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 02/08/2018

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 1870343/IL99586	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.620a) 300.1210b) 300.3300e)1)2)3)4)5) 300.3300g) 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 300.620 Admission, Retention and Discharge Policies a) All involuntary discharges and transfers shall be in accordance with Sections 3-401	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 through 3-423 of the Act. 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 care needs of the resident. 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) Section 300.3300 Transfer or Discharge e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed	S9999		

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S9999	Continued From page 2 transfer or discharge; (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below."; (Section 3-403(c) of the Act) 4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act) 5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act) g) A copy of the notice required by subsection (d)(1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, the resident's representative, and, if the resident's care is paid	S9999		

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S9999	Continued From page 3 for in whole or part through Title XIX, to the Department of Healthcare and Family Services. (Section 3-405 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident was free from mental abuse by coercing a resident into signing a behavior contract in order to return to the facility following hospitalization, and threatening the resident with involuntary discharge. These failures resulted in psycho-social harm when R1 appeared tearful and stated he felt afraid, on a daily basis, of being involuntarily discharged from the facility. This applies to 1 resident (R1) reviewed for residents rights and involuntary discharge. The findings include: On January 30, 2018 at 9:05 AM, R1 was sitting in bed eating breakfast. R1 said, "About a week ago, around 5:00 AM, I was sitting in my room and got a bloody nose. There was blood everywhere and it wouldn't stop. I got aggravated because I felt like it was taking too long for the staff to address my concerns. I was screaming and then I threw my water pitcher across the room to get someone's attention. I was in a private room on that day. The water pitcher landed on the floor and slid out into the hallway. I never intentionally threw it at anyone, I was just trying to get someone's attention. Later they came and told me I was being sent out to a psych	S9999		

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hospital. I had to stay there for three days. While I was at the psych hospital the facility made me sign a contract saying I wouldn't misbehave or they would kick me out. I also had to agree to return to a double room and not have my private room anymore. I didn't know my rights so I just signed the contract because I was afraid they wouldn't let me come back here. I felt very sad because I knew they didn't want to take me back. The facility did not give me a copy of the bed hold policy before they sent me to the psych hospital. I didn't know they had to take me back. I would never have signed the behavior contract if I knew they had to take me back. Now I lay here afraid every day that if I don't get dressed or don't go to physical therapy they are going to kick me out. I don't like to wear clothes when I lay in bed because they are restrictive and uncomfortable. I prefer to just wear the incontinence brief and cover myself with a sheet. I will get dressed if I go to therapy, but will remove the clothes as soon as I return to my room."

R1 became tearful when discussing the possibility of being involuntarily discharged from the facility and being moved from his previous room. R1's previous room remained empty during the observation period of January 30, 31 and February 1, 2018.

On January 31, 2018 at 1:04 PM, R1 was laying in bed. R1 was wearing only an incontinence brief and covered himself with a sheet. R1 complained of right abdominal pain. R1 said, "I refused to go to therapy today because of the pain I'm having. Now I'm worried they are going to kick me out because of that contract I signed." R1's physician was notified and orders were received and initiated.

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On February 1, 2018 at 12:00 PM, R1 was laying in bed wearing only an incontinence brief and covered with a sheet. R1 said he continued to have abdominal pain and the previously ordered X-ray and urinalysis were negative for bowel obstruction and urinary tract infection. R1 said he refused therapy due to his abdominal pain.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility in September 2017 with multiple diagnoses including kidney stones, chronic pain, weakness, spinal fusion, hypothyroid, opioid dependency, history of falling, morbid obesity, major depressive disorder, anxiety, and diabetes.

R1's MDS (Minimum Data Set) dated November 9, 2017 shows R1 is cognitively intact, feels down and depressed at times, has no behaviors, no rejection of care, requires extensive assistance with most ADLs (activities of daily living) and is occasionally incontinent of bladder, and always incontinent of bowel. The MDS shows R1 is totally dependent on facility staff for bed mobility and transfers.

R1's care plan dated October 2, 2017 shows: "[R1] is resistive to care as noted by refusing to get out of bed, comply with therapy and eat meals. Becomes physically and verbally abusive to staff when encouraged to comply. Goal: [R1] will cooperate with care evidenced by not showing verbal or physically abusive behavior to staff through next review date. Interventions/Tasks: Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care. Give clear explanation of all care activities prior to and as they occur during each contact. Praise [R1] when behavior is appropriate."

