

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Manor Court of Maryville		STREET ADDRESS, CITY, STATE, ZIP CODE 6955 State Route 162 Maryville, IL 62062	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to ensure residents were free from abuse for 1 of 4 residents (R1) reviewed for abuse in the sample of 6. This failure resulted in R1 experiencing physical pain, fear and worry. Findings include: 1-R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses including hemiplegia, abnormalities of gait and mobility, and Parkinson's disease. R1's Minimum Data Set (MDS) dated [DATE] documented R1 was cognitively intact, used manual wheelchair, and was dependent for transfers. 2-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including dementia. R2's MDS dated [DATE] documented R2 was moderately cognitively impaired, used manual wheelchair, and had verbal and physical behaviors. R2's Care Plan dated 8/12/24 documents R2 has verbal and physical aggression toward others. On 7/14/26 at 8:00 AM, V2, Director of Nursing (DON), stated R2 wheeled over to R1 in the dining room, pinned her against the wall, and pulled her arm back behind her. R2 cannot come back to the Facility, because R1 is traumatized. R1's Progress Note by V3, Licensed Practical Nurse (LPN), dated 6/18/26 at 11:08 AM, documents, CNA (Certified Nursing Assistant) reported that a male resident was being ruff with female resident. CNA stated that male resident had put females resident arms behind back and used profanity. On 7/14/26 at 9:29 AM, V3 stated V7 came to her and reported R2 tried to put R1's hand behind her wheelchair. R1 told V3 that R2 did not hurt her, but he tried to put her hand somewhere. The Facility's Undated Written Statement by V7, CNA, documents, I (V7) was emptying dining room. Came back (R2) had (R1)'s arm behind her chair pulled back as far as he could. I intervened (R2) then started screaming, ?Fu** you, you are full of sh**.' I took (R1) to nurse and explained what happened. (R2) was separated from dining room and taken to TV as a redirect. On 7/14/26 at 1:15 PM, V7, CNA, stated R1 and R2 were eating lunch in the dining room when he saw that R2 had R1's arm behind her like they were playing tug of war. V7 told R2 he could not do that, then pushed R2's wheelchair to another area and notified V3. V7 stated he feels much better knowing R2 cannot come back to the Facility for the safety of all residents. R2's Progress Note by V4, Licensed Practical Nurse (LPN), dated 6/18/26 at 11:00 AM documents, This Nurse was made aware that this resident had another resident by her arm with her arm behind her back pushing her up against the dinning {sic} room table in the dinning {sic} area during breakfast. Resident was escorted out by another Nurse away from dinning {sic} area and into the hallway. On 7/14/26 at 1:22 PM, V4 was unavailable for interview by phone. On 7/14/26 at 9:10 AM, R1 stated R2 wanted her to move in the dining room, but she was having trouble moving her feet. R2 kept saying, Back, back, back, then he grabbed her left arm and put it behind her and twisted it. R1 stated, It hurt. He was trying to open my fingers so he could put my hands where he wanted. R1 clarified she thought R2 was going to put her hand on his private parts, but staff intervened before that happened. R1 stated she had bruises (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145728
		If continuation sheet Page 1 of 3

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F 0600 Level of Harm - Actual harm Residents Affected - Few	that have since resolved. R1 stated she was afraid at the time but now thinks she is alright as long as R2 cannot return to the Facility. R1 stated R2 has been gone from the Facility for a couple months now, but R1 overheard another resident ask about him recently and thought to herself, Why would you bring him up again? R1 stated she tries very hard not to think about R2. R2's Progress Note dated 6/26/26 documents V9, R1's Family, stated she would do anything she could to ensure R2 did not return to the Facility because R1 was very upset by the incident and very frightened by R2. On 7/14/26 at 4:12 PM, V9 stated R1 had never been treated like this before and is worried R1 will have PTSD (Post-Traumatic Stress Disorder) from this incident. The Facility's Final Report sent to IDPH on 6/18/26 documents, (R2) grabbed female resident (R1) by her left arm and bend it behind her back forcefully as she walked by him in the dinning room. (R1) yelled out and staff in dinning room quickly intervened to remove his hand and remove resident from dining room. (R1) had some bruising to her left wrist but no other injuries. (R2) was with staff member until such time as he was transported to (Local Hospital). On 7/15/26 at 10:35 AM, V10, Nurse Practitioner (NP), stated the Facility made her aware of the 6/18/26 incident between R1 and R2. She stated if R2 would ever come back into the Facility there would be a big problem, but R2 is not here and she thinks R1 is doing ok mentally and emotionally. On 7/15/26 at 10:40 AM, V2 stated she expects the Facility to follow its abuse policy. The Facility's Abuse Prohibition and Reporting Policy revised 3/30/26 documents the facility actively prohibits resident abuse. The purpose is to protect residents from any kind of abuse, including verbal, sexual, mental, and physical abuse.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to give the required 30 day notice for involuntary discharge (IVD) and would not allow resident to return to the Facility with a pending appeal for 1 of 6 residents (R2) reviewed for admission, transfer and discharge in the sample of 6. Findings include: 1-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including dementia. R2's Minimum Data Set (MDS) dated [DATE] documented R2 was moderately cognitively impaired, was dependent for transfer, and had both physical and verbal behaviors. R2's Care Plan dated 8/12/24 documents R2 has verbal and physical aggression to others. R2's Progress Note by V4, Licensed Practical Nurse (LPN), dated 6/18/26 at 11:00 AM documents, This Nurse was made aware that this resident had another resident by her arm with her arm behind her back pushing her up against the dinning {sic} room table in the dinning {sic} area during breakfast. Resident was escorted out by another Nurse away from dinning {sic} area and into the hallway. R2's Progress Note dated 6/18/26 at 1:42 PM documents R2 was sent to (Local Hospital) with an involuntary petition for admission. R2's Progress Note dated 6/23/26 at 1:00 PM documents (Local Hospital) was contacted and informed that R2 would not be able to return to (Facility). R2's Progress Note dated 6/23/26 at 2:12 PM documents V5, R2's Family, was notified that R2 would need new long term placement from the hospital and would not be able to return to the Facility. R2's Progress Note dated 6/27/26 at 8:00 AM documents IVD paperwork was given to R2 at (Local Hospital). R2's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated 6/26/26 documents R2 is being emergently discharged for the physical safety of other residents, the facility's staff, or visitors. The effective date of the proposed discharge was 6/23/26. R2's Discharge Orders dated 6/26/26 document R2 experienced behaviors in the Facility, was sent to (Local Hospital) and is unable to return to the Facility. On 7/14/26 at 8:00 AM, V2, Director of Nursing (DON), stated on 6/18/26, R2 pinned R1 against the wall and pulled her arm back behind her. The Facility sent him to (Local Hospital) and he remains there. V2 gave R2 IVD paperwork a few days after he was admitted to (Local Hospital), and the Facility just cannot take him back. V5 appealed the discharge and there is an upcoming court hearing. On 7/14/26 at 3:23 PM, V8, Ombudsman, stated the Facility should have taken R2 back after the routine three day psychological evaluation. The IVD paperwork was sent to V8 and V5 on 6/26/26, so they were supposed to keep R2 for 30 days after that and not discharge R2 with a pending appeal. The Facility's Transfer of a Resident Policy revised 1/11/23 documents, Should the resident choose to appeal a transfer to another facility, the facility shall not transfer pending the results of the appeal.		