateral ankle wound was approximately 1.3 cm round and covered in 80 percent slough. R2's right lateral heel was approximately 2.0 cm by 1.5 cm with a slight depth and red in color. On 6/27/25 at 12:15 PM V2 (DON) stated, (R2) did not get the Braden Pressure Ulcer Risk Assessments done weekly for four weeks after admission or quarterly. The only Braden Pressure Ulcer Risk Assessment (R2) had done was on 6/24/25. (R2's) treatments to the left lateral ankle and right lateral heel were not done as ordered on 6/20/25. (R2's) wounds to the left lateral ankle and right later heel were caused by pressure. (R2) did not have pressure relieving interventions to the heels or ankles prior to developing the pressure ulcers. (R2's) care plan does not include (R2's) low air-loss mattress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	3. R3's Face Sheet documents R3 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of a Fracture to the Right Femur, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Major Depressive Disorder, Chronic Pain, Hypertension, Cognitive Communicative Deficit, and Hearing Loss. R3's admission Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] documents a score of 16 indicating R3 was at risk of development of pressure ulcers. This same Braden Scale documents R3 was chairfast, had no limitations in mobility, 3 and required moderate to maximum assistance in moving to prevent friction and shearing. R3's admission MDS assessment dated [DATE] documents R3 was significantly cognitively impaired, was dependent on staff for turning left to right, personal hygiene, and transferring to the chair. This same MDS documents R3 was at risk for developing pressure ulcers, had no pressure ulcers upon admission, and was not on a turning/repositioning program. R3's Significant Change MDS assessment dated [DATE] documents R3 is severely cognitively impaired, is dependent on staff for turning left to right, personal hygiene, and transferring to the chair. This same MDS documents R3 was at risk of developing pressures, had no pressure ulcers as of 4/25/25, and was not on a turning/repositioning program as of 4/25/25. R3's Medical Record dated 3/25/25 through 6/27/25 does not include any Braden Scale Pressure Risk Assessments weekly times four weeks after admission, or after a change in condition except for the one assessment dated [DATE]. R3's Progress Notes dated 6/14/25 at 4:59 AM and signed by V15 (LPN/Licensed Practical Nurse) document, Two cm open area noted to right ischium. Area cleansed and hydrocolloid applied. R3's current Physician's Order Sheets dated 5/26/25 through 6/26/25 document, Start Date: 6/14/25 apply hydrocolloid to right ischium every three days and as needed. R3's Treatment Administration Records dated 6/14/25 through 6/26/25 document R3 did not get a treatment performed as scheduled to the right ischium on 6/20/25. R3's Initial Wound Evaluation and Management Summary dated 6/19/25 and signed by V14 (Wound Physician) documents, Stage two pressure wound of the right ischium partial thickness. Etiology: Pressure. Stage two. Duration: Less than one day. Wound Size: 1.0 cm by 0.7 cm by 0.1 cm. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, and float heels in bed. Low air loss mattress. Dressing Treatment Plan: Hydrocolloid three times per week and as needed if saturated, soiled, or dislodged. R3's Wound Evaluation and Management Summary dated 6/26/25 and signed by V14 (Wound Physician) documents, Stage two pressure wound of the right ischium partial thickness. Etiology: Pressure. Stage two. Duration: Less than eight days. Wound Size: 1.0 cm by 0.7 cm by 0.1 cm. General Recommendations: Off-load wound, reposition per facility protocol, turn side-to-side in bed, and float heels in bed. Low air loss mattress. Dressing Treatment Plan: Hydrocolloid three times per week and as needed if saturated, soiled, or dislodged. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's Care Plan dated 3/25/25 through 6/26/25 does not include the physician ordered pressure relieving interventions to provide a low air-loss mattress, off-load pressure to the wound, or float R3's heels while in bed. On 6/26/25 V2 (Director of Nursing) stated, (R3) has had no other Braden Scale Pressure Sore Risk Assessments since admission 3/25/25 and should have had a Braden Pressure Risk Assessment done weekly after admission and after a change of condition. On 6/26/25 from 11:35 AM through 2:00 PM and 6/27/25 at 9:15 AM R3 was lying in bed on her back, on a regular mattress (not low air-loss as ordered by the physician). R3's heels were lying directly on the bed. R3 did not have heel protection boots on, or her heels off-loaded as ordered by the physician. On 6/27/25 at 9:15 AM V2 (Director of Nursing/DON)) performed the wound treatment to R3's right ischium. When removing the hydrocolloid dressing, R3 was moaning and saying ouch. The right ischium wound was approximately 1 cm round pink with reddened skin surrounding the wound. During this