Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6005698 | A. BUILDING: ______<br>B. WING ______ | C<br>03/06/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORINGS OF ARLINGTON HEIGHTS | 761 OLD BARN LANE<br>ARLINGTON HTS, IL 60005 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Initial Comments<br><br>Complaint Investigation:<br>1890998/ IL 100300 - F697<br>1890789/ IL 100074 - No deficiency<br><br>Facility Report Investigation:<br>FRI 1/26/18- IL 100270 - F689 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.1210b)<br>300.1210d)6<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 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<br><br>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<br><br>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. | S9999 | Attachment A<br>Statement of Licensure Violations | |

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/28/18

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| MOORINGS OF ARLINGTON HEIGHTS | 761 OLD BARN LANE ARLINGTON HTS, IL 60005 |

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| S9999 | Continued From page 1 | S9999 | | |

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 evidenced by:

Based on interview and record review, the facility failed to ensure that a resident was safely positioned and supported during process of transfer from recliner chair to bed. This affected one of three residents (R3) reviewed for falls in a sample of 9 which subsequently resulted to R3 sustaining a fracture.

Findings include:

R3's incident report documented:
-On 1/26/18, around 10:45 am, (V6 - Certified Nursing Assistant/CNA) who was assigned to (R3) asked (V5- CNA) to help transfer R3 from the (tilt recliner chair) to the bed. As V6 was trying to straighten the bed of R3 before transfer, V5 was trying to prepare R3 on (tilt recliner chair), positioned the (tilt recliner chair) in an upright position. (R3's) poor trunk control caused R3 to fall forward, and out of chair.
- (R3) sustained a bump on forehead, and was showing signs of pain on the right hip area. R3 was sent to emergency room for further evaluation.
- (R3) returned to facility on 1/26/18, at around 6:15 pm, with negative finding on computed tomography scan of head and diagnosis of right hip fracture.

Interviews were conducted with facility staff.

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| **MOORINGS OF ARLINGTON HEIGHTS** | **761 OLD BARN LANE ARLINGTON HTS, IL 60005** |

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| S9999 | Continued From page 2<br><br>On 2/27/18 at 11:01 am, V5 was interviewed in the conference room. V5 stated that during that day, V6 had asked V5 for assistance to transfer R3. V5 stated that R3 transfers using a mechanical lift, with 2 staff assistance. V5 stated that while V6 was fixing bed, V5 lifted R3's (tilt recliner chair), from a 45 degree tilt to an upright 90 degree position. V5 stated that V5 was at the back of the (tilt recliner chair), since the only way the chair can be reclined pressing a lever located at the back of the chair. V5 stated that R3 fell forward, with all of R3's body falling off the chair. V5 stated that V6 was in front of the chair but could not react enough to stop R3 from falling.<br><br>On 2/27/18 at 11:43 am, V6 was interviewed in the conference room. V6 stated that V6 has been assigned to care for R3 for about 3 years. V6 stated that R3 is alert, would rarely respond, confused and not able to follow requests. V6 stated that R3 had been slowly declining and needed total assistance with all ADLs (Activities of Daily Living) including bed mobility and transfers. V6 stated that R3 needed two-person assistance and that a mechanical lift was used to transfer R3. V6 stated that R3 sat in the (tilt recliner chair) because R3 had the tendency to slide down, slump, was unable to sit upright for long periods of time and also because R3 has involuntary "jerks." V6 stated that after breakfast, R3 looked tired that R3 needed to be transferred to bed. V6 stated that V6 had asked V5, who was at that time standing by the nurses' station, to assist with transferring R3 back to bed. V6 stated that V5 has assisted V6 in transferring R3 in the past. V6 stated that V6 was fixing the bed and that V5 was at the back of R3's chair. V6 stated that V6 didn't see V5 adjusting the chair, as it happened so fast. V6 stated that V5 felt R3's head on V6's feet. V6 stated, R3 screamed but | S9999 | | |

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| S9999 | Continued From page 3<br>V6 had asked if R3 was ok and R3 replied that R3 was. V5 stated that V4 was called to the room.<br><br>On 2/27/18 at 11:47 am, V4 (Registered Nurse) was interviewed in the conference room. V4 stated that R3 had been declining over last few months and was under hospice care. V4 stated that R3 was dependent on staff for all ADLs (Activities of Daily Living) and used (tilt recliner chair) when out of bed. V4 stated that R3 didn't have any trunk control, had recently lost weight and unable to maneuver chair and that the (tilt recliner chair) was appropriate for R3. V4 stated that R3's (tilt recliner chair) was usually reclined to a 45 degree angle. V4 stated that every week, there is an updated list regarding what kind of assist need, how to transfer, what equipment to use for transfer and how many person assistance would each resident needs. V4 stated that this is where staff would get information about transfers and equipment and it is communicated through report by both nurses and CNAs. V4 stated that R3 was transferred via mechanical lift with two person assistance. V4 stated that V4 was not at the room at the time of the incident but V5 had called V4. V4 stated that as soon as V4 entered the room, V4 found R3 was on the floor and the (tilt recliner chair) was parallel to the bed. V4 stated that V6 was at the head of the bed and when V4 asked V6 about the incident, V6 had told V4 that V6 didn't see what happened because V6 was fixing the pillows by the head of R3's bed and then just felt R3 at V6's feet. V4 stated that V5 said that V5 tilted the (tilt recliner chair) to an upright position and R3 fell forward. V4 stated that V4 observed R3's entire body lying on the floor on the right side ...V4 stated that R3 was sent to the hospital and returned the same day with diagnosis of fracture of right hip but without | S9999 | | |

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| S9999 | Continued From page 4 | S9999 | | |

any treatment.

