Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004832 | A. BUILDING: ______ B. WING ______ | C 06/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SYMPHONY OF CHICAGO WEST | 5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644 |

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| S 000 | Initial Comments<br><br>FRI of 5/19/2022/IL147557 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6<br><br>Section 300.610 Resident Care Policies<br><br>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.<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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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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.

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 Requirement were NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to supervise a resident who had a history of falls to prevent repeated falls; and failed to implement individualized progressive fall prevention interventions for a resident who was identified to be at risk for falls. These failures affected one resident (R2), out of 2 residents, reviewed for falls. R2 fell three times within two weeks and had a fourth fall with injury to the head and face, that required hospitalization, with a diagnosis of Closed Head Injury and Fall.

Findings include:

R2's hospital records dated 5/19/2022, page 13, under "Diagnosis and Plan/Problem List", written by V20 (Hospital Physician) states: #1. Close

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Head Injury; #2. Fall. In addition, page 16 shows that R2 had "Traumatic Ecchymosis of Face and Facial Laceration". Page 12, under "Diagnosis and Plan" shows that R2's hospital admitting diagnoses were "Closed Head Injury and Fall".

On 6/6/22 at 10:45am, the facility's reported incident that was sent to state agency was reviewed. The final report dated 5/26/22 shows that R2 was found on the floor with two hematomas and a laceration above the left eye. This report also shows that was in the hospital from 5/19/22 to 5/23/22.

R2's admission diagnoses include but are not limited to Hypertension, Diabetes, Schizoaffective Disorder, Anemia, Anxiety, Depression, Syncope and Collapse, Hypoglycemia, Dementia, and History of Falling.

On 6/6/22 at 10:40am during observation of residents on the fourth floor, R2 was observed in the wheelchair several times moving around in hallway unsupervised, far away from the nursing station, and not within view of any staff member.

Facility's Falls Incident Reports presented by V3(Restorative Nurse) shows that R2 recently had falls as follows:
Dated 1/7/22; Location: Resident's room; Nursing Description; resident was noted sitting on her buttock by her bed on the floor.
Dated 1/9/22; Location: Resident's Room; Nursing Description; CNA (Certified Nursing Assistant) informed writer that resident was on the floor; writer observed resident lying on her left side on floor next to bed.
Dated 1/20/22; Location: Resident's Room; Nursing Description; Resident was observed on the floor with bleeding noted to the right side of

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| S9999 | Continued From page 3<br>her forehead.<br>Dated 5/19/22; Location: Resident's Room; Sent to Emergency Room.<br><br>R2's Fall care plan dated 11/09/2019 documents in part - Focus: "Resident is unable to use call light due to cognitive status. Interventions: Resident will be evaluated for specific safety alert device."<br>R2's Fall Risk Screen dated 5/23/22, documents in part, Category: Moderate Risk. 3. History of Falls within last six months, 5. Multiple Falls.<br>R2's Minimum Data Set (MDS), dated 4/8/22, documents that R2 has a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicates that R2 has severe impairment. Section G. Functional Status: Bed Mobility, Transfer, Locomotion on unit, requires extensive assistance.<br><br>On 6/7/22 at 1:07pm, V8 (Social Worker) was interviewed regarding R2's fall that resulted in hospitalization. V8 stated that V8 was walking down the hall and heard someone yelling for help and went into R2's room and saw that R2 was on the floor. V8 explained that V8 "ran to get the nurse and we both came into the room and assisted (R2) to the wheelchair."<br><br>On 6/7/22 at 12:00pm, V4 (License Practical Nurse, LPN) was interviewed regarding R2's fall. V4 stated that the social worker (V8) notified V4 that R2 was on the floor. V4 stated that R2 was lying face down on the floor when V4 came into the room. V4 explained that V4 assessed R2 before moving R2 off the floor. V4 added that the social worker helped V4 get R2 up off the floor. V4 explained that R2 had a mark on R2's head and a laceration on the left side of R2's face. V4 added that the Nurse Practitioner came to the | S9999 | | |

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| S9999 | Continued From page 4<br>floor to do an assessment and ordered to send R2 to out for an evaluation.<br><br>On 6/7/22 at 1:45pm, V10 (Nurse Practitioner, NP) was interviewed regarding R2's several falls and her professional opinion about preventing repeated falls. V10 stated that V10 was aware of previous falls of R2. Regarding the fall on 5/19/22, V10 stated that V10 assessed R2 and observed a hematoma above R2's left eye. V10 explained that when V10 was asking R2 questions, R2 would not answer any questions. V10 added that V10 sent R2 to hospital for evaluation. The Surveyor inquired from V10 about the Interventions dated 11/9/2019 on R2's care plan to evaluate resident for specific safety alert device. V10 stated, "I do not know what device they are talking about." V10 stated that she (V10) will follow up on it and get back with the surveyor. V10 did not get back to the Surveyor.<br><br>On 6/7/22 at 2:08pm, V19(Care Plan Nurse) was interviewed about R2's care plan. V19 stated that R2 cannot use call light because of R2's cognition. The Surveyor Inquired from V19 about the intervention in R2's care plan regarding resident being evaluated for specific safety alert device. V19 responded, "That's not supposed to be there, that's wrong." V19 stated that R2 needs to be closer to the nursing station.<br><br>R2's Progress Notes dated (5/19/22) at 3:17pm written by V4 (LPN) states: Writer notified by the social worker that the resident was in the room on the floor next to the bed. After lifting the resident back to the bed, noted a hematoma x 2 and a laceration above the left eye with minimal drainage. Completed head to toe assessment. BP (Blood Pressure) 125/74, P(Pulse) 72, 02(Oxygen) 96% RR (Respiration Rate) 20. NP | S9999 | | |

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| S9999 | Continued From page 5<br><br>(Nurse Practitioner) and PCP (Primary Care Physician) notified. Unable to reach her daughter POA (Power of Attorney). NP spoke with the son on POC (Plan of Care). Ambulance has been called to transport resident to Local Hospital ED (Emergency Department) for CT (Cat Scan) of head.<br><br>Facility's Policy with review date 6/21 and titled, "Falls Management", documents, in part, under "General": The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe and environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed.<br><br>(B) | S9999 | | |