| 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 03/16/2023 |

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

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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of<br><br>3-2-23/IL157310 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to ensure the resident received adequate supervision and assistive devices to prevent serious injury to the resident. This failure affected one (R2) of three residents (R1, R2 and R8) reviewed for accident prevention by not using proper transfer practices. This failure resulted in R2 sustaining a skin tear during transfer, which required sutures at the local hospital.<br><br>Findings include:<br><br>R2 is a 99-year-old female resident with diagnoses including Heart Failure, Dementia with Psychotic Disturbance and History of Falls. R2's BIMS (Brief Interview for Mental Status) score | S9999 | | |

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| S9999 | Continued From page 2<br>indicated R2 is not able to be interviewed.<br><br>Minimum Data Set scores R2 at 3 (Extensive Assistance) with 2 (One-person physical assist) for transfer.<br><br>R2 is care planned as a high risk for falls due to impaired mobility, strength and cognition related to Dementia, Urinary Tract Infection, Dysuria, arthritis, malaise and fatigue and history of falls.<br><br>Facility Incident Report dated 3/2/23 states that on 3/2/23 at 13:15, R2 was transferred to the bed from her wheelchair by V13 (Certified Nursing Assistant/CNA) and sustained a skin tear. Wheelchair was beside bed with chair legs still attached. V13 stated that resident was not letting go of the wheelchair during transfer and her leg brushed against the bedframe causing the skin tear. A gait belt was not used during transfer. The bedframe was noted to have missing covers over the aspects of the frame. Skin tear measures 7X3 cm. Bleeding at site noted. Resident denied pain at this time. ROM (Range of Motion) to BLE (Bilateral Lower Extremities) is at baseline. Noted no swelling or bruising at site. MD was notified and ordered to send to Emergency Room for evaluation. Following evaluation, writer notified that resident received sutures to site and they are to be removed in 10-14 days.<br><br>Conclusion: It was concluded that resident sustained a skin tear during transfer due to resisting care. Interventions: Bedframe covers to be installed on bed. V13 was educated to remove wheelchair leg rests, use a gait belt during transfer, and to go at resident pace during transfers, thus decreasing chance of injury. Going at the resident pace will decrease chance of resident resisting care and holding onto the | S9999 | | |

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| S9999 | Continued From page 3<br>wheelchair during transfers. Resident is now a 2-person transfer.<br><br>On 3/13/23 at 12:50PM, R2 was observed in corridor being assisted with lunch directly outside her room. R2's bed was against the wall. A floor matt was next to the bed. The metal bed frame directly under the mattress protrudes approximately 2 inches out from bottom of mattress. At this time the exposed metal bedframe was observed with foam padding on outside frame rail. This was done after the 3/2/23 incident.<br><br>Hospital record dated 3/2/23 shows R2 was diagnosed with a left lower leg laceration of 9 centimeters in length which required 8 sutures.<br><br>On 3/14/23 at 3:06PM, V13 (Agency CNA) with V2 (Director of Nursing/DON) present stated, "I have been a CNA almost 4 years. I am a certified CNA. On the day of incident, I was about to take my break; the nurse told me I had to transfer R2. I had to use rest room. I finished and went to R2's room. I needed to transfer R2 into the bed from the wheelchair. I put my arms under R2's armpits. I lifted R2. As I lifted R2 she held onto the arms of wheelchair. It became clumsy. I managed to pivot R2 to the bed. R2's legs hit the metal sides of the bed. When she was fully in bed, I saw she was injured on R2's right leg. There was an open wound. The skin was cut open; you could see the flesh behind the skin. I went to tell the nurse. We went back to the room. The nurse went to tell V16 (Assistant Director of Nursing/ADON). R2 did not cry or anything. V16 came. V16 asked me what happened, and I told her. V16 told me I shouldn't have proceeded to transfer when I saw the condition of R2 holding the arms of wheelchair. R2 wasn't combative. V16 told me I should have | S9999 | | |

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| S9999 | Continued From page 4<br>used a gait belt to do the transfer. I have worked in the facility several times. I haven't had any incidents during transfers at this facility before. The facility trained me in transfer. When transferring you should check the assistance needed and whether it's one, two or three-person transfer. R2 was a one-person transfer. This is displayed on the entrance of room. I am supposed to use a gait belt. If the person is not able to stand then you use a gait belt. When you do a one person transfer you are supposed to use a gait belt. R2 needed a gait belt. I didn't have the gait belt on me. I forgot the gait belt when I went in her room. I am familiar with the facility transfer policy which states to use a gait belt. I am familiar with the policy by inservices given regularly.<br><br>On 3/16/23 at 9:50AM V16 (Assistant Director of Nursing) stated, "I was with R2 after the incident happened. I saw the skin tear. R2 was assessed and sent to the hospital. I told V13 (CNA) that he shouldn't have proceeded with the transfer from wheelchair to bed if she was holding onto the arms of the wheelchair. I told V13 that he was supposed to use a gait belt for the transfer. V13 did not have his gait belt."<br><br>On 3/14/23 at 1PM, V11 (Registered Nurse/RN) stated, "I take care of R2. She had her stitches taken out today. I wasn't here when the accident happened. I heard that a CNA was transferring R2 from wheelchair to bed. The CNA bumped R2's leg on the bedframe and caused a skin tear. She had to go to the hospital. R2 was a 1-person transfer. Since the accident she is now a two-person transfer. The CNAs are supposed to use a gait belt for all transfers. I don't think the CNA used a gait belt." | S9999 | | |

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| S9999 | Continued From page 5<br><br>On 3/14/23 1:10PM, V12 (RN) stated, "R2 was injured during a wheelchair to bed transfer. R2 hit her leg on the bedframe. She got stitches out today. All staff are supposed to use a gait belt when transferring a resident. The staff who transferred R2 did not use a gait belt."<br><br>On 3/15/23 at 11AM, V2 (DON) stated, "All staff are to use a gait belt during transfer of a resident. This is facility policy. V13 (CNA) was supposed to use a gait belt during the transfer of R2. V13 failed to use a gait belt. If V13 used a gait belt it could have prevented injury to R2."<br><br>On 3/15/23 at 1:35PM, V7 (Medical Director) stated R2 sustained a skin tear from bumping her leg on the metal bedframe of her bed. It is very possible that the accident could have been prevented if the CNA used a gait belt for a better transfer. R2 has skin that is very thin and brittle due to age. Her skin is easily injured.<br><br>Facility Resident Handling Policy documents, "Gait belt usage is mandatory for all resident handling with exception of bed mobility and medical contraindications. The gait belt will be considered a part of the certified nursing assistants' uniform."<br><br>(B) | S9999 | | |