STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015879	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

(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: 22610072/IL154476	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) 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 allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. 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. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document thorough post fall investigations. The facility also failed to implement post-fall, fall prevention interventions. These failures affect two of three residents (R1,	S9999		

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S9999	Continued From page 2	S9999		

R2) reviewed for falls on the sample of six. These failures resulted in R1 having three falls during the month of November 2022. R1 was found to have a mildly comminuted fracture of the medial aspect of the superior left pubic ramus with mild displacement and angulation and a non-displaced fracture of the medial aspect of the inferior left pubic ramus.

Findings include:

1.) a.) R1's Care Plans dated 4/19/22 document R1 is at risk for falls due to generalized weakness and history of falls. These care plans document R1 may have poor safety awareness related to a diagnosis of Dementia. These care plans include fall prevention interventions including to provide toileting assistance routinely and as needed.

R1's Fall Risk assessment dated 10/18/22 documents R1 is a high risk for falling.

R1's Fall Investigation dated 11/13/22 documents R1 has moderate impaired cognition. This investigation documents on 11/13/22 at approximately 11:45am, R1 was witnessed standing in R1's room between the two beds straightening the blankets on R1's bed and before V19 (Certified Nursing Assistant/CNA) could intervene, R1 lost R1's balance and fell. R1 was noted to be incontinent at the time of the fall. R1 was seen in the Emergency Room with no findings and came back to the facility with orders for Physical and Occupational Therapy for weakness and that these orders were "already active." This investigation documents R1 has several considerations that increase R1's risk for falls including a past medical history of Non-traumatic Chronic Subdural Hemorrhage, Muscle Wasting and Atrophy, Dementia,

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S9999	Continued From page 3 Unspecified Lack of Coordination, Unsteadiness on Feet, Need for assistance with personal care, abnormal posture, pain, muscle weakness, and age-related osteoporosis as well as vitamin B12 deficiency anemia, insomnia, and vitamin D deficiency all of which increase R1's risk for falls and injury related to falls. This investigation documents "the probable root cause of the fall was the resident standing to straighten (R1's) bedcovers." This investigation documents staff are to ensure bed is made if R1 is not in bed and to encourage R1 to call for assistance when straightening up R1's bed. R1's fall event report for this fall documents R1 stood up and fell back toward the bed, however R1's progress notes located within this fall event report document R1 leaned forward and fell down. R1 progress notes dated 11/13/2022 document at 1:03 PM the facility received a call from V25 (R1's family) voicing concerns related to R1's fall and V25 had noticed times of increased confusion with R1. This investigation does not document when R1 was last toileted. This investigation also documents R1's bed was already made at the time of this fall. This investigation documents a handwritten witness statement by V19 (CNA) documenting R1 was last seen at 10:00am, sitting in R1's wheelchair with reason of "breakfast." This statement documents V19 was the only staff member on the unit at the time of R1's fall. There is no documentation of when R1 was last toileted prior to this fall. There is no documentation of an interview with R4, R1's roommate regarding this fall. On 1/10/22, the facility provided documentation of therapy service dates (evaluation dates and dates of therapy discharge) for R1 which include as follows: Physical Therapy - Evaluation date 4/19/2022 -	S9999		

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MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S9999	Continued From page 4 Discharge date 5/27/2022 Evaluation date 10/2/2022 - Discharge date 10/2/2022 Occupational Therapy - Evaluation date 4/20/2022 - Discharge date 5/27/2022 Evaluation date 10/3/2022 - Discharge date 10/3/2022 Speech Language Pathology - Evaluation date 4/21/2022 - Discharge date 5/27/2022 Evaluation date 6/9/2022 - Discharge date 10/29/2022 There is no documentation R1's orders from R1's Emergency Room visit due to R1's fall on 11/13/22 for Physical and Occupational Therapy for weakness were active as the facility's investigation documents were. There is no documentation R1 received PT/OT as ordered by the emergency room. On 1/4/23 at 1:05pm, V19 (CNA) stated on 11/13/22 R1 had a fall and was "found" between resident beds, near the foot of the bed. V19 stated R1 likes to "grab" at everything including bed sheets and items that are on the floor such as ant bait stations. V19 stated on 11/13/22, R1's bed was made prior to the fall in hopes R1 would not try to fix the sheets. V19 stated V19 could not recall if R1's room call light was on but R4, R1's roommate would alert staff to R1 doing things R1 is not supposed to do and may have turned the light on. V19 stated V19 did not see the fall occur, V19 just found R1 on the floor. V19 stated R1 was incontinent at the time of this fall and that R1 had been toileted some time before breakfast. V19 stated he did not recall taking R1 to the toilet, but R1 had been provided with incontinence care. V19 stated V19 was unable to identify additional staff who were working on the unit at the time of R1's fall but since R1 did not document additional	S9999		

