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 01/20/2022

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

(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 Investigation: 2290088/IL142066 FRI of 1/2/2022/IL142469	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b)5 300.1210c) 300.1210d)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. 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 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,	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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 Observation, Interview and Record Review, the facility failed to provide staff direct supervision for two residents (R1 and R4) well known to be high risk for falls. This failure resulted in R1 and R4 sustaining falls that required emergency transfers to local hospitals. R1 was diagnosed with Intracranial Subdural Hematoma and received sutures to the left brow and R4 was diagnosed with traumatic subarachnoid hemorrhage and Contusion of the scalp Findings include: R1 is a 74 year old male admitted to the facility 11/21/2021 with diagnoses that include, Muscle Weakness, Epilepsy, Cognitive Communication Deficit and Hypertension. Minimum Data Set (MDS) dated 12/03/2021 reads a Brief Interview Mental Status (BIMs) score of 09, indicating cognitive impairment. Functional Assessments indicate R1 requires extensive assistance of 2 person physical assistance with Bed mobility, walking and transferring. On 1/19/2022 at 4:19pm, R1 was observed resting in a low bed, a fall matt was in place on the floor at the bedside. Resident not able to be	S9999		

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S9999	Continued From page 2 interviewed. On 1/18/2022 at 12:26PM V12 (Certified Nurse Assistant), said I have to get R6 off of the toilet, I transferred R6 to the toilet and before leaving them, told R6 to pull the light when done. I didn't know R6 was a fall risk. On 1/19/2022 at 2:30PM V5 (Restorative Nurse) said, the residents are assessed for falls on admission, and I put them on the red leaf program if the fall risk score is 10 or above, if they have a fall, and if they have a history of falls. The regular staff know not to leave Residents on the toilet unattended. The agency staff are instructed about the red leaf program and what is expected of them and are given a brief orientation on how to chart, what not to do. It is not acceptable to leave a resident unattended on the toilet. They shouldn't be left alone in the reclining wheel chair because the residents can jump right out. On 1/20/2022 at 10:09AM V2 (Director of Nursing) said, A resident who has a history of epilepsy and one sided weakness should not be left to toilet by themselves due to safety reasons. Especially if they are a high risk of falling. Fall assessments are to be done on admission and quarterly and whenever there is a fall incident. R1's records indicate the following: Fall Risk Screenings and scores: 11/21/2021- 19, 12/23/2021- 17, 12/28/2021- 18 and 1/10/2022- 21. R1's progress note written on 12/23/2021 at 1:44PM indicating that R1 had exhibited increased weakness during skilled therapy treatment and new orders were received from the	S9999		

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S9999	Continued From page 3 Nurse Practitioner. Physician Order Sheet reviewed for 12/23/2021 include Orders to Continue Physical Therapy to further address strength, activity intolerance and functional mobility. On 12/23/2021 at approximately 8:39PM, a Certified Nursing Assistant (CNA) assisted R1 to the toilet and left R1 on the toilet unsupervised and went to get R1 a beverage. When the CNA came back to the room, R1 was found lying face down on the bathroom floor in blood. The facility called for emergency service (911), and R1 was diagnosed with an Intracranial Subdural Hematoma and received sutures to the left brow. R1 was transferred to the nearest Community Hospital and thereafter required transfer to a hospital with a higher acuity level of care. R4 is a 90 year old male that was admitted to the facility 10/22/2021 with diagnoses that included Difficulty in walking, Muscle wasting and atrophy, Dementia, Atrial Fibrillation and Thrombocytopenia. Minimum Data Set dated 10/28/2021 has a BIMS score of 02 indicating severe cognitive impairment. Functional Assessment indicates R4 required Extensive assistance with bed mobility and required two person physical assistance with transfers. R4 Records reviewed Fall Risk Screen dated 11/30/2021 has score of 17 -High Risk of Falling. Another dated 1/02/2022 scored 16- High Risk of Falling. R4 has a known history of attempting to self-ambulate and is known by staff to have poor judgment. On 1/02/2022 R4 fell in the facility after left unattended in the dining area. At some time in the evening during dinner service, V6 (C.NA)	S9999		

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S9999	Continued From page 4 observed R4 lying on the floor in the dining area. R4 had a laceration to the right forehead which was bleeding. The facility called emergency services (911) and R4 was taken to a local hospital and was diagnosed with traumatic subarachnoid hemorrhage and Contusion of the scalp. R4 was thereafter transferred to a higher level acuity hospital for further treatment. R4 Physician Order Sheet and Medication Administration Record Dated 10/30/2021 indicated that R4 was receiving heparin sodium injections for anti-coagulation every 8 hours while in the facility. R4's Care Plan Interventions include placing R4 on the Facility Fall Intervention Program. V6 (CN.A) and V19 (Registered Nurse) were interviewed on 1/19/2022 regarding the fall that occurred on 1/02/2022 At 10:53AM V6 (CNA) said, the nurse left the area to administer wound care to another resident and I helped. R4 was left alone sitting in the reclining wheel chair. When I finished, I came out and went past the common area and saw R4 on the floor, so I called out for the nurse immediately. R4 is a fall risk, and I didn't think that R4 could try to get out of the chair. At 2:18PM V19 Registered Nurse said, I was R4's nurse the day R4 fell. R4 was sitting in a recliner at the dining room, because R4 often would try to get up to walk. I was watching R4, but then I had to answer a call light. It was dinner time and I was the only nurse working the two hallways on the 2nd floor. R4 was the only person watching television in front of the nurses' station and was placed there because I wanted to watch R4. Facility provided: Fall Prevention and Management reads: once a resident is determined to be at high risk of falling, the admitting nurse/unit nurse will alert staff and will	S9999		

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S9999	Continued From page 5 place that resident in the Red Leaf Fall Prevention Program based on the following criteria: a.) A resident with a Fall Risk Assessment score of 10 and above, and/or b.) A resident who had a recent fall with injury regardless of his/her recent Fall Risk Assessment score. All staff will be knowledgeable and respond appropriately to residents identified with the Red Leaf. (A)	S9999		