STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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 441	Continued From page 37 following this procedure to ensure resident's linen and towels were cleaned in a sanitary manner. Review of the facility's Infection Control Disinfection in the Laundry Process documented the following: "In addition to cleaning linens and producing an aesthetically pleasing product for residents... the main role of the laundry operation is to disinfect the linen before sending them to the nursing unit." However, this was not being done for residents in the facility. During an observation of incontinence care on 3/26/13, E15 was observed to keep the same gloves on through the entire procedure. R1 was incontinent of moderate amount of feces. E15 was observed searching R1's drawers looking for peri wash after he removed the adult diaper and notice that R1 was incontinent of stool. E15 was observed to touch the door knob and walk down the hall way to the supply room looking for "peri wash." E15 returned to R1's room and continued with the procedure wearing the same gloves. During an interview with E2 (DON) on 3/26/13, E2 stated that staff should remove gloves and wash their hands after resident contact. Review of the facility's policy and procedure for handwashing verified the same.	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1210b)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 38 300.1210d)5) 300.3240a)	F9999		

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 39 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. Restorative measures shall include, at a minimum, the following procedures: 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 40	F9999		

Based on observation, interview and record review the facility failed to consistently and accurately assess, monitor and implement pressure relieving methods to help prevent the development of pressure ulcers for 3 residents (R3, R7 and R24) at risk out of a sample of 24 residents.

As the result of this failure, R24, who was admitted to the facility without pressure sores, developed an unstagable area to his left heel and a stage III to his right heel.

This failure also resulted in R3 being admitted to the emergency room with a stage III pressure sore on buttocks and heel, the facility's staff was unaware of the opened areas.

The findings include;

1. R24 was admitted to the facility on 6/16/2008 with diagnoses which included mental status change, dementia, Parkinson and history of seizure disorder. R24 was assessed as totally dependent on staff for all levels of activities of daily living.

Review of the facility's nurses treatment notes dated for 12/31/2012 noted R24 acquired bi-lateral heel wounds, with co-morbidity factors documented as dementia and incontinence. The right heel wound was assessed as 3.0 cm in length and 3.5 cm width, reddened area with black wound bed. The left heel wound measurement was recorded as 2.8 cm in length and 3.5 cm in width. Interventions that were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 41 documented "off-load, moon boots applied and follow up with the physician." By 2/13/13 both heels had progressed to unstagable. On 3/28/13 during an interview with E14 (treatment nurse), E14 stated that he was not aware of how R24 developed his heel ulcers. 2. Review of R3's Face Sheet was observed to have documentation that R3 is a 81 year old female, who was admitted to the facility originally on 12/24/2011. R3 has diagnosis including: Dementia, Dysphagia, Contractures, Cardiovascular Accident, and Recurrent Pressure Sores on buttocks and heel. Review of R3's care plan documented that she had a potential for skin breakdown and it was a focus of concern in her care. But, the care plan interventions were general and not specific. Review of R3's recent Braden Scale Assessments, dated 3/27/2013 and 2/27/2013, documented that R3 is at risk for the development of pressure sores due to: immobility, moisture to skin, inadequate nutrition and friction and shearing. Review of R3's Wound Care Assessment Sheet documented that R3 developed opened wounds in the facility on the following dates: 10/03/2012 Stage II on Right Lower Buttocks	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 42 10/16/3012 Stage II on Outer Medial Buttocks 10/18/2012 Stage II on Right Outer Buttocks. No documentation found after 1/30/13 regarding R3's wounds and/or treatment in the nurses notes. Review of R3's Physician Order Sheet,dated, 2/01/2013, had no documentation of pressure sore treatment, only an order to check her skin three times a week. R3's nursing note, dated 3/05/2013, documented that R3 was sent to local emergency room for care at 3 PM for abnormal labs. Review of R3's Hospital Face Sheet documented that R3 arrived at the hospital emergency room on 3/05/2013 at 3:45 PM. Review of R3's History and Physical, dated 3/06/2013, from the hospital documented the following: "... Work up in the emergency room showed that... The patient (R3) was also found to have a stage III decubitus ulcer on her sacrum and another ulcer on her left heel. For all the above, the patient (R3) was admitted for further evaluation and management..." R3's son (Z2, Power of Attorney) was interviewed on 3/28/2013. Z2 stated that he was informed by the hospital's emergency room physician that his mother had a pressure sore on the buttocks and heel. During the initial tour on 3/26/2013. R3 was observed with dressings on her buttocks and left	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 43	F9999		

heel. R3 was observed to be cognitively impaired with dysphagia, and contractures. R3 was also observed to be dependent upon staff for incontinence care and to be turned and repositioned.

