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 09/11/2024

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 Facility Reported Incident of August 30, 2024 IL177669	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)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 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, 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	S9999		

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 09/11/2024

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		

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.
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:
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 and assistance to prevent accidents.

These rquirements are not met as evidenced by:

Based on observation, interview, and record

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 09/11/2024

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		

review, the facility failed to immediately notify a physician of a fall with new onset of pain, failed to monitor and assess a resident post fall for pain and change of condition, failed to provide pain medication for a resident experiencing pain after a fall; and failed to perform a safe transfer for 1 of 3 residents (R1) reviewed for quality of care. This failure resulted in R1 experiencing a fall and fracturing his left arm and shoulder and not being transferred to the acute care hospital for evaluation for 19 hours after a fall with a fractures.

The findings include:

R1's face sheet showed he was admitted to the facility on 12/28/22, with diagnoses to include congestive heart failure, dysphagia, Chronic Obstructive Pulmonary disease, Malignant neoplasm of prostate, Alzheimer's Disease with late onset, muscle weakness, venous insufficiency, chronic kidney disease, atherosclerotic heart disease of native coronary artery, unsteadiness on feet, anxiety disorder, repeated falls, and abnormality of gait and mobility.

R1's facility assessment, dated 7/2/24, showed he has severe cognitive impairment and requires substantial/maximal staff assistance for transfers. (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.)

R1's care plan, initiated 12/28/22, showed, "Resident Care Information". This care plan showed an approach started 6/29/24 "Approach: Safe Resident Handling; Procedures- Transfer Method: stand aid transfer..." This care plan showed a new approach, started 9/10/24,

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 09/11/2024

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		

"Approach: Safe Resident Handling; Procedures-Transfer Method: full mechanical lift with staff assist of two..."

R1's Incident Report showed, "At approximately 5:45 AM on 8/30/24, it was reported to the nurse that resident had been lowered to the floor when transferring due to bilateral weakness of his legs. Resident complains of some pain to the left shoulder area but range of motion was assessed to be WNL (within normal limits), and Tylenol was given for pain. At approximately 1:29 PM on 8/31/24, resident was complaining of increased pain to left arm. He was assessed and bruising noted and unable to complete ROM (range of motion). Order received to send to ER (emergency room) for evaluation. Resident transferred to [local acute care hospital] at 1300 (1:00 PM) on 8/31/24 for evaluation. Resident returned from [local acute care hospital] at 19:19 (7:19 PM) on 8/31/24 with orders for sling to the left arm at all times. Pain management provided with ice and oral medication. Orthopedic appointment scheduled for 9/6/24. X-ray of left shoulder conclusion: Humeral head neck impacted angulated comminuted fractures seen. X-ray of left elbow conclusion: Subtle nondisplaced fractures injury at the posterior lip of olecranon. Advanced demineralization is noted. [Nurse Practitioner] confirmed diagnosis of osteopenia. Therapy to evaluate for safest level of transfer need and strengthening."

R1's Acute Care Hospital Emergency Room documents, dated 8/31/24, showed, "... Patient Visit Information... Humerus fracture... Prescriptions: 1. Hydrocodone/acetaminophen 5-325 mg every 4 hours as needed... Procedure: Radiographic image of the shoulder, left 2-4 views... Indications: Fall yesterday. Hematoma on

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 09/11/2024

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		

left arm, with decreased use of arm... Conclusion: Comminuted angulated impacted fractures seen with surrounding soft tissue swelling... Procedure: Radiographic image of the elbow, left... Indications: Fall yesterday; hematoma on left arm with decreased usage.. Conclusion: ... Correlate for subtle nondisplaced fractures injury at the posterior lip of olecranon. Soft tissue swelling..."

R1's 8/30/24 Nursing Note entered at 5:45 AM showed, "This nurse was called into residents room by CNA (Certified Nursing Assistant). CNA reported resident was slowly lowered to the ground due to resident bilateral lower extremity weakness. Resident typically transfers with 1 assist to wheelchair. Resident reports pain to left shoulder area that is new. PRN (as needed) Tylenol administered for pain relief. No injuries observed. ROM (range of motion) within normal limits for resident.... POA (power of attorney) and NP (Nurse Practitioner) notified."

R1's Physician Notification form, dated 8/30/24 at 5:25 AM, showed it was reviewed by the V16 (NP/Nurse Practitioner) on 9/3/24.

R1's next nursing note was dated 8/30/24 at 8:23 PM and showed, "Post fall observation. Vital signs within normal limits for this resident. Continues to have complaints of discomfort to the left shoulder. Scheduled Tylenol administered as ordered. continues on antibiotic treatment for suspected osteomyelitis..." This was the only pain relief medication administered to R1 between 5:38 AM and 8:23 PM.

