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
	IL6000353	A. BUILDING: _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY SENIOR LIVING	111 EAST WASHINGTON BENSENVILLE, IL 60106

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S 000	Initial Comments Facility Reported Incident of 2/18/18/IL100563	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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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: 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 interview and record review, the facility failed to provide supervision and ambulation assistance to a resident identified as a high risk for falls and failed to keep common areas free of accident hazards.	S9999		

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This failure resulted in 1) R1 sustaining a intertrochanteric fracture of right hip and 2) R2 sustaining a partial acute non-angulated distal radial fracture of left elbow-hand.

This applies to 2 residents reviewed for falls/injuries in the sample.

The findings include:

1. On 2/26/18 at 10:45am, R1 was observed sitting in the D wing dining area. There was no staff around supervising R1. R1 was dozing on and off, rubbing her right arm and right thigh area. R1 was alert and oriented to only her name. R1 stated she could not recall her fall but knew there is pain in the right thigh area where she was intermittently rubbing. R1 stated, "I fell, but I can't remember what happened to me, You see my memory is bad". R1 was sitting in a wheelchair with her back turned to the television. On 2/26/18 at 4: 30pm, R1 was sitting in a wheelchair in her room with V10 and V11 (family members). R1 was half asleep. V10 stated R1 has not been the same since after her fall. V10 stated R1 has not been eating or drinking and has refused to do anything. V11 stated she flew in from another state when she heard R1 was not responding well. V11 stated it was difficult to even get R1 to take her medications in apple sauce. V11 stated R1 has refused to take even drinks from her. V10 stated he is concerned R1 is not eating or hydrating since after her fall and surgery. On 3/1/18 at 11:05am, V11 stated nothing has changed regarding R1's condition since hospitalization. That R1 has continued not to eat but drank little. V11 stated R1 was very agitated at the facility on 2/28/18 when she visited.

On 2/26/18 at 4:50pm, both V10 and V11 spoke

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to V12 (Nurse Practitioner) about R1's decline in physical and mental status and reduced appetite since the fall. V12 stated R1's blood will be drawn the next day. At 4:50pm, V12 stated it is a big concern that R1 is barely eating. V12 stated she was present at R1's lunch and she barely ate. V12 stated since this is a new development for R1, she would recommend some testing for R1.

The electronic medical record (EMR) showed R1 was admitted to the facility on August 1, 2016 with diagnoses that included bladder cancer, Alzheimer disease, constipation, skin cancer, osteoporosis and recently right femur fracture. R1's minimum data set (MDS) dated 2/6/18 showed R1 requiring limited assistance of one person physical assist with ambulation on and off the unit. R1's care plan dated 8/2/16 showed R1 is at risk for falls related to impaired cognition and impaired safety awareness. Interventions include: if resident appears tired, offer a nap". It also showed, "resident is supervision with transfers".

Facility's incident report dated 2/18/18 showed R1 had a fall on the way to main dining room while ambulating with the CNA. The report also showed, 'Nurse immediately assessed R1 and R1 complained of pain to right hip. Vitals taken and stable. MD notified with new order to send R1 to the ER for evaluation and treatment. 911 called. POA made aware. Called the hospital and R1 was admitted with intertrochanteric fracture of right hip".

On 2/27/18 at 9:04am, V9 certified nursing assistant (CNA) stated she started working at the facility as a bed maker in August 2017. She then completed her CNA course and started working on the floor as a CNA in mid January 2018. V9 stated she usually worked on units A and E. V9

