STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145208	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEVIEW HEALTH CARE CENTER	**8100 SOUTH HARLEM AVENUE BRIDGEVIEW, IL 60455**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to properly assess resident's change in condition (R305) for a resident who expired in the facility and failed to document that resident was being monitored and repositioned every two hours as ordered by physician. Findings Include: Resident # 305 is a [AGE] year old female who was admitted to the facility on [DATE], and expired [DATE] at the facility. Resident's medical history includes, but not limited to Dementia in other Diseases classified elsewhere with behavioral disturbance, Traumatic Subarachnoid Hemorrhage without loss of consciousness subsequent encounter, Laceration without foreign body of other part of head, sequela, Unsteady on feet, [MEDICAL CONDITION] Unspecified, [MEDICAL CONDITION] with Acute Exacerbation, Type 2 Diabetes with Diabetic [MEDICAL CONDITION], etc. Per record review, Resident # 305 had a fall in the facility on [DATE], was admitted to the hospital and treated for [REDACTED]. Facility assessment of resident's ability on Activities of Daily Living (ADL) dated [DATE] coded resident as dependent on staff with extensive assistance. Facility MDS assessment tool dated [DATE] coded resident with a BIMs score (Brief Interview for Mental Status) of 3 on cognition, ,[DATE] and ,[DATE] (Meaning extensive assist with 2 persons physical assist and total dependence) on staff for all ADL activities. Review of physician order [REDACTED]. Flush [DEVICE] with 300ML four times a day, (0500, 1100, 1700 and 2300). Record urine output every shift. Resident also had a care plan to provide [DEVICE] feeding and water flushes as ordered, check and change for incontinence every two hours. Provide peri care and apply moisture barrier cream after each incontinence episode. A review of nurse's note indicates that the last documentation on the resident was the previous day on [DATE] at 16:53, the note reads as follows: Resident alert and verbal no c/o pain hob elevated [DEVICE] intact bowel sounds active resident positioned for comfort and properly aligned in beds/p bruise from s/p fall mild bruising noted cleansed and dressing applied call bell in reach mouth care rendered. At 17:33, nurse's note reads Foley catheter intact 200 cc output yellow urine, no mucus or sediment noted in f/c. [DATE] 07:40 Nurses Note, V21 documented, Resident expired this morning @630am. Family informed and funeral home to pick up remains. Funeral home (named). Md paged, awaiting call back. [DATE] at 1:50PM, V12 (LPN) stated that resident expired at 6:30am on [DATE], usually 2 nurses have to declare a resident dead, they determine that through assessment of vitals, absence of pulse or blood pressure, and lung sounds. When asked if theses assessments should be documented, V12 said that she did not recall what exactly happened that day and why she did not have detailed documentation. [DATE] at 9:30AM, V2 (DON) presented a hand written document by V12, stating that resident was a DNR as well as on Hospice, that she informed hospice of the resident's passing. She added in her hand written statement that she remember that a lot was going on that night including a code and that was why she did not document properly. V2 (DON) stated that she will find some evidence that resident was receiving hospice care and documentation on staff rounding. [DATE] at 10:50am, V2 (DON) stated, I could not find any documentation that she was seen that night by CNA or anyone, she was not on hospice. V2 added that the facility does not have any policy and procedure on patient monitoring and documentation. [DATE] at 3:36PM, V22 (Medical Doctor) stated, looking in the medical record, there is no way of knowing what happened without documentation, resident had extensive medical issues and its likely one of her medical conditions, I am not sure if they had an autopsy done. Resident was discharged from the hospital after she fell and was stabilized from the hemorrhage she sustained when she fell . V22 cannot recall if patient was hospice, I know she was a DNR. When asked his expectation from the nurses when a patient dies, he said that they should assess for a pulse and if there is none, start CPR if patient is a full code. He added that all his patients in the facility should be monitored overnight.