

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>146110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SMITH CROSSING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10501 EMILIE LANE</b> <b>ORLAND PARK, IL 60467</b>		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=G	<p>Complaint Investigation: #1673982/IL87031: No deficiency #1674002/IL87054: F323</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide visual supervision to a confused and sedated resident in the bath room. The facility failed to use a gait belt to transfer a resident. This applies to one resident (R1) out of six residents reviewed for falls. This failure resulted in R1 falling off the toilet and receiving a laceration to the right eyebrow, a closed head injury and a fracture to the maxillary sinus. R1 was admitted to the facility April 8, 2014 per the admission face sheet. The Physician order sheet dated showed that R1 was admitted to the facility with Dementia, Transient Cerebral Ischemic attack, Heart Disease, Anxiety, Osteoarthritis, Dysphagia, Depression and anemia. An incident report dated July 17, 2016 showed that R1 fell while on the toilet at 6:30pm. The</p>	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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F 323	<p>Continued From page 1</p> <p>report showed that E7 CNA (Certified Nursing Assistant) was toileting R1. E3 left R1 alone on the toilet to get R1 ' s pajamas. The note showed that E3 heard a noise from the bathroom and found R1 on the floor. The note showed that R1 received a laceration to the right eyebrow and was sent to the community hospital for treatment and evaluation.</p> <p>The nursing notes dated July 17, 2016 showed that earlier in the day at R1 was exhibiting signs of anxiety and agitation. The note showed that R1 was given a sedative at 4:30pm by E8 RN (Registered Nurse). The note showed that R1 was sent to the community hospital for evaluation and treatment. The note showed that R1 returned at 9:45pm with the diagnosis of acute head injury, closed fracture of the maxillary sinus and a laceration to the right eyebrow. E8 RN documented that R1 had six sutures in place over the right eyebrow, a scrape to the left knee and bruising to both knees and right shoulder.</p> <p>The current care plan for R1 showed that R1 was to be assisted with toileting, activities of daily living and ambulation. The care plan showed that R1 was not to be left unattended in the activity room and to keep R1 at the nurses ' station for close observation during the evening and night shift until R1 was asleep or tired.</p> <p>The Minimum Data Set dated June 16, 2016 and April 7, 2016 showed that R1 required one person physical assist during all care including toilet use. A progress note dated May 25, 2016 by an Advanced Practice Nurse showed that R1 had moderate to severe cognitive loss, memory loss, confusion, disorientation and short attention span. A progress note written by Z1 Physician dated June 24, 2016 showed that R1 required assistance with all activities of daily living. On July 20, 2016 at 9:52 am E6 Restorative</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>Nurse said that gait belt is to be used with all transfers.</p> <p>On July 20, 2016 at 2:00pm in the conference room Z1 Physician for R1 said that R1 should be supervised while on the toilet. Z1 stated, " R1 now requires two assistants for toileting. " Z1 said that R1 had started on Lorazepam daily to calm her behaviors.</p> <p>On July 21, 2016 at 2:17pm in the conference room E8 Registered nurse said that R1 had been given Ativan earlier in the day. E8 said that R1 had an unsteady gait; behaviors prevented R1 from following directions, poor safety awareness. E8 said that a gait belt was not seen by her when R1 fell. E8 did not take a gait belt off of R1. E8 stated, " R1 is not the kind of resident to leave alone on the toilet in the bathroom " . There was no documentation in R1's clinical record or on the incident report for July 17, 2016 to show that a gait belt was in use during the transfer to the toilet.</p> <p>On July 19, 2016 at 9:30am R1 was sitting in a wheelchair with head slouched down. R1 had bruising to the right forehead, cheek and right side of neck. Six sutures noted in place to the right forehead. R1 did not open eyes or respond to verbal stimuli. Bruising was seen to knees, arms face, neck and jaw.</p> <p>On July 19, 2016 at 10:48 am E3 CNA (Certified Nursing Assistant) brought R1 to the bathroom for toileting. E3 pushed to wheelchair up to the toilet at an angle. E3 instructed R1 to stand up and to hold on to her. R1 required extensive cueing before performing the task. R1 was unsteady on her feet slightly swaying back and forth. E3 instructed R1 to turn with her and then R1 was pivoted to be placed on the toilet. R1 was not able to urinate and E3 instructed R1 to stand. Again with much cueing R1 stood with a slight</p>	F 323			

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F 323	Continued From page 3 sway in her stance. E3 kept her body close to R1 and leaned as far as she could to get wet cloths out of the sink. R1 continued to sway. E1 instructed R1 to grab the hand bar on the wall next to the toilet. R1 had rolled up gauze in the right hand which was contracted making it impossible for R1 to grab the bar securely with the right hand. Again after much prompting R1 held onto the bar with the left hand only and continued to sway. E3 provided care and applied a new disposable brief on R1. At no time did E3 use a gait belt during this transfer.	F 323			