STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146023	A. BUILDING _____ B. WING _____	11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTHUR HOME, THE	**423 EBERHARDT DRIVE ARTHUR, IL 61911**

(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) COMPLETION DATE
F 371	Continued From page 4 surfaces of ice maker were encrusted with lime, scale and a brown rusty residue. The ice machine is a water cooled machine and it has water running continuously. This ice machine supplies ice for the resident meals. 4. On 11-17-12 at 9:05 A.M., six #(number) 10 metal cans of food were on a transport cart in the kitchen. The cans of food were open with the lids floating on and in the food. Two of 6 cans had dents in the seams. The 2 cans contained corn. One can had a large dent in the side seam that was indented into the side of can at least 3/4 of inches and the top and bottom of the can collapsed into the center of the can. The second can of corn top and side seams were dented. The Cook, E4 was asked if the can of food was going to be used and stated that she was going to heat it up for the lunch meal. E4 stated that she was not told that she was not to use food from dented cans, but she had "heard something about it". According to the Centers for Medicare and Medicaid Services CMS 672 form, "Resident Census and Conditions of Residents", 47 residents reside at the facility.	F 371		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS; 300.610a) 300.1210d) 6) 300.2210a) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 5 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 300.2210 Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidence by:	F9999		

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F9999	Continued From page 6	F9999		

Based on record review and interviews the facility failed to ensure that the pressure sensitive alarm was maintained in proper working order for R12. R12 sustained a head injury from a fall which resulted in a 4 centimeter laceration to the left frontal scalp which required multiple sutures. R12 is one of six residents reviewed for falls in a sample of 12.

Findings include:

The Physician's Order Sheet (POS) dated August 2012 lists the following diagnoses for R12: Lewy Body Dementia with Parkinson's Motor Symptoms, Hyperlipidemia and Asthma.

The Minimum Data Set dated 5/30/12 lists R12 as moderately impaired in daily decision making skills and is totally dependent on staff for bed mobility and requires extensive assist requiring two staff with toileting and transfers. The facility's fall assessment dated 6/21/12 and 7/9/12 lists R12 as high risk for falls.

R12's Nurses Notes dated 7/9/12 at 8 PM states "CNA (certified nursing assistant) went into (R12's) room to assist (R12) to bed, (R12) was found laying on the floor in room covered with blood. (R12's) geriatric chair was across room. Black leather chair was against wall and (R12) was laying with head against side of recliner.....Laceration approximately 10-15 cm (centimeter) in circular shape was noted on left forehead...Blood was noted coming from mouth, nose and left ear. 3 cm cut was noted on left cheek bone area. Open area noted to inside right

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F9999	Continued From page 7	F9999		

calf, left knee, right hand red/bruising , right elbow and forearm-scraps and right elbow bruising.....Seat alarm was not activating." Nurses Notes dated 7/9/12 at 9 PM documents "Ambulance transported (R12) to Emergency Room..."

The facility's "Event Form "dated 7/9/12 states" (R12) was found on the floor in room covered in blood. (R12) hit his head and had several abrasions and bruises on extremities...." Same form section titled "Outcome/Conclusions" states "Root Cause human error (R12) attempted to get up on own. Wife had been in earlier but when she left (R12) was left in geriatric chair and (R12's) alarm was not working properly."

E2, DON (Director of Nurses) stated on 11/9/12 at 9:30 AM "I went to check the alarm after (R12's) wife told me the alarm did not work properly . The alarm looked like it had been pulled and where the wires connected to the pad the wires were a little bare. The facility policy is that the transportation aide (E5) checks all the alarms weekly. I replaced (R12's) alarm due to not working properly."

The facility was unable to provide a policy on the procedure of checking the alarms to ensure they were in proper working order.

E2, stated on 11/9/12 at 9:30 AM , "The facility has no policy or system in place regarding the procedures to check the alarms to ensure the alarms were working properly."

E5, Transportation Aide, confirmed on 11/9/12 at 10:30 AM, E5 only checked the alarms once a

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F9999	Continued From page 8 week and there was no specific policy stating this information. R12's Discharge Summary from the Emergency Room dated 7/9/12 states "Laceration Repair" "....the laceration was 4 cm long.... The site was then repaired with 4-0 Ethilon sutures..." "Encounter Diagnoses 1. Head Trauma 2. Scalp Laceration" (B)	F9999		