PRINTED: 07/27/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	IL6001168	B. WING	C 06/16/2023	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PAVILION OF BRIDGEVIEW, THE

8100 SOUTH HARLEM AVENUE BRIDGEVIEW II 80455

100		IEW, IL 60	155	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments	S 000	See 201 129 A	
52	Facility Reported Incident of 5/27/2023/ IL160485	18 ₈ 8	, ** \$ 58.0	1.0
S9999	Final Observations	S9999		
	Statement of Licensue Violations	1177		
	300.1210b) 300.1210c) 300.1210d)6)	~	1 H 7 2 7 2 1	
8	Section 300.1210 General Requirements for Nursing and Personal Care	ş4		a '}y 8-3
	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 care needs of the resident.			
	c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	2. 63		
	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:			and the second
юс н И	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		Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	æ	IL6001168	B. WING		C 06/16/2023		
NAME OF				STATE, ZIP CODE			
PAVILIO	N OF BRIDGEVIEW, T	IME	JTH HARLEN IEW, IL 604				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE
S9999	Continued From pa	age 1	S9999	N.S.			
	that each resident r and assistance to p	receives adequate supervision prevent accidents.					20
<u>(i)</u>	These requirements by:	ts were not met as evidenced				ž.	
2	review the facility fa incontinence care to staff members prov resulted in a reside resulted in a five da		, , =				
	The findings include	e:	121	III			0 322
\$ 1 \$ 2	is a 71 year old mal but are not limited to protein calorie maln respiratory failure, a deficit following non hemorrhage, anemal the brain, encephal	cord dated 6/16/23 shows he ale and his diagnoses include, to, Alzheimer's disease, severe nutrition, type 2 diabetes, acute attention and concentration n-traumatic subarachnoid lia, heart disease, disorder of lopathy, cerebral infarction, mental status, and anxiety.	(10				# 18 07 #
3	shows R1 is not cog extensive assistant members for bed m	a Set (MDS) dated 5/8/23 gnitively intact and requires ce by two or more staff nobility (how a resident moves osition, turns side to side, and e in bed).	5	55		2	
	shows R1 is blind, if anticoagulant (blood therefore, should av	Plan provided by the facility hard of hearing, and is on of thinners) therapy and void activities that could result accare plan shows R1 has an				ş	

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9e 172.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		₩.		55] ,	C	
		IL6001168	B. WING		06/	16/2023	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, 9 I TH HARLEN	STATE, ZIP CODE			
PAVILIO	N OF BRIDGEVIEW, 1	ME	IEW, IL 604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
S9999	Continued From pa	ige 2	S9999	=	file op		
200		t and requires extensive staff to turn and reposition him	.351	8		-	
	shows R1 has an of (anticoagulant) to be to (4/25/23) and aft (5/31/23) for his he Summary from the	eview Report dated 6/16/23 order for Apixaban be given twice a day both prior er R1 was hospitalized ad injury. R1's After Visit hospital dated 5/31/23 shows of from 5/27/23 to 5/31/23.					
	5/31/23 from the hold admitting diagnose hemorrhage for wh 5/27/23. The FTR is the hematologist with being "subdural heatherapy." The FTR Attending Note whitill and at high risk of acute subdural heatherapy of the brain CT scan white from prior study 4/2 frontoparietal hypering administration of the hemory of	fer Report (FTR) dated ospital shows R1's hospital shows R1's hospital ich he was admitted on includes a consult note from ith the reason for consultation matoma on anticoagulation includes a Neurocritical Care ich shows, "Patient is critically of clinical deterioration due to natoma." The FTR includes a ich shows, "Impressions: New 20/23, a subtle small right redense extra-axial fluid ely subdural hematoma."					
	7:12 AM shows "Up resident was being in bed to be change and bumped his he further observation reddened area to ri Health Status Note shows, "Resident was	nt Note for R1 on 5/27/23 at con CNA during rounds cared for and was turned over ed and was turned to (SIC) far ad against the siderail, with resident noted having ght side of head." The facility's for R1 on 5/28/23 at 12:59 AM was admitted to hospital with osis) right frontal subdural					

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6001168 06/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8100 SOUTH HARLEM AVENUE **PAVILION OF BRIDGEVIEW, THE BRIDGEVIEW, IL 60455** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 On 6/16/23 at 9:28 AM, R1 was lying in his bed with his left leg hanging off the edge of the bed and his head about a third of the way down from the top of the bed. There was a sign above R1's head of bed showing R1 is blind and wears hearing aids. R1 was unable to engage in a conversation or answer questions. On 6/16/23 at 9:38 AM, V15, CNA, was observed as she provided incontinence care, including turning and positioning, to R1 without any other staff assistance. On 6/16/23 at 9:44 AM, V16, Licensed Practical Nurse (LPN), said R1 requires total assistance with his care. On 6/16/23 at 11:32 AM, V13, Certified Nursing Assistant (CNA), said she was providing incontinence care for R1. V13 said she turned R1 on his side and he jolted forward and hit his head on the side rail, so she went and got the nurse to assess him. When the nurse was finished, V13 finished cleaning R1 and was lowering R1's bed and the fan fell over and hit R1 on his head in the same area where he had just hit it on the side rail. V13 said there was a red area on R1's right temple area. V13 said she was providing R1's care by herself. V13 said R1 needs two people to do his incontinence care because he moves around a lot, but no one was helping her. On 6/16/23 at 11:17 AM, V14, LPN, said she was the day nurse the morning after R1 hit his head. V14 said R1 had a hematoma to his right frontal forehead. V14 said she told V2, (DON) Director of Nursing, that R1 was taking blood thinners and V2 recommended they send R1 to the hospital.

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STATE FORM

PRINTED: 07/27/2023 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C IL6001168 B. WING_ 06/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8100 SOUTH HARLEM AVENUE **PAVILION OF BRIDGEVIEW, THE BRIDGEVIEW, IL 60455** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 4 S9999 (A)

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