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
	IL6016794	A. BUILDING: ______ B. WING ______	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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 1842139/IL101548	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.2210a) 300.2210b)1 300.3240a) 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	

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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 300.2210 Maintenance

a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies.

b) Each facility shall:

1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards.

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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, observation and record review, the facility failed to ensure that safety measures including secured side rails, adequate supervision, safe positioning in bed and assistance were implemented to prevent falls from bed for 6 residents (R3, R4, R5, R7, R8, R9) reviewed for fall prevention. This failure resulted in R3 falling from bed sustaining Bilateral Subdural Hematomas.

Findings include:

1. R3's Admission Sheet identifies her as an 84 year old female admitted to the facility on 01/08/18 with diagnoses of Cerebral Vascular Accident (CVA) with left hemiplegia.

The Minimum Data Set (MDS), dated 01/14/18, identifies R3 to have short/long term memory loss with severe cognitive impairment. The MDS documents R3 requires extensive assist of two staff for bed mobility and transfer.

The care plan, dated 01/08/18, identifies R3 to have the potential for falls due to weakness, impaired mobility, balance, hemiplegia, age, self-transfer attempts, cognitive deficits and history of falls. The Goal is to have no falls with interventions being: high sided mattress (03/23/18), keep in lowest position (03/23/18),

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Call don't fall sign in room as a reminder to call for assistance and do not attempt to reposition self, fall risk assessment per protocol, and keep personal items and frequently used items within reach, encourage her to request assistance to reach items if needed all dated 01/08/18. The Care Plan identifies R3 to have been readmitted to the hospital on 03/30/18 and remains at risk on readmission.

On 04/04/18 at 11:45 AM, R3 was in bed with her side rails in up position. She had a scoop mattress, but her bed was not in low position. R3 was lying flat. She had bilateral blackened eyes and bruising down the right side of her face. R3 spoke slowly, but was cooperative as she was rolled to the right by V10 and V11, Certified Nurse Aide (CNA), with no problem. R3's left arm and leg are flaccid. R3 moved her right leg out to the right during bed mobility, but made no attempt to assist staff.

The EHR (Electronic Health Record) Progress Notes, dated 03/22/18, entered by V5, Registered Nurse (RN), documents at 2050 (8:50 PM), R3 was "on the floor left side of bed with her head toward the head of the bed, Range of Motion (ROM) WNL (Within normal limits)" noting that R3 was already flaccid on the left side. The note documents R3 to have a hematoma right side of the forehead and after contacting the physician, was sent to the emergency room (ER) for evaluation due to her being on anticoagulants. The progress note documents R3 returned to the facility on 03/23/18 at 1:30 AM with negative X-rays noted.

The EHR Progress Notes dated 03/26/2018 at 16:12 (4:16 PM), documents, "Called into guest's room by PCA (Personal Care Assistant), Guest

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vomited approximately 150 ml (milliliter) red tinged fluid. Guest c/o (complained of) pain in chest. Called daughter (V12) who would like guest evaluated at ER. (Local Ambulance) called, upon their arrival guest had an additional 250 ml of red tinged fluid. Guest transferred to stretcher and transported via ambulance." The EHR Progress Notes, dated 3/26/2018 at 22:38 (10:38 PM), documents, "Per ER charge nurse," guest is being admitted to ICU (Intensive Care Unit) for bilat (bilateral) subdural hematoma and GI (gastric-intestinal) bleed. The Progress Notes document R3 returned to the facility on 3/30/18 and was placed on Hospice.

The facility's Event Report documents under Evaluation for the fall on 3/22/18 as "It is the conclusion of the facility that R3 slid off bed onto the floor on her left side" and a High sided mattress with bed in low position when occupied being implemented as a result. There is no explanation as to how R3 slid off the bed given that she requires extensive assist of two staff for bed and transfer mobility and the investigation fails to reflect where in the bed R3 was just prior to the fall or if the hand rails were up and functional.

The Hospital History and Physical, dated 3/26/18, documents R3 to have "Extensive bilateral acute subdural hematomas at the cerebral convexities, with smaller acute subdural hematomas in the interhemispheric fissure and along the tentorial leaflets. There may be epidural components to the hematoma at the right front convexity. The hematomas are new since prior CT (computed tomography) from 4 days earlier. Largest extra-axial hematoma measures up to 3 cm (centimeters) in-depth. There is mild mass effect on the underlying cerebral hemispheres, with 4

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mm (millimeters) of leftward shift of the septum pellucidum." The impression documented "83 year old female with fall 3 days ago, now with large bilateral subdural hematomas."

