STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING _____ B. WING _____	C 01/23/2020

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

(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 Complaint Investigation 2010109/IL119283	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Findings 300.610a) 300.1010h) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health,	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 1	S9999		

safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 2	S9999		

and assistance to prevent accidents.

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 regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to assess a resident with a change in condition, and obtain emergency transport and treatment. Which resulted in delay of medical care for R1. This applies to one of four residents (R1) reviewed for change in condition in the sample of 7.

The findings include:

R1's undated face Sheet shows R1 was first admitted to the facility on December 31, 2019. R1 has diagnoses to include , acute cystitis (Bladder infection), hydronephrosis with kidney stones and urethral stones.

R1's Facility Assessment dated January 11, 2020 shows R1 has no cognitive impairment.

On January 21,2020 at 4:04 PM, R1 was lying in her bed at the local hospital. R1's door to her room showed she was on enteric contact precautions. R1 had an intravenous antibiotic infusing into her left arm. R1 was asked if she recalled the night of her fall at the facility. R1 stated that day she wasn't feeling quite right. She had no appetite. She felt warm. The nurse took her temperature and said it was elevated and gave her some Tylenol and encouraged her to drink some fluids. R1 stated she remembered an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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	S9999		

aide coming in later on the second shift and checking her temperature. R1 stated sometime during the night she had an accident of stool. R1 stated she was not normally incontinent of stool. She thought she put her call light on but no staff came in to check on her. Awhile later she remembers her right leg falling off the bed. R1 stated she can move her legs but if her leg falls off the bed she does not have the strength to put it back on the bed. The next thing she (R1) remembers was the CNAs yelling her name and she was on floor on her back. The CNA's were using the mechanical lift to get her off the floor. R1 remembered waking up in the hospital. R1 stated she and her mother were told by the emergency room doctor that they had a difficult time getting a temperature and blood pressure and he (ER physician) believed she must have been on the floor for a long time; like a couple of hours. R1 stated she has no idea how she ended up on the floor or how long she was on the floor.

On January 21, 2020 at 11:57 AM, V3 (Licensed Practical Nurse- LPN) stated she was working the night shift on January 14, 2020. V3 stated she was not R1's nurse that night it was V4(LPN) . V4 asked her (V3) to give R1 her morning medications because V4 could not go into R1's room.(Family and Resident had requested V4 not provide care to R1 following an episode of V4 being rude to R1) R1 was scheduled to have surgery the morning of the 15th. V4 wanted her to give R1 her medications around 5:00 AM. V3 stated she never gave R1 her medications. V3 stated around 4:30-5:00 AM, she was called to R1's room and R1 was face down on her stomach on the floor. R1 was not talking she was going in and out of consciousness. She was drowsy but would respond.
V4 was called to the room. V3 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 4	S9999		

assessed R1 and did a neurological check. V3 stated she did not do any vital signs on R1. V5 and V6 (Night CNAs) used the mechanical lift to put R1 back into her (R1's) bed to clean her up. R1 was not responding appropriately; her skin was dry and cool to the touch. R1 had BM on her that looked like it had been on her for awhile. V3 stated she did not go back into R1's room until the paramedics arrived at approximately 6 AM.

On January 21, 2020 at 12:32 PM, V4 (LPN) stated R1 was alert and her cognition was pretty good. R1 would ring when she wanted the staff. We did not go into her room unless she put the light on. V4 stated she worked the night of January 14, 2020 and was R1's nurse. V4 stated she didn't see R1 except from the doorway of R1's room. V4 stated R1's mother did not want her to see R1 at all. V4 stated around 4:40 AM she was in the doorway of R1's room and saw R1 on the floor face down with BM all over. The aides put her in bed and cleaned her up.
V4 stated around 5:00 AM a female from the local ambulance company showed up with a wheelchair to take R1 to the hospital for a scheduled surgery. V4 stated she asked the woman if she had a cart because R1 could not go by wheelchair. The woman told her she only had a wheelchair. V4 stated she called the local ambulance company and told them to bring a gurney because R1 had fallen. V4 stated she could not remember if she called for the ambulance before or after the woman came with the wheelchair. V4 stated R1 was not responding per her usual. V4 stated she did not do any assessments on R1. V3 did the assessments. V4 was not sure who called the doctor or when the doctor was called.

