STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009401	A. BUILDING: _____ B. WING _____	C 10/27/2017

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SYMPHONY AT THE TILLERS	4390 ROUTE 71 OSWEGO, IL 60543

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigation 1776297/IL97704	S 000		
S9999	Final Observations Statement of Licensure Violations Licensure 1 of 1 300.610a) 300.1210c) 300.1210d)6) 300.3240a) 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.	S9999	Attachment A Statement of Licensure Violations	

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Section 300.1210 General Requirements for Nursing and Personal Care

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

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These Regulations were not met as evidenced by:

Based on record review and interview, the facility failed to provide adequate supervision for a resident (R1) at high risk for falls. This failure resulted in R3 falling and sustaining a traumatic brain injury/acute subdural hemorrage requiring emergent craniotomy surgery.

This applies to 1 of 3 residents (R1) reviewed for falls in a sample of 3.

Findings include:

The Face Sheet documents R1 is 65 years old with the following diagnoses: Dysphagia, cognitive communication deficit, muscle weakness, traumatic subdural hemorrhage, Parkinson's disease, aphasia, nonrheumatic Aortic (Valve) Stenosis, anemia, GERD (Gastroesophageal Reflux Disease), repeated falls, restlessness and agitation, Hyperlipidemia, hypertension, prophylactic surgery, Gastrostomy status, left artificial knee joint, and major depressive disorder.

The H&P (History and Physical) from the discharging hospital dated 3/19/17 documents: R1 has Parkinson's disease with (status post) s/p DBS (Deep Brain Stimulator) placement, also hydrocephalus s/p shunt. R1 has worsening headaches after suffering multiple falls at home. After admission, the patient was discovered with a right frontal ICH (Intracranial hemorrhage) that was treated with a right frontal craniotomy for

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evacuation of ICH. Cardiology service recommended that the patient be restarted on therapeutic anticoagulation due to a history of mitral valve repair. At this time, the patient has been started on therapeutic bridge with Lovenox with titration of Coumadin.

Functional History: has been falling approximately 2x/week recently per wife.

The Nurse's Notes and Admission Assessment 4/13/17 completed by E4 (Nurse) documents that R1 was admitted to the facility because of multiple falls.

The Interim Care Plan 4/13/17 documents: history of falls, increased weakness; interventions- fall protocol, safety alarms as indicated; goal- will be free from serious injury from falls during stay.

Fall Risk Screen documented by E4 (nurse) did not correlate with R1's medical records/documented history. The screen was completed as follows:
-Date of admission-over 3 months (score 0); less than 3 months (score 2). E4 checked over 3 months even though R1 was just admitted that day.
-History of Falls within last six months- 1-2 times (score 2), Multiple falls (score 5). E4 checked 1-2 times even though she documented on the admission assessment and nursing notes that R1 was admitted for multiple falls.

The Incident/Accident report sent to the state surveying agency documented: On 4/13/17 around 11:30PM, staff attended to the alarm that went off and noted patient on the floor with bleeding on patient's head. The statement documented by E3 (CNA/Certified Nursing

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S9999	Continued From page 4 Assistant) reads: I heard alarm sounding, so I went to the room right away and as I was turning off the alarm, (patient fell backward) bathroom door opened up and pt fell backward to the floor. The Fall Event documents R1 fell on 4/13/17. What was resident doing just prior to fall-sitting on the toilet seat in the bathroom. Resident was transported to local medical center due to visible bleeding from the back of the head. The POS (Physician's Order Sheet) documents the following order: 4/13/17 Coumadin 10mg, give 1 tablet by mouth at bedtime every Mon, Wed, for Aortic Valve Replacement. On 10/26/17 at 10:37am, E3 stated when she came on duty for night shift, she received report and was told R1 was a little confused and continent. E3 stated "I did not know if R1 could ambulate, so the instructions were to use a wheelchair. We were not to walk R1." E3 stated she did not see a wheelchair in R1's room; E3 stated when she heard R1's alarm sounding she went to the room. E3 stated "By the time I got there R1 had gotten out of bed and was on the toilet." E3 stated "I entered the room and noticed R1 wasn't in bed, so I opened the bathroom and saw R1 on the toilet. I said stay right there, pull the cord when you're finished." E3 stated as she was in R1's room turning off the alarm R1 fell backwards out the bathroom door and hit R1's head on the floor. E3 stated E3 did not stay near the door while R1 was in the bathroom. E3 also stated "I did not see R1 stand, I closed the door. I did not latch it. I don't know if R1 was trying to flush the toilet but R1 fell out of the bathroom. I did not latch the door." E3 stated she could not see R1 in the bathroom. E3 did not see R1 stand/fix R1's clothing. E3 stated "I don't know if	S9999		