There was no evidence of R1 being assessed by a nurse from 5:45 AM on 8/30/24 through 8:23 PM on 8/30/24.

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 09/11/2024

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		

R1's 8/31/24 Nursing Note entered by V17 (RN) at 5:22 AM showed, "Resident is being monitored post fall and for treatment of possible osteomyelitis... Resident did not voice any issues or concerns throughout the night."

R1's 8/31/24 Nursing Note entered at 1:29 PM showed, "Resident reporting moderate pain to left arm from fall, he was unable to tolerate any ROM, significant purple bruising noted from elbow to wrist. [Physician] was notified and gave order to send to the ER (emergency room).... transferred resident to [acute care hospital] for eval at 1:00 PM."

R1's 8/31/24 Nursing Note entered at 9:32 PM showed, "Received report from [acute care hospital] prior to resident's return. He is to wear sling to LUE (left upper extremity). Resident had no meds at hospital and slept the whole time. He has new orders for Norco 5/325 q4h (every 4 hours) PRN (as needed) for pain to LUE fx (fractures)... PRN Tylenol was given...."

R1's 9/1/24 Nursing Note entered at 5:41 AM showed, "Resident has been moaning et (and) expressing feelings of pain et discomfort, does state having pain in left shoulder, have attempted different positions..."

On 9/10/24 at 1:17 PM, R1 was lying in bed with his eyes closed. R1 had a sling on his left arm. R1's wife was at bedside.

On 9/10/24 at 9:30 AM, V2 (DON/Director of Nursing) provided a typed out statement that showed, "I talked to [V11, Certified Nursing Assistant/CNA] this morning about how she was transferring [R1] on Friday morning. She showed

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 09/11/2024

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		

me using the stand aid, that she pushed it up to him where he was sitting on the bed. His feet were placed on the stand aid and she assisted him to place his hands on the bar that you pull up with. She then said that he was a hard lift to get him to stand and before she could lower the seat pads, his legs gave out and he was still holding on to the bar..."

On 9/10/24 at 10:49 AM, R3 said staff transfer her using the stand aid. R3 said the staff don't use a gait belt when transferring her, but "they will help me stand by reaching under my arms and lifting or they will pull me up by my hands."

On 9/10/24 at 1:17 PM, V5 (R1's Spouse) said she comes to the facility every day and stays from approximately 1:00 PM until 7:00 PM. V5 said R1 would be transferred different ways depending on who was working. V5 said some of the staff would use a gait belt, and some wouldn't when using the stand aid. V5 said some staff would just grab R1 by the back of his pants to assist him up. V5 said the nurse called and told her R1 had a fall. V5 said when she got to the facility on 8/30/24 she could tell he had pain, but nothing 'too bad' if he was laying still. V5 said when they would try and move R1 he was hurting and he did not want to move his arm.

On 9/10/24 at 2:03 PM, V3 (RN/Registered Nurse) said she was working at the time of R1's fall on 8/30/24. V3 said she was doing her morning medication pass when she heard V11 (CNA/Certified Nursing Assistant) yelling because R1 was in the middle of falling while she was transferring him from the bed to his wheelchair. V3 said when she entered R1's room to assist, he was already laying on the floor. V3 said there was a stand lift in the room, but it was in the corner of

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 09/11/2024

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		

room and not near where R1 was laying on the floor. V3 said it did not appear V11 was using the stand lift at the time of the fall. V3 said she did not witness how R1 ended up on the floor. V3 said as she was heading down the hall to respond to R1's room, V11 opened the door and R1 was already on the floor. V3 said V11 told her R1 was a stand pivot transfer.

On 9/10/24 at 2:19 PM, V6 (CNA) said she worked 8/30/24 starting at 6:00 AM. V6 said when she came on shift, V11 and V3 were using the mechanical lift to get R1 off of the floor. V6 said she uses the electric stand lift when transferring R1 because he is not strong enough to bear the weight in his legs and arms to use the stand aid. V6 said R1 was not a stand pivot transfer. V6 said she was told V11 was trying to transfer R1 as a one person assist. V6 said R1 has not been a one person assist for months, and would not be capable to being transferred with one assist. V6 said it was obvious R1 was in a lot of pain because he would scream out in pain if staff touched his arm or tried to move him. V6 said it was obvious to her R1 had an injury.

On 9/10/24 at 2:25 PM, V12 (CNA) said staff use the stand aid when transferring R1, but they have to use 2 people.

