STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004550	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY PALOS PARK	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

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S 000	Initial Comments Facility Reported Incident of October 1, 2021/IL139045- F689 Facility Reported Incident of October 4, 2021/IL139416- F689	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210)b)5 300.1210)c) 300.1210)d)6 Section 300.1210 General Requirements for Nursing and Personal Care 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 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 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 be knowledgeable about his or her residents' respective resident care plan. 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. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a plan with interventions to include monitor and supervision to reduce or prevent a fall incidents, the facility also failed to use the electric mechanical lift to transfer a dependent resident. These failures affected 2 of 3 (R1/R2) residents reviewed for fall preventions and safe transfers. These failures resulted in R1 having two unwitnessed falls within 2 weeks resulting in a hematoma and hospitalization for a closed head injury, two inch laceration and a fracture pelvic, and R2 being injured during a transfer sustaining a 10cm x 30mm laceration to the right lower leg requirng a surgical repair. Findings Includes: 1. R1 was admitted with the diagnosis of Dementia with behavior disturbance, Hearing Loss, Unspecified Macular Degeneration, difficulty walking, lack of coordination. Brief	S9999		

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S9999	Continued From page 2 interview for mental status dated 10/4/21 documents a score of zero. Section G (functional status) documents: R1's walking was only stabilized with staff assistance. R1 required extensive assist with two plus person physical assist with transfers and walking in the room. Walking in the corridor occurred only once or twice with two plus person physical assist. Balance during transition and walking: R1 was only stabilized with staff assistance. Care plan intervention dated 10/25/18 documents keep R1 within visual to monitor position while sitting in the wheelchair. Care plan initiated 6/3/19 document: R1 is high risk for falls related to confusion, gait and balance problems, unaware of safety needs and vision impairment, legally blind r/t macular degeneration and Dementia. Fall assessment dated 7/26/21 documents: R1 was high risk for falls. Incident report dated 9/13/21 documents: Staff heard a loud noise. R1 was observed on the floor out of the wheelchair on her right side. The wheelchair folded. R1 had a lump on the right side of her head. Incident report dated 9/26/21 documents: R1 attempted to stand, fell and hit her head with complaints of pain to right side of the body. On 10/27/21 at 3:39pm, V4 (cna) said, R1 stands up from the wheelchair all day. It's a reflex. On 10/27/21 at 4:16pm V6 (nurse) said, I was getting report. I heard a thud. It was two to three certified nursing assistance standing around in the small dining room. R1 had a behavior of standing up all the time. R1 fell in the hallway just pass the bathroom. R1 was on the floor with her head against the baseboard bleeding. R1 shouldn't have fallen with as many staff member that was present. The cna said, I turned my back and R1 fell. R1 was not sitting in view of the staff	S9999		

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S9999	Continued From page 3 members in the small dining room. On 10/28/21 at 10:55 am, V2 (DON) said, R1 had a fall on 9/13. R1 was sitting in the common area, staff heard a loud noise, looked up R1 was on the floor, the wheelchair was standing up but folded. R1 was very impulsive. R1 does stand up from the wheelchair. R1 pushed away from the table. The staff was monitoring the common area but did not see R1 get up due to moving another resident. The staff member vision was blocked by the pole. The pole was a blind spot. It was reported R1 was restless on the day shift. On 10/28/21 11:26am, V1 (administrator) said, R1's fall on 9/13/21 was in the common area. R1 probably tried to close the wheelchair. The staff member did not see R1 because the pole was in the way. R1's fall on 9/26/21 was in the hallway, in view of the nursing station, the nurse were giving report, V12 (cna) went to throw trash away. Staff heard R1 fall but did not see R1 until she was on the floor. On 10/28/21 at 1:07pm, V12 (cna) said, I went to throw away diaper in the soiled utility room. I took my eyes off R1 for a second. I heard R1 drop, R1 was on the floor with a cut on the head which was bleeding. Had I known, R1 was going to stand up, I would have placed R1 next to the staff that was monitoring instead in the hallway. Incident note dated 9/13/21 documents: R1 fell from wheelchair. Observed on floor on her right side. Stated that she hit her head. Lump observed on Right side of head. Care plan intervention dated 9/13/21 documents: cna/nurse to offer walk R1 when she appears restless. Maintenance to check wheelchair.	S9999		