time V2 stated, I do not know if (R3's) heels should be off-loaded or if (R3) is supposed to have a low air-loss mattress or heel boots. I will have to look at (R3's) orders. On 6/27/25 at 12:30 PM V16 (Wound Nurse) stated, I did not get (R3) a low air-loss mattress or pressure relieving boots. I do rounds with (V14) and have never looked at (V14's) recommendations. I will make sure I look now. (R3's) air-loss mattress and pressure relieving boots never got added to (R3's) care plan. The staff should always make sure (R3's) pressure is off (R3's) ischium wound and heels. On 6/27/25 at 10:30 AM V14 (Wound Physician) stated the facility should always off-load R3's heels to prevent pressure to the heels and the facility should have contacted hospice to order a low air-loss mattress and prevalon boots for the resident. R3's wound to the right ischium was caused from pressure. R1 and R3's wounds were caused from pressure according to my notes. V14 verified R1, R2, and R3 should have had pressure relieving interventions tried prior to development of pressure ulcers to prevent their (R1, R2, and R3's) pressure ulcers from developing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to implement enhanced barrier precautions and contact precautions during wound and incontinence cares for four of four residents (R1-R4) reviewed for infection control practices in the sample of four. Findings include: The facility's Enhanced Barrier Precautions Policy dated 3/28/24 documents, It is the policy of the facility to use proper PPE (Personal Protective Equipment) during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi-Drug Resistant Organisms) to staff hands and clothing. 1. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designated to reduce transmission of multidrug resistant organisms that employs targeted gown and glove use during high contact resident care activities. 2. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. 3. EBP are indicated for residents with any of the following: a. Infection or colonization with a targeted MDRO contact precautions do not otherwise apply. b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care, or wound care. The facility's Infection Control Policy dated 12/17/19 documents gowns, gloves, and proper hand washing will be applied when entering the room and utilized during all cares with residents in transmission based precautions/contact precautions. 1. R1's current Care Plan documents R1 has ESBL (Extended-Spectrum Beta-Lactamase) of the urine and requires contact isolation. This same Care Plan documents R1 has a stage four pressure injury to the right lateral ankle and requires EBP during cares. On 6/27/25 at 9:30 AM R1 was lying in bed and had an enhanced barrier precautions sign, and a contact precautions sign posted on her door. V2 (Director of Nursing/DON) entered R1's room and performed a wound treatment to R1's right outer heel. During this wound treatment V2 did not wear a gown. 2. R2's current Care Plan documents R2 has MRSA of the wound and requires contact isolation. This same Care Plan documents R2 has a stage four pressure injury to the left lateral ankle and stage three pressure ulcer to the right heel that requires EBP during cares. On 6/27/25 at 9:48 AM R2 was lying in bed and had an enhanced barrier precautions sign, and a contact precautions sign posted on his door. V2 (DON) entered R2's room and performed a wound treatment to R2's left lateral ankle and R2's right lateral heel. During these wound treatments V2 did not wear a gown. During this same time V7 (CNA/Certified Nursing Assistant) assisted V2 with R2's wound cares and helped R2 to place his penis in a urinal. V7 did not wear a glove during wound cares or while helping R2 with the urinal. 3. R3's current Care Plan documents R3 has a stage two pressure injury to the right ischium that requires EBP during cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pekin Manor	1520 El Camino Drive Pekin, IL 61554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/25 at 9:15 AM R3 was lying in bed and had an enhanced barrier precautions sign posted on R3's door. V2 (Director of Nursing/DON) entered R3's room and performed a wound treatment to R3's right ischium. During this treatment V2 did not wear a gown. 4. R4's Physician's Orders dated 6/18/25 through 6/27/25 document, Start dated 6/18/25 EBP due to buttock wound. On 6/27/25 at 10:30 AM R4 was lying in bed and had an enhanced barrier precautions sign posted on her door. During this time R4 had feces down both of her legs and up her stomach. V19 (LPN/Licensed Practical Nurse) and V20 (CNA) provided R4 with incontinence cares. During R4's incontinence cares V19 and V20 did not wear a gown. On 6/27/25 at 10:00 AM V2 (Director of Nursing) stated, I should have worn a gown while doing wound cares with (R1, R2, and R3). Staff should wear gowns and gloves during wound cares and incontinence cares with all residents who are in contact precautions or enhanced barrier precautions.