On January 21, 2020 at 1:22 PM V5 (Night CNA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 5	S9999		

and on January 22, 2020 at 9:33 AM, V6 (Night CNA) stated R1 was alert. V5 was told by the night nurse (V4) not to go into R1's room unless she rang. V6 said she checked on R1 at midnight and she was sleeping in bed. V5 stated she peeked in on R1 around 2:00 AM and she was sleeping. The next time they saw R1 was when they went into R1's room to get her up for her scheduled appointment. R1 was lying face down on the floor covered in feces. Around 4:50 AM, she (V5) and V6 went into R1's room to get her up and ready. R1 was on the floor face down covered in feces. V6 left to go find the nurse. V6 couldn't find the nurse but she brought in V3. V3 looked at R1 and said we need to put R1 in bed and get her cleaned up. V5 stated while she and V6 were cleaning up R1 we kept calling her name and she (R1) was responding. She (R1) was not acting her usual way. V5 stated R1 felt cold to the touch and as time went by her color went from pale to dusky and her eyes kept rolling back. Her lips were purple. V5 stated neither of nurses came back to check R1 her until the paramedics arrived.

On January 22, 2020 at 9:33 AM, V6 (Night CNA) stated she was working the night of January 14, 2020. V6 stated she was not assigned to R1's hall but V5 was. V6 said she saw R1 was when she and V5 went into R1's room to get her up and ready for her appointment around 4:00 AM. R1 was face down on the floor by the bed on the door side of the room. R1 wasn't saying anything she was mumbling. V6 stated she went to get the nurse and V5 stayed with R1. V6 stated she went up to V4 (R1's nurse) and reported to her R1 was on the floor. V4 told her R1 would have to wait because she could not go into R1's room. V6 stated she then went to find another nurse, found V3 a couple of minutes later, and V3 went with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 6	S9999		

her to R1's room. V3 was calling out R1's name and R1 seemed to go in and out of consciousness. V3 checked R1 out and told us to use the lift to put her back in bed because she had been incontinent of BM. When we were rolling her over onto the sling she opened her eyes and said "What are you doing." then closed her eyes again. V5 and I lifted her to her bed and V3 left the room. V6 stated no vital signs were taken on R1. V6 said she and V5 cleaned up R1. V6 stated R1 was cold to the touch. V6 stated while they were cleaning R1 up a day shift CNA (V12) came into the room wanting to know what happened. It was around 5:30 AM. The ambulance came around 6;00AM, and R1 left the facility.

On January 22, 2020 at 8:30 AM, V13 (Day CNA) stated the morning of January 15. 2020 around 5:30, she saw R1 lying in her bed. The third shift aides were saying R1's name trying to get R1 to respond. They were waiting for the ambulance to arrive. R1 was dusky in color.

On January 21, 2020 at 11:25 AM, V7 (Paramedic) stated they received a call from the facility for a patient who fell. When they arrived on scene the patient (R1) was in bed. The patient was only responding to painful stimuli. V7 said no one at the facility knew when she (R1) fell or how long she was on the floor. The patient extremities "were super cold". We tried to initiate an IV but were unsuccessful. We attempted to get her temperature but were unsuccessful, her heart rate was 76 in a sinus rhythm. We were not able to get a blood pressure. We transported her to the local hospital.