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S9999	Continued From page 4 Progress note dated 9/26/21 documents: R1 fell on floor and hit head. R1 had an opened area on head and complaint of pain on right side. 911 called, R1 was transported to hospital. Care plan intervention dated 9/26/21 documents: do not leave resident unattended in hallway or common areas at any time due to high fall risk. Serious Injury Incident Report dated 9/27/21 documents: On 9/26/21, R1 was observed laying on the floor in front of her wheelchair in the hallway. R1 was noted bleeding from the head with complaints of pain to right side of body. R1 was placed in the common area near the nursing station for easy visual checks, staff entered the dirty utility room to throw out garbage. A couple seconds later, staff member heard a noise, came out of the dirty utility room and noted R1 laying on the floor in front of her wheelchair on the right side. At the same time, V6 (nurse) heard the same noise. It seems R1 stood up, lost balance and fell forward. R1 was admitted with Closed Head Injury, Laceration and Fracture of the right ramus. Hospital paperwork dated 9/27/21 documents: staff member went to throw something in the garbage and heard R1 fall. R1 had a fall resulting in a closed head injury, two inch laceration to the forehead and a fracture of the right pubic ramus (pelvic ring). Fall Prevention and Management Policy dated 11/2018 documents: Resident receives appropriated supervision to prevent avoidable accidents. 2. R2 was admitted with the diagnosis of Alzheimer's disease, Dementia, Neuropathy,	S9999		

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S9999	Continued From page 5 Bilateral Macular Degeneration and hearing loss. Brief interview for mental status dated 8/6/21 documents a score of zero. Section G (functional status) documents: R2 required extensive assist with two plus person physical assist with transfers. R2 uses a wheelchair for mobility. Care plan initiated 8/22/18 documents: R2 has an ADL self-care performance deficit related to Alzheimer's Dementia, Impaired balance, Macular Degeneration and hearing impairments. R2 requires the electronic lift with two staff assistance for transfers. Incident report dated 10/3/21 documents: R2 was being transferred from the bed to the wheel chair by cna when R2's right lower lateral leg hit the wheelchair causing a nine inch laceration to the right lateral leg. R2 was transferred to the hospital. On 10/28/21 at 10:55am, V2 (DON) said, R2 has a high back wheelchair, during a transfer, R2 scraped her leg on the wheelchair. R2's leg rest were removed, when the leg rest are not attached to the wheelchair. There are pieces that stick out. R2 was being transfer by one staff member. V19 (cna) transferred R2. R2 required electric lift which requires two people. R2 is dead weight. All staff members including agency have been trained on where to find a residents lift status (kardex) and trained on lifts. On 10/28/21 at 1:31pm, V19 (cna) said, I proceed to transfer R2 in the wheelchair. I placed R2 in the wheelchair. R2 said, my leg hurts. R2's leg was bleeding. I called the nurse immediately. The nurse, said R2 required an electronic lift. I was not aware that R2 required a lift and did not know where to access that information. I had been getting R2 up in the wheelchair by myself because R2 was so light.	S9999		

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S9999	Continued From page 6 Serious Injury Incident Report dated 10/8/21 documents: R2 was being transferred by V19 (cna) R2 stated, that her leg hurt. V19 looked down and noted blood dripping from R2's right leg. R2's laceration was caused by scratching leg on the wheelchair. Hospital paperwork dated 10/3/21 documents: R2 had a laceration without foreign body measuring 10 centimeter (length) and 30 millimeters (depth) to the right lower leg requiring sixteen sutures for a laceration repair. Employee warning record dated 10/3/21 documents: V19 (cna) improperly transferred R2 without following the Kardex resulting in resident injury. Safe Resident Handling dated 12/2018 documents: Manual lifting is unsafe and is not permitted. Resident transfers will be designated into one of the following categories: H -mechanical lift transfer with 2 assist. (B)	S9999		