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 12/10/2021

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

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S 000	Initial Comments FRI of 10/21/2021/IL140080	S 000		
S9999	Final Observations Statement of Licesure Violations 300.1210c) 300.1210d)6 Section 300.1210 General Requirements for Nursing and Personal Care 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, 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 follow their fall policy by not using preventive strategies for one resident (R1) out of three residents reviewed for falls. This failure resulted in R1 falling from his bed, hitting his head on the floor subsequently sustaining a laceration above his right eyebrow requiring 9	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

sutures. R1's fall strategies that were written on R1s' care card and documented on R1's minimum data sheet,were not applied.

Findings Include:

Facility's fall policy denotes 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 environment as possible

R1's care card dated 10/13/21 denotes R1 as a fall risk. Safety interventions include the use of a bed side mat. While dressing, grooming, transfers, R1 is a 2 person assist.

R1's Current Activities of Daily Living (ADL) assistance dated 10/20/21 Section G. denotes: Total dependence, Two+ person physical assist. Bed mobility- how resident moves to and from lying position and turns side to side: Extensive assistance, Two + person physical assist.

R1's Health Status/Progress Note Text dated 10/21/2021 01:00 reads : "Was made aware by coworker that resident had fallen, upon entering room observed resident in room on floor by bed in sitting position with CNA at his side and noted blood on floor and on resident. Resident alert verbally responsive with confusion. CNA stated he slid off bed to floor during care being provided, Resident assisted to bed. Upon full body assessment noted right eye with open area, site cleansed with normal saline and pressure dressing applied, PROM performed, Denies any pain/discomfort. VS T98.2, P79, R20, BP 164/84,

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S9999	Continued From page 2 spo2 97% on room air. Doctor notified made aware of incident, orders received to send resident out for eval r/t eye injury. 911 called and awaiting arrival. Wife made aware of incident and that he was sent out for eval." R1's ambulance run sheet dated 10/21/21 denotes staff indicated they were providing care when R1 rolled out of bed onto linoleum floor. 1 ½ inch laceration over right eyebrow. R1 denies any pain. No other obvious signs of trauma. R1's hospital record dated 10/21/21 denotes 79-year-old male with previous stroke presented to emergency room after fall from bed. Normal range of motion. Head: right periorbital erythema, 4-centimeter laceration over the right eyebrow -Skin Closure: Patient tolerated the procedure well with no complications; 9 sutures During interview on 12/7/21 at 12:15pm, V2 (Restorative Nurse)stated based of the activities of daily living (ADL) assessment, a care card is written up for that specific resident which the aides should read so they know the type of ADL care that specific resident needs. V2 also stated from the ADL assessment, a care card is written and placed inside the closet of each resident in their room to be used by any staff member providing care to that particular resident. V2 stated R1 had a care card in his closet in his room with pertinent information for staff to use. V2 stated V4 Certified Nurse Aide (CNA) was trained and should have known where R1's care card was and used the information on his care card to provide him care. On 12/7/21 at 1:05 pm, V3 (Fall Coordinator)	S9999		

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S9999	Continued From page 3	S9999		

stated he has been the fall coordinator for three years. V3 stated part of his duties are to update care plans after falls and speaks with Interdisciplinary team (IDT) to find the root/cause of a fall. V3 stated with any fall HE has to speak to the nurses and aides involved. V3 stated after R1s' he fall spoke to the aide (V4) assigned to R1 on 10/21/21. V3 stated he was told by V4 that she was changing R1's diaper and had R1 centered in the middle of the bed when R1 suddenly slid off the bed onto the floor. V3 stated V4 informed him that after R1 fell out of the bed she ran to get the nurse. V3 stated V4 told him that she was cleaning R1 by herself. V3 stated care cards are in all the resident's rooms inside the resident's closet for staff to use and to refer to so they know what care to provide to that particular resident.

On 12/7/21 at 2:20pmV4 (CNA) stated she has worked at the facility for three months on the night shift. V4 stated came in to work that night (10/21/21) around 10pm making rounds and providing patient care to those residents that needed it. V4 stated R1 was one of the last residents on her side that she had got to and noticed that he was wet. V4 stated she removed the sheets and told R1 that she was going to provide care to him and R1 verbalized that he understood. V4 stated removed R1's gown, wiped his stomach, turned him on his side left side and had him in the center of the bed. V4 stated she was holding R1 with one arm, R1 was holding onto the mattress. V4 stated suddenly while wiping R1's back R1 started sliding off the bed and she could not grab him in time before he fell out of the bed onto the floor. V4 stated that when R1 fell onto the floor their were no floor mats on the floor by his bed. V4 stated was not aware that

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S9999	Continued From page 4 R1 was supposed to have floor mats next to his bed. V4 stated she got R1's nurse and she assessed him and saw R1 had a cut on the side of his head by his eyebrow. V4 stated they cleaned R1 and got him ready for the ambulance to take R1 to the hospital. V4 stated she was told about a care card being in the closet of the resident's room but was not aware of a care card for R1 being his room. V4 stated was not told in any shift change report that R1 required two people to turn him in the bed or wash him in the bed. V4 stated if had been aware that R1 required two people to turn or get washed up would have gotten another staff member to help her. V4 stated she told R1 that she was sorry and R1 responded that it was not her fault. On 12/7/21 at 3:20pm V5 Licensed Practical Nurse (LPN) stated she was R1's nurse since he has been admitted to the facility. V5 stated she worked the night shift and did not ever see R1 getting up. V5 stated she came to work on the night of 10/21/21 and was helping another patient out. V5 stated V4 (CNA) called to her and reported that R1 fell out of the bed while she was cleaning him up. V5 stated she assessed R1 and noted he had laceration above his eye. V5 stated she then called R1's doctor and got order to send R1 to the hospital. V5 stated there are green care cards is the residents room put in by the restorative team to tell staff what a resident need are, like one or two people to provide ADL or help with transfers. On 12/9/21 at 9:30amV9 (Doctor) stated R1 did sustain laceration from the fall. V9 stated the laceration that R1 sustained over his right eyebrow could be attributed from the fall that he had from the bed on 10/21/21.	S9999		

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