On 2/27/18 at 2:59 pm, V29 (RN/Restorative Manager) was interviewed in the conference room. V29 stated that before a resident could use the (tilt recliner chair), an assessment to determine appropriateness is conducted by (skilled) therapy department and then re-assessed by restorative department during quarterly assessments. V29 stated that R3 needed total assistance with ADLs and did not follow instructions. V29 also confirmed in a statement that R3 used a (tilt recliner chair) due to poor body trunk control, being unable to sit without support, needing to be positioned and needing total care from staff. V29 stated that R3 was unable to sit upright without support. V29 stated that each resident's needs related to ADL care, support and equipment are communicated via a list that is being updated weekly. V29 also stated that staff is educated on transfers and use of (tilt recliner chairs) annually.

On 2/27/18 at 4:00 pm, V3 (Assistant Director of Nursing) was interviewed in the conference room. V3 stated that R3 had poor trunk control, needs total assistance in all transfers and mobility, needs assist in turning and repositioning on bed and chair, has episodes of involuntary jerking movements, not able to follow instructions and has poor strength and balance. V3 stated that V3 conducted the investigation of the fall and concluded that the root cause was (staff) attentiveness and focus during this transfer which caused the fall.

R3's 2/2018 Physician order sheet document:
May use reclining wheelchair
Notes: May use a recliner wheelchair to accommodate height and get more trunk support

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| S9999 | Continued From page 5<br><br>R3's current care plan documents:<br>Therapeutic use of enabling device, recliner wheelchair (tilt recliner chair) - poor trunk control<br><br>R3's 12/15 Functional needs assessment as documented by V29, Rehabilitation potential: Poor. (R3) continues to be dependent on staff with all areas of ADL functions ...R3 uses a recliner wheelchair for better sitting positioning.<br><br>R3's 1/26/18 (acute hospital) emergency department record documented:<br>Seen by V30 (Hospital Physician)<br>Reason for visit: Fall<br><br>(B) | S9999 | | |

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| | 146007 | A. BUILDING ______ B. WING ______ | C 03/06/2018 |

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| F 000 | INITIAL COMMENTS<br><br>Complaint Investigation:<br>1890998/ IL 100300 - F697<br>1890789/ IL 100074 - No deficiency<br><br>Facility Report Investigation:<br>FRI 1/26/18- IL 100270 - F689 | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that a resident was safely positioned and supported during process of transfer from recliner chair to bed. This affected one of three residents (R3) reviewed for falls in a sample of 9 which subsequently resulted to R3 sustaining a fracture.<br><br>Findings include:<br><br>R3's incident report documented:<br>-On 1/26/18, around 10:45 am, (V6 - Certified Nursing Assistant/CNA) who was assigned to (R3) asked (V5- CNA) to help transfer R3 from the (tilt recliner chair) to the bed. As V6 was trying to straighten the bed of R3 before transfer, V5 was trying to prepare R3 on (tilt recliner chair), positioned the (tilt recliner chair) in an upright | F 689 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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| F 689 | Continued From page 1<br>position. (R3's) poor trunk control caused R3 to fall forward, and out of chair.<br>- (R3) sustained a bump on forehead, and was showing signs of pain on the right hip area. R3 was sent to emergency room for further evaluation.<br>- (R3) returned to facility on 1/26/18, at around 6:15 pm, with negative finding on computed tomography scan of head and diagnosis of right hip fracture.<br><br>Interviews were conducted with facility staff.<br>On 2/27/18 at 11:01 am, V5 was interviewed in the conference room. V5 stated that during that day, V6 had asked V5 for assistance to transfer R3. V5 stated that R3 transfers using a mechanical lift, with 2 staff assistance. V5 stated that while V6 was fixing bed, V5 lifted R3's (tilt recliner chair), from a 45 degree tilt to an upright 90 degree position. V5 stated that V5 was at the back of the (tilt recliner chair), since the only way the chair can be reclined pressing a lever located at the back of the chair. V5 stated that R3 fell forward, with all of R3's body falling off the chair. V5 stated that V6 was in front of the chair but could not react enough to stop R3 from falling.<br><br>On 2/27/18 at 11:43 am, V6 was interviewed in the conference room. V6 stated that V6 has been assigned to care for R3 for about 3 years. V6 stated that R3 is alert, would rarely respond, confused and not able to follow requests. V6 stated that R3 had been slowly declining and needed total assistance with all ADLs (Activities of Daily Living) including bed mobility and transfers. V6 stated that R3 needed two-person assistance and that a mechanical lift was used to transfer R3. V6 stated that R3 sat in the (tilt recliner chair) because R3 had the tendency to | F 689 | | |