On January 22, 2020 at 11:27 AM, V2 (Director of Nursing) stated the night nurses on duty the night

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING _____ B. WING _____	C 01/23/2020

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

(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 7	S9999		

of January 14th reported to her the the CNA's went into R1's room around 4:40 AM to get R1 up and ready for her procedure. R1 was on the floor next to the bed in the prone position. There was BM all over the floor. R1 was not following commands, thats all I know. V2 stated R1's vital signs should have monitored on the night shift to see if her temperature went back up and give her more Tylenol if needed. V2 was asked if it was normal nursing procedure to move a resident face down on the floor who was in and out of consciousness to her bed. V2 stated if the resident was going in and out of consciousness the nurse should have called 911 and the resident should have been left on the floor. V2 was asked if she was aware that after V3 did her initial assessment of R1 and then told the aides to put her in bed and clean her up for her appointment. The nurse should have been monitoring R1 throughout the night. The nurse should have taken vitals signs or have the aide take vitals signs after the fall, then they would have known of her condition. They (nurses) should have called 911 right away.

R1's Progress Notes for January 15, 2020, show at 5:38 AM, staff went to assist resident with ADLs (Activities of Daily Living) prior to doctors appointment. R1 was observed on the floor face forward in a prone position. Call placed to local ambulance to pick up resident related to fall. The resident was unable to follow commands. The resident was incontinent of a large foul smelling bowel movement with mucous. At 5:40 AM, orders received from on call physician to send to the emergency room for evaluation. (One hour after resident found on the floor)

R1's vital sign documentation was requested for January 14-15, 2020. R1's Vital Signs report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING _____ B. WING _____	C 01/23/2020

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

(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 8	S9999		

shows the last time R1's vital signs were recorded in the electronic system was on January 14, 2020 at 9:10 AM showing her temperature was 97.9 degrees Fahrenheit with a pulse of 100, respirations of 16 breaths per minute and a blood pressure of 134/90. The facility's CNAs Duties List for the evening shift (2:00 PM-10:30 PM) shows R1's temperature was taken; no time was documented. R1 had temperature of 97.7 degrees Fahrenheit (F), 100.1 degrees F. and then 99.5 degrees F. There was no evidence of any vitals signs being documented after the evening shift on January 14, 2020 for R1.

R1's Event dated January 15, 2020 at 4:40 AM, showed R1 had an unwitnessed fall. R1 was not exhibiting any signs of pain. R1 was unable to complete range of motion of her extremities. R1 was lethargic and drowsy, she does not perceive the environment fully, but responds to stimuli appropriately but slowly with a delay. R1's facial muscles are absent and she has weak movement of all four extremities. R1's pupils are round and sluggish. R1 is unable to speak. R1 only responds to pain. Immediate measures taken- R1 was sent to the Emergency Room for evaluation. R1's physician was notified of the incident at 7:26 AM on January 15, 2020 (Almost three hours later).

R1's Emergency Department Note dated January 15, 2020 showed R1 was seen by the emergency room physician at 6:21 AM, R1 was brought to the emergency department by EMS from a local nursing home. R1 is a resident of a nursing home and was found down on the ground face down not responding other than to noxious stimuli, very cold upon arrival. R1 was moaning and groaning and is unsure how long she was on the ground. She was hypotensive upon arrival (to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 9	S9999		

emergency department) and had no IV (intravenous) access. R1's pulses were thready but palpable. She received a total of 3 liters of IV fluids during the course of her stay in the emergency department.
She has a UTI with a mild left shift. Her troponin was negative. Her ABGs (Arterial Blood Gas) shows R1 to be in metabolic acidosis...IV fluids and levophed were given with marked improvement of her blood pressures... She is now alert and talking. She will be admitted to the intensive care unit stable but fair/critical condition.

At 10:02 AM, ED note shows, ".. patient was in critical condition given the hypotension and her presentation without these measures the patient's condition would have deteriorated possibly lead to death."

R1's first recorded blood pressure at the hospital was at 7:49 of 75/51, with a temperature of 97.9 degrees F, pulse oxygen of 99 percent on 2 liters of oxygen. At 8:04 AM her blood pressure was 108/62.

The facility Change in condition Policy dated December 2002, shows the nurse will asses and notifiy the physician when there is a significant change in condition. The nurse will document these changes in the clinical record.

