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 11/22/2022

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 Investigation of Complaints: 2278983/IL153180	S 000		
S9999	Final Observations Statement of Licensure Violations: 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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S9999	Continued From page 1 care needs of the resident. 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 observation, record review and interview, the facility failed to provide supervision for a resident with wandering behaviors and Dementia. As a result, R1 left the secured unit and eloped from the facility without facility knowledge. R1 was found by a bystander on the grounds of neighboring independent living complex near a high traffic area and the bystander notified emergency services. As a result, R1 was transported to the local hospital and was noted with a head injury and nasal fracture and required emergency medical treatment. This applies to 6 of 6 residents (R1 through R6) who were reviewed for supervision and safety from a total sample of 10. The findings include:	S9999		

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1. Face sheet shows that R1 is 69 years-old who was admitted to the facility on 10/12/22. R1 has multiple diagnoses which include maxillary fracture, left side, subsequent encounter for fracture with routine healing, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, generalized muscle weakness, other abnormalities of gait and mobility. Minimum Data Set (MDS) dated 10/19/22 indicates that R1 is cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 2. The same MDS indicates that R1 requires extensive assistance with walking and transfer and is totally dependent with mobility outside the unit. R1 resides in the secured unit of the facility that houses cognitively impaired residents.

On 11/9/22 at 11:25 AM, R1 was in the dining room, sitting, and waiting for lunch. R1 was awake but confused. R1 was able to respond to simple yes and no questions. R1's left periorbital area was swollen, with black, blue, and red discoloration, as well as his left cheek. The sclera or the white area of the eye was reddened from the trauma. R1 also showed the palm of his left hand at the base of his left thumb which was also bruised. R1 stood up and started to pace around the dining room. On 11/7/22, R1 was actively wandering.

On 11/10/22 at 10:55 AM, V1 (Administrator) showed where R1 was approximately found by bystanders. The area is in the ground of the neighboring independent living and is near a high traffic street. This was measured by V4 (Maintenance Director) to be 199 yards from the nursing facility.

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S9999	Continued From page 3 V10 (Certified Nursing Assistant/CNA) stated on 11/9/22 at 1:46 PM that R1 has dementia and has the tendency to wander and attempts to exit open doors. V10 added that on 11/07/22 R1 was being given medications by V7 (Nurse) in the dining room around 6:00 PM. V10 stated that when he returned to the dining area about 6:15 PM after giving care to another resident, R1 was not in the dining room. According to V10, R1 could not be located after checking the unit, R1's room and the bathrooms. V10 then notified V7 about R1's status. V10 did not know how R1 was able to leave the secured unit without anyone knowing. According to V10, R1 frequently attempted to open exit doors, but since R1 wears wander guard and the alarm is activated when R1 tries to leave. The unit staff then started looking thoroughly for R1 in all the bedrooms, bathrooms, and other rooms of the secured unit. V7 notified V2 (Director of Nursing/DON), and everyone started looking for R1. V11 (the other CNA) went outside the building but did not find R1. They checked the other units; they couldn't find him. Around 8 PM that same night, V7 (Nurse) informed V10 and V11 that the local hospital called to report that R1 was in the hospital. On 11/9/22 at 3:35 PM, V7 (Nurse) stated that V7 started the shift by making rounds and doing head count to make sure that everyone was present. According to V7, R1 was in and out of the dayroom and bedroom. V7 added that R1's family is very involved and visit every day during mealtime. On 11/7/22 at around 5:30 to 6 PM, V7 started checking the blood glucose level of the diabetics and administering medications to all scheduled residents. V7's medication cart was	S9999		

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just outside the dining area because she was passing medications (From observation, the dining area is in one of the inner corners of the secured unit. It has a short hallway and does not have a direct visual access to all the hallways and exit doors). V7 gave R1 his crushed medications, he spit it all out and walked away. V7 thought that R1 went back to his room which he usually does. R1's family left after dinner. Later, V7 looked for R1 to give him his uncrushed medications, and V10 approached and informed her that he couldn't find or locate R1. V7 stated that three of them (V7, V10, V11) started looking in the hallways, bathrooms, bedrooms, and other areas for R1 and called the supervisor. V7 added that since R1 could not be located, an amber alert was called, and all units were conducting a head count and searching for R1. V10 and V11 started to search for R1 outside of the facility but did not locate R1. V7 stated that R1 is a wanderer, he is a high risk for fall and elopement. He wears a wander guard in the right wrist. V7 could not explain how R1 was able to leave the unit without setting off the alarm.

