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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145904 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>02/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Smith Village |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2320 West 113th Place<br>Chicago, IL 60643 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure that proper number of staff were used in transferring one of four residents (R1) to prevent accidental hazard in the sample who requires two persons assist in transfers from chair to bed or bed to chair. This failure affected R1 who was transferred from chair to bed by one staff instead of two. As a result, R1 sustained laceration of left lower leg, was sent to the hospital and the laceration required eighteen (18) sutures to be repaired. This has a potential to affect all 70-residents residing at the facility.</p> <p>Findings include:</p> <p>R1's medical record admission Record showed that R1 was originally admitted to the facility on [DATE] and the latest admission date was 08/26/24 with a diagnosis list that includes but not limited to Unspecified intracapsular fracture of the left femur, subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, syncope and collapse, unspecified atrial fibrillation, mixed hyperlipidemia, ataxic gait, muscle weakness(generalized), muscle wasting and atrophy, major depressive disorder, single episode unspecified, Unspecified Dementia unspecified severity without behavioral disturbance and anxiety. R1 was sent to the hospital on [DATE] and was treated for diagnoses that includes laceration of lower leg initial encounter and cellulitis of left lower extremity. R1 was discharged from the facility on 10/11/2024.</p> <p>According to facility incident report, on 10/02/24 R1 was assisted from chair to the bed by V5 CNA (Certified Nurse's aide) not following the plan of care of using two persons assist and, in the process, R1 sustained skin tear (referring to laceration to left lateral lower leg that required 18 (eighteen) sutures from the local hospital.</p> <p>R1's medical record PT (Physical Therapy) Evaluation and Treatment notes with certification period 8/16/2024 to 10/14/2024 showed documentation that transfers from chair/bed-to chair transfer = dependent indicating that R1 is dependent on staff in performing this task, maximum of two person assist.</p> <p>R1 progress notes, V6 RN (Registered Nurse) describe the injury site as skin tear to LLE (Left Lower Extremity), hollow area noted adipose tissue exposed.</p> <p>On 02/06/2025 at 10:20am, V2 DON (Director of Nurse's) stated that the incident occurred during the evening shift and was reported 10/03/25. V2 stated that the CNA incorrectly transferred the resident (referring to R1).</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>On 2/06/25 at 12:06pm, V8 CNA (Certified Nurse's aide) stated that she was usually assigned R1 in the morning shift when on duty. V8 stated that R1 needs two staff (persons) assistance when transferring from bed to wheelchair. V8 stated that the PT (Physical therapy) /OT (Occupational Therapy)/ Restorative department staffs are usually on the floor walking residents, and they will help with routine care of the residents as needed. In additional will bring R1 for meals and therapy.</p> <p>On 02/06/2025 at 12:09am, V9 (Restorative Nurse) stated that R1 is clinically compromised with ADL's (Activity of Daily Living) not wanting to get up. R1 had hip surgery and due to the surgery R1 was dependent on staff and not functionable. We educated the nursing staff including the CNAs that R1 was on hip precaution due to the hip surgery and R1 requires two persons assistant with transfers. All the residents have the green card or/and yellow card in their rooms that showed what kind of assistance needed and there is a 24-hour report on the computer that the CNAs can access to show the plan of care in assistant level.</p> <p>At 1:06pm V19 OT (Occupational Therapist) stated I worked with R1 and R1 needs two persons assist the day R1 was admitted to the day R1 was discharged . Staff must not transfer R1 by themselves, R1 becomes anxious, fearful due to fall history because R1 used to be very independent and now must depend on others. Multiple training was given to the family and staff before discharge from the (facility). V19 stated the PT/OT notes showed that R1 needs 2-person assistant with transfer and that for the incident on 10/02/2024, (V5) transferred R1 incorrectly by self and according to what was reported R1 got injured from (V5)'s action.