Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013189	A. BUILDING: _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S 000	Initial Comments Complaint Investigation: 1947814/IL116881	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3240a) 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 procedures:] 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/06/19

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S9999	Continued From page 1	S9999		

All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed assess for the root cause of falls and failed to implement progressive interventions to prevent future falls and skin tears for 7 of 7 residents (R3, R4, R5, R14, R21, R22, R23) reviewed for falls and skin tears in the sample of 27. This failure resulted in R5 falling and sustaining fractures of the face, neck and

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S9999	Continued From page 2	S9999		

upper back bone.

Findings include:

1. R5's Minimum Data Set (MDS) dated 8/6/19 documents R5 has severe cognitive impairment for daily decision making and never/rarely makes decisions and requires more than 50 to 75 percent help from two staff for transfers, toilet use. The MDS documents R5 is not steady, only able to stabilize with staff help when moving from seated to standing, moving on and off toilet, and transfer from bed to chair or wheelchair and vice versa.

R5's Care Plan dated 8/27/19 documents, "At risk for falling related to recent illness/hospitalization and new environment, Hard of hearing, bilateral hearing aids/right ear deaf, Impaired memory, History of falling.

R5's Johns Hopkins Fall Risk Assessment Tool dated 3/5/19 documents R5 is a high fall risk.

R5's electronic record from 4/19/2019 until 9/30/2019 documents 20 falls as follows:

R5's Event Report dated 4/19/19 documented at 3:00 PM, R5 had a witnessed fall in the day room as she stood from wheelchair and attempted to walk. The Report documented that directly after the fall R5 held the back of her head. The Report documented she had bruising to the back of her head. The Report documented the following immediate interventions put into place after fall were: bed alarm, chair/wheelchair alarm, increased toileting and low bed.

R5's Problem Evaluation Notes Report documents the intervention/Approach to address

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S9999	Continued From page 3	S9999		

R5's fall on 4/19/19 as "Staff inservice to assist/encourage to go to activity department to participate in group activity between noon and evening meals."

R5's Event Report dated 4/25/19 documented at 3:55 PM, R5 had a witnessed fall in the day room when she attempted to stand from her wheelchair, stumbled over her feet, fell backwards and hit her head on the floor. The Report did not document if her chair/wheelchair alarm sounded to alert staff of her movement. The Report documented she sustained a bump on the back of her head. The Report documented the following immediate interventions put into place after the fall were: chair/wheelchair alarm, ice, rest, increased toileting and low bed.

R5's Problem Evaluation Notes Report documented the Interventions/approaches to address R5's fall on 4/25/19 were to conduct vital signs for 72 hours after her fall. There were no interventions to address R5's need for increased supervision.

R5's Event Report dated 4/29/19 at 2:28 PM documented R5 had an unwitnessed fall in her room. The Report does not document what R5 was doing prior to the fall. The Report documented she was found on the floor but had no injuries. The Report did not document any immediate interventions put into place after this fall.

R5's Problem Evaluation Notes Report documented the interventions/approaches to address R5's fall on 4/29/19 were to have a clothes tab audible safety device and for physical therapy to screen.

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S9999	Continued From page 4	S9999		

R5's Event Report dated 5/6/19 documented at 6:33 AM R5 had a witnessed fall in her bathroom. The report documented she had a "bump" but did document the location of this bump. The Report did not document if R5 was in her bed or wheelchair prior to the fall. The Report documented the immediate interventions put into place after this fall as: bed alarm, chair/wheelchair alarm, ice, rest and alternate call.

R5's Problem Evaluation Notes dated 5/6/19 documents the interventions/approaches to address R5's fall on 5/6/19 as " Audible safety device to bed related to fall 5/6/19."

R5's Event Report dated 5/20/19 documents at 6:09 AM, R5 had an unwitnessed fall in her room. There was no documented description of the fall including if R5 was in bed or in her wheelchair prior to this fall. There was no documentation if R5's safety alarms were activated and sounding prior to this fall. There were no immediate interventions to address this fall documented on this report. There was no documentation R5 sustained injuries from this fall.

R5's Problem Evaluation Notes dated 5/21/19 documents R5 was sent to hospital for x-ray regarding her fall on 5/20/19. The Note documented the x-ray was negative. The Note documented the interventions/approaches to address R5's fall on 5/20/19 were "Audible safety device bathroom door related to fall on 5/20/19. Occupational Therapy Screen wheelchair modification."

