STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146108	A. BUILDING _____ B. WING _____	C 12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PEORIA	**6900 NORTH STALWORTH PEORIA, IL 61615**

(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) COMPLETION DATE
F 323	Continued From page 3 E4/Physician verified that R1's injuries would probably had not been as serious if the fall mats were in place and the bed was in the low position.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.1210d)6) 300.3240a) 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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F9999	Continued From page 4	F9999		

These Requirements are NOT MET as Evidenced by:

Based on interview and record review, the facility failed to have fall precautions in place at the time of a fall for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 sustaining a subdural hematoma (beneath the surface swelling) and a C6 anterior interior endplate fracture (neck fracture).

Findings include:

Facesheet for R1 documents an admit date of 11/27/12 (latest return to the facility from hospital) and lists the following diagnoses: congestive heart failure, hypertension, malignant neoplasm of the pancreas, diabetes mellitus and dementia.

Consult Note for R1 dated 11/26/12 from local hospital admission documentation states, "CT (Computed Tomography) of the head does show a right high parietal subdural hematoma (beneath the surface swelling) that is acute...CT of the cervical spine shows C6 anterior inferior endplate fracture (neck fracture)."

Neurosurgery consultation note dated 11/25/12 documents that "patient (R1) was brought to the emergency department today because she has had a fall this morning followed with altered mental status. Per her son, patient wheeled herself into an empty room at the nursing home and then fell off the bed. Staff estimates that patient got out of bed around 5 a.m. and was found around 6:30 a.m."

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F9999	Continued From page 5 The current Care Plan for R1 dated 9/13/12 states, "Resident at risk for falling related to decreased safety awareness secondary to impaired cognition, moderately impaired decision making, history of falls, diagnosis of dementia and diabetes mellitus. Resident displays periods of altered perception/awareness of her surrounding and occasionally becomes restless. She is also hard of hearing." The current Care Plan for R1 dated 9/13/12 includes the following interventions/approaches: Approach Start Date: 11/25/2012 Ensure is in correct bed Approach Start Date: 9/6/2012 Change battery in alarm Approach Start Date: 4/23/12 Scoop mattress Approach Start Date: 1/13/2012 Chair Alarm Approach Start Date: 11/7/09 Encourage to assume a standing position slowly Approach Start Date: 11/7/09 Low bed with mats at bedsides. 1/5/12 Fall mats at bedside. On 12/4/12 at 7:20 AM, Z1/Family Member stated that R1 had five or six falls since 2002. Safety Event documentation for R1 dated 11/25/12 indicates that R1 was found in vacant resident room, laying next to the bed and had sustained a head laceration. Resident Progress Noted for R1 dated 11/25/12 documents, "At 6:20 AM CNA (Certified Nursing Assistant) supervisor alerted this nurse that the resident was on the floor bleeding in (another resident room). Resident had taken herself to	F9999		

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F9999	Continued From page 6 another room to sleep and apparently fell out of bed. Resident noted to have nickel sized laceration to the middle of her forehead. Also another laceration on right side of forehead. Moderate amount of bleeding from both wounds. Resident agitated, not wanting to stay in a laying position...Called 911 at 6:25 AM." On 12/21/12 at 9:45 AM, E3/CNA stated, "We were short staffed and a CNA that works second shift stayed over to help. The second shift CNA reported to E3/CNA that R1 was not in her regular room." E3/CNA verified she checked on R1 at 4:00 AM and the bed was not in the low position and floor mats were not in place." On 12/5/12 at 8:30 AM, E2/DON (Director of Nursing) verified that R1 fell asleep in the wrong bed and the chair alarm did not sound because the wheelchairs were being washed and that the floor mats were not put in place. On 12/27/12 at 9:05 AM, E4/Physician verified that on 11/25/12 R1 fell asleep in the wrong bed. According to E4, the bed was not put in the low position and floor mats were not put in place because the staff did not want to wake her. E4/Physician verified that R1's injuries would probably had not been as serious if the fall mats were in place and the bed was in the low position. (A)	F9999		