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 03/07/2024

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

(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 Complaint Investigation: 2471591/IL170239	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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	S9999		

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S9999	Continued From page 1 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. 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 requirements are not met as evidenced by: Based on interview and record review, the facility failed to have fall prevention interventions in place for a resident at risk for falls. This failure resulted in R1 falling out of bed and sustaining a subdural hematoma. This applies to 1 of 3 residents (R1) reviewed for accidents. The findings include: The facility's January 19, 2024, Final Serious Injury Incident and Communicable Disease Report documented the following: "CNA [Certified Nurse Assistant] notified the nurse on duty that R1 was noted on the floor by her bed. R1 stated that she was trying to get something off her table when she tipped over and fell from the bed. R1 was observed with a hematoma and bleeding to	S9999		

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S9999	Continued From page 2	S9999		

the left side of the head." Report showed, "Root Cause: Per R1, she was trying to get something from her table when she tipped over and fell from her bed. R1 possibly hit her head on the bedside table causing the hematoma to left side of head." The Report did not mention that a fall mat was in use at the time of R1's fall.

The facility's January 14, 2024, Post Fall Evaluation Assessment from 4:00 AM which includes questions and checkboxes showed, "Floor mat on floor? No." It also showed "Was fall witnessed? No." and "Was Resident wearing oxygen as prescribed at time of fall? No." R1's November 13, 2023, Risk for Falls Assessment showed R1 was at risk for falls.

On March 1, 2024, at 10:52 AM, V4 (LPN/Licensed Practical Nurse) said she worked the 11 PM to 7 AM shift on January 14, 2024, and was the nurse caring for R1. V4 said she was called to the room by the CNA (V5) and upon entering the room, saw R1 on the floor. V4 said there was blood all over the floor and the fall mat was either standing up or against the wall. V4 said she did not believe the fall mat was in place because there was blood on the floor and not on the fall mat.

On March 1, 2024, at 11:08 AM, V5 (CNA) was called, and a voicemail left requesting a return call. As of March 6, 2024, at 9 AM, V5 had not return the surveyor's call.

On February 28, 2024, at 08:28 AM, V17 (R1's Family Member) said that on January 14, 2024, around 4 AM, R1 fell out of bed and hit her head and went to the hospital. V17 said there were supposed to be mattresses alongside the bed and if there were, she would not have hit her

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S9999	Continued From page 3	S9999		

head and had a brain bleed. V17 said R1 needed surgery and ended up becoming unconscious and died on February 1, 2024. V17 said R1 had prior falls and was dependent on the staff to get her out of bed as she was bedridden.

R1's December 6, 2023, care plan showed R1 was at risk for falls related to impaired functional mobility due to weakness and contractures to bilateral lower extremities. R1's care plan goal showed R1 would have no injuries from a fall. R1's fall prevention interventions include on February 4, 2023, and November 13, 2023, place floor bed with floor mat when resident is in bed and on May 2, 2022, to keep needed items, water, etc. in reach. On May 20, 2022, staff were to frequently check resident at night and on May 2, 2022, to have the call light within reach.

On March 5, 2024, at 02:48 PM, V6 (R1's Physician) said R1 was an elderly woman with dementia, who was generally deconditioned. V6 said R1 was at a high risk for falls and measures including low bed with the mattress on the floor were initiated. V6 said the floor mat should have been there as she had previously had a fall in November of 2023. V6 said if R1 was bed bound, she should have had a fall mattress. R1's progress note dated November 13, 2023, at 07:24 AM showed, "At approximately 2:30 am, the resident was noted on the floor."

R1's face sheet showed R1 was admitted with diagnoses including multiple sclerosis, generalized muscle weakness, lack of coordination, cognitive communication deficit, contracture of muscle, left lower leg and right lower leg, unsteadiness on feet, need for assistance with personal care, and abnormal posture. R1's MDS (Minimum Data Set) dated

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S9999	Continued From page 4 November 21, 2023, showed R1 had moderate cognitive impairment. R1 required partial assistance from staff for bed mobility and was dependent on staff transfers. R1's MDS also showed R1 had no impairment with her upper extremities. R1's January 15, 2024 [History and Physical] CT Brain or Head showed " ...Conclusion: Large acute on chronic left frontal, parietal and temporal subdural hematoma measuring up to 2.1 [centimeters]." R1's [Emergency Department] Provider Notes showed "[Computed Tomography of Head] performed. I personally interpreted the images- Large [Left Subdural Hematoma] with midline shift. On exam, [R1's] mental status is similar, though slightly slower to respond. [Left] pupil now lightly larger than the [Right]..." The facility's Falls- Clinical Protocol policy (revised August 2008) showed Based on the preceding assessment, the staff and physician will identity pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling ...Causes refer to factors that are associated with or that directly result in a fall ...Frail elderly individuals are often at greater risk for serious adverse consequences of falls. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented." (A)	S9999		