

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

PRINTED: 01/07/2009  
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>09/12/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE MARYVILLE, IL 62062</b>	
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>Annual Licensure and Certification Survey.</p> <p>This was not an extended survey.</p> <p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>3. On 9/10/08 at 11:44am, E4, LPN (Licensed Practical Nurse) was observed to administer R17 Ativan 0.25mg 1 tab during the noon medication pass in the dining room. Review of R17's POS (Physician's Order Sheet) shows the order for the Ativan to be given at 8am, 2pm and 8pm. Interview with E4 shortly after the medication pass indicates she didn't realize she had given the Ativan "that early". Interview with E2, DON (Director of Nursing) on 9/11/08 during the daily meeting indicated R17's original order was written for TID (three times a day) and the facility determined the times to be 8am-2pm-8pm. The facility failed to follow the signed physician's orders for R17's Ativan use.</p> <p>Based on record review and observation, the facility staff failed to timely administer medication(s) and to document the effectiveness of administered pain medications for 2 of 13 sampled residents (R1 and R11) and 1 off sampled resident (R12).</p> <p>Findings include:</p>	F 281		9/13/08
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 281	<p>Continued From page 1</p> <p>1. R1's Minimum Data Set (MDS), dated 5-23-08, documented that R1's cognition was moderately impaired with short and long term memory problems, extensive assistance of one to two plus persons physical assistance with activities of daily living and moderate pain daily. R1's Care Plan, problem start date of 12-22-07, documented that R1 was at high risk for falls, with a fall with injury on 7-10-08, with at least one care plan approach to "monitor for pain and administer analgesics as needed".</p> <p>R1's PRN (as needed) Medications Flowsheet, dated 7-12-08 to 8-11-08, documented that R1 was administered "Lortab 5/500...1-2 tab (tablets) oral every 4 hours as needed" for a diagnoses of pain fifteen (15) times in that time period; however, R1's PRN Medications Notes did not document every medication administration nor the effectiveness of the pain medication administered. R1's PRN Medications Flowsheet, dated 8-31-08 to 9-30-08, documented that she was administered Lortab on 9-7-08; however, R1's PRN Medication Notes did not document the administration of the medication nor the effectiveness of the pain medication.</p> <p>2. R11's MDS, dated 7-1-08, documented that R11's cognition was severely impaired with short and long term memory problems, extensive to total assistance of one to two plus persons physical assistance with activities of daily living and moderate pain daily. R11's Care Plan, problem start date 3-7-08, documented that R11 was care planned for pain related to an old fracture.</p> <p>R11's PRN Medications Flowsheet, dated 8-31-08 to 9-30-08, documented that R11 was administered "Roxanol (morphine) 20mg/ml</p>	F 281			

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F 281	Continued From page 2 every two as needed...dx pain", on 9-6-08 and 9-8-08, and "Lortab 5/500...1-2 tabs every 4 hours as needed...dx pain" twice on 9-4-08, however, her PRN Medication Notes, did not document all medications given and/or the effectiveness of the pain medication administered.	F 281			
F 314 SS=D	<b>483.25(c) PRESSURE SORES</b>  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: 3. Review of the clinical record identifies R4 as an 85 year old male readmitted to the facility on 9/8/08 following hospitalization for a fractured femur. Admission assessments indicate R4 had a stage II pressure ulcer of his coccyx which was treatment with a hydrocolloid dressing. Review of the care plan completed prior to R4's most recent hospitalization which had been updated since his return identifies him to be a risk for skin breakdown and indicates he had a history of pressure ulcers. The interventions indicate staff were to reposition R4 every two hours as needed, encourage intake, skin checks weekly and pressure reducing mattress to bed among others.  On 9/9/08 at 11:10am, R4 was observed to have a crinkled up DuoDerm to his coccyx area	F 314		9/15/08	

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F 314	<p>Continued From page 3</p> <p>which was brought to the CNA's (Certified Nurses Aides) attention at the time. R4 was transferred to the reclining wheelchair and left at bedside. R4 was observed to remain up in his chair until 2:45pm when he was transferred back to bed. No fluids were offered at either time. The facility failed to provide R4's with preventative measures identified as needed in his care plan. .Based on record review, interview and observation, the facility staff failed to provide timely turning and repositioning and pressure sore prevention for 3 of 13 sampled residents (R1, R4 and R11).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>R1's Minimum Data Set (MDS), dated 5-23-08, documented that R1's cognition was moderately impaired with short and long term memory problems, extensive assistance of one to two plus persons physical assistance with activities of daily living including bed mobility and transfer, moderate pain daily and no pressure sores. R1's Care Plan, problem start date of 12-22-07, documented that R1 was care planned for being at a increased risk for pressure ulcers, bruising and skin tears related to decreased mobility, incontinence, frequent loose stools and decreased nutrition. R1 was continuously observed, on 9-9-08 from 11:25a.m. to 2:00p.m., without timely turning and repositioning. R1's buttock and back of thighs were observed, on 9-9-08 at 2:00p.m., to be deeply creased and reddened.</li> <li>R11's MDS, dated 7-1-08, documented that R11's cognition was severely impaired with short and long term memory problems, extensive to total assistance of one to two plus persons</li> </ol>	F 314			