On 11/9/22 at 4:05 PM, V11 (Nurse Aide) stated that on 11/7/22, prior to R1's elopement incident, R1 was with his wife who was visiting at that time. Around 6 PM to 6:15 PM that same evening, V11 was giving a shower to his resident, while V7 (Nurse) was outside the dining room passing medications. Then V10 (the other CNA) approached V7 and V11 and told them that R1 was missing. They checked all the bedrooms, and other rooms. V11 went outside and around the building, but he couldn't find R1. V11 stated that he had no idea how R1 got out of the facility.

V9 (Dietary Staff) was interviewed on 11/9/22 at 12:09 PM and stated that he and V15 (Dietary

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Staff) noted that R1 was outside the secure unit on 11/7/22 in the adjacent (unsecured) unit. V9 stated that R1 asked them for a cigarette. According to V9, V15 recognized R1 as being a resident from the secure unit so V9 and V15 notified two nurse aides that R1 was in their hallway. V9 added that the one nurse aide told him it was fine for R1 to be in unsecured unit as R1 was just going to "sit there". V9 then stated as V9 and V15 were returning to the kitchen they heard the alarm.

V15 (Dietary Staff) was interviewed on 11/14/22 at 9:30 AM and stated that on 11/7/22 between 6:15 to 6:30PM, the exit door to the secure unit was beeping. According to V15, the beeping means that someone passed through the door, and it did not close on time. V15 stated V15 put in the code for the door and opened the door to leave the secure unit and found R1 outside of the secure unit. V15 stated this was reported to the two nurse aides and a short time later the alarm went off. V15 added that one of the nurses came out and asked if anyone had seen a resident leave via the exit door.

V6 (Nurse) was interviewed on 11/9/22 at 1:09PM and stated that on 11/7/22 while passing medications about 6:00PM she heard the door alarm. V6 stated she asked the staff if they saw anyone leave and then conducted a head count. V6 added that all the residents on her unit were accounted for, and she then went and reset the door alarm. V6 stated that a few minutes later she was instructed to do another head count since R1 was missing. V6 was not informed by staff that R1 had been seen on her unit off the secure unit. V6 stated that if she had been informed of R1's presence on her unit, she would have returned R1 to the secure unit and notify the

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S9999	Continued From page 6 nurse. On 11/9/22 at 4:21 PM, V12 (CNA in the unsecured unit) stated that she was never notified that R1 was in their unit, or else she would have done something. When the alarm sounded, she was at the nurses' station. V12 didn't see anyone that was not supposed to be there except for the kitchen staff who passed by leaving with the carts. V12 did not see R1 in the hallway of their unsecured unit. When the alarm sounded, they did head count, and nobody was missing. V12 never spoke to the kitchen staff that time. On 11/9/22 at 4:30 PM, V13 (CNA) stated that she was working in the unsecured unit when she heard that someone was missing (R1) from the secured unit. When they heard it, they immediately did a head count. Prior to the sound of alarm, one of the kitchen staff (V15), asked if she knew the person (man), she noticed that there were three of them in the hallway. V13 did not know the third person, she was not sure if the person was a visitor, a staff, or a resident. V13 told V15 that she does not know the man. V13 added, she was busy at that time picking up trays. V1 (Administrator), V2 (Director of Nursing), R1's family members and facility maintenance staff all returned to the facility to look for R1. V2 then received a phone call from the local hospital to identify a person the hospital thought was the missing resident. R1's family went to the hospital to identify R1. The EMS/911 (Emergency Medical Services) documentation dated 11/7/22 shows: The EMS paramedics was dispatched to respond to a call with regards to someone bleeding. The paramedics arrived on scene with law	S9999		

