STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	08/24/2020

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

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 0689 **Level of harm -** 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 observation, record review and interview, the facility failed to provide supervision, identify and implement resident specific fall interventions, and provide safe transfers for fall prevention for 2 of 3 residents (R2, R3) reviewed for falls in the sample of 6. This failure resulted in R2's fall sustaining subarachnoid hemorrhage (brain bleed), left orbital (around eye) fracture, and zygomatic (cheek bone) fracture requiring hospitalization . Findings include: 1. The Facility fall log, dated 1/18/20-8/18/20, documents that R2 has had 7 falls since 3/30/20. R2's Quarterly Fall Risk Assessment, dated 5/18/20, documents R2 as high risk for falls with a score of 25 (a score of greater than 16 equals high risk for falls). R2's Minimum Data Set (MDS), dated [DATE], documents R2 has severely impaired cognition, requires supervision and set up only for walking in room and toileting, and requires supervision and one person physical assist for transfers. R2's Annual Fall Risk Assessment, dated 8/17/20, documents R2 as high risk for falls with a score of 22. R2's care plan, dated 8/16/19, documents that R2 is at a risk for falls related to recent illness/ hospitalization and new environment, [DIAGNOSES REDACTED]with impaired safety awareness, unspecific visual loss, [MEDICAL CONDITION] and subarachnoid hemorrhage. Under Resident Care Information, approaches with start date 2/3/20 include: alternate call light, mobility: ambulates without devices, Safe Resident Handling Procedure- Transfer Method: Stand pivot transfer with gait belt with one assist. Under Risk for Falls, approaches include encourage resident to call for assist before getting out of bed or transferring and encourage resident to stand slowly (dated 8/16/19), encourage resident to use side rails/enablers as needed (dated 8/16/19). Fall Investigation Report documents R2's fall 5/1/20 at 1:15 PM in the hallway. Reason- right leg gave out, complaint of pain back of head. Report documents no injury. Approach of distant supervision, dated 5/1/20, was added to R2's Care Plan for risk for falls. There was no direction on the specifics of distant supervision. Fall Investigation Report documents that R2 fell on [DATE] at 12:34 PM walking to his bed. Report documents that R2 stated felt shaky. Stated bumped left side of face and left side on table. Physician review on 6/1/20 documents Plan: Fall meds reviewed, nothing is new causing resident to fall. Resident has history of [MEDICAL CONDITIONS](stroke), maybe TIA (mini [MEDICAL CONDITION]) and weakness caused from last [MEDICAL CONDITION]. IDDM (insulin dependent diabetes mellitus) - recommend increasing 70/30 has helped some, will follow blood sugars and consider adding [MEDICATION NAME]. Possible [MEDICAL CONDITION] ([MEDICATION NAME] BID ([MEDICAL CONDITION] medication twice daily)) Decrease [MEDICATION NAME] 25 mg (milligrams) BID. R2's Care Plan for risk for falls had no additional approaches added for the 6/1/20 fall. Fall Investigation Report documents on 6/26/20 at 6:42 PM R2 walking to the bathroom, stated reason for fall as being dizzy. Root cause: R2 states he got dizzy and fell . Report documents that R2 has hypertension so orthostatic BP (blood pressure) for 72 hours every shift related to fall. R2's Care Plan for risk for falls had no additional approaches added for the 6/26/20 fall. Fall Investigation Report documents unwitnessed fall on 7/25/20 at 11:22 PM, R2 fell coming from the bathroom. R2 stated had a dream and maybe got up too quick. Root cause analysis documents returning from restroom without assistance, states had a dream made him get up quick. Receiving therapy services at this time. Teaching per nurse on importance of use of call light for assistance related to unwitnessed fall. R2's Care Plan for risk for falls had no additional approaches added for the 7/25/20 fall. Fall Investigation Report, dated 8/6/20, documents that R2 fell in the bathroom at 12:58 PM. The report documents the reason as blacked out. The form documents an abrasion and R2 complaining of a headache. Root cause analysis dated 8/7/20 at 10:00 AM documents walking to the bathroom and blacked out per R2. Documents that R2 has [MEDICAL CONDITION], unspecified visual loss and [MEDICAL CONDITION], poor safety awareness, advise R2 to ask for help with ambulation, and closely monitor related to fall on 8/6/20. Was later sent out for evaluation due to neurological deficits and transferred to another hospital with a subarachnoid hemorrhage, fractured left eye orbit and fractured zygomatic process, and admitted to the hospital. R2's CT (computed axial tomography) Scan without contrast, dated 8/8/20 documents a small acute subarachnoid hemorrhage, Left orbital inferior and lateral wall fracture, Left zygomatic arch fracture and Left maxillary sinus fracture R2's notes document that R2 returned from hospital on [DATE], reviewed fall care plan, low