On 3/27/2013 at 10:45 AM, the treatment nurse (E14) was observed changing R3's opened wound on the buttocks and left heel. E14 stated R3 had a stage III on the buttocks and unstagable on the left heel. E14 stated she was not aware that R3 had developed pressure sores until she returned from the hospital facility on 3/05/2013. E14 said that R3 has a history of reoccurring pressures sore developing in the facility, which healed and reopened. E14 described R3's pressures sores as being healed before she was admitted to the hospital. E14 said that R3's daughter-in-law told him that she was informed by the hospital that R3 had pressure sores, and her pressure was debride at the hospital.

The nurse (E26), who sent R3 to the hospital on 3/05/2013. During an interview on 3/27/2013, E26 stated that R3's did not have any opened wounds when she was sent to the hospital on 3/05/2013. E26 said she did skin checks for R3 twice a week.

R3's primary physician was interviewed on 3/28/13. Z1 said that R3's skin integrity was poor and she could start breaking down within 24 hours. Z1 agreed that R3 required close monitoring of her skin integrity. But, Z1 did not explain why the nursing staff did not have any orders for more frequent skin checks, so any pressure sore could be identified, assessed and treated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 44 3. On 3/22/2013 at 1:24 PM, the wound on R7's elbow and left foot were observed. E14 measured R7's elbow wound to be 0.4 cm x 0.5 cm. E14 said that R7's elbow wound was a stage III. E14 stated that R7's elbow wound developed in the facility. E14 said this wound was caused by her immobility and pressure from the arm rest of her wheel chair. E14 stated, "We start applying a pillow under her elbow, while in the wheel chair." However, E14 did not identify any preventive measures applied to prevent the pressure of her arm rest from causing a pressure sore. Review of R4's Face Sheet documented that R7 is a 76 year old female. R7 had diagnosis including: Dementia, Cardiovascular Accident and Dysphagia. Review of R7's care plan and wound care documentation did not address intervention for pressure of R7's elbow until her wound developed. Review of the facility's policy Prevention of Pressure Sore documented the following: "Any resident that is assessed as being at risk for skin breakdown will have specific preventative measures implemented and care planned... Equipment... elbow protector... Use elbow and heel protectors as necessary... Positioned to prevent pressure from medical devices such as tubes casts, braces, etc... Notify the POA... Pressure ulcer investigation completed upon discovery... " However this policy was not being followed in the care of the above resident's care.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 45 (B) 300.610a) 300.610c)4)A)B)C)D) 300.610c)4)F) 300.1210b) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 46 movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs; B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling; C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment; D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances; F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 47 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. Restorative measures shall include, at a minimum, the following procedures: Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 48	F9999		

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to provide adquate monitoring/supervision to one resident (R23), who has a poor cognitive status with a history of frequent falls, failed to analyze each of R23's falls occurrence to ensure the application of appropriate safety interventions/measures, and failed to ensure safe technique was utilized during the transfers of two residents (R1 and R11) out of the sample of 24.

This failure resulted in R23 having an avoidable fall and sustaining a Intracrainal Hemotoma.

This applies to three out of eight residents (R23, R1 and R11) in a sample of 24 residents, who were identified at risk for falls.

Findings include:

1. Review of R23's Face Sheet documented that R23 is a 84 year old male with diagnosis including: Vascular Dementia, Alzheimer with Behavior Disturbances.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 49	F9999		

Review of the facility's Accident Log documented that R23 experienced multiple falls in the facility. R23 fell on the following days: 12/10/2012, 12/14/2012, 01/03/2013, 01/05/20113, 1/06/2013 and 1/16/2013.

Review of the Incident Investigation Report, dated 1/16/2013, documented that R23: "fell when he was left in a room by himself and fell... Nursing observation: Staff heard resident calling for help, noted resident sitting sideways with ...walker on the floor. Noted moderate amount of bleeding from head... Number of falls: past 60 days: 5... Physical Factors: poor safety jugement; behavior/cognitive factors; wandering/pacing... Probable Cause: wheelchair was in the way... Intervention: do not leave in room in wheel chair unattended... residents fell forward in ...walker and hit his forehead on floor causing a laceration to his forehead requiring 7 sutures..."