On 04/04/18 at 1:09 PM, V12, R3's daughter/Power of Attorney (POA), stated the day before R3 fell, she had thrown her right leg over her left leg, but was unable to turn over due to her being centered in bed. V12 stated she was told that a new staff named V7 (CNA) was taking care of her mother the evening of the fall and did not check on her every hour as she should have. V12 stated she has at times come in and found R3's grab/hand rail on the bed not secured causing it to swing out so she had concerns with that if they are rolling her into it, she would fall. V12 stated R3 had only one other fall at the facility last year during a prior admission when R3 was rolled off the bed during care by a staff member. V12 could not recall the date or the staff member. V12 stated staff is aware that the rails don't always latch.

On 04/04/18 at 1:20 PM, V10, CNA, stated she's worked with R3 for the past year off and on and knows she will throw her right leg out of bed on the right side, but has never known her to try to get up unattended. V10 stated the bed rails "sometimes won't lock... you have to be sure you check them because they will swing out if you don't lock them." V10 stated she has had to call maintenance a few times to have the rails repaired because they don't secure in place. V10 stated if R3 "is centered on the bed, she's not going anywhere." V10 recalled R3 telling her she was looking for her keys when she fell on 03/22/18, but acknowledged that she is confused.

On 04/04/18 at 3 PM, V5, RN, who was working

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when R3 fell on 03/22/18, stated she had just been in R3's room giving her medication. When asked how R3 was positioned in bed, V5 stated R3 was on her left side, "maybe a little too close to the side of the bed". V5 stated she left R3's room after giving her medication and heard her say "Ohhhhh." When she went back into the room, R3 was on the floor with her head toward the top of the bed. V5 stated she thinks R3 hit her head on the bedside chest then on the wall. V5 stated she checked her out and got the CNAs (V6 and V7) to help put R3 back in bed. V5 stated when she went to move the side rail out so they could move R3 into the bed with the full body mechanical lift, she noted the rail was not secured in place and swung out easily. V5 stated she did not tell anyone about the rail being unsecured and no one interviewed her about the fall after the occurrence. V5 stated she was unaware of who the last person was to see R3 in bed. V5 stated she wanted R3 to be evaluated due to the fact that she was receiving both Lovenox and Coumadin 4-6 mg, blood thinners. V5 stated she doubted had the rail been secured, that R3 would have fallen from the bed.

On 04/04/18 at 2:30 PM, V6, CNA, stated if R3 is centered in the bed, she isn't going anywhere. V6 stated she was surprised that R3 fell as she never attempts to get up from bed unattended. V6 stated she recalled R3's prior fall last year and stated a CNA was rolling her over and rolled her out of bed onto the floor.

On 04/04/18 at 2:55 PM, V7, CNA, that worked the night of R3's fall on 03/22/18, stated she couldn't recall when she had last seen R3, but remembered when they went into the room to help put her back to bed, R3 was lying with her head toward the head of the bed. V7 estimated

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that it had been at least 2 hours since she had last seen R3 that night. V7 stated she has had trouble getting the bed rails to secure in place at times too.

On 04/04/18 at 11:30 AM, V9, Care Plan Coordinator, stated she just added the attempts to get up on her own after R3's fall on 03/22/18, adding that she's never known her to do that. V9 stated she revised the care plan to include low bed and scoop mattress after her fall as well.

There is no evidence the facility adequately identified the root cause of R3's fall and failed to identify that the side rail was not secured in place at the time. The facility also failed to determine if R3's position in bed was appropriate just prior to the fall. There is no documentation or revision within the care plan that addresses the need of the CNAs to ensure the rails are adequately secured, R3 is properly positioned in the center of the bed and adequate supervision is done.

On 04/05/18 at 8:40 AM, when asked about the hand rails not securing, V13, Licensed Practical Nurse (LPN), stated she will "occasionally have people complain about the bed rails not latching, but never (R3)." V13 stated the rails are functional, but have to be latched properly or they will swing out.

An Event Report completed by V13, LPN, documents under Notes, "03/22/18 at 23:27 (11:27 PM) Guest had a fall from bed but writer did not witness. Per PCA, guest did not hit her head and slid off the bed onto her knees. Guest knees do show signs of redness from the fall but skin is intact. All other skin is also intact to her feet. Per family request, X-rays have been ordered for LUE (left upper extremity). The report

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documents under Evaluation "It is the conclusion of the facility that (R3) fell from bed to floor. 2 person assist for bed mobility and high sided mattress" to be implemented as a result of the fall.

On 04/05/18 at 8:40 AM, V13, LPN, stated the CNA, V18, who no longer works at the facility, called her into the room and R3 was on the floor. V13 stated V18 told her "she rolled her to her weak side and she rolled out of bed." V13 stated she thought R3 was "bottom heavy" as she landed on her knees with her head on the bed. V13 stated she fell on her weak side so she couldn't use her hand to grab the rail. V13 remembered both hand rails being up at the time of the fall.

There is no evidence the facility identified the root cause of the fall as being improperly positioned prior to rolling her to the side.

2. On 04/05/18 at 9 AM, R5 who was identified on 04/04/18 as being interview able by the facility, stated she has had her rails not be secured when she went to use them so she "knows better now to make sure they are secured" before she grabs them to move herself.