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MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S9999	Continued From page 5 names on R1's written witness statement, the staff were "probably" agency staff. V19 stated V19 "thought maybe" R1 was trying to adjust bed sheets because of R1 was located near R1's bed, however V19 was unsure. b.) R1's Fall Investigation documents R1 had a fall on 11/16/22 at 7:30am. This investigation documents R1's cognition as moderately impaired. The investigation documents at approximately 7:30am, R1 was observed sitting on the floor on R1's buttocks in front of R1's wheelchair in the hallway. R1 reported mild left-hand pain with normal range of motion. There was a small bruise noted to the posterior left hand related to a blood draw on 11/13/22. This investigation documents prior to the fall, R1 had last been observed "sitting in the hallway" and R1 had been dressed and toileted 20 minutes prior to falling. R1 was incontinent of bladder at the time of the fall. R1 stated R1 "just stood up" and fell. This investigation documents immediate interventions including analgesics, "alternate call" and increased frequency of visual checks. R1's Investigation Report documents the root cause of R1's fall on 11/16/22 as "self-transferring" with interventions including staff to assist to the dining room upon rising in the morning and offer snack/beverage as R1 allows and orthostatic vital signs. There is no documentation as to an investigation in to why R1 was attempting to "self-transfer." There is no documentation as to investigation in to R1's incontinence at the time of the fall. This investigation documents V19 and V31 (CNAs) were working on the unit at the time of R1's fall. V19's written witness statement dated 11/16/22 documents V19 thinks the fall occurred because "(R1) was soaked and tried to stand up" and that V19 last observed R1 at 7:00am "to get dressed" but does not document if R1 was	S9999		

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S9999	Continued From page 6 toileted at that time or provided incontinence care. There is no documentation of a witness statement from V31. R1's progress notes dated 11/16/22 at 8:21 AM document Orthostatic vital signs were obtained with a lying blood pressure and pulse and two blood pressures and pulses while sitting. There is no documentation of a blood pressure or pulse while R1 was standing. R1's care plans dated 11/16/22 document R1's risk for falls and that R1 may have poor safety awareness related to Dementia with interventions including Orthostatic Vitals but does not include how often to complete the orthostatic vital signs. On 1/4/23 at 1:05pm, V19 stated V19 was working on the unit R1 resides on 11/16/22 when R1 was found on the floor. V19 stated staff were in the middle of getting residents up. V19 stated V19 was in "a room" and had come out of the room and found R1 sitting in front of the doorway. R1 was in the hall prior to the fall because the facility tries not to leave R1 alone in the wheelchair in R1's room "due to wandering." V19 stated V19 could not recall if V19 got R1 ready that morning. V19 stated R1 "is more of a brief change" and that R1 was not offered/attempted to be taken to the bathroom for R1 to attempt to use the toilet. V19 stated if R1 was taken to toilet, it was R1 telling staff R1 wanted to be taken to the bathroom to use the toilet. V19 stated, "if we took (R1) to the toilet we would have to stay with (R1) because (R1) would get up on R1's own." V19 stated R1 was pretty wet/soaked with urine at the time of this fall. c.) R1's fall investigation documents R1 had a fall on 11/24/22 at 8:43am. This investigation	S9999		

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MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S9999	Continued From page 7	S9999		

documents R1 is a high risk for falls. This investigation documents on November 24th, 2022, at 8:45 AM R1 was observed on the floor near the sink in R1's room. R1 was complaining of pain to R1's posterior head and R1's left hip. This investigation documents R1's range of motion was within normal limits and all extremities. Due to the use of anti-platelet medication combined with R1's head pain in addition to R1's hip pain the facility was concerned about R1's condition and felt R1 needed to be further evaluated. During R1's emergency room visit and X-ray of R1's hip with pelvis results document a non-displaced fracture of inferior pubic ramus on the right side. This investigation also documents, "additionally, the resident has experienced significant weight loss over the past month from 108 pounds on November 8th, 2022, to 102 pounds on November 28th, 2022. This shows a general decline in the resident's condition." This investigation also documents R1 first complained of left hip pain on November 23rd, 2022, and R1's primary care physician was notified and a left hip X-ray was requested via fax. Later that same day the facility followed up with the office on the request for a left hip X-ray with no response to the request for an X-ray being received prior to the fall the following day. This investigation documents on the day of the fall R1 was assisted from bed and provided with morning cares including bruising R1's teeth and continence cares hair care and her face and hands were washed at approximately 7:30 AM. Prior to the incident R1 was last seen at 8:25 AM in her wheelchair in the hall. The wheels to R1's wheelchair were noted to be unlocked and R1 stated R1 was trying to get to the sink when R1 fell. This investigation documents based on the investigation the probable root cause of the fall

