Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001168	A. BUILDING: ______ B. WING ______	C 11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEVIEW HEALTH CARE CENTER	8100 SOUTH HARLEM AVENUE BRIDGEVIEW, IL 60455

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S 000	Initial Comments Facility Reported Incident of 10/26/2019/IL117451 Licensure Violations	S 000		
S9999	Final Observations 300.610a 300.1210b) 300.1210d)6) 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

Section 300.1210 General Requirements for Nursing and Personal Care

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.

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to follow their policy to use a gait belt for a resident identified as a fall risk for one (R1) of three residents reviewed for falls. This failure resulted in R1 being taken to the emergency department and diagnosed with a subdural hematoma.

Findings include:

Emergency department trauma note dated 10/27/19 denotes R1 presented as trauma consult with subdural hematoma status post mechanical fall. R1 was admitted to the hospital. Hospital records dated 10/26/19 - 10/27/19 denotes: CT of the head performed. CT impression: left parietal and parieto-occipital scalp hematoma.

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R1's diagnosis include Dementia and history of repeated falls (03/01/19). R1's 10/26/19 fall report denotes: V6's(CNA) statement as "I was at the doorway of her room and V15(Nurse) was walking beside R1, V15 stopped at the nurse's cart when R1 passed the doorway. Both V15 and I called R1 to comeback. R1 tried to walk backwards and turn."

Fall Risk Evaluation dated 10/17/19 denotes: R1 as "At Risk, due to intermittent confusion, 1-2 falls in past 3 months, poor vision, balance problem while standing and walking, and decreased muscular coordination."

Physical Therapy Evaluation dated 10/10/19 by V14 (Physical Therapist) denotes: Reason for referral due to decline in functional abilities and increasing fall risk. Balance is poor."

R1's Functional Status Assessment dated 10/22/19 denotes: "Extensive assistance with one-person physical assist for transfers and locomotion on and off the unit. Extensive assist is defined as staff provide weight bearing support. Balance during transition and walking is denoted as not steady, only able to stabilize with staff assistance for moving from seated to standing position. as Activity for walking or turning around did not occur. Devices normally used: wheelchair, no walker.

On 11/19/19 at 11:10AM V16, Nurse, said we always use a gait belt on all one-person assist residents. V16 said she verbally reports when residents need devices and gait belts.

On 11/19/19 at 12:10PM V15, Nurse, said he was assigned to R1 on 10/26/19. V15 said he reported

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to V6, Certified Nursing Assistant (CNA), that R1 required 1 assist with transfers and walking. Before the fall V15 had seen V6 walking by R1 and then she was standing in R1's room's doorway. V15 said R1 had walked past her room and when she was called to come back she tried to turn and lost her balance. V15 said R1 hit her head when she fell. V15 said he is not sure if the CNA had her hands on R1 while R1 was walking. V15 said he cannot remember if V6 had a gait belt on R1. V15 said when R1 fell V6 was standing in front of R1 and not in the proper position to assist her. V15 said he saw a bump and could feel it was raised on the back of R1's head. V15 said R1 developed pain and was provided pain medication and ice to her head. V15 said he notified the Physician of the fall and current anticoagulation therapy and he was instructed to send R1 to the hospital for evaluation.

On 11/20/19 at 9:44 AM, V6 said she was walking along side R1 on 10/26/19 to take her to the bathroom. V6 said she had been assigned to R1 before. While walking to her room R1 had walked past her door, V6 said she called R1 to come back. V6 said she was standing by R1's door, and R1 was between her room and the next room. V6 said while R1 was walking back to the room she lost her balance, fell back, and hit her head. V6 said R1 was using her walker and she did not put a gait belt on R1. V6 said she has not had to use a gait belt while working in the facility. V3 said if she is told to use a gait belt or sees it in the care plan she will use it.

On 11/19/19 at 3:00PM V12, CNA, said if a resident has a sign with the letter "G" over the bed she is to use a gait belt. V11, CNA, said she only uses a gait belt if the transfer status is a "1

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and G" otherwise a gait belt is not used. V11 said V3, Restorative Nurse, trained her on the use of gait belts.

On 11/19/19 V18, CNA, said she uses the gait belt to assist residents with transfers and walking. V18 said she would hold onto the gait belt while walking with a resident and would not let go of the belt while walking.

On 11/19/19 V16 said gait belts are used on all one assist residents.

On 11/19/19 V17, Therapy Manager, said R1 was on caseload from 10/10/19 until 10/23/19. During this time R1 was not safe to walk on her own due to poor balance and poor standing ability. V17 said R1 required assist to stand and would not be able to safely stand and turn around without physical assistance from staff. V17 said for R1 she would recommend 1 assist to walk with hands on and the use of a gait belt. V17 said for safety she would not recommend walking in front of someone with balance issues.