The facility Emergency Policy with a revision date of April 3, 2018 shows it is the policy to provide emergency care to a resident in need of it, the nurse in charge of the resident will evaluate the resident's condition, the nurse assigned will stay with the resident...the second nures will notify the Director of Nursing, and the residents physician and follow his orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 10	S9999		

(A)

2 of 2 Findings

300.610a)
300.1210a)
300.1210b)5)
300.1210c
3001210d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 11	S9999		

allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 12	S9999		

that each resident receives adequate supervision and assistance to prevent accidents.

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 regulations were not met as evidence by:

Based on interview and record review the facility failed to ensure a resident was transferred in a safe manner for one of four (R4) residents reviewed for falls in the sample of 7. This failure resulted in R4 falling and sustaining fractured ribs.

The findings include:

R4's undated face sheet shows diagnoses to include weakness, glaucoma and osteoartritis. R4's care plan dated October 2019 shows she has decreased vision related to glaucoma and is at a risk for falls related to recent illness and hospitalization and a new environment. Her interventions for care include staff assistance of one person with a gait belt and walker for transfers and ambulation. R4's facility assessment dated October 22, 2019 shows she has no cognitive impairment and requires limited staff assistance of one person for transfers and ambulation.

On January 21, 2020 at 10:26 AM, R4 stated she fell during a shower. V9 (CNA-Certified Nursing Assistant) was giving her the shower. R4 stated the floor was slippery and she slid forward and hit her lower back on the shower seat. R4 stated she was barefoot at the time. "There should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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		

been a towel down, normally they put a towel down so I don't slip." R4 stated she did not have a gait belt on. R4 stated her back did not hurt right away, but started to her during the night. They did an x-ray and said she had broken ribs. R4 stated she feels fine and has no pain except for when she coughs.

On January 21, 2020 at 2:05 PM, V9 (CNA) stated when she gives showers she puts a towel down on the floor so the residents don't slip on the floor. V9 stated she does not use a gait belt to transfer when giving showers. V9 stated the night of the incident (January 7, 2020) she was to give R4 a shower. R4 is alert and can make her needs known. R4 uses a walker and is blind. V9 turned on the water to get the water warm and R4 started walking towards the shower bench with her walker and before V9 could put the shower bench down R4 started to sit down, the shower bench hit R4 in the back. V9 stated she was able to get R4 onto the shower bench and give her her shower. V9 stated she did not have a gait belt on R4 and was not sure if there was a towel on the floor.

On January 21, 2020 at 2:15 PM, V2 (Director of Nursing) stated gait belts are to be used for all transfers, it is a part of their (CNAs) uniform. Residents who are being walked with a walker require the use of a gait belt. V9 should have had a gait belt on R4 and walked with her to the shower seat and removed the gait belt when R4 was seated on the bench. Gait belts are used for safety.

R4's Progress Note dated January 8, 2020 at 4:32 AM, showed "R4 states she fell during a shower after dinner on January 7, 2020. R4 states she slid off shower seat onto the ground

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 01/23/2020

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

(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 14	S9999		

and was lifted back to the shower seat by 1 assist. Resident complains of left lower flank pain..."

R4's Radiology report dated January 8, 2020 shows an acute nondisplaced fractures of her left 10th and 11th ribs.

The facility's Final Incident Report dated January 10, 2020, shows on January 7, 2020, a CNA was assisting R4 into the shower, R4 was reaching for a grab bar and attempting to sit down before the shower seat was unfolded from the wall. R4's feet slipped a little and the CNA caught R4 so she did not fall, but in the process hit her back left lower ribs on the shower seat.

The facility's Gait Belt policy with a revision date of December 2002, shows,"It is the policy of the facility that all direct care staff shall use a gait belt when transferring or ambulating residents. Purpose of using a gait belt:for the protection of both staff and residents during ambulation and transfers....No resident will be transferred or ambulated without the use of a gait belt, unless to do so is contraindicated and this would be identified on residents plan of care..."

(B)