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R1 was a fall risk, honestly I don't remember. They said he was a little confused." When asked about R1's alarm E3 replied "Normally alarms are on residents that are fall risk. I was not told about supervision or monitoring. I did what I normally do if I see residents on the toilet. I gave R1 privacy, R1 looked stable. I had known R1 not even 30 minutes."

On 10/26/17 at 11:20am, E4 (Nurse) stated she admitted R1 with diagnosis of multiple falls and head injury. E4 stated she got R1's medical history from the discharging hospital records and R1's spouse. E4 added "So I put the alarm right away." When asked when she last saw R1, E4 replied "At 7:00PM. R1 was in bed. R1 was really a high fall risk. I asked the aide to make multiple rounds and treated R1 as a high fall risk." E4 stated "R1 needs assistance moving from one place to another, so someone should be with R1. We could not leave him in 1 place without anybody there. I told this to the oncoming nurse, they need to make frequent rounds because R1 is high fall risk with a head injury." E4 stated that with R1 being high fall risk someone should've stayed "by the door (bathroom). If you stay by the door, that would be fine. Per facility protocol you must stay with the resident at all times, which means by the door. But I reported to the next nurse that R1 was high fall risk." E4 also stated "R1 was really, really high fall risk."

On 10/26/17 at 3:13pm, E5 (CNA) stated she worked with R1 during PM shift on 4/13/17. E5 documented that R1 urinated 3 times her shift. When asked about where R1 urinated/assistance provided, E5 stated she doesn't remember. E5 stated the facility doesn't document whether the resident used the commode, bed pan or incontinent brief. E5 stated "that's how it's in the

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system, we just document how many times."

On 10/26/17 at 11:39am, E2 (Director of Nursing/Falls coordinator/Quality Assurance Director) stated the protocol for high fall risk is to assess the environment and add interventions. E2 stated the policy is to make frequent rounds and frequent checks if the resident requires assistance to toilet. E2 stated R1 was seated when E3 came in. "If R1 was standing, I would advise her to be with R1." E2 stated R1 had not had physical/occupational therapy evaluation as of yet.

On 10/26/17 at 1:03pm, Z1 (Nurse Practitioner/Provider) stated R1 had multiple medical comorbidities. Z1 stated R1 was not stable to be in the bathroom alone and needed 24 hour care, "a sitter. It takes like seconds for people to fall." I think in the back of R1's head, R1 just wanted to get up and go."

H&P (History and Physical) received from the local hospital documenting the events relating to the fall/injury R1 sustained on 4/13/17 read: - this is a 65 year old patient with past medical history significant for Parkinson's disease. Also history of mechanical aortic valve replacement on chronic Coumadin therapy. Also history of right subdural hematoma after patient sustained a fall in March 2017. Was treated and discharged to the facility for further rehab. The patient subsequently fell again. Patient was brought to emergency room and noted to have a laceration to the back of the head. The CT (Computed Tomography) scan of the brain showed a 1.7cm acute subdural hemorrhage with effacement of the ventricles. INR was reversed. Neurosurgery was consulted. (R1) became less responsive. (R1) was unable to protect (R1's) airway and

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S9999	Continued From page 7 therefore intubated. (R1) had elevations of blood pressure to systolic blood pressure in the 200s. (R1) underwent emergent evacuation and underwent a craniotomy. (R1) also had a feeding tube placed. On 10/26/17, the facility was asked to provide their Falls policy. The facility's policy titled "Falls" read: A Fall risk will be completed on admission, readmission, and quarterly, with each significant change and after each fall. -Residents at fall risk will be identified for staff awareness The policy did not address how to care for residents that are high risk for falls. (A)	S9999		