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete weekly skin check, assess, inform nurse and documents new area of redness to heel and follow preventative wound care intervention for one of six residents (R29) who were reviewed for pressure sores. On 09/29/20 at 10:03 AM, V16 (CNA) R29's heels lay directly on top of a blanket. V16 stated that R29 can really only move her upper body. R29 was not able to make any significant movements during turning and repositioning with legs and feet and required 2 staff to turn her in bed. V16 gave R29 a bed bath and when she was finished caring for R29, surveyor asked V16 to remove her socks so I may observe her heels. When socks removed, observed dark red area to left inside and bottom of heel where it is laying on the blanket. V16 looked at R29's foot but did not make a comment about redness to heel. V16 stated that she has to inform the nurse about an area of redness under her arm only. After repositioning, V16 returned R29's heels directly on flat blanket and not offloaded or suspended heel. V16 notified V20 (Licensed Practical Nurse, LPN) and V15 (Wound Care Nurse) of red area under arm only in my presence. V20 and V15 not notified of reddened left heel. On 09/29/20 at 10:20am, V15 (Wound Care Nurse) stated that I checked R29's, bony places, legs and feet last week. She had no new reddened areas or breakdown. R29 is noted to be at risk for skin breakdown. She has an order for [REDACTED]. R29 has no new changes that I am area. Interventions for prevention of pressure sores are noted on her care plan. On 9/30/20 at 1:34pm, V15 removed R29's socks and stated that there is redness to R29's left heel, this a change for R29 and she should have been notified by V16 after it was observed. CNA's are to look at residents heels daily during bed baths and care. Intervention of offloading heels should be done every 2 hours. If R29 refuses, then it should be documented and attempted again. R29 has [DIAGNOSES REDACTED]. R29's medical record notes she requires extensive assistance from staff with 2 people plus physical assistance to move in bed. Physician orders [REDACTED]. R29's shower sheet dated 9/29/20 does not note redness to left heel. R29's skin assessment dated [DATE] notes that R29 is at risk for pressure ulcers and is unable to make significant changes indecently. R29's care plan notes she has potential for ulcers due to dementia, incontinence and skin assessment. Interventions note to elevate heels off the bed and follow facility policies and procedures for the prevention/treatment of [REDACTED]. The prevention of pressure ulcers policy documents to review the residents care plan for any special needs of the resident. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation to that area and subsequent destruction of tissue. The most common site of a pressure ulcer is where the bone is near the surface, like heels. Routinely screen, document and immediately report any signs of a developing pressure ulcer to the supervisor. When in bed, every attempt should be made to keep heels off the bed by placing a pillow from knee to ankle or with other devices. Impaired or decreased mobility, decreased functional ability and a resident not capable of moving without assistance and who is confined to bed that requires a schedule of turning are additional conditions that indicate a resident is at risk for pressure ulcer. Staff will perform routine skin inspections daily and Nurses are to be notified to inspect the skin if skin changes are identified.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on observation, interview and record review, the facility failed to implement fall interventions for two residents (R27 and R34) by using a non-working bed alarm and failing to have effective interventions for a resident with known fall risk who has a known history of not using call light for assistance with walking. 9/28/20 at 11:20 am, surveyor heard alarm in R34's room and observed him get up and walk to the bathroom with an unsteady gait. V17 (Licensed Practical Nurse, LPN) heard alarm and went into the room. V17 stated the R34 does not use the call light even though we ask him and he has a bed alarm to alert us since he is a high fall risk. He has a green falling star outside of room on the door frame which indicates high risk for falls. 09/29/20 at 10:49 AM, R34 was lying in bed. R34's bed alarm was clipped to side rail but there was no light on it. When turned the alarm over, surveyor observed there are no batteries in the machine which means it does not work. 09/29/20 at 10:58 AM, V20, Licensed Practical Nurse, (LPN) stated that R34 gets up, uses the bathroom and walks without assistance. That is an issue because he needs supervision and an unsteady gait. He had a fall last on 9/2/20. He was observed on the floor. He has a bed alarm as a fall intervention. I haven't heard the alarm today. R34 then scooted down to the foot of the bed, off the alarm pad and it did not sound when working with physical therapy. V20 stated, usually by the time we hear the alarm, he is up and walking already. 09/29/20 at 12:00pm,V19 (Certified Nursing Assistant, CNA) set up lunch tray in R34's room and left. Alarm box is visible when facing resident. 