STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146102	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR COURT OF FREEPORT	**2170 WEST NAVAJO DRIVE FREEPORT, IL 61032**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** Based on interview and record review, the facility failed to keep a resident's medical information confidential for one of three residents (R2) reviewed for medical records in the sample of 8. The findings include: On 3/12/20 at 9:00 AM, V7, Receptionist, said she arranges transportation as needed for medical appointments. V7 said On 2/17/20, I called V13, R1's family member, to let her know R1 left for her medical appointment. V13 usually meets R1 at the appointments when R1 takes the local the bus service. I call V13 when the bus leaves so she can meet R1 at the appointment. On 2/17/20, V13 called me back and requested to talk to the nurse because another resident's medical information (R2's) was sent with R1 to the doctor appointment and the doctor needed R1's information. V13 told me it was R2's medical information that was in the envelope. At 9:35 AM, V1, Director of Nursing (DON) said that on 2/17/20, somebody made a mistake. R1's name was on the outside of the envelope sent to the appointment, but R2's medical information was in it. We send a copy of the resident's face sheet and the Continuity of Care Document (CCD) when they go to outside appointments. At 2:05 PM, V4, Registered Nurse, said she gave R1 the white envelope of records prior to her 2/17/20 medical appointment and did not verify the contents beforehand. Night shift gets that stuff ready. R1's name was on the envelope. V1, Administrator, just told me about the mix-up now and as far as I know we haven't changed our procedure for this process. I only look in the envelopes when residents return from the appointments. A resident's personal health information should not be shared with people not needing this information. R2's undated face sheet showed R2's birthdate, social security number and medical diagnosis. R2's undated CCD showed R2's family contact information, medication list, medical diagnosis, vital signs, insurance information and immunization history. The facility's 4/2/19 Health Insurance Portability and Accountability Act (HIPPA) Policy showed the policy purpose was to ensure the confidentiality of health information. This policy showed the facility will protect resident health information and limit access to those who need the information to provide treatment, payment and health care operation. The 10/17 Illinois Department of Aging Resident Rights booklet showed residents have the right to confidentiality of records.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's safety after multiple falls for one of three residents (R1) reviewed for falls in the sample of 8. The findings include: On 3/17/20 at 11:35 AM, V1, Director of Nursing (DON) said R1 was hospitalized [DATE] after falling and breaking her hip at the facility. At 2:14 PM, V1 said care plans should be reviewed for new approaches and at least reviewed after each incident. At 1:20 PM, V9, Minimum Data Set (MDS) Coordinator, said whenever an event happens the resident care plan should be updated. With each fall event, there should be a different intervention to keep them off the ground in the future. If this doesn't happen, the resident could continue to fall or have a major fall with injury. R1's fall risk assessments dated 11/26/19 and [DATE] showed R1 was a high fall risk. R1's facility assessment dated [DATE] showed has a history of falls with injury. R1's fall documentation showed the following falls in R1's room or bathroom: 3/1/20, 2/19/20, 2/18/20, 2/10/20, 2/7/20 at 6:35 AM and 9:28 AM, and 12/28/19. R1's fall care plan showed it was last reviewed on 2/18/20. The facility's 11/28/19 Care Plan Policy showed to develop a care plan will meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. There are no interventions to make R1's room or environment safer after each fall incident.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on interview and record review, the facility failed to track, monitor and evaluate employee illnesses. This failure has the potential to affect all 98 residents in the facility. The finding include: The 3/12/20 facility data sheet showed 98 residents in the facility. On 3/12/20 at 9:30 AM, V3, Human Resources Director, said he has been logging employee illnesses for 3/20. Prior to 3/20, employee illnesses were not logged for tracking purposes. V3 said he forgot to add some employees to the log, so the dates are not in order. At 9:35 AM, V1, Director of Nursing (DON), confirmed prior to 3/20, employee illnesses were not logged for tracking purposes. V1said I can tell you right now, my infection control logs are not up to date. I don't review the monthly employee call off log. I usually talk about it day to day, week to week, if someone is sick. At 10:30 AM, V2, Dietary Manager, said call offs are entered into the payroll computer program. I was just told today (by V3) to start logging the reason (symptoms) in the comment section. At 2:14 PM, V1 said if resident and staff infection control data is not tracked an illness could spread through the whole building unmonitored. Infected staff can make residents sick and could lead to an outbreak. The facility's Employee Infection Monitoring Log dated 3/20 showed out of sequence dates of absence. There were no Employee Infection Monitoring Logs to review prior to 3/20. The facility's computer generated log of employee absences from 3/1/20 to 3/12/20 does not indicate any symptomology for sick days. The facility's resident infection control logs were incomplete for December 2019, January 2020 and February 2020. There was no (NAME)2020 resident infection control log to review. The facility's 12/17/19 Infection Control Policy showed the facility shall develop a practical system of reporting, evaluating and keeping record of infections among residents and personnel in order to provide an indication of an outbreak level of all nosocomial infections, to trace the source of an infection, review both individual and institutional factors, and to identify potential outbreak situations.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.