

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Manor Court of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891</p> <p>Based on observation, interview, and record review the facility failed to ensure neurological assessments were performed after an unwitnessed fall for 1 of 3 residents (R1) reviewed for falls in the sample of 3.</p> <p>The findings include:</p> <p>R1's face sheet printed on 2/4/25 showed diagnoses including but not limited to right lower leg amputation, dementia, and urinary retention. R1's facility assessment dated [DATE] showed no severe cognitive impairment and requires staff supervision or touching assistance with toileting.</p> <p>The facility Serious Injury Incident Report dated 2/3/25 showed R1 was found on the bathroom floor the morning of 2/2/25. R1 was bleeding on the forehead, was sent to the local hospital, and received sutures.</p> <p>On 2/4/25 at 9:35 AM, R1 was lying on his bed and his daughter (V7) was present. R1 had a bandage on his right forehead and dark bruising on top of each of his hands. R1 had a right-side prosthetic (mechanic leg attachment) and an indwelling catheter. R1 stated he got up by himself and went to the bathroom. R1 said he fell and hit his head somewhere in his room. R1 was slightly confused and could not recall the time or location of the fall.</p> <p>On 2/4/25 at 9:35 AM, V7 (R1's daughter) stated R1 has fallen in the past and is known to get up without waiting for staff assistance. V7 stated he can wheel himself to the bathroom. R1 knows he should not be getting up alone, but he is just so determined he can still do it by himself.</p> <p>On 2/4/25 at 11:08 AM, V3 (LPN-Licensed Practical Nurse) stated she was working the morning R1 fell . V3 said she was at the nurses station sometime between 3:30 or 3:40 AM when she heard R1 yelling help, help from his room. V3 said her and another aide (V4) went to the room and found R1 on the floor next to the toilet. V3 said the wheelchair was tipped over and he was bleeding from his head. V3 said R1 was able to move his extremities, she did vital signs, and asked if he had pain. V3 said she did not know what to do next, so she called over to the other unit and had to ask another nurse where to send R1. V3 said R1 was transferred into bed by V4 and V5 (CNA-Certified Nurse Aides). V3 said R1 was sent to the local emergency room the same day.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/4/25 at 11:46 AM, V4 (CNA) said she was working the morning R1 fell . V4 said she heard R1 yelling from his room and went in with V3 (LPN). V4 said she thought it was sometime around midnight but was not certain. V4 said R1 was on the floor next to the toilet and bleeding from his head. V4 said R1 was transferred to the bed by herself and V5.</p> <p>On 2/4/25 at 1:42 PM, V5 (CNA) said R1 fell in his bathroom sometime around 3:00 to 4:00 AM. V5 said he was bleeding from his head, and she helped transfer him back to the bed.</p> <p>R1's local emergency room notes dated 2/2/25 at 5:01 AM showed a laceration of the forehead, left and right hand contusions and neck muscle strain.</p> <p>R1's progress notes dated 2/2/25 showed he was found on the floor bleeding from the head. The note showed a head-to-toe assessment was done, range of motion, and no pain. The note showed R1 appeared to need sutures, so he was sent to the ER. The noted was written at 6:33 AM (approximately three hours after the fall).</p> <p>R1's event report dated 2/2/25 at 6:27 AM was reviewed and the entire neurological check list section was blank. The report only documented his vital signs as of 6:27 AM. (approximately three hours after the fall).</p> <p>On 2/4/25 at 2:01 PM, V2 (Director of Nurses) stated, We do not have any neurological assessments following R1's fall. It was an oversight on the nurse's part (V3). We use a lot of agency nurses and unfortunately, they don't always know what to do after a resident falls. V2 said the time line of events is confusing since all the documentation was done after R1 had been sent out. V2 said any resident that has an unwitnessed fall should have neurological checks started immediately and continue every 15 minutes, every half hour, every hour etc. for at least 72 hours. V2 said head to toe assessments are not the same as neurological assessments. V2 stated proper neurological assessment are important to ensure there are no sudden change in condition or pressure building up inside the head. V2 said it is a standard nursing care, especially with a head injury.</p> <p>The facility was unable to supply any neurological checks performed on R1 following the unwitnessed fall on 2/2/25.</p>		