STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005706	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY MAPLE CREST	4452 SQUAW PRAIRIE ROAD BELVIDERE, IL 61008

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statment of Licensure Violations 300.610a) 300.1210a) 300.1210b)5) 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 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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S9999	Continued From page 1 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) 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. 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	S9999		

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S9999	Continued From page 2 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 were not met as evidence by: Based on observation, interview, and record review the facility failed to provide adequate supervision for a resident (R10) with a history of falls and failed to ensure safety interventions were in place. These failures resulted in R10 having an unwitnessed fall and sustaining a laceration to her eye brow and a maxilla (facial) fracture. The facility failed to provide adequate supervision for a resident (R49) with a history of falls and failed to ensure a resident was positioned properly while dining alone in her room (R7). This applies to 3 of 5 residents (R10, R7, R49) reviewed for safety and supervision in the sample of 20. The findings include: 1. On 8/16/22 at 11:24 AM, R10 was lying on her back in bed, at a diagonal angle. Her head was near the bottom of the right side rail and her feet were hanging off the opposite side of the bed. R10's feet were touching the wheelchair, parked next to R10's bed. R10's left eyebrow had a glued laceration and the left side of her face had bruises at various stages of healing. R10 had greenish yellow bruising noted under her left eye. There was deep purple bruising to her left eye brow and above her left eye. R10's left cheek had several bruised areas with varying colors of light purple and greenish yellow. R10 did not have any	S9999		

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S9999	Continued From page 3 fall mats in her room. R10 said she wasn't sure what happened to her eye, but it does hurt sometimes. R10 said she thinks whatever happened, it was at night. On 8/17/22 at 9:51 AM, R10 was lying on top of her bed linens, fully clothed with her shoes on. R10 was lying diagonally across the bed with her head near the bottom of the right side rail and her legs hanging off the side of the bed. R10's wheelchair was parked next to the bed and it appeared resident had self-transferred. There were no fall mats on the floor. On 8/17/22 at 11:30 AM, R10 was lying in bed awake. R10 was lying diagonally across the bed with her legs hanging off the bed, from her knees down. At 2:25 PM, R10 was lying on her right side in bed. R10's head was near the side rails and her legs were bent slightly. R10 had her lower legs, from her feet to her knees, resting on the seat of the wheelchair. (During all the above observations, R10's door was open and she was visible from the hallway. The facility staff walked passed R10's room numerous times and did not reposition R10. The facility's Incident Report Form dated 8/13/22 showed R10 fell at 1:48 AM and sustained a left maxilla fracture and 2 centimeter laceration to her left eyebrow. This document showed, "Resident self-transferring and sustained a fall, bleeding noted to left eyebrow, pressure applied. NP (Nurse Practitioner) notified and orders to send to the hospital obtained... Resident was self-transferring without shoes on and fell in the hallway. Resident returns to facility at 8 AM with a fractured left maxilla and 2 cm laceration to left eyebrow that was closed with glue... Gripper socks to be applied at night..."	S9999		

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R10's Facesheet dated 8/17/22 showed R10 had diagnoses to include, but not limited to: anxiety disorder, thyroid cancer, congestive heart failure, hypothyroidism, dementia without behavioral disturbance, major depressive disorder, unspecified fall, and stroke.

R10's facility assessment dated 5/23/22 showed she had severe cognitive impairment; required extensive assistance of 2 or more staff for bed mobility, transfers, and toilet use; required extensive assistance of 1 staff for personal hygiene and bathing; was not steady without staff assistance; and had 2 or more falls since admission.

R10's Fall Risk Assessment dated 7/24/22 showed she was at "high risk" for falls.

R10's EMR (Electronic Medical Record) showed 8 fall events since 1/1/22. R10 had falls on 1/6, 1/16, 3/1, 3/27, 4/26, 4/30, 7/24, and 8/13. R10's Fall Event dated 8/13/22 showed was found in the hallway. R10 had hit her head. R10's left pupil was misshapen/sluggish response. R10 had regular socks on. R10 had a laceration to her left eyebrow.

