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	IL6009732	A. BUILDING: _____ B. WING _____	C 01/11/2021

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 Complaint Investigation: Facility Reported Incident of September 27, 2020/IL128652 Facility Reported Incident of September 27, 2020/IL128795	S 000		
S9999	Final Observations Statement of licensure Violation: 300.610a)b)c) 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. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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. 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,	S9999		

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S9999	Continued From page 2 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. These requirments were not meet as evidenced by: Based on observation, interview and record review the facility failed to provide safe transfer for 2 of 3 residents (R1 and R6) reviewed for transfer. This failure affected R1 and R6 and has the potential to affect all 44 residents residing at the facility. R1 and R6 were transferred during care without staff assistance or use of transfer device. This failure resulted in R1 sustaining a mild impaction fracture of the distal right radius. In addition, the facility failed to report to the State Agency a resident with unknown injury. This failure affected R1 and has the potential to affect all 44 residents residing at the facility. Findings include: On 1/5/21, R1's medical record face sheet showed that R1 was originally admitted 5/1/2020 to assisted living section of the facility with diagnosis that includes but not limited to Muscle Weakness, Unspecified Mood (Affective)	S9999		

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S9999	Continued From page 3 Disorder, and Unspecified Dementia without behavioral disturbances, and Iron Deficiency Anemia. On 1/5/21 at 9:26am, R1 was noted in her room sitting in a wheel chair, R1 was unable to remember how she got the bruises on 9/23/20 and the reported incident of 9/27/20. Review of R1's clinical notes report showed that R1 was noted with bruises to the right wrist during shower on 9/23/20. On 9/26/20 swelling was noted and X-ray was done. Result showed there was a mild impaction fracture distal right radius. According to the initial facility report sent to the regional office on 9/27/20, under the Description/ Summary of Incident documented that resident was observed with redness to right wrist during shower on 9/23/20, X-ray was ordered by MD (Medical Doctor), and received result today indicating a mild fracture distal right radius". The final report dated 10/1/20 under Resolution of Incident documented that "Resident was transferred during shower improperly resulting in mild impaction Fracture to distal right radius. Resident received an X-ray and had an appointment with Ortho. New orders to follow up with OT (Occupational Therapy). Staff to receive education. Resident has osteoarthritis also osteoporosis. R1's facility tool used in assessing residents MDS (minimum Data Set) dated 5/04/20 section G ADL (Activities of Daily Living) assistance coded R1 under transfer as 3/3 which indicated that R1 needs extensive assistance and two person assistance. R1's facility tool used in assessing residents MDS	S9999		

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(minimum Data Set) dated 9/29/20 with completed date of 11/03/20 section G ADL (Activities of Daily Living) assistance coded R1 under transfer as 3/2 which indicated that R1 needs extensive assistance and two person assistance.

On 1/5/21 at 10:03am, interview conducted with V7 LPN (Licensed Practical Nurse) wound care nurse who completed the final incident report sent to the regional office. V7 explained that she is the wound care nurse and any skin issues are reported to her for follow up. V7 explained that in her talking with V6 CNA (Certified Nurse's Aide), V6 admitted that she transferred R1 during shower without use of appropriate transfer device.

On 1/5/21 at 11:53am, interview was conducted with V8 (Restorative Nurse/Assisted living Coordinator). V8 stated R1 is non mobile requires assistance for feeding, dressing, bathing and transfer.V8 stated R1 needs use of gait belt and two person assistance with transfer. V8 explained that V6 CNA (Certified Nurse's Aide) did not use the appropriate transfer method in transferring R1. V8 explained that V6 held R1's hand and turned pivoting R1 into wheel chair without use of gait belt. The surveyor asked V8 whether V6 used the appropriate transfer method in transferring R1. V8 replied, "No she did not follow the recommended transfer use of gait belt."

Review of R1's medical record did not show that R1 had a fall on 9/23/20.

