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	07/24/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to monitor post fall neurological checks, failed to notify the physician of an unwitnessed fall and failed to follow care plan interventions for one resident (R3) of three residents reviewed for falls in the sample of three.This Failure resulted in R3 sustaining a left hip fracture from an unwitnessed fall in the unit dining room at 3am in the morning.Findings include:Physician Order Report Summary indicates R3 was admitted to the facility 11/29/23 with diagnoses that include Anxiety, Arthritis, Severe Dementia with Agitation, and Insomnia.Comprehensive Cognitive assessment dated [DATE] indicates R3 is severely cognitively impaired.On 7/24/25 at 1:05pm R3 was observed sitting in a wheelchair during a church group activity. R3's head was down and appeared to be sleeping.On 7/24/25 at 1:10pm V4, RN (Registered Nurse) stated prior to R3's fall, R3 ambulated slow and steady with her walker, rarely using a wheelchair.Nurse Note dated 7/1/25 at 3:30am documented by V5, Agency Nurse indicates V5 was called by a CNA (Certified Nursing Assistant) with information that R3 had fallen. Note indicates V5 arrived in the lobby area of the unit to find R3 seated on the floor against a chair which is by the wall. Note indicates R3 is alert and oriented. When V5 asked R3 what happened, R3 responded that she had been walking around with her walker and fell. Note indicates V5 and CNA staff assisted R3 into a chair by the wall and V5 collected vital signs which were documented as: (blood pressure) 126/70, Pulse 70. Temperature 97. 3F (Fahrenheit) and Respirations 20. Note indicates R3 is later escorted to her room.Nurse Note dated 7/3/25 at 5:58pm as documented by V9, (Nurse Supervisor) Recorded as Late Entry on 7/7/25 at 2:49 pm) indicates Verbal statement by V5, RN (Registered Nurse) as follows:At approximately 3am on 7/1/25, (V5) was called by CNA staff with information that (R3) had fallen. (V5) arrives to the dining area of the unit to find (R3) seated on the floor against a chair which was by the wall. (R3) is alert and oriented. When (V5) asks (R3) what happened, (R3) said she was walking around with her walker and fell. (V5) and CNA staff assisted (R3) on to the chair and (V5) collected vitals. (V5) assessed LOC (Level of Consciousness) to conclude that R3 is alert to person and place. R3 is able to participate in getting up from the floor as V5 and CNA assist her. R3 is calm and compliant during transfer. R3 skin is intact with no wounds or openings. No injuries noted. (R3) c/o (complains of) pain to back and side, gave pain medication to (R3) and later escorted to her room by this nurse who assess(es) her movements for any limping. No limping noted as (R3) independently uses walker with nurse to her side.On 7/24/25 at 2:30 pm V9 stated she called V5 (on 7/3/25) to confirm V5's documentation was complete. V9 confirmed at that time that V5 did not complete neurological checks and did not notify the physician of R3's fall. V9 also confirmed there was no follow up documentation of R3's complaints of back and side pain and there was no medication administration documentation that pain medication was administered for R3's complaints of pain. Nurse Note dated 7/1/25 at 7:28am (documented by V3, LPN/Licensed Practical Nurse) indicates R3 refused to get up this am due to extreme pain at left hip/thigh area. Note indicates ROM (Range of Motion) completed, but with complaints of pain. Note indicates R3 does have pain at times, but usually does not refuse to get out of bed. Note indicates physician notified requesting X-rays and granted; POA (Power of Attorney) updated. R3 transferred to via ambulance to obtain X-rays. Report to hospital; Administrator notified of transfer.On 7/24/25 at 2:50pm V3, LPN stated, I did not receive any nurse/shift report regarding (R3's) fall until after I was told by my dayshift CNA's that there was something wrong with (R3). V3 stated the dayshift CNA's were waiting for her to arrive (the morning of 7/1/25), barely had time to take off my coat when the dayshift CNA's stopped me in the hallway, so I went directly to (R3's) room. V3 stated R3 was in severe pain and was most likely in pain all night. V3 stated she had one of the CNA's stay with R3 while she immediately contacted the physician regarding R3's pain. V3 stated, I didn't know what was wrong with (R3) but she needed to be sent out. V3 stated after she made arrangements to have R3 transported to the hospital. V3 stated she finally received report from V5 and all V5 reported was that (R3) fell and was put back in bed. Nothing else.Attempts made to contact V5 for interview on 7/24/25 were unsuccessful.On 7/24/25 at 2:20pm V8, CNA stated R3 does get up sometimes at night and will come out of her room without her walker. V8 stated, (R3) is not supposed to walk around by herself. Current Care Plan indicates R3 requires assistance of one with walker or ambulation. Care Plan indicates R3 has a history of falls prior to admission and is at risk for falling related to poor safety awareness, doesn't use the call light and has a diagnosis of Dementia. Care plan also indicates observe frequently and place in supervised area when out of bed (date initiated 1/17/25) Incident Report dated 7/1/25 indicates R3 was last

