STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145208	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Bridgeview, The	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32115 Based on observation, interview, and record review the facility failed to ensure a resident who required extensive assist with toileting was provided incontinent care in a timely manner for 2 or 4 residents (R2, R9) reviewed for Activities of Daily Living (ADL) in the sample of 13. The findings include: 1. R9's Physician Orders printed 5/5/24 showed her original admission to the facility was 4/19/24 with diagnoses to include: dementia, major depressive disorder, and diabetes. An Order dated 4/29/24 shows to turn and reposition every 2 hours and as needed. R9's Care Plan initiated on 4/30/24 shows she has an ADL deficit related to confusion, impaired balance, and limited mobility. She has a diagnosis of dementia and requires total assist with ADLs., is non ambulatory, and is incontinent of bowel and bladder. This care plans shows an intervention for bed mobility: the resident requires (extensive assist) by 2 staff to turn and reposition. An intervention for Personal Hygiene shows R9 is totally dependent on (1) staff for hygiene. The Toilet Use intervention dated 5/1/24 shows the resident is not toileted. R9's progress noted dated 4/29/24 at 9:18PM shows she was readmitted to the facility . wound to sacrum .requires total assistance x 2 staff to accomplish ADL tasks at this time. On 5/4/24 at 9:27 AM, R9 was in the dining room in a reclining wheelchair. R9's chair was in the reclining position, with R9 resting on her back and bottom. Her legs were in the upright position, and her knees were bent. At 11:53AM, R9 was still in the back of the dining room in her wheelchair, in the reclined position. At 11:57AM, R9 was served lunch and V6 (Certified Nurse Assistant-CNA) began feeding R9. R9 remained sitting on her bottom, and her legs remained in the upright position, extending off the bottom of the chair. At 12:07PM, V4 (CNA) said she would be changing R9 after lunch. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/24 at 1:02PM, V4 wheeled R9 in her reclining chair to her room. V4 said she was assigned to R9 for the day, and R9 was already up in her chair when her shift started (at 7:00AM). V4 said this is the first time she has changed R9 (6 hours after her shift started). V4 and V5 (CNA) used a mechanical lift to transfer R9 from her chair to her bed. V4 removed R9's pants and incontinence brief. The front of R9's brief appeared wet with urine. After cleaning R9's perineal area, V4 rolled her to her left side to remove her brief. The back of R9's brief was visibly saturated with urine. R9 had a bordered dressing to her coccyx that was saturated, no longer adhering to her skin, and falling off. V4 placed R9 on her back and said her dressing was wet and needed changed. V4 said she did not know R9 had a wound to her bottom, this was the first time she had seen it. V4 verified her (R9's) incontinence brief was saturated with urine. V9 was asked if there were any special interventions in place for R9 regarding her wound, care etc., and she said not that I'm aware of, she just came back recently from the hospital. On 5/5/24 at 9:58AM, V3 (Wound Care Nurse) said R9 should be turned and repositioned every 2 hours and she should be checked for [incontinence brief] changes every 2 hours. It is very important for incontinence care every 2 hours and as needed to keep R9's wound dressing clean and dry. On 5/5/24 at 11:49AM, V15 (Registered Nurse-RN) said it is important to keep residents clean and dry, especially if they have a wound. V15 said the residents should be checked every 2 hours for toileting, or as needed. On 5/5/24 at 11:55AM, V16 (RN) said it is important to make sure the residents are clean and dry. V16 said toileting and incontinence care should be done frequently, every 2 to 2.5 hours or as needed. 