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
	IL6016059	A. BUILDING: ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH CROSSING	10501 EMILIE LANE ORLAND PARK, IL 60467

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S 000	Initial Comments Complaint Investigation #2376263/IL162569	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident.

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 300.3240 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 requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to provide safe transfer assistance and trained facility staff neglected to provide safe transfer assistance resulting in resident injuries and falls. This applies to 2 residents (R1-R5) reviewed for transfers. This failure resulted in R1 incurring a fracture of the right femur and R3 incurring a fracture of her right humerus.

Findings include:

1.R1's Face Sheet dated 8/9/2023 documents R1 as a 93 year old with diagnoses to include a right periprosthetic fracture around an artificial knee joint, Vascular Dementia and History of a Stroke.

On 8/4/2023 12:15 PM V28 (R1's Daughter)

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S9999	Continued From page 2 stated she was at the facility on 7/9/2023. After lunch R1 had to use the bathroom and was transferred using a stand assist mechanical lift by V9 (Former Nursing Assistant). V28 stated V9 was the only staff member present completing R1's transfer and V9 did not have R1's legs strapped into the machine properly. V28 stated, "typically the girls strap her legs in, and she was not secured against the (leg) plate like she usually is which left too much give." V28 stated the next day (7/10/2023) she adjusted R1's feet in the wheelchair and as she moved R1's right leg she yelled out in pain, and she became less responsive. V5 (Nurse) heard R1's scream, responded and called the paramedics because R1 was not as responding as usual. V28 stated as the paramedics were lifting R1 from the wheelchair to the stretcher she again yelled in pain. V28 stated R1 frequently complains of knee pain but her tone and frequency was different this time. R1 continued to complain of knee pain in the emergency room and after continuing to complain of pain on 7/11/2023 in the hospital an X-ray was done, and a fracture was found. V28 stated R1 was initially admitted with pneumonia. On 8/7/2023 at 10:21 AM V9 stated on 7/9/2023 she worked 6 AM-2:30 PM and completed 2 sets of transfers using the stand assist mechanical lift with R1. V9 stated the first transfer was in the morning when she was getting her dressed and out of bed into her wheelchair. V9 stated she used the stand assist mechanical lift to transfer R1 despite being unable to get her left leg positioned on the machine correctly. V9 reported R1's right leg was where it should be, but her left leg was on the left edge of the platform, almost off and not flush. V9 further stated R1's left leg was straight, not bent at the knee so the only leg that was correctly placed was the right and all her	S9999		

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weight was placed on her right leg as she was lifted. V9 stated after lunch V28 "supervised" her while she transferred R1 to the toilet then back to her chair. V9 denied any other issues during the transfers but stated R1 did say, "Oh my knee," and she was more "quiet and fussy" during care when she is normally compliant. V9 confirmed she was trained to use 2 staff for all transfers with mechanical lifts and additionally was provided additional training.

The facility Administrator Timeline of Events dated 7/28/2023 documents an investigation was completed, and a discrepancy was identified on a written statement completed by V9. V9 wrote in her statement she was being assisted by V19 (Nurse) for R1's transfers, called off during the investigation and also was a no call, no show causing the facility to be suspicious of V9's behavior. The facility concluded during this investigation that the likely cause of injury to R1 occurred during one of V9's stand assist mechanical lift transfers. V9 was to be terminated but resigned via text instead of reporting to the facility.

On 8/4/2023 10:10 AM V3 (Outgoing Director of Nursing) stated the facility was notified of R1's fracture and an investigation was started. R1 did not have any reported falls or incidents that the facility could identify. During interviews with staff, it was identified only one staff was present, instead of the required two when V9 transferred R1 on 7/9/2023. V3 stated V9 is very petite and if R1 had fallen in any scenario V9 would require a second person and a mechanical lift to get R1 off of the floor therefore a fall from the stand assist lift was ruled out.

On 8/4/2023 10:10 AM V2 (Interim Administrator)

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stated "I suspect all signs point to something occurring on that shift with that aide (V9)."

On 8/7/2023 at 9:50 AM V7 (Restorative Nursing Assistant) stated, she is one of the Nursing Assistant mentors and trains new Nursing Assistants on use of the lifts including return demonstrations. V7 stated V9 received additional hands on transfer training because she requested additional training. V7 stated part of V9's additional training included V7 working with V9 only on transfers for an entire shift. V7 stated V9 was able to successfully demonstrate safe transfers.

R1's Final Orthopedic Consultative Report completed by V18 (Orthopedic Physician) documents R1 with diffuse bone demineralization and a transverse comminuted fracture of the distal right femur. This fracture is located around the area of a surgical artificial knee replacement completed 10/2011. V18 discussed treatment options with V28, an immobilizer was placed to the right the leg and surgery was declined.

