STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016901	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHBRIDGE OF ARLINGTON HTS	1200 N ARLINGTON HEIGHTS RD ARLINGTON HEIGHTS, IL 60004

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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		

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care needs of the resident.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 observation, interview and record review the facility failed to have fall interventions in place for a resident at risk for fall and failed to ensure a resident was transferred safely for 2 of 20 residents (R33 and R36) reviewed for safety and supervision in the sample of 20. This failure resulted in R36 falling and sustaining a right ankle fracture that required surgical repair.

The finding include:

1. R36's Face Sheet shows that she admitted to the facility on 4/28/25 with diagnoses of: cellulitis of right and left lower limbs, unsteadiness of feet, abnormalities of gait, reduced mobility and morbid obesity.

R36's Functional Status Note dated 4/29/25 shows that R36 requires partial/moderate assistance to stand from sitting and transfer from bed to chair.

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On 6/9/25 at 11:35 AM, R36 was lying in bed. R36 had a cast on her right lower leg. R36 said that she fell in the bathroom and broke her leg.

On 6/10/25 at 10:20 AM, V34 (R36's Spouse) said that he came in on 5/11/25 and R36 was sitting on the bathroom floor and had fallen. V34 said that a couple days later, R36's right leg was bruised, and her foot was pointed in an abnormal position. V34 said that eventually R36 had an X-ray and it showed that she had a fracture in two areas, and she had surgery.

On 6/10/25 at 12:19 PM, V22, Certified Nursing Assistant (CNA) said that on 5/11/25, R36 had a fall in the bathroom. V22 said that he brought R36 into the bathroom to transfer to the toilet. V22 said that he instructed R36 to hold the grab bar and stand. V22 said that as R36 stood up, she lost her balance and started to fall. V22 said that he tried to place the wheelchair under her before she fell but was unable to. V22 said that when R36 fell, her right knee hit the floor, but she was still holding onto the grab bar and standing on her left leg. V22 said that he guided her to a sitting position on the floor. V22 said that when she was in the sitting position on the floor, her left leg was extended in front of her, and her right leg was under her weight, so he moved her right leg from under her and placed it in front of her. V22 said that he did not have a gait belt on R36 when the fall occurred because he did not have one but one was put on her when V32 came to help get her up off of the floor.

On 6/11/25 at 12:51 PM, V32 said that V22 had requested her assistance to help with R36. V32 said that she entered R36's room and R36 was on the floor in the bathroom. V32 said that they

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applied a gait belt and lifted her up off the floor and into her wheelchair.

On 6/11/25 at 12:52 PM, V22 was re-interviewed at the request of V4 (Director of Nursing) V22 stated, "I do believe I did have a gait belt on before the fall." V22 explained the fall again in detail. V22 was then notified that this surveyor had spoken to V32 and V32 said that they applied the gait belt to R36 before they lifted her to her wheelchair. V22 stated, "To be honest, I don't remember the scenario whatsoever. I do not remember exactly when the gait belt was put on."

On 6/11/25 at 10:38 AM, V4 (Director of Nursing) said that R36 was a one person assist with a gait belt for transfers. V4 said that staff should always use a gait belt for the resident's safety. V4 said that it is likely that R36 received a small fracture during her fall on 5/11/25 but it worsened due to participation with therapy. V4 said that R36 had no other incident that had happened between R36's fall and the finding of the fracture.

R36's right ankle X-ray results from 5/21/25 shows, "There is an acute fracture of the distal fibula and of the medial malleolus with subluxation of the tibia on the talus medially.... There is soft tissue swelling diffusely."

R36's Orthopedic Surgery Consult Note dated 5/22/25 shows, "Patient is a 69 y.o. female who presents with right ankle fracture. She presented to my clinic today for this issue. The patient fell at her rehab on Mother's Day (5/11). She states that she had pain and swelling to the ankle over the past week and then they eventually got x-rays after she was in too much pain to ambulate with PT (Physical Therapy) .... there is moderate swelling to the ankle diffusely. There is

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tenderness medial and laterally.... Assessment: Right ankle bimalleolar fracture subluxation ...Plan for ORIF (Open Reduction Internal Fixation) right ankle 5/23."

The facility's Final Investigation Summary dated 5/23/25 shows, "Resident Injury-Confirmed Fracture Post-Fall....Based on the clinical record and timeline, no localized symptoms or signs of ankle injury were evident immediately following the assisted fall on 5/11/25 or in the days afterward.... However, the subsequent right ankle fracture confirmed on 5/21/25 may reflect an initially minor or hairline fracture caused by the assisted fall. Factors supporting this possibility include: The resident's high pain threshold and non-localized chronic lower extremity pain masking early injury. Morbid obesity contributes to mechanical stress and potential progression of injury."

The facility's Gait Belt Policy revised on 1/2025 shows, "Staff will use a gait/transfer belt on residents who need limited to total assistance with transfer or walking."

2. R33's facility assessment dated 3/21/25 showed R33 is a 94-year-old female with impaired cognition and was admitted to the facility on 1/9/24 with diagnosis which include dementia and unspecified disorientation.

On 6/9/25 at 9:05 AM, R33's door was closed at this time. Upon entering R33's room, R33 was lying in bed diagonally across the mattress with her right foot off the edge of the bed and her head near the upper left bed mobility rail. Several fall mats were across the room leaning against the opposite wall from the bed. R33's bed was approximately two and a half to three feet above

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the ground which is not the bed's lowest position.

On 6/10/25 at 1:20 PM and at 6/11/25 at 9:00 AM, R 33 was in bed with the fall mats stacked against the opposing wall from the headboard.

On 6/10/25 at 1:25 PM, V26 CNA stated R33's fall mats should be next to the bed.

On 6/11/25 at 9:44 AM, V35 CNA stated we are usually notified by the nurse or during morning report if a resident is a fall risk. V35 stated R33 does have fall mats, and they should be next to her bed when R33 is in it.

R33's medical records showed R33's last Fall Assessment was completed on 9/11/24. R33 is listed as having a moderate risk for falls.

R33's Care Plan showed R33 has a risk for falls with an intervention of having fall mats "landing pads" in position while in bed and have the bed in the lowest position.

R33's Physician Orders has an order for floor mats and low bed position with a start date of 10/3/24.

On 6/11/25 at 11:35 AM, V2 Director of Nursing stated a residents fall interventions should be in place when a resident is in bed (fall mats, bed in low position, door open etc.).

(A)