Review of R23's Incident Investigation Report, dated 1/21/2013, documented the following: "Incident occurred on 1/21/2013 at 7 in the hallway... R23 fell while in ...walker on right side. R23 complained of pain in right arm and shoulder decreased ROM (Range of Motion)... Nurmber of Falls: past 30 days: 7 ...Physical Factors: behavior/cognitive factors; poor safety judgement... Probable Cause: resident leaned to the right side tipping the ...walker toward the right side... Intervention: do not leave in room in wheel chair/chair unattended."

The director of nursing was interviewed 4/03/2013 at 2:12 PM. E2 said before R23 fell on 1/16/2013 the intervention being used to keep R23 safe was to monitor him and not leave him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 50	F9999		

alone in his room. E2 stated that R23 should have stayed in the common areas for monitoring. But, E2 said that a therapist left R23 alone in his room. E2 said that R23 was assessed by physical therapy for the use of the walker before he fell on 1/16/2013. However, E2 said another assessment was not completed after R23 fell from the walker on 1/16/2013. This lack of reassessment of the walker did not ensure it was safe for R23 to continued to use this device.

The nurse who sent R23 to the hospital when he fell on 1/21/2013 was interviewed on 4/02/2013 at 3:15 PM. E13 said that R23 could be combative, verbally abusive, so we kept a certified nurses aide with him. E13 could not recall what CNA was monitoring R23 when he fell. E13 said she recall that this CNA said she was following R23 but R23 fell. E13 said she came and saw R23 on the floor. E13 said she sent R23 to the hospital and later learned R23 had a serious injury. E13 stated, "It should not have happened, but you could not stop him for doing what he wanted to do."

2. On 3/26/13, E15 was observed to transfer R1 from his wheel chair to his bed. E15 grabbed R1 under both arms and and pulled him (R1) up and out of his wheel chair, bristly turned him around and placed him abruptly on the bed. E15 was observed wearing a gait belt around his (E15) waist. R1 made the statement "wait a minute. They are always in a hurry."
A review of the facility' current minimal data assessment for R1 noted that R1 is to transfer with one assist. Also, R1 has been assessed to ambulate in room and hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 51	F9999		

During an interview with E2 (DON) on 3/28/13 at approximately 3:10 PM, E2 stated that staff are to use gait belts with all one assist transfers.
A review of the facility's policy and procedure for transferring a resident noted that staff are to inform resident of the procedure, place a gait belt around the resident's waist, ask the resident to scoot to the front edge of the chair, make sure brakes are on, and assist the resident to stand and pivot around to the bed.

3. On 3/26/13 at 11:00 a.m. E16 (Restorative CNA) was observed transferring R11 from his bed to his wheel chair. R11 was noted sitting on a bed in a low position. E16 did not raise the bed to a higher position to make it easier for R11 to stand. E16 grabbed R11 under his left arm and grabbed the back of R11's pajamas, stood R11 into a standing position, and pivoted R11 into the wheel chair. E16 had a gait belt around her waist which she did not use to transfer R11. When E16 was asked why she did not raise R11's bed and use the gait belt prior to R11's transfer to the chair; no answer was given.

Review of R11's admission face sheet showed R11 had admission diagnoses which included hip injury.

Review of R11's CAA (Care Area Assessment) for falls dated 3/22/13 showed R11 was at high risk for falls. R11's MDS dated 3/12/13 showed R11 as an extensive, 2 person assist transfer.

The facility's incident tracking log showed R11 had an unwitnessed fall in the facility's dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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
F9999	Continued From page 52 room on 3/13/13 and complained of pain to the right hip. R11 was sent to a nearby emergency room and was hospitalized with a suspected hip fracture although it was unfounded. Review of R11's plan of care addressing falls did not show the monitoring that should be done to prevent falls for R11. R11's care plan also did not show the type of transfer that should be performed on R11 such as 1 person, 2 person, mechanical lift, gait belt, etc ... Interview with E2 (Director of Nurses) on 3/28/13 at 3:00 p.m. noted E2 to say R11 should be transferred with a gait belt. Review of the facility's policy on Transfer Activities included steps in the procedure to: 1. Obtain assistance of another individual if necessary for safe transfer. 2. Place bed in position with the top of the mattress at the level of the wheel chair seat. 3. Apply transfer (gait) belt. 4. Hold the transfer belt from underneath, straighten your hips and legs slightly and lift the client to a standing position on the count of three. 5. Pivot on your foot farthest from the wheel chair and position the resident over the wheel chair seat. 6. Lower the resident into the wheel chair by fexing your hips and knees. (B)	F9999		