STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146108	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peoria	6900 North Stalworth Peoria, IL 61615

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review, the facility failed to have a Practitioner Order for Life-Sustaining Treatment/ POLST in the Medical Record one resident (R191) reviewed for Advanced Directives in the sample of 24. Findings include: The Advanced Directives policy dated 2/2018 documents Policy: The facility shall support the resident's right to request, refuse and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Purpose: To ensure that the resident and/or representative has been informed and educated about the right to formulate an advance directive, and the facility's policy regarding these rights; and the resident has been assisted in exercising these rights; and the residents' choices regarding these rights have been incorporated into the treatment, care and services. Procedure: Staff will determine, at the time of admission, whether or not any advance directives are present, and make an effort to obtain pre-existing directives. Staff shall then ensure that they are placed in the resident's medical record. Pertinent facility staff and the physician shall be made aware of the existence of these directives. If no directives are in place, staff shall provide education, verbally and in writing, to the resident regarding their right to develop advance directives and to refuse medical or surgical treatment per State law. Assistance will be provided as necessary. Findings include: R191's current computerized medical record, documents R191 was admitted to the facility on [DATE] with a diagnosis of Acute Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity (Primary), Permanent Atrial Fibrillation (Admission), Neuralgia and Neuritis, Other Lack of Coordination, Difficulty in Walking, Muscle Weakness (generalized), Muscle Wasting and Atrophy, Right Hand and Left Hands, Unsteadiness on Feet, Hyperlipidemia, Permanent Atrial Fibrillation, Parkinson's Disease, Hypothyroidism, Essential (Primary) Hypertension, and Heart failure. R191's MDS (Minimum Data Set) dated 5/16/24 documents a BIMS (Brief Interview for Mental Status) Score of 13/15, indicating R191 is cognitively intact. On 5/13/24 at 11:28 AM, there was no Advance Directive for R191 found in R191's Electronic Medical Record. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24, V1/Administrator was asked what the code status was for R191. At 12:00 PM, V1 provided a Hospital discharge date d 5/10/24 for R191 that documents Shock OK, no compressions. Before V1 left the room, V1 was shown the Electronic Medical Record that documented R191 was a Full Code. V1 stated she did not know how that got put in the system. On 5/14/24 at 12:21 PM, V2/Director of Nursing stated that there has not been any paperwork signed by R191 or V4/R191's Power of Attorney for R191's Code Status. V2 also stated, Until there is paperwork signed the resident is a Full Code. I have nothing that pertains to the Code Status. On 5/14/24 at 12:35 PM, V3/Social Service Director stated that the POLST is signed when a resident is admitted . V3 stated she did not get the POLST signed when R191 admitted and V3 does not know what R191's Code Status is supposed to be. V3 also stated (R191's) cognition is fine but I didn't ask (R191) about her Code Status. On 5/14/24 at 1:01 PM, R191 stated, I thought they (the facility) already had it from the hospital. I don't want to have my ribs broke. I want a DNR (Do Not Resuscitate). V4/R191's Power of Attorney was in the room and stated, I would think you would want to be a Full Code, but it is your choice. V3/Social Service Director was also in the room and stated that there were other choices that could be made. V3 showed V4 the paperwork and the options. V4 stated to R191, You could do Full Code with selective treatments. R191 agreed and signed the paperwork. On 5/14/24 at 1:21 PM, V4 stated I was in here on Friday and was not asked about the code status. Then today I got a call (V4 pulled out her phone) at 11:24 AM, 11:31 AM, and 11:35 AM asking me to come in and sign the paperwork. On the third call I was yelling at them to stop harassing me and I would be in as soon as I could. If they had done this on Friday, they would not have to harass me. V4 also stated that R191 knows what she is doing and can make her own decisions. On 5/15/24, the facility provided R191's POLST dated 5/14/24, that was signed by R191 The POLST documents that R191 wants Cardiopulmonary Resuscitation with Selective Treatment. The POLST form was signed by R191's Primary Physician on 5/15/24.

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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 Care Plan for two of 16 residents (R16 and R27) reviewed for care plans in the sample of 24. 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 timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1. R16's current computerized medical record, documents R16 was admitted to the facility on [DATE] with a diagnosis of Non-Pressure Chronic Ulcer of Buttock with Unspecified Severity (Primary); Type 2 Diabetes Mellitus with Unspecified Complications; Chronic Obstructive Pulmonary Disease; Essential (Primary) Hypertension; Anxiety Disorder; Vascular Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Other feeding difficulties; Dysphagia, Oropharyngeal Phase; Transient Cerebral Ischemic Attack; Vascular Dementia, Mild, with Agitation; Malignant Neoplasm of Bladder; Complete Traumatic Amputation of One Left Lesser Toe. R16's MDS (Minimum Data Set) dated 3/24/24 documents a BIMS (Brief Interview for Mental Status) Score of 11/15, indicating moderate cognitive impairment. On 5/14/24 at 11:12 AM, R16 stated that he has lost weight but doesn't know why. R16's Dietician Note dated 5/8/2024 at 12:44 PM, documents that R16 has recent weight changes. Current weight at 159 pounds, a decrease of 25 pounds in the past three months. R16's current Care Plan has no mention of R16's recent weight loss. R16's weight log documents R16's weight on 3/20/24 was 177.2 pounds, and R16's weight on 5/8/24 was 158.8 pounds. This is a 18.4 pounds lost, 10.38 percent in three months. On 5/16/24 at 11:11 AM, V2/Director of Nursing verified there is no Care Plan in place for R16's weight loss. 2. R27's current computerized medical record, documents R27 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease with Late Onset (Admission); Essential (Primary) Hypertension; Gastro-Esophageal Reflux Disease without Esophagitis; Other Specified Diseases of Anus and Rectum; Chronic Kidney Disease, Stage 2 (mild); Overactive bladder; Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms; Pain, Unspecified; Vitamin D deficiency; Hyperlipidemia; and Generalized Anxiety Disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's MDS (Minimum Data Set) dated 3/21/24 documents a BIMS (Brief Interview for Mental Status) Score of 14/15, indicating R27 is cognitively intact. On 5/15/24 at 1:15 PM, R27 stated that he has scrotal pain often and is given an ice pack and pain medication. R27's Nursing Note dated 5/4/24 at 5:41 AM documents that R27 complained of 10/10 sharp, needle-like pain to an isolated superficial/fleshy area of his scrotum. R27 stated that these abrupt painful episodes occur frequently and intermittently. There were no evident visual issues nor any palpable abnormalities. There was no redness, but antifungal cream was applied, and Tylenol 650 mg (milligrams) PO (by mouth) was given. R27's Nursing Note dated 5/4/24 at 3:08 PM, documents that R27 complained of throbbing pain to his scrotal area this morning. Pain was rated at 8/10. As needed Tylenol was given with minimal effectives. An icepack was applied to the area, R27 states pain is now 0/10. Scrotal pain is chronic for R27. R27's Base Line Care Plan dated 3/15/24 documents Pain management as needed. A Comprehensive Care Plan was not developed for R27 addressing R27's pain. R27's Medication Administration Record dated 5/1-5/15/24 documents R27 has experienced back and scrotal pain 12 of 15 days ranging from 2/10 to 8/10. On 5/16/24 at 11:15 AM, V2/Director of Nursing verified there is no Care Plan in place addressing R27's scrotal pain.

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	146108	A. Building B. Wing	05/16/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview and record review, the facility failed to ensure showers and nail care were provided for two of two residents (R4 and R191) reviewed for activities of daily living in the sample of 24. Findings include: The Personal Care of Residents policy dated 12/2002, documents It is the policy of the facility to provide a plan of personal care for residents. To provide that residents of the facility receive adequate care. Procedure: 1. Each resident shall have proper daily personal attention and/or care, including skin, nails, hair and oral hygiene, in addition to treatment ordered by the physician. 2. Each resident shall have at least one complete bath and hair wash weekly, and as many additional baths and hair washes as necessary for satisfactory personal hygiene. 1. R4's current computerized medical record, documents R4 was admitted to the facility on [DATE] with a diagnosis of Chronic Kidney Disease, Stage 2 (mild)(Primary, Admission); Stiffness of Right and Left Shoulder; Other Reduced Mobility; Muscle weakness; Hereditary and Idiopathic Neuropathy; Tachycardia; Edema; Urinary Tract Infection; Acute Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity; Pain; Mild Cognitive Impairment of Uncertain or Unknown Etiology; Venous Insufficiency (Chronic) (Peripheral); Essential (Primary) Hypertension; Peripheral Vascular Disease; Congenital Hypothyroidism with Diffuse Goiter; Hypothyroidism; Hyperlipidemia; Hypo-Osmolality and Hyponatremia. R4's MDS (Minimum Data Set) dated 4/9/24 documents a BIMS (Brief Interview for Mental Status) Score of 15/15, indicating R4 is cognitively intact. R4 has upper extremity impairment on both sides and requires partial assistance for showering and is occasionally incontinent of bowel and bladder requiring set up/cleanup assistance. On 5/15/24 at 1:23 PM, R4's fingernails were observed and had pink fingernail polish on them that was chipped. The fingernails were dirty and all different lengths. The shorter nails were uneven with some sharp, jagged edges. R4's index finger fingernails were the longest and had a dark brown, black debris adhered underneath them. On 5/15/24 at 1:23 PM, R4 stated, My fingernails are all different lengths. I'd like my fingernails shorter than what they are. They need to be cut. They are too long and break. I have hangnails that bother me. They put paint on my nails but don't cut them. I have asked but it doesn't get done. On 5/16/24 at 11:18 AM, V2/Director of Nursing stated that the Certified Nursing Assistants are responsible for nail care when showers are given unless the resident is diabetic. If the resident is a diabetic, then a nurse should cut the nails or there is a Podiatrist that comes to the facility. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R191's current computerized medical record, documents R191 was admitted to the facility on [DATE] with a diagnosis of Acute Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity (Primary); Permanent Atrial Fibrillation (Admission); Neuralgia and Neuritis; Other Lack of Coordination; Difficulty in Walking, Muscle Weakness (generalized); Muscle Wasting and Atrophy, Right Hand and Left Hands; Unsteadiness on Feet; Hyperlipidemia; Permanent Atrial Fibrillation; Parkinson's Disease; Hypothyroidism; Essential (Primary) Hypertension; and Heart failure. R191's MDS (Minimum Data Set) dated 5/16/24 documents a BIMS (Brief Interview for Mental Status) Score of 13/15, indicating R191 is cognitively intact, has lower extremity impairment on both sides and requires partial assistance for showering. On 5/14/24 at 1:26 PM, R191 stated I would sure like to have a shower. On 5/14/24 at 1:27 PM, V4/R191's Power of Attorney (in R191's room) stated (R191) came in on Friday and still has not had a shower. On 5/15/24 at 12:43 PM, V2/Director of Nursing stated that R191 did not get a shower on Friday because R191 came in late. On 5/15/24 at 1:13 PM, R191 stated I finally got a shower last night after supper. I came in on Friday and had not had a shower for five days before that in the hospital. I didn't ask for one on Friday, but I did on Saturday, Sunday, and Monday. They said they were too busy. (V4/R191's Power of Attorney) came in yesterday (Tuesday) and insisted I get a shower. R191's Nursing Note dated 5/10/24 at 3:16 PM, documents R191 was readmitted the facility from the local hospital at 2:50 PM (Friday). The facility Shower Schedule (not dated) documents that R191 is to have a shower on day shift on Tuesdays and evening shift on Fridays.

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	146108	A. Building B. Wing	05/16/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30224 Based on observation, interview, and record review the facility failed to complete psychotropic assessments prior to the use of antipsychotic medications, document the resident's response to non-pharmacological interventions to manage behaviors/symptoms, and to ensure the resident has behaviors that warrant the use of antipsychotic medications for two of three residents (R5, R22) reviewed for antipsychotic medication use with the diagnosis of Dementia or Alzheimer's Disease in the sample of 24. Findings include: The Facility's Psychopharmacologic Drug Usage Procedure dated 10/18/17, states 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 5/13/24, 5/14/24, and 5/15/24, during random observations, R5 was confused but exhibited no behaviors. R5's electronic diagnosis list documents R5 has a diagnosis of Vascular Dementia. R5's current computerized Physician Orders document R5 receives Zyprexa (antipsychotic medication) 10 mg (milligrams) by mouth every morning and Zyprexa 2.5 mg by mouth every evening for a diagnosis of Bipolar Disorder. R5's Care Plan last updated 4/29/24, documents R5 has a diagnosis of Bipolar Disorder and takes Zyprexa twice a day. This same care plan does not document R5's target behaviors for the use of Zyprexa. R5's electronic medical record dated 1/1/24 through 5/15/24, does not document R5 has any behaviors to warrant the use of Zyprexa, a psychotropic medication assessment that was completed prior to initiating Zyprexa, or R5's response to non-pharmacological interventions. On 5/15/24 at 1:30 p.m., V8 (Certified Nurse Aide) stated R5 cusses and will hit at staff but not residents. V8 stated, (R5) only cusses at us or occasionally swings his arms when cares are being given. If you have a conversation with him, he is very pleasant. He has more behaviors in the late afternoon and evening time. On 5/15/24 at 1:35 p.m., V6 (Certified Nurse Aide) stated R5 has no behaviors that put him at risk for harming himself or another resident. V6 stated (R5) cusses a lot and he will get a little aggressive (with direct care staff) when providing cares. He doesn't want us to mess with him and wants to be left alone. Any other time he doesn't have behaviors. I think his cussing is just his normal way to talk. It's not really a behavior. It's just him. (continued on next page)

