STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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 September 21, 2021/IL138739 Facility Reported Incident of October 3, 2021/IL139512	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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
S9999	Continued From page 1	S9999		

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.

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide supervision and failed to implement fall prevention interventions for three of three residents (R2, R3, R4) reviewed for falls/injury. These failures resulted in R3's (10/3/21) right femur fracture, R2's (9/21/21) left 9th rib fracture and R4's (10/20/21) right thumb dislocation.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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
S9999	Continued From page 2	S9999		

1. R3's diagnoses include dementia. R3's Brief Interview for Mental Status (BIMS) score of 5 indicates R3 is cognitively impaired.

R3's 8/10/21 functional assessment affirms R3 requires extensive assistance (1 person physical assist) with transfers.

R3's 10/3/21 incident report states patient complained of pain to right knee. Patient stating that [R3] knee was bumped during transfer. Interviews were conducted, staff denying any incidents/bumping of leg.

R3's 10/3/21 x-rays include: Right Knee impression: impacted, acute distal femoral shaft fracture. Right Femur impression: There is a complete acute oblique fracture through the distal medial femoral condyle cleaning it from the lateral femoral condyle and femoral shaft. There is approximately 5 mm (millimeters) of proximal displacement of the fracture fragment. There is soft tissue swelling of the right knee.

R3's fall care plan includes the following interventions; (4/27/20) Frequent monitoring due to covid 19 restrictions. (6/19/20) encourage patient to ask for assistance with transfers. Which were implemented prior to 10/03/2021 fall. R3's care plan also states: (10/8/21) Resident requires use of a gerichair due to poor balance, poor sitting posture and poor trunk control. (10/26/21) Potential for injury due to history of falls. Interventions: check on resident frequently and place resident in visible view of staff when up in chair as resident will allow. Call light within resident's reach when in room.

On 10/26/21 at 2:37pm, V5 (Certified Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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
S9999	Continued From page 3 Assistant) was observed exiting R3's room. R3 was left in the room. unsupervised, sitting in an upright gerichair and leaning forward. R3's call light was observed on the bed out of sight/reach. Surveyor inquired where R3's call light was located R3 responded "I don't know anything about that" and affirmed (R3) was unable to locate it. On 10/26/21 at approximately 2:39pm, surveyor inquired where R3's call light should be located V5 responded "It should be next to [R3] or on [R3]." Surveyor inquired about R3's fall prevention interventions V5 stated "[R3's] sitting up, we normally don't have the chair sitting up. I know [R3's] chair should be sitting back." V5 exited R3's room again without reclining the chair. On 10/27/21 at 2:55pm, surveyor inquired about R3's 10/3/21 injury. V8 (Nurse Case Manager) stated "[R3] accused a specific CNA, [R3] said it was a male CNA. As [R3] put it, he was from Africa and said he had wild hair. We were able to narrow it down to [V9] who had [R3] the previous day (3-11 shift)." Surveyor inquired about the root cause analysis of R3's injury and V8 stated "The outcome was that something did happen because [R3] has a fracture but we don't know what happened. [R3's] memory is very poor and [R3] has dementia. Something obviously happened because there was a fracture he (V9) is denying that he bumped her leg during the transfer and [R3] is saying that he (V9) did. I don't know who to believe because of [R3's] history but it is possible that he (V9) did not know that her leg was bumped." 2. R2's diagnoses includes altered mental status. The 9/4/21 functional assessment affirms R2	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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
S9999	Continued From page 4 requires extensive assistance (1 person physical assist) with transfers. R2's 9/21/21 incident report states patient was observed lying supine on the floor near the foot of (R2's) bed. Patient unable to state how fall occurred due to altered mental status. Interviews were conducted with staff but the incident was not witnessed. R2's 9/21/21 Chest CT (Computed Tomography) includes a non-displaced indeterminate age fracture of the left lateral 9th rib. R2's 9/2/21 care plan includes the following fall prevention interventions: call light within resident's reach when in the room. Apply floor mats when resident is in the bed. On 10/26/21 at 2:25pm, R2 was lying in bed. The call light button was observed beneath R2's left knee out of sight/reach. Surveyor inquired where the call light was located R2 responded "I'm not sure." Surveyor inquired about the scab observed on R2's left elbow R2 stated "I fell about two or three times in here. I was on a whatchamacallit, the wheelchair yeah. I was on it and when I got out it seemed like it wanted to walk away from me ." On 10/26/21 at 2:29pm, V4, CNA (Certified Nursing Assistant) entered the room surveyor inquired about the location of R2's call light V4 stated "[R2] is lying on it right now" surveyor inquired where R2's call light should be located V4 responded "Clipped to [R2's] shirt." Surveyor inquired about R2's fall prevention interventions V4 stated "We have [R2's] floor mat put down, that's pretty much it." Surveyor inquired where R2's floor mat was currently located R2	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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
S9999	Continued From page 5 responded "Right now it's behind [R2's] bed" and removed it from behind R2's headboard. Surveyor inquired if R2 requires staff assistance for transfers V4 stated "I believe [R2] is a one person." Surveyor inquired if R2 received staff assistance getting into the bed R2 stated "Not today." R2's wheelchair was adjacent to the bed and within reach. 3. R4's diagnoses include dementia. R4's 9/27/21 functional assessment affirms R4 requires 1 person physical assist with transfers. R4's 6/22/21 care plan includes the following fall prevention intervention: encourage and assist as needed to wear non-slip footwear. R4's 10/20/21 incident report states patient observed lying supine on the bathroom floor. Noted right thumb out of alignment with pain during palpation. Patient was noted wearing worn out slides with slipper socks. On 10/26/21 at 2:45pm, surveyor inquired about the 10/20/21 fall and R4 stated "I twisted my thumb. I got up from the bed to use the bathroom. I usually hold the wall right up here (pointing to the bathroom door frame) I couldn't reach the bar (adjacent the toilet). I fell and hit my hand on the toilet. Surveyor inquired if staff was present when [R4] fell. R4 responded "No." R4's 10/20/21 right fingers x-ray includes reason for exam: right thumb subluxation. Impression: dislocation of the interphalangeal joint of the thumb has been reduced. On 10/26/21 at 2:59pm, surveyor inquired about the root cause of R4's 10/20/21 fall V6 (Licensed	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT 87TH STREET	2940 WEST 87TH STREET CHICAGO, IL 60652

(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
S9999	Continued From page 6 Practical Nurse) stated "It was the shoes [R4] had on, so we (facility) changed [R4's] shoes." On 11/1/21 at 12:30pm, surveyor inquired about appropriate fall prevention interventions for residents at risk for falls and V11 (Physician) responded "With a high fall risk there's gonna be a call light within reach that's generally the case." Surveyor inquired about potential harm to a resident (at risk for falls) if fall prevention interventions are not implemented and the resident is unsupervised V11 stated "With any fall the potential harm is fractures. If there's any head trauma they could have intracranial bleed." The facility falls management policy (reviewed 6/21) states residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. (A)	S9999		