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	09/26/2024

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review, the facility failed to cover a urinary catheter bag with a privacy bag for one of 24 residents (R18) reviewed for dignity in the sample of 33 Findings include: The Resident Rights Booklet, dated 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must be safe, clean, comfortable, and homelike. R18's current computerized medical record documents R18 was admitted to the facility on [DATE], with diagnoses which included Neuromuscular Dysfunction of Bladder, Overactive Bladder, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Essential (Primary) Hypertension. R18's MDS (Minimum Data Set) Assessment, dated 8/29/24, documents a BIMS (Brief Interview for Mental Status) Score of 14/15, indicating cognition intact and has an indwelling catheter. R18's Care Plan, dated 8/18/21, documents R18 has a catheter related to neuromuscular dysfunction of bladder. R18's Physicians Order, dated 12/19/23, documents R18 has a (indwelling) catheter. On 9/23/24 at 12:20 PM, R18 was sitting in the dining room. R18's urinary drainage bag was not covered with a privacy bag. The urinary drainage bag was hooked under R18's chair, and the bag with urine was visible. R18 was asked if she would like the catheter bag to be covered. R18 stated she thought it was covered and if not, she would like it covered. On 9/23/24 at 12:25 PM, V4/Registered Nurse verified R18's catheter bag was not covered with a privacy bag, but should be. On 9/25/24 at 10:12 AM, V2/Director of Nursing stated catheter bags are to be covered with a privacy bag. V2 also stated, There is no policy for using a dignity bag to cover the catheter bag, but that is standard practice.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review, the facility failed to notify the facility Ombudsman of Facility Discharges/Transfers, monthly, for two residents (R26 and R67) of 7 reviewed for discharges in the sample of 33. Findings include: 1. R26's current Medical Record, documents R26 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease, Anxiety, Vascular Dementia, Peripheral Vascular Disease, Fibromyalgia, Essential (Primary) Hypertension, and Severe Sepsis with Septic Shock R26's Nursing Note, dated 6/3/24 at 10:56 AM, documents R26 was taken to the hospital for evaluation. R26's Nursing Note, dated 6/3/24 at 11:13 AM, documents R26 was admitted to the hospital with a diagnosis of UTI/Urinary Tract Infection. R26's Social Service Note, dated 6/11/24 at 12:15 PM, documents R26 was back in the facility. R26's Nursing Note, dated 6/18/24 at 6:23 AM, documents emergency services were called to take R26 to the emergency room . R26's Nursing Note, dated 6/18/24 at 9:51 AM, documents R26 is being admitted to the hospital. R26's Nursing Note, dated 6/26/24 at 5:24 PM, documents R26 returned from the hospital. R26's Bed hold Notice, dated 6/4/24, documents R26 went to the hospital on 6/3/24 for a diagnosis of UTI/ Urinary Tract Infection. R26's Bed Hold Notice, dated 6/19/24 documents R26 went to the hospital for sepsis. The Admit/Discharge Report, dated 6/1/24 - 6/30/24, does not document R26 was discharged to the hospital on 6/3/24 and 6/18/24. On 9/25/24 at 10:37 AM, V5/Social Services stated R26 was not on the June 2024 list of admit/discharge that was provided to the Ombudsman. V5 also stated, The information was put in the system. I don't know why it didn't show up on the report. 2. R67's current Medical Record documents R67 was admitted to the facility on [DATE], with diagnoses which included Chronic Kidney Disease Stage 3, Sepsis, Anxiety, Essential (Primary) Hypertension, and Chronic Systolic (Congestive) Heart Failure. R67's Nursing Note, dated 1/9/24 at 4:46 PM, documents R67 was not responding to questions or stimuli. R67 was sent to the hospital for evaluation and treatment. R67 left the facility at 4:40 PM. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R67's Nursing Note, dated 1/9/24 at 6:07 PM, documents R67 was admitted to the hospital with a diagnosis of UTI/Urinary Tract Infection. R67's Nursing Note, dated 1/13/24 at 1:46 PM, documents R67 returned to the facility. R67's Bed Hold, dated 1/10/24, documents that R67 went to the hospital on 1/9/24 with a diagnosis of UTI/Urinary Tract Infection. The Admission/Discharge Log, dated 6/1/24 to 6/30/24, does not document R67 was discharged to the hospital on 1/9/24. On 9/25/24 at 10:42 AM, V5/Social Services stated R67 was not on the January 2024 list of admit/discharge that was provided to the Ombudsman. V5 also stated, The information was put in the system. I don't know why it didn't show up on the report.