On 9/10/24 at 2:38 PM, V4 (CNA) said she worked day shift on 8/30/24 after R1's fall. V4 said, "[R1] was hurting a lot. I touched his arm and flinched and winced. When we would roll him he said 'ow ow ow' which was something he never did... His pain stayed the same throughout my shift, he wouldn't eat, he just stayed in bed. I tried to feed him and he spit it out." V4 said she thought R1 was a two assist for transfers.

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 09/11/2024

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		

On 9/10/24 at 3:28 PM, V9 (CNA) said she worked day shift on 8/30/24 after R1's fall. V9 said, " We were taking care of him and he was screaming and hollering in pain. I told the nurse something was wrong with him. She said he was lowered to the floor and had no injuries. I told her he is not acting like someone who was 'lowered to the floor'... I was really upset because the nurse wasn't listening to me. I told her 'I'm sorry but he is hurt.' They didn't send him out. She kept dismissing me and saying she got in report he was fine..." V9 said she knows they had started using the electric lift for R1 because he was not strong enough for the manual stand aid.

On 9/10/24 at 3:41 PM, V7 (RN/Registered Nurse) said R1's fall happened just before she came on shift. V7 said she received in report that R1 had a witnessed fall with no injury, and was told they gave R1 some Tylenol. V7 said she went in and saw R1, and he looked tired, and said his arm was sore. V7 said, "I checked on him and there appeared to be nothing abnormal or of concern." There was no evidence of V7 assessing R1 found in his medical record. R1's August 2024 eMAR (electronic Medication Administration Record) showed no pain control medication was administered during V7's shift on 8/30/24 from 6:00 AM to 2:30 PM.

On 9/11/24 at 9:48 AM, V13 (CNA) said R1's transfer status was to use the manual stand aid.

On 9/11/24 at 11:44 AM, V11 (CNA) said she was the aide that was transferring R1 when he fell. V11 said she went into R1's room and had him sitting up at the edge of the bed. V11 said she went to get the stand aid and went back to R1's room to transfer him. V11 said the stand aid has two grab bars for the resident to grab. V11 said

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 09/11/2024

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		

she positioned the stand aid in front of R1, and placed his hands on the first bar, and had him start to stand. V11 said she then moved R1's hands to the second bar so he would stand up higher. V11 said as R1 was starting to stand up further and she trying to put the seat flap down behind him, R1's legs gave out and he started to fall. V11 said R1 let go of the stand aid with one hand, but kept one hand on the bar as he was falling. V11 said as R1 was going down to the floor she was able to get behind him. V11 said she was trying to get R1 to let go with his other hand to be lowered. V11 said R1 has good and bad days, and can usually follow directions such as letting go of the bar. V11 said she was yelling for help, and when the nurse arrived to R1's room, she had already lowered him to the floor and he was leaning against her legs. V11 said she moved the stand aid away from R1. V11 then said V3 (RN/Registered Nurse) responded to the room moved the stand aid. V11 said she did not use a gait belt during R1's transfer with the stand aid, and had never been told before that she needed to use one. V11 said since the fall happened V2, DON (Director of Nursing), has told them they have to use a gait belt when performing a stand aid transfer, so they are able to assist a resident if they become weak during the transfer.

On 9/11/24 at 12:42 PM, V15 (ADON/Assistant Director of Nursing) said, "When a fall happens, the nurse on duty notifies the provider and family. If it is urgent, they will get an order to send the resident to the hospital. After a fall, the CNAs get vitals on the resident for 3 days, as fall follow ups and the nurses should be doing an assessment. They would document their assessment under the progress notes. They know to do and document assessments after falls because that is

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 09/11/2024

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		

what they are trained to do here. They should be monitoring for changes." V15 said she would have expected the day shift nurse on R1's hall to do an assessment and document in the medical record, especially since the fall had just happened prior to her starting her shift. V15 said R1 should be monitored for pain, and pain should be treated appropriately. V15 said resident's should be assessed for range of motion after falls and if there is pain, they should notify the provider and either send to the hospital or get x-rays in house. V15 said they have meetings every other Friday and discuss transfer status changes along with other topics. "The staff know they can always downgrade a transfer status, but they can't go to a lesser assistance without the resident having a physical therapy evaluation.: V15 said to be appropriate for the stand aid, the resident would have to be able to reach and pull themselves up, but they don't need to be able to bear their own weight, but if the staff is having to physically assist the resident into the standing position they would need to use a gait belt. V15 said if a resident is having more difficulty transferring, she would expect the staff to downgrade their transfer status and let the administrative staff know so they can get a therapy evaluation ordered.