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stated 2/18/18 was her first day to work on unit D, subsequently she was not familiar with the residents on unit D neither did she obtain report of the residents she took care of that day including R1. V9 stated she was instructed by one of the nurses on the unit to take R1 to the main dining area for dinner. V9 stated upon entering R1's room, R1 was sleeping so she woke R1 up and informed R1 she had to take R1 to the main dining room. V9 further stated R1 appeared 'woozy' when she got up. V9 stated when she got to the hallway with R1, R1 was pointing to the employee's lounge door, so V9 stated she asked R1 if she would like to be taken through the employee's lounge area (which is a short cut) to the main dining area. V9 stated R1 said yes and they proceeded. V9 stated she opened the employee's lounge door (fire door), held it for a few seconds and released the door. V9 stated R1 did not finish walking through the door before the door quickly slammed on R1's head and knocked R1 down to the floor. V9 stated she is seven months pregnant so she could not hold R1 back from falling. V9 also stated she did not use a gait belt while ambulating with R1. V9 stated while R1 was on the floor, R1 started crying. So V9 called the nurse. V9 started she has seen other staff taken residents through the employee's break room in the past. V9 stated she should have held on to the door longer for R1 to completely pass before letting go of the door. V9 stated there was no employee in the break room when the incident occurred. V9 stated on 2/20/18, she was informed by V14 (Human Resources Director) and V15 (scheduler) not to come back to work the next day.

On 2/26/18 at 4:15pm, V8 (Nurse) stated he was the nurse on duty when R1's incident occurred on 2/18/18. V8 stated he was in another resident's

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room when he heard another staff calling his name. V8 stated he ran to where R1 was lying inside the employee's lounge crying and confused. V8 stated he called 911 and sent R1 to the hospital. V8 stated he regularly works on the D unit and is very familiar with R1. V8 stated R1 was always a happy, slightly confused but pleasant resident prior to the fall.

On 2/26/18 at 11am, V4 CNA stated she is a regular CNA on D unit. V4 stated she knows R1 well. That R1 was sweet but confused and needs one person assist. V4 stated R1 used to walk around until after the fall.

On 2/26/18 at 11:05am, V7 CNA stated R1 used to walk the unit by her self prior to the fall, she just needs to be supervised.

On 2/26/18 at 11:30am, V5 CNA was supposed to care for R1 this morning but unfortunately she did not realize R1 was part of her assignment. V5 started working in the facility two weeks ago. V5 stated she did not get enough training prior to working so she did not know who to ask about her assignment. V5 stated she started her shift at 7am and has not performed any care for R1 and the other residents on the 5200 wing.

On 2/26/18 at 11:40am, V6 (Nurse) stated it is a problem that V5 does not know her complete assignment. V6 stated she shared V5's assignment with her at the beginning of the shift. V6 stated R1 is a sweet lady that walks around the unit with supervision.

On 2/27/18 at 9:50am, V3 (Restorative Nurse) stated taking R1 through the employee's lounge is not a normal route to the main dining area. V3 stated R1 should have been taken through the

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hallway to the main dining room. V3 stated the employee's break room is a non resident area. V3 further stated V9 should have used a gait belt prior to ambulating R1. On 3/1/18 at 10:40am, V3 stated R1 is automatically a high risk for falls due to previous fall history. On R1's fall risk assessment dated 2/18/18 where R1 received a score of 4.0. V3 stated the assessment did not reflect R1's status because R1 fell and should have received a higher score.

On 2/27/18 at 12pm, V21 CNA, stated it is a requirement for staff to have gait belts on residents that requires supervision. V21 stated R1 was able to do a lot prior to fall and was always participating in activities.

Review of R1's EMR showed V12's progress note on R1 dated 2/26/18 "..who suffered a mechanical fall at the facility prompting transfer to the hospital. R1 was with right intertrochantric fracture and underwent right intra medullary fixation of right hip 2/21/18. R1 was seen at lunch, 'not eating much', does not have appetite. Per nursing staff, R1 has been eating poorly". On On 3/1/18 at 11:05am V11 stated R1's appetite is still very

Review of R1's X-ray report dated 2/18/18 after the fall showed, "4 part intertrochanteric fracture of the right hip".

R1's EMR also showed R1 with falls on: 7/25/17: R1 had slipped in the hallway while been escorted to the dining room- No injuries noted.
On 3/2/17: R1 was observed sitting on the hallway floor next to her room. No injuries noted.
On 12/27/17: R1 was observed on the activity floor against a chair. R1 stated she fell off the chair". No injuries noted.

