

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  11/01/2024
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on interview and record review the Facility failed to prevent resident physical abuse for 1 of 3 residents (R54) reviewed for abuse in the sample of 39.</p> <p>Findings include:</p> <p>R54's Physician Order Sheet (POS) dated February 2024 documents a diagnosis of Alzheimer disease with late onset, wedge compression fracture vertebrae, subsequent encounter for fracture with routine healing, atherosclerotic heart disease of native coronary artery without angina pectoris, stent 1999 &amp; 2004, unspecified dementia, unspecified severity without behavioral disturbances, psychotic disturbance and anxiety, conductive hearing loss, age related osteoporosis.</p> <p>R54's Minimum Data Set (MDS) dated [DATE] documents R54 was severely impaired for cognition for activities of daily living.</p> <p>R54's Care Plan dated 11/9/2022 documents Problem: (R54) has chosen to receive Hospice care from (Hospital) Hospice related to Alzheimer's. R54's Care Plan does not address abuse.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R54's Incident Report dated 2/20/2024 at 10:15 AM, Notified by (V6, Licensed Practical Nurse), notified me that she observed a hospice aide strike resident (R54) across the head with both hands and she yelled at the hospice aide to stop, and the aide stated, 'I was pushing her head away to keep her from biting me.' 10:20 AM, V7, Hospice aide, that was identified as the alleged perpetrator was instructed not to go back into the resident care area, and a statement obtained from (V7) that stated she was providing assistance for resident and she was trying to bite me, and I insistently was pushing her way from me although I know (V6) thinks I was slapping (R54) but I wasn't. I asked for her contact information, (V7's phone number) was given to me as a phone number and she was instructed to leave and not return until such time as I contact her and allow her back into the facility. 10:40 Resident assessed for injuries and no injuries noted. Resident unable to communicate but has no signs or distress on her face and appears calm currently. 10:55 was informed by (V6) that she notified the POA (Power of Attorney) and the Physician, no injuries were noted per assessment she stated and to her the resident does not look upset or having any distress. 10:45 AM, Notified (Local Police Department) of allegation, at approximately 11:10, an Officer came to the facility and interviewed staff and took statements from staff, information was provided about the alleged perpetrator, and case number was documented. Written statement by V6 undated documents, Call light was on and entered the room. When I entered the room (V7) slapped resident on both sides of her head simultaneously by each ear creating a 'slapping' sound. I yelled, 'Hey' Hospice CNA looked up and said, 'she bit me.' Another facility nurse and CNA came into the room. Stayed with the resident while I left to report to management. A statement undated from V7 documents, (R54) was biting me when nurse walked in the room, and I was pushing her head away from my arm.</p> <p>On 10/30/2024 at 9:00 AM, V6, Licensed Practical Nurse stated, I remember the CNA hospice aide (V7). (R54's) call light was going off that day and I went into her room and when I entered the room I saw (V7) slap (R54) with an open hand on both sides of her head and when she saw me she jumped back and said (R54) bit me, she bit me, like she was trying to make it okay what she had done.</p> <p>R54's Police Report documents, On Tuesday February 20, 2024, at approximately 11:48 A.M. I, (V11, Local Police Officer) responded to (Facility) in reference to an aggravated battery that occurred earlier that day. Upon my arrival I made contact with the site manager, identified as: (V1). (V1) stated that at approximately 10:15 A.M. a nurse witnessed a contract hospice CNA employed by (Hospice Company) smack a patient on both sides of the head above her ears with enough force to make a crack sound. (V1) identified the nurse and hospice CNA as (V7). I spoke with (V6) who stated she noticed the call light on for patient she identified as (R54). (V6) stated that (R54) is physically unable to activate the call light. (V6) stated she went to check on (R54) and upon entering the room witnessed (V7) smacking (R54) on both sides of her head above the ears with an open palm with enough force to make a crack sound. (V6) shouted, 'Hey'.</p> <p>The Abuse Policy with a revision date of 1/2017 documents, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental and/or physical conditions, cause physical harm, pain and mental abuse including abuse facilitated or enabled through the use of technology. Physical abuse means the infliction of injury on a resident that occurs other than by accidental means, whether or not the injury required medical attention, Physical abuse must include, but is not limited to such acts as: hitting, slapping, kicking, hair pulling and pinching, etc.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35156</p> <p>Based on observation, interview, and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination for 4 of 4 residents (R16, R29, R40 and R54) reviewed for food sanitation in the sample of 39.</p> <p>Findings include:</p> <p>On 10/29/2024 at 12:14 PM, in the kitchen off the 300-hall there was a small kitchenette. Inside the kitchenette was a sink for handwashing but the faucet was not in working order and no water would come out.</p> <p>On 10/29/2024 at 12:18 PM, V4, Dishwasher, was wearing gloves and took the following temperatures of the food on the steam table and documented in the Logbook. The mashed potatoes were documented at 114.0 F (Fahrenheit), the meat (chicken) was documented as 113.0 F regular, the pureed meat 132.0 F, the pureed vegetables (lima beans) 132.0 F and the gravy was documented at 113.0 F. V4 then proceeded to serve the food without reheating any of the items that were below 135.0 F.</p> <p>On 10/29/2024 at 12:19 PM, V4 stated he was not sure what temperature the food should be when hot and at the steam table but that is what he got from the kitchen, and he is not a [NAME] but rather a dishwasher.</p> <p>On 10/29/2024 at 12:33 PM, R29 was served mechanical meat (Chicken) covered with gravy on top of it.</p> <p>On 10/29/2024 at 12:39 PM, R16 was served a divided plate with pureed meat, pureed vegetable, both items topped with gravy.</p> <p>On 10/29/2024 at 12:40 PM, R40 was served pureed meat (chicken) covered in gravy and pureed vegetable (lima beans) covered in gravy.</p> <p>On 10/29/2024 at 12:43 PM, R54 was served pureed meat (chicken) covered in gravy and pureed vegetable (lima beans) covered in gravy and was served.</p> <p>On 10/30/2024 at 9:28 AM, the following residents were documented as receiving pureed and/or mechanical diets on the 300-hall: R16, R29, R40 and R54.</p> <p>On 11/1/2024 at 9:59 AM, V37, Dietician stated, I would expect all food temperatures to be taken before the food service and any temperature below 135.0 Fahrenheit, to be taken back to the kitchen and reheated to a temperature of 165 degrees Fahrenheit (F). Any food temperature below 135 degrees can create the perfect environment for bacteria to grow and cause somebody to get sick for food borne illness. All food below 135 degrees should not be served to residents.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Food Service/Holding Temperature Policy dated 7/12/2023 documents, To provide guidelines for safe serving /holding temperatures for foods served in the Dining Services department. Cooked meat 135 degrees (F) or higher, cooked vegetables 135 degrees or higher, soups, gravy or broths 135 degrees or higher.</p>