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MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S9999	Continued From page 8	S9999		

was R1 self-transferring and standing unassisted to use R1's sink with post fall interventions of providing assistance for R1 to and from meals as R1 allows and to assist R1 to activities after breakfast and cares as R1 allows. R1's Event Report for this fall documents R1 complained of left hip pain following the fall with "rotation/deformity of upper left extremity" marked as present. Three written witness statements by V31, V32 and V33 (CNA) document R1 was last seen by staff at 8:25 AM that morning in the hallway. Two statements, V32 and V33 (CNA) document R1 was incontinent at the time of the fall. There is no documentation in the investigation that R1 had been taken to/provided assistance to use the toilet, only that R1's brief was clean and had incontinence cares provided. There is no documentation in the investigation related to rotation/deformity of left upper extremity marked as being present on the event for R1's fall on 11/24/22. This investigation documents R1's Hospital History and Physical dated 11/30/22 documents R1 is in distress and ill-appearing. This H&P documents R1 presented to the emergency room with recurrent falls, a right hip fracture as per V25 (R1's Family) which was non-operable. R1 presented to the emergency room and ended up being admitted with poor oral intake, severe dehydration, and dysphagia with right hip pain plus recurrent falls. Additional diagnoses include hypernatremia secondary to dehydration, recurrent falls at the facility.

R1's X-ray results of the pelvis and right and left hip dated 12/1/22 document a mildly comminuted fracture of the medial aspect of the superior left pubic ramus with mild displacement and angulation. There is a non-displaced fracture of the medial aspect of the inferior left pubic ramus. These results do not document any right pelvic

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	IL6015879	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S9999	Continued From page 9 fractures. On 1/5/22 at 3:00pm, V2 (Director of Nursing/DON) stated V2 thought the fall investigations were being completed thoroughly but there is no documentation of some of the details in the investigations. V2 stated the facility usually just reviews the handwritten witness statements while completing investigations unless there are questions about what is written on the statements, the investigation does not include calling or interviewing witnesses. 2.) a.)R2's Care Plans dated 12/28/22 document R2 has potential for injury from falls related to generalized weakness and a history of falls. R2 may have poor safety awareness due to Dementia and has diagnoses including Parkinson's Disease, Bipolar, and Arthritis. These care plans document the goal is to reduce the risk for major injury related to falls with fall prevention interventions including to encourage and remind R2 to call for assist prior to toileting and for staff to provide toileting assistance routinely and as needed. R2's Fall Assessment dated 11/23/22 documents R2 is a High risk for falls. R2's Minimum Data Set (MDS) dated 11/23/22 documents R2 is cognitively intact. R2's Fall event form documents R2 had a fall on 12/13/22 at 11:20am. This form documents R2 was self-ambulating from R2's bathroom to R2's bed and lost balance and fell. This form documents R2's call light was on, and an unidentified Certified Nursing Assistant (CNA) was walking to R2's room and heard a crash and found R2 on the floor. R2 complained of pain and	S9999		

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MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S9999	Continued From page 10 had an abrasion to the left shoulder. This form documents immediate measures and interventions taken including to complete neurological checks and observe R2. R2's Progress Notes dated 12/13/22 at 11:20am document R2 was observed sitting on the floor beside the bed. R2's back was resting on the side of bed with legs extended in front of R2. R2 stated R2 was walking from the bathroom with the walker and lost R2's balance and fell. R2 was reminded R2 requires assistance with ambulation. R2 was upset and stated it was the facility staff's fault for not helping R2. There is no documentation regarding the investigation of how long the call light was on. There is no documentation regarding the investigation of if R2 was going to or coming from the bathroom. R2's fall investigation summary for R2's fall on 12/13/22 documents the root cause of this fall as "self-transferring" with a post fall intervention to place non-skid strips to the right side of R2's bed. This summary does not document why R2 was self-ambulating/transferring. This summary documents, "(R2) was planning to self-ambulate to the bathroom" although there is no documentation of this statement in the investigation other than the final summary of the investigation. There is no documentation in this investigation as to when R2 had last been assisted or offered to be assisted to the toilet. There is only one witness statement by V31 in R2's investigation although this witness statement documents multiple additional staff members including V19, V31, V34 (CNAs) were working on the unit at the time of R2's fall on 12/13/22. b.) R2's Fall Investigation documents R2 sustained a fall on December 26th, 2022, at 4:40	S9999		

