STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000228	A. BUILDING: _____ B. WING _____	C 03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ARLINGTON HEIGHTS	715 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005

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S 000	Initial Comments Investigation of Complaint Number 1991505/ IL109998	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	**Attachment A** **Statement of Licensure Violations**	

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations are not met as evidence by:

Based on interview and record review the facility failed to provide two person assistance and/or

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S9999	Continued From page 2 supervision for a resident during shower. This resulted in resident falling in the shower and sustaining scalp laceration, and subdural hematoma. This applies to one of three residents (R1) reviewed for falls in the sample of three. The findings include: R1 was admitted on 8/30/18 with diagnoses which includes traumatic subarachnoid hemorrhage, Alzheimer's Disease, dementia with behavioral disturbance, bipolar disorder, anxiety disorder, and contracture of shoulder, right elbow and hand. R1 has a previous history of fall at the facility on 9/11/18. The final incident report sent to the State survey agency shows that on 9/11/18 at 8:40 AM, R1 was found on the floor next to her bed with bleeding on the left side of the face. The hospital reports showed a small subarachnoid hemorrhage, nondisplaced fracture of the left orbital floor and laceration of left eyebrow which required sutures. The final incident report sent to the state survey agency dated 2/21/19 showed on 2/14/19 at 4:45 PM, R1 fell forward out of the shower chair unto the floor in the shower room. The nurse aide was unable to prevent the fall. R1 was lying on her right side and was bleeding from the head. Nursing staff provided first aid and 911 was called. R1 was transferred to the hospital. The hospital CT (computerized tomography) of Brain without Contrast dated 2/14/19 showed results of a large scalp hemorrhage and small high left parietal convexity subdural hematoma. Hospital records showed R1 was admitted to ICU (Intensive Care Unit). The Certificate of Death	S9999		

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showed R1's date of death was on 3/4/19. The causes of death were closed head injury and fall.

The MDS (Minimum Data Set) dated 1/14/19 showed R1's cognitive skills as severely impaired. The functional status for both transfer and bathing were coded as total dependence with two or more persons physical assist.

The 9/14/18 fall risk assessment identified R1 as high risk for falls. A care plan was created on 8/30/18 identifying that R1 was at risk for falls due to cognitive and physical limitations. The care plan for transferring showed R1 required a mechanical lift with 2-person maximum assist.

On 3/12/19 at 1:10 PM, V3 (Certified Nursing Assistant/CNA) stated that on 2/14/19 at approximately 3:30 PM when she was making her initial round, R1's husband requested her to give a shower to R1 in the shower room. V3 explained to him that she will ask for assistance and will give the shower. R1 was in the room sitting in a reclining wheelchair. V3 stated she gathered the supplies needed and asked V4 (CNA) to help her. V4 told V3 to undress R1 and he will be back to help. R1's husband brought the wheelchair near the shower room and V3 explained to him that she will take care of the rest. V3 stated she brought R1 in the shower room and reclined the wheelchair to a lying position and undressed R1. V4 came and assisted V3 transfer R1 to the shower chair. V3 stated no device was used to transfer R1. V3 stated V4 told her to call him when she was done showering R1. V3 stated she showered R1 by herself.

On 3/12/19 at 3:00 PM, V3 was interviewed again for clarification. V3 stated she was not sure if she activated the call light. V3 stated she pushed R1

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on the shower chair towards the door and opened the door to call V4. V3 stated V4 came immediately and was getting the reclining wheelchair that was inside the shower room when R1 leaned forward and fell.

On 3/12/19 at 2:05 PM, on a telephone interview, V4 (CNA) stated V3 (CNA) asked him to help her transfer R1 from the reclining wheelchair to the shower chair. V4 stated they both lifted R1 from the wheelchair to the shower chair. V4 stated they did not use a transfer device. V4 stated he did not stay in the shower room to help bathe R1 because the family did not want male staff to provide the shower. After V3 finished showering R1, V3 opened the shower room door to call V4. V4 stated he does not think the call light was activated. V4 stated by the time he reached the shower room door, R1 was already falling forward to the floor and could not get to R1 on time to prevent the fall. V4 stated V5 (CNA) was following him behind to also assist.

On 3/12 19 at 8:40 PM on a telephone interview, V5 (CNA) stated she was passing by when V3 (CNA) asked for her help. V4 (CNA) was also walking towards the shower room and V5 followed right behind V4. V5 stated V3 was standing by the door and V5 saw R1 wriggling back and forth. V5 stated by the time she approached the shower room door, R1 had already fallen. V7 and V8 (Nurses) who worked the morning shift were still in the unit also came to assist R1 who was on the floor. V5 could not recall if the call light was on. V5 stated it takes two people to transfer R1.

On 3/13/19 at 2:00 PM, V7 (Registered Nurse/RN) stated that on 2/14/19, she worked the morning shift and was completing her

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documentation when V4 (CNA) came out of the shower room at approximately 4:00 PM - 4:30 PM to report that R1 fell. V7 stated she went to the shower room and saw R1 lying on the floor on her right side close to the door with legs towards the door. Blood was on the floor. V7 stated she applied pressure on R1's head with a towel. The evening shift nurse called 911. Paramedics arrived within 5 minutes and took over the care and brought R1 to the hospital. V7 stated R1 needed two persons for transfer and for shower. V7 stated the call light was not activated. V7 stated since R1 was unable to support herself due to contractions, V7 stated V3 should have given the shower in the reclining chair and needed to use a transfer lift machine for transfers.

On 3/13/19 at 2:15 PM, V8 (RN Supervisor) stated that on 2/14/19, she worked the 7 AM - 3 PM shift and was assigned to care for R1. V8 stated she was finishing her work when she heard V3 (CNA) calling for help by the shower door. V8 stated V7 (RN) arrived at the same time so V8 went to get gauze and abdominal pads. Since there were staff attending to R1, V8 went back to the nursing station to assist with the paperwork for transfer. V8 stated R1 was unable to speak prior to the fall. V8 stated she would have instructed V3 to wait for help since it takes two persons to shower R1 who is a total care and was unable to support herself in the shower chair.

On 3/13/19 at 10:05 AM, V2 (Director of Nursing/DON) stated that CNAs should provide care in the safest possible manner.

On 3/13/19 at 9:50 AM on a telephone interview with V6 (Physician), stated he could not say if the fall was preventable because it would have to be

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S9999	Continued From page 6 determined if the facility was following the usual procedure such as the number of persons required to provide the specific care or if the fall was due to lack of staffing which would be nursing issues. (A)	S9999		