Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C B. WING IL6013189 01/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6955 STATE ROUTE 162** MANOR COURT OF MARYVILLE MARYVILLE, IL 62062 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Facility Reported Investigation (FRI) to incident of 12/26/21/IL142016 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 Attachment A b) The facility shall provide the necessary care Statement of Licensure Violations and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with

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

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a diagnosis of Ankylosing Hyperostosis (condition

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED IL6013189 B. WING 01/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6955 STATE ROUTE 162** MANOR COURT OF MARYVILLE MARYVILLE, IL 62062 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) \$9999 Continued From page 2 S9999 in which new bone is laid down on the vertebrae forming spurs or bridges). R2's Physician Order dated 12/26/21 documents a diagnosis of left tibia stress fracture. R2's Care Plan dated 07/07/20 documents "(R2) has chosen receive Hospice care from Heartland Hospice related to Cerebral Artherosclerosis." R2's Care Plan dated 07/10/18 documents "Safe Resident Handling Procedures: Transfer Method: full mechanical lift large combi Level of assistance: 2 assist sling style: combi sling size XL." R2's Nursing Note dated 12/22/21 at 11:53 AM documents "Nurse brought to my attention that resident had a bruise to inner left foot. After assessing area an investigation was put into place." R2's Nursing Note dated 12/26/21 at 7:00 AM documents, "Res. (Resident) moaning and reaching for her L (left) knee when moved or repositioned. LLE (left lower extremity) relaxed not stiff like her norm. MD (physician) notified." R2's Nursing Note dated 12/26/21 at 12:08 PM documents "x-ray of LLE ordered. Leg swollen and bruised." R2's Nursing Note dated 12/26/21 at 6:40 PM documents "This writer received notification of an iniury to residents L Knee a fracture that was identified. Physician, Hospice and POA (Power of Attorney) notified. Investigation initiated and began calling staff that had assisted resident in

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the previous 3 days. Statements received bruising had been noted to her left foot on

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X-ray Company) came here to X-ray her. She's

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