

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>			
(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	F 000					
F 279 SS=D	<p>Incident investigation of 7/9/08/ IL36272</p> <p>Not an extended survey.</p> <p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Facility failed to develop a plan of care with quantifiable objectives for 1 resident on the sample, R1.</p> <p>Findings include:</p>	F 279					
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.

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
(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 279	<p>Continued From page 1</p> <p>1. R1 was originally admitted to the Facility on 4/7/08, with diagnoses, in part, of Cerebrovascular Accident with right sided weakness, Dysphagia and COPD. Facility incident investigation, dated 7/9/08 and signed by E1, Administrator, states "At approximately 1100 hrs. on 7/9/08, R1 attempted to self transfer rather than using the call light and was found on the floor in the restroom on the 300 hall. R1 was unwilling to extend her right hip and complained of pain. R1's physician, family and emergency services were notified and she was transferred to the hospital for evaluation. At 1500 hrs., I was notified that R1 was admitted with a fracture of her right hip. Upon her return, she will not be left in the restroom unattended".</p> <p>R1's most recent Minimum Data Set (MDS), shows that she has short and long term memory problems; is moderately impaired in cognitive skills for daily decision making; requires the extensive physical assistance of one person for toilet use; has unsteady sitting balance; and, has no symptoms of pain.</p> <p>R1's Facility Resident Assessment Protocols, dated 4/16/08, shows the following: "Communication: R1 has communication deficits through she does make her wants and needs know. She will use signs and gestures when she is unable to voice her wants. R1 sometimes struggles to find the correct words to express her thoughts.</p> <p>Falls: is at risk for falls according to her falls assessment and diagnoses of CVA, incontinence, use of psychotropic medication and unsteady gait. R1 ambulates with gait belt and limited assist and has made staff aware that she is willing to work to get well and go home".</p> <p>During an interview with E3, Certified Nurses Aide (CNA), on 7/14/08, it was stated that R1</p>	F 279			

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
(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 279	<p>Continued From page 2</p> <p>always uses the call light; communicates by saying Ahh-Ahh for Yes and Ahh for No; and the number of staff it takes to transfer her depends on whether she is having a "Good" or "Bad" day. E3 defined "Good" and "Bad" days for R1 in the following manner: if R1 is having a lot of pain in her leg on the effected side, it takes 2 people to transfer her and they never leave R1 alone on the toilet on "Bad" days. A "Good" day is described as R1 having minimal pain on her effected side and 1 staff is able to assist her with transfers. E3 was asked if R1 is a fall risk. E3 stated that no one has ever told her that R1 is a fall risk and R1 does not have an alarm therefore, E3 would not view R1 as being at risk for falls.</p> <p>During an interview with E4, CNA, on 7/14/08, it was stated that R1 is not a fall risk as E4 has never been told that R1 is a fall risk. Additionally, R1 does not have a body alarm which would indicate that she is at risk for falls.</p> <p>During a review of R1's Facility Plan of Care, dated 7/8/08, the following was noted: "Problem: Resident is at risk for injury from falling due to many factors not limited to but including: CVA, DM. Goal: Resident will experience minimal injuries from falling. Approach: 1. As resident will allow, keep bed in low position. 2. Offer resident call light while in room, if resident will allow, attach in resident reach. 3. Assist with ambulation, transfer, and movement. Report any gait disturbances for further review."</p> <p>R1's plan of care does not list the factors that could contribute to R1 falling; how R1 is to be transferred; how many staff members it takes to safely transfer R1 and whether staff is to stay with her while she is on the toilet. R1's plan of care does not address pain and how it effects her</p>	F 279			

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
(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 279	Continued From page 3 physical abilities; subsequent care; and interventions to mitigate pain. R1's plan of care does not address how she communicates and how staff can effectively communicate with her.	F 279			
F 323 SS=G	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 review and interview, the Facility failed to develop and implement interventions to reduce the risk of falling for 1 resident on the sample, R1. This failure resulted in R1 being left unattended on the toilet and sustaining a hip fracture which required surgical intervention.  Findings include:  1. R1 was originally admitted to the Facility on 4/7/08, with diagnoses, in part, of Cerebrovascular Accident with right sided weakness, Dysphagia and COPD. Facility incident investigation, dated 7/9/08 and signed by E1, Administrator, states "At approximately 1100 hrs. on 7/9/08, R1 attempted to self transfer rather than using the call light and was found on the floor in the restroom on the 300 hall. R1 was unwilling to extend her right hip and complained of pain. R1's physician, family and emergency services were notified and she was transferred to	F 323			

