STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146076	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

(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 000	INITIAL COMMENTS Incident Report Investigation to incident of 6/17/16 / IL86809	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure R1 was safely transferred using a sit to stand with two staff member s to assist for one (R1) of three residents reviewed in the sample of three residents reviewed for transfers. The faciliy's failure resulted in R1 sustaining a subarachnoid hemorrhage. Findings include: R1's Physician Order Sheet (POS) dated July 2016 documents R1's diagnoses as Subarachnoid Hemorrhage, Muscle Weakness, Cognitive Communication Deficit, History of Falling, Cerebral Vascular Accident, Muscle Wasting and Atrophy, Syncope and Collapse, and Multiple Sclerosis. This same POS also documents a physician's order for an anticoagulant since R1's admission to the facility on 1/23/15. R1's Brief Interview for Mental Status (BIMS) dated 5/30/16 documents R1's score of 8	F 323		

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

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F 323	Continued From page 1	F 323		

indicating R1 as cognitively moderately impaired. R1's pre-fall (6-17-16) Fall Risk Assessment dated 3/24/16 documents a score of 19 indicating R1 is a high fall risk. R1's Care Plan dated 5/25/16 documents R1's mobility as left-sided weakness and Multiple Sclerosis impacting R1's transfers. This same Care Plan also documents the requirement to use the stand aide (sit to stand) with the assistance of two members for transfers for R1.

R1's Progress Notes dated 6/17/16 documents "(R1's) knees gave out while standing....and (R1) fell onto the floor on left side....immediate formation of a softball sized hematoma to left side of head." R1's Progress Notes dated 6/20/16 document R1 returned to the facility where R1 resides.

R1's Patient Summary dated 6/17/16 from R1's Emergency Room (ER) visit documents R1 arriving on 6/17/16 at 9:56 AM in critical condition, on an anticoagulant, in pain at left eyebrow area from a mechanical fall at the facility where R1 is staying. The Computed Tomography Report from the ER visit dated 6/17/16 for R1 documents the findings as evidence of a small area of Subarachnoid hemorrhage in the left occipital lobe due to a ground-level fall at the nursing home striking left forehead on concrete (initial encounter). R1's diagnosis from the ER report dated 6/17/16 documents R1 as having a Subarachnoid Hemorrhage following injury. The ER report dated 6/17/16 for R1 documents R1 arrived with threat for imminent organ system collapse secondary to fall with head injury, on anticoagulation...patient stabilized for transfer to local trauma facility.

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F 323	Continued From page 2	F 323		

The Trauma Evaluation History and Physical dated 6/17/16 documents R1 as taking Plavix 75 milligrams (mg) everyday. This same report documents active hospital problem as a fall - on coumadin/plavix (blood thinning medication) and a subarachnoid hemorrhage with a plan to admit to trauma. This report also documents International Normalized Ratio (INR) reversed with Fresh Frozen Plasma (FFP) and Vitamin K. The brain scan without contrast dated 6/18/16 impression documents slight increased size of the probable Subarachnoid blood within a left parietal sulcus...there may be a tiny adjacent parenchymal hemorrhage.

On 7/12/16 at 12:07 PM, E3, Certified Nurse Assistant (CNA) stated on 6/17/16 E3 was getting R1's weight and as getting resident back into wheelchair, R1 fell. E3 stated R1 requires the use of a sit to stand for all transfers and has been for a while. E3 stated E3 weighed R1 by herself. E3 stated E3 should have been a two person transfer according to R1's 5/30/16 Care Plan. E3 also stated "I should have used the stand aid (sit to stand) and another CNA when weighing the resident (R1)...I made a bad judgement call".

On 7/12/16 at 12:37 PM, E2 Director of Nursing (DON) stated on 6/17/16 E3 thought it was okay to weigh R1 with no assist but R1 is supposed to be "a stand aide (sit to stand) transfer with two assist." E2 also stated E3 transferred R1 incorrectly and E2 doesn't see how R1 could have fallen if the transfer was done correctly.

On 7/13/16 at 3:30 PM E1 Administrator stated E3 was weighing R1 on 6/17/16 in the hallway and R1 sat down before E3 was able to get the wheelchair under R1. E1 stated E1 would expect

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F 323	Continued From page 3 E3 to follow R1's Care Plan and to use a stand aide, gait belt and two assist (with transfers). E1 stated E3 transferred R1 by E3's self. On 7/14/16 at 2:00 PM, Z1, Physician stated the Subarachnoid Hemorrhage was caused from the fall R1 had on 6/17/16 at 10:02 AM. This failure resulted in R1 falling and sustaining a Subarachnoid Hemorrhage.	F 323		