STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146179	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge of Arlington Hts	1200 N Arlington Heights Rd Arlington Heights, IL 60004

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure a resident received showers for 1 of 1 resident (R203) reviewed for activities of daily living in the sample of 14. The findings include: R203's face sheet printed on 5/8/24 showed an admitted [DATE] and diagnoses including but not limited to multiple sclerosis, quadriplegia, cervical disc disorder, and need for assistance with personal care. R203's facility assessment dated [DATE] showed no cognitive impairment or memory problems. The assessment showed R203 is totally dependent on staff for showers and bathing. The same assessment showed it is very important to R203 to choose between a bath or a shower. On 5/7/24 at 11:00 AM, R203 was lying in bed and covered up to the waist with a light sheet. R203's hair was greasy and uncombed. R203 stated he has not been offered a shower since he was admitted (18 days ago). R203 said staff have quickly wiped him down with peri wipes once or twice but that is about it. R203 said he has asked for a shower, but staff won't do it. R203 said he must use a bed pan for bowel movements and wants to be cleansed more frequently than just a wipe under the arm pits and buttocks. R203's bath schedule and bath sheets were reviewed from the day of admission on 4/19/24. The daily shower schedule showed Wednesdays and Saturdays as his scheduled shower days. Skin Observation Worksheets/shower sheets showed refusals on 4/20 and 4/24. The bed bath was given on 4/27. The dates of 5/1 and 5/4 were missing. (4 of the 5 scheduled days were missing showers or bed baths.) R203 was given a bed bath on 5/8, during the survey. On 5/8/24 at 9:39 AM, R203 and his wife stated he never refuses showers or bed baths. R203 said he is not even offered them, so how in the world could he refuse. R203 said he was shocked he got a bed bath today and that was the first one in quite a while. On 5/8/24 at 12:17 PM, V11 (Certified Nurse Aide) stated R203's wife visits almost every day and is aware of the care he gets daily. V11 said R203 is alert and fully aware of what is going on around him. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/24 at 9:11 AM, V16 (Registered Nurse) said residents should be receiving showers as they are scheduled, at least two times per week. If a resident refuses, they should be offered on the next day or when they prefer it. V16 said R203 has no memory problems and can express his wishes. On 5/9/24 at 9:30 AM, V2 (Director of Nurses) said all residents should be showered twice a week and as needed. they should be getting showered based on their preference. It is important for infection prevention, dignity, wound prevention, and feeling better about oneself. Good hygiene maintains overall good health. The facility's Activities of Daily Living (ADL) policy revision dated 3/2018 states: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure a physician ordered dressing was in place for a resident at risk for skin breakdown for 1 of 3 residents (R203) reviewed for pressure ulcers in the sample of 14. The findings include: R203's face sheet printed on 5/8/24 showed an admitted [DATE] and diagnoses including but not limited to multiple sclerosis, quadriplegia, cervical disc disorder, and need for assistance with personal care. R203's facility assessment dated [DATE] showed no cognitive impairment or memory problems. The assessment showed R203 is totally dependent on staff for showers, bathing, lower body dressing, and transfers. The same assessment showed R203 is at risk for developing pressure ulcers. R203's pressure ulcer risk assessment dated [DATE] showed a moderate risk. R203's order summary report showed an order start dated 4/23/24 for: Sacrum-cleanse with NS (normal saline), apply foam dressing every day shift every Tues, Thurs, Sat for protection. R203's care plan showed a focus area start dated 4/19/24 for risk for impaired skin integrity. Interventions included provide skin care per facility guidelines and as needed. On 5/7/24 at 11:00 AM, R203 was lying in bed and covered up to the waist with a light sheet. R203 stated he had a chronic sore on his backside for a long time and it has healed before he arrived at the facility. R203 said it was a stage 4 pressure ulcer. R203 said the nurses had been putting a thick bandage on the area to keep it from breaking down again. R203 said he has a catheter for urine collection, but he uses a bed pan for bowel movements. R203 said the nurses change the bandage sometimes but he was unsure how often. R203 said for some reason they haven't been doing it lately. On 5/8/24 at 11:56 AM, V9 (Certified Nurse Aide) and V10 (Physical Therapy Assistant) changed R203's brief and rolled him from side to side. R203's sacrum (upper buttocks) area was observed and there was no foam dressing present. The sacrum had a grapefruit size, circular reddened area. On 5/9/24 at 9:19 AM, V2 (Director of Nurses) stated R203 is at a high risk for skin break down. He needs the foam dressing on his sacrum to protect the bony area. The dressing should be monitored and in place at all times. Staff should report any soiled, wet, or missing dressing right away. It is important to prevent any future breakdown. V2 was asked to provide documentation of the dressing being changed as ordered. At 10:48 AM, V2 stated there was no record of the dressing changes being done. The facility's Pressure Ulcers/Skin Breakdown policy revision dated 4/2018 states: The physician will order pertinent wound treatments, including pressure reduction surfaces, .dressings (occlusive, absorptive, etc.) . The policy states: In addition, the nurse shall describe and document/report the following: d. current treatments, including support surfaces .