R5's Event Report dated 6/3/19 documents at 4:41 PM, R5 had a witnessed fall in the day room. The report documented R5 was sitting in the day

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S9999	Continued From page 5	S9999		

room, staff saw her stand but could not get to her in time.

R5's Problem Evaluation Notes dated 6/3/19 documents interventions/approaches to address R5's fall on 6/3/19 documented " Staff Inservice to engage/encourage (R5) to participate in activity that she enjoys, painting/drawing/coloring when she is sitting at activity table in dayroom related to fall on 6/3/19."

R5's Event Report dated 6/4/19, documents at 4:21 PM R5 had a witnessed fall in the dining room when she stood from her wheelchair and hit her head. She sustained a bump to the back of her head.

R5's Problem Evaluation Notes dated 6/5/19 documents interventions/approaches to address R5's fall on 6/4/19 as " Busy board related to fall out of wheelchair on 6/4/19."

R5's Event Report dated 6/11/19 documents at 1:06 PM, R5 had a witnessed fall in the day room. The report documented she was sitting in her wheelchair prior to her fall. The Report did not document if R5 was being engaged in activities or had the busy board. The Report did not document if R5 fell while standing from her wheelchair or turned her wheelchair over. The report did not document her wheelchair alarm sounded. The report did not document if R5 sustained injuries from this fall. The Report documented the immediate measures implemented to address this fall was "chair alarm."

R5's Nurse's Note dated 6/11/2019 at 1:09 PM documents, "Resident had a witnessed fall @ (at) PM. Attempted to stand in day room without

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S9999	Continued From page 6	S9999		

assistance." The Note documented "Resident has an abrasion noted to right ear. Bruise also noted to right wrist."

R5's Problem Evaluation Notes dated 6/11/19 documents intervention/approach to address this fall as "Staff in serviced to ensure that (R5) is in her proper wheelchair with anti-rollback bars related to the fall on 6/11/19."

R5's Event Report dated 6/15/19 documents at 7:02 AM. R5 had an unwitnessed fall in her room. This Report had no description as to where R5 was found and if she had fallen from her bed or wheelchair. The Report did not document if any safety alarms were sounding.

R5's Problem Evaluation Notes dated 6/17/19 documents intervention/approach to address the fall as "Staff in serviced to encourage/assist (R5) up out of bed first in AM for AM meal related to fall on 6/15/19."

R5's Event Report dated 6/19/19 documented at 11:20 AM, R5 had an unwitnessed fall in her room. The Report documented a Certified Nurse's Aide (CNA) heard R5's alarm sounding and found her on the floor at the foot of her bed.

R5's Problem Evaluation Notes dated 6/19/19 documents interventions to address R5's fall as "Bilateral body pillows when in bed related to fall on 6/19/19."

R5's Event Report dated 6/20/19 documents at 3:40 AM, R5 had an unwitnessed fall in her room. The Report documented that R5 has been continually trying to get up herself. The Report did not document if R5's alarms were sounding when R5 was found. The Report document she had

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S9999	Continued From page 7	S9999		

pain in her left lower extremity. The Report documented immediate measures taken as: bed alarm, increased toileting.

R5's Problem Evaluation Notes dated 6/20/19 documents interventions to address R5's fall as "Staff Inservice to ensure that (R5's) audible safety device is on and operable at all times. Care Plan reviewed. No new changes. Transferred to (Hospital) ER for evaluation of fall." There were no interventions or reassessment to address R5's need for increased supervision.

R5's Event Report dated 7/2/19 documents, at 1:02 AM. R5 had an unwitnessed fall in her room. The Report documented R5 was in bed prior to the fall and a CNA found her on the floor next to her bed. The Report did not document if R5's safety alarms were sounding. The report documented the immediate measures taken after the fall were the bed alarm and low bed.

R5's Problem Evaluation Notes dated 7/2/19 documents interventions to address R5's falls as "Bilateral floor mats while in bed related to fall on 7/2/19." There were no interventions to address R5 getting out of bed unsupervised or need for increased supervision.