R10's Progress Note dated 8/13/22 at 3:39 AM, showed, "100 wing nurse informed this writer that R10 was on the floor on 100. Assessed and noted R10 laying face down, partially on her left side, in front of room 100, fully clothed with regular socks on, moderate amount of blood draining from face, body kept in alignment and rolled over; 2 inch deep laceration noted to left eyebrow, resident kept immobile. NP and hospice notified and received order to send to emergency room..." R10's Progress Note dated 8/13/22 at

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S9999	Continued From page 5 8:15 AM showed, "Returned from local hospital with closed fracture of left side of maxilla and facial laceration. The laceration was closed with glue. Tylenol given for facial discomfort. Hospice in facility and stated that they will order her safety mats for the floor while in bed. Gripper socks were provided for when out of bed..." R10's Interdisciplinary Note dated 8/15/22 showed, "R10 fell on 8/13 at 1:30 AM. Resident was found in the 100 hall facedown after self-transferring. Root Cause: resident has poor safety awareness and attempts to self-transfer and ambulate. She was fully dressed with regular socks and no shoes..." R10's Nurse Practitioner Narrative dated 8/16/22 showed, "... Resident is seen for follow-up after being seen in the emergency room related to a fall during the middle of the night. She tried to ambulate alone and fell face first on the floor. She sustained a laceration to her left forehead that was glued. She also sustained a fracture to the left maxilla... She complained of the left side of her face is sore... She has some bruising in left orbital (eye) area and also on left check/jaw area... Laceration to left temporal area scabbed and approximated with glue...Facial pain related to maxillary fracture and laceration. Pain controlled with Tylenol..." R10's Actual Fall Care Plan initiated 7/29/22 showed interventions to include: "Educate staff to monitor resident frequently for transfer needs. Encourage resident to wait for assistance..." R10's Potential for Falls Care Plan initiated 10/26/21 showed, "Resident at risk for injury from falls due to unsteady gait. Goal: The facility will reduce the likelihood of the resident experiencing	S9999		

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an injury related to a fall... Interventions include: ...Event occurred 11/14: Gripper socks placed on resident... Event occurred 4/30: Staff to continue increased rounds; if resident is anxious offer to get resident up and dressed for the day.

On 8/17/22 at 4:32 PM, V3 (Wound Care Coordinator) said she saw R10 recently because she had a laceration to her forehead from a fall and to go to the emergency room. She likes to self-transfer and we have to keep a close eye on her. She doesn't realize she needs help.

On 8/18/22 at 7:35 AM, V10 (Licensed Practical Nurse - LPN/Night Shift Clinical Supervisor) said he was working the night of 8/13/22, when R10 fell. V10 said he was assigned 200 hall and the first part of 100 hall. V10 said he had seen R10 earlier in the night and she was resting in bed. R10 is alert to self, is unsteady with transfers, and had extremely poor cognition. R10 came from assisted living to the facility because she was falling excessively. R10 keeps falling, as she continues to decline overall. R10 has had multiple falls. I did not see R10 fall. I was on the 200 hall and V12 (100 hall Registered Nurse - RN) came and told me R10 had fallen and was bleeding. The night she fell, she was fully clothed and 2-3 doors down from her room, in the hallway. I'm not sure how she dressed herself and got down the hallway that far. R10's head was facing the nurses' station. She was lying face down, partially on her left side. Her left arm was tucked underneath her. She didn't really say anything. She didn't know what happened. She just wanted to get up and put her shoes on. R10 had regular socks on, but no shoes. We carefully log rolled R10 onto her back to see where the blood was coming from. R10 had blood on her face and had a "heck of a head injury." There was a laceration

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that was bleeding, so we held pressure and she had bruising and swelling from landing on her face. The facial swelling was quite pronounced and by the time she left with EMS her left eye was almost swollen shut. V13 (CNA) stayed with R10. V11 (CNA) came in at 2:00 AM and sat with R10 until EMS arrived. It was the craziest thing. She had on an incontinence brief, pants, shirt, socks and no one heard a thing. R10 came back from the emergency room later that morning. R10 doesn't mean to cause any problems or break rules, it's just her cognition declining. She doesn't realize she can't get up without help. If R10 is in bed, the bed should be in the lowest position and she should have fall mats now. R10's legs should not be hanging off the bed. It's bad for circulation and tempts her to get up and take off.