09/29/20 at 1:06 PM, R34's alarm still has no batteries in it while he is in bed. R34's fall risk assessment notes he is at risk for fall and has a history of falls. R34's care plan and incident note stated he is at risk and had a fall on 9/2/20. He attempted to walk without staff assistance, lost his balance and fell . Intervention added at this time was a bed alarm to alert staff of postural changes. 9/29/20 at 8:45am, R27 was in bed which was raised to waist height with floor mats on both sides. R27 is confused. V19 (Certified Nursing Assistant, CNA) lowered it to the ground and stated it should always be lowered to the ground. 9/30/20 at 10:30am, V2 (Director of Nursing, DON) stated that starting every morning, restorative staff go to room to ensure interventions are in place including alarms and devices. All staff are to ensure interventions are in place and to intervene if they see it is not. R27's incident note and care plan notes she is at risk of falls due to advanced age, impaired cognition with poor safety awareness, decreased mobility, weakness, unsteadiness and one sided weakness. R27 sustained a mechanical fall on 09/17/2020 @ 7:12am from bed due to poor safety awareness and impaired cognition. Intervention put in place was to provide bed in low position and keep brakes locked at all times.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to apply moisture barrier cream during incontinence care for three of five incontinent residents (R27, R29 and R40) when reviewed for bowel and bladder. 09/29/20 at 8:45am, V19 (Certified Nursing Assistant, CNA) stated that R27 is incontinent of bowel and bladder and I am going to change her adult brief. With gloves on, V19 removed R27's adult brief that was saturated with urine. V19 cleaned her per perianal area then applied a new adult brief without applying barrier cream to skin. R27's care plan revised last on 8/2/20 notes that that she has incontinent episodes and requires staff assistance with toileting tasks. Interventions note to provide peri-care and apply moisture barrier after each incontinent episode. R27's physician orders [REDACTED]. On 09/29/20 at 09:47 AM, V16, CNA stated I am going to change R40, who is incontinent. V16 removed adult brief which was wet with urine and stool. V16 put on a new adult brief with no barrier cream. V16 stated that there is an ointment in her drawer but I didn't use it now. Most of the time I use it on her bottom the last time I change her on my shift. On 9/29/20 at 10:22am, V15 (Wound care nurse) stated that barrier cream, should be applied to R40's peri area and buttocks every time she is changed after incontinence care. On 09/29/20 at 10:03 AM, V16 (CNA) removed R29's adult brief and cleaned her perianal area. R29's skin on buttocks was red and V16 stated that R29 urinates a lot. V16 put a new adult incontinence brief on resident without applying barrier cream. On 09/29/20 at 10:20am, V15 (Wound Care Nurse) stated that R29 has a barrier cream applied after each incontinent episode. On 09/30/20 at 10:30 AM, V2 (Director of Nursing, DON) stated that CNA's should apply barrier cream for all incontinent residents after cleaning. It is kept at the resident's bedside and applied by CNA's. R29's care plan notes she is dependent on all staff for care and is incontinent. Interventions lists to apply moisture barrier after each incontinent episode. Physician orders [REDACTED]. Incontinence care, peri-care policy notes the procedure is to provide cleanliness, to prevent infections and skin irritation by reviewing residents care plans for any special needs of the resident.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their established policy and procedure for infection control and prevention by failing to ensure that staff wear full personal protective equipment (PPE) before entering an isolation room (R58, R94 and R204), failing to ensure that multi use patient care equipment was properly sanitized (R60), failing to ensure that staff follow proper hand hygiene during incontinence care (R27, R29, and R40), failing to leave personal patient care item in an isolation after use (R29) and failure to properly remove PPE prior to exiting an isolation room (R29). This failure has the potential to affect all 102 residents in the facility. Findings include: 09/28/20 11:35AM, observed lunch on the third floor, V6 (C.N.A) was seen entering an isolation room for (R94) with a lunch tray and no Personal Protective Equipment (PPE), except for a surgical mask. When confronted with this observation, V6 stated, I was supposed to wear a PPE before entering the room, I just didn't wear one. At 12:46PM, V5 (RN), was observed entering the same isolation room for (R94) with no PPE except for a surgical mask. When surveyor asked V5 why she did not wear any PPE, she said, she should have worn PPE but she forgot. 