| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145868 | A. BUILDING _____ B. WING _____ | 11/10/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARLINGTON REHAB & LIVING CTR** | **1666 CHECKER ROAD LONG GROVE, IL 60047** |

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| F 465 | Continued From page 31<br>failed to ensure that supplies are stored off the floor in 3 of 3 supply rooms located on Unit 100, Unit 200 and Unit 300.<br><br>Findings include:<br><br>The 3 Units were toured with E15 (Housekeeping Supervisor), E16 (Maintenance Supervisor), and E17 (Facility Maintenance Director) on 11/8/11, between 10:30 AM and 12:30 PM, on 11/8/11. Three cases of clean gloves, one case of oxygen humidifiers, one case of intravenous start kits, one case of 1000cc saline bags, and one case of 16 ounce bottles of Milk of Magnesia were stored on the Unit 300 supply room floor. Two cases of diapers were stored on the Unit 200 supply room floor. The facility's main supply room, located on Unit 100, contained the following items on the floor; multiple cases of facial tissue, diapers, gloves, medication cups, suction canisters and oxygen humidifiers, along with three cases of enteral feedings. This was confirmed by E15, E16 and E17. During these observations, E17 stated supplies should be stored off the floor. | F 465 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.610a)<br>300.1210b)5)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a | F9999 | | |

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| F9999 | Continued From page 32<br>Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<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>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.<br><br>Based on interview and record review the facility failed to to follow their Fall Care Plan intervention for 1 resident (R17) with a skull fracture. This failure resulted in R17 falling again and sustaining a laceration to the back of her head with active bleeding, requiring her to be sent to the emergency room. This is for 1 resident (R17) out of 9 reviewed for falls in the sample of 26. | F9999 | | |

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| F9999 | Continued From page 33 | F9999 | | |

These requirements are not met as evidenced by:

R17 was admitted to the facility on 9/21/11 status post a fall with head laceration and staples to the back of the head according to the initial Minimum Data Sets (MDS) dated 9/28/11 and nursing notes dated 9/21/11. R17's Care Area Assessment (CAA) Summary triggered for falls due to R17's history of falls, impaired balance during transitions, diuretic use and being in a new environment, according the CAA narrative dated 10/3/11. R17 was assessed to be at moderate risk for falls according to the 9/22/11 fall assessment. R17 required supervision (Oversight, encouragement or cueing) for walking in her room, according to the 9/28/11 MDS. On 10/15/11 at 4:00 AM R17 slipped on water that she had spilled on the bathroom floor and sustained a laceration to the back of her head according to the occurrence report. Prior to the fall R17 was observed to be unsteady and was advised to use the call light to assist with ambulation according to the facility's investigation. R17 was sent to the emergency room and was diagnosed with a skull fracture, according to the nursing notes dated 10/15/11. R17 was re-admitted to the facility on 10/18/11 at 3:39 PM. A bed alarm was ordered and the care plan was updated per the following "10/18/11 bed alarm ordered upon readmit." On 10/19/11 at 3:10 AM R17 fell again according to the nursing notes and occurrence report dated 10/19/11. R17 sustained a laceration to the back of the head with active bleeding and was sent to the emergency room, according to the 10/19/11 nursing notes. The investigation report dated 10/19/11 documents that the bed alarm was not

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| F9999 | Continued From page 34<br>in place.<br><br>On 11/10/11 at 10:50 AM, E6 (Restorative Nurse) stated that the bed alarm was ordered but was not in place at the time of R17's fall on 10/19/11. E6 said that the bed alarm should have been in place when R17 was re-admitted on 10/18/11. E6 said that the order was put in the computer in a manner that did not require the nurse to sign off on the application of the alarm. E6 said that the night nurse (E21) was not aware that R17 had an order for a bed alarm.<br><br>The facility's Fall Prevention and Risk Assessment policy and procedure dated 9/1/11 documents "Risk factors and fall prevention measures for individual residents will be documented on the resident's comprehensive care plan and communicated to the direct care staff for implementation" (emphasis added).<br>B<br><br>300.615e)<br><br>Section 300.615 Determination of Need Screening and Request for Criminal History Record Information<br><br>e) In addition to the screening required by Section 20201.5(a) of the Act and this Section, a facility shall, within 2 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, | F9999 | | |

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| F9999 | Continued From page 35<br>and other identifiers as required by the Department of State Police. (Section 20201.5(b) of the Act)<br><br>This requirement was not met as evidenced by:<br><br>Based on interview and record review the facility failed to initiate background checks of newly admitted residents within 24 hours of admission. This failure is for 6 residents (R41, R42, R43, R44, R45 and R46) out of the last 10 admissions.<br><br>The findings include:<br><br>R41 was admitted to the facility on 11/4/11; the background check was initiated on 11/8/11.<br><br>R42 was admitted to the facility on 11/4/11; the background check was initiated on 11/8/11.<br><br>R43 was admitted to the facility on 11/4/11; the background check was initiated on 11/8/11.<br><br>R44 was admitted to the facility on 11/4/11; the background check was initiated on 11/8/11.<br><br>R45 was admitted to the facility on 10/28/11; the background check was initiated on 10/31/11.<br><br>R46 was admitted to the facility on 10/28/11; the background check was initiated on 10/31/11.<br><br>On 11/8/11 at 9:30 AM E3 (Office Manager) said that background checks are not always initiated within 24 hours because sometimes residents are admitted on Friday, Saturday and Sunday. | F9999 | | |