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor post fall pain and failed to notify the physician of complaints of post fall pain for one resident (R3) of three residents reviewed for falls in the sample of three. This failure resulted in a lack of pain management post fall for 5 hours after R3 sustained a left hip fracture. Based on interview and record review the facility failed to monitor post fall pain and failed to notify the physician of complaints of post fall pain for one resident (R3) of three residents reviewed for falls in the sample of three. This failure resulted in a lack of pain management post fall for 5 hours after R3 sustained a left hip fracture.Findings include:Physician Order Report Summary indicates R3 was admitted to the facility 11/29/23 with diagnoses that include Anxiety, Arthritis, Severe Dementia with Agitation and Insomnia. Comprehensive Cognitive assessment dated [DATE] indicates R3 is severely cognitively impaired.Nurse Note dated 7/3/25 at 5:58pm as documented by V9, Nurse Supervisor Recorded as Late Entry on 7/7/25 at 2:49 pm) indicates Verbal statement by V5, RN (Registered Nurse) as follows:At approximately 3am on 7/1/25, (V5) was called by CNA staff with information that (R3) had fallen. (V5) arrives to the dining area of the unit to find (R3) seated on the floor against a chair which was by the wall. (R3) is alert and oriented. When (V5) asks (R3) what happened, (R3) said she was walking around with her walker and fell. (V5) and CNA staff assisted (R3) on to the chair and (V5) collected vitals. (V5) assessed LOC (Level of Consciousness) to conclude that R3 is alert to person and place. R3 is able to to participate in getting up from the floor as V5 and CNA assist her. R3 is calm and compliant during transfer. R3 skin is intact with no wounds or openings. No injuries noted. (R3) c/o (complains of) pain to back and side, gave pain medication to (R3) and later escorted to her room by this nurse who assess(es) her movements for any limping. No limping noted as (R3) independently uses walker with nurse to her side.Nurse Note dated 7/1/25 at 7:28am (documented by V3, LPN/Licensed Practical Nurse) indicates R3 refused to get up this am due to extreme pain at left hip/thigh area. Note indicates ROM (Range of Motion) completed, but with complaints of pain. Note indicates R3 does have pain at times, but usually does not refuse to get out of bed. Note indicates physician notified requesting X-rays and granted; POA (Power of Attorney) updated. R3 transferred to via ambulance to obtain X-rays. Report to hospital; Administrator notified of transfer.On 7/24/25 at 2:50pm V3, LPN stated I did not receive any nurse/shift report regarding (R3's) fall until after I was told by my dayshift CNA's that there was something wrong with (R3). V3 stated the dayshift CNA's were waiting for her to arrive (the morning of 7/1/25), barely had time to take off my coat when the dayshift CNA's stopped me in the hallway so I went directly to (R3's) room. V3 stated R3 was in severe pain and was most likely in pain all night. V3 stated she had one of the CNA's stay with R3 while she immediately contacted the physician regarding R3's pain. V3 stated I didn't know what was wrong with (R3) but she needed to be sent out. V3 stated after she made arrangements to have R3 transported to the hospital, she finally received report from V5 and all V5 reported was that (R3) fell and was put back in bed. Nothing else.Nursing Note dated 7/1/25 at 12:35pm indicates V3, LPN was informed that R3 had been admitted to the hospital for left hip fracture. Medication Administration Record dated 6/28/25 to 7/1/25 indicates the following pain medications were ordered for R3 at the time of the fall on 7/1/25: Tylenol (analgesic) 650mg (milligrams) every six hours as needed for pain and; Tramadol (opioid analgesic) 50mg every six hours as needed for pain.Medication and Treatment Administration Records June 28/2025 through July 1, 2025 found no assessment of R3's pain post fall 7/1/25 at 3am despite R3 complaining of back/side pain post fall and no documentation of any pain medication administered post fall.Current Care Plan had no active problem of pain management prior to or after R3's fall on 7/1/25.No nursing notes were found or presented to describe descriptors or intensity of back and side pain.Attempts made to contact V5 for interview on 7/24/25 were unsuccessful.Facility Policy/Pain Management dated 3/3/2022 documents: Purpose - To identify residents experiencing pain to establish control of pain to the resident's satisfaction and to relieve related symptoms. Staff Responsible: All staff. Procedure: Residents will be observed/asked about pain at a minimum of each shift by the nurse using a standardized 0-10 scale or Verbal Descriptor Scale to determine pain intensity. The physician will then be contacted, if needed, regarding the pain indicators. Licensed staff will document any contact with the physician and the physician's response. Residents will be monitored until pain is resolved or is under control and periodically thereafter. Licensed staff will document any complaints of pain and the resident's response to the medication/treatment in the resident's record.