STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: _____ B. WING _____	C 11/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

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S 000	Initial Comments Complaint 1948549/IL117697	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to implement effective interventions, document fall investigations and provide increased supervision to prevent falls for two residents (R1, R2) reviewed for falls. This failure resulted in R2 falling and obtaining a fractured fibula (lower leg bone).

Findings include:

On 11/20/19 at 10:00 AM, R2 was in her room sitting in her wheelchair, attempting to get up by

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S9999	Continued From page 2	S9999		

herself. Surveyor turned R2's call light on and told V11, Certified Nurse Aide (CNA) R2 was trying to get up by herself.

On 11/21/19 at 9:40 AM, R2 was in her room, sitting in her wheelchair, her call light was not within reach. The call light was approximately 4 feet behind her on her bedside table. Surveyor told V7 CNA (R2) could not reach her call light and V7 went into room and put the call light next to R2 and asked R2, "Who wheeled you into the room?" R2 stated, "I don't know."

R2's Face Sheet, undated, documents R2 was admitted to the facility on 9/23/19 with diagnoses of Fracture of T11-T12 Vertebra, Fracture T5-T6 Vertebra, Stable Burse Fracture of Third Lumbar Vertebra and Urinary Tract Infection.

R2's Minimum Data Set, dated 9/30/19, documents R2's has moderately impaired cognition. The MDS documents R2 requires extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff person physical assistance for transfers, bed mobility and dressing. R2's MDS documents she requires extensive assistance of one staff person for personal hygiene.

R2's Care Plan, dated 9/23/19, "Problem: At risk for falls related to weakness, impaired mobility, balance, age, cardiovascular disease and history of falls prior to admit. High sided mattress as she swings her legs outside the bed." The Care Plan documents "Approach: Therapy as ordered for mobility. Keep personal items and frequently used items within reach. High sided mattress on bed to define bed boundaries. Fall risk assessment on admit and per protocol. Encourage to call for assistance as needed-easy operation touch light.

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S9999	Continued From page 3	S9999		

Call don't fall sign in room as a reminder to call for assist prior to getting up.

R2's Progress Note dated 9/25/19 at 4:55 PM documented "Guest found on floor next to bed sitting on bottom." The Note continued "Reviewed, with family present, importance of using call bell for assist before getting up. Guest verbalized understanding."

R2's Care Plan approach, dated 9/25/19 documented "Keep bed in lowest position when in bed, adjust height of bed as needed for care."

When requested, the facility was unable to provide a documented fall investigation for R2's fall on 9/25/19.

R2's Progress Note, dated 9/26/19 at 2:45 AM documented "Guest found trying to get out of bed again without assist earlier despite high sided mattress placed on bed prior to HS (at night) and bed low to ground." The Note documented R2 would be monitored closely and was on frequent bed checks."

R2's Progress Note, dated 9/27/19 at 4:43 AM documented "Guest found sitting on bottom next to bed on routine Q (every) 30min rounding." The Note documented "Guest cannot comprehend that she is not to get out of bed without help Guest cannot comprehend use of the call light for assistance."

R2's Care Plan Approaches, dated 9/27/19 documented "Keep in supervised areas as much as possible, 30-minute checks in room. Check for need to toilet at least every 2 hours on odd hours and as needed. Frequent rounding to check on needs."

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S9999	Continued From page 4	S9999		

When requested, the facility was unable to provide a documented fall investigation for R2's fall on 9/27/19.

R2's Progress Note, dated 9/29/19 at 3:55 PM documented "Had unwitnessed fall at 0100 (1:00 AM). Stated she was trying to get out of bed to look out of the window to see the thunderstorm. Pt (Patient) was not able to confirm or deny head injury. Upon assessment, no sign of head or extremity injury." The Note documented she was transferred with a gait belt back to bed with assistance of two staff persons.

R2's Progress Notes for Fall on 9/29/19 document, "Had another fall on 9/29/19 at 5:05 AM. When asked why she got up she said she didn't want to bother us by calling and she needed to go to the bathroom but repeatedly denied needing to void when she was rounded on. Patient hit her head pretty hard as the sound of her falling was heard from the hallway and she was found with her head under the wheelchair. Upon assessment, she had a pretty big closed head injury at the back of her head and her right ankle had become 3+ edema. Right ankle was painful to the point where it became non-weight bearing related to pain." The Note documented R2 was sent to local emergency department.