2. R2's facility assessment dated [DATE] shows she has severe cognitive impairment, is always incontinent of bowel and bladder, and is dependent on staff for toileting. R2's ADL care plan revised on 4/15/24 shows she requires total assistance by one staff with personal hygiene, and toilet use. R2's care plan for bowel and bladder incontinence revised 4/15/24 has an intervention to check for incontinence care every 2 hours and as needed. On 5/4/24 at 9:23AM, R2 was sitting in her wheelchair in the dining room at a table, drinking apple juice. R2 was observed at 9:40AM, in the dining room, resting her head on the table. At 10:07AM, R2 was sitting in her wheelchair, in the dining room. At 11:02AM, V5 wheeled R2 from the dining room table to her room. V5 said she started her shift at 7:00AM, she was the assigned aide for R2, and this was the first time she was changing R2 (4 hours after the start of her shift). V5 said she checked her around 8 and she did not need changed then. V5 put a gait belt on R2 and helped her stand from the wheelchair and pivot to the bed. Upon standing, the back of R2's pants were visibly wet with urine. After assisting R2 to bed, V5 removed her pants and incontinence brief. R2's incontinent brief was saturated with urine and soiled with stool. V5 cleaned R2's peri-area, and used multiple wipes to clean R2's bottom of stool. A new incontinence brief and clean pants were put on R2, and V5 transferred her back to her chair and wheeled her to the dining room. On 5/4/24 at 9:50 AM, V5 said R2 is not able to tell them she needs go to the bathroom and she is usually incontinent of urine. On 5/4/24 at 10:00AM V4 said they normally take R2 to the bathroom after breakfast, and after lunch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/24 at 12:16AM, V16 (CNA) said R2 should be toileted about every 2 hours, she should be taken to the bathroom after breakfast and after lunch.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 32115 Based on interview and record review the facility failed to ensure a referral was made for a hearing aid request for 1 of 3 residents (R2) reviewed for resident rights in the sample of 13. The findings include: R2's facility assessment date 4/19/24 shows she has severe cognitive impairment, and is dependent on staff for Activites of Daily Living. This assessment shows R2 has minimal hearing difficulty. R2's physician order set printed 5/5/24 shows she has a diagnosis of dementia. R2's order set shows an order on 10/13/23 may have audiology evalation and May recieve the services of dentist/opthamologist, and audiologist PRN. On 5/4/24 at 2:28 PM, V33 (family member) said she had reported concerns to the director (V34). On 5/6/24 at 10:38AM, V34 (Liaison) said she is the liaison and does take resident and family complaints. V34 said she is usually the first one the family contacts, especially in the beginning. V34 said R2's family member contacted her on March 17, 20204, about concerns with Activity of Daily Living care and she reported those to the Director of Nursing (DON). V34 said there was a request made in the beginning of the year, February 2024, asking if she [R2] could have hearing aids. V34 said she let V2 (DON) know. V34 said if a concern is brought to her, she passes it on to the appropriate department. On 5/6/24 at 9:20AM, V1 (Administrator) said they have an audiology service that comes to the facility to see the residents. V1 said social services puts together the request for audiology. If a request is made for a resident, they would make a referral to audiology. On 5/6/24 at 11:36AM, V2, DON, said she was not aware a request was made for R2 to get hearing aids. V2 said social services may have received the request for hearing aids. V2 said if there was a request made, or if the resident had to go out to be seen by audiology, there would be an order. V2 reviewed R2's orders and verified there was no order for audiology. V2 said if a request was made, they would contact the place to schedule the appointment if it was an outside office, or would add the resident to the schedule for R2 to be seen in house. V2 said she would have made sure an evaluation was done if she received the request. On 5/6/24 at 2:38PM, V35 (Social Service Director) said if a request is made for hearing aids, she would add the resident to the list and have the audiologist see the resident on the next visit. V35 said they have an audiologist that comes every 6-8 weeks, and she provides them with a list of residents who need evaluations. V35 said she was unsure when the audiologist was last at the facility, but they will be at the facility on 5/10/24. V35 said she just started in this position March 25, 2024, and no list was provided to her on who was last seen, or who still needed to be seen. V35 said she did not have a request for R2 to seen by audiology. V35 verified R2 was not on the list to be seen on 5/10/24 but could be added if needed. On 5/6/24 at 4:39 PM, V1 verified that a referral was never made to audiology, and that R2 was added to the list to be seen on 5/10/24. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Care of Hearing Impaired Resident revised 11/2013 shows Arrange for consultation with an otologist if needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 32115 Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for a resident with a pressure injury, failed to ensure a pressure injury dressing was kept clean and intact, and failed to assess and implement treatment for a resident with a newly identified pressure injury for 2 of 3 residents (R3, R9) reviewed for pressure injury in the sample of 13. The findings include: 1. R9's Physician Orders printed 5/5/24 showed her original admission to the facility was 4/19/24 with diagnoses to include dementia, major depressive disorder, and diabetes. An Order dated 4/29/24 shows to turn and reposition every 2 hours and as needed, and offload heels while in bed every shift. A physician ordered dated 5/1/24 shows coccyx-clean with NSS [normal saline solution], apply medihoney, calcium alginate, cover with bordered dressing every 8 hours as needed for wound care if soiled or displaced. R9's record shows her weight on 4/29/24 was 129.2 pounds. R9's Care Plan initiated on 4/30/24 shows she has an ADL deficit related to confusion, impaired balance, and limited mobility. She has a diagnosis of dementia and requires total assist with ADLs., is non ambulatory, and is incontinent of bowel and bladder. This care plans shows an intervention for bed mobility: the resident requires (extensive assist) by 2 staff to turn and reposition. An intervention for Personal Hygiene shows R9 is totally dependent on (1) staff for hygiene. The Toilet Use intervention dated 5/1/24 shows the resident is not toileted. R9's care plan initiated on 5/1/24 shows R9 has actual skin impairment .pressure ulcer - stage 3 - Coccyx. Interventions include pressure relieving mattress to protect the skin while in bed, keep skin clean and dry. There were no interventions to off load heels while in bed, or to turn and reposition every 2 hours as needed. R9's progress noted dated 4/29/24 at 9:18PM shows she was readmitted to the facility . wound to sacrum . requires total assistance x 2 staff to accomplish ADL tasks at this time. On 5/4/24 at 9:27 AM, R9 was in the dining room in a reclining wheelchair. R9's chair was in the reclining position, with R9 resting on her back and bottom. Her legs were in the upright position, and her knees were bent. At 11:53AM, R9 was still in the back of the dining room in her wheelchair, in the reclined position. At 11:57AM, R9 was served lunch and V6 (Certified Nurse Assistant-CNA) began feeding R9. R9 remained sitting on her bottom, and her legs remained in the upright position, extending off the bottom of the chair. The back of her chair had been raised, with her sitting in a partial upright position. At 12:07PM, V4 (CNA) said she would be changing R9 after lunch. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/24 at 1:02PM, V4 wheeled R9 in her reclining chair to her room. V4 said she was assigned to R9 for the day, and R9 was already up in her chair when her shift started (at 7:00AM). V4 said this is the first time she has changed R9 (6 hours after her shift started). V4 and V5 (CNA) used a mechanical lift to transfer R9 from her chair to her bed. V4 removed R9's pants and incontinence brief. The front of R9's brief appeared wet with urine. After cleaning R9's perineal area, V4 rolled her to her left side to remove her brief. The back of R9's brief was visibly saturated with urine. R9 had a bordered dressing to her coccyx that was saturated, no longer adhering to her skin, and falling off. V4 placed R9 on her back and said her dressing was wet and needed changed. V4 said she did not know R9 had a wound to her bottom, this was the first time she had seen it. V4 verified her incontinence brief was saturated with urine. V9 was asked if there were any special interventions in place for R9 regarding her wound, care etc., and she said, not that I'm aware of, she just came back recently from the hospital. On 5/4/24 at 1:30PM, V7 (LPN) was preparing the new dressing for R9. V7 said this was the first time he saw R9's wound. V7 and V3(Wound Care Nurse) turned R9 on her side and removed the soiled dressing, partially in place to the coccyx. There was an irregular pale white shaped wound to the left and right buttock area extending over a small portion of the coccyx. The