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F 314	Continued From page 4 physical assistance with activities of daily living including bed mobility and transfer, moderate pain daily and no pressure sores. R11's Care Plan, problem start date 3-7-08, documented that R11 was care planned for being at an increased risk for skin breakdown related to diagnoses of Cerebrovascular Accident with right sided Hemiplegia, use of blood thinner and decreased mobility with at least one care plan approach to turn and reposition every 2 hours. R11's perineal care was observed, on 9-9-08 at 11:51a.m. at which time an intact dressing was observed on R11's coccyx and left hip. E7, Licensed Practical Nurse (LPN), stated on 9-10-08 at 1:20p.m., that R11's coccyx and left leg areas were due to R11 sliding in bed and that R11 was total care. R11 was continuously observed, on 9-9-08 from 12:00p.m. to 3:00p.m., without timely turning and repositioning and during that time frame R11 did not move nor was she observing sliding in bed which was not excessively elevated. The facility's Weekly Infection Control Report, dated 8-9-08 to 8-15-08, documented that R11 had an in-house acquired suspected deep tissue injury of her right heel 4cm x 7.3cm. The facility did not provide any refutation or documentation documenting that the facility provided pressure sore and/or wound preventative measures to prevent R11's coccyx, left hip and heel pressure sores/wounds other than a physician's statement that documented that R11 would be at increased risk for skin breakdown due to her progressive decline associated with her disease process.	F 314			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards	F 323		9/26/08	

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F 323	<p>Continued From page 5</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to ensure that 2 (R12 and R4) of 13 in house sampled residents receives adequate supervision and assistance devices to prevent accidents. This failure resulted in a fracture femur for R4 when the facility failed to ensure adequate supervision of R4 when he repeatedly attempted to get up unassisted and fell three times within a 4 1/2 hour period of time on 8/26/08. This failure resulted in harm for R12 when the facility failed to have adequate supervision on 8/16/08 when she fell out of her chair sustaining a laceration of her forehead which required sutures.</p> <p>Findings include:</p> <p>1. Review of the MDS (Minimum Data Set) dated 8/1/08 identifies R4 as being an 85 year old male readmitted to the facility in February following hospitalization for a fractured hip. R4's diagnoses include Anxiety, Weakness, Chronic Pulmonary Obstructive Disease, and pain among others. The MDS indicates R4 has short/long term memory deficits with moderate cognitive impairment and required extensive assist of one staff for most activities of daily living with impairment in standing and sitting balance. A FALL RISK ASSESSMENT was completed on 8/11/08 and indicates R4 had prior falls, balance</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>problems when standing/walking, decreased muscular coordination, and lurching/swaying/slapping gait. The assessment also indicates he has unsteady gait and dementia. According to the care plan dated 8/12/08, R4 was assessed to be at risk for falls due to unsteady gait and diagnoses of anemia and osteoarthritis, use of routine pain medications, impaired balance, impaired safety awareness, and history of falls. The care plan indicates R4 required assist with ambulation and transfer due to unsteadiness, and will attempt to ambulate and transfer independently. The care plan also indicates R4 sustained three falls on 8/26/08, one of which resulted in a fractured right leg. Interventions listed on the care plan include no safety devices in use at the time of his three falls on 8/26/08.</p> <p>Review of the nurses notes dated 8/25/08 at 1:28am indicates R4 was sleeping on and off and was easily redirected back to bed. The nurses notes indicate at 9:49pm. R4 was up looking for his truck... the writer indicates several attempts were made to re-orient R4 without success. At 11pm the same night, the nurse writes R4 "upset out of room in hallway at nurses station Ativan given and redirected to bed." There is no indication staff assessed R4 for additional supervision and or safety devices at the time R4 repeatedly attempted to get up.</p> <p>At 2am on 8/26/08, the nurses notes again indicate R4 was up in the hallway, confused and was redirected to bed when he stated he was looking for his care and wife. The notes written at 9:04am indicate R4 attempted to leave on 200 hall door and was redirected. The note states R4 was up and down the entire breakfast and continued to state he wanted to go home. At 1:38pm, the nurses notes again indicate R4</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>attempted to exit on 200 hall door and was redirected by two staff members. The note states staff "continue to monitor." Again, there is no indication the facility reassessed R4's fall risk due to his behaviors and no evidence the facility provided added supervision due to his restlessness and repeated attempts to exit the building.</p> <p>Review of an EVENT DETAILS report indicates on 8/26/08 at 6:56pm, the nurse was called to the residents room where R4 was observed to be on the floor on his hands and knees facing the window. R4 was noted to have abrasions to bridge of his nose and right forehead. The note continues to state he was "assisted to bed." The report indicates measures taken at the time included the "falling star program." There is no evidence the facility reassessed R4's needs to ensure his safety at the time of this fall.</p> <p>R4 fell again at 8:59pm with no injuries noted. The INVESTIGATION indicates R4 had "been very anxious and agitated throughout the day and staff had tried numerous interventions to calm him and redirect him. The report indicates R4 was found on the floor in his room on his back having taken off his night clothes and put on his pants. The report indicates he was assisted back to bed. Again, there is no indication the staff implemented interventions that included more adequate supervision and/or safety devices to ensure R4's safety in light of his increase anxiety, confusion and repeated attempts to get up and out of the door. The nurses notes documented R4's attempt to get up out of his chair unassisted and sustained a skin tear of his arm. The nurses notes state "res had attempted to get up again from bed and sustained a skin tear to R elbow 3 cm (centimeters) in diameter..."</p>	F 323			

