STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF BRONZEVILLE	3400 SOUTH INDIANA CHICAGO, IL 60616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility failed to ensure that staff were aware of resident fall prevention interventions, failed to implement fall prevention interventions and failed to provide adequate supervision for three of three residents (R1, R2, R3) in the sample reviewed for falls. These failures resulted in the following serious injuries; R1 sustained a laceration requiring staples. R3 sustained a laceration requiring steri-strips. Findings include; The (8/13) falls policy & procedure states residents at fall risk will be identified for staff awareness. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. Recent Falls Risk Screens affirm that R1, R2, and R3 have had multiple falls at the facility from 2019 to 2020. On 3/9/20 at 2:30pm, V3 (Certified Nursing Assistant), V4 (Activities Aide) and 44 residents (including R1, R2, R3) were observed in the dining room. Surveyor inquired about R2's fall prevention interventions. V3 stated That you will have to ask the Nurse about because that I don't know. Surveyor inquired about R3's fall prevention interventions V3 responded Once again, you would have to ask the nurse about that. I usually refer to the nurse before I touch anybody. Surveyor inquired who was assigned to supervise the dining room. V3 replied I'm watching the dayroom while she's doing activities and affirmed there were only two staff present in the dayroom/dining room. At approximately 2:40pm, surveyor inquired if there was adequate staff in the dining room V4 stated Usually we have two or three aides in here. Surveyor inquired about R2's fall prevention interventions. V4 replied I don't have that. Surveyor inquired how staff identify residents at risk for falls V4 stated I usually go by their wrist. Their wristbands will tell us they are fall risk. R2 was observed not wearing a fall risk wristband at this time. R1 was observed sitting in a specialty wheelchair (adjacent the wall) in the dining room. She was not assisted to a table during ongoing puzzle activity and was not engaged with staff or peers. V4 inspected R1's wrist (as requested) for a fall risk wristband and stated She doesn't have one. Surveyor inquired about R1's fall prevention interventions V4 responded She usually has someone close by her, I don't know where she went. 1.) R1 is a [AGE] year old with [DIAGNOSES REDACTED]. R1's (7/26/29) care plan states resident is at risk for fall related to impaired mobility, weakness and [CONDITION]. Interventions; frequent monitoring. a.) R1's (1/14/20) incident report states; resident observed inside room on floor. No witnesses found. b.) R1's (2/24/20) incident report states; Incident Location: Dining room. Resident was observed on the floor. Resident slid out of the chair. Injury: laceration top of scalp. R1's (2/24/20) State report of patient injury states; resident returned from hospital with 2 staples to head. (2/24/20) Witness statements include but not limited to the following; when was the last time you visually observed the resident and what were they doing at that time? Per V8 (Certified Nursing Assistant) the last time I saw the resident was in the dayroom, she was at the table with her head down. Per V9 (Licensed Practical Nurse) I seen (R1) in the dayroom at 5:50pm with her head down on the table. Per V10 (Certified Nursing Assistant) her nurse did tell me to lay her down but when I was about to it was time to pass trays for dinner. On 3/11/20 at 1:48pm, surveyor inquired about R1's (2/24/20) fall. V10 stated The incident could have been prevented, everybody on the floor had an opportunity to do something about it, but just overlooked it. She was sleeping in the chair in the dayroom with her head on the table. She was in a regular wheelchair not a (Brand Name) chair. I could have put her in a (Brand Name) chair cause she was sleeping. 2.) R3 is an [AGE] year old with [DIAGNOSES REDACTED]. R3's (1/2/20) fall risk screen determined a score of 18 (high risk). R3's (1/29/19) care plan states resident is at risk for fall related to impaired mobility, weakness, and [CONDITION]. Interventions; close monitoring for safety. On 3/9/20 at approximately 2:36pm, R3 was observed sitting idle in a wheelchair (in the dining room walkway). She was not assisted to a table during ongoing puzzle activity and was not engaged with staff or peers. R3's (2/20/20) incident report states; nurse heard a loud noise. Upon entering day room patient on floor with laceration above left eye. R3's (2/20/20) State report of patient incident states; resident returned from hospital, left forehead noted with 5 steri-strips in place. On [DATE] at 2:55pm, surveyor inquired about R3's (2/20/20) fall. V7 (Licensed Practical Nurse) stated The patient is always confused and is a huge fall risk. When I was done with the med (medication) pass, I heard a boom. The other nurse said she fell , head first. She was on the floor when I got there. There were two CNAs (Certified Nursing Assistants) in the dining room. The CNAs said she had been leaning forward all morning I guess trying to get out the chair. I guess she leaned too far forward that day and fell out the chair. 3.) R2's [DIAGNOSES REDACTED]. R2's (11/11/19) fall risk screen determined a score of 15 (moderate risk). a.) R2's (8/17/16) care plan states; resident experiences functional incontinence. Interventions; maintain uncluttered environment. R2's (12/13/19) incident report states; resident was observed on the floor in supine position on top of the scale. He stated I fell . No witnesses found. Predisposing factors; clutter. b.) R2's ([DATE]/19) care plan states; resident is at risk for fall related to impaired mobility and weakness. Interventions include; frequent monitoring. R2's (2/12/20) incident report states; resident fell in the hallway while walking to the dining room. Predisposing factors; improper footwear. On 3/9/20 at approximately 2:35pm, R2 was observed ambulating (in the dining room) with an unsteady gait. He grabbed both handles of peers' wheelchair to maintain balance, then stood there and lingered. V3 subsequently escorted R2 to a chair. He was wearing a shoe on his right foot and a sock on his left foot. At approximately 2:38pm, surveyor inquired why R2 was wearing only one shoe V4 replied I'm not sure and affirmed she would check into it. On [DATE] at 11:04am, surveyor inquired how staff identify residents at risk for falls if fall risk wristbands are not on. V5 (Licensed Practical Nurse-Unit Manager) responded Once you've had two falls you automatically have the bands on. Surveyor inquired why on 3/9/20, R2 was not wearing a fall risk wristband V5 replied He must have taken it off. On 3/12/20 at 10:04am, surveyor inquired about the potential harm to a patient that falls. V11 (Medical Director) stated for anybody above the age of 65 any fall puts them at great risk especially for fracture. There's a significant risk for harm for any patient falling.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.