DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ____ B. WING ____	C 07/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(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 000	INITIAL COMMENTS Complaint #0843001/IL36040 No extended survey was conducted.	F 000		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record, observation and interview the facility staff failed to provided supervision for one resident (R1) who had a personal alarm and consistent behavioral documentation and care plan approaches for one resident (R4) who had a history of falls for 2 of 5 sampled residents. Findings include: 1. R1's Minimum Data Set (MDS), dated 6-23-08, documented that R1's diagnoses were, in part, Schizophrenia and Dementia with a problem of an unsteady gait, cognition modified independence with short and long term memory problems, staff supervision and set up assistance with transfer and location off unit, limited staff assistance of one person physical assistance with walking in room and in corridor, impaired balance while standing and wheelchair as primary mode of locomotion. R1's Care Plan, problem start date of 8-3-06,	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1	F 323		

documented that R1 was at risk for falls related to diagnosis of pubic fracture, history of psychoses and dementia, unsteady gait, cognitive impairment with attempts to stand up alone., psychotropic drug use and history of falls with at least one intervention to utilize bed and/or chair alarms. R1's Nursing Notes, dated 7-1-08, documented that R1 was on the third day of an antibiotic treatment for Urinary Tract Infection.

A resident's personal alarm was heard sounding, half way down the 100 hall, when touring the 100 hall with the E1, Administrator, on 7-1-08. R1 was found in the dining room which was a located at the end of the 100 hall and at a distance from the location that the resident's personal alarm was heard sounding. R1 was found sitting in a dining room table chair with her wheel chair alarm sounding. Staff were not in attendance of R1 and were unaware that R1 had self transferred herself from her wheel chair to the dining room chair and that her alarm was sounding until the observation was made during tour.

2. R4's MDS, dated 5-23-08, documented that R4's cognition was modified independence and that R4 required limited staff assistance of one person physical assist with bed mobility, transfer, ambulation and tolieting, impaired standing balance and unsteady gait. R4's Care Plan, problem start date 5-13-08, documented that R4 was at risk for injury from falling due to many factors not limited to but including weakness, shortness of breath at times, unsteady balance and gait with at least one intervention to monitor ambulation, transfer and movement and to offer assistance as needed.

R4's Event History documented that R4 at fallen on 6-3-08 without injury, 6-23-08 without

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F 323	Continued From page 2 injury when going to bathroom and twice on 6-24-08 with the first fall documentation documenting that R4 was found on the floor in a large amount of liquid stool and a bruising to his right third digit. The facility provided a Behavioral Observation Form, dated from 6-23-08 to 6-25-08, when asked what the facility did to provide R4's care planned monitoring. The Behavioral Observation Form documented two observations on 6-23-08 and 5 observations on 6-25-08 which stated that R4 was seen toileting at 9:15 and at 10:30, 11:00, 11:20 and 11:30 getting out of wheel chair. E7, COTA, stated, on 7-1-08 at 2:45p.m., that R4 was in therapy on 6-25-08 from 9:00 to 11:00 and 2:00 to 2:30 which was not consistent with the Behavior Observation Form documentation that documented R4 was toileting at 9:15 and getting out of his wheel chair and not in therapy on 6-25-08 at 10:30 and possibly 11:00. E7 also stated that R4 had been provided a wheeled walked and that the wheel walker was placed in R4's room on 6-10-08 and removed on 6-25-08. R4 was admitted to a local hospital on 6-25-08 at 9:41p.m. R4's care plan did not document that R4 had a wheel walker nor did his care plan document any approached for the of his wheel walker usage for R4's unsteady balance and gait or ambulation, transfer or movement assistance.	F 323		