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 03/03/2023

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SYMPHONY LINCOLN PARK	1366 WEST FULLERTON AVENUE CHICAGO, IL 60614

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S 000	Initial Comments Investigation of Facility Reported Incident: 12/10/22/IL00155825 12/10/22/IL00156554 12/10/22/IL00156794	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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 regulations were not met as evidenced: Based on interview and record review, the facility failed to provide adequate fall prevention and supervision for two residents (R7, R8). This failure resulted in R7 sustaining a fall with sutures noted on right side of forehead, bridge of nose and above right eyebrow. R8 resulted sustaining a fall with stitches on the forehead. Findings include: R7 is 80 years old. R7 diagnoses include but are not limited to hepatic encephalopathy; alcoholic cirrhosis of liver with ascites; unspecified asthma; hyperlipidemia; anemia; thrombocytopenia; history of falling; esophageal varices without bleeding; other abnormalities of gait and mobility; other symptoms and signs involving the musculoskeletal system; cognitive communication deficit; Covid-19.	S9999		

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S9999	Continued From page 2 According to MDS (Minimum Data Set), date 11/15/2022, R7 has a BIMS (Brief Interview for Mental Status) score of 13/15. R7 requires extensive assistance with two-person physical assist for bed mobility and transfer. R7 requires extensive assistance with one-person physical assist to walk in room, for locomotion on/off unit and for toilet use. R7 is not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking (with assistive device if used), turning around while walking, moving on and off toilet, surface-to-surface transfer. R7 uses a walker, wheelchair. According to progress note, date 12/11/2022, R7 returned from hospital after sustaining a fall the morning of 12/10/22, sutures noted on right side of forehead, bridge of nose and above right eyebrow. R7 New Admission Fall Risk Screen, date 11/8/2022, categorizes R7 as a high risk with a score of 20. R7 Recent Falls Fall Risk Screen, date 11/26/2022, categorizes R7 as a high risk with a score of 18. On 3/1/23 at 9:15 AM, V7 (Assistant Director of Nursing/Falls Coordinator) stated "Upon admission, R7 was cognitively intact and had a BIMS (Brief Interview for Mental Status) of 13 according to the MDS. After R7 had Covid in December R7 wasn't the same. R7 was not cognitively intact. R7 could ambulate with a walker. R7 was capable to use the call light. R7 was impulsive, liked to do things on own. Due to impulsiveness R7 was a high fall risk. R7s fall	S9999		

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S9999	Continued From page 3	S9999		

interventions included bed in lowest position with wheels locked, call light within reach, floor mats, education to use the call light, especially with transferring, environment clutter free, purposeful rounding, referred to skilled therapy. R7 was in the bed and got up on own, lost balance while transferring and fell. R7 was unable to provide details. R7 told the nurse "I fell, I don't know." The nurse found R7 on the floor, did an assessment, there was bleeding on the forehead. The nurse cleaned the area and put a dressing, did vitals, neuro check, range of motion. R7 was put back in bed. The nurse called the NP (Nurse Practitioner) who gave orders to send R7 to the ER (emergency room). The hospital did a CT (Computerized Tomography) of head, negative of abnormalities, CT of spine negative of fractures. R7 came back with 3 sutures on the forehead."

According to Covid 19 Abbott Binax Now Antigen Test Results, date of test: 12/3/22, R7 test result: positive

On 3/1/23 at 11:56 AM, V21 (Rehab Director) stated "R7 had PT (Physical Therapy), OT (Occupational Therapy), and ST (Speech Therapy) from 11/22-12/22. R7 was fairly high level/independent. R7 was confused. R7 was mobile, unsteady, agitated, verbally/physically aggressive toward therapy staff. R7 goals for PT were to increase lower extremity strength, transfers, standing balance, walk with walker, getting in/out of bed. R7 goals for OT were toileting transfers, total body dressing, arm strength. R7 goals for ST were insight into deficits, increase safety awareness, problem solving. R7 reached highest potential due to confusion level and lack of cooperation. R7 was confused and forgetful. R7 had the physical ability to use a call light but not the cognitive

