STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004733	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY LINCOLN PARK	1366 WEST FULLERTON AVENUE CHICAGO, IL 60614

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S 000	Initial Comments Facility Reported Incident of August 3, 2022 IL150741 Facility Reported Incident of August 19, 2022 IL150756	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 c) 300.1210 d)6) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued From page 2 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 are not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure staff are aware of resident fall prevention interventions, failed to implement fall prevention interventions, failed to notify IDPH (Illinois Department of Public Health) of serious incident/accident within regulatory requirements (R5), and failed to provide supervision for three of three residents (R5, R6, R7) reviewed for falls. These failures resulted in R5 sustaining skin tears and a right femoral neck fracture, R6 sustaining a scalp laceration which required staple repair, and R7 sustaining a forehead laceration which required suture repair. Findings include: 1. R5's (8/19/22) BIMS (Brief Interview Mental Status) determined a score of 13 (cognitively intact). R5's (8/19/22) functional assessment affirms extensive assistance is required for transfers and toilet use. R5's (8/1/22) fall risk screen determined a score of 13 (moderate risk).	S9999		

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S9999	Continued From page 3 R5's (7/21/22) care plan includes potential for falls, resident at risk for injury from falls. Intervention: Anticipate and meet resident needs. Have commonly used items within reach. R5's (8/16/22) 4:00 AM fall event states prior to fall resident lying on the bed. Per patient, he was trying to reach for his walker. Last time the resident was observed: 2:00 AM. Did the resident hit their head? Not witnessed. Left elbow skin tear. R5's new fall intervention includes floor mats to be put at bedside when resident in bed. R5's (8/19/22) fall event states prior to fall resident lying on the bed. Resident stated, "I want to get up and walk so I can go home. My legs are weak that's why I fall." Did resident hit their head? Not witnessed. Right elbow, right arm skin tears. Right trochanter redness, complained of pain. Range of motion painful in upper/lower extremities. R5's (8/19/22) progress notes state CNA (Certified Nursing Assistant) doing rounds, patient observed on the floor. Patient is alert and oriented to self with confusion and forgetfulness. Bed in lowest position, call light within reach. [floor mats were excluded]. R5's (8/19/22) initial facility reported incident states, "Resident was noted on the floor by staff. No visible injury was noted at this time. All extremities can move at baseline with moderate pain on the right hip. Medical Doctor notified with order to transfer resident to hospital. Follow up call made at the hospital resident will be admitted to hospital. No reports of any injury related to the fall. Today, report received that resident x-ray on the right hip result revealed mildly displaced/angulated fracture of the right femoral	S9999		

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S9999	Continued From page 4 neck." R5's (8/19/22-8/22/22) progress notes exclude documentation of any follow-up to inquire about resident status, admitting diagnosis and/or injuries (as stated in the 8/19/22 initial report). R5's (8/21/22) hip x-ray (electronically verified by radiologist at 3:36pm) includes mildly displaced/angulated fracture of the right femoral neck. IDPH was notified of R5's (8/19/22) fall/injury on 8/22/22 at 4:33pm (over 24 hours after R5's injury was identified). On 9/7/22 at 12:02 PM, surveyor inquired about R5's functional status. V11 (Registered Nurse) stated, "He cannot even stand up, he's like really weak in the knees." Surveyor inquired about R5's fall prevention interventions. V11 responded, "We put like the bed in lowest position, and we put the call light within reach. We (me and the CNA) also do rounding like every hour. That's what I remember." Surveyor inquired about R5's (8/19/22) incident. V11 responded, "As far as I remember the CNA passed by the room and he (R5) was already on the floor. What was in place is the bed in the low position and call light was in reach, but because of the mentation, he (R5) was not able to use the call light. I cannot remember if there was a floor mat." On 9/8/22 at 11:16 AM, surveyor inquired about the regulatory requirement for incidents resulting in serious injuries. V2 (Assistant Director of Nursing) stated, "The initial is to be reported within 24 hours of finding out that there is serious injury, and then the final is within 5 days." Surveyor inquired about R5's (8/19/22) incident.	S9999		

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S9999	Continued From page 5 V2 responded, "Hospice came to do the assessment after he fell; he was sent to the hospital the same day. A couple days later admissions got notified (from the hospital) that they did an x-ray for him and he had a fracture. We sent the initial report a couple hours after we found out." Surveyor advised that nothing pertaining to R5's follow-up and/or notification of R5's injury were documented in the progress notes, and inquired when exactly facility staff contacted the hospital for R5's follow-up, and/or when the facility was notified (by the hospital) of R5's injury. V2 replied, "You can only base it on what we wrote on the initial sending out. I believe we found out in the morning and we sent it out in the afternoon." Surveyor inquired why IDPH was notified of R5's injury over 24 hours after R5's x-ray was verified by the radiologist on 8/21/22. V2 stated, "Did this happen on a Sunday? Surveyor affirmed 8/21/22 was on a Sunday, and inquired why he (V2) asked. V2 responded (V3/Quality Assurance Nurse) and I aren't here on the weekend; we work Monday through Friday so no one was here to report it." 2. R6's (8/5/22) BIMS determined a score of 2 (severely impaired). R6's (8/5/22) functional assessment affirms extensive assistance is required for transfers and toilet use. R6's (5/4/22) fall risk screen determined a score of 12 (moderate risk). R6's (7/16/22) initial facility reported incident states resident was noted on the floor. Laceration noted on midline scalp. MD (Medical Doctor) notified with order to transfer resident to Emergency Room for evaluation. Resident	S9999		