9/29/2020 at 9:03am, V7 (CNA) was observed inside an isolation room for (R58) on the second floor with no PPE except a surgical mask. When asked why she was not wearing a PPE, she said, the room is not an isolation room. Surveyor pointed out a contact isolation sign on the door, then V7 said, that was a mistake, resident is not on isolation, you can ask the nurse. V7 then removed the isolation sign from the door and took it away. At 9:30am, V8 (LPN) stated that (R58) is still on contact isolation for ESBL in the urine. She added that she does not remember the isolation order being discontinued and that they just collected a second urine sample for the resident. At 10:10 AM, V2 (DON) said, R58 is still on contact isolation precautions, the CNA (V7) made a mistake. 09/30/20 9:02AM Observed V10 (LPN) for medication pass, she went into a Droplet precaution isolation room to give medication to R60 who was on Airborne and droplet isolation precaution as a PUI for COVID-19. V10 had a surgical mask, face shield and a gown but no gloves, she proceeded to check resident's blood pressure and temperature, placing equipment on a bedside table, close to a urinal filled with urine. V10 finished with resident, washed her hands after removing PPE and left the full urinal on the table. When asked abour infection control, V10 said, I could have emptied the urine, but did not have any gloves. V10 then proceeded to use the same blood pressure cuff and thermometer that she placed on her medication cart without cleaning on another resident who is not on isolation. When asked what will be the implication of her action, V10 stated, It could cause a cross contamination, I should have cleaned it with a bleach wipe, I just forgot. On 9/29/20 at 8:38am, V19, Certified Nursing Assistant (CNA), walked in R204's room with just surgical mask on. She was making the bed within 3 feet of resident and walking around where he was sitting. V19 had no gown or gloves on. R204's room has isolation sign on the door with bin outside of the room. On 09/28/20 at 11:20AM, V17, Registered Nurse, RN stated that R204 is on droplet and contact isolation to monitor for COVID as he goes in and out of the facility three times a week for [MEDICAL TREATMENT]. On 9/29/20 at 8:45am, V19 stated that when residents are on droplet precautions, there are signs on the door. We should wear gown, gloves, mask and face shield. R204's care plan notes strict droplet and contact isolation. Interventions list for staff to wear masks, gloves and a gown if soiling with respiratory secretions likely. Droplet precaution policy notes some infectious agents transmitted by the droplet route also may be transmitted by direct and indirect contact routes. Staff should wear a gown, gloves and for residents suspected of COVID-19 should wear a face shield or goggles. 09/29/20 at 8:45am, R27's door stated isolation and has bin outside the door with personal protective equipment, PPE. V19 (Certified Nursing Assistant, CNA) stated that R27 is on isolation and placed a package of wipes on R27's bedside table. V19 removed R27's wet adult brief and cleaned her peri-area. With the same gloves, V19 applied a new adult brief and touched lines and resident's body. With the same gloves, V19 removed her face shield and placed it in between her legs, laying directly on her uniform, before it was cleaned. Before leaving the room, V19 took the incontinent

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) wipe package off the bedside table and placed the wipes on the clean linen cart in the hallway. V19's face shield was also laying on the clean linen cart. V19 stated I put my face shield on top of the clean rags inside the linen cart after I cleaned it. We are supposed to store in a bag in between uses. 09/29/20 at 09:47 AM, V16 (CNA) removed R40's adult brief which was wet with urine and stool. V16 wiped the urine and stool from R40. With the same gloves, V16 applied a new adult brief. With the same gloves, V16 then ran her gloves over R40's hair then used a brush on her hair. 09/29/20 at 10:03 AM, V16 (CNA) removed R29's adult brief which was wet with urine. With the same gloves, V16 cleaned R29's perianal area then applied a new adult brief and gown. V16 went on to touch R29's linens, hair and pillows before taking her gloves off. 09/30/20 at 10:30 AM, V2 (Director of Nursing, DON) stated that during incontinence care, gloves should be changed between dirty to clean areas then hands washed before applying new gloves. 9/30/20 at 2:00pm, V2 stated that wipes in isolation rooms should not be placed onto clean linen cart and should stay in that isolation room due to infections. Face shields should not be placed on clothes. Handwashing policy states all personel shall follow the handwashing procedue to help prevent the spread of infections to other personnel, residents, and visitors. Employees must wash their hands or use alchohol-based hand sanitizer after removing gloves. The use of gloves does not replace handwshing/hand hygiene.