On 9/11/24 at 1:00 PM, V2 (DON/Director of Nursing) said, "If you are performing a transfer and the resident can't understand what they are supposed to be doing, their transfer status needs to be looked at. The resident needs to be able to grab onto the bar and bear his own weight to use the stand aid. It was never brought to my attention they were struggling or were needing assistance with his transfers. Staff should all know the resident's transfer status and it should be a consistent. We can make him a (mechanical lift) without waiting for therapy, so they would

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 09/11/2024

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		

have been able to do that, and let us know he will need to see therapy. If a resident is having difficulty, they should be having someone else help them." V2 said she expects staff to use a gait belt with the stand aid for the safety of the resident in the event that the resident's knees buckle they would have something to grab onto besides their pants. V2 said she expects post fall assessments and vital signs to be documented for at least 72 hours after the fall. V2 said, "The CNAs do the vitals and turn into the nurses, but the nurses should be monitoring them, so if there is any changes in range of motion or increased pain they can let the doctor know. The nurse should have contacted the doctor, and let the doctor know (R1) had a fall rather than place a note in the nurse practitioners binder to be reviewed on the nurse practitioner's next office day." V2 said if R1 was complaining of pain she would have expected there to be pain medications given and the physician or nurse practitioner notified.

On 9/11/24 at 1:35 PM, V17 (RN) said she works night shift. V17 said she does not go into resident's rooms unless she is passing medications or if the aides report their vitals are "off." When asked about assessing a resident who had recently had a fall, V17 said she would not go in and assess a resident just because they had a recent fall.

On 9/11/24 at 1:45 PM, V16 (Nurse Practitioner) said staff completed a physician notification form and placed it in her binder in the facility for review on her next visit. V16 said she would have expected staff to call and notify her of R1's fall with new onset of pain so she could give orders. V16 said if she had been notified immediately of R1's fall with new onset of pain, she would 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 09/11/2024

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		

ordered an x-ray to be done in house, or would have given orders to transfer R1 to the acute care hospital for evaluation. V16 said if a resident is experiencing a new onset of pain, especially after a fall, it needs to be addressed. V16 said R1 had been experiencing a steady decline in health and his transfer status should have been reassessed, because incidents like this happen more frequently when residents are declining.

The facility's policy, revised 12/02, showed, "... Subject: Change in a Resident's Condition; Purpose: Our facility shall promptly notify the resident, and/or resident's representative, and his or her attending physician of changes in the resident's condition and/or status... Procedure: 1. The nurse will notify the resident's attending physician when: a. The resident is involved in any accident or incident that results in an injury..."

The facility's policy and procedure, revised 4/3/18, showed, "... Subject: Emergencies; Policy: It is the policy of the facility to provide emergency care to a resident in need of it.... Falls: 1. Check the resident immediately for ability to move extremities; 2. Check resident's ability to explain what happened; evaluate resident's condition before the fall.; 3. Check if, or with anyone who witnessed the accident. Determine if possible, where, how, and when the accident occurred.4. check for any apparent dislocation or possible fracture. If any signs of this are noted, stabilize resident until ambulance arrives... 6. Call the resident's physician..."

The facility's policy and procedure revised 3/3/22 showed, "... Subject: Pain Management; Policy: The facility is dedicated to the philosophy that all residents should be as free of pain as possible, through a combination of medical intervention

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 09/11/2024

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		

and functional therapy. Purpose: To identify residents experiencing pain to establish control of pain to the resident's satisfaction and to relieve related symptoms.... 3. Residents will be observed and asked about pain at a minimum of each shift by the nurse using a standardized 0-10 scale or Verbal Descriptor Scale to determine pain intensity. 4. The physician will then be contacted, if needed, regarding the pain or pain indicators..."

The facility's policy and procedure, revised 4/3/18, showed, "... Subject: Emergencies; Policy: It is the policy of the facility to provide emergency care to a resident in need of it.... Falls: 1. Check the resident immediately for ability to move extremities; 2. Check resident's ability to explain what happened; evaluate resident's condition before the fall.; 3. Check if, or with anyone who witnessed the accident. Determine if possible, where, how, and when the accident occurred.4. check for any apparent dislocation or possible fracture. If any signs of this are noted, stabilize resident until ambulance arrives... 6. Call the resident's physician..."

The Standing Transfer Aid user's manual showed, "... Transfer functions of all types are quick and require minimal caregiver assistance. Each unit is equipped with a crossbar where users can grasp and pull their self up into a standing position using their own strength. ... A patient or resident who qualifies to use the [stand aid] must have enough leg and lower body strength to stand up and remain in the standing/sitting position. Adequate arm strength is required if the patient must use the cross-bar... For patients who lack these requirements, a sit-to-stand lift such as the electric powered patient lift is preferred and recommended."

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 09/11/2024

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 (A)	S9999		