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 12/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 11/11/22/IL153760	S 000		
S9999	Final Observations Statement of Licensure FindingViolations: 300.610a) 300.1210b) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 observation, interview and record review, the facility failed to supervise three cognitively impaired residents (R11, R53, and R62) who are at high risk for falls and have a history of falls from having repeated falls and failed to implement fall prevention interventions as care planned for two residents (R11 and R53) in a total sample of 29 residents. As a result, R11 fell and sustained a 2-centimeter laceration to the left posterior head that required four staples and bruising to the right hand. Findings include: R11's Face Sheet documents an admission date of 11/1/22 and diagnoses including but not limited to intracranial injury w/o (without) loss of consciousness, anxiety disorder, dementia, osteoarthritis, abnormalities of gait and mobility, muscle weakness and history of falling. R11's 11/14/22 BIMS (Brief Interview for Mental Status) determined a score of 3, indicating that R11's cognition is severely impaired.	S9999		

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S9999	Continued From page 2 R11's 11/2/22 Admission "Fall Risk Assessment" documents, in part, "Overall score of 10 or above represents HIGH RISK. Calculated overall score: 10." The facility fall report reviewed from July-December 2022 documents that R11 sustained a fall on 11/2/22 at 7:15 AM with no injury and on 11/11/22 at 7:15 pm with injury and sent to hospital. R11's 11/3/22 care plan documents, in part, "Problems: (R11) is at risk for injury related to fall risk. (R11) is admitted to skilled rehab from independent living. She (R11) experienced a fall while a resident in independent living that resulted in a subdural hematoma." Falls in skilled rehab then listed on 11/2/22 and 11/11/22. Interventions include but are not limited to, "Keep (R11) in public area as much as possible for increased supervision; Continue to increase frequent rounds and monitoring for the resident; Communication boards/signs in Italian placed in resident room." On 12/05/22 at 9:50 AM, V1 (Executive Director) provided the surveyor with the Initial and Final Facility Reported Incidents reports that were sent to the state agency for the alleged incident that occurred on 11/11/2022. The Final Investigation report documents, in part, "She (R11) is one person assist with transfers, speaks Italian, and needs cueing and redirection. On the evening of November 11, 2022, around 7 pm, resident was toileted and assisted to bed and then at approximately 7:30 PM, the Nurse on duty reported she was making rounds and observed resident on floor next to her (R11) bed and soiled. The nurse assessed resident and then assisted resident to bathroom and incontinence care provided. During her assessment, the nurse used	S9999		

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S9999	Continued From page 3 hand gestures to determine any signs of pain or discomfort. The resident pointed to the lateral side of her hand and expressed pain. The nurse continued to further assess resident and noted a small laceration to her head ...Resident returned from ER (Emergency Room) with results of no right-hand fracture, negative CT (Computed Tomography scan), and staples to the laceration sustained from her (R11) fall." On 12/07/22 at 1:53 PM, V23 (LPN/Licensed Practical Nurse) who was the nurse on duty on 11/11/22 stated that she (V23) was rounding on her (V23) residents at the start of her (V23) shift around 7pm when she (V23) found R11 on the floor next to her (R11) bed. V23 stated that during the initial assessment R11 was pointing to her right hand and had pain upon palpation so the physician was contacted for an x-ray order. Per V23, a CNA (Certified Nursing Assistant) noted blood in R11's hair so when V23 inspected it, a laceration was found to R11's scalp and the resident was sent to the hospital for evaluation. The surveyor inquired what fall precautions are in place for R11. V23 replied, "We do pretty much a one to one with her. We keep her with a staff member. If the CNAs were busy, I would keep her with me. If they were available to take her, they would take her to keep her in close visuality to make sure nothing happens." V23 stated that this was an intervention that was in place from the first day that R11 came to the facility. The surveyor inquired where the assigned CNA was at the time of the fall. According to V23, she (V23) did observe a CNA in the break room when she (V23) arrived for her (V23) shift but did not know which CNA was assigned to which patients at the time and proceeded to obtain report from the previous nurse and do her (V23) rounds.	S9999		