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Review of R1's physical therapy discharge summary dated 2/8/18 showed, "R1 performs ambulation 200 feet without assistive devices with standby assist.." On 3/1/18 at 11:24am, V22 (Rehabilitation Manager) stated R1 was recently discharged from rehab department 2weeks prior to the fall of 2/18/18. V22 stated residents that require a standby assist means someone has to be there to supervise their ambulation. The person must walk closely to the resident and have a gait belt on the resident to help catch the resident in case of a fall.

2. On 2/26/18 at 2:10pm, R2 was observed sitting at the nurses's station with the nurse. R2 has a left arm cast on. R2 stated she fell a few days ago but cannot remember how she fell. R2's EMR shows R2 was admitted to the facility 11/12/17 with diagnoses that included dementia, muscle weakness, scoliosis, breast cancer and hypertension.

Review of facility's fall incident dated 2/15/18, showed "Around 5:15pm, R2 was walking dragging her walker on her side and she tripped over the weighing machine in the small dining room in unit E and fell on her left elbow hit the machine". The report also showed that R2 had a skin tear which was bleeding, skin tear measured 7cm length and 3cm wide and another skin tear on the middle finger of her left hand measuring 0.5cm length and 0.5cm wide".

On 2/28/18 at 10:31am, V17 stated she was inside the E unit small dining area on 2/15/18 supervising about 10 residents including R2 when R2 fell. V17 stated R2 was done with her dinner, got up from her table and walked around other

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tables to socialize. V17 stated in the process, R2 had her walker side ways and she redirected R2 to put her walker in front of her. V17 stated she was standing by the door of the small dining area, putting the dirty dishes away when she noticed R2 falling over the weigh scale. V17 stated it was too late to catch R2 from falling into the weighing scale because it was quite a distance from her. R2 fell onto the weigh scale and landed on her left hand. V17 stated she called the nurse and it was noticed that R2's hand was bleeding.

On 2/28/18 at 9:25am, V16 (Social service Director/Manager memory unit) stated R2 has moderate to severe cognition loss. V16 stated R2 is able to ambulate with her walker. When asked about weigh scale in the small dining area, V16 stated the scale was being used by restorative aides and has been removed from the dining area.

On 2/28/18 at 1:23pm, V18 (Doctor) stated R2 always moves around confused. V18 stated R2' left wrist fracture was related to the latest fall she sustained. V18 stated R2 is high risk for falls that's why she is in the dementia unit". V18 stated she was not sure why weigh scale would be in the dining area.

Review of R2's EMR showed R2 with multiple falls at the facility: 1/9/18 report showed=R2 was walking, got exhausted and fell. 1/3/18 report showed=R2 was seen lying on her right side on the floor of her room. The report showed resident thought she rolled out of bed"..bruises noted elbow and left knee. 12/6/17 report showed=R2 was found on the floor. The report showed R2 wanted some cool air". R2's fall risk assessment dated 12/8/17 and 2/15/18 scored R2 as 11.0-high risk. R2's care plan initiated 11/20/17

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showed R2 enjoys walking in hallway yet does not seek exit.. and the intervention showed, "keep hallways as free of items as possible to prevent risk of fall".

R2's care plan also showed R2 is at risk for fall has dementia, gait is steady. The care plan also showed an intervention of: maintaining a clear pathway in room, free of obstacles. It also showed supervision when R2 is ambulating on the unit and in her room".

On 2/26/18 at 2:10pm, an observation of the small dining area was made. There was no weigh scale in the small dining area. V3, Restorative Nurse stated the weighing scale has been removed by the facility, stored away in another room and only brought out for use. V3 stated the weighing scale should not have been in the dining room as it constituted a fall hazard for R2.

R2's physician order sheet (POS) dated 2/17/18 showed, "abdominal binder every shift for pain in her left chest from the fall". Review of R2's medical diagnostic services dated 2/15/18 showed R2 with partial acute non-angulated distal radial fracture of left elbow-hand.

(A)