On 8/9/2023 at 10:37 PM V18 documented in email correspondence R1's type of fracture typically occur from some trauma, likely the result of an injury from a fall, or a twisting mechanism in R1's osteopenic bones.

On 8/8/2023 11:30 AM V15 (Physical Therapist) stated all mechanical lifts require 2 staff to be present during the transfer. V15 stated failure to have 2 staff during mechanical lift transfers creates a risk of the resident not being set up properly for the lift, to spot the resident during the transfer, and increases the risk of a fall. V15 stated proper positioning on a stand assist lift includes knees not protruding outward over the

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feet, body weight should be distributed properly so too much pressure is not placed on the knees, both feet have to be secured on the footboard and knees are to be placed against the leg support and buckled in properly. In addition, proper feet placement reduces the torque and pressure applied during the transfer. V15 stated R1 would not be able to cognitively comprehend to correct her feet placement and the force would have been downward onto her legs if she only had one foot correctly placed during a transfer. V15 stated proper lift technique reduces the chance of injuries and improper technique could have contributed to R1's injury and cause the fracture.

On 8/4/2023 at 1:10 PM V6 and V7 (Nursing Assistants) transferred R1 to bed using a mechanical lift. R1 had an immobilizer brace that encompassed a majority of her right leg and she complained of discomfort during the transfer.

R1's 5/17/2023 Restorative Nursing Program Evaluation documents R1 as a 2 person assist using a stand assist mechanical lift.

R1's Minimum Data Set dated 2/24/2023 documents R1 with severe cognitive impairments and requiring 2 persons extensive assist for transfers.

2. R3's Face Sheet dated 8/9/2023 documents R3 as a 92 year old with diagnoses to include history of left patella fracture, muscle wasting and atrophy and neuropathy.

R3's 5/24/2023 Final Report of Resident Injury, dated 5/24/2023, documents on 5/23/2023 R3 complained of bilateral shoulder pain and right arm pain after a stand assist mechanical lift

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transfer. An X-Ray was completed and showed a fractured right humerus.

On 8/9/2023 at 2:08 PM V29 (Agency Nursing Assistant) stated, she transferred R3 on 5/23/2023 with no other staff assisting. V29 stated, "It was an unfortunate accident. I wasn't being as cautious as I should have been. I have been a Nursing Assistant since 2008 and have done a sit to stand (stand assist mechanical lift) many times. I was by myself and didn't get the other Nursing Assistant. I didn't have her secured in there as well as I thought. I put her in and lifted her up and as I was moving her to the bathroom, I noticed her foot had slipped off and she slipped down in the lift and she started complaining her arm and shoulder hurt..."

On 8/7/2023 V12 (Restorative Nurse) stated V29 notified the nurse R3 had slipped during a transfer using the stand assist mechanical lift hurting her arm. R3 was found with a fracture which was consistent with the injury. V12 stated V29 is from an agency and did not have another staff member present as required.

R3's Shoulder Radiology Report 5/23/2023 documents R3 with a fracture of the right humerus at the surgical neck (proximal humerus).

R3's Physical Therapy Discharge Summary dated 3/12/2023 documents R3 is to transfer via a stand assist mechanical lift with 2 staff.

8/7/2023 at 1:37 PM V1 (Administrator) stated agency staff are trained through their employer and the agency validates their staff have the proper training prior to sending them to work at the facility. V29 was an agency employee, and the agency was notified V29 can no longer work

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at the facility.

The policy Safe Resident Handling dated May 2022 documents staff participating in resident handling and movement shall always practice safer resident handling techniques. This policy further documents gait belts are required for all transfers and the use of a mechanical lift or stand assist lift requires 2 staff to perform the transfer.

The policy Accidents and Supervision dated March 2023 documents each resident will receive adequate supervision and assistive devices to prevent accidents. This policy documents specific interventions are to be implemented to reduce a resident's fall risk, including implementation of specific interventions as part of the resident's plan of care.

The policy Abuse, Neglect and Exploitation dated 8/26/2022 documents it is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect, exploitation and misappropriation of resident property. Neglect is defined as failure of the facility, its employees or service providers to provide goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility will implement policies and procedures to prevent and prohibit all types of abuse and neglect that achieves identifying correcting and intervening in situations in which abuse and neglect is more likely to occur with the deployment of training and qualified registered, licensed and certified staff on each shift in sufficient numbers to meet the need of the residents and assure the staff assigned have knowledge of the individual resident's care needs.

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