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F 323	Continued From page 8  According to an EVENTS DETAIL report dated 8/26/08, R4 fell again at 10:42pm. The addition information sections states "nurses on 3-11 walked by his room and found him sitting on the floor between the refrigerator and bed. No apparent injuries... assisted to his w/c (wheelchair) with gait belt and assist of 2 staff. Wants to get to the other side of the room. Markedly confused, gave Ativan .5mg at this time with 2 Tylenol 500mg. Stated he was hurting, general pain. Couldn't state where." The nurses notes entry written shortly after this time at 11:38pm states "continue to try and go somewhere...." There is no indication the staff implemented any further safety precautions at the time or let him stay up in his wheelchair under supervision since he continued to get out of bed. Nurses notes written on 8/27/08, the day following R4's three falls indicates he was complaining of pain and at 9:13am, a pull alarm was placed due to recent falls the previous night. The physician was notified of R4's complaints of pain and an order was received for a right hip/leg x-ray at 12:49pm. R4 was diagnosed with a fractured right femur and transported to the hospital for an open reduction. Interview with E2, DON (Director of Nurses) on 9/11/08 indicates it was normal behavior for R4 to be up wandering in his wheelchair and R4 had been especially anxious on 8/26/08. E2 indicated staff walked him outside, etc during that day and finally positioned him at the nurses station when he continue to attempt to get up so staff could watch him. E2 indicated R4 had no falls after being placed in view of staff at the nurses station. However, E2 did confirm that no further assessment on R4 was done on 8/26/08 and no safety devices were put into place until	F 323			

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F 323	<p>Continued From page 9</p> <p>the next day on 8/27/08. E2 indicated the nurses have since been "empowered" to assign a 1:1 staff for a resident who is agitated and repeatedly attempting to stand up/transfer without assistance to ensure safety.</p> <p>Review of the facility's policy titled ACCIDENT/INCIDENT PREVENTION indicates when a resident has been identified as a high risk for accident/incidents interventions will be put in place per the individual resident assessment and care plan. The policy indicates interventions may include, but are not limited to the following: maintain close supervision of confused resident, monitor during high times according to the individual's history, after pain meds, during the night, Place high risk residents in rooms near nurse's station, and personal alarms among others. The facility failed to follow their policy to ensure R4's safety when they didn't continue to monitor R4 but rather placed him in bed when he wanted to get up, failed to maintain close supervision of R4 when he was markedly more confused as evidenced by his repeated attempts to exit the building to go home, find his truck and failed to assess R4 for safety devices which include a personal alarm as indicated by the policy until the next day after he had fallen three times and sustained a fractured femur.</p> <p>Observation of R4 throughout the survey showed him to be totally dependent on staff for all aspects of mobility.</p> <p>2. Review of the MDS dated 7/28/08 identifies R12 as being an 84 year old female admitted to the facility on 11/1/07 with diagnoses of Parkinson's Disease, Anorexia, Confusion, fracture femur, and Dementia among others. The MDS indicates R12 has short/long term memory deficits with severe cognitive impairment and</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>requires extensive assist of two staff for all activities of daily living including mobility. The MDS indicates R12 has balance deficits with both sitting and standing and has had falls with the past 30 and 31-180 days. According to the POS, R12 had a body alarm ordered on 2/15/08. The care plan identifies R12's increased risk for falls due to Parkinson's, unsteady gait, cognitive impairment with attempts to stand up alone, psychotropic medications use and history of falls. The care plan also indicates R12 has a fall on 7/3/08 during an independent transfer, 8/16/08 which resulted in sutures to head and a fall on 8/24/08 with no injuries noted.</p> <p>Review of the fall EVENT REPORT dated 7/3/08 at 7:37pm indicates under "additional event info" that "visitor told writer that res (resident) was attempting to transfer self from w/c (wheelchair) to stationary chair, got right hand caught in w/c and fell on buttox.". The report does not indicate whether the alarm was sounding or not.</p> <p>Review of a FALL RISK ASSESSMENT dated 7/28/08 indicates R12 scored a 19. The assessment indicates a score of 10 or more indicates risk for falling and requires care planning. However, there is no indication the facility reassessed R12's use/effectiveness of the body alarm and/or changed the care plan interventions.</p> <p>The EVENT REPORT dated 8/16/08 at 9:29pm under additional event info again fails to indicate whether or not R12's alarm was sounding at the time R12 was found on the floor. The report states "As I was walking down 100 hall I say resident laying on the floor with a pool of blood surrounding her head..." There is no mention of the alarm and no indication as to whether staff was responding to the alarm or not</p>	F 323			

