Illinois Department of Public Health

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 03/03/2022

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 Complaint Investigation FRI to 1/24/22/IL143699	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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	S9999	Attachment A Statement of Licensure Violations	

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resident to meet the total nursing and personal care needs of the resident.

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 observation, interview and record review, the facility failed to supervise dementia residents identified as high risk for falls, failed to implement new interventions when the old interventions were not working and failed to ensure previous fall interventions are applied per care plan to minimize the risk of injury for 2 (R1, R2) of 3 residents reviewed for falls in the sample of 3 residents. These failures resulted in R1 sustaining a fractured left 5th finger, a laceration to the head and skin tears; and R2 sustaining a left hip fracture from falling from the bed and requiring surgery that was not consented to due to advance age and poor cognition.

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The findings include:

On 3/1/22 at 11:45 AM accompanied by V3 (Assistant Administrator), the 3rd floor was toured. Inside R1's and R2's room, there were no floor mats. V3 showed that R1 now has a bed alarm that is silent but alerts the nurse that R1 is out of bed. This intervention was not seen in the care plan. Both R1 and R2 were in the 3rd floor living room area being supervised. R1 was seated in a wheelchair on 6 inch thick seat cushion that was covered with a pillowcase; which can be slippery if not positioned correctly and R2 was dozing with her head down toward her chest seated in a regular wheelchair. R1 no longer had the finger splint on her pinky. Staff stated it was just removed per physician's order.

On 3/1/22 at 12:30 PM with V5 (Restorative Licensed Practical Nurse/LPN), stated that fall interventions depend on the individual. Some of the interventions are education of the call light, lowest bed position, floor mats, toileting program, restorative exercises to build strength, keep in supervised areas, toilet after meals, wing-tipped mattresses, wedges and positioning pillows. V5 stated that floor mats are not good for ambulatory residents due to it being a tripping hazard. Asked about R2. V5 stated R2 is non-ambulatory, very anxious and moves herself from laying down to sitting up. V5 stated that R2 should of had floor mats in the room. As for the non-slip device, V5 stated that the skilled therapy department informed V5 that the non-slip device should be put under the seat cushion and not over the seat cushion. Asked V5 how is the non-slip device going to work to prevent R1 from sliding out of wheelchair? V5 stated he was surprised by what the skilled therapy department told him but V5

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claims that R1's non-slip device should be under her seat cushion and not over the seat cushion. V5 was asked about increased observation and purposeful rounding; and what the frequency was for observing and rounding? V5 stated that it's 30 minutes to an hour. Asked which is it, 30 minutes or one hour and V5 stated every hour is the frequency.

On 3/1/22 at 1:15 PM in R1 and R2's room, R1 is asleep in the low bed and no non-slip device was seen on top of the seat cushion in her wheelchair. V4 (assigned Certified Nurse Aide/C.N.A.) was providing personal care to R2. At 1:20 PM, V4 leaves the room and fails to lower R2's bed; which is 36 inches from the floor and didn't apply floor mats. There were no floor mats in the room at all. V4 (assigned CNA) stated R1 is not on any toileting program because R1 can say when she wants to use the toilet. Later at 1:30 PM, R2 was still without floor mats and the bed was 36 inches from the floor.

R1 is identified as high risk for falls per the Fall Risk assessments dated 2/2/22 and 12/28/21. The assessments document R1 to be alert, and oriented times three (person, place and time) with confusion. R1 has a brief interview mental score (BIMS) of 15 per the annual minimum data set (MDS) dated 11/22/21. The psychiatric nurse practitioner evaluation done on 2/17/22 documents R1 to be severely impaired with her cognition. R1 does have a diagnosis of Dementia. R1 has had numerous falls, mostly unsupervised, while residing in this facility. R1's care plan documents three falls in 2022. The 1/30/22 fall was when R1 slid from her wheelchair on her way to the toilet, the 1/24/22 fall was when she tried to transfer self from toilet back into her wheelchair and sustained a left 5th finger fracture. The