On 11/19/19 V14 said she treated R1 10/10/19; 10/11/19; and 10/22/19. At the time R1 was discharged from therapy she required assistance from staff, needed encouragement, and told V14 in Philippine she was afraid of falling. V14 said she communicated with R1 in Philippine language because this is R1's primary language. V14 said when R1 was discharged from therapy she did not have the endurance to walk from the dining room to her room, and at times could only walk 10 feet. V14 said R1 had declined since the evaluation on 10/10/19. V14 said R1 was unsafe to turn around by herself. V14 said for safety R1 required one person, hands on assistance, walker, and use of a gait belt. V14 said R1's feet

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shuffled or hesitated, and she would fatigue while walking. V14 said R1 fluctuated in her ability to walk.

On 11/19/19, V3 Restorative Nurse said R1 had a history of falls prior to 10/26/19. V3 said on 10/26/19 R1 was ambulating to the bathroom with staff assistance, stumbled, and fell back before staff could catch her. The fall occurred in the hall outside of R1's room. V3 said she was not in the building when the fall happened. V3 said R1 had been declining and was recovering from pneumonia. The root cause of the fall on 10/26/19 was determined to be weakness and unsteady gait. V3 said V13, Restorative CNA, trains staff on transfer status cards and gait belt use. V3 said the CNA involved was from an agency and she does not train agency staff regarding resident care. V3 said the number "1" on a transfer card is used to identify residents who require extensive assist by 1 person and staff is expected to be hands on and use a gait belt.

On 11/19/19 V2, Director of Nursing, said as far as our understanding R1's subdural hematoma is related to her fall. V2 said residents at risk for falls include residents who have fallen in the past.

On 11/20/19 at 9:48AM V2 said agency staff is made aware of resident care needs verbally in huddles, shift to shift report, and bed side rounds. V2 said the agency does competency testing for their staff. V2 said all facility staff and agency staff is expected to follow facility policies. V2 said the restorative and therapy departments discuss resident's ambulation and transfer status and identify who needs a gait belt for transfers and / or ambulation.

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On 11/20/19, V13 said at orientation for facility staff she discusses gait belt use and the Resident Handling Policy. V13 said CNAs are instructed to have a gait belt on them at all times. V13 said all CNAs are issued a gait belt. V13 said it is not reasonable to expect a CNA to work a shift without a gait belt. V13 said she does not train any agency staff on the use of gait belts. V13 said she instructs staff that a transfer status of "1" and "G" require the use of a gait belt. V13 said a gait belt can be used at any time, not only when designated by "G" or "1".

On 11/20/19 at 10:30AM, V17 said on or before 10/26/19 R1 did not have contraindications for the use of a gait belt.

On 11/20/19 at 1:10PM, V2 said the Resident Handling Policy was revised in October 2019. The changes made included a new transfer category for a lift and the disciplinary action section, V2 said she does random checks for gait belt use, but none are documented. V2 said she has not disciplined any one related to gait belt violations.

On 11/20/19, V3 said it would not be reasonable for a CNA to work a shift without a gait belt being used. V3 said all CNAs are supposed to use gait belts including agency CNAs.

On 11/20/19, V10, Care Plan Nurse, said if asked about a resident's transfer or ambulation status based on review of the balance assessment, denoted on the Minimum Data Set section G0300, marked not steady then she would instruct CNAs to use hands on assist and a gait belt. V10 said a gait belt is used to guide or stabilize a resident.

On 11/20/19 V9, Nurse Practitioner, said she was

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S9999	Continued From page 7 following R1 due to her declining status. V9 said R1 had been declining cognitively, becoming weaker, and she determined her Dementia was progressing. R1 had negative results for any acute process contributing to her decline. Due to R1's declining status V9 said she was at increased risk for falls and based on the facility Resident Handling Policy, the best practice for safety would be to use a gait belt during transfers or walking. V9 said R1 did not have a contraindication for gait belt use on or before 11/19/19. V9 said some contraindications would include pelvic fractures, rib fractures, abdominal mass, and things that could be aggravated by the belt. V9 said being on a blood thinner would increase a resident's risk of developing a subdural hematoma. V9 said R1 did not have symptoms of a subdural hematoma prior to 10/26/19 and the fall is probably related to R1's subdural hematoma. V9 said R1's age and use of blood thinner increase her risk for complications related to subdural hematoma. V9 said the adverse risks of a subdural hematoma includes hemorrhage, loss of function, and death. According to nurse's notes dated 11/19/19, noted raised area on the back of her (R1's) head measured 2.5 centimeters in length and 1.5 centimeters in width. Gait Belt Policy(undated) denotes: Gait Belt usage is mandatory for all resident handling, except for bed mobility and medical contraindications. Fall Management Policy(undated) denotes: "The staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."	S9999		

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