

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6016133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/25/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANOR COURT OF FREEPORT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2170 WEST NAVAJO DRIVE FREEPORT, IL 61032</b>		
(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  Facility Reported Incident of November 19, 2024 IL181409	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.1210 b) 300.1210 d)6)  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. 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.  These requirements are not met as evidenced by:  Based on interview and record review, the facility failed to ensure a resident was wearing non-skid	S9999		

Illinois Department of Public Health

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

TITLE

(X6) DATE

Electronically Signed

12/05/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6016133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/25/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANOR COURT OF FREEPORT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2170 WEST NAVAJO DRIVE FREEPORT, IL 61032</b>		
(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
S9999	<p>Continued From page 1</p> <p>footwear and was being held by the gait belt when being transferred/ambulated for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3 residents. This failure resulted in R1 falling and sustaining a rib fracture, two transverse process fractures of the lumbar vertebrae, and a skin tear.</p> <p>The findings include:</p> <p>R1's Face Sheet, dated 11/25/24, shows R1 was admitted to the facility on 10/2/24. R1's diagnoses include, but are not limited to, fracture of neck of right femur (hip), presence of right artificial hip joint, Parkinson's disease, muscle weakness, unsteadiness on feet, pain, and an unspecified fall.</p> <p>R1's Fall Risk, dated 10/2/24, shows R1 was a high fall risk.</p> <p>R1's Care Plan (problem start date 10/3/24) shows R1 is at risk for falling.</p> <p>The facility's Event Report, completed 11/20/24 at 3:26 PM, shows R1 had a fall on 11/19/24 at 9:42 PM in his room. The report shows R1 feels he fell because he slipped as the CNA was transferring him to bed. R1 complained of pain to his left ribs and a skin tear was noted. Evaluation Notes from the report state, "Encourage use of non-skid footwear for transfers and ambulation."</p> <p>R1's Progress Notes, dated 11/19/24 at 9:24 PM, shows the nurse observed R1 lying on his backside on the floor in his room. R1 reported he slipped when transferring to his bed without wearing shoes. R1 said he hit his back and head and felt like he cracked a rib.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6016133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/25/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANOR COURT OF FREEPORT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2170 WEST NAVAJO DRIVE</b> <b>FREEPORT, IL 61032</b>		
(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
S9999	<p>Continued From page 2</p> <p>R1's Progress Notes, dated 11/19/24 at 11:04 PM, shows facility staff spoke to a nurse at the hospital and were informed R1 fractured his left posterior twelfth rib and left lumbar vertebrae (L3 and L4) transverse process and sustained a skin tear on his left arm.</p> <p>R1's CT abdomen and pelvis without contrast study, dated 11/19/24 at 10:33 PM, shows the following: Impression: Left posterior 12th rib fracture. Left L3 and L4 transverse process fractures.</p> <p>On 11/25/24 at 9:20 AM, V3, Licensed Practical Nurse, said she was doing her med pass and the shift coordinator, V6, reported a resident was on the floor. V3 said V4, Certified Nursing Assistant (CNA), was in the room with R1 when she arrived. V3 said R1 was lying on his back on the floor and had a skin tear on his left forearm. V3 said R1 was wearing regular socks, "they are slippery socks" and no shoes. V3 said R1 said it felt like his rib cracked. V3 said R1 told her he slipped. V3 said she was, "not sure why they would put a gait belt on him and not shoes."</p> <p>On 11/25/24 at 11:22 AM, V4 said she was assisting R1 from his recliner to his bed. V4 said R1 stood up and took a couple steps with his walker and fell back and sideways into the window. V4 said it happened so fast she was unable to catch him. V4 said she was not holding onto R1's gait belt when he fell, she just had her hands on his waist and was guiding him. R1 was wearing socks and no shoes. When asked if she would have done anything differently, V4 replied she would have made sure R1 had shoes on, and would have held on to him tighter.</p> <p>On 11/25/24 at 11:42 AM, V2, Director of Nursing</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6016133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/25/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANOR COURT OF FREEPORT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2170 WEST NAVAJO DRIVE</b> <b>FREEPORT, IL 61032</b>		
(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
S9999	Continued From page 3  (DON), said V4 told her she was transferring R1 to his bed, and R1's feet started slipping and she could not catch him from falling. V2 said after investigating R1's fall, she educated staff to make sure they are holding on to the gait belt, and to be cognizant about what the residents are wearing.  On 11/25/24 at 12:19 PM, V5, Assistant DON, said V5 said R1 was a fall risk. V5 said they treat everyone as if they are a fall risk and they use a fall risk scale (Johns Hopkins Fall Risk Assessment Tool) to identify residents who are at a higher risk for falls. V5 said all residents should have non-skid socks or shoes on when they get up.  (A)	S9999			