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S9999	Continued From page 4 ability even with education." On 3/2/23 at 11:38 AM, V5 (Social Service Director) stated "R7 was here long term due to declining physically and mentally. Upon admission R7 was cognitively intact, after R7 had Covid, R7 declined mentally and physically." According to "Illinois Department of Public Health Report of Resident Incident/Accident", on 12/10/2022 at around 8:30AM, R7 was noted on the floor by staff doing purposeful rounds, alert, awake, verbally responsive and not in any form of distress. It was determined that fall occurred due to R7s intention to get out of bed and transfer self to wheelchair without assistance, R7s action resulted to accidental fall as R7 was unable to maintain balance and ended up on the floor, beside R7s bed. According to R7 care plan, initiated 11/8/2022, bed in lowest position with wheels locked, floor mats to both sides of bed added 12/10/2022 after R7s fall. R8 is 79 years old. R8 diagnoses include but are not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; unspecified dementia; traumatic subdural hemorrhage with loss of consciousness of unspecified duration; hypothyroidism; hyperosmolality and hypernatremia; hyperkalemia; personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits; unspecified psychosis not due to a substance or known physiological condition; other symptoms and signs involving the musculoskeletal system; aphasia; cognitive communication deficit; chronic kidney disease; atherosclerotic heart disease of	S9999		

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S9999	Continued From page 5 native coronary artery without angina pectoris. According to MDS, date 1/28/2023, R8 has a BIMS score of 4/15. R8 requires extensive assistance with two-person physical assist with bed mobility and transfer. R8 requires extensive assistance with one-person physical assist for locomotion on unit. R8 is totally dependent for toilet use requiring one-person physical assist. R8 is not steady, only able to stabilize with staff assistance when moving from seated to standing position and surface-to-surface transfer. R8 has impairment with upper and lower extremities on both sides in range of motion. R8 uses a wheelchair. According to progress note, date 1/9/2023, staff found R8 lying on the floor at the side of the bed during rounds. Laceration immediately noted to R8's head with fresh blood. R8 New Admission Fall Risk Screen, date 11/26/2021, categorizes R8 as a high risk with a score of 19. R8 New Admission Fall Risk Screen, date 1/5/2023, categorizes R8 as a moderate risk with a score of 13. On 3/1/23 at 9:15 AM, V7 (Assistant Director of Nursing/Falls Coordinator) stated "R8 was not cognitively intact, had a BIMS (Brief Interview for Mental Status) of 4. R8 was in bed, wanted to get up, lost balance while trying to get up on own. R8 fell and hit head. The CNA (Certified Nursing Assistant) found R8 and called the nurse who did an assessment. R8 had blood on the forehead. The nurse cleaned the sight, did vitals, neuro checks. They put R8 back in bed, called the NP (Nurse Practitioner) who ordered to send out to	S9999		

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S9999	Continued From page 6	S9999		

the hospital. A CT (Computerized Tomography) of the head and spine was negative of abnormalities and fractures. R8 came back to the facility with stitches on the forehead. R8 had no falls before then so was not a high fall risk. R8 was not able to use the call light. R8s fall interventions included fall mats, bed in lowest position with wheels locked, purposeful rounding. Purposeful rounding is checking the resident for pain, positioning, if need changing, personal items close to patient, comfortable in bed. They are done every 1 to 2 hours."

On 3/1/23 at 10:28 AM, V19 (Certified Nursing Assistant) stated "I didn't see R8 fall. Nobody witnessed the fall. Another CNA found R8. We went to R8s room with the supervisor. R8 was on the floor by his bed. There was bleeding from R8s forehead. R8s bed was low, the fall mats were on the floor. R8 didn't tell us what happened. R8 was mumbling, nothing we could understand. The nurse assessed R8. We got R8 into bed. The nursed called the ambulance."