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Facility documentation shows a Petition for Involuntary/Judicial Admission for R1 dated January 22, 2018. The petition shows: "On 1/22/18 at 7:00 AM, [R1] became verbally and physically aggressive. [R1] is throwing water pitchers and personal objects at staff and peers. [R1] remains agitated and verbally abusive. [R1] is in need of immediate hospitalization to prevent harm to self or others. Per MD sent to hospital for psychiatric eval and placement." Facility documentation shows R1 was transferred to the local psychiatric hospital on January 22, 2018 and returned to the facility on January 26, 2018.

The facility's Behavior Contract for R1 dated January 26, 2018 shows: "I [R1] will begin this contract upon my return to [the facility] to help in assuring my success and overall quality of care here at [the facility]. This contract will be used to assist in determining my future at [the facility]. I will follow all [facility] policies and procedure and behavior expectations, which include the following: 1. Refrain from being verbally and physically abusive toward staff and residents. 2. Comply with daily care as recommended by physician and IDT (interdisciplinary team). 3. Will comply with getting dressed and up in wheelchair daily. 4. Comply with restorative program and perform daily exercise program. If I fail to abide by the guidelines listed above, I understand that I will be liable for the following consequences: 1 Involuntary discharge from [the facility]. By signing this contract all parties agree to the stipulations in the document and will follow accordingly. *Also discussed move to double room." The contract was signed by R1 and V14 (Marketing Director/Hospital Liaison) on January 26, 2018.

V17's (Psychiatrist) documentation dated January

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23, 2018 shows: "Diagnostic Impressions: Major depressive disorder, recurrent, severe without psychosis. [R1] is stable, not suicidal, not homicidal, able to care for self and not showing violent behavior..."

On February 1, 2018 at 9:39 AM, V1 (Administrator) and V2 (DON-Director of Nursing) said R1 was not given a copy of the facility's bed hold policy prior to his discharge to the psychiatric hospital on January 22, 2018.

On January 31, 2018 at 9:50 AM, V6 (LPN-Licensed Practical Nurse) said, "On January 22, 2018 at 5:45 AM I was right outside [R1's] room and I noticed he was bleeding. I had a towel and ice on my cart and I went in and cleaned him up. I told him I was going to get ice and more towels. He pulled the call light and yelled the "F" word. He threw a water pitcher towards me and it landed in the room across the hall. Usually that time of the day there is a resident who sits out in the hallway, but that morning the resident was not sitting there. No residents were near [R1] when he threw the water pitcher, though the spilled water worried the resident across the hall who was afraid it was close to the oxygen concentrator in his room. I've never had problem with him in the past. I had him Monday and he was nice to me."

On January 31, 2018 at 11:18 AM, V9 (Ombudsman) said the facility had not contacted her prior to January 31, 2018 with any concerns, including behavior problems or alternative facility placement for R1. V9 said she was not contacted prior to R1 signing the behavior contract. V9 said she would have advised R1 not to sign the behavior contract.

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On February 1, 2018 at 1:08 PM, V14 (Director of Marketing/Hospital Liaison) said, "I told the social worker at [psychiatric hospital] that [R1] didn't fit into our community. [V15] (Caseworker) said she would try to find another facility that would take [R1]. Two days later she called and said he was ready to come back. [R1] refused for her to send papers to other facilities, so we had to take him back. I went out and saw him. I gave him a copy of the behavior contract and read it out loud to him, and asked him if he had any questions. I told him if he wouldn't sign it and agree to these terms, he couldn't return to the facility. The behavior contract was a condition for him to come back and I believe he knew that."

On February 1, 2018 at 3:32 PM, V15 said, "Initially the facility said they would prefer alternate placement for [R1]. [R1] insisted he wanted to return to the facility. Everything they said that he was here for we never saw. They made him sign a contract in order to return to the facility."

The facility's Abuse Prevention Program Policy dated February 2018 shows: "Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental

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S9999	Continued From page 9 means (210 ILCS 45/1-103). Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5). Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation (42 CFR 483.12 Interpretive Guidelines.) (B)	S9999		