wound edges were pink and slightly red around the outer most aspect. The inside of the wound appeared clean. V7 cleaned the wound with normal saline, applied medihoney, and placed a calcium alginate square dressing over the wound. V7 then covered the wound with a bordered foam dressing, dating the outer dressing. No date was observed on the soiled dressing that was removed. After completing the wound care, V7 and V3 left. V4 finished covering R9 and left the room. R9's heels were left resting directly on the bed. At 2:55PM, V7 went into R9's room. R9's heelswere resting on the mattress, and her toes were resting on the end of the bed. R9 had a box attached to the foot of the bed, controlling the air mattress. The top of the box had a white sticker that said, continuous 150. V7 said they always put R9's heels up, but he wasn't sure where the pillow was, maybe they sent it to laundry. After looking around R9's room, V7 left the room and got a pillow and came back in and placed it under the lower portion of R9's legs, by the ankles. V7was asked to verify the setting on the air mattress pump. V7 said yes the arrow on the dial was set at 120. V7 said the company adjusts the setting when they set the bed up, we (nurses) don't touch it. On 5/4/24 at 3:07PM, V3 said the air mattress setting is determined by resident weight. V3 looked at R9's machine and said it should be set at continuous- 150 (what the sticker showed on top). She looked at the machine and said it was between 130 and 150. V3 changed the dial to align with 150. She said if it's too firm, it defeats the purpose, and if it's too soft it wouldn't help either. The weight needs to be distributed evenly. V3 looked at the sticker and said she placed it on the machine based of [R9's] weight. On 5/4/24 at 1:40PM, V7 said R9 should be repositioned every 2 hours, and her heels should be elevated when she is in bed. V7 said the goal would be to keep R9's dressing clean and intact. On 5/5/24 at 9:58AM, V3 said R9 should have her heels offloaded while in bed. She should have an air loss mattress and be turned and repositioned every two hours. If she is up in her chair, they should be checking to see if she needs her [incontinence brief] changed. They can also reposition her in her chair every two hours. V3 said it is very important for R9 to have incontinent care every 2 hours and as needed to keep her dressing as clean and dry as possible. She does not have a catheter, so they have to keep her clean. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/24 at 11:51AM, V16 (RN) looked at the setting on R9's air mattress machine. V16 verified the arrow on the dial was set at 180. V16 said the machine is set when the company sets the mattress up. V16 pointed at the white sticker that said, continuous 150 and said she did not know why it was set at 180, and she would change it to 150 because that is what the sticker said. V16 said it is important to keep residents clean and dry. Toileting and incontinence care should be done every 2 to 2.5 hours. V16 said when R9 is up in her chair, they should be taking her to bed for toileting/incontinence care and laying her down, so she is not sitting there on her bottom. V16 said they try not to keep her up a long time, and it would be hard to reposition her in her chair. On 5/5/24 at 1:10PM, V2 (Director of Nursing) said pressure ulcer interventions include an air mattress, turning and repositioning every two hours, and keeping the resident clean of urine and stool. V2 said it is very important to check the resident every two hours to make sure they are clean and dry. 2. R3's Facility assessment dated [DATE] shows she had severe cognitive impairment and required partial to moderate assistance from staff with toileting, upper and lower body dressing, and personal hygiene. This assessment shows she required supervision or touching assistance with sitting to standing, toilet transfers, and walking. This assessment showed she was at risk for skin impairment but had no unhealed pressure injuries. R3's Physician Orders printed 5/5/24 shows she had diagnoses to include dementia, type II diabetes with foot ulcer, major depressive disorder, generalized anxiety, and morbid obesity. R3's order dated 12/5/23 shows Skin assessment one time a day every 7 days. On 5/4/24 at 11:20AM, V3 (Wound Care Nurse) said on admission, R3 had wounds, but they resolved. V3 said R3 had no wounds when she discharged to the hospital (3/17/24), that were identified