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S9999	Continued From page 4 On 12/07/22 at 3:05 PM, V25 (CNA) stated that on 11/11/22, "I happened to be at the charting desk outside of (R11's) room when the day shift CNA (V18 Restorative Aide) was giving him (V22 Agency CNA) report, so I heard (V18) tell him (V22) that (R11) is one to one." According to V25, (V18) told V22 that R11's caregiver leaves at 4:30pm so after that she (R11) needs to be closely monitored and he (V22) responded, "Oh ok." V25 added that she (V25) has taken care of R11 in the past and "we wouldn't leave her (R11) alone in the room" because R11 was a "high fall risk" and in report V25 was instructed to not leave R11 unsupervised. V25 also reported that on 11/11/22 when she (V25) returned from her (V25) scheduled break around 7-7:30 pm, she (V25) observed V22 sitting in the break room on his (V22) personal laptop. On 12/07/22 and 12/08/22, the surveyor attempted to contact V22 (Agency CNA) multiple times but was unsuccessful. On 12/07/22 at 2:07 PM, the surveyor walked with V14 (Restorative Nurse) to R11's room and inquired if there were any signs in Italian. V14 replied, "No. There should be because I made them myself." V14 added that staff should have brought the signs with R11 when R11 was transferred from the first to the second floor. On 12/08/22 at 10:26 AM, V18 (Restorative Aide) stated, "I remember giving him (V22) a walk-through of the whole set. I told him (V22) that he (V22) has to keep a close eye on (R11) because she's (R11) a busy body; she (R11) likes to move around a lot and that she's (R11) a one-to-one assist." The surveyor inquired what V18 meant by one-to-one assist. V18 replied, "Like somebody has to sit with her (R11). So, if	S9999		

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S9999	Continued From page 5 you're giving care to somebody else, you have to make sure somebody else is sitting with her (R11)." V18 added, "I told him that she (R11) has a caregiver and the caregiver leaves between 4 and 4:30 PM. He said, 'Ok.'" On 12/08/22 at 10:47 AM, the surveyor inquired what is the risk to a resident who has an unwitnessed fall. V29 (R11's Primary Physician) replied that any injury can occur depending on how hard the resident fell. V29 listed, "Fracture, head trauma, bruises, concussion, laceration, intracranial bleed ...anything." R11's 11/11/2022 "Emergency Department APP (Advanced Practice Physician) Note" authored by V26 (PAC/Physician Assistant-Certified) and cosigned by V27 (DO/Doctor of Osteopathic Medicine) documents, in part, "History of Present Illness: (R11) ... presents to the ED (Emergency Department) with son from nursing home unwitnessed fall PTA (Prior to Arrival) ...Physical exam: Skin: 2 cm (centimeter) linear laceration to left posterior head ... dried blood noted. Musculoskeletal: TTP (Tenderness to Palpation)-scant edema (swelling) and ecchymosis (bruising) overlying posterior right 4th and 5th metacarpals (hand bones) ... Laceration repair: skin closure: staples. Number of sutures: 4." R53's Face sheet documents an admission date of 9/2/2022. R53's 10/14/22 BIMS, determined a score of 9, indicating R53's cognition is moderately impaired. R53's 09/02/22 Admission "Fall Risk Assessment" documents, in part, "Overall score of 10 or above represents HIGH RISK. Calculated	S9999		

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S9999	Continued From page 6 overall score: 14." R53's 9/14/22 care plan documents, in part, "(R35) is at risk for falls related to: impaired mobility, muscle wasting cervical disc disorder, OA (osteoarthritis), lumbar spondylosis, SOB (shortness of breath), pain, muscle weakness, incontinence, difficulty walking, gait abnormalities, poor safety awareness, DM (diabetes mellitus), HTN (hypertension), NSTEMI (non-ST Elevation Myocardial Infarction), atrial flutter, CAD (Coronary Artery Disease), CKD (Chronic Kidney Disease), heart failure, hx (history) of falls, hx hip replacement." Interventions include but are not limited to: "Keep call light within reach at all times and encourage (R53) to ask for assistance." The facility fall report reviewed from July-December 2022 documents that R53 had a fall on 9/4/22 at 10:20 PM with no injury; 10/9/22 at 2:15 AM with no injury; and 11/23/22 at 1:23 AM with "min injury. Not sent to hospital." On 12/05/22 at 10:41 AM, R53 was observed sitting in a recliner next to the window in R53's room. R53's call light was noted on R53's bed, not within reach. At 10:43 AM, this observation was brought to the attention of V30 (Restorative CNA) who verified that the call light was on top of the bed and when the surveyor inquired if R53 was able to reach the call light from his (R53) position, V30 replied, "No. I wouldn't have set it here." The surveyor inquired what the risk is of not having the call light within reach. V30 replied, "He's (R53) not going to be able to call and he (R53) could get up and fall." The 3/3/22 "Protocol for: Fall Prevention, Response and Management" documents, in part, "Policy: (Facility) is committed to minimizing	S9999		