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on observation, interview, and record review the facility failed to ensure a drainage bag was not laying on the bed, was kept below the level of the bladder, and a dignity bag was used to cover the drainage bag. The facility failed to ensure catheter tubing was not kinked or occluded. This applies to 3 of 3 residents (R287, R22, R190) reviewed for catheters in the sample of 14. The findings include: 1. On 5/7/24 at 9:44 AM, R287 was laying on her back in bed with her catheter tubing kinked and occluded under her right leg. There was cloudy yellow urine present in the catheter tubing. R287 stated she did not know why she had a catheter and has had it since she was in the hospital. On 5/08/24 at 1:34 PM, V2 DON stated there shouldn't be any kinks in the catheter tubing. The resident shouldn't be laying on the tubing because it can cause urinary retention. The urine needs to have good flow to get out and if it doesn't it can lead to a urinary tract infection and sepsis. It puts them at higher risk for infection. The Order Summary Report dated 5/8/24 for R287 showed diagnoses including chronic obstructive pulmonary disease, acute and chronic respiratory failure, myocardial infarction, hypertension, rheumatoid arthritis, type 2 diabetes mellitus, atherosclerotic heart disease, anxiety disorder, sepsis, acute and subacute endocarditis. R287 did not have a diagnosis for the use of the urinary catheter. The Care Plan dated 5/2/24 for R287 showed she has a urinary catheter. Check tubing for kinks during care and change position. The facility's Urinary Catheter Care policy (2022) showed check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kinks. 2. On 5/7/24 at 11:16 AM, R22 was laying on his back in his bed with the catheter drainage bag laying on his bed. V12 CNA (Certified Nursing Assistant) came into R22's room and stated she was going to get R22 up. R22's catheter drainage bag was pointed out to V12 who stated the drainage bag is not supposed to be in the bed for infection control. On 5/8/24 at 9:18 AM, R22 was sitting up in bed with drainage bag on lower side of bed that was visible from the hallway. There was a dignity bag hanging on his bed next to the catheter drainage bag. At 9:21 AM, V13 CNA came into R22's room and stated R22's catheter drainage bag should be covered because that is what his daughter requests. V13 stated R22's daughter wants the drainage bag covered when he is in bed and up in his chair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 1:34 PM, V2 DON (Director of Nursing) stated the catheter bag should always be below the bladder. V2 stated she recommends the dignity bags be used all of the time. There isn't a specific policy about it. The CNAs know to use the dignity bags. V2 stated the drainage bag should not be laying in the resident's bed; there is a risk of backflow of urine. It is also for infection control. The Urinalysis Report dated 5/3/24 for R22 showed a high amount of protein, white bloods cells, and bacteria present; trace ketones, positive for nitrite, moderate blood and leukocytes present. The Nurses Note dated 5/3/24 for R22 showed the urine culture and sensitivity report was received, had escheria coli present. The results were relayed to the physician and the resident was started on macrobid 100 mg twice a day for 7 days. The Face Sheet dated 5/8/24 for R22 showed diagnoses including traumatic subdural hemorrhage, cerebral infarction, paraplegia, osteomyelitis of vertebra, hypertension, urinary retention, and paroxysmal atrial fibrillation. The Care Plan for R22 dated 4/22/24 showed he has a urinary catheter. Position catheter bag and tubing below the level of the bladder and away from the entrance room door. The facility's Urinary Catheter Care policy (2022) showed position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 34891 3. R190's face sheet printed on 5/8/24 showed diagnoses including but not limited to corticobasal degeneration, Parkinson's disease, monoplegia of left upper limb, and dysphagia. R190's facility assessment dated [DATE] showed no cognitive impairment and dependent on staff for oral and personal hygiene. R190's order summary report showed an order dated 4/18/24 for a foley catheter due to urinary retention. R190's care plan showed catheter interventions including: Position catheter bag and tubing below the level of the bladder and away from entrance room door. On 5/7/24 at 10:09 AM, R190 was lying in bed and the urinary drainage bag was hanging on the bed railing. The bag was facing the