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32875 Based on interview and record review the facility failed to develop a Person Centered Care Plan for one resident (R67) out of 24 reviewed for Care Plans in a sample of 33. Findings Include: The Care Plan Policy, dated 6/1/22, documents, 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 meter resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 6. The comprehensive care plan will be developed within 7 (seven) days after the completion of the comprehensive MDS (Minimum Data Set) assessment as outlined in the RAI (Resident Assessment Instrument) manual guidelines. Address other factors identified by the interdisciplinary team, or in accordance with the resident's preference, will also be addressed in the plan of care. 9. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. R67's current Medical Record documents R67 was admitted to the facility on [DATE], with diagnoses which included Chronic Kidney Disease Stage 3, Sepsis, Anxiety, Essential (Primary) Hypertension, and Chronic Systolic (Congestive) Heart Failure. R67's MDS (Minimum Data Set) Assessment, dated 1/20/24, documents R67 takes an anticoagulant. R67's Physicians Order for Eliquis 5 mg/Milligrams documents a start date of 1/13/24, Take Eliquis 5 mg twice a day. Care Plan, dated 9/24/24 at 3:59 PM, documents, (R67) uses an anticoagulant medication related to CHF (Congestive Heart Failure). On 9/26/24 at 9:32 AM, V10/MDS/Care Planner, stated R67 did not have a Care Plan for an anticoagulant until 9/24/24, although there should have been.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review, the facility failed to change an oxygen tubing/humidifier bottle for one resident (R2) of two residents reviewed for oxygen therapy in the sample of 33. Findings Include: The Oxygen Therapy policy, dated 3/16/17, documents, To provide a source of oxygen to persons experiencing an insufficient supply of same. Procedure: 7. Oxygen set-up (cannula/mask, tubing) must be exchanged every 7 (seven) days. R2's current Medical Record documents R2 was admitted to the facility on [DATE], with diagnoses which included Acute Respiratory Failure with Hypoxia (Primary), Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure with Hypercapnia, and Shortness of Breath. R2's Care Plan documents R2 has COPD/Chronic Obstructive Pulmonary Disease, Chronic Respiratory Insufficiency, Obstructive Sleep Apnea, Restrictive Lung Disease, Recent Respiratory Acidosis, Recent Acute Hypercapnia, and Respiratory Failure. R2's oxygen setting is to be at three liters. R2's Physician Order, dated 3/30/24, documents oxygen at three liters continues every shift. R14's Physician Order, dated 3/12/24, documents oxygen at 2 (two) liters per minute by nasal cannula every shift. On 9/23/24 11:25 AM, R2 was sitting in her room wearing oxygen. It was connected to the humidifier bottle. The humidifier bottle was dated 8/18/24. On 9/23/24 at 11:26 AM, V4/Registered Nurse verified the date on the humidifier bottle was 8/18/24. V4 also stated the tubing and humidifier bottle is to be changed weekly on the night shift. On 9/25/24 at 10:12 AM, V2/Director of Nursing stated oxygen tubing and humidifier bottles are supposed to be changed weekly. The staff are to date the tubing and humidifier bottle when they are changed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34048 Based on observation, interview, and record review, the facility failed to document a diagnosis and monitor for specific adverse behaviors to warrant the use of an antipsychotic medications for one of five residents (R249) reviewed for unnecessary medications in a sample of 33. Findings include: The facility's Psychopharmacological Drug Usage Procedure, revised 10/18/17, documents the documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis, as well as medications response and adverse consequences. R249's current Medication Administration Record documents to take Quetiapine (antipsychotic) 25mg daily for Alzheimer's disease, unspecified. On 9/23/24 at 10:30am, R249 was being assisted to his wheelchair, cooperative with care. On 9/24/24 at 1:30pm, R249 was sleeping in his wheelchair. On 9/25/24 at 10:30am, R249 was sleeping in his wheelchair. R249 was encouraged to lay in bed but refused. On 9/25/24 at 11:30am, V13, Certified Nursing Assistant, stated R249 does not show any signs of adverse behaviors. V13 verified R249 is cooperative with care. On 9/25/24 at 1:30pm, R249 was sleeping in his wheelchair in his room. On 9/25/24 at 11:45am, V6, Assistant Director of Nursing, verified R249 does not have any adverse behaviors or diagnosis for the use of an antipsychotic medication. V6 stated R249 shows signs of increase confusion in the evenings, but is easily redirected.