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S9999	Continued From page 7 resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, it is this community's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. All staff will be responsible in assisting with the implementation of the Facility's Fall Management Program to ensure the safety of all residents in the community ...Standards and Practice Guidelines: ... 3. An indicated score of "high" risk for falls, or history of falls will require the development of a care plan with interventions designed to reduce the risk and/or re-occurrences. 4. The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Standard fall/safety precautions for all residents: All staff will be oriented and trained on the Fall Prevention Program upon hire, annually and as needed. At the time of admission, and in accordance with the plan of care the resident will be oriented to use the call nurse device. The nurse call device will be placed within the resident's reach at all times ...In addition to the use of Standard Fall Safety Precautions, the following interventions will be implemented for resident identified at risk: 1. The resident will be checked frequently or as according to the care plan, to assure they are in a safe position/environment. The frequency of safety monitoring will be determined by each resident's risk factors and plan of care." The September 2017 "Call Lights: Accessibility and Timely Response" Policy documents, in part, "The purpose of this policy is to assure the facility	S9999		

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S9999	Continued From page 8 is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance ...Policy Explanation and Compliance Guidelines: ... 5. Staff will ensure the call light is within reach of resident and secured with each interaction in the residents' room or bathroom and as needed." On 12/5/22 and 12/6/22 during observation of residents on the nursing units, R62 was observed and interviewed. R62 could not respond to any questions regarding any of the fall incidents and could not use call lights to ask for staff assistance. R62's face sheet shows that R2 has multiple diagnoses which include but are not limited to Dementia, History of Falling, and Abnormalities of Gait and Mobility. R62's MDS (Minimum Data Set) dated 10/1/2020, section C states that R62 has a BIMS (Basic Interview for Mental Status) score of 5 out of 15 (severe mental impairment). R62's MDS dated 10/1/2020, Section G (Functional Status) shows that R62 requires assistance to walk, to transfer from bed or from chair. R62's Fall Risk Assessment dated 11/17/2022 shows that R62 has a score of 18 (High Risk for Falls). On 12/06/22 at 2:10pm, V14 (Restorative Nurse) was interviewed regarding why R62 was not supervised closely and had 8 falls within 6 months. V14 stated that R62 was previously residing at the Assisted Living side of the facility and wanted to do things for herself. V14 later presented eight records of R62's falls within the past 6 months. The fall incident records are as	S9999		

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S9999	Continued From page 9 follows: 8/1/22 at 1:30am - R62 fell in her room and was sent to the hospital and returned. 8/4/22 at 8:30am - R62 fell in the hallway with no injury. 8/31/22 at 8pm - R62 fell in the common area. 8/31/22 at 10:30pm - R62 fell in the common area. 10/1/22 at 2:40pm - R62 fell in his room with minimal injury. 10/27/22 at 8am - R62 fell in the common area. 11/4/22 at 12:30pm - R62 fell while trying to walk. 11/15/22 at 5:50pm - R62 fell in the Dining Room and was sent to the hospital and returned. R62's care plan initiated on 6/20/22 states that R62 is at risk for injuries related to falls related due to several medical diagnoses including but not limited to Dementia, Alzheimer's Disease, Muscle Weakness, history of falls, and Poor Safety Awareness. Facility's policy on Accidents and Supervision dated September 2015 with latest revision date of January 2022 states in part: Each resident will receive adequate supervision and assistive devices to prevent accidents. (B)	S9999		