STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009732	A. BUILDING _____ B. WING _____	C 10/13/2017

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SMITH VILLAGE	2320 WEST 113TH PLACE CHICAGO, IL 60643

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S 000	Initial Comments Complaint 1784445/IL95667	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6 300.3240a) 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 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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S9999	Continued From page 1 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: 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. 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 are not met as evidenced by: Based on interview and record review, the facility failed to implement fall prevention monitoring and interventions to prevent one resident (R11) of 10 residents reviewed for falls in a sample of 16 residents. This failure resulted in a subsequent fall of R11 with a laceration on the scalp requiring staples and cerebral hemorrhage (Intraventricular Hemorrhage). Findings include: Admit/Transfer/Discharge logs and census activity indicate that R11 was initially admitted to the facility (Assisted Living) and had a fall on 10/13/2016 with a fracture of left Humerus and was transferred to skilled memory support nursing unit on October 14th 2016. In skilled	S9999		

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unit, R11 had falls on 10/21/2016, 10/25/2016 and 04/12/2017. With the fall on 04/12/2017 R11 had laceration on the scalp with severe bleeding repaired with staples and intraventricular hemorrhage.

R11's Physician Order Sheet (POS) dated 04/2017 includes the diagnoses in part: Syncope and collapse, mild cognitive impairment, Cognitive communication deficit, Generalized muscle weakness, Abnormalities of gait and mobility, Difficulty in walking, Fracture of left Humerus, Osteoarthritis, Hypertensive heart disease with heart failure, Pulmonary Embolism with acute corpulmonale, Chronic congestive heart failure, Chronic Atrial fibrillation, Long term use of anticoagulants, Cerebral infarction, Dementia without behavioral disturbances, Sprain of Right knee, Urinary tract infection and Insomnia. R11 was on medications such as anticoagulants, Diuretics, pain relievers and medications that cause hypotension.

R11's initial fall risk assessment in the skilled memory support unit dated 10/14/2016 indicates R11 has intermittent confusion, has history of falls in past 3 months, is chair bound and needs assistance with elimination, have problems while standing, on medications that cause hypotensive effect and dizziness, R11scored high risk for falls but the column for calculated overall score and interventions were left blank.

R11's fall risk assessment dated 10/21/2016 indicates that R11had a score of 14- high risk for falls. Interventions: Resident has poor safety awareness due to cognitive communication deficit. Use fall/safety precautions to alert staff of

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postural changes. Resident does not comprehend use of call light. Staff will frequently check on resident when in room, if noted awake escort resident to common areas for supervision. R11's fall report indicates R11 had a fall in resident's room on 10/21/2017 at 05:30am, R11 was noticed to be on her knees by the bed with upper body on the bed. The root cause of the fall is due to resident action or internal risk factors. Resident status prior to fall: The number of staff in assistance- None.

R11's fall report reads: On 10/25/2016 resident (R11) had a fall in the dining room at 3:56pm, R11 was watching a movie in her wheel chair with alarm in place and was observed laying on her right side on floor of dining room a few minutes later and the environment was quiet with no one around. The root cause of the fall is due to resident action or internal risk factors. Fall occurrence specific follow up and resident status prior to fall: The number of staff in assistance - None. RECOMMENDATIONS: When moving residents from an area, make sure you don't leave anyone behind. Everyone should be watching residents, even nurses.

R11's fall report reads that on 04/12/2017 R11 had a fall in the dining room at 2:00pm; R11was found lying on the floor, holding back of her head with blood coming from her head, complained of dizziness. Nurse heard a loud bang and saw resident lying on the floor. 911 was called and R11 was transferred to local community hospital for head injury.

Clinical Notes Report dated 04/12/2017 by the nurse reads: Resident was in the dining room sitting in a regular chair. I heard the chair alarm, when I look through the window from the sitting

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area I saw the resident losing her balance and going backward. I ran toward her, but she already hit the floor, and hit her head. Resident verbalized she was dizzy and was bleeding from the head. - No staff was watching when R11 was left behind in the dining room.

Nurse's notes dated 04/13/2017 reads that R11 was admitted in the Intensive Care Unit (ICU) with intracranial hemorrhage and six staples to the head.

Hospital records from the community hospital's emergency room physician documentation read the following: Two centimeters laceration on right occipital scalp with mild surrounding contusion. Laceration of the scalp was repaired with staples and Vitamin k was given to stop bleeding. Radiologic studies of the head on 04/12/2017 and 04/13/2017 indicated small intraventricular hemorrhage layering in the occipital horn of the right lateral ventricle.

R11's nursing care plan reads R1 is at risk for injury related to fall risk. Goals: R11 will have measures in place to decrease incidents of injuries related to falls. Interventions include in part: Assist R11 with toileting, activities of daily living and ambulation as needed. Monitor altered cognition (Dementia) for progression, decline in safety awareness. Assess R11 on-going for fall risk. Keep R11 in public areas as much as possible for increased supervision. Staff will escort R11 to common area if noted awake in room for supervision. Resident should not be left in the dining room. Resident should be monitored at all times. R11 is also care planned for dementia with interventions of providing "Person-directed" interventions, validation and redirection.

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S9999	Continued From page 5 On 10/12/2017 at 3:45pm, Z2 (Primary Care Physician) stated " Because the CT(Computer Tomography) Scan (Special X-ray) showed cerebral hemorrhage, anticoagulant was kept on hold and Vitamin K was given.When a resident is at high risk for falls, the resident should not be kept on anticoagulants or it depends on the clinical condition of the resident and judgment of the cardiologist. Or the staff should have closer supervision of the resident to avoid falls." On 10/13/2017 at 11:30am, E4 (Restorative Director) stated in part " After the fall on October 25th 2016in the dining room, the fall prevention interventions in place were to make sure that She (R1) was not left alone in the dining room and to monitor her closely in the dining room. But the numbers of falls were increasing in number, she (R11) was not able to be redirected, if the staff had monitored her closely, we could have avoided the fall and injury on April 12th 2017." On 10/13/2017 at 12:30pm, E2 (DON) stated "In general, on a given day at the lunch time, there is at least staff which includes 4-5 CNA's (Certified Nursing Assistant), one nurse, one life enrichment aide and two additional aides for feeding. The fall on 04/12/2017 happened after lunch. I'm not sure why she (R11) was still in the dining room alone. The staff that I mentioned above is responsible to transfer residents out from the dining room into the common area. The fall was witnessed by the nurses from the window; the nurse was not in the dining room. If they were in the room, they could have avoided that fall. On 10/16/17 at 12:25pm, Z3 (Cardiology physician) stated, "For this resident (R11), I wrote	S9999		

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my last note in January 2017 for medical attending to follow up with controlling the anticoagulant medication. I didn't follow her after that. I was not aware of the fall in April 2017."

Facility's job description for Restorative Aide-Certified Nurse Assistant reads in part: Provides a neat and safe orderly department and environment for the residents.

The facility policy titled "Fall prevention, Response and Management "reads in part: The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well-being. All staff will be responsible in assisting with the implementation of the facility's fall management program to ensure the safety of all residents in the community. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as necessary. This policy was not followed.

(A)