Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ IL6000228 B. WING 05/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST CENTRAL ROAD PROMEDICA SKILLED NURSING AH **ARLINGTON HTS, IL 60005** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S 000 Initial Comments S 000 Facility Reported Incident of 5/7/23/IL160095 Final Observations S9999 Statement of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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. 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: All necessary precautions shall be taken 6) 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. These requirements are not met as evidenced by: Attachment A Ctatement of Licensure Violations Based on observation, interview, and record review the facility failed to safely provide

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AH STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- •	E CONSTRUCTION	(X3) DATE SURVEY		
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Seyes Continued From page 1 incontinence care to a resident by not having two staff members provide the care. This failure resulted in a resident falling from bed causing a change in condition that required a resident to be sent to the emergency room for two lacerations and a bloody nose that needed 6 sutures, tissue adhesive, and nasal packing to control the bleeding. This applies to 1 of 3 residents (R1) reviewed for safety supervision in the sample of 3. The findings include: R1's Care Plan showed R1 was 82 years old. R1's Care Plan showed R1 had the diagnoses of hemiplegia and hemiparesis, Alzheimer's, muscle weakness, and muscle wasting with atrophy. R1's Care Plan showed R1 had a self care deficit related to physical and cognitive limitations. Under interventions listed to assist R1 with bathing/showering, lower body dressing, and tolleting as needed with 2 person physical assist that was initiated on 12/20/22. The Care Plan also showed R1 was at risk for falls, had a history of inaccuracy of movements, coordination deficits, and involuntary body movements. A facility assessment done on 4/28/23 showed for tollet use and cleansing self after eliminations that R1 required extensive assistance of 2 staff members. On 5/22/23 at 8:36 AM, R1 was in bed. At the center of R1's forehead were 5 steri-strips that covered about a 5-6 centimeter (cm) area. R1 also had a small laceration to the bridge of his nose. On 5/22/23 at 8:36 AM, V4 (Certified Nursing	S9999	incontinence care to staff members proveresulted in a reside change in condition sent to the emerger and a bloody nose adhesive, and nasa bleeding. This appreviewed for safety 3. The findings include R1's Face Sheet shert's Care Plan should hemiplegia and her weakness, and must R1's Care Plan should related to physical a Under interventions bathing/showering, toileting as needed that was initiated or also showed R1 was of inaccuracy of modeficits, and involunt Afacility assessment toilet use and clean R1 required extensimembers. On 5/22/23 at 8:36 center of R1's foreit covered about a 5-6 also had a small lact nose.	o a resident by not having two ride the care. This failure int falling from bed causing a that required a resident to be not room for two lacerations that needed 6 sutures, tissue if packing to control the lies to 1 of 3 residents (R1) supervision in the sample of supervision in the sample of a supervision in the sample of second and the diagnoses of niparesis, Alzheimer's, muscle scle wasting with atrophy. Wed R1 had a self care deficit and cognitive limitations. I listed to assist R1 with lower body dressing, and with 2 person physical assist in 12/20/22. The Care Plan is at risk for falls, had a history overments, coordination intary body movements. Int done on 4/28/23 showed for sing self after eliminations that ive assistance of 2 staff AM, R1 was in bed. At the lead were 5 steri-strips that 6 centimeter (cm) area. R1 ceration to the bridge of his					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000228 05/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST CENTRAL ROAD PROMEDICA SKILLED NURSING AH **ARLINGTON HTS, IL 60005** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 Assistant- CNA) said the steri-strips to R1's forehead and laceration to his nose were the result of a fall. On 5/22/23 at 8:37 AM, V3 (CNA) said R1 required two staff to provide incontinence care. On 5/22/23 at 10:51 AM, V6 (CNA) said she was familiar with R1. V6 said before R1 had a fall on 5/7/23, R1 required 2 staff members to get a bed bath/incontinence care. According to V6, 2 staff members were required because R1 was unpredictable with movements and having 2 staff members helped prevent falls. V6 said when getting R1 cleaned up one staff member was to be on each side of the bed to ensure R1 did not fall out of bed. On 5/22/23 at 11:20 AM, V9 (Registered Nurse) said on 5/7/23 V10 came to him and said R1. "Slipped" out of her hands and fell. V9 said the fall created a change in R1's condition. V9 added the change in condition was the result of R1 hitting his head during the fall causing a laceration to his forehead, a laceration to his nose, and a bloody nose. V9 said R1 was sent emergently to the hospital because of the bleeding. V9 said R1 required several sutures and nasal packing to control the bleeding. On 5/22/23 at 12:01 PM, V10 (CNA) said on 5/7/23 R1 was incontinent of stool. V10 said she was standing on one side of the bed providing incontinence care/bed bath to R1 when R1 rolled off of the opposite side of the bed falling onto the floor. V10 said she was the only staff member that was providing care to R1 when he fell. V10 said it takes 1 or 2 staff members to provide incontinence care to R1 based on R1's behaviors. V10 said R1's behaviors include having

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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23)	hemiplegia and hem weakness, and mus R1's Care Plan sho	wed R1 had the diagnoses of niparesis, Alzheimer's, muscle scle wasting with atrophy. wed R1 had a self care deficit and cognitive limitations.		es So se er				W	
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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN		(X3) DATE SURVEY COMPLETED C			
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	On 5/22/23 at 11:20	AM, V9 (Registered Nurse)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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