</p> <p>At 1:16pm, V18 PT (Physical Therapist) stated that she is familiar with R1. V18 stated that R1 needs two (2) persons assistance with transfers. V18 stated that both herself and V19 do evaluation of the residents together to decide whether the resident needs a mechanical lift or sit to stand assistance. V18 stated that with R1, R1 needs 2 persons assistance with lateral transfer. V18 stated that R1 should not be transferred with a mechanical lift device because with any hip surgery and hemiarthroplasty that R1 had; it will force R1's hip to flexion greater that 90 degrees and this is contraindicated. The surveyor asks whether it is appropriate to transfer R1 with one person assist, V18 stated that transferring R1 alone is wrong. V18 stated that the staff must follow the green sheet in residents' room that showed the individual care needed which is updated as to resident needs.</p> <p>At 4:08pm, V5 CNA (Certified Nurse's Aide) stated that on that day (referring to 10/02/2024), I had given R1 a shower. Pulled R1 to the side of the bed for dinner. R1 tried to get out the wheelchair and R1 said I can do this, I (V5) put the gait belt around R1 and asked for R1 to reach for the bed side rails to turn into the bed easily and I picked up R1's legs and put it on the bed. That was when I noticed that R1 got a skin tear on the leg, I can't remember which leg. I left out of the room and called the nurse (referring to V6) who decided to send R1 to the hospital. When the surveyor asked V5 how many staff are needed and whether there is any transfer device used in transferring R1, V5 stated that in R1's case the needs were changing rapidly and by now I cannot remember what it was that day. V5 stated one person assistance means transfer must be done with one staff and use of gait belt, two persons assistance means two people with use of gait belt. The surveyor then asked if a resident is marked for two people assist and one staff did the transfer task, whether that is appropriate. V5 stated that will not be appropriate because the resident can fall, can have skin tear and staff can also injure self.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>On 2/10/2025 at 11:15am, V17 (Physician) stated that he cannot remember seeing the resident. V17 stated that the facility staff has reminded him of what happened with the incident (referring to 10/02/24 incident resulting in injury). V17 stated that skin tear can be managed with compression, dressing and we (referring to the facility) can keep the resident. If the resident must receive sutures, it is laceration, the resident must be sent out, it means they (facility) cannot take care of it there (facility).</p> <p>R1's Hospital report presented dated 10/2/2024 showed instructions documented that R1 was seen and evaluated after an injury that resulted in a laceration. In addition, R1 was treated for soft tissue infection.</p> <p>Facility Job Description for CNA (Certified Nursing Assistant) documented that the purpose of this position is to work under the direction of the charge nurse. Provides assists with all areas of ADL's. Assists in observing and reporting changes in resident's condition. Accountabilities and job duties listed includes but not limited to always understanding and adherence to resident rights. Ensures proper positioning of all residents while in bed or wheelchair, making sure that all mattresses and positioning device are in place, and carries out restorative programs.</p> <p>The facility job description for RN (Registered Nurse) documented that RN purpose is to be responsible for all nursing care administered to residents, including but not limited to overall supervision of the nursing assistants. Accountabilities and job duties listed includes but not limited to always understanding and adherence to resident rights.</p> |   |  |

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| <p>F 0909</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure that the bed frame is locked to the size of the mattress for the safety of one resident (R1) reviewed for injury. As a result, R1's left lower leg made contact with the loose bed frame during transfer into bed causing a laceration. R1 was sent to the hospital and the laceration was repaired with 18 sutures. This has the potential to affect all 70 residents residing in the facility.</p> <p>Findings include:</p> <p>R1's medical record admission Record showed that R1 was originally admitted to the facility on [DATE] and latest admission date was 08/26/24 with diagnosis list that includes but not limited to Unspecified intracapsular fracture of the left femur, subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, syncope and collapse, unspecified atrial fibrillation, mixed hyperlipidemia, ataxic gait, muscle weakness(generalized), muscle wasting and atrophy, major depressive disorder, single episode unspecified, Unspecified Dementia unspecified severity without behavioral disturbance and anxiety. R1 was sent to the hospital on [DATE] and was treated for diagnoses that includes laceration of lower leg initial encounter and cellulitis of left lower extremity. R1 was discharged from the facility on 10/11/2024.</p> <p>According to facility incident report on 10/02/24, R1 was assisted from chair to the bed by V5 CNA (Certified Nurse's aide) not following the plan of care requiring use of two persons assist and, in the process, R1 sustain skin tear (referring to laceration to left lateral lower leg that required 18 (eighteen) sutures from the local hospital.</p> <p>On 02/10/25 at 4:29pm, V23 (Case Manager) was asked why V5 was written up for the incident on 10/02/2024? V23 stated that the write-up was for (V5) improperly transferring the resident (referring to R1). V23 stated that R1 was transferred with one-person assistance instead of 2-person assistance. V5 transferred R1 from wheelchair to bed and in the process R1 bumped the leg on the bedframe and caused the skin to open. Having 2-person would have made the transfer of R1 safe. After the facility administrative investigation of the cause of the skin tear (referring to the lower leg extremity laceration) we found out that the bed frame was larger than the bed mattress at the time of the transfer. The bed frame needed to be adjusted by pulling the lever (part of the bedframe) to adjust it, so it is stable. It was corrected after the incident. The surveyor asked who is responsible for making sure the bedframe is not larger than the mattress. V23 stated that the maintenance department are supposed to do that.</p> <p>On 2/11/25 at 9:02am, V25 Assistant Maintenance Manager EVS (Environment Services) stated that the bed frames maximum width is 42 inches, the facility standard mattress is 42, but the bedframe can be extended to about 80 inches. V25 stated that the bed frame can be adjusted down to 39 inches and if the mattress is narrower then it becomes a safety issue. The maintenance staff is responsible for making sure the bed frames are properly secured it's a safety issue.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0909</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>At 9:21am, V2 (DON) demonstrated on the bed frame with V25 and V26 present on how it was loose when the administration investigated the incident and what went wrong with the bed frame causing R1's injury laceration to lower left leg. V2 stated that the middle part of the bed frame was wider than the bed mattress causing R1's leg to make contact with the bed frame and resulted in the skin tear (Laceration). V2 stated that at the time of incident the bed frame was wider than the bed mattress and that's what caused the injury when the resident (R1) leg made contact (Bump) with the bed frame and that is what we reported (referring to IDPH (Illinois Department of Public Health)).</p> <p>On 2/11/25 at 9:22am, V26 EVSD (Environment Services Director) stated that we do not check on bed frames to check whether they are locked or loose. There is no reason for the bed frame to be out of place. V26 stated that all the facility beds should be at a 42 inches setting 100% of the time. The surveyor asked what measures have been put in place since the incident of 10/02/2024 to make sure this does not repeat itself. V2 who was present at the time stated that we (Facility) will have to put in a work order for the maintenance staff to come and check the bed frame.</p> <p>At 9:36am, the surveyor asked how they are monitoring the safety of the beds, V2 stated that a system must be put in place for checking the bed frames.</p> <p>As at 4:20pm on 2/11/25 the facility was unable to provide any work order or documentation that shows that a process has been put in place to ensure safety and prevention of such incident.</p> <p>The facility in-service instruction on Bed frame size, how and when to adjust the size, mattress sizes indicated that as a safety precaution the staff should make sure the bedframes are adjusted to match the mattress size correctly. Regular mattress size 42 inches wide, APM 42 inches wide, and Bariatric APM 48 inches wide. Bed frames can extend in length to 84 inches if needed.</p> <p>The facility policy on Safe and Home Environment with implementing date of 2/10/23 documented in part that in accordance with residents' rights, the facility will provide safe, clean, comfortable, and homelike environment which includes but not limited to ensuring that the resident can receive care and services safely and does not pose a safety risk.</p> <p>The facility Job description for job title Director of Facility management documented that the purpose of this position primary responsibilities includes but not limited to oversight of building and grounds maintenance, and to daily management of the facility operations and direct supervision of staff involved in these operations. Accountabilities and job duties listed includes but not limited to always understanding and adherence to resident rights, ensuring that the (facility) residents are always safe and secure. Listed primary job duties includes but not limited to ensures compliance with health safety and environment regulations. Making regular rounds.</p> |   |  |