STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145420	A. BUILDING _____ B. WING _____	C 05/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CHRISTIAN VILLAGE REHAB & SNF	**111 EAST WASHINGTON BENSENVILLE, IL 60106**

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F 323	Continued From page 6 (Lorazepam) to keep her relaxed. Z1 also stated, he would expect the staff to monitor R1 closely after administering anxiolytic medication, which could cause dizziness.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1210b) 300.3240a) 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	F9999		

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F9999	Continued From page 7 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. Restorative measures shall include, at a minimum, the following procedures: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on observation, record review and interview the facility failed to monitor and supervise a resident (R1) after administering antianxiety medication. The facility also failed to develop and implement specific and individualized interventions to prevent R1 from	F9999		

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F9999	Continued From page 8 falling. As a result: R1, who was identified at risk for falling, had fallen on 4/12/13 after receiving antianxiety medication. R1 sustained intratrochanteric fracture of proximal left femur. This is for one of two residents (R1) in the sample of eight residents reviewed for falls. Findings include: On 5/2/13 at 10:20 am R1 was in her bed, the bed was not in lower position. R1 was hard of hearing, restless, and unable to carry on conversation. R1's 1/3/13 Fall Risk evaluation scored '10,' a total score of greater than '10' represents high risk for falling. The risk factors included problems with R1's balance, problem while standing and walking; has decreased muscle coordination; requires use of assistive devices (cane, wheel chair walker, furniture); takes medications including psychotropic medications that would place her at risk for falling. The 1/3/13 evaluation also showed R1 has predisposing disease conditions. The facility did not further evaluate these risk factors to develop and implement individualized specific interventions to prevent R1 from falling. R1's 4/5/13 Care Area Assessment (CAA) for falls also had no evaluation of the risk factors identified per 1/3/13 Fall Risk score. R1's 1/8/13 care plan indicated her gait, standing balance, decreased muscle strength, history of falls, use of wheel chair were the factors for	F9999		

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F9999	Continued From page 9	F9999		

falling as noted in 1/3/13 fall risk score.

One of the interventions of 1/8/13 fall care plan was to keep call light within reach and answer promptly. It is not clear how the facility will ensure that R1 who has memory impairment and confused (per 4/5/13 minimum data set), would remember and use call light.

On 5/14/13 after evening meal (from 5:50 pm to 7:30 pm) on 'A' wing where R1 used live had residents (R6, R7 and R8) their nurse call lights on for assistance. These residents are alert and oriented to time place and person. The staff did not answer call lights in timely manner. These residents made comments: 'I take care of my self, but some needs to remove box from the top of my bed, so I could go to sleep, the box is heavy;' 'I need ice water, we ate shrimp for dinner;' 'I put the light on to go to bath room, some one came and turned off my call light, did not come back to help.'

R1's 4/22/13 fall care plan that was developed after her fall on 4/12/13. One of the interventions is to 'ensure bed is low position. The facility did not implement this intervention for R1 on 5/2/13.

On 4/11/13 5:00 pm it R1's Nurses Notes showed, she manifested extreme agitation, confusion, low grade fever; which got worse since it started at 3:00 pm, and her mental status has changed. The Nurses Notes also showed at 1:00 am R1 received Lorazepam 0.5 mg. R1's April 2013 Medication Administration Record (MAR) showed Lorazepam was discontinued on 4/9/13. R1 also had an order on 4/11/13 to receive Lorazepam 0.5 mg twice daily. The MAR for April 2013 showed R1 did not receive any Lorazepam

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F9999	Continued From page 10	F9999		

0.5 mg on 4/11/13 or 4/12/13, but it was noted in her Nurses Notes and incident report that the Nurse gave Lorazepam 0.5 mg on 4/12/13. On 5/30/13 at 10:30 am E2 (Director of Nurses) said 'that means the nurse gave the medication, but did not sign out in MAR.' There was no specific plan with individualized interventions to administer or discontinue Lorazepam and or how to monitor R1 after she received the medication.

R1's 4/12/13 4:20 am incident report showed at 4:20 am E7 (night shift nurse) heard bed alarm sound. When E7 responded, she found R1 on the floor lying next to her bathroom door. The facility did not analyze R1's 4/12/13 fall to rule out if, her change in mental status, toilet need, use of Lorazepam, environmental factors including proper functioning of bed and bed alarm, staff response time to provide assistance, have contributed to R1's falling. The investigation report also did not show, if the facility interviewed any staff or residents.

R1's 4/12/13 hospital record indicated she sustained Intratrochanteric fracture of proximal left femur.

E7 on 5/2/13 at 1:55 pm per phone interview, stated she heard R1's bed alarm sound, and by the time she went to R1's room, she found R1 on the floor lying next to her bath room. E7, stated she did not see how R1 reached to her bath room and landed on floor.
R1's room is the first room (30 feet away) from the Nurses Station, and her bed is 6 feet away from her bed. E7 could not explain how R1 managed to get up from bed un noticed by staff, got up from bed, and made to bath room and landed on the floor. R1 had physical functional

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F9999	Continued From page 11 limitations including altered mental status, gait and standing problems, decreased muscle strength, confused, disoriented and wheel chair dependent for ambulation. E7, also stated she did not know where the Certified Nurse Aides were at the time of R1 falling on 4/12/13. On 5/15/13 at 2:35 pm interviewed physician (Z1), via telephone. Z1 stated, R1 was progressively getting worse with her Dementia, eating poorly, had change in condition (altered mental physical status) preceding her fall, receiving anxiolytic (Lorazepam) to keep her relaxed. Z1 also stated, he would expect the staff to monitor R1 closely after administering anxiolytic medication, which could cause dizziness. (B)	F9999		