R5's Event Report dated 7/7/19 documents at 8:32 AM, R5 had an unwitnessed fall in her bed room but did not document where she fell in her room. The Report documented she was grabbing the knot on the back of her head, crying, after the fall. The report documented she sustained a bump and bruise to the back of her head. The report did not document if the R5 was in bed or in her wheelchair at the time of the fall. The report did not document if R5's safety alarms were sounding.

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S9999	Continued From page 8	S9999		

R5's Problem Evaluation Notes dated 7/7/19 documents the interventions to address R5's fall as "Staff in serviced to ensure that bathroom door audible safety device is on and operable at all times related to fall on 7/7/19."

R5's Event Report dated 7/17/19 documents at 2:31 AM. R5 had an unwitnessed fall in her room and had a right forehead bruise with a bump. The Report did not document where R5 was found and if her safety alarms were sounding.

R5's Problem Evaluation Notes dated 7/17/19 documents interventions to address R5's fall as "PT (Physical therapy) to observe related to fall on 7/17/19. Staff in service to offer snack, conversation, activity when (R5) is awake during night hours/unable to sleep, assist to staff area."

R5's Event Report dated 7/23/19 documents at 6:13 AM R5 had a witnessed fall from her wheelchair at the nurse's desk. The Report documented that she was attempting to get up out of wheelchair. The Immediate measures taken to address this fall was "Resident kept by staff at all times."

R5's Problem Evaluation Notes dated 7/23/19 documents interventions to address R5's falls as "Referral to Therapy to evaluate related to fall on 7/23/19." This was the same as the interventions on 7/17/19.

R5's Event Report dated 7/28/19 documents at 12:07 PM R5 had a witnessed fall in another resident's room. The Report did not document if R5 was in her wheelchair or ambulating. The Report did not document what the resident was doing in the other resident's room or the

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S9999	Continued From page 9	S9999		

circumstances surrounding the fall.

R5's Problem Evaluation Notes dated 7/29/19 documents the interventions as "Staff in service to ensure (R5)'s hearing aids are in place and operable at all times related to fall on 7/28/19."

R5's Event Report dated 8/16/19 documents at 4:20 AM, R5 had an unwitnessed fall in her bathroom. The report documented R5 was in bed prior to the fall. The report documented she had right should pain and right arm pain. The report documented she was found on the floor near the TV. The Report documented she was sent to the emergency room for evaluation.

R5's Problem Evaluation Notes dated 8/16/19 documents interventions to address R5's fall on 8/16/18 as "Staff education to inquire/ask (R5) if she prefers tv on/off at night."

R5's Event Report dated 8/18/19 documents at 6:02 AM. R5 had an unwitnessed fall in her room. The report documented "Writer and CNA heard pressure alarm sounding. resident was observed behind closed bedroom door, sitting on the floor with her back parallel to the wall."

R5's Problem Evaluation Notes dated 8/18/19 documents the interventions for R5's falls as "Staff education to ensure that bedroom door is open at all times related to fall on 8/18/19." There were no interventions to address increased supervision for R5.

R5's Event report dated 9/18/19 documents at 3:03 PM R5 had an unwitnessed fall at the nurse's station when she attempted to stand on her own. The Report did not document if R5's safety alarms sounded.

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S9999	Continued From page 10	S9999		

R5's Problem Evaluation Notes dated 9/18/19 interventions for R5's falls as "Staff in service /education to assist (R5) to dining room, transfer to dining room chair from wheelchair when awake before PM meal, offer meaningful conversation, enjoys folding clothes, offer snacks related to fall on 9/18/19."

R5's Event Report dated 9/22/19 documents at 10:16 AM. R5 had a witnessed fall in the dining room while attending church service. The report documented she had injuries to her facial area.

R5's Problem Evaluation Notes dated 9/22/19 documents interventions for R5's falls as "EMS (emergency medical service) 911. Sent to (hospital) for eval of fall 9/22/19. Readmitted status post fall on 9/23/19 with diagnoses of multiple facial fractures, T5-T7 process, resident is to wear a cervical collar at all times. Bruising to both eyes, face swollen. Distant observation staff in service/education to ensure (R5) is always in sight related to fall on 9/22/19."

