Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146193	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Rochelle	2203 Flagg Road Rochelle, IL 61068

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45540 Based on interview and record reviewed the facility failed to notify a resident's Power of Attorney (POA) after the resident left the facility. This applies to 1 of 3 (R1) residents reviewed for notification. The findings include: On 9/16/2024 at 9:18AM, V3 Registered Nurse (RN) said on 9/10/2024 at 6:30PM [R1] wanted to leave the facility to go back home. V3 said [R1] left the facility AMA (Against Medical Advice) and was advised by staff to remain in the facility. V3 said [R1] left the facility with V4 (R1's Significant Other) in V4's car, who also brought [R1] to the facility from the hospital. V3 said she did not contact V5 (R1's Power of Attorney - POA) after R1 left the facility. V3 said she would normally contact the POA if a resident leaves the facility but did not in this case. On 9/16/2024 at 9:56AM, V2 DON (Director of Nursing) said facility staff notify the Power of Attorney (POA) when a resident leaves the facility. On 9/16/2024 at 9:03AM, V6 RN said when a resident discharges the physician, DON, and POA are notified of a resident's discharge. On 9/16/2024 at 10:38AM, V7 Hospital Unit Manager stated on 9/5/2024 at 12:37PM [R1's] surgical consent was completed via telephone by [R1's] POA. V7 said [R1] did not sign her own consent. V5 is listed as R1's Power of Attorney for Health Care since of 4/2/2018.

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