R2's Progress Note, dated 9/29/19 at 11:00 AM documented R2 returned from the hospital and all diagnostic tests were negative. The Progress Note documented "Guest encouraged to please call for assistance, do not try to get up alone for any reason."

R2's Progress Note, dated 9/29/19 at 5:24 PM, documented "Writer sitting at desk charting at this

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S9999	Continued From page 5	S9999		

time, heard 'thud' and call out for help upon arriving to (resident's room) guest is found on the floor once again on her back. Informed writer that she hit her head once again and that 'things were spinning currently." The Note documented R2's bed was in the low position, high side mattress was in place, touch call light was in place. The Note documented that R2 was once again informed she should not try to get up alone and the danger of the doing this without help and R2 voiced understanding.

R2's Care Plan Approaches, dated 9/29/29, documents, "Encourage activities of interest, assist in providing items. House calls. Do not leave unattended in bathroom."

When requested, the facility had no documented investigation R2's falls occurring on 9/29/19. There was no documentation the facility assessed R2 for the need for increased supervision.

R2's Progress Note, dated 10/1/19 at 6:45 AM documented R2 had multiple falls and sustained a bruise to the back of her head and was complaining of right foot pain. The Note documented the right foot was swollen and bruised. Progress Note at 8:51 AM documented V10, R2's Physician ordered an x-ray.

R2's X-ray results, dated 10/3/19 documented she had a right fibular (leg) fracture.

R2's Progress Note, dated 10/09/19 at 6:10 AM, documents "0610 found guest laying sideways on the side of the bed. Able to move extremities. Has bilat (bilateral) redness to her knees." The Note documented V10 was notified and ordered x-ray of both knees. R2's Progress Note at 2:05

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S9999	Continued From page 6	S9999		

PM documented the x-ray results showed no fractures.

When requested, the facility had no documented investigation of R2's fall occurring on 10/9/19.

R2's Progress Note, dated 10/20/19 at 10:37 AM documented "Nurse and CNAs (Certified Nurse's Aides) rounded on pt (patient) every 30 mins (mins) to an hour because of Hx of multiple falls. Reminded multiple times to call for needs. Rounded at 0300 (3:00 AM) and CNA found her on the floor in the bathroom. Pt did not attempt to call out for help."

R2's Fall Event investigation, dated 10/20/19 documented the root cause of R2's falls as "confusion: resident self transferred to bathroom." The Interventions listed on this Investigation was "frequent safety checks." The Investigation did not document how often "frequent checks" should be conducted to prevent R2 from falling in the future.

R2's Care Plan Approaches, dated 10/20/19 documented "Frequent safety checks."

R2's Progress Note dated 11/5/19 documented "Guest is (full body mechanical lift) to and from bed this shift, does continue to try to reposition self in chair and trying to get out of bed when in low position." The Note documented "will continued to encourage guest to use this and not try to get up w/o (without) assistance."

R2's Progress Note, dated 11/19/19 at 4:08 PM documented "Guest was observed on the bedroom floor in a sitting position against her wall."

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S9999	Continued From page 7	S9999		

When requested, the facility did not have a documented investigation of R2's fall on 11/19/19.

R2's Progress Note, dated 11/20/19 at 7:59 AM documented "guest found on the floor in her room next to the bed near her window."

R2's Progress Note, dated 11/20/19 at 11:35 PM documented "On rounding, guest found in bathroom on toilet. Had apparently ambulated in there independently. Assisted back to bed, tried to re-orient her to her surrounding but she remains pleasantly confused." The Note documented "will continue frequent rounding on guest." The note did not document how often "frequent rounds" were to be conducted.

On 11/21/19 at 3:10 PM, V2 Director of Nurses (DON) was asked if R2's interventions were working for her, V2 agreed they were not.

The facility Policy and Procedure for Falls, not dated, documents in part, "Purpose: To identify interventions related to the guest's specific risks and causes to prevent the guest from falling and try to minimize complications from falling." The Procedures documented "#4. The licensed nurse is responsible for completing a fall risk assessment following a fall as well as identifying and implementing relevant interventions to try to minimize serious consequences of falling. #5. The licensed nurse will complete a Fall Event as well as a Progress Note in the Electronic Medical Record, which provides as much information regarding the fall as possible." The Procedures continued "#7. If falling occurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. #8. If the underlying causes cannot be readily identified or corrected,

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S9999	Continued From page 8 staff will try various interventions, based on assessment of the nature of the falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable." (A)	S9999		