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	146108	A. Building B. Wing	05/16/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 1:40 p.m., V7 (Certified Nurse Aide) stated R5 does not have any behaviors that put him at risk to harm himself or other residents. V7 stated R5, Really just cusses a lot. Not really at us, but in general. He will try swinging at staff when providing cares like toileting or getting him dressed. He's never aggressive with other residents. His behaviors are worse in the evening. I think it may be sundowners from his Dementia. 2. On 5/15/24 at 12:52 p.m., R22 was sitting in his wheelchair in the lounge. R22 was pleasant and talkative. R22 did not exhibit any negative behaviors. R22 watched television while peers around him participated in different activities. R22's electronic medical record documents R22 has a diagnosis of Vascular Dementia. R22's current computerized Physician Order Sheet documents R22 receives Seroquel (antipsychotic medication) 100 mg (milligrams) every morning and Seroquel 125 mg at bedtime for a diagnosis of Unspecified Psychosis. This same Care Plan does not document R22's target behaviors for the use of an antipsychotic medication. R22's MDS (Minimum Data Set) assessment dated [DATE], documents R22 has severely impaired cognition; no documented behaviors; and receives Antipsychotic medication on a regular basis. R22's electronic medical record dated 1/1/24 through 5/15/24, does not document R22 had any behaviors to warrant the use of Seroquel, a psychotropic medication assessment that was completed prior to initiating Seroquel, or R22's response to non-pharmacological interventions. On 5/15/24 at 1:00 p.m., V7 (Certified Nurse Aide) stated R22 had no behaviors to justify the use of an antipsychotic medication. V7 stated R22 was never aggressive or pose any harm to himself or others. On 3/15/24 at 12:40 p.m., V2 (Director of Nursing) stated the only behavior monitoring is done by the licensed nurses. V2 stated, The nurses monitor the resident each shift and if a behavior or side effect is noted, then they document the occurrence in the progress notes. There is no behavior tracking completed by the Certified Nurse Aides. We have no psychotropic medication assessment that we complete. I have not seen (R5 or R22) have behaviors to warrant the use of (antipsychotic medications). On 5/16/24 at 1:20 p.m., V1 (Administrator) stated the facility does not have a specific policy on Antipsychotic medication use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 31283 Based on interview and record review, the facility failed to perform infection surveillance regarding logging, tracking and trending of resident and employee illnesses and infections. This failure has the potential to affect all 38 residents residing in the facility. Findings include: The facility's Infection Control policy (12/17/19) documents the following: Infection Control Committee Members: Administrator, Director of Nursing, Infection Preventionist, Maintenance/Housekeeping Supervisor, Food Service Supervisor, Medical Director, and Facility Pharmacist. The Infection Control Committee: Shall be responsible for surveillance of any suspected or known nursing home potential infection, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards. Also process surveillance and correction of infection potentials in all nursing facility departments. This policy also documents the following: The Infection Control Committee should do the following: Review system for reporting, evaluation and keeping records of infections among resident and personnel in order to provide an indication of the endemic level of all nosocomial infections, to trace the source of infection and to identify epidemic or potential epidemic situations; To accomplish our objectives, the committee shall meet on a quarterly basis and, when necessary, hold additional meetings to consider problems arising in this area of responsibility. This same policy documents, Data Collection by Surveillance: Person to be responsible for surveillance will be appointed by the Director of Nursing. This person will be responsible for gathering the (1) Who, (2) What, (3) When, (4) Where, and (5) How of the suspected infectious condition. Data to be collected will answer the above (5) requirements. General information may be obtained from the nurse's infection control sheet, obtaining the following data: Nursing staff will develop weekly reports on antibiotics, including review to ensure appropriate use of antibiotics; Residents with abnormal drainage or broken areas in the skin which may be media for infection, including surgical incisions; Residents complaining of upper respiratory difficulty which may be infectious in nature; Residents with indwelling catheters; Residents with IV's (intravenous access); Resident with gastro feeding tubes. From the information gathered, a visual observation of the resident should be made and evaluated. The above gathered information will be reviewed and compiled into numbers and types of infections. A report will be prepared with the total number, types, and severities or infection and will be submitted to the Infection Control Committee. The Infection Control Committee will review the information and try to establish a pattern of infection. Based on the information received, the Infection Control Committee will evaluate policies and procedures for the prevention and control of infections and recommend corrective measures when and where necessary. The surveillance data will be kept on file for future reference. (continued on next page)

