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	IL6009732	A. BUILDING: _____ B. WING _____	01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH VILLAGE	2320 WEST 113TH PLACE CHICAGO, IL 60643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

care needs of the resident.
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.1210 General Requirements for Nursing and Personal Care

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.

These requirements are not met as evidenced by:

Based on interviews and record review the facility failed to follow their fall policy to minimize resident's falls and or injuries, failed to provide adequate supervision and failed to implement specific interventions for (R39) 1 of 6 residents identified as a fall risk in the sample of 12. This failure resulted in R39 being found unconscious on the bathroom floor with a bleeding hematoma to the back of the head. 911 was called to the facility, Cardiopulmonary Resuscitation (CPR) was initiated; shortly after R39 went into full cardiac arrest. (ALS) Advanced Life Support measures were initiated by the paramedics and R39 was transferred to the local Emergency room

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S9999	Continued From page 2	S9999		

where R39 was pronounced dead.

Findings Include:

During a review of R39's record on 01/19/2022 at 11:00 am, it noted (R39) was a 93 year old with Diagnoses of Dementia, Difficulty in walking, Glaucoma, Hyperlipidemia, Hypertension, Kidney Disease, Muscle Weakness, Repeated Falls and Urinary Tract Infection (UTI).

R39's MDS (Minimum Data Set) dated 9/03/2021 noted R39 in Cognition as 4 out of 15 indicating cognitive impairment related to Dementia. R39 was a 3/2=Extensive Assist with one person physical assist for Bed mobility, Transfer, Walk in the room, Locomotion on and off the unit, toileting and Personal Hygiene. The MDS noted R39 to have a history of multiple falls.

R39's care plan indicated R39 had falls on the following dates:

10/23/2021 - R39 was observed on the floor in the bathroom with a dash to the back of the head. 911 was called, resident sent to the hospital and died shortly after entering the emergency room.

10/7/2021 - R39 was observed ambulating unattended to the bathroom by Dietary aide, Resident reported feeling weak and was lowered to the floor by Dietary aide. No injury.

8/28/21- R39 was observed on the floor after nurse heard a loud thump from R39's room. Resident attempted to get up out of bed without assistance. No injury noted.

8/22/21 - R39 was observed in the bathroom laying on her right side. Resident had a right

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S9999	Continued From page 3 eyebrow laceration, resident sent out to the hospital. 6/24/21 - R39 was observed lying on right side in the common area. Resident was in front of recliner and walker off to the side. Resident was asked what happened and responded she wasn't sure. Resident has minor bruise on left hand, x-rays ordered. 5/18/21 - (R39) had repeated falls within a 4 hour period- Resident transferred to the hospital Emergency room for evaluation. CT scan and EKG done in ER. Post care summary states Diagnosis: Traumatic Injury of Head and to F/U with family physician within 3 days. Staff instructed to make frequent rounds for safety. 4/1/21 - R39 was walking in the hallway and lost balance per maintenance. No injuries noted 1/6/21 - R39 was observed lying face down in the hallway on the floor. Previous year falls on 07/11/2020 Resident had 2 falls on the same day, R39 was observed on the floor in the hallway and on the floor in front of room-mates cabinet. R39 sustained skin tears noted to the left arm. 5/26/2020 - R39 had a fall and doesn't know how it occurred. No injuries noted. 5/25/2020 - R39 was observed in the washroom on the floor and wasn't sure how she got on the floor. 4/23/2020 - R39 was observed on the floor in the bathroom, she was upset with staff. No injuries noted.	S9999		

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S9999	Continued From page 4 4/16/2020 - R39 was observed walking toward the door and falling. No injuries noted. The facility did not put any new interventions in place to prevent or minimize R39's falls and to avoid serious injuries. Fall Risk assessment were reviewed for each fall. R39 scored a 10 and 11 on assessments indicating a number greater than 10 = HIGH RISK. Review of R39's medication indicated R39 had an order for multiple anti-depressant medications that may cause drowsiness, dizziness, diarrhea, constipation or upset stomach. Medications as followed: Lipitor 40 mg. three times weekly at 9pm. Start date - (8/27/2021) , Mirtazapine 15 mg. 1 tab at hour of sleep, (start date - 08/31/2021) Cymbalta - 30 mg. capsule 1 capsule every morning (start date 09/28/2021). Meclizine 12.5 mg. tablet (1 tab), one time daily start date 04/07/2021 and discontinued on 08/24/2021. R39's Incident Report: Dated 10/23/2021 at 2:38 am -Resident was observed by (V16) assigned CNA (Certified Nursing Assistant) on the floor in her bathroom. V13 (Nurse) arrived, assessed R39 who appeared to be pale in the face with a tiny bit of blood present. V13 reported she was not able to obtain a blood pressure on R39 and that R39's oxygen level was at 74%. R39 begin to become unresponsive, V13 notified the physician and was instructed to send R39 out 911. The local Fire Department arrived at 2:45 am. Investigation Statements: V13 (Nurse), October 23, 2021, no time noted - I	S9999		

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S9999	Continued From page 5	S9999		

saw resident in bed around 2:30 am. Resident was asleep at that time. Resident was awake at the beginning of my shift and watching television. Resident went to bed, took her medicine and no problems. V15 (CNA) heard when the resident fell, she was right outside of resident room. Resident got up on her own and went to the bathroom.

V11 (Executive Associate Director) - October 23, 2021, no time noted - resident was observed on the floor in her bathroom, assessed by V13 to be pale color, decreased oxygenation level and undetectable blood pressure. R39 was transferred via 911 to the ER for a change in condition. Staff statement collaborate resident change in condition and listed chief complaint as Cardiac Arrest that caused the fall.

V16 (CNA) - October 23, 2021, no time noted - I had just come out of a resident room and headed to another resident room when V15 called me. I heard a loud thump in the room around 2:00 am. I hadn't checked on R39 my entire shift. I didn't know resident could get up and walk around on her own. V13 (nurse) told me not to disturb resident sleeping. Resident's walker was with resident when she fell, it was on top of her on the floor. The resident was on her back.

V15 (CNA) - October 23, 2021, no time noted - I was in the hallway and heard a thump, I went in and saw R39 on the floor with her walker. Resident usually calls with call light in her hand she didn't use it. I didn't hear R39 get up. I got the nurse (V13) who was in another resident room, I don't recall the time. We picked up R39 and put her in the chair. Resident seemed out of it, we put her in the bed and put oxygen on her. When resident was assessed she had a cut on the back

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S9999	Continued From page 6 of her head and was bleeding. 911 came and the police. Review of Paramedic Run Sheet: Dispatched to the facility on 10/23/2021 at 2:45 a.m., R39 was Unconscious/Breathing. Cardiopulmonary Resuscitation (CPR) was initiated by the local Fire Department at 3:00 a.m. Compressions were continuous, intermittent with bag valve mask. 10/23/2021 at 3:07 a.m. - Local Fire Department witnessed R39 go into full cardiac arrest. Patient was found lying in bed, Nursing home staff said patient had a hematoma on the back of her head. Upon moving patient into the ambulance crew noted patient to be apneic. Ambulance monitor not capturing rhythm, crew completed call with an E120 monitor and downloaded both into the report. Advanced Life Support (ALS) care and Cardiopulmonary Resuscitation (CPR) were initiated. Patient given 2 rounds of Epinephrine in route with change in patient condition. Dispatch Time for Run Sheet: Dispatch Date/Time: 10/23/2021 at 2:45 am, Unit in route: 10/23/2021 at 2:47 am, Arrived at Scene 10/23/2021 at 2:52 am, Arrived to Patient: 10/23/2021 at 2:57 am, Left Scene 10/23/2021 at 3:16 am, Patient at Destination: 10/23/2021 at 3:21 am, Patient transfer of care: 10/23/2021 at 3:24 am to hospital without further incident. Care released to Emergency Room nurse on staff. Emergency Room - Hospital Record: 10/23/2021 at 3:51 am - Patient (R39) is a 93 year old with a history of Hypertension, Chronic Kidney Disease and Dementia who presents to the Emergency Department (ED) from the nursing home with cardiac arrest. Per local Fire Department, the patient was found unresponsive with agonal	S9999		

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S9999	Continued From page 7	S9999		

respirations and shortly thereafter went into cardiac arrest. CPR and ACLS initiated and the patient was intubated prior to arrival.

Death Certificate - Review of R39's death certificate noted cause of death as Coronary Artery Disease, due to or as a consequence of. The death certificate is documented with time of death as 0341 pm. The hospital records noted the time of death in the Emergency room as 0341 am.

Interviews:

During a phone interview on 01/19/2022 from 1:47 pm - 2:04 pm, V13 (Nurse) was asked what happened on 10/23/2021 when R39 was found on the floor unconscious. V13 stated "I started my shift at 6pm, R39 was up sitting in the dining room watching television. R39 got up and went to bed." Surveyor asked V13 did R39 walk to the bedroom by herself. V13 stated "yes R13 always walks with her walker around the unit and goes to the bathroom by herself." V13 stated "I saw R39 in bed around 2:30 am, R39 was asleep at that time. I was called to the room, when I arrived R39 was lying flat on her back on the bathroom floor. There was some blood on the floor. I asked R39 did she hit her head and she said yes. I told V15 and V16 (Certified Nursing Assistants) to help me sit R39 up against the entry way. I told one of them to get a wheelchair and we lifted R39 up off the floor to the wheelchair and then put R39 in bed so I could assess her."

During a phone interview on 01/19/2022 from 2:06 pm - 2:13 pm, surveyor asked V15 (CNA) what happened the night R39 was found in the bathroom on the floor. V15 stated "I was in the hallway when I heard a loud thump, I went into

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S9999	Continued From page 8	S9999		

R39's room and I saw R39 on the floor in the bathroom with the walker on top of her." V15 was asked if R39 was responsive. V15 stated "No, she was unresponsive until we placed her in bed." V15 was asked if there was blood on the floor and if R39 had an injury. V15 stated "Yes, there was blood on the floor and R39 had a gash in the back of her head, I told V13 about the gash in the back of R39's head. I was not the assigned CNA, V16 was her aide. I called out to V16 who got V13 out of another resident's room. When V13 and V16 came into the bathroom, we picked R39 up off the floor, placed her in a wheelchair and transferred her to the bed."

During a phone interview on 01/20/2022 at 11:56 am with V16 (CNA), surveyor asked V16 what happened on 10/23/2022 when R39 was found on the floor in the bathroom. V16 stated "I had just come out of another resident room when I heard a thump around 2:00 am. I hadn't checked on R39 during my whole shift because V13 told me not to disturb the resident when sleeping." Surveyor asked V16 if she saw or looked in on R39 at any time prior to R39's fall incident. V16 said "No I did not. I did not know R39 could get up and walk around by herself." Surveyor asked V16 how often should they round on residents. V16 stated "every 2 hours but I was told not to disturb R39 because she can become agitated, I went into the bathroom, I saw R39 lying on her back on the floor with the walker on top of her. Myself, V16 (CNA) and V13 (Nurse) picked R39 up off the floor and placed her in the wheelchair. R39's head went forward and V13 said let's get her to the bed, so we transferred R39 to bed, V13 left the room, I guess to call 911. V13 told myself and V15 to put R39 up against the entrance of the bathroom and get a wheelchair. R39's head went forward; I called her name, but she didn't

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S9999	Continued From page 9	S9999		

answer. V13 said let's get her in the bed. We applied oxygen, V13 ran to the nursing station, I guess she went to call 911. (R39) started having secretions come out of her mouth. V13 kept saying R39 was a Do Not Resuscitate (DNR)."

V16 was asked how long has she been employed by the facility? V16 replied 15 years, I work seasonal every other week.

V16 was asked if she saw blood on the floor, V16 said yes. Surveyor asked V16 if R39 had a gash in the back of her head. V16 said yes. Surveyor asked V16 if they were supposed to pick R39 up off the floor knowing she hit her head and was bleeding. V16 said no, but V13 (nurse) told us to help get R39 off the floor into a wheelchair and put R39 in bed so she could assess her.

On 01/20/2022 at 11:02 am, surveyor called (V18) Physician and (V19) Alternate Physician, left voicemail to call regarding an investigation of R39's record. Surveyor did not receive a call back from the physician or the physician office.

Facility's Policy - Fall Prevention, Response and Management (Revision date - March 3, 2019) -

Although not all falls are preventable, staff can manage some contributing factors related to falls.

Purpose: To describe the process for identification of fall risk and interventions that may be used to manage and decrease the number of falls, therefore preventing resident injury.

C. Upon admission, quarterly and annually the resident will be assessed for fall risks using the Fall Risk
Assessment Tool. This tool will be used to

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S9999	Continued From page 10 evaluate eight clinical parameter including: (Overall Score of 10 or above represent HIGH RISK). a. Level of Consciousness/Mental Status b .Fall History in past 3 months c .Ambulation/Elimination Status d. Vision e. Gait/Balance f. Systolic Blood Pressure Changes g. Medications h. Predisposing Medical Conditions D. Nurse on Duty/Restorative Nurse to implement Fall Interventions as needed. f. Do not leave resident unattended in bathroom g. Safety rounds/checks j. Resident assisted to the bathroom as needed (A)	S9999		