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 _____	08/14/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 22 in the walk-in freezer below the refrigeration unit. A thick accumulation of ice also coated the floor in the back of the freezer. 4. Also on the dietary tour with E3 from 9:30 AM to 10 AM on 8/7/06, the outer surface of the convection oven was worn off and not easily cleanable. Also the floor inside the milk cooler in the food storeroom was corroded with rusty colored water on it. 5. During the general tour with E5 on 8/8/06 at 9:30 AM, the grabbar unit was loose from the wall by the toilet in the 500 hall shower room.	F 456		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a)1) 300.690a)2) 300.690b) 300.690c) 300.3240b) 300.3240c) 300.3240d) 300.3240e) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification	F9999		

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F9999	Continued From page 23 shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. d) A facility administrator who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. These regulations were not met based on	F9999		

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F9999	Continued From page 24 interview and record review, which revealed that the facility failed to: A. Follow its abuse prohibition policy when staff became aware of allegations made by R14 and R 27 of incidents of rough treatment by E12 (2nd Shift Coordinator) in that these staff did not notify the administrator so investigations ensuring the protection of the residents could have been conducted. B. Thoroughly investigate these allegations and suspend E12 when the survey team notified E1 (Administrator). Findings include: On the first day of the survey, 8/7/06, at approximately 2:30 PM, E1 was asked if any abuse, neglect, or misappropriation of property allegations had been received from residents or families since the last certification survey in October 2005. E1 stated that she had not had any allegations since the last survey. During the resident group interview, conducted on 8/8/06 from 10:45AM to12:00PM, when the residents were asked about how they are treated by staff, R20 stated that she did not like the manner in which E12 (2nd Shift Coordinator) talked to her. R20 said that E12 is always telling her what and what not to do. Other residents in the meeting also expressed dissatisfaction with E 12's demeanor, but had no complaints with any other staff. R14 stated that E12 is "rough" and that last month E12 "dropped" him in bed twice and tipped his wheelchair sideways one time. R 14, when asked about reporting the incidents, said that he had not told E1 (Administrator), the former Director of Nursing, or the new Director of Nursing (E2) about it.	F9999		

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F9999	Continued From page 25 An interview with E1 was done on 8/8/06 at approximately 2:20PM; E1 was informed of the allegations of rough treatment by E12 made by R 14. E1 stated that she usually talks with R14 on a daily basis, and that he never mentioned any of this to her. E1 said that she would investigate this and report back to the survey team about what she learned. Later that afternoon and all of the next morning (8/9/06), E12 was still noted working in resident areas of the facility. Interview with E1, on 8/9/06 at approximately 1: 15PM, regarding the progress of the investigation indicated that she had done it and would bring the paperwork in. At 1:45PM E1 brought 3 small yellow note pages: one page was E1's summarization of interviews with R14 and E12 conducted at 4:30PM 8/8/06, and the other 2 pages were notes written by the Assistant Administrator (E16) and the 1st Shift Coordinator (E17) regarding what R14 had told them on 7/25/ 06 about his dislike for the way E12 presents himself. There were no written statements in the report from E12 or any other staff or residents. E 1 said that her interview with R14 the day before did not produce any details of the roughness allegation, but that R14 had told E16 and E17 on 7/25/06 about this incident that occurred the evening before. E1 further said that her conclusion was that no abuse occurred on E12's part, and that E12 would be allowed to work, but would no longer provide care for R14. Review of R14's nursing notes dated 7/24/06 and written by E19 (nurse) indicated that at 10:07PM the resident was very agitated with E12, and that E12 reported to E19 that R14 tried to kick him and was yelling at him. This entry also read that	F9999		

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F9999	Continued From page 26 R14 reported to E19 at that time that E12 was " being too rough" with him. The entry concluded with information that R14 said that E19 did not care about him or anyone else and that R14 continued yelling after E19 and E12 left the room. Interview with E19 on 8/9/06 at 2:00PM regarding the above nursing note indicated that R14 gave him no specifics at the time how E12 had been rough with him when E12 put him to bed that night. When asked as to whether he had reported the allegation to E1 or E2, E19 stated that he had not because he "never considered it abuse." E19 also stated that R14 does not normally get that agitated when care is being provided, and that he did not know why R14 got that way that evening. Interview with E17 on 8/9/06 at 2:10 PM confirmed that R14 had approached her in the hall on the afternoon of 7/25/06 and asked if she could do something about E12, because E12 was rough with him the night before and that he did not like E12. E17 stated that she immediately went up to E16's office with him where he told E 16 the same thing. E17 said that R14 never gave them any details as to how E12 was rough with him, but that he expressed his dislike for E12. E 17 also reported that none of the nurse aides she supervises have told her that R14 has been combative with them. A confidential interview 8/9/06 at 2:45PM with a staff member from a department other than nursing who wished not to be identified, stated that R14 and also R27 about a week ago at different times reported to her that E12 had been rough with each of them when putting them to bed. The staff member stated that she reported	F9999		

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F9999	Continued From page 27 the issue with R27 to E20 (Activity Director) and the incident concerning R14 to E17, since E20 was not working at that time. Interview with E20 at 3:10PM on 8/9/06 indicated that she had not received any allegations concerning rough handling of residents lately, only an issue pertaining to staff dressing procedure involving R27. E20 said that R27 prefers to be dressed in a certain way by staff. Interview with R14 at 9:00AM on 8/10/06 concerning the incident with E12 on the evening of 7/24/06 indicated that E12 came in his room to put him to bed. R14 stated that he required 2 staff to transfer him, but E12 said he could do it himself. R14 said that E12 did not use a gait belt for the transfer and grabbed him by the armpits, while R14 was instructed to hold onto E12's neck with his right arm. R14 said that after he "landed" in bed, he was not centered in the bed, so E12 took hold of him and dragged him across the bed. R14 stated that he told E12 at the time,"D---, you're rough," to which E12 replied, "You think I'm rough, just lay there and be quiet." R14 further said that E12 then left the room and was talking with E19 for awhile before they both came back. R14 stated that E19 never asked him what had happened. When R27 was interviewed at 10:35AM on 8/10/06 and asked if there were any nursing staff that were not nice or were rough with him, he identified E12 as the only staff with whom he had a problem. R27 said he is paralyzed on his left side and that staff have to be careful of his left shoulder which is painful at times. R27 said that E12 handled his left side roughly and is too quick whenever E12 took care of him. R27 said that he	F9999		

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F9999	Continued From page 28 reported this problem with E12 last week to E1 and E16, who said they would talk to E12. R27 reported that E12 has not taken care of him since then. The facility's Abuse Prohibition Policy # 1.13 last revised 12/04, under section B, "Initial steps and reports of alleged abuse or neglect," states: 1 - Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator. & 4 - If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident. The policy also specifies under section D. Abuse or neglect examination and protection: 1 - The shift nurse on duty who is first made aware of any allegations of abuse or neglect concerning any resident shall immediately examine the resident involved to determine whether the resident is in any distress or has suffered any injury. The nurse shall take all steps necessary to protect the resident from danger, and document as necessary. 2 - If the incident involves suspected abuse, then the shift nurse shall assure that the suspected abuser has no further contact with the resident involved or with any other resident." (A)	F9999		