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 04/20/2017

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	Final Observations Complaint Investigation # 1742221/ IL 93257 STATEMENT OF LICENSURE VIOLATIONS Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. This requirement WAS NOT met as evidenced by: Based on interview and record review, the facility failed to notify the Illinois Department of Public Health, Regional office of falls resulting in serious injury in 3 of 3 residents, R1, R2, R3, in the sample of 5. Findings include: 1. R1's Progress Notes, dated 2/5/17, written by E7, Registered Nurse (RN), document "Staff found resident on the floor behind the nurse's station. Resident c/o (complaint of) pain in head and back. Upon inspection, a small amount of blood was noted on the back of resident's head. Staff got resident up and brought her to the nurse's station. After staff had left to get another resident up, this resident got up from her w/c (wheel chair) and walked behind the nurse's station and fell. Resident was found on her back near the cabinet by the sink on the 400/500 side of the nurse's station. Resident is being	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

transported to (local hospital) for observation and evaluation. MD (Medial Doctor) aware."

The facilities Accident and Incident Log for February 2017 documents R1 sustained a fall resulting in a laceration and was sent to a local hospital for treatment. This log documents "NO" under the section "IDPH (Illinois Department of Public Health) Notified.

E1, Administrator, stated on 4/17/17 at 10:30 AM, he could not find any documentation that this incident was reported to IDPH.
E1 stated un 4/18/17 at 2:30 PM, he is ultimately responsible for all notification to IDPH.

The facility's Policy and Procedure "Accident and Incident Report, Dated 10/02, documents, in part "F. If Department of Public Health notification is required, it the responsibility of the Director of Nursing or Administrator to do so."

2. R2's Progress Notes, dated 2/18/17, written by E5, RN, documents "Resident has a unwitnessed fall in room. CNA (Certified Nursing Assistant) was rounding she heard moaning when CNA walked by resident's room. Resident was noted sitting on the floor with large amounts of blood. Nurse assessed resident and noted a large hematoma to the back of resident's head with a large gash. Resident was alert, able to respond to verbal commands, able to move all her extremities. No external rotation or deformities noted. 911 called by another nurse while this nurse stayed with resident to control bleeding and until EMS arrived."

The facilities Accident and Incident Log for February 2017 documents R2 sustained an unwitnessed fall resulting in a laceration and was

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S9999	Continued From page 2	S9999		

sent, by ambulance, to the local hospital. This log documents "NO" under the section "IDPH" notified.

E1, Administrator, stated on 4/17/17 at 10:30 AM, he could not find any documentation that this incident was reported to IDPH.
E1 stated un 4/18/17 at 2:30 PM, he is ultimately responsible for all notification to IDPH.

3. R3's Progress Notes, dated 2/3/17, written by E7, documents "Staff came into resident's room and found resident on the floor next to her bed. Resident states that she got up because she wanted to. Resident attempted to get up and walk without assistance and fell to the floor. Resident is very confused. No s/s (signs/symptoms) of injury, no c/o (complaint of) pain. Eyes are PERRLA (pupils equal, round, react to light, accommodation). Hand grasps and strong and equal. Resident can move all extremities without pain. MD and POA (Power of Attorney) aware."

The facilities Accident and Incident Log for February 2017 documents R3 sustained an unwitnessed fall resulting in a laceration and was sent, by ambulance, to the local hospital. This log documents "NO" under the section "IDPH" notified.

E1, Administrator, stated on 4/17/17 at 10:30 AM, he could not find any documentation that this incident was reported to IDPH.
E1 stated un 4/18/17 at 2:30 PM, he is ultimately responsible for all notification to IDPH.

(B)