bed, mats at bedside when in bed, alternate call light program initiated. Medical doctor (MD) added Kepra to med regimen per MD to assist with [MEDICAL CONDITION] disorder at hospital. Approaches of low bed and alternate call light were added to R2's Care Plan for risk for falls on 8/13/20. The alternate call light had already been an approach since 2/3/20 under R2's Resident Care Information Care Plan. Fall Investigation Report documents that R2 had an unwitnessed fall in his bathroom on 8/15/20 at 2:21 PM. The reason identified was attempting to self ambulate to bathroom. Root cause analysis documents got weak and fell . Intervention identified to re-educate per nurse related to use of call light. Will request u/a (urinalysis) from MD due to urinary frequency, staff inservice/education to give R2 verbal reminders not to ambulate without assistance. Evaluation Notes, dated 8/17/20, on R2's fall risk Care Plan documents, Inservice/education to give R2 verbal reminders not to ambulate/transfer without assistance R/T (related to) unwitnessed fall attempting to ambulate self to bathroom without assistance on 8/15/2020. No additional approaches were added to R2's fall risk care plan. On 8/13/20 at 10:15 AM, V3, Certified Nursing Assistant (CNA) stated that she had taken care of R2 prior to hospital admission, V3 stated that R2 used be independent before he fell . V3 stated stated that before his fall when went to hospital he would ambulate to the bathroom, and walk independently. V3 stated that R2 is now in a wheelchair. On 8/13/20 at 9:08 AM, V7 and V8, CNAs, transferred R2 from the wheelchair to bed. V7 place a gait belt around R2 under his armpits, across top of R2's chest with the buckle on the right side of R2's chest. When assisting R2 to stand, V7 grasped the gait belt by the buckle. On 8/20/20 at 2:43 PM, V14, Physician, stated that reminding a resident with memory impairment to use their call light or ask for help prior to getting up is not going to work. V14 stated he would expect the facility to follow their accident/ incident policy in regards to location of resident rooms for high fall risk. 2. On 8/18/20 at 9:20 AM, R3 was up in a reclining geriatric chair in reclined position with feet elevated. R3's call light was not within reach and was hanging on the bed. No floor mats were present beside R3's chair. R3 had yellow fading bruising to her right frontal skull extending down temporal side of her face. R3 stated when she falls it is because she wants to get up. R3's Nurses notes, dated 8/12/2020 at 10:45 AM, documents that R3 was found on the floor and slid out of reclining geriatric chair that was in reclined position, root cause analysis documents that mats are to be placed beside reclining geriatric chair when R3 is in her chair. R3's Care Plan with intervention dated 8/13/20 documents mats are to be placed by R3's chair when R3 is up in her chair. R3's most current fall risk assessment dated [DATE] documents R3 is at high risk for falls with a score of 20 (score greater than 13 is high risk for falls). R3's MDS, dated [DATE], documents that R3 is cognitively impaired. R3's MDS also documents that R3 is totally dependent and requires 2 plus staff assistance for bed mobility and transfers. R3's undated Face sheet documents R3 has Dementia. On 8/18/20 at 9:30 AM, V11, Licensed Practical Nurse (LPN), stated that she observed R3 on the floor on 8/12/20. V11 stated that R3 scoots herself down, and that R3 can move. V11

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) stated that R3 was reclined back in a reclining geriatric chair when she fell . 08/24/2020 3:15 PM, V1, Administrator, stated that staff are trained to use gait belts and the gait belt is to be placed around the resident's waist. V1 stated that he was aware that R3 did not have mats beside her wheelchair as identified as an intervention to be in place. The Facility's Accident and Incidents policy and procedure, dated 8/2014, documents under Accident/ Incident Prevention, When a resident has been identified as a high risk for accidents /incidents, interventions will be put into place per individual assessment and care plan. The policy documents the interventions may include, but not limited to the following: monitoring of residents when mobile, assist with transfers when unsteady, ensure call light is within reach and working, monitor during high risk times according to resident's history, monitor gait balance and fatigue with ambulation, place high risk residents in rooms near the nurse's station as appropriate. Under accident investigation, the policy documents, When accidents/incidents are unwitnessed the area around the resident should be analyzed for probable cause. If a resident is falling more often in a particular area, at a particular time or during a particular activity, this should be identified in the investigation and interventions put into place to assist in reoccurrences. The Facility's Gait Belts policy and procedure, revised 12/2002, documents proper body mechanics will be used when transferring a resident, and staff will be orientated on proper use of gait belts and proper body mechanics.