to her. On admission she had MASD (moisture associated skin disorder) to her abdominal fold, a skin tear to her left buttock cheek, pressure ulcer to left inner foot, fungal infection to her right great toe, and skin stripping to right. V3 said the last assessment by wound care, was completed on 11/22/23. V3 said the nurse will notify her (wound care) of any new skin concerns. The nurse would assess the new wound, call the doctor and obtain orders, and notify her. She will then do the assessment. On 5/5/24 at 12:16PM, V29 (CNA) said she cared for R3 prior to her going to the hospital. V29 said right before she left, she had an opening on her heel. She could not remember for sure which heel. V29 said it looked like a sore, it was red, and it hurt to touch. V29 said it looked like if you had a scab, and then pulled the scab off, there was definitely dead skin there. V29 said R3 said her heel was hurting. I was showering her, and she said it hurt. The CNAs do skin checks during showers, and she would report anything . scratches, redness, bruise, cracked skin, anything that doesn't look right to the nurse. V29 said they also document on the shower sheet. V29 said R3's nurse was not on the floor, so she reported the sore to the nurse covering the other side (V30-LPN), and she came and looked at it. V29 said R3 did not say how it happened, just said it hurt. On 5/5/24 at 12:35PM, V30 said she was working on the floor with R3 on a previous shift. V30 said an activity girl (V31-Activity Director) told her that R3 had a sore on her foot. V30 said she told [V31] to make sure she reported it to the wound care nurse. V30 said she was not R3's nurse and did not assess the wound. She said she did not report it to R3's nurse (V32-nurse) that day, because it was towards the end of the shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/24 at 1:00PM, V31 said she remembered R3. V31 said she reported a wound she saw on R3's heel to the nurse. V31 said she noticed R3 had been very busy. She had croc like shoes on, and her heel was out of the back (soft, rubber, slipper like shoes that slide on and off, leaving the back of the foot exposed). V31 said R3 did not have socks on, and the back of her heel was out. That's how she saw it. V31 said she told the nurse (V30) right away. She remembers V30 went over and looked at it and was cleaning it. V31 verified the date she noticed the sore was on 3/15/24, which was election day at the facility. She had it noted on her calendar. On 5/5/24 at 1:10PM, V2 (DON) said it sounds like R3 could have had a blister to the back of her heel from walking in her crocs. The blister may have opened, caused from friction to the heel. V2 reviewed R3's record and said there was no assessment of the wound. V2 said when a new wound is found the nurse should provide first aide, notify the doctor, obtain an order, and wound care would follow up. V2 said yes she believe a blister to the heel would be considered a pressure injury. R3's Bath/Skin check list dated 3/11/24 and 3/14/24 shows yes in the skin clear box. No areas of concern are identified on the body diagram on these sheets. Review of R3's progress notes show no assessment or identification of a wound to R3's heel, prior to her discharge to the hospital on 3/17/24. An assessment of R3's heel wound was requested and not provided by the facility. The facility policy Prevention of Pressure Ulcers/Injuries revised 1/2019 shows: 1. 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 (blood flow) to that area and subsequent destruction of tissue. 2. The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. Risk Assessment 5. CNAs will inspect the skin on a daily basis when performing or assisting with personal care or ADL.s b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.). Mobility/Repositioning At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. Risk Factor-Friction and Shear 9. Shoes need to be monitored for proper fit to avoid development of blisters, corns, and calloused areas. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer/Skin Breakdown - Licensed Professional Policy revised 12/2018 shows: Assessment and Recognition 2. In addition the nurse shall describe and document/report the follow a. Full assessment of the pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. Treatment/Management 1. The physician will order pertinent wound treatment, including pressure reduction surfaces, wound cleaning and debridement approaches, dressing .