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 04/04/2022

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 Investigation of Facility Reported Incident of 3/07/22/IL145087	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to R1. This failure resulted in R1 sustaining a fall which required R1 to go to the hospital due to sustaining a closed displaced supracondylar fracture of the distal end of right femur (thigh bone, or femur, is broken at the knee). and 6 staples to R1's head. Finding includes: R1's Face sheet documents that R1 has a diagnosis which include but not limited to: Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, unspecified injury of head subsequent encounter, history of falling, Alzheimer's disease with early onset, and vascular dementia. R1's Brief Mental Status Interview (BIMS) dated 12/09/21 documents that R1 is moderately impaired. R1's Brief Mental Status Interview (BIMS) dated 03/11/22 documents that R1 is severely impaired. R1 was not interviewable for this investigation.	S9999		

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S9999	Continued From page 2 Facility's document dated 03/07/22 and titled "Unexplained Accident/Incident Investigation" documented in part: "R1 was observed next to the bed on the mat on the floor, supine with R's head towards the radiator and feet towards the bed. R1 was with the Certified Nursing Assistant (CNA) at the time of fall... R1 was noted with a raised area to the back of R1's head with small opening. R1 was sent to the hospital for evaluation." Facility's fall incident report dated 03/08/22 documents that R1 sustained a laceration to the back of R1's head. R1's progress note authored by V23 (Registered Nurse, RN) documents that R1 had swelling to the right upper leg and 6 staples to the back of R1's head. R1's progress note authored by V24 (Registered Nurse, RN) documents that R1 returned from local hospital with a brace on her right lower extremity. On 03/30/22 at 2:54 pm, V21 (Certified Nursing Assistant, CNA) was interviewed regarding R1's incident on 03/07/22 and V21 stated that V21 provides care to R1 frequently and is familiar with R1's care. V21 stated that R1 is a total body lift and stays in the bed for the 3:00 pm - 11:00 pm shift. V21 stated that on 03/07/22 around 9:00 pm, V21 was providing perineal care to R1 and that R1 was not able to help V21 with turning and repositioning. V21 also stated that R1's legs are contracted in a bent position and that R1's hands are contracted in a fist position. V21 stated that V21 stood on R1's right side and turned R1 to the edge of the bed towards the window onto R1's left	S9999		

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S9999	Continued From page 3 side which was the opposite side of where V21 was standing. V21 stated that R1's hands remained contracted into a fist position and that R1 was not able to assist with the turning and repositioning, or able to hold onto the half side rail on R1's bed. V21 had V21's left hand on R1's shoulder supporting R1. V21's right hand was wiping R1 with a cleaning wipe, while R1 was laying on R1's left side at the edge of the bed. V21 stated as V21 reached for an incontinence brief for R1, V21 removed V21's left hand from R1's shoulder, no longer holding R1, leaving R1 unsupported at the edge of the bed. R1's feet began to slip off edge of the bed first then R1's entire body landed on the floor mat on the floor next to R1's bed. V21 also stated, "I usually keep my hands (V21 referring to V21's hands) on a resident to prevent them (referring to a resident) from falling or ask for help. On this day with R1, I didn't feel R1 had any declines, so I (V21) did her (R1) by myself (V21). On 03/31/22 at 10:49 am, V2 (Director of Nursing, DON) was interviewed regarding residents who are one person assist for bed mobility. V2 stated that residents who are 1 person assist should have the ability to help with turning and positioning in bed as well as be able to hold their (the resident's) position by placing hands and holding onto the half side rail if the resident has good trunk control. V2 stated residents who cannot assist with bed mobility should have a 2 person assist for safety. Surveyor asked V2 if a staff is having difficulty turning and repositioning a resident in bed what should the staff member do? V2 stated, "If a staff is having difficulty turning and repositioning a resident in bed staff should return the resident to the original position if they notice a resident is not helping with the repositioning." V2 also stated that	S9999		

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S9999	Continued From page 4 residents should not be rolled or turned to the edge of the bed during turning and repositioning. Residents should be turned to the center of bed because it is not safe for a resident to be on the edge of the bed. On 03/31/22 at 12:58 pm, V17 (Registered Nurse, RN) was interviewed regarding the incident related to R1 on 03/07/22. V17 stated that R1 is a resident who has contractures to bilateral hands and unable to straighten fingers, contractures to bilateral lower extremities, non-ambulatory and requires total assistance with care. V17 also stated that R1 is unable to use R1's side rails to assist with repositioning and that R1 receives total care from staff for bed mobility. V17 stated that V21 (Certified Nursing Assistant, CNA) did not ask for assistance with R1's care or report any changes with R1's status prior to R1 falling from the bed on 03/07/22 when V21 was providing R1 with care. On 03/31/22 at 1:08 pm, V19 (Physical Therapist, PT) was interviewed regarding R1's care. V19 stated that when V19 assessed R1 in November 2021, that R1 could not follow commands and was totally dependent on staff for bed mobility. V19 explained that R1 could not help with bed mobility, positioning and needed total assistance for changing, dressing, and transfers. V19 was asked regarding turning and repositioning residents who could not assist with bed mobility. V19 stated, "I would not recommend turning a resident to the opposite side of where you are standing to reposition them to the edge of the bed because a person cannot use their body to help prevent the resident from falling. The resident can roll out of bed and hurt themselves if the person assisting is standing opposite from the side the resident is turning and unable to assist.	S9999		

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S9999	Continued From page 5 03/31/22 at 2:59 pm, Surveyor requested R1's Assessment for Minimum Data Set (MDS) dated 12/09/21 section G. A. Bed mobility from V2. V2 stated there is no restorative program for turning and repositioning for R1 for the 12/09/21 MDS, and that the facility did not have a restorative nurse at that time. R1's progress notes authored by V17 (Registered Nurse) dated 03/07/22 documents that V21 (Certified Nursing Assistant, CNA) reported R1 fell off the side of the bed and sustained a bump to the back of R1's head and that 911 was called at 9:47 pm for R1. R1's progress notes authored by V17 (Registered Nurse) dated 03/08/22 documents that an x-ray was performed to R1's right lower extremity, pelvis, and right foot and the results showed a fracture to distal right femur with orders to send resident to emergency room for follow up. R1's hospital records documents that R1 was sent to the emergency room (ER) on 03/08/22 with x-ray imaging performed to the right knee that confirmed that R1 sustained a comminuted fracture of the distal femur with slight anterior angulations and 6 staples to R1's head. Facility's Reportable Incidents from January 2022 through March 2022 reviewed and documents that R1 sustained a fall with injury on 03/07/22. Facility's Accident and Incident Reports from January through March 2022 reviewed and documents that R1 sustained a fall with injury on 03/07/22. R1's Fall Care plan dated revised on 11/29/21 documents in part that R1 is at risk for falls due to	S9999		

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S9999	Continued From page 6 impaired mobility, confusion, incontinence, psychoactive drug use, psychosis and unaware of safety needs. R1's Fall Activities of Daily Living (ADL) care plan dated initiated 03/29/18 documents in part: R1 has ADL self-care performance deficit secondary to impaired mobility, decrease in ADL's. Physical limitations: Balance problems, gait strength, endurance. Facility's "Certified Nurse Assistant, C.N.A." job description, documents in part: Cooperate with inter-departmental personnel, as well as other facility personnel to ensure that nursing services can be adequately maintained to meet the needs of residents. (A)	S9999		