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S9999	Continued From page 7 enforcement and met a man who has no identification and was placed under a name of John Doe (Who was later identified as R1). R1 was noted having a contusion above left eyebrow and with abrasions on both hands. The paramedics and the law enforcement were unable to find out what language R1 was speaking. There was no ID or information that could be gathered from R1. R1 made a motion to the paramedics which showed that he fell on the sidewalk. The paramedics also noticed a puddle of blood that R1 made a motion that it came from his nose. R1 was brought to the hospital for further evaluation. The EMS documentation of the timeline of service shows that they received a call on 11/7/22 at 6:26 PM. They arrived at the scene of incident at 6:35 PM. They begin to transport R1 to the hospital at 6:43 PM and arrived at 6:54 PM. Hospital Emergency Department (ED) record dated 11/7/22 shows that R1 was treated for Maxillary sinus fracture and injury of the head and left sinus with internal hemorrhage. Nursing Note dated 11/8/22 at 12:48 AM documents: R1 came back from the hospital at 11: 55 PM, after an elopement and a fall incident. The staff did a head-to-toe assessment and observed swelling and hematoma around the left periorbital area with abrasion and dressing on it. R1 had discoloration near to left side cheek above the left side lip measuring 1.5-centimeter (cm) X 1.0 cm. There were scratches on both knees without any deep injury. CT scan of the head results shows left periorbital hematoma and left maxillary sinus fracture. On 11/14/22 at 10:43 AM, V3 (Assistant Director	S9999		

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of Nursing/ADON) said that if a staff saw someone wandering in their unit and not sure if it's a resident or a visitor and that someone is not familiar to them, they should approach the person and ask question and redirect where this person is supposed to be.

On 11/9/22 at 4:41 PM, V2 (DON), stated that there were 3 staff in the secured unit who were working at the time of R1's elopement. These staff were V7 (Nurse), V10 (CNA), and V11 (CNA). On the day of the incident, V2 arrived at the facility approximately past 7 PM to help search for R1. V2 was searching outside the building, and at the same time communicating with V1(Administrator) who was also looking for R1. She later received a call from V1 and informed her that the assisted living received a call from the local hospital. R1's family was in the facility at that time, and they went to the hospital to identify R1.

On 11/15/22 at 11:44 AM, V5 (R1's Physician) said that if a resident who is cognitively impaired is identified as a high risk for elopement and fall then he should be in a secured unit and be closely monitored for safety.

Admission notes dated 10/12/22 documents, R1 has a history of dementia, he was unable to make needs known. According to family R1 wanders in the room and is a high fall risk. R1 was unable to use the bathroom, he needs 1:1 always monitoring.

Nurse Practitioner notes dated 10/13/22 documents that R1 has dementia and has history of suicide attempt. R1 has decreased mobility, poor strength, muscle atrophy, all extremities examined. R1 with severe dementia, confuse.

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S9999	Continued From page 9 Social Service Note dated 10/19/2022 documents: R1 can express himself and understand in his native language and simple English phrases. R1 will push on unit door yet easily redirects. R1 wears wander guard as a precaution. Restorative Notes dated 10/27/22 documents: R1 is at risk for fall due to impaired functional mobility, unsteady gait, impaired cognition, and increased weakness. R1 will be assisted with activities of daily living (ADL) care as needed and all efforts will be praised. The protocol in monitoring high risk for elopement resident, is that a staff is supposed to be present in the hallway to monitor. To make sure no one goes to other people's room or try to escape through the exit door. When the nurses pass medications, they help monitor the hallway. The staff usually make unit rounds every 2 hours. R2 through R6 are residents who are on the list of the facility's elopement risk. Per documentation from the progress notes, assessments, MDS and care plan, R2 through R6 were identified as cognitively impaired, ambulatory, and displayed elopement risk behavior. These 6 residents can be potentially affected with the facility's failure of adequate supervision. Facility's Elopement and Search Policy and Procedure dated February 2014 indicates: Policy: To establish methods for protecting residents who are at risk for elopement and for conducting an organized search for a resident who cannot be located.	S9999		

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S9999	Continued From page 10 Policy Specifications: 1. All nursing personnel are responsible for: a. Knowing the whereabouts of resident for which they are assigned. c. Staff are responsible for keeping the nurse informed of a resident's whereabouts. 7. All staff are responsible for promptly going to the location and determining the cause of the activated audible alarm. 14. All facility staff will be informed of residents at elopement risk. (A)	S9999		