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	146108	A. Building B. Wing	05/16/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/16/24 at 02:30 PM, V11 (Registered Nurse/Infection Preventionist) stated she took on the role of the facility's Infection Preventionist in December 2023. V11 stated that she does not have a log of resident infections or a log of employee illnesses to provide for review. V11 confirmed that no infection logging, tracking or trending is being conducted at the facility. V11 stated, I do MDS (Minimum Data Set Assessments), Restorative, and I am also the Infection Preventionist. I did the Infection Preventionist training, but that's about it. I have not had the opportunity to start any of it. I have seen three different people in the roles for the Dietary Manager and Social Service Director, so I have been having to complete the areas of the MDS that they are typically responsible for. V11 confirmed that she is often pulled to work the floor providing direct resident care when there's a call in at the facility. V11 then stated although her portion of infection control and antibiotic use is supposed to be discussed at the facility's Quarterly Assurance Meetings, it has not been discussed at the past two meetings since she has been in the role as the Infection Preventionist. The facility's Daily Staffing Sheets (dated 04/29/24 - 05/12/24) document that V11 (Registered Nurse/Infection Preventionist) was assigned to work the floor providing direct resident care on nine of the 14 days. On 05/16/24 at 11:15 AM, V2 (Director of Nursing) confirmed that V11 does work on the floor often, It is not for her entire shift, but she does go work the floor when needed. V2 stated she was not aware that a log for resident infections and illness and an employee illness log was not being maintained and stated it should have been. The Long-Term Care Facility Application for Medicare and Medicaid form dated 05/13/24 and signed by V1 (Administrator), documents 38 residents currently reside in the facility.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 31283 Based on interview and record review, the facility failed to ensure their antibiotic stewardship program was implemented. This failure has the potential to affect all 38 residents residing in the facility. Findings include: The facility's Antibiotic Stewardship policy (Revised 12/18/19) documents the following: It is the policy of the facility to follow an Antibiotic Stewardship program, including the core elements as outlined by the CDC (Center for Disease Control and Prevention). The purpose of the program is to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events. Procedure: Antibiotic Stewardship is part of Infection Control Program, including standardized tools such as UTI (urinary tract infection) SBAR (situation, background, assessment, and recommendation) and McGreer Criteria. The facility will track antibiotic use daily. The facility will communicate with the physician(s) prescribing antibiotics with a Utilization report on a monthly bases and as needed. All nurses, upon hire and as needed, will be educated regarding proper assessment for infection prior to calling physician. The facility will ensure the pharmacy reviews all antibiotic usage for appropriateness. Antibiotic use will be calculated on a monthly basis for QAPI (quality assurance and performance improvement) purposes. The facility will monitor for all adverse reactions/outcomes related to antibiotic therapy. The facility will involve the laboratory in our QAPI meetings as applicable. Information gathered will be communicated to all staff. On 05/16/24 at 02:30 PM, V11 (Registered Nurse/Infection Preventionist) stated she took on the role of the facility's Infection Preventionist in December 2023. V11 stated that she does not have a log of resident infections, antibiotic use or employee illnesses to provide for review. V11 stated, We are supposed to follow McGreer's criteria. I am supposed to keep a log of antibiotic use, and it hasn't been done. Not all of the nurses are completing the form that is supposed to be completed for this, so forms are not being completed regularly and I have found some residents who were prescribed antibiotics, and I have had to complete the form after the fact. I am not logging any of it, so I have nothing I can show you. Antibiotic use was not discussed at the last two QA (Quality Assurance) meetings since I did not have the information compiled.' The facility's Daily Staffing Sheets (dated 04/29/24 - 05/12/24) document that V11 (Registered Nurse/Infection Preventionist) was assigned to work the floor providing direct resident care on nine of the 14 days. On 05/16/24 at 11:15 AM, V2 (Director of Nursing) confirmed that V11 does work on the floor often, It is not for her entire shift, but she does go work the floor when needed. V2 stated she was not aware that logs required for the facility's infection control program, specifically pertaining to resident infections/illnesses, antibiotic use, and employee illnesses was not being maintained, and stated it should have been. The Long-Term Care Facility Application for Medicare and Medicaid form, dated 05/13/24 and signed by V1 (Administrator), documents 38 residents currently reside in the facility.