| 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 _____ | 03/04/2022 |

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

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| S 000 | Initial Comments<br><br>Annual Certification and Licensure | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210b)<br>300.1210d)6<br>300.1220b)3<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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:<br><br>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.<br><br>Section 300.1220 Supervision of Nursing Services | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.<br><br>These Requirements were nt met as evidenced by:<br><br>Based on observations, interviews, and records reviewed, the facility failed to provide effective interventions for fall preventions and failed to provide supervision to prevent residents from falling for 2 of 22 sampled residents (R2, and R69).<br><br>Findings include:<br><br>1. R69 Fall risk assessment on admission dated 2/5/22 documents R69 is a high risk for falls.<br><br>On 03/01/22 9:26 AM Resident R69 states she fell here at the facility. Resident R69 states, she doesn't remember getting up from the toilet but she saw the floor coming at her when she fell. R69 has forehead is bruised red/green, purple, and a dried bloody scab seen on the bridge of Resident R69 nose. R69's nose is slightly | S9999 | | |

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| S9999 | Continued From page 2<br>swollen. R69 states she broke 3 bones in her nose.<br><br>R69's hospital discharge instructions on 2/21/22 document R69 suffered a open fracture of nasal bones. Review of R69 reportable documents R69 as a high fall risk and R69's nose fracture as a result of the fall. The fall reportable also documents that the nurse found sitting upright on the bathroom floor, and R69 stated she was attempting to transfer to the bathroom independently, but she lost her grip on the toilet bar and fell hitting her face on the ground.<br><br>On 03/03/22 11:12 AM V14 (Nurse) states Resident R69 was a fall risk before she came to the facility. V14 states R69 requires 1 assist person assist with ADL (activities of daily living). Resident R69 is impulsive and got up before the staff could help her off the toilet. V14 states, "Yes. She (R69) was known to be impulsive before she fell here at the facility." V14 states the night shift found R69 on the floor around 2:00 AM.<br><br>On 3/3/22 at 1:31 PM V19 (CNA) states, they go with R69 to assist with bathroom and wait for her when she is done and assist her back. I don't remember any fall precautions before. V19 states before R69 fell she was an assist to the toilet and we could leave and she would call me when done.<br><br>On 3/4/2022 at 9:04 AM V20 (CNA) states the nurse said R69 did not have call light on when she fell. V20 states she was assigned to R69 the night of 2/20/22, the day before R69 fell. V20 states R69 frequently gets out of the bed, but once I remind her to use her call light she does. V20 states R69 got out of the bed without assistance, the night I had her. V20 states, R69 | S9999 | | |

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| S9999 | Continued From page 3<br><br>goes to the bathroom frequently during the night. V20 states, she worked on the same floor, but R69 was not assigned to her the night R69 fell. V20 states, she told the V22 (CNA) that night that R69 fell, before she fell that R69 is supposed to call but you have to watch her frequently. I told V22 (CNA) "to keep an eye on her (R69) because she (R69) is supposed to ring the bell but that's not a guarantee." "The night before she fell when I had her, I told the nurse that R69 was transferring by herself," V20 states. V20 states, she let the aid (V22) know that both R69 and her roommate go to the bathroom frequently, but R69 goes even more than her roommate.<br><br>On 3/4/2022 at 10:03 AM V2 (DON) states staff need to check frequently with R69 because she is impulsive. She is trying to show her daughter that she is independent. Resident R69 told me she doesn't want to be a burden.<br><br>The facility's fall management policy dated 6/21 documents the following: [T]he facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.<br><br>2. The facility's fall incident log indicated that R2 had falls on 10/16/21, 11/17/2021, 11/21/2021, 1/7/22 and 1/21/2222. The care plan was revised with interventions to decrease fall risk on 10/16/21, 11/17/2021 and 11/21/2021. The care plan was not revised after the fall for 1/7/22 and 1/21/22.<br><br>On 3/2/22 at 3:00 PM V12 (Restorative Nurse) stated that an intervention should have been in place after a fall. V2 (Director of Nursing) stated that the care plan should be updated as soon as possible after a fall. | S9999 | | |

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| S9999 | Continued From page 4<br>On 3/2/2022 at 3:00 PM V11 (MDS/Care Plan Coordinator) stated that all care plans are updated by V12.<br><br>R2's care plan had no interventions in place for falls for the dates of 10/16/21, 11/17/21 and 11/21/21.<br><br>On 3/4/22 at 11:30 AM, a progress note dated 1/7/22 at 12:07 PM reads "Resident experienced a fall at approximately noon. Resident was noted on the floor laying on his back alongside his bed .... Resident states he was trying to reach something in his bottom drawer and slid of this cushion attached to his wheelchair and landed on his bottom ... No apparent injuries noted ...."<br><br>On 3/4/22 at 11:45 AM, a progress note dated 1/25/22 at 1:31 PM reads, "Residents with fall on 1/21/22 in bathroom while brushing teeth. No injuries noted. Resident was standing and got water on the floor which may have contributed with fall ....POA and MD notified of fall."<br><br>Facility policy titled 'Falls Management reviewed 6/21 includes; the facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing... All residents' falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Responsible Party: RN, LPN and DON. Fall Prevention Guidelines for all residents upon Admission/Re-admission: 1. A Fall Risk will be completed on admission, readmission and quarterly, with each significant change and after each fall .... Facility Guideline following a fall incident ...2. Complete a fall event. This event includes the circumstances surrounding the fall, devices in use, full body observation for injury, pain, range of motion, and neuro checks as | S9999 | | |

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| S9999 | Continued From page 5<br>needed. 3. A fall Risk is completed by the nurse at time of the fall and then reviewed by the clinical leadership.<br><br>Facility policy titled 'Care Plans" reviewed 5/21 includes; ; each resident will have a care plan that is current, individualized, and consistent with their medical regimen. Responsible Party; ... Rehab ....4; The care plan are updated at least every 90 days or with a significant change of the resident by the team members initiating the care plan ..... 7; the care plan consist of the following: ...C, Intervention are actions taken to achieve the goal. These intervention should build on the resident's strengths, be realistic, and identify those responsible for the interventions.<br><br>(B) | S9999 | | |