3. On 04/05/18 at 9:17 AM, R7 also identified by the facility as interview able on 04/04/18, stated she has had them be loose when she's grabbed them, but the facility has "fixed" the problem and she hasn't had any other incidences where they weren't secured.

4. On 04/05/18 at 8:55 AM, R8's bedrail on her right side was not secured in place.

5. On 04/05/18 at 8:58 AM, R9's rails on both

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S9999	Continued From page 9 sides were not secured, but appeared to be in the correct position. At that time, V17, CNA, was told of the rails not being secured at the time for R8 and R9. V17 stated she didn't know that. At 9:20 AM on 04/05/18, V13 stated both R8 and R9 definitely use their side rails for mobility both for bed and transfer and the rails need to be secured at all times. 6. R4's MDS, dated 09/06/17, identifies him to have no deficits with short term memory, but deficits with long term memory. The MDS also documents R4 to require minimal assist of one staff for bed mobility and transfer. The care plan, dated 8/31/17, documents R4 to have a potential for falls due to weakness, impaired mobility, balance, age and self-transfers. The goal is to improve to a safe level of independence and will have no injuries. Interventions include assist to toilet upon request, Call don't fall sign in room as a reminder to call for assist prior to getting up, encourage to call for assistance as needed, provide reminders, keep personal items and frequently used items within reach and therapy as ordered for mobility. An Event Report, dated 09/13/17 completed at 7:55 AM, documents R4 was last seen in his room. The report documents at 3:35 AM, R4 was found on the floor at bedside. R4 was sent to the emergency room for evaluation and returned to the facility at 4:15 AM with no fractures identified. The Evaluation Note documents, "It is the conclusion of the facility that (R4) was found on the floor in room. (R4) attempted to self-transfer from bed to w.c. (wheelchair) without call light	S9999		

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S9999	Continued From page 10 usage or staff assist. Verbal staff assist and call re-education given. High sided mattress to bed" was the intervention added to the care plan as a result. On 04/04/18 at 1:09 PM, V12, daughter, stated her father, R4, had a fall at the facility last year when he went to use his side rail and it wasn't secured. V12 stated she witnessed the rail not being secure the day before he fell. V12 stated R4 said "he'd grabbed the rail and it came out causing him to fall." On 04/04/18 at 3 PM, V5, RN, stated she had noted R4's stump was scraped and when she asked how it happened, he said the hand rail "folded" when he grabbed it and he fell out of bed. V5 stated she did not say anything to anyone else about R4's allegation of the unsecured railing. There is no evidence the facility identified an accurate root cause of R4's falls and revised his falls prevention plan to include ensuring secured side rails if R4 was to use them to help him get up or for bed mobility. On 04/05/18 at 12:01 PM, V21, Maintenance Supervisor, stated the only thing that is holding the rail secured is a plastic bushing which can act like a screw going up and down causing the pin that holds the railing in place to become misaligned. V21 stated he has never had a railing brake. V21 stated staff has to "wiggle the bolt until the pin aligns to fall into the chamber in order for the railing to latch." V21 stated he educates staff when he gets a call that a railing is not working. V21 stated he last checked R3's bed on 03/30/18 and 12/04/17 adding that he does every bed checks quarterly or as needed.	S9999		

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On 04/05/18 at 1:20 PM, V2, Director of Nurses (DON), stated she was unaware that the staff were having problems with getting the hand rails latched securely and was never told by V12 that R4's fall occurred when his railing was not latched properly. V2 also stated she was unaware that V5, RN, noted R3's railing was unsecured immediately following her fall and that she was positioned too close to the side of the bed.

V22, Nurse Practitioner, stated on 04/05/18 at 2:15 PM stated the railings at the facility would be to enable residents to get in/out of the bed or to aid be mobility and would assume staff keeps them secured.

On 4/5/18 at 4:45 PM, V23, Technical Assistant for Bed Company, provided the handbook sheet on the "Assist Handle" for the bed used in the facility. V23 stated if the Handles were not secured in place, it would be a safety risk and could cause someone harm. The Handbook documents for the "Assist Handle Two Position" bed - "The assist device is intended for use as an aid in entering or exiting the bed sleep area, as well as a stable handle hold during self-positioning within the bed sleep area" and under "Warnings: Serious Injury or Death," it documents "Do not use this assist device until you have verified that it is locked in place. Injury to resident or care giver may result if this procedure is not followed."

The facility's undated Fall Management Program policy/procedure documents the program is designed to identify guests at risk for falls, initiate interventions to reduce falls and thus reduce the risk of injury due to falls. Under Policy, it documents "Interventions will be implemented according to the guest's need identified during

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S9999	Continued From page 12 assessment. If a systematic evaluation of a guests fall risk identifies several possible interventions, the staff may choose to prioritize interventions." (A)	S9999		