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
(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	<p>Continued From page 4</p> <p>the hospital for evaluation. At 1500 hrs., I was notified that R1 was admitted with a fracture of her right hip. Upon her return, she will not be left in the restroom unattended".</p> <p>Hospital History and Physical, dated 7/9/08, states "(R1) has a likely right subcapital femoral neck fracture, following an injury at the nursing home. She apparently was able to bear some weight on her leg, with significant assistance, and she can hold her hip flexed, which would be consistent with a stable and impacted femoral neck fracture. We will treat this surgically, by placing cannulated screws across the fracture site. Should the fracture lose its reduction by surgical time, then she will likely need a bipolar hip replacement". R1 returned to the Facility on 7/13/08, following repair of her right hip fracture.</p> <p>R1's most recent Minimum Data Set (MDS), shows that she has short and long term memory problems; is moderately impaired in cognitive skills for daily decision making; requires the extensive physical assistance of one person for toilet use; has unsteady sitting balance; and, has no symptoms of pain.</p> <p>R1's Facility Resident Assessment Protocols, dated 4/16/08, shows the following: Falls: is at risk for falls according to her falls assessment and diagnoses of CVA, incontinence, use of psychotropic medication and unsteady gait. R1 ambulates with gait belt and limited assist and has made staff aware that she is willing to work to get well and go home".</p> <p>During an interview with E2, Director of Nursing, on 7/14/08, it was stated that R1's physical abilities vary from day to day but, R1 normally is able to use the call light. E2 said that sometimes it takes 1 staff member and sometimes 2 to transfer R1 safely.</p> <p>During an interview with E3, Certified Nurses</p>	F 323			

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
(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	<p>Continued From page 5</p> <p>Aide (CNA), on 7/14/08, it was stated that R1 always uses the call light; communicates by saying Ahh-Ahh for Yes and Ahh for No; and the number of staff it takes to transfer her depends on whether she is having a "Good" or "Bad" day. E3 defined "Good" and "Bad" days for R1 in the following manner: if R1 is having a lot of pain in her leg on the effected side, it takes 2 people to transfer her and they never leave R1 alone on the toilet on "Bad" days. A "Good" day is described as R1 having minimal pain on her effected side and 1 staff is able to assist her with transfers. E3 was asked if R1 is a fall risk. E3 stated that no one has ever told her that R1 is a fall risk and R1 does not have an alarm therefore, E3 would not view R1 as being at risk for falls. E3 was asked where she would go to find information concerning how a resident is to be cared for. E3 said that she would ask the nurse or check the Cardex.</p> <p>During an interview with E4, CNA, on 7/14/08, it was stated that R1 is not a fall risk as E4 has never been told that R1 is a fall risk. Additionally, R1 does not have a body alarm which would indicate that she is at risk for falls. E4 was asked where she would go to obtain information regarding how a resident is to be transferred. E4 said that she would ask the nurse or shift coordinator. E4 was unaware of any written plan for resident's care.</p> <p>During a review of R1's Facility Plan of Care, dated 7/8/08, the following was noted: "Problem: Resident is at risk for injury from falling due to many factors not limited to but including: CVA, DM. Goal: Resident will experience minimal injuries from falling. Approach: 1. As resident will allow, keep bed in low position. 2. Offer resident call light while in</p>	F 323			

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

PRINTED: 07/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
(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	<p>Continued From page 6</p> <p>room, if resident will allow, attach in resident reach. 3. Assist with ambulation, transfer, and movement. Report any gait disturbances for further review."</p> <p>R1's plan of care does not list the factors that could contribute to R1 falling; how R1 is to be transferred; does not define how much or what type of "assistance" is needed; how many staff members it takes to safely transfer R1 and whether staff is to stay with her while she is on the toilet. R1's plan of care does not address pain and how it effects her physical abilities; subsequent care; and interventions to mitigate pain.</p> <p>Facility Policy and Procedures for Transfers states "1. Establish what the resident's level of function is and if there are any precautions, i.e.: a. check the chart for any documentation related to the resident's ability to transfer and/or ambulate (hospital records, therapy notes, care plan, etc.)". The Facility failed to follow its own policy by not establishing R1's level of functioning.</p> <p>Facility direct care staff did not identify R1 as being at risk for falls and left her alone on the toilet which resulted in R1 falling from the toilet and sustaining a hip fracture.</p>	F 323			