

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

PRINTED: 07/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145819</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/13/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLAREMONT REHAB &amp; LIVING CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089</b>		
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F 465	Continued From page 11 shower were loose. A linen cart was in the shower room. Non-sterile gloves, clean white plastic bags, and adult incontinence pads were resting on top of the clean linen. The linen cover was resting on top of the cart.  d. The shower stalls on all three floors had grout missing.  E7 stated, " The items that were found during the tour should be addressed, and I will begin fixing these problems immediately."  During the course of the survey, 03/10/13 to 03/13/13 the first floor hall way carpeting was dirty with several heavy stained areas.  The CMS 672 form titled "Resident Census & Condition of Residents" dated 3/10/13 documented that there were 168 residents residing at the facility.	F 465			
F9999	FINAL OBSERVATIONS  Licensure Violations  300.610a) 300.1210b) 300.1210d)6) 300.3240a)  Section 300.610 Resident Care Policies	F9999			

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F9999	Continued From page 12 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 300.610 Resident Care Policies  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.	F9999			

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F9999	<p>Continued From page 13</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p>	F9999			

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F9999	Continued From page 14  These Regulations were not met as evidenced by:  Based on record review and interviews the facility failed to monitor and provide toileting assistance to prevent accident to a resident identified as high risk for falls and with history of multiple falls.  This applies to 1 of 10 residents (R22) reviewed for fall in the sample of 26.  This failure resulted in R22's fall incident on 2/22/13 requiring emergency room evaluation and treatment due to head trauma. R22 was diagnosed with acute fracture of the left distal phalanx of the thumb and right forehead laceration, requiring sutures on the right forehead.  Findings include:  R22 has multiple diagnoses which include Alzheimer's disease.  R22's most recent significant change MDS (Minimum Data Set) dated 12/12/12 was coded to reflect that the resident has temporal orientation and recall problems. R22 requires extensive assistance x one person physical assist with transfers, ambulation, locomotion on and off the unit, toilet use and personal hygiene.	F9999			

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F9999	<p>Continued From page 15</p> <p>R22's fall risk assessment dated 1/31/13 reflected a score of "13", indicating that the resident is high risk for falls</p> <p>R22's records showed evidence that the resident had history of unwitnessed falls on:</p> <ul style="list-style-type: none"> <li>- 4/20/12 (6:10 PM), R22 attempted to transfer herself to the toilet but did not make it. No injury was sustained.</li> <li>- 5/27/12 at 6:50 PM, R22 was found on the floor screaming for help inside the bathroom. R22 sustained hematoma and skin tear on the right lower extremity.</li> </ul> <p>R22's occurrence report dated 2/22/13 indicated that at approximately 11:25 AM inside the shower room, the resident was found on the floor in front of the toilet laying on her right side with her right arm under her. R22 had a large laceration noted on the right forehead with large amount of bleeding with reports of pain. R22 was also noted with skin tears on both knees and between first and 2nd fingers on the left hand. R22 was transported to the emergency room via 911 for evaluation and treatment of the head trauma.</p> <p>R22's progress notes dated 2/22/13 indicated that the resident came back to the facility from the hospital with laceration over the middle of the forehead, 8 cm in length with 12 sutures. R22 also had laceration over the palmar surface of the left thumb with dressing in place. The same progress notes reflected that the resident was also diagnosed in the hospital with UTI (Urinary Tract Infection). R22's physician progress notes dated 2/23/13 (10:51 AM) indicated that the resident was diagnosed in the emergency room</p>	F9999			

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F9999	<p>Continued From page 16 with left hand fracture and right forehead laceration. R22's hospital x-ray result indicated an acute fracture of the left distal phalanx of the thumb.</p> <p>R22's occurrence follow up report dated 2/26/13 indicated that R22 requested to be toileted prior to her fall but was not taken to the washroom immediately. R22 attempted to toilet herself without assistance from the staff and subsequently fell.</p> <p>On 3/13/13 at 10:20 AM, E10 (Activity Aide) stated that on 2/22/13 around 11:00 AM, (E10) brought R22 to the 3rd floor small dining room because the resident wanted to use the washroom. Per E10 she informed E11 (CNA) about R22's request to use the washroom. According to E10, E11 told her to place R22 by the 3rd floor nursing station with the other residents, to which she complied. E10 stated that after placing R22 by the 3rd floor nursing station, she left the 3rd floor unit and went back to the 1st floor to assist other residents. E10 stated that she did not toilet R22 nor did she inform any other staff about R22's need to use the washroom.</p> <p>On 3/13/13 at 10:32 AM, E11 stated that on 2/22/13 at around 11:00 AM, E10 told E11 that R22 wanted to use the washroom. According to E11 she told E10 to go to the 3rd floor nursing station and tell the other CNA to take R22 to the washroom because, she (E11) was watching and attending to the other residents inside the small dining room. E11 stated she saw E10 wheel R22 towards the 3rd floor nursing station, but she does not know if E10 told the other CNA about</p>	F9999			

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F9999	<p>Continued From page 17</p> <p>R22's request to use the washroom and/or who took R22 to the washroom.</p> <p>On 3/13/13 at 10:50 AM, E12 (CNA) stated that he was the assigned staff for R22 on 2/22/13 during the 7 - 3 shift. According to E12 no one informed him that R22 needed to use the washroom on 2/22/13, prior to the fall incident. E12 stated that R22 normally would inform the staff if she wants to use the washroom. Per E12, R22 is capable of wheeling herself to the washroom, can open door and would attempt to transfer self from wheelchair to the toilet. E12 stated that, if R22 verbalized the need to use the washroom, the resident should be assisted immediately because she will attempt to toilet herself without assistance, which is not safe.</p> <p>R22's high risk fall care plan indicated multiple approaches dated 12/13/12, which included close monitoring of the resident and toileting the resident according to the care plan. Further review of R22's care plan dated 12/13/12, indicated that the resident had limited ability to toilet self safely related to cognitive and functional issues. There were multiple approaches which included; toileting the resident upon request and reminding the resident not to transfer independently or attempt to toilet without assistance.</p> <p>On 3/12/13 at 3:00 PM, E2 (Director of Nursing) stated that upon investigation of the fall incident of R22 on 2/22/13, it was concluded that the resident requested to be toileted, but was not taken immediately by the staff. R22 attempted to toilet herself without assistance from the staff and in the process, R22 fell and sustained injury.</p>	F9999			