On 3/1/23 at 11:35 AM, V20 (Certified Nursing Assistant) stated "It was an unwitnessed fall. I was R8s CNA (Certified Nursing Assistant) that day. I was rounding on R8. I was checking on R8 more often because previously R8 went out for a stroke. The fall was after I put R8 to bed after dinner. R8 was on the floor. I asked R8 what happened. R8 was not able to tell me what happened. I got the nurse who assessed R8. R8 had a cut on his head. I saw blood. I monitored R8 until the ambulance came. R8 was not able to walk. R8 was total assistance. R8 was not able to use a call light because of dementia/cognitive impairment. R8 was never a high fall risk until after the stroke. I was told by the nurse that earlier that day R8 had been anxious to get out of

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the bed alone. The fall happened second shift. I got R8 up to a chair and put R8 at the nursing station because the nurse told me R8 was trying to get up on the previous shift. R8s bed was low, fall mats on the floor. R8 could not walk, R8 could only pivot."

On 3/1/23 at 11:56 AM, V21 (Rehab Director) stated "R8 was evaluated for Occupation Therapy the day of the fall, before the fall. R8 was receiving PT (Physical Therapy), OT (Occupational Therapy), and ST (Speech Therapy) 1/17/23-2/10/23. The PT goals were increasing leg strength, siting balance, standing balance, bed mobility, transfers, eventually walking, wheelchair mobility. The OT goals were splint/orthotic device to manage tone in upper extremities, dressing, shoulder range of motion, increased sitting balance during ADLs (Activities of Daily Living). The goals of ST were improve producing automatic speech, expressive communication, verbally respond to yes/no questions, tolerate thin liquids, least restrictive diet to minimize aspiration. R8 plateaued/reached highest potential. R8 was receiving OT 11/2/22-11/23/22. R8 last had PT in 4/22-5/22. R8 was dependent with mobility, no assistive devices. R8 was not able to use a call light cognitively or physically. R8 was discharged from therapy due to family choosing hospice placement."

On 3/1/23 at 3:31 PM, V27 (Licensed Practical Nurse) stated "R8 had an unwitnessed fall during the evening. The CNA (Certified Nursing Assistant) heard something. We went into R8s room. R8 was sitting on the floor near the bed, with right arm on the bed. I did an assessment, vitals, and cleaned R8s wound. There was a cut on R8s forehead with little bleeding. We got R8

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S9999	Continued From page 8 back in bed. The CNA stayed in the room with R8 while I went to call the on-call NP (Nurse Practitioner) who ordered to send R8 out. R8 could walk but needed assistance, R8 was unsteady. R8 has dementia. R8 was not able to use the call light. We treat everyone as a fall risk and keep beds in lowest position and do frequent rounding." On 3/2/23 at 11:38 AM, V17 (Social Service) stated "R8 was on the 3rd floor (dementia unit). R8 was transferred closer to the nursing station after the fall. R8 had severe dementia and was not able to make decisions." According to "Illinois Department of Public Health Report of Resident Incident/Accident", on 1/9/2023 at around 9:00PM, staff doing purposeful rounds noted R8 lying on the floor at the side of the bed: alert, awake, and responsive. Findings revealed that accidental fall occurred due to R8s intention to get up from bed on own without staff assistance. R8 has the capability to get up from the bed and sit on the edge of the bed but requires staff assistance to actually transfer from the bed. R8 attempted to transfer from the bed on own, with the intention to stand, without staff assistance, lost balance due to bilateral lower extremity weakness, and as a result, fell to the ground. According to R8 care plan, initiated 11/26/2021, bed in lowest position and wheels locked, floor mats to both sides of bed added 1/9/2023 after R8s fall. On 3/2/23 at 11:38 AM, V5 (Social Service Director) and V17 (Social Service) stated BIMS 0-7 is severe cognitive impairment, not able to make decisions. BIMS 7-12 is moderate	S9999		

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S9999	Continued From page 9 cognitive impairment. BIMS 13-15 is cognitively intact. BIMS is just one aspect to determine if cognitively intact, it can fluctuate depending on what's going on with the resident. Facility policy "Falls Management", review date 2/23, documents in part: 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 an environment as possible. Facility policy "Safety and Supervision of Residents" date 10/2021, documents in part: Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual residents assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition. (B)	S9999		