doorway and fully visible from the hall. At 12:29 PM, the drainage bag was in the same position. On 5/8/24 at 9:50 AM, the drainage bag was still on the bed rail, uncovered and facing the door to the hall. At 10:27 AM, V11 (CNA-Certified Nurse Aide) performed catheter care for R190. The catheter stat lock (device used to secure and prevent tubing from pulling out) was not secure. The device was damp, curled under at the edges, and not attached to the thigh in any way. V11 laid the drainage bag on top of R190's feet and rolled her from side to side to change the incontinence brief. The tubing was pulling and tangled at her feet during the process. V11 emptied the drainage bag into a urinal and tapped the tubing against the edge. V11 reinserted the tubing into the bag holder without any sanitation or cleansing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/24 at 9:34 AM, V2 (Director of Nurses) stated the statlocks are needed to secure the tubing to the inner thigh. It is needed to keep if from kinking up or pulling out during care. Any statlocks that are soiled, wet or damaged should be reported and replaced immediately. Drainage bags should remain below the level of the bladder at all times to prevent backflow into the bladder. Infection and retention problems are a big potential for residents with catheters. Proper drainage bag technique includes keeping the tubing clean and uncontaminated. It should be sanitized if it touches anything. Privacy bags should be used to maintain resident dignity. The facility's Catheter Care policy revision dated 8/2022 states: 3 . Avoid splashing and prevent contact of the drainage spigot with the nonsterile container. The facility's Dignity policy revision dated 2/2021 states: 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure oxygen was administered at the physician prescribed rate for 1 of 1 resident (R192) reviewed for oxygen in the sample of 14. The findings include: R192's face sheet printed on 5/8/24 showed diagnoses including but not limited to chronic obstructive pulmonary disease, chronic diastolic heart failure, burns, left radius fracture, and hypertension. R192's facility assessment dated [DATE] showed supervision or touch assistance needed from staff for oral hygiene, toileting, showers, and personal hygiene. The same assessment showed no cognitive impairment. R192's order summary report shows a physician order start dated 4/27/24 for: Apply oxygen 2L/min (liters per minute) as needed to keep O2sat (oxygen saturation level) above 92% every shift for sob (shortness of breath). On 5/7/24 at 10:17 AM, R192 was seated in a wheelchair in his room. An oxygen line with the nasal cannula was inserted in his nose. The portable oxygen tank on the back of the wheelchair showed the level set at zero liters per minute (off). R192 stated he did not think the oxygen was running and was unsure if anything was coming out of the tubing. R192 said he wears it all day to help his breathing. At 12:34 PM, R192 was still in the wheelchair in his room. R192 was audibly wheezing and breathing in a labored manner. R192's oxygen was still set at zero liters. V8 (RN-Registered Nurse) was asked to verify the oxygen setting. V8 said it is not on at all and it is likely due to the therapy department turning it off earlier in the morning. V8 said R192 needs it set at two liters continuously or else he will desaturate (low blood oxygen level). V8 said R192 has breathing issues and the oxygen is necessary to keep his levels correct. On 5/9/24 at 9:07 AM, V16 (RN) said resident's oxygen should be set at the level ordered by the physician. Too low of a level can cause issues like labored breathing, shortness of breath, and heavy use of abdominals. Oxygen settings should be checked during all care. It is important to ensure it is at the correct level for resident safety and overall good health. On 5/9/24 at 9:32 AM, V2 (Director of Nurses) stated it is important oxygen is administered as ordered to prevent hypoxia, shortness of breath, or respiratory distress. Low oxygen levels can cause confusion, falls, and low brain function. The facility's undated Oxygen Administration policy revision dated 10/2010 states: 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 20042 Based on observation, interview, and record review the facility failed to honor a resident's food preference and find an appropriate alternative for 1 of 1 resident (R300) reviewed for food preferences in the sample of 14. The findings include: On 5/8/24 at 9:14 AM, R300 stated she got eggs this morning for breakfast. R300 stated she can't even stand the smell of eggs; it makes her sick to her stomach. R300 stated she keeps getting eggs for breakfast even though she told staff that she doesn't like them and is allergic to them. R300 stated she just eats the oatmeal that is sent up. On 5/8/24 at 9:25 AM, V13 CNA (Certified Nursing Assistant) stated, R300 is not allergic to eggs; she doesn't like eggs. V13 stated they bring her eggs, and she won't eat them; she usually just eats her oatmeal. V13 stated R300 was not the only resident that doesn't like eggs and doesn't want them. V13 stated there are other residents on the second floor that don't want the eggs. V13 stated they