R1's medical record clinical notes dated 9/23/20 timed 6:56pm, V15 RN (registered Nurse) documented in part that CNA (Certified Nurse's Aide) noted a bruise to resident's wrist area

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S9999	Continued From page 5 during shower and upon assessment bruise is in the anterior and lateral aspect of the right wrist. R1's clinical note dated 9/25/20 timed 5:45am, V18 (RN) documented that bruises to right wrist anterior and lateral aspect noted swollen and red with redness. MD (Medical Director) notified with order for X-ray. R1's medical record review did not show any documentation that Regional agency was notified on 9/23/20 and 9/25/20. On 1/5/21 at 3:18pm, V14 during interview stated the initial report was faxed to the regional office on 9/27/20, five days after the initial knowledge of the bruising. On 1/5/21, V2 DON (Director of Nurses) stated the bruising was not reported because it was just a bruise and not all bruises are reported. According to the report sent to the regional office the facility concluded that R1 was transferred during shower improperly resulting in R1 sustaining a mild impaction fracture to distal right radius. The facility policy presented on Injuries of Unknown Origin with effective date November 5, 2018 documented that "All unexplained injuries, including bruises, abrasions and injuries of unknown source will be investigated". The policy purpose documented that this will provide guidance to staff and standard protocol for investigating and reporting injuries of unknown origin. Procedure includes but not limited to implementing reporting and investigation procedures in accordance with the facility's abuse policies and procedure. An injury should be	S9999		

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classified as an "injury of unknown origin "when the source of injury was not observed by any person or the source of the injury could not be explained by the resident, extent of the injury and location of the injury.

On 1/5/21 at 1:09pm, R6 was noted in the washroom on the toilet sit with the door opened and the main entrance door to the room also opened. V12 CNA (Certified Nurse's Aide) was noted standing by the door donning gloves on both hands. At 1:13pm, V12 assisted R6 from the toilet sit into the wheel chair without use of assistive device for transfer. Assistive device noted hanging on the back of the washroom door. When the surveyor asked V12 about the appropriate transfer plan of care for R6, V12 replied, "That I don't know." The surveyor then asked V12 about the facility documentation tool for the CNA. V12 stated I don't know whether it is in there. V12 searched on the tablet and was unable to find it. The surveyor asked what other way can V6 know about the plan of care for transfer. V6 replied, a yellow card is attached to the cupboard (referring to the credenza). Both V6 and the surveyor read the instruction on manual transfer for R6. The instructions read one person assist with instruction to "always use gait belt." The surveyor asked V12 whether the instruction was followed when transferring R6. V12 replied, "I did not use the gait belt, I thought (R6) was fine."

R6's facility tool used in assessing residents MDS (minimum Data Set) section G ADL (Activities of Daily Living) assistance coded R6 under transfer as 3/3 which indicated that R6 needs extensive assistance and two person assistance.

On 1/5/21 at 2:44pm, interview conducted with V6 CNA, V6 explained that she gave R1 a shower on

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S9999	Continued From page 7 9/23/20 and after getting R1 to bed she noticed the bruising on R1's wrist. V6 stated and informed the nurse about it. When the surveyor asked V6 about the transfer device used, V6 replied that she did not use any transfer device, but another staff helped in the transfer. When the surveyor asked about the name of the staff that assisted V6, V6 replied that she has forgotten the name of the staff who assisted her in transferring R1 into wheel chair. V6 stated, "She transferred R1 into the shower chair and back into the bed by holding her hands, putting a hand under R1's arm pit." V6 told the surveyor that she did not know why the facility is saying she is the cause of R1's fracture stating R1 did not fall. V6 stated the facility just changed the type of transfer device for R1 and did an in-service on it including use of gait belt with transfer. On 1/7/21 at 11:48am, interview conducted with V15 (Physician). The surveyor asked V15 what is the risk that can be expected if the required transfer device is not used when transferring a resident. V16 stated, "A fall can occur and with fall injury like fracture can occur." When the surveyor asked V16 of notification, V16 stated the only way the facility will have X-ray ordered is if he was notified. V16 stated he was notified of the incident. At 12:32pm, when the surveyor asked about using the appropriate recommended device for transfer, V16 stated, "That's what we want done if the resident needs use of (transfer device) that's what should be used to avoid injury." The facility Gait Belt Use policy with revision date August 15th, 2015 pointed out that all CNA (Certified Nurse's Aide) shall carry a gait belt as part of their uniform for purpose of safely assisting residents that cannot independently ambulate or transfer. Purpose of the policy	S9999		

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S9999	Continued From page 8 documented that it is the policy of this facility to use gait belt (transfer device) with residents that cannot independently ambulate or transfer for purpose of safety. The facility policy on Safe Transfer with revision date October 16, 2018 documented that it is the facility policy to ensure resident transfers are done in a safe manner. Purpose to provide guidance to staff and a standard protocol for resident transfers in order to provide safest transfer possible. And procedure includes but not limited to identifying the resident transfer method via resident summary located in room or on touch screen. When assisting the resident to transfer to wheel chair gait belt to be applied and use pivoting technique. This guidelines was not followed. (B)	S9999		