

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Healthbridge of Arlington Hts		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N Arlington Heights Rd Arlington Heights, IL 60004	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</p> <p>Based on observation, interview, and record review the facility failed to ensure a call light was within reach for a high fall risk resident which applies to 1 or 6 residents (R1) reviewed for safety in a sample of 16.</p> <p>The findings include:</p> <p>R1's Admission Record printed on 3/10/25 showed R1 is an eighty five year old female resident admitted to the facility with diagnoses which include post surgical amputation, reduced mobility, needing assistance with personal care, absence of left leg below the knee.</p> <p>R1's Fall assessment dated [DATE] showed R1 is at High Risk for Falling.</p> <p>On 3/10/25 at 11:50 AM, R1 was sitting in their wheelchair with the bedside table across them eating lunch. R1 stated she was admitted to the facility after having her left lower leg amputated after having blood flow complications in her leg. R1's call light was wrapped around the bed rail on the opposite side of the bed from R1. R1 stated she would not be able to reach that. R1 demonstrated by leaning towards bed. The call light was approximately 2-3 feet away.</p> <p>On 3/10/25 at 12:00 PM, V11 Certified Nursing Assistant stated R1 needs assistance with transfers to the wheelchair and toileting. R1 uses a sit to stand mechanical lift device for the transfers. V11 stated before you leave a resident's room their call light needs to be placed where they can reach it.</p> <p>On 3/10/25 at 12:10 PM, V2 Director of Nursing stated residents call lights should be placed with in the resident's reach.</p> <p>The facility's Call light Policy dated 9/2022 showed call lights need to be accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and the floor.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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