| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6001689 | A. BUILDING: _____ B. WING _____ | C 03/12/2020 |

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| SYMPHONY OF BRONZEVILLE | 3400 SOUTH INDIANA CHICAGO, IL 60616 |

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| S 000 | Initial Comments<br><br>Complaint Survey: 2081597/IL120602 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.1220b)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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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 requirements are not met as evidenced by:

Based upon observation, interview and record review, the facility failed to ensure that staff were aware of resident fall prevention interventions, failed to implement fall prevention interventions and failed to provide adequate supervision for three of three residents (R1, R2, R3) in the sample reviewed for falls. These failures resulted in the following serious injuries; R1 sustained a laceration requiring staples. R3 sustained a laceration requiring steri-strips.

Findings include;

The (8/13) falls policy & procedure states residents at fall risk will be identified for staff awareness. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk.

Recent Falls Risk Screens affirm that R1, R2, and R3 have had multiple falls at the facility from 2019 to 2020.

On 3/9/20 at 2:30pm, V3 (Certified Nursing Assistant), V4 (Activities Aide) and 44 residents (including R1, R2, R3) were observed in the dining room. Surveyor inquired about R2's fall prevention interventions. V3 stated "That you will have to ask the Nurse about because that I don't know." Surveyor inquired about R3's fall prevention interventions V3 responded "Once again, you would have to ask the nurse about

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that. I usually refer to the nurse before I touch anybody." Surveyor inquired who was assigned to supervise the dining room. V3 replied "I'm watching the dayroom while she's doing activities" and affirmed there were only two staff present in the dayroom/dining room. At approximately 2:40pm, surveyor inquired if there was adequate staff in the dining room V4 stated "Usually we have two or three aides in here." Surveyor inquired about R2's fall prevention interventions. V4 replied "I don't have that." Surveyor inquired how staff identify residents at risk for falls V4 stated "I usually go by their wrist. Their wristbands will tell us they are fall risk." R2 was observed not wearing a fall risk wristband at this time. R1 was observed sitting in a specialty wheelchair (adjacent the wall) in the dining room. She was not assisted to a table during ongoing puzzle activity and was not engaged with staff or peers. V4 inspected R1's wrist (as requested) for a fall risk wristband and stated "She doesn't have one." Surveyor inquired about R1's fall prevention interventions V4 responded "She usually has someone close by her, I don't know where she went."

1.) R1 is a 96 year old with diagnoses which include; dementia.

R1's (1/14/20) fall risk screen determined a score of 15 (moderate risk).

R1's (7/26/29) care plan states resident is at risk for fall related to impaired mobility, weakness and Alzheimer's. Interventions; frequent monitoring.

a.) R1's (1/14/20) incident report states; resident observed inside room on floor. No witnesses found.

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b.) R1's (2/24/20) incident report states; Incident Location: Dining room. Resident was observed on the floor. Resident slid out of the chair. Injury: laceration top of scalp.

R1's (2/24/20) State report of patient injury states; resident returned from hospital with 2 staples to head.

(2/24/20) Witness statements include but not limited to the following; when was the last time you visually observed the resident and what were they doing at that time? Per V8 (Certified Nursing Assistant) the last time I saw the resident was in the dayroom, she was at the table with her head down. Per V9 (Licensed Practical Nurse) I seen (R1) in the dayroom at 5:50pm with her head down on the table. Per V10 (Certified Nursing Assistant) her nurse did tell me to lay her down but when I was about to it was time to pass trays for dinner.

On 3/11/20 at 1:48pm, surveyor inquired about R1's (2/24/20) fall. V10 stated "The incident could have been prevented, everybody on the floor had an opportunity to do something about it, but just overlooked it. She was sleeping in the chair in the dayroom with her head on the table. She was in a regular wheelchair not a (Brand Name) chair. I could have put her in a (Brand Name) chair cause she was sleeping."

2.) R3 is an 84 year old with diagnoses which include; generalized muscle weakness, difficulty in walking and Alzheimer's disease.

R3's (1/2/20) fall risk screen determined a score of 18 (high risk).

R3's (1/29/19) care plan states resident is at risk

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for fall related to impaired mobility, weakness, and Alzheimer's. Interventions; close monitoring for safety.

On 3/9/20 at approximately 2:36pm, R3 was observed sitting idle in a wheelchair (in the dining room walkway). She was not assisted to a table during ongoing puzzle activity and was not engaged with staff or peers.

R3's (2/20/20) incident report states; nurse heard a loud noise. Upon entering day room patient on floor with laceration above left eye.

R3's (2/20/20) State report of patient incident states; resident returned from hospital, left forehead noted with 5 steri-strips in place.

On 3/10/20 at 2:55pm, surveyor inquired about R3's (2/20/20) fall. V7 (Licensed Practical Nurse) stated "The patient is always confused and is a huge fall risk. When I was done with the med (medication) pass, I heard a boom. The other nurse said she fell, head first. She was on the floor when I got there. There were two CNAs (Certified Nursing Assistants) in the dining room. The CNAs said she had been leaning forward all morning I guess trying to get out the chair. I guess she leaned too far forward that day and fell out the chair."

3.) R2's diagnoses include; unspecified cataract and difficulty in walking.

R2's (11/11/19) fall risk screen determined a score of 15 (moderate risk).

a.) R2's (8/17/16) care plan states; resident experiences functional incontinence. Interventions; maintain uncluttered environment.

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R2's (12/13/19) incident report states; resident was observed on the floor in supine position on top of the scale. He stated "I fell." No witnesses found. Predisposing factors; clutter.

b.) R2's (4/1/19) care plan states; resident is at risk for fall related to impaired mobility and weakness. Interventions include; frequent monitoring.

R2's (2/12/20) incident report states; resident fell in the hallway while walking to the dining room. Predisposing factors; improper footwear.

On 3/9/20 at approximately 2:35pm, R2 was observed ambulating (in the dining room) with an unsteady gait. He grabbed both handles of peers' wheelchair to maintain balance, then stood there and lingered. V3 subsequently escorted R2 to a chair. He was wearing a shoe on his right foot and a sock on his left foot. At approximately 2:38pm, surveyor inquired why R2 was wearing only one shoe V4 replied "I'm not sure" and affirmed she would check into it.

On 3/10/20 at 11:04am, surveyor inquired how staff identify residents at risk for falls if fall risk wristbands are not on. V5 (Licensed Practical Nurse-Unit Manager) responded "Once you've had two falls you automatically have the bands on." Surveyor inquired why on 3/9/20, R2 was not wearing a fall risk wristband V5 replied "He must have taken it off."

On 3/12/20 at 10:04am, surveyor inquired about the potential harm to a patient that falls. V11 (Medical Director) stated for anybody above the age of 65 any fall puts them at great risk especially for fracture. There's a significant risk

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| S9999 | Continued From page 7<br>for harm for any patient falling.<br><br>(B) | S9999 | | |