STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003958	A. BUILDING: _____ B. WING _____	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF MORGAN PARK	10935 SOUTH HALSTED STREET CHICAGO, IL 60628

(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 Complaint Investgation 2181106/IL131096	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210d)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 meet as evidenced by:

Based on interview and record review facility failed to follow their fall policy for one resident (R1) out of three residents reviewed for falls. This failure resulted in a facility staff member forgetting to implement one of the safety measures/precautions that was part of R1' plan of care; which was for R1 to wear a helmet/head

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gear while she's up out of bed and subsequently R1 sustained a head injury: Subarachnoid hemorrhage and fracture of zygomaticomaxillary, after falling onto the floor without her helmet on.

Finding Include:

R1's care plan initiated 1/9/20 denotes at risk for fall related to weakness; intervention initiated 12/15/20 R1 will wear helmet while out of bed.

V3 (Licensed Practical Nurse) she stated 2/25/21 at 3:30pm worked on the floor with R1 for a few months and she had history of a couples of falls. V3 stated it was not until late December or January that they were using a helmet for R1 because she had a previous fall. V3 stated the helmet was an intervention they came up with to minimize any injuries if R1 fell. V3 stated V2 (Certified Nurse Aide) had worked with R1 before and V2 was responsible for putting R1's helmet on after R1 was cleaned, dressed and gotten up out of bed. V3 stated on that particular morning (2/17/21) was called to the hallway and saw R1 in the hallway on the floor with no helmet on and bleeding from her right upper cheek. V3 stated assessed R1 for range of motion, put ice pack to her upper jaw then called her doctor who ordered R1 to be sent out to the hospital for evaluation.

2/17/2021 09:00 R1's Health Status/Progress Note Text: Resident noted on floor in hallway with laceration to right cheek, area cleaned, steri strips placed over area, resident medicated for pain, able to move all extremities within normal range, ice pack applied to area. Np notified with order to send to Hospital for evaluation.

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R1's hospital record dated 2/17/21 denotes open tripod fracture of zygomaticomaxillary and Subarachnoid hemorrhage. Follow with orthopedic clinic 3/4/21.

2/19/2021 07:44 Restorative Nursing: Note Text is a readmit to the facility s/p hospitalization for a fall with tripod facial fractures and subarachnoid hemorrhage. Resident is alert to name only with confusion. Resident has a history of Dementia.

V5 (Nurse Practitioner) she stated on 2/26/21 at 10:45am got a call the other morning (2/17/21) that R1 fell and told the facility to send R1 out for a Computed Tomography Scan (CT). V5 stated R1 had CT of the head and spoke to the ER physician whom told her from looking at the CT scan he saw small bleed inside her skull on the temporal side which another term Subarachnoid Hemorrhage. V5 stated the hospital kept R1 for observation to see if the bleed was going to get bigger. V5 stated the hospital watched R1 and the bleed inside the skull was not getting bigger or the pressure was not increasing. V5 stated that after R1 was in the hospital couple of days R1 returned to the facility with the head injury and fracture to her cheek bone area which medically called Tripod fracture of the Zygomaticomaxillary. V5 stated the helmet does help minimize head injuries and a good tool if used properly. V5 stated the helmet can help minimize any impact if the resident falls. V5 stated if R1 had the helmet would have probably prevented the head injury she sustained.

V2 (Certified Nurse Aide) she stated on 2/26/21 at 10:20 am on that morning of 2/17/21 just had

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given R1 a shower and was walking R1 out of the shower room when suddenly someone called for help and placed R1 in a chair in the hallway but forgot the helmet in the shower room. V2 stated went to assist another resident that was calling for help but did place R1 in her chair with her hipster on and proper footwear but did not place her helmet on. V2 stated as she was going into assist the other resident heard a nurse heard staff call for help. V2 state went back into the hallway and saw R1 on the floor and she was bleeding from side of her face. V2 stated the nurses assessed R1 and they helped her get back into the chair and attended to her injury. V2 stated she was written up for leaving R1's helmet off. V2 stated she was just rushing a little too much, trying to help another resident and mistakenly rushed off and forgot to put R1's helmet on. V2 stated had taken care of R1 before and normally get her cleaned put all her safety items on her like the helmet, hipsters and proper footwear on before she leaves her to provide patient care to her other residents.

Facility's staff interview dated on 2/17/21 denotes V2 stated "Got R1 dressed, put on her hipsters and clothes. Had R1's helmet in the shower room with her as they were exiting the shower room heard someone call for help. Sat R1 in a chair in the hallway and ran to assist with the other resident. Came back R1 was on the floor".

V1 (Fall Coordinator) she stated on 2/25/21 at 3:05pm did an investigation after R1 had fell and discovered R1's aide (V2) had washed R1 up that morning and placed her in the hallway in a chair when suddenly a nurse called for assistance and that V2 walked away to help that nurse. V1 stated part of her investigation was to review the facility

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cameras and noted V2 had placed R1 in her chair with the hipster on but did not put R1's helmet on. V1 stated saw R1 get up from her chair walk a little then turn around stumble then fall onto the floor and hit her head. V1 stated V2 placed R1 in a chair without the helmet on that was supposed to be one of R1's safety measures. V1 stated the V2 was disciplined because she did not make sure one of R1's safety measures were in place before she left her in the hallway sitting.

V2's discipline notice dated 2/17/21 denotes poor performance; failure to ensure R1's had on all safety devices. Corrective action employee committing when dressing a resident all safety precautions should be in placed to ensure residents safety.

Facility's fall policy denotes Residents at fall risk will be identified for staff awareness. Residents at risk for falls will have Fall Risk identified on the plan of care with interventions implemented to minimize fall risk. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.

Facility's use and care of helmet manual denotes headgear can substantially reduce the risk of head injury.

(A)