On 8/18/22 at 1:01 PM, V7 (NP) said she is familiar with R10. R10 is confused and has a wheelchair. The facility called me the other night and said she had gotten out of bed and fell face first, hitting her head. R10 was sent to the ER and she sustained a laceration to her head and a maxillary fracture. The injuries were caused by the fall, she did not have either injury prior to falling. R10 has had previous falls. She needs to be watched closely. It would not be safe for R10 to be lying in bed with her legs hanging over the side or resting on the seat of the wheelchair.

On 8/18/22 at 2:05 PM, V12 (RN) said she was the nurse assigned to R10's hall when she fell (8/13/22). V13 (CNA) was working with me that night. She went to answer a call light at the other end of the hall and I was in the bathroom, by the nurses' station. We did not see R10 fall. V13 told me R10 had fallen and was on the floor in the hallway. I went to check R10. She was lying on her left side and V13 said she thought she saw

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blood. I told her not to move R10 and I went to get V10 (LPN). V10 came back with me and we carefully turned R10 onto her back. There was blood on the floor and the side of her face. There was a laceration above her left eyebrow that was bleeding, so we cleaned her up and applied pressure. V13 told me that R10 was in bed the last time she saw her before the fall. R10 has done this before. She wakes up in the middle of the night and thinks it's time to get up. She will get herself dressed and walk into the hall. R10 wasn't saying much when she was on the floor. She said she wanted to get up and she thought it was time to go to breakfast.

The facility's Fall Management Policy reviewed 6/21 showed, "The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible... 2. Residents at risk for falls will have Fall Risk Identified on the interim plan of care with interventions implemented to minimize fall risk..."

2. On 8/16/22 at 9:28 AM, R7 was yelling for help. R7 yelled three times, but no staff responded. R7 was lying in bed. The head of the bed was elevated at approximately 50 degrees. R7 was positioned down in the bed, so her head and shoulders were positioned over the bed in the bed. This caused R7's head to be pushed forward with her chin touching her chest. R7 had her breakfast tray on the overbed table, in front of her. R7's head was below the level of the tray. R7 had sausage and toast on her plate, a cup of coffee sitting on the table (near the edge of the overbed table, not on the dietary tray), and a bowl

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S9999	Continued From page 9 of oatmeal resting on her chest. R7 was attempting to eat her oatmeal with a spoon. The surveyor asked R7 if she needed help. R7 replied, "Obviously! I need to be pulled up in bed, so I can eat. It's very hard to eat like this. It's hard to swallow. I want to have my coffee, but I don't want to spill it on myself." R7 did not have dentures in her mouth. R7's Face Sheet dated 8/17/22 showed diagnoses to include, but not limited to: coronary artery disease, heart failure, seizures, osteoarthritis, dysphagia, lack of coordination, dysarthria, aphasia, right side weakness, anxiety disorder, stroke, peripheral vascular disease, and major depressive disorder. R7's facility assessment dated 5/16/22 showed R7 had severe cognitive impairment; required extensive assistance of two persons for bed mobility, transfers, and toilet use; required extensive assist of one person for personal hygiene; and was always incontinent of bowel and bladder. R7's Speech Therapy Evaluation and Plan of Treatment dated 6/21/22 showed, "Patient was referred to ST due to coughing episode witnessed by nursing staff indicating the need for ST to assess/evaluated least restrictive oral intake. R10 has a complicated medical history including a stroke and seizures. R10 had no postural difficulties (ability to maintain posture while eating). R10's recommendations to facilitate safety and efficiency was for R10 to follow general swallow techniques and precautions. On 8/17/22 at 3:10 PM, V4 (Restorative Nurse) said the residents should be up and out of bed in a chair or in the dining room for meals.	S9999		