have called the kitchen to let them know R300 doesn't want eggs, but they don't listen. On 5/8/24 at 9:54 AM, V14 RD (Registered Dietician) stated everyone that comes into the facility she meets with and will go over the menu with them. V14 stated she obtains likes and dislikes, will put them in her progress notes and then lets the dietary manager know. V14 stated when a resident comes in, they are given an orange welcome bag with the menu in it, and she goes over the menu. V14 stated if there is something the resident doesn't like, she will suggest an alternative and then lets the dietary manager know. V14 stated she talked to R300 and gave an alternative to the kitchen for R300's eggs but she needed to follow up on that. The Week 1 facility menu (no date) showed on Sunday, Monday, Tuesday, Wednesday, Thursday, and Saturday eggs are served for breakfast. The Week 2 facility menu (no date) showed on Sunday, Monday, Tuesday, Wednesday, Thursday, and Saturday eggs are served for breakfast. The Face Sheet dated 5/8/24 for R300 showed diagnoses including type 2 diabetes mellitus, hypertension, acute kidney failure, and bacteremia. The Nutrition Form dated 5/3/24 for R300's admission on 5/1/24 showed she is on a carbohydrate controlled diet, has no known food allergies and dislikes eggs. The summary showed R300 is able to feed herself and verbalize food choices, which are provided. The Care Plan dated 5/3/24 for R300 showed, potential nutritional problem due to diagnosis of diabetes mellitus; therapeutic diet. Monitor tolerance of diet. RD educated guest on importance of adhering and reason for therapeutic diet. RD to evaluate and make diet change recommendations as needed. The facility's Food Preference policy (2021) showed, the food item requested by the residents will be provided as requested and in accordance with residents' diet orders. A designated person will monitor to make sure that food preferences are honored at all times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview and record review the facility failed to initiate Enhanced Barrier Precautions (EBP) for residents with an increased risk of contracting a Multi-drug Resistant Organism (MDRO) during high contact activities for 8 of 10 residents (R198, R292, R22, R287, R190, R301, R203, R291) reviewed for infection control in the sample of 14 and 7 residents (R29, R202, R30, R294, R204, R200, R201) outside the sample. The findings include: The facility Matrix provided on 5/7/24 showed the following residents had invasive medical devices and/or pressure ulcers: R287, R198, R291, R190, R202, R30, R301, R203, R201, R22, and R200. The facility's Wound Report dated May 2024 showed the following residents had chronic wounds (pressure ulcers, venous stasis ulcers, or diabetic ulcers): R198, R292, R29, R202, R30, R294, R204, R22, and R200. A facility wide tour was conducted on 5/7/24 and 5/8/24, the residents listed above did not have EBP signs on door, nor did they have an isolation cart with PPE (Personal Protective Equipment) outside their rooms. On 5/7/24 at 11:06 AM, R301 was in his wheelchair in his room. R301 had a below the knee amputation. R301 said he had a problem with his right leg for years. R301 said he had a history of infections in his legs that he was taking IV (intravenous) antibiotics for. R301 said the reason for the amputation was he had three infections in his leg and blood. R301 has a PICC (Peripherally Inserted Central Catheter) in his arm and an IV pump in his room. R301 said the facility had changed his stump dressing earlier today and the staff wore a mask and gloves. R301 said the staff never wore a gown during his care. R301's door didn't not have a EBP sign on it, nor was there an isolation bin with PPE supplies near R301's door. On 5/8/24 at 9:59 AM, R301 had IV antibiotics running into the PICC line in his left arm. V15 (Registered Nurse - RN) was at R301's bedside with a mask and gloves on. V15 said R301 gets antibiotics twice a day at 9 AM and 9 PM. V15 said R301 was on antibiotics for an infection in his blood and because of his recent amputation. V15 did not done a gown before providing care to R301's PICC line. R301 removed the IV tubing from R301's PICC line and placed a cap on R301's PICC line. R301's Face sheet dated 5/8/24 showed he was admitted on [DATE] with diagnoses to include, but no limited to: orthopedic care following a surgical amputation; acute osteomyelitis of right ankle and foot; acquired absence of right foot; Methicillin susceptible staphylococcus aureus infection; peripheral vascular disease; bacteremia (systemic infection of the blood); atrial fibrillation; reduced mobility; generalized muscle weakness; Charcot's Joint in right foot/ankle; history of brain cancer; major depressive disorder; and seizures. R301's facility assessment dated [DATE] showed he was cognitively intact and had central IV access. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R301's Physician Order Sheet (POS) did not contain orders for EBP. This document did show orders for an antibiotic (Vancomycin) IV every 12 hours for bacteremia and orders for PICC line maintenance. R301's Provider Note dated 5/8/24 showed R301 was admitted to the facility following a hospitalization for a right foot infection. This document showed R301 underwent a right below the knee amputation for chronic osteomyelitis and non-healing right foot ulcers. This document showed R301 was on IV Vancomycin for MRSA bacteremia. On 5/8/24 at 9:30 AM, V6 (RN) was preparing medications to administer through R198's G-tube (gastrostomy tube). There was not a EBP sign on R198's door, nor was there an isolation cart with PPE supplies. V6 prepared 16 medication cups for administration and entered R198's room at 9:50 AM. V6 explained the procedure to the resident, washed her hands and applied gloves. V6 did not put on a gown. R198 was in a bariatric air bed and had a G-tube to his abdomen. V6 leaned against R198's bed to check the placement of the G-tube, moved about his room, and administered each of the 16 medications cups. Each time V6 reached for the medication cups or fluid for flushing the G-tube her legs and abdomen came in contact with R198's bed. V6 administered R198's G-tube medications for the next 20 minutes and did not wear a gown the entire time. R198's Face sheet showed he had diagnoses to include, but not limited to: CHF (congestive heart failure), diabetes, Parkinson's disease, ischemic cardiomyopathy, severe chronic kidney disease, and gastrostomy (G-tube) status. R198's POS did not show an order for EBP. R198 had more than 20 medications ordered daily to be given through the G-tube. (R198's G-tube would be accessed numerous times throughout the day to administer these medications.) On 5/8/24 at 10:27 AM, V11 (Lead CNA - Certified Nursing Assistant) provided incontinence care, catheter care, and emptied R190's catheter. V11 was wearing a mask and gloves. V11 did not have a gown on during this care. R190's door did not have an EBP sign and there was not an isolation cart with PPE supplies outside the room. R190's Face sheet dated 5/8/24 showed diagnoses to include, but not limited to: corticobasal degeneration, Parkinson's disease, need for assistance with personal care, reduced mobility, dysphagia, anxiety, and contracture of left upper arm. R190's POS dated 5/8/24 had orders for an indwelling catheter, but no orders for EBP. On 5/8/24 at 11:56 AM, V9 (CNA) and V10 (PTA - Physical Therapy Assistant) provided incontinence care, rolled R203 from side to side in the bed, emptied his catheter, and transferred him with a mechanical lift. V9 and V10 did not put gowns on during this high contact care. R203's door did not contain a sign for EBP and there was not an isolation bin with PPE supplies near his door. R203's Face sheet dated 5/8/24 showed diagnoses to include, but not limited to: multiple sclerosis; infection and inflammatory reaction due to indwelling catheter; functional quadriplegia; anxiety; need for personal assistance with cares; reduced mobility; and generalized muscle weakness. R203's POS showed orders for an indwelling catheter, but no orders for EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146179	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge of Arlington Hts	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/24 at 2:46 PM, V3 (Infection Control Nurse) said the facility had a good supply of PPE. V3 said the facility used washable, white gowns and they would be kept in a bin outside the room, labeled, Clean gowns. V3 said the gowns are single use gowns and should be placed in the soiled laundry after each use. V3 said the facility may initiated EBP if a resident had a history of infections, especially MDRO's or was at high risk for infection with an MDRO. V3 said a EBP sign would be posted on the resident's door and the isolation cart and PPE supplies would be outside the resident's room. V3 said a resident isn't placed on EBP just because they have an invasive medical line, but if there were signs of infection at the site, then EBPs would be started. V3 said EBP are used to protect the residents and staff against MDRO infections. These practices keep everyone safe and prevents the spread of infections. On 5/9/24 at 10:29 AM, V2 (DON - Director of Nursing) said she didn't realize that residents with chronic wounds and residents with invasive medical devices needed to be on EBP. The facility's Enhance Barrier Precautions Policy dated 2022 showed, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation: 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of MDROs to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . 3. Examples of high-contact resident care activities requiring use of gown and gloves for EBPs include a. dressing; b. bathing/shower; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care . 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization . 9. Staff are trained prior to caring for residents on EBPs. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside of the resident rooms . The Centers for Medicare & Medicaid Services' QSO-24-08-NH Memo titled Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), showed effective 4/1/24, facilities must implement EBP. This document showed, .EBP are indicated for residents with any of the following: Infection or colonization with CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (i.e., Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility .