STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006696	A. BUILDING: _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD CROSSING	6016 NORTH NINA AVENUE CHICAGO, IL 60631

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S 000	Initial Comments Complaints 2286794/IL150532 2286103/IL149731	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to 1) safely transfer a resident (R4) & 2) failed to monitor a dementia resident (R1) for toileting assistance. These failures affected two	S9999		

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S9999	Continued From page 2	S9999		

residents reviewed for falls with serious injury. R4 sustained laceration to the occipital (back) of the head and a nondisplaced corner fracture of the right T12 (back fracture) that required hospitalization. R1, with history of falls, sustained a closed left hip fracture after a fall.

Findings include:

Hospital medical records dated 08/19/2022, notes R4 presented to the hospital after a fall. The fall caused a scalp laceration to the back of R4's head (required 6 staples) and a back fracture.

R4 is a 77-year-old female. R4's diagnoses are but not limited to irregular heartbeat, heart failure, diabetes, heart disease, high blood pressure, right side body paralysis, kidney disease, and altered mental status. R4's BIMS (Brief Interview for Mental Status) dated 07/03/2022, notes R4 is alert. R4's MDS (Minimum Data Set) documents that R4 requires two people when R4 is being transferred. R4's care plan notes that R4 is a high risk for falls.

Progress note dated 08/19/2022, notes while passing evening medication, V7 (CNA) assigned to R4, called out for help in R4's room. Staff approached R4's room and observed R4 on the floor lying across the base of the mechanical lift. The head of R4 rested on the side of the bed frame. R4 was alert, conscious, and verbally responsive to commands. R4 had a laceration on the occipital area of head (back of head) with moderate bleeding. V7 stated the sling on the mechanical lift malfunctioned while attempting to transfer R4 from wheelchair to bed. V7 called for assistance from other nursing staff. R4's physician and family were notified. Staff received orders to send R4 to the emergency room for

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S9999	Continued From page 3 immediate attention. Staff called 911 emergency service for transportation assistance for R4. On 08/25/2022, at 12:50PM, V1 (Administrator) stated, "The sling, which I have, tore. The straps tore. Otherwise R4 was perfectly transferred. The sling was under R4. R4 stated R4 must go to the bathroom really bed. When V7 started to transfer R4, V7 noticed the sling broke, and everything happened so fast. V7 stated V7 heard a strap tear. R4 landed on R4's bottom on the floor and hit R4's head. R4 was awake and alert through the whole thing. R4 was screaming for help. V7 stated V7 moved R4 alone because the nurse was right there." On 08/25/2022, at 1:04PM, V4 (Registered Nurse) stated, "I came to the facility around 3:00PM. I was starting with the afternoon medication passage. I saw R4 sitting in the doorway. I told R4 to go to the bathroom. The aide (V7) that was assigned to R4's room was right behind me. I was down the hallway. I heard a call for help. I stopped medication pass. I saw R4 on floor with R4's head resting towards the bed frame. I could see that R4 had a gash. I asked the aides to help while I called for the other nurses. I did not witness anything. I only saw that R4 was on the floor. I did ask the aide what happened. The aide stated the sling gave away. I did not talk to R4, but I did determine that R4 was conscious and alert." On 08/25/2022, at 1:22PM, V6 (Corporate Nurse) stated, "V7 stated that V7 transferred R4 by himself. V7 stated that R4 was screaming for help and that is why the V7 transferred R4 by himself." On 08/25/2022, at 1:50PM, V8 (Medical Doctor) stated, "The fracture of the vertebrae (back) is	S9999		

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S9999	Continued From page 4 from the fall. R4 was admitted to the hospital with a vertebrae fracture." On 08/25/2022, at 2:06PM, R4 stated, "I was coming back to the room. I was in the wheelchair. There was one aide that was there. I ended up falling at the end of the bed and hit my head. I needed five stitches in my head. The aide was using the lift and I was in a sling. I did not black out. I was fully with it. I was taken to the hospital. They usually use two people when they move me. After it happened, I was in pain, and my back is sore. The neurologist confirmed that I have a small fracture in the vertebrae." On 08/26/2022, at 1:58PM, V7 (Certified Nursing Assistant) stated, "I was working sitting at the desk. The nurse was saying that R4 was trying to ambulate to go to the bathroom and R4 cannot stand. R4 had a mechanical lift sling underneath R4 already. I went in R4's room and the nurse asked if I could help R4 to the toilet. I asked R4 if R4 could stand. R4 tried and could not stand. I asked if R4 had on an incontinence brief and R4 said yes. I told R4 I would put R4 back in bed. I went to get the lift. I got it and came back to the room. I transferred R4 without any issue from chair to the bed. I proceeded to give R4 direct care and put a new incontinence brief on R4. I got the mechanical lift ready. I went to grab lift and I heard the strap break. I heard a thud. I turned around instantly. R4 hit R4's head against the bed frame and the rest of R4's body hit the floor. The nurse came in and assessed R4. The other nurses came in. Another nurse brought another sling. R4 was put into the bed with the lift. Two people are required to move residents when transferring with a mechanical lift. There was no one else to transfer R4 with me because I could not find anyone. This was first time working in this	S9999		

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facility. There was no in servicing or expectation training before I started. The risk of transferring by myself is the residents falling and hurting themselves. I would say getting another person would have helped the situation and the sling should be checked."

Facility policy titled Resident Handling Policy "Limited Lift", undated, notes the policy exists to ensure a safe working environment for resident handlers. Any transfer with a mechanical lift requires two-person assistance.

R1 is an 83-year-old female. R1's diagnoses are but not limited to left leg fracture, dementia with behaviors, Alzheimer's disease, anxiety disorder and cognitive communication deficit. R1's MDS (Minimum Data Set) dated 07/24/2022, notes R1 is not alert and needs total assistance from staff. Review of R1's falls note that R1 has had three falls in the facility. R1's fall on 07/09/2022, resulted in a major injury.

Progress note dated 07/09/2022, notes R1 sitting on the floor, legs straight facing the bedside table. R1 is alert and verbally responsive. R1 complained of pain to the left knee, femur and hip. R1 is unable to raise leg, put weight on it or bend knee. No swelling or bruising noted at this time. R1 denies hitting R1's head and denies losing consciousness. R1 states R1 doesn't know why or how R1 fell out of bed. Vitals assessed and were normal. R1 was sent to the local hospital after R1's physician was notified. Injury was documented as a closed fracture of the left hip.

On 08/25/2022, at 12:29PM, R1 was seen in the dining room. R1 could not answer any questions and was not alert. R1's had a winged mattress in

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S9999	Continued From page 6 R1's room. The facility informed the surveyor that the facility does not have a fall coordinator. On 08/25/2022, at 1:15PM, V5 (Certified Nursing Assistant) stated, "R1 was on the floor when I came in the room. I had to call the nurse's attention. I do not recall the nurse's name. I do not remember the time. R1 was on the floor mat by the bed. I remember providing incontinence care to R1 before R1 went to bed. I check on the residents at 1:00AM and at 4:00AM. R1 requires hourly rounding. " On 08/25/2022, at 1:22PM, V6 (Corporate Nurse) stated, " Whenever there is a reportable, I make sure that things are being identified. The root cause of the fall is R1 woke up and had to urinate. R1 is confused and got up without assistance." R1's care plan lists interventions before and after R1's fall. Before R1's 07/09/2022, R1's interventions were staff escort R1 to and from meals, remind R1 to use walker, anticipate R1's needs. Interventions after R1's 07/09/2022 fall are providing a winged mattress, fall mats, hourly rounding and low bed. (A)	S9999		