

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145689	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2020
NAME OF PROVIDER OF SUPPLIER MANORCARE OF ELK GROVE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP 1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007	
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 F 0677	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview and record review, the facility failed to provide ADL (assistance of daily living) to a resident who was unable to provide self care and toilet themselves in a timely manner. This applies to 1 of 5 residents (R4) reviewed for ADL assistance. The findings include: According to the POS (physician order [REDACTED]). The Minimum Data Set (MDS) dated [DATE] showed R4 needed extensive assistance with (bed mobility, dressing, personal hygiene and toileting) and required total dependence for eating. The care plan (last revised 1/9/2020) showed R4 has ADL self care deficit as evidenced by needing assistance with most of ADLs related to physical limitations, presence of contracture to both upper extremities; requires assistance .for transferring from one position to another .as evidenced by presence of contractures on both hands; urinary and bowel incontinence related to impaired mobility and potential for dental or oral cavity health problem related to edentulous state. On 3/11/20 at 11:46 AM, in the presence of V2 (Director of Nursing/DON), R4 stated I haven't been changed at all today. I am so wet. When I poop, they let this stuff stay on me for 1-2 hours and I hate the smell of it. Staff will come in and turn the call light off, saying they will be back. It takes a long time if they come back at all. R4 stated yesterday (3/10/2020) V10, CNA (certified nursing assistant) said he was going to come back after his lunch break around 10:00 AM to wash me and never did. I have not had my face washed in two days or even been offered a wash cloth. My mouth taste yucky and I haven't had any mouth care in 2 days. On 3/11/20 at 12:10 PM, V10, in the presence of V2, stated he was unable to provide care to R4 on the previous day because he (V10) was tied up with another resident that required a lot of time to assist. On 3/11/20 at 11:58 AM, V9 (CNA), in the presence of V2, confirmed she was the assigned care provider for R4 and her shift began at 6:30 AM. V9 stated she had not been able to change R4's incontinent brief, did not offer R4 a wash cloth, nor offer oral care to R4.</p>		
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.