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S9999	Continued From page 4 1/12/22 fall had R1 on the floor parallel to the bed. In 2021, R1 had seven falls. The unsupervised falls were in R1's room on 2/10/21, 2/20/21 and 3/6/21; where R1 slid from the wheelchair and sustained a skin tear to left elbow and forearm. 5/5/21 and 5/10/21 falls occurred when R1 attempted to self transfer and fell. The 7/21/21 fall was when R1 tried to transfer self from bed to wheelchair to use the toilet. The 11/23/21 fall, R1 sustained a head laceration after attempting to go to the toilet and was sent to hospital and returned with surgical tape on the forehead laceration. R1's interventions are always the same and never change. R1's interventions have been to encourage R1 to use call light, educate R1 on bed positioning, supervise resident during use of toilet, frequent and purposeful rounding, increase observations, ensure wheelchair is locked, provide restorative services to maintain strength, use of a non-slip device and to initiate a toileting program to ensure staff are involved during toileting and to keep track of frequency of toilet breaks. The intervention for the 3/6/21 fall was the use of the non-slip device in the wheelchair which has not been seen in use. The toileting program was an intervention for the fall of 1/24/22. After R1's 1/30/22 fall, the facility's investigation documents assigned CNA stated that R1 will sit on toilet for 5 to 6 times in an hour and not void at all. In addition, R1 does not use the call light. Another CNA interviewed after the fall, stated that the cushion on wheelchair is large and that makes it difficult for the resident to reposition self and sit back further in wheelchair. R2 is high risk for falls per 1/17/22 and 1/30/22	S9999		

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fall assessments. R2 is severely impaired with her cognition (BIMS of 7) and requires extensive assistance from the staff for her activities of daily living per the quarterly MDS 1/4/22. R2's diagnosis includes Dementia. R2 has had 5 falls 1/30/22, 1/15/22, 1/12/22, 12/11/21 and 11/25/21 in 4 months' time. The 1/30/22 fall and the 12/11/21 fall were from the bed. The other falls were from the wheelchair due to sliding off cushion. The intervention was to apply a non-slip device to the wheelchair cushion to prevent sliding from wheelchair. This same intervention was added on 11/8/20, 4/4/21 and on 1/15/22. There was no mention of the non-slip device being in place for the 1/15/22, 1/12/22 and 11/25/21 falls, when R2 slid from her wheelchair. R2 did sustain a left hip fracture from falling from the bed on 6/25/21 and the intervention was to lower the bed. R2's other interventions were frequent rounding, meeting resident's needs prior to leaving her, increased monitoring, place at nurses' station for more supervision and to provide activities. Floor mats were not seen as a current intervention. Although surgery was recommended for R2, V8 (R2's daughter) decided due to R2's advanced age and poor cognition status that surgery would not be performed for the distal left femoral fracture per June 26th, 27th and 28th of 2021 nurses notes.

R2 had falls from the bed on 6/17/20, 6/3/20, 5/17/20, 5/6/20 and 5/5/20 but no injury prior to the 6/25/21 hip fracture from a fall. The interventions were to re-educate the use of call light, frequent rounding, keep personal items close by and increased supervision for a severe cognitively impaired resident.

On 3/2/22 at 10:53 AM in R1's room, V6 (assigned CNA) was supervising R1 on the toilet

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S9999	Continued From page 6 but V6 needed cued not take her eyes off R1 as R1 was hovering over the toilet wiping herself with her head downward. On the toilet room door frame was a blank Toileting Log. Asked V6 about the toileting log and V6 stated that the log has been there for a couple of weeks. After R1 was done with toilet use and assisted back to the main living area, V6 returned and filled out the log for that toilet break. The day shift for CNAs is 6:30 AM to 2:30 PM per V4 (Certified Nurse Aide); but there were no entries for earlier in the day. On 3/2/22 at 10:55 AM, V5 (Restorative Licensed Practical Nurse/LPN) stated the silent alarm pad was implemented 2 days ago for R1. As for the toileting log for R1, it was implemented after the 1/24/22 fall. V5 was only able to present 9 days of R1's toileting log instead of 37 days of toileting. V5 stated that one Certified Nurse Aide (CNA) told him she threw them out because she did not know what they were for. Asked the purpose of collecting the toilet log information? V5 stated "not sure" what he's going to do with the toilet log. At 11:11 AM, V4 (Certified Nurse Aide) stated he has seen the toileting log up in R1's toilet room but does not know what it is for because no one has informed him to use the log. On 3/2/22 at 2 PM, V1 (administrator) stated that the silent bed alarm took some time and effort to connect and set up due to the technology of it. V1 stated she understands that the Fall Prevention Program needs a major overhaul and more over-sight for V5. The facility's policy labeled FALL PREVENTION, RESPONSE AND MANAGEMENT documents it is the facility's commitment to minimize resident falls and/or injury so as to maximize each resident's physical, mental and psycho-social	S9999		

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S9999	Continued From page 7 well-being. While preventing all resident falls is not possible, it is this community's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. Residents at risk for falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and addressed on the plan of care. Residents requiring staff assistance will not be left alone during a bath, shower or toileting. The resident will be checked frequently or as according to the care plan, to assure they are in a safe position/environment. The frequency of safety monitoring will be determined by each resident's risk factors and plan of care. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. This was not followed. (A)	S9999		