Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146091	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peru	3230 Becker Drive Peru, IL 61354

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34048 Based on observation, interview, and record review the facility failed to ensure a call light was within reach for two of 32 residents (R8 and R20) reviewed for call lights in a sample of 46. Findings include: The facility's Call Light policy, revised 01/04, documents to be sure call light is within reach before leaving the room. 1. On 10/28/24 at 11:30am, R20's call light was on the floor at the head of the bed. R20 was on the other side of the bed attempting to stand up. R20 stated that she wanted to go to bed but did not know where her call light was. 2. On 10/28/24 at 11:35am, R8 was in a reclining chair by the door to the room. R8's call light was hooked to the sheets, under the blanket, on the opposite side of her bed. R8 was unable to find her call light. On 10/28/24 at 11:35, V6, Certified Nursing Assistant, was stopped when walking down the hall and asked to assist R20. V6 verified that R20's call light was on the floor and should be within R20's reach. V6 also verified that R8's call light was not within her reach. On 10/29/24 at 1:45pm, V2, Director of Nursing, stated that it is the facility's expectation that the call light be within reach, prior to staff leaving the room.

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: 146091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peru	3230 Becker Drive Peru, IL 61354

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396 Based on interview and record review, the facility failed to ensure a resident with a new diagnosis of mental illness was referred to the state agency for a level II PASARR (Preadmission Screening and Resident Review) evaluation for one of one resident (R3) reviewed for PASARR screening in the sample of 46. Findings include: R3's current electronic medical record profile and Face Sheet, documents R3 was admitted to the facility on [DATE] and diagnosed with Schizophrenia on 2/19/24. R3's most recent Level I PASARR evaluation, dated 3/17/22, documents at the time of evaluation R3 had mental health diagnoses of: Major Depression, Paranoid personality, and Anxiety. R3's medical record does not document that R3 has had any further PASARR screening or evaluation since R3's new diagnosis of Schizophrenia in February 2024. On 10/30/24 at 11:42 AM, V8 (Social Service Director) stated We switched over to a new system of PASARR screenings in 2022. (R3) had an onsite evaluation in March of 2022. At that time (R3) did not have the diagnosis of Schizophrenia. That diagnosis was added in February of 2024. I am not sure when I am supposed to redo her PASARR screen. I am going to have to call them and find out. I am thinking it should have been re-done in February with the new Schizophrenia diagnosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peru	3230 Becker Drive Peru, IL 61354

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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

31283

Based on observation, interview, and record review, the facility failed to implement new fall prevention interventions after repeated falls for one of four residents (R60) reviewed for falls in the sample of 46.

Findings include:

R60's current medical record documents R60's diagnoses to include: Alzheimer's Disease; Repeated Falls; Muscle Weakness (generalized); and Other Abnormalities of Gait and Mobility.

R60's Fall Risk Assessment (dated 10/14/24) documents a score of 25, indicating R60 is a high risk for falls.

On 10/28/24 at 09:55 AM, R60 was reclined in a recliner in the day room near the television covered with a blanket. R60's eyes were closed at this time. V13 (Certified Nursing Assistant) stated R60 has declined some recently. I think there was talk about Hospice, but her husband is waiting to see if she'll bounce back any. V13 stated R60 has lost weight, has developed a pressure ulcer on her bottom and has a history frequent of falls.

R60's Minimum Data Set Assessment (dated 07/30/24), Section C, documents a Brief Interview for Mental Status score of 0, indicating severely impaired cognition. This same assessment documents in Section GG, R60 requires supervision or touching assistance to walk 10 feet (Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space); Walk 50 feet with two turns (Once standing, the ability to walk at least 50 feet and make two turns); and Walk 150 feet (Once standing, the ability to walk at least 150 feet in a room, corridor, or similar space).

The facility's Fall Log documents that R60 has fallen 13 times at the facility on the following dates: 07/04/24, 07/05/24, 07/07/24, 08/01/24, 08/14/24, 08/18/24, 09/01/24, 09/07/24, 09/29/24, 10/03/24, 10/08/24, 10/12/24, and 10/17/24.

R60's Fall Investigation (dated 08/01/24) documents R60 was found on the floor after ambulating unassisted in her room. This same investigation documents, Care plan reviewed and updated. R60's current care plan has no mention of R60's 08/01/24 fall, or a new intervention implemented following this same fall.

R60's IDT (Interdisciplinary Team) Evaluation Note (dated 08/01/24) documents, (R60) had a fall with no complaints of pain or injuries sustained. She was ambulating unassisted in her room. (R60) continues to be impulsive, transfer and ambulate unassisted, and has repeated falls related to severe Alzheimer's Disease. She enjoys spending time in her room which already addressed in the problem and will frequently shut her door. Care Plan reviewed and remains appropriate, continue with plan of care.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Manor Court of Peru		STREET ADDRESS, CITY, STATE, ZIP CODE 3230 Becker Drive Peru, IL 61354	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:30 AM, V12 (Care Plan Coordinator) stated R60's care plan was reviewed after her 08/01/24 fall, however, no increase in supervision or additional fall prevention intervention was implemented at that time. R60's Fall Investigation (dated 08/14/24) documents R60, attempted to get out of bed unassisted when she lost her balance and fell . R60's current care plan has no mention of R60's 08/14/24 fall, or a new intervention implemented following this same fall. R60's IDT Evaluation Note (dated 08/14/24) documents, Care Plan reviewed and appropriate, continue with plan of care. On 10/31/24 at 10:35 AM, V12 stated R60's care plan was reviewed after her 08/14/24 fall, however, no increase in supervision or additional fall prevention intervention was implemented at that time. As of 10/31/24, R60's medical record did not contain documentation that new fall prevention interventions were implemented after R60's 8/1/24 or 8/14/24 fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peru	3230 Becker Drive Peru, IL 61354

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 34048 Based on observation, interview, and record review the facility failed to ensure a urinary collection bag was in a privacy cover and kept off the floor for one of three residents (R22) reviewed for catheters in a sample of 46. Findings include: The facility's Catheterization (Drainage Bag) policy, revised 01/04, documents that to attach the drainage bag to the frame, below the level of the resident's bladder, not touching the floor. On 10/28/24 at 10:00am, R22's urinary drainage catheter bag was hanging on the lower aspect of her reclining chair. R22's urinary drainage bag was uncovered and draining cloudy yellow urine. On 10/28/24 at 12:00pm, R22 was in the dining room in her reclining chair. R22's urinary drainage bag was hanging, uncovered, on the outer aspect of her reclining chair. V6, Certified Nursing Assistant, verified that R22's urinary drainage bag was not covered. On 10/29/24 at 8:45am, R22 was in the main dining area in her reclining chair. R22's urinary drainage bag was hanging, uncovered, under the reclining chair. At 12:30pm, R22 was in her room, with the urinary drainage bag, uncovered, under her reclining chair. During observations made on 10/29/24 R22's urinary drainage spout was unhooked from the collection bag and touching the floor. On 10/29/24 at 1:45pm, V2, Director of Nursing, stated that she did see R22's urinary drainage bag uncovered. V2 stated that it is the policy of the facility to cover all the urinary drainage bags with a privacy cover. V2 also verified that the urinary drainage bag is not to be touching the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER: Manor Court of Peru		STREET ADDRESS, CITY, STATE, ZIP CODE: 3230 Becker Drive Peru, IL 61354	

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396 Based on observation, interview and record review, the facility failed to document a diagnosis and identify target behaviors to warrant the use of Seroquel (antipsychotic medication) and document a care plan to address behaviors and antipsychotic use for two of three residents (R6, R79) reviewed for antipsychotic medications in the sample of 46. Findings include: The facility's Psychopharmacologic Drug Usage Procedure policy, dated 10/18/17, documents A Psychopharmacologic Drug is any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. This includes the following types of drugs: antipsychotic, antidepressants, anti-anxiety medications, and sedatives/hypnotics. Procedure: Use of psychopharmacological medications requires assessment by the attending physician, and specific orders must be written by the attending physician with supporting diagnosis. Psychopharmacological medication usage must also be addressed in the Care Plan, including goals, likely medication effect and potential adverse consequences. This same policy documents Documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis, as well as medication response and adverse consequences. 1. On 10/28/24 at 11:28 AM, R6 was sitting in the dining room in a wheelchair with a mechanical lift sling under him. Other residents were seated at the same table with R6. R6 was quiet and not exhibiting any behaviors. R6's current Physician Order sheet, dated 10/31/24, documents R6 has an order for Quetiapine (Seroquel, antipsychotic medication) 50 MG (milligrams), take 1 tablet by mouth two times a day. R6's current Care Plan, dated 5/30/24, documents R6 is [AGE] years old and has diagnoses including but not limited to; Dementia without behaviors, Abnormal weight loss, Depression and Mood Disorder. This same Care Plan documents (R6) has diagnoses of Depression, Anxiety, Insomnia, Attention-deficit hyperactivity disorder (ADHD) and Mood Disorder. Administer Quetiapine 50 MG twice a day as ordered related to Mood Disorder. Monitor for side effects, including boxed warnings. This Plan of Care does not list psychiatric behaviors or side effects to monitor for quetiapine use in elderly. R6's Behavior Analysis sheets, dated 4/29/24-10/29/24, document R6 has exhibited two physical behaviors and three verbal behaviors in the past six months. These behaviors list a date and time but no explanation as to what the behavior was. All five behaviors document staff was able to easily alter the resident's behavior with non-pharmacological interventions. On 10/29/24 at 2:00 PM, V9 (Certified Nursing Assistant) confirmed she has worked at the facility for a long time and works a shift from 3:00 AM until 2:00 PM. V9 stated (R6) hasn't been eating and needs assistance with meals. He is also more sleepy lately. No current behaviors that I can recall. He used to have behaviors but mostly it was if his roommate kept him up all night then he would be more moody, would cuss and had some falls. (R6) isn't harmful to other residents or himself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146091	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peru	3230 Becker Drive Peru, IL 61354

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 2:10 PM, V10 (Registered Nurse) stated (R6) has had no recent behaviors. He used to have some rejection of care, he would walk on his own and not ask for help or use a call light. He would then get upset when told to use it. (R6) is not harmful to other residents or himself. Maybe was harmful towards staff at one time. 2. On 10/28/24 at 11:50 AM, (R79) was sitting in her wheelchair in the dining room at table and was eating lunch independently. R79 was seated next to other residents and was not displaying any behaviors. R79's current Physician Order sheet, dated 10/30/24, documents R79 has an order for Quetiapine (Seroquel, antipsychotic medication) 25 MG (milligrams), take 1 tablet by mouth two times a day. R79's current Care Plan, dated 10/8/24, documents R79 is [AGE] years old and has diagnoses of Alzheimer's disease and Dementia. This Care Plan documents (R79) has Depression, Anxiety, Insomnia, and Mood Disorder. (R79) can be tearful at times. Administer Quetiapine 25 MG twice a day as ordered. Monitor for side effects, including boxed warnings. This Plan of Care does not list psychiatric behaviors or side effects to monitor for quetiapine use. R79's Psychotropic Medication consent, dated 9/17/24, documents R79 was prescribed Seroquel 25 MG two times a day for Mood Disorder. R79's Behavior Analysis sheets, dated 4/29/24-10/29/24, document R79 has exhibited two physical behaviors, two verbal behaviors, 17 behaviors of wandering and ten other behaviors in the past six months. These behaviors list a date and time but no explanation as to what the behavior entailed. R79's nursing progress notes for dates and times related to behavior sheets do not list details on what behaviors R79 has exhibited over the past six months. On 10/29/24 at 2:00 PM, V9 (Certified Nursing Assistant) stated (R79) has had no behaviors lately. Back in the day when she had them, (R79) would stand up and she broke her hip. (R79) has no other behaviors. She was in memory care (locked unit), but we moved out here after hip fracture. On 10/29/24 at 2:10 PM, V10 (Registered Nurse) stated (R79) usually in the evening time she has typical behaviors of sundowners (increased confusion in the evening). (R79) gets restless and has to be re-directed. (R79) is not harmful to herself or other residents though. On 10/30/24 at 11:13 AM, V2 (Director of Nursing) confirmed both R6 and R79 are taking Seroquel for Mood Disorder. V2 stated (R6) is verbal at times towards staff. Like if they are trying to help him with care or it is time to eat. He will direct profanity towards us. The physical behavior for him is usually if we're trying to help him, he will refuse because of the Dementia. He doesn't understand. Those physical behaviors are also towards staff. (R6) is not harmful towards other residents or himself. (R79) has some behaviors that are mostly agitation with staff. (R79) doesn't always like to be provided care that she needs. (R79) tries to stand unassisted and when we are trying to get her to sit back down, she will become agitated and strike out at us. (R79) is not harmful towards other residents or herself. V2 confirmed that both R6 and R79's care plans do not address the antipsychotic medication or behaviors adequately. V2 confirmed that both residents do not exhibit behaviors that are psychotic in nature or unrelated to dementia, to justify the use of Seroquel.