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 04/24/2022

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

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S 000	Initial Comments Facility Reported Incidents: From 3/30/22/IL145638	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210 c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal 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. 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 record review and interview the facility failed to ensure a resident receives adequate supervision and assistive devices to prevent accidents in one (R1) of three (R1, R2 and R3) residents included in the sample by not using proper transfer assistive device and failing to use a two person assist in the use of transfer assistive device. This failure resulted in a serious injury to R1. Findings include: V3 (CNA) failed to use the proper transfer	S9999		

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S9999	Continued From page 2	S9999		

assistive device. V3 failed to use two persons for the transfer per facility policy.
R1 is a 96-year-old female with a diagnosis including History of Falls, Muscle Weakness, Osteopenia and Iron deficiency anemia.
R1 has a BIMs score of 11. R1 is presently on hospice care.
R1 clinical notes dated 3/29/22 states including V6 (Nurse) notified by CNA that resident was assisted to bathroom via sit to stand. Resident was unable to tolerate sit to stand. Post transfer resident with C\O pain to left shoulder and left elbow. Unable to perform range of motion. Resident medicated for pain with Tylenol around 2PM. Left arm elevated on small pillow for comfort. Heat pack applied for pain relief. MD notified and ordered Xray to left shoulder and left elbow.

R1 hospital record dated 3/30/22 shows x ray results of traumatic closed displaced fracture of left shoulder with anterior dislocation, initial encounter.

On 04/22/22 at 11:35AM, V1 (Administrator) stated we did investigation into R1 incident with a dislocated shoulder. R1 recently had care plan changed to mechanical lift with two persons for any transfers including to the toilet room. V3 (CNA) failed to properly transfer R1 to the toilet room. V3 failed to view the care card located in R1s room before the transfer. V3 used a sit to stand instead of mechanical lift with two persons. During R's returning to bed her weight shift resulted in R1 fracturing and dislocating her left shoulder. During investigation of the incident V3 quit employment.

On 04/22/22 at 11:43AM, V2 (DON) stated V3 (CNA) did not do a proper transfer. The CNA

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S9999	Continued From page 3	S9999		

failed to look at the care card located in R1s room before taking her to the toilet. V3 used a sit to stand. R1 was complaining of shoulder pain. We ordered a x-Ray in house. We ordered pain medication. We updated our policy to say if in house x-Ray exceeds 5 hours we have to send to hospital for evaluation. We sent R1 out. The hospital found a fracture and dislocated left shoulder. We did an investigation and found that V3 transferred R1 by herself from bed to toilet room and back to bed with a sit to stand. When coming back from toilet room R1 let go of bars causing weight to shift and causing dislocation. We in-serviced V3 and staff on proper transfer. V3 quit before we could take any action with her.

On 04/22/22 at 12:09PM, V4 (Physician) stated R1 is on hospice due to decline and family request. R1 was admitted to the hospital previous to incident for vaginal bleeding and possibility of cancer. R1 is 96 years old. The family decided not to have her treated. R1 was declining. R1 was injured due to CNA not using proper transfer.

On 04/22/22 at 12:30PM, V5 (Restorative Nurse) stated the CNA who transferred R1 used the old method of sit to stand to transfer instead of mechanical lift to transfer. V3 failed to view the care card located in room before transferring R1. During return from toilet to bed she let go of the hand bar and her weight transferred causing the left shoulder injury.

On 04/22/22 at 2PM, V6 (Nurse) stated V3 (CNA) reported to me that R1 was complaining of pain. I went to resident's room. Family members were there and told me that while V3 was transferring R1 with a sit to stand to transfer she complained of pain. R1 did not have the strength to hold on to the hand bar and her weight shifted. I gave her

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S9999	Continued From page 4 pain medication and notified the doctor. The Doctor ordered an X-ray. It was the end of my shift. I later found out she had an injury to her shoulder. V3 was supposed to use a mechanical lift with two staff to do the transfer. V3 (CNA) could not be contacted during investigation. V3 is no longer workin at facility. Facility interview document statement with V3 (CNA) dated 3/30/22 shows the following facts per interview of V3 of transfer incident by the Director of Nursing and Restorative Nurse. Managers Present during phone interview of document statement, V2 (DON) and V5 (Restorative Nurse). Did you transfer R1 prior to bathroom transfer? No, the first time transferring R1 was when I took her to the bathroom. Walk me through your transfer. CNA informed me the resident wanted to go to the washroom. I was monitoring the common area and I switched with V10. I asked V10 how to transfer her, he stated sit to stand. Resident was in the bed, and I wheeled her into the bathroom using sit to stand, I lowered her to the toilet. Did you transfer R1 alone? Yes. Was she holding on the sit to stand? She was holding onto the bar when I took her to the bathroom. I had her strapped in appropriately and her legs as well. Did she complain of pain at all? She complained of pain when she was holding onto the bars, coming out of the bathroom. She appeared tired when coming out of the bathroom because she let go of the bars. Her arms were tired of holding on, so I was trying to work quickly to get her back to bed. Did she bump her head? No, I have no recollection of that.	S9999		

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S9999	Continued From page 5 When you don't know how to transfer a resident, what do you do? Look at the report sheet or ask someone that might know / is familiar with the floor. When you were orientating, how were you instructed to find out how a resident transfers? 24 hr. report, care cards and nurse. Did you have 24-hour sheet with you? No, I placed it on the desk. Are you familiar with the yellow cards in the room? Yes. Did you look at that before transferring the resident? No. Do you feel you need more education with transfer? Maybe just the different pads / slings. R1's current MDS Section G states R1 requires 2 person assist for transfer. R1 current care plan (SSL-ADL Functioning) states including R1 requires full hands on assistance with bed mobility, transfers (Hoyer lift w/2 person assist) and toileting. R1 "Care Card" dated by V1 as 3/18/22 which located in residents' room for staff reference, states including "Hoyer transfer (2-person asst.)" Restorative clinical note dated 3/9/22 12:30PM states restorative aid recognized that resident had more difficulty with standing/transferring while using sit to stand. Resident yellow card changed from sit to stand to Hoyer lift for transferring. 24-hour CNA report updated to Hoyer lift as transfer device. Physician, V4 stated he did not want to write orders for therapy at the time. Facility policy Titled Safe Transfers Effective Date: August 2002. states including: III. Procedure:	S9999		

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S9999	Continued From page 6 6. When using a mechanical lift for transfer such as Hoyer or Sit to Stand staff should use a two-person method. 7. Requirement for use of sit to stand i. Resident able to follow direction ii. Resident able to bear 30% of leg weight iii. Resident is able to hold on 8. If resident is unable to meet the above requirements, they must be transferred using a Hoyer lift. (B)	S9999		