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S9999	Continued From page 11 PM in R2's room. This investigation documents R2's past medical history of a right femur fracture, Parkinson's, unspecified Dementia with Behaviors, syncope and collapse, muscle wasting and atrophy, muscle weakness, difficulty in walking, a history of falling, heart failure, and abnormalities of gait and mobility as well as lack of coordination. At the time of the fall R2 was on aspirin 81 milligrams daily. This investigation documents R2's cognition as cognitively intact with a root cause of R2 slipping out of R2's wheelchair. R2's care plan was updated with post fall interventions including physical therapy to screen for wheelchair position and safety, a cushion secured with (brand name adhesive) to the wheelchair, and that R2's wheelchair was replaced. There is no documentation in this investigation of an assessment of the wheelchair R2 was using at the time of the fall. This investigation documents R2 was last seen by staff sitting in the wheelchair in R2's room. This investigation documents at the time of the fall there was significant bleeding from R2's right forehead. R2 was transferred to the local emergency room and found to have a Subdural Hematoma. R2 was deemed to not be a good candidate for neurosurgical intervention and was transported back to the facility from the local emergency department. When R2 was asked what happened, R2 stated, "something is wrong with my wheelchair. (R2) slid out" R2 guesses. This investigation documents the probable root cause of the fall was R2 slipping from the wheelchair but does not document why R2 "slipped from the wheelchair. This investigation documents R2 was having right sided head pain. This investigation documents hospital discharge instructions with diagnosis including fall, traumatic hematoma of forehead, acute Subdural hematoma, hand laceration, and skin tear. This	S9999		

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S9999	Continued From page 12 investigation documents one witness statement from V21 (CNA.) There are no additional witness statements from staff working on the unit R2 resides on at the time of this fall. There is no documentation the state survey agency was notified of the major injury R2 sustained of an acute Subdural hematoma from R2's fall on 12/26/22. R2's Progress Notes dated December 26th at 5:22 PM document V22 (Licensed Practical Nurse/LPN) heard "HELP ME" being called out while passing pills in the hallway. R2 was found on the floor lying on the right side holding R2's head with R2's left arm. R2 stated R2 thinks something is wrong with his chair and that R2 guesses R2 just slipped out of R2's chair. The emergency room records document a Computed Tomography of the Head exam results dated 12/26/22 that document R2's exam revealed an acute Subdural hematoma along the right temporal and right frontal convexity measuring up to 0.4cm (centimeters) in diameter. Additional emergency room documentation dated 12/26/22 documents R2 sustained a scalp hematoma abrasion that was closed with adhesive closure, a scalp hematoma measuring 5cm by 6cm in diameter, two dorsal superficial skin tears that were closed with adhesive closure and a 2cm laceration to the right ring finger. R2's Investigation for R2's fall on 12/26/22 documents a hospital emergency room report dated 12/29/22 documents R2 returned to the emergency department on December 29th, 2022, with chief complaint of decreasing responsiveness. The emergency department trauma service felt in light of R2's do not resuscitate status there was nothing additional	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015879	A. BUILDING: _____ B. WING _____	C 01/10/2023

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

they could offer then continued do not resuscitate and comfort measures. R2's hospital notes document R2 was observed to have "extensive" facial bruising. These notes document R2 was discharged back to the facility on 12/29/22 in "critical" condition.

On 1/5/22 at 3:00pm, V2 (Director of Nursing) stated V2 did not report R2's major injury of an Acute Subdural Hematoma with use of Aspirin (Antiplatelet) medication because R2 only went to the emergency department and did not receive further intervention like a drain or sutures. V2 stated V2 just usually reports broken bones or if a resident requires sutures.

The facility's Accident and Incident Report policy dated 4/2/2019 documents the objective of the policy is to document all accidents and incidents occurring to resident's, visitors, and employees. This policy documents if the State Survey Agency notification is required, it is the responsibility of the Director of Nursing or Administrator to do so. This policy documents in all cases, there must be an exact description of the accident/incident including witnesses and statements. The Resident Accident & Incident Reports form dated March 2002 documents a blank spreadsheet the facility uses to document the residents incidents and accidents including the possible cause and that the cause was investigated and notifications were made, including a notification to the State Survey Agency.

The facility's Emergencies policy dated 4/3/18 documents immediate care of a resident after a fall including to check the residents ability to explain what happened and evaluate the residents condition before the fall. Determine if possible where, how and when the accident

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S9999	Continued From page 14 occurred. If a head injury has occurred notify the physician immediately for orders to transfer the resident to the emergency room. "A"	S9999		