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S9999	Continued From page 6 returned to facility, received one staple on her midline scalp. New fall interventions in place. R6's fall care plan includes the following interventions (6/21/18) Call light within resident reach when in room. (7/26/18) Bed in low position. On 9/6/22 at 12:31 PM, surveyor inquired about R6's fall prevention interventions V4, LPN (Licensed Practical Nurse), stated, "I'm a floater but we try to put her in the dining area for activity, we lower the bed, and put the call light in reach." R6 was lying in bed (in high position), and the call light was out of sight and reach. Surveyor inquired about the location of R6's call light. V4 responded, "I'm trying to find it cause it's not next to her, it was on the floor." Surveyor inquired about the height of R6's bed. V4 replied, "To me it's a little higher than, I need to lower it." Surveyor inquired if R6's bed was waist high at this time. V4 replied, "I think so." On 9/7/22 at 2:25 PM, surveyor inquired about R6's functional status. V9 (Licensed Practical Nurse) stated, "She can't walk; she's wheelchair bound." Surveyor inquired about R6's (7/16/22) fall. V9 responded, "I saw her sitting in the wheelchair, I turned my back and started doing something. I heard a noise, turned around and she fell out the wheelchair. She was sitting in the hallway. She had a cut on the back of her head, so they put a staple in there." Surveyor inquired about R6's fall prevention interventions. V9 replied, "I don't know what was in place for her." 3. R7's (7/30/22) BIMS determined a score of 7 (severely impaired). R7's (7/30/22) functional assessment affirms	S9999		

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S9999	Continued From page 7 extensive assistance is required for transfers and toilet use. R7's (7/29/22) fall risk screen determined a score of 7 (moderate risk). R7's care plan states (6/4/21) resident needs assistance to ambulate. (8/3/22) ensure call light button is within resident easy reach at all times while in room. R7's (8/1/22) initial facility reported incident states staff doing rounds noted resident on the floor. Laceration with small amount of blood noted on left forehead. MD notified with order to send resident to hospital. Resident returned to facility, received sutures on the left forehead. R7's fall event includes Effective Date: 8/1/22 (6:59 AM). When was the resident last toileted 12:16 AM, when was the last time resident was observed 3:45 AM. On 9/6/22 at 12:45 PM, surveyor inquired about R7's fall prevention interventions. V5 (LPN) stated, "He has a low bed, non-skid socks and call light within reach." R7 was lying in bed, however, the call light was out of reach, and on the floor. [R7's call light cord was tied to the side rail and the side rail was below the mattress]. Surveyor inquired about the location of the call light. R7 was able to reach the call light cord, however, was unable to easily access the button, because it was caught between the mattress and side rail. On 9/8/22 at 10:14 AM, surveyor inquired about R7. V21 (LPN) stated, "When I first got there, he (R7) was able to walk around and go to the bathroom, but now he's not able to function like	S9999		

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S9999	Continued From page 8	S9999		

he used to. Now he has to be changed and washed-up cause he can't." Surveyor inquired about R7's fall prevention interventions. V21 responded, "We check on him and have like normal protocol for that, and he can use the light." Surveyor inquired about the facility protocol for checking on residents. V21 replied, "I check on the residents every hour cause some are functioning less than others, and some of them are a fall risk." Surveyor inquired about R7's (8/1/22) incident. V21 stated, "The CNA was doing rounds when she found him on the floor. He was going to the bathroom and laid outside the (bathroom) door. He has a walker and didn't have his walker with him. He didn't have any socks on his feet. I saw a gash on his head so I called 911 and sent him out. He did get stitches."

On 9/8/22 at 2:19 PM, surveyor inquired about potential harm to a resident that sustains an unwitnessed fall. V30 (Assistant Medical Director) stated "My first concern would be a head injury, skin and soft tissue injuries, and fractures of the spine and long bones. There's an infinite number of possibilities."

The falls management policy (revised 6/21) states the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and 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 fall risk will be completed upon admission, readmission, and quarterly, with each significant change and after each fall. Residents at risk for falls will have Fall Risk identified on the interim plan of care with interventions implemented to minimize fall risk...All incident and accident with serious physical injury will be initially reported as required

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S9999	Continued From page 9 to the Health Department. (A)	S9999		