R5's Hospital Trauma Admission History and Physical (H and P) dated 9/22/19 documents,"87 year old status post fall out of wheelchair 9/22 at her SNF and reportedly striking her head. Patient is demented at baseline. Admitted for management of facial fractures and delineation of cervical spine surgery." R5's History and Physical documents, "Plan/Assessment: Nasal bone fracture, Right zygomatic arch fracture - non-operable, head of bed above 30 degrees; C5/T5-7 spinous process fracture - spinal precautions."

On 10/29/19 at 2:59 PM, V8, Certified Nursing Aide (CNA), wheeled R5 in her wheelchair to the

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S9999	Continued From page 11	S9999		

bathroom. V8 carried washcloths and adult incontinent brief on her left hand while pushing R5 in her wheelchair inside the bathroom. As they entered the bathroom, V8 reached to her left to put the supplies on top of the sink, R5 suddenly stood up and walked the last couple of steps towards the toilet without V8 locking the wheelchair breaks and without using a gait belt on R5. V8 was able to hold/grab R5's arms and guided R5 to sit in the toilet.

On 10/29/19 at 3:15 PM, V8 stated she should have used the gait belt on R5 but R5 was very quick and just stood up before she could lock the brakes and use a gait belt on R5.

On 11/13/19 at 1:35 PM, V29, Occupational Therapist, stated she saw R5 for a few post fall evaluations. V29 stated she tried to work on balance because it would seem like R5 just wanted to get up and walk for no reason and did not know if R5 understood what therapy wanted her to do, or maybe she could not hear so she could not follow instructions and verbal cueing. V29 stated R5 was hard of hearing even with a hearing aid on. V29 stated they could never get R5 to do the balance or any other exercises because she would go another way if she is instructed to go this way, or she would do something else.

On 11/13/19 at 1:40 PM, V28, Physical Therapist, stated she tried to do different things/approaches, but they were not making any progress so R5 was discharged from PT. V28 stated R5 was a very high fall risk because she was very impulsive. It was very hard to figure out what was going on with her. V28 stated R5 always needed assist with transfers and walking. V28 stated therapy exhausted all efforts to help R5. V28

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S9999	Continued From page 12	S9999		

stated because of her impulsivity, R5 need much supervision and activities to keep her safe and busy to reduce her risk of falling.

2. R4's MDS dated 7/14/19 documents R4 is oriented to place and person and needs staff contact assistance to stabilize herself during transfers from seated to standing, moving on and off toilet and surface to surface transfers.

R4's Physical Therapy (PT) Evaluation Notes dated 6/26/19 documents, "Medical Diagnosis: Non-traumatic Subarachnoid hemorrhage (6/5/19). Patient suffered a Cerebrovascular accident (stroke) on 6/5/19. Was in acute care hospital for 20 days. Now presented to therapy with right sided weakness impacting ability to perform transfers and ambulation." The PT Notes further document R4 needs partial moderate assist (needs 50 percent help of the task to lift the weight of the body in standing position, or to move a limb or wheelchair, for example) with transfers to chair/bed, sit to stand, to toilet and ambulation.

R4's Face Sheet, undated, documents R4 was admitted on 6/25/19 and was discharged to the hospital on 7/14/19. R4's Event Reports on Falls are as follows:

R4's Event Report dated 6/27/19 documents at 1:59 PM R4 slid down to floor from toilet with help of staff in R4's bathroom. The Report documented R4 was attempting to wipe herself and leaned over too far and lost balance.

R4's Problem Evaluation Note, dated 6/27/19 documented interventions for R4's fall as "Staff in service on the importance of close monitoring while toileting residents with CVA related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013189	A. BUILDING: _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	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
S9999	Continued From page 13	S9999		

weakness r/t (related to) fall on 6/27/19."

R4's Event Report dated 6/28/19 documents at 1:09 PM R4 fell from her wheelchair in the television room. The report documented "Poor balance control while in wc (wheelchair)."

R4's Problem Evaluation Note Report, dated 6/28/19 documented the following interventions "Staff in serviced to encourage/assist (R4) to activity department after emails, ensure that (R4) is within eyesight of staff when up out of bed."

R4's Event Report dated 6/29/19 documents at 5:00 PM R4 had an unwitnessed fall in her room. The Report documented R4 stated she was sitting on the side of her bed attempting to get up from her bed and slid out. The Report documented she was found on her right side of her bed, on her back.