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S9999	Continued From page 10 Sometimes R7 wants to stay in bed. If R7 stays in bed, then the head of the bed should be elevated and her body should be in good alignment. The staff should be aware of R7's needs. V4 was asked if R7's head should be below the level of the tray. V4 replied, "No, unpleasant things could have happened. She could have choked or burned herself." On 8/18/22 at 8:48 AM, V27 (Speech Language Pathologist) said all residents should be upright when eating, as close to 90 degrees as possible, for safety. If a resident is lying back, the food can fall back and block their airway. They are usually more alert when they are in an upright position. I did evaluate R7, but she didn't need any special recommendations. General Swallow Precautions include: eating at a slow rate, proper positioning, and nothing in their mouth when they lay down. R10 should not be slouched down in the bed. That would be a problem and a safety concern. R7 should have been assisted with positioning when her tray was delivered. On 8/18/22 at 9:02 AM, V1 (Administrator) said the facility did not have a Swallowing Policy or a Policy that described "General Swallow Precautions." 3. R49's facesheet shows that she was admitted on 07/20/21 with diagnoses to include metabolic encephalopathy; disorder of muscle, unspecified; lack of coordination; generalized muscle weakness, and cognitive communication deficit. The facility assessment dated 07/21/22, showed R49 has no cognitive impairment and requires extensive assistance of 1 staff member for dressing. R49's Fall Risk Screen dated 07/20/22, shows	S9999		

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S9999	Continued From page 11 that R49 is a high risk for falls and has a history of multiple falls. The same assessment shows that R49 is unable to independently come to a standing position. R49's Fall Event dated 8/14/22 showed R49 experienced a fall on 8/14/22 at 08:00 AM. The same document showed R49 hit her head and reported a headache and a pain level of 3 (on a scale of 1-10), and she was sent to the emergency room for evaluation. R49's Care Plan initiated on 6/15/22 shows,"Potential for falls, Resident is at risk for injury from falls...interventions.... get to know resident's habits to anticipate resident's needs... check on resident frequently and place resident in visible view of the staff when up in chair when resident will allow". R49's Care Plan initiated on 7/20/21 shows, " [R49] has an Activities of Daily Living (ADL) Self Care Performance Deficit related to weakness.... Interventions... Transfer: [R49] requires 1 staff participation with transfers... Dressing: [R49] requires 1 staff participation to dress". The Fall Incident log provided by the facility on 8/18/22 shows that R49 fell five times from 3/5/22 to 8/14/22. On 8/16/22 at 09:56 AM, R49 was sitting in her wheelchair in her room. R49 had a bluish, red discoloration on the right side of her forehead. On 8/16/22 at 09:56 AM, R49 said that she fell this past Sunday (08/14/22) in the morning when she was trying to put on her pants. R49 said she does not receive the assistance she needs. R49 said on the day of her fall, the Certified Nurse	S9999		

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SYMPHONY MAPLE CREST	4452 SQUAW PRAIRIE ROAD BELVIDERE, IL 61008

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S9999	Continued From page 12 Assistant (CNA) came into her room, handed her clothes to her and told her that she could get dressed herself, then left the room. While R49 was trying to put on her pants, she fell off the bed onto the floor and hit her head. R49 said she yelled for help and the CNA came back in. R49's Inter Disciplinary Team (IDT) note dated 8/15/22 at 01:05 PM showed, "[R49] had a fall on 8/15 at 0830. Resident was found on floor in between bed and closet. Resident states she pulled up her pants and just fell over....". On 8/17/22 at 2:15 PM, V15, Licensed Practical Nurse (LPN) said, "[R49] usually doesn't dress herself. She can dress upper body herself, but needs help with her lower body". On 8/17/22 at 2:20 PM V26, CNA, said that she was on duty on the day of R49's fall. V26 said, "I have not seen her dress herself, but she can". On 8/17/22 at 3:10 PM, V4, Restorative Nurse said, "From what I heard [R49] was trying to adjust her pants. She stood up and went to adjust them and fell to the floor. She will self transfer and our staff knows to kind of keep an eye on her. She will ask for help at times. In the morning when staff round, the night shift will offer to get her up and dressed. She can stand on her own but she shouldn't". V4 said that R49's clothes should not have been given to her. The facility's policy titled 'Falls Management' with review date of 06/21 showed " This facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005706	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed ..... ". (A)	S9999		