

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/30/2018
NAME OF PROVIDER OR SUPPLIER MANOR COURT OF MARYVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 6955 STATE ROUTE 162 MARYVILLE, IL 62062		
(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) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/15/18

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S9999	Continued From page 1 procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement effective interventions and provide supervision to prevent falls for 1 of 4 (R404) residents reviewed for accidents in the sample of 42. This failure resulted in R404 sustaining a non-displaced fracture of her right hip. Findings include: The Minimum Data Set (MDS), dated 04/03/18, documented R404 has a Brief Interview of Mental Status (BIMS) score of 05, indicating severe cognitive impairment. The MDS further documents R404 is severely impaired, requires limited assistance with transfers, personal hygiene, toilet use, and utilizes wheelchair for mobility device.	S9999		

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S9999	Continued From page 2 R404's Care Plan, dated 12/27/17, documents R404 was admitted to the facility with an unspecified displaced fracture 2nd cervical vertebra with a neck brace in place. The Care Plan documents R404 was at risk for falling related to recent fall at previous Long Term Care Facility, history of falls, and diagnosis of unsteadiness on feet. The Care Plan documents interventions to address falls "alternate call light, activities of interest and instruct resident to call for assist before getting out of bed or transferring." R404's Investigation Report documented R404 fell on 03/19/18. R404's Event Report for un-witnessed fall in bathroom dated 03/19/18 at 3:00 PM, documented in part, "Why does resident think they fell?: trying to get off toilet without assist." The Report documented other contributing factors to falls as "noncompliant with transfers. Transfers without assist after frequent reminders." R404's Care Plan was revised on 3/19/18 with approach "Bathroom Door Alarm." Event Report for fall dated 04/03/18 at 11:55 AM, documented R404 self-reported that she fell during the night while trying to take herself to the bathroom. The Event Report documented "Stated her feet became entangled with each other, causing her to trip and fall onto floor landing on buttock. Denies hitting head. Bruising noted to mid-spine and coccyx area of buttock. Both areas of bruising are dark purple in color." The Note section under the Event report, dated 4/6/2018 documented "Chatted with (R404) and daughter in TV Lounge, (R404) is pleasant and alert, stated that she is just fine and verbalized understand	S9999			

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S9999	Continued From page 3 that she needs assistance in her bathroom and understands the bathroom door alarm is a reminder." R404's Care Plan for fall 04/03/18, documented an approach for R404 to be prompted with toileting program 8:00 PM-8:00 AM, every 2 hours when awake. R404's Fall Risk Report dated 04/11/18, documented history of one or more falls within the previous 6 months. The Fall Report documented "Requires assistance or supervision for mobility, transfer, or ambulation, unsteady gait," reflecting a score of 24, identified as High Fall Risk. Event Report for fall dated 4/15/18 at 8:30 PM, documented "What was resident doing just prior to fall?"- walking in room unassisted. Progress Note: Resident noted laying against wall by door." R404's Investigation Report, dated 04/15/18, documented she fell on 04/15/18. On 04/15/18 at 8:30 PM, R404 sustained a fall from her chair. This resulted in a non-displaced fracture to right greater trochanter (hip). On 7/26/18 at 12:15 PM, V2, Director of Nursing (DON) stated, she would expect staff to continue with frequent resident checks to all residents. V2 also stated the evening of 7/25/18, she had to remind staff residing at the nursing station, to walk up and down the hall and visually check on each and every resident while in their rooms. On 7/26/18 at 11:10 AM, V27, Certified Nurse Aide (CNA) stated that R404 needs reminders to not to get up out of bed or wheelchair without calling for assistance.	S9999			

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S9999	Continued From page 4 On 7/26/18 at 3:16 PM, V28, R404's Family Nurse Practitioner, stated she would expect facility staff to perform hourly rounding and to increase the supervision for R404. V28 also stated she had personally educated R404 regarding calling for assistance from staff back in February and March of 2018. On 7/26/18 at 10:12 AM, R404's room 213, located at the end of the hall, bathroom door alarm was manually activated and was not audible from midway hall location and/or nurse station. The facility's policy and procedure, dated 8/2014 and entitled, "Accidents/Incidents Prevention," documented in part: "Monitoring of the resident when mobile, Assist with the transfers when the resident is unsteady, maintain close supervision of confused residents, monitor during high risk times according to the individuals history, (after pain medication, during night hours, after meals etc.) Place high risk residents in rooms near the nurse's station as appropriate." (B)	S9999			