R4's Problem Evaluation Note, dated 7/1/19 documented the intervention was "family education regarding staff assistance r/t fall on 6/29/19."

R4's Event Report dated 6/30/19 documents at 1:30 PM, R4 had a witnessed fall in the bathroom. The Report documented that R4 was attempting to transfer off the toilet with the help of a staff member. R4 fell to floor and sustained a laceration to the back of her head measure 1 centimeter (cm) by 2 cm. The Report Note section documented "Nurse called to resident room by CNA. Upon arrival resident was observed on the bathroom floor with small amount of blood near her head. CNA stated that she was assisting the resident off of the toilet when the resident began to lean to her right and lost her balance and she was unable to stop her

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	IL6013189	A. BUILDING: _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S9999	Continued From page 14	S9999		

from falling."

R4's Problem Evaluation Note, dated 7/1/19 documented the interventions to address R4's falls as "Raised toilet seat r/t fall on 6/29/19."

R4's Event Report dated 7/14/19 documents at 3:37 PM, R4 had a witnessed fall in main lobby. The Report documented "Nurse stated that she heard the residents chair alarm and looked up to see resident standing up from her chair and was beginning to lean to her side. Nurse stated she attempted to make it to the patient to avoid the fall, but was too far away. The Report documented she sustained a laceration to the right side of her head. The Report documented R4 briefly lost consciousness, 911 was called and she was sent to the hospital.

R4's Nurses Notes dated 7/14/19 at 3:38 PM, documents," 911 called at this time related to fall." Nurses Notes dated 7/14/19 at 6:09 PM, documents, "Call placed to (hospital) for patient update. CT (Computed Tomography) showed subarachnoid hemorrhage (bleeding between the space between the brain and the tissue covering the brain) present, no fractures, family opting for hospice.

R4's Hospital CT Scan Result dated 7/14/19 documents Bilateral acute subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain).

On 11/12/19 at 2:00 PM, V3, Care Plan Coordinator, stated there was no Fall Risk Assessment done on R4.

On 11/12/19 at 11:15 AM, V27, Occupational Therapist (OT), stated R4 needed hands on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013189	A. BUILDING: _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S9999	Continued From page 15	S9999		

assist of continuous guiding and guarding during transfers when R4 was discharged to the hospital on 7/14/19.

On 11/13/19 at 10:27 AM, V20, Physician/Medical Director, stated he was aware R4 had a previous subarachnoid bleeding and was hospitalized in a different hospital for a long time before coming to the facility. V20 stated without comparing the imaging results between the two subarachnoid hemorrhages, he can't give an absolute answer. V20 stated, typically, radiology would do a comparison but these were two different hospitals and maybe nobody thought of requesting the earlier imaging report for comparison so there is no way of quantifying the results. V20 stated an important question to consider is did (R4) bleed and fall or did she fall and bleed. V20 stated as long as the facility provided maximum fall precaution approaches and followed their policies, the facility could not have not done anything more short of restraining the resident.

3. R3's Care Plan updated 10/29/19 documents, " At Increased risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization. Skin tear to left lateral calf, Unstageable ulcer to left heel, Skin tears to left and right forearm. Approaches: Treatment to skin tear to left forearm, right forearm, left lateral calf per MD order until healed, monitor for s/s of infection every shift notify MD. Geri sleeves on at all times except for hygiene."

R3's Physician Order dated 10/2019 documents, "Geri-sleeves on at all times except for hygiene (started 7/8/19).

On 10/28/19 during lunch meal service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013189	A. BUILDING: _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S9999	Continued From page 16	S9999		

observation at the 200 Hall Dining room from 12:26 PM until 12:47 PM, R3 sat in her wheelchair. R3 was wearing a Geri sleeve on her right forearm and none on the left arm.