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

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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>09/12/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE MARYVILLE, IL 62062</b>		
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F 323	<p>Continued From page 11</p> <p>at the time she was found on the floor. R12 was transported to the emergency room for sutures of the head laceration. R12 returned to the facility.</p> <p>R12 was documented as having another fall on 8/24/08 in the dining room with no injuries reported. An EVENT REPORT indicates at 10am, R12 "was found by CNA (Certified Nurses Aide) asleep in dining room hallway, CNA asked resident to lift up feet so she could push her back to her room, resident then slid forward in chair to her knees on floor..." The facility failed to transport R12 in a safe manner.</p> <p>Review of the progress note dated 8/25/08 at 7:59am indicate the fall committee determined the resident is not independently ambulatory, so the lab buddy would not restrict her movement. It continues to state "as alarm has been attempted in the past and was not appropriate for this resident." Interview with E2, DON, on 8/11/08 during the daily meeting indicates R12 had the alarm on and it was sounding when the three falls occurred even though the incident report didn't reflect this. The DON indicated an alarm was appropriate if it reminded the resident to call/wait for assistance or if staff were able to respond to the alarm before the resident fell. The facility failed to provide adequate supervision of R12 in an effort to prevent falls, failed to reassess R12 in a timely manner in an effort to determine if the body alarm and/or staff supervision was adequate to prevent further falls and failed to ensure that the safety device (body alarm) in use during the falls was appropriate given her cognitive impairment and inability to use call light and/or wait for assistance according to their policy of falls prevention.</p> <p>Observation of R12 on 9/11/08 show her to be independently mobile in her wheelchair with a lap buddy on going about the facility on her own.</p>	F 323			

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F 325 SS=D	<p><b>483.25(i) NUTRITION</b></p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 2 residents, R6 and R9, of 13 in house sampled residents, who have dysphasia, receive thickened liquids as ordered.</p> <p>Findings include:</p> <p>1. Record review of R9's Physician Order Sheet, POS, of September 2008 shows R9 has a diagnosis of Dysphagia and has an order for a mechanical soft diet with nectar thickened liquids. R9 was observed at noon meal on 9-9-08 to receive unthickened water, apple juice and hot chocolate. R9's milk was thickened to nectar consistency. R9 was observed to drink the unthickened liquids.</p> <p>On 9-10-08, at noon meal, R9 received thickened milk that had visible lumps of thickener, unthickened apple juice and another thickened juice. There was a pitcher of regular ice water at his table and R9 had a water glass with no water in the glass.</p>	F 325		9/15/08	

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F 325	<p>Continued From page 13</p> <p>Speech Language Pathology Screening of 7-27-08 states, "Resident exhibited coughing and choking with thin water. Current diet most appropriate."</p> <p>EX) R6's Minimum Data Set (MDS), dated 6-17-08, documented that R6's cognition was modified with short and long term memory and supervision with eating and fluids. R6's Care Plan, problem start date 3-10-08, documented that R6 was care planned for therapy (thickened liquids), textured diet and utilization of adaptive eating equipment related to present physical condition. R6's Therapy Order, dated 6-11-08, documented that R6's diet was to be mechanical soft with nectar thickened liquids due to decreased oral sensation and increased aspiration risk.</p> <p>R6 was not provided thickened liquids during the following observations: on 9-9-08 at the noon meal R6 served unthickened water, juice, tea and coffee; on 9-10-08 at the breakfast meal R6 was served unthickened water and juice; and, on 9-10-08 R6's bedside water pitcher contained unthickened water which was confirmed during an interview with E10, Licensed Practical Nurse (LPN).</p>	F 325			