R3's Clinical Record documents the following skin tears between 8/2019 thru 10/2019 as follows:

a. Event date: 8/9/19 at 9:39 PM documents, "Skin tear to right lower arm. 1.5 centimeters (cm) x 1.5 cm. Staff was getting R4 ready for bed and became combative and started trying to hit staff and right lower arm hit bedrail."

b. Event date: 10/7/19 at 2:45 AM documents, "Skin tear to left lateral calf 4 cm x 2 cm. Resident got skin tear while toileting, resident had tried to kick staff when her leg scraped against staff name badge causing skin tear 4 cm x 2 cm. " Nurses Note dated 10/17/19 documents, "New orders to start doxycycline 100 mg twice a day for 7 days related to cellulitis to left lower leg and medihoney and nonadherent dressing to left lateral calf."

c. Event date: 10/25/19 at 6:17 AM documents,"skin tear to right forearm. 8 cm skin tear to right anterior forearm." Nurses Notes dated 10/25/19 at 6:10 AM documents,"8 cm skin tear found on anterior right forearm. Area cleaned and skin approximated. Steri strips applied, bleeding controlled, and dry dressing applied."

d. Nurse's Notes dated 10/29/19 at 10:07 AM, documents, "Resident was combative during dressing has new skin tear to left forearm 9 cm."

On 10/28/19 at 1:25 PM, V9, Certified Nursing Aide (CNA), stated R3 should be wearing geri sleeves on at all times. V9 stated R3's skin is so

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MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S9999	Continued From page 17 fragile she has had skin tears on her arms and leg and she struggles during care. On 10/28/19 at 2:19 PM, V14, CNA, stated R3 has an order for geri sleeves on both upper extremities to protect from skin tears. V14 stated R3 gets combative at times during care. 4. R23's Care Plan, review date 10/03/2019, documents "(R23) is at risk for falls related to weakness and history of falls. Resident is receiving medications that are associated with increased fall potential. Resident has balance deficits and impaired safety awareness. Floor mats bilateral bedside when in bed." On 10/31/2019 at 1:54 PM, R23 was bed and no floor mats were at R23's bedside. 5. R21's Care Plan, dated 9/5/2019, documents "(R21) is at risk for falling related to recent illness/hospitalization, impaired injury, and new environment. Bilateral floor mats when in bed. " On 10/31/2019 at 1:55 PM R21 was in bed and no floor mats were on the floor. On 11/12/2019 at 2:40 PM to 3:20 PM R21 was in the bed and no floor mats were observed on the floor. The mats were laying against wardrobe. 6. R22's Care Plan, review date 9/20/2019, documents "(R22) is at risk for falling related to weakness. Resident is receiving medications that are associated with increase fall potential. Vitamin D deficiency, resident has balance deficits and impaired safety awareness related to dementia. Mats at bilateral BS (bedside) while in bed."	S9999		

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	IL6013189	A. BUILDING: _____ B. WING _____	C 11/18/2019

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MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S9999	Continued From page 18	S9999		

On 10/31/2019 at 1:57 PM, R22 wasin bed and no floor mats were at bedside.

On 11/12/2019 at 2:40 PM to 3:20 PM R22 was in the bed and no mats at bedside. R22's floor mats were against wardrobe.

7. R14's Care Plan, dated 11/2/2019, documents "(R14) at risk for falling related to recent hospitalization and new environment, history of multiple falls, right foot drop, glaucoma, fall with rib fracture. Floor mats bilateral bedside when in bed."

On 11/12/2019 at 9:40 AM V23, Garden Court Coordinator and V24, CNA, assisted R14 into the bed. V24 then lowered the bed into the low position and raised the head of the bed. V24 placed the call light in R14's hand. V23 and V24 left the resident's room without placing floor mats at bedside. Floor mats observed against R14's wardrobe.

On 11/12/2019 at 9:45 AM to 10:50 AM, R14 was observed at 15-minute intervals in bed. No bilateral mats were at R14's bedside.

On 11/13/2019 at 10:33 AM, V22, Licensed Practical Nurse (LPN), stated, "The CNAs put mats in place when they put the resident to bed, if that's what the care plan says. We do whatever the care plan says."

On 11/13/2019 at 10:45 AM, V37, CNA, stated, "The CNA puts the mat down after we lay the resident down ."

On 11/13/2019 at 11:56 AM, V24, CNA, stated, "The mats are in place anytime the resident is in bed and the CNA puts them in place."

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S9999	Continued From page 19 On 11/14/2019 at 9:58 AM, V23, Garden Court Coordinator, stated, "If a residents care plan has floor mats, the mats are put in place after the bed is lowered to the lowest position and the CNAs are to check to make sure they are down prior to leaving the room." (A)	S9999		