STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014195	A. BUILDING: _____ B. WING _____	C 03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BUFFALO GROVE	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

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S 000	Initial Comments Statement of Licensure Violations. Facility Reported Incident of March 14, 2019/IL110460.	S 000		
S9999	Final Observations 300.1210(a) 300.1210(b) 300.1210(c) 300.1210(d)(6) 300.1220(b)(3) 300.3240(a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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.

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S9999	Continued From page 2	S9999		

The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

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

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure fall interventions were implemented for a resident who has had multiple falls and is a high fall risk. These failures resulted in R1 rolling off the bed and sustaining a laceration to the eye that required sutures.

This applies to 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 3.

The findings include:

R1's current facesheet shows he was admitted to the facility on March 16, 2018, and has diagnoses that include unspecified dementia with behavioral disturbances, repeated falls, muscle weakness, delusional disorder, anxiety disorder, and Alzheimer's disease. R1's January 17, 2019, Minimum Data Set (MDS) shows R1 is cognitively impaired, and requires extensive assistance performing Activities of Daily Living (ADLs) that include turning and repositioning when in bed.

R1's active care plan shows he is high risk for falls and has had multiple falls. Interventions to the same care plan were initiated on August 31, 2018, to include support pillow when lying in bed, thick fall mat in place when resident is lying in

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S9999	Continued From page 3	S9999		

bed. The same care plan additionally shows that R1 has behavioral issues and can become physically and verbally aggressive. R1's January 26, 2019, Fall Risk Screening shows R1 has had multiple falls and is high risk for falls.

R1's March 14, 2019, Nursing Progress Notes show at 9:55 AM a Certified Nursing Assistant (CNA), called for a nurse to report R1 had fallen out of bed. R1 was lying on the floor on his left side close to the bed. R1 had a cut on the left eyebrow and was complaining of back pain. 911 was called and R1 was transported to a local community hospital emergency room for evaluation. R1's March 14, 2019, Nursing Progress Note shows R1 returned to the facility at 3:54 PM and had received 6 sutures to his left eyebrow.

The Facility Incident Report Investigation shows on March 14, 2019, at 9:55 AM, V7 (CNA) was completing morning care for R1 and was in the process of positioning R1's recliner along the side of the bed when R1 made a sudden motion and rolled off the side of the bed onto the floor.

On March 19, 2019, at 11:25 PM, V7 said he was in the room with R1 on March 14, 2019, and was completing morning care and getting him dressed. V7 said R1 had been agitated that morning, he was upset and striking out at him while he was dressing and positioning him. V7 said he turned R1 onto his side, the side rail to the bed was down, the bed was not at the lowest position, and he had already removed the fall mat from the floor. V7 said he turned his back to R1 and went to get R1's reclining wheelchair to move it closer to the bed and by the time he turned back around R1 was on the floor. V7 said R1's fall mats should always be down.

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S9999	Continued From page 4	S9999		

On March 19, 2019, at 2:10 PM, V2 (Director of Nursing) said she was called the day R1 fell. V2 said when she got to R1's room he was lying on his floor on his left side and was ultimately sent to the emergency room for evaluation of a laceration on his left eyebrow. V2 said she spoke with V7 who was the CNA providing care to R1 when he fell out of bed and she was upset because she didn't understand how this could happen that fast. V2 said she had to re-educate V7 to make sure that he always places the resident's bed is in the lowest position especially if he is turning away from the resident, and to re-position a resident in a manner that would not allow for them to roll off the bed. V2 said R1 should have had fall mats down when he was in bed.

On March 19, 2019, at 12:11 PM, V3 Registered Nurse (RN) said he is the fall coordinator for the facility and went to R1's room when he was informed R1 had fallen. V3 said R1 should have fall mats down when he is in bed but the fall mats were not down because V7 was getting R1 ready to get up. V3 said R1 had falls on August 31, 2018, January 7, 2019, January 19, 2019, and January 26, 2019. V7 said on August 31, 2018, interventions were added for R1 to include fall mats when resident is in bed. V7 said R1 has poor safety awareness and he turns without knowing he will fall. R1's current care plan shows that interventions including ensuring the resident is properly positioned, and to maintain the bed in the lowest position were not added until March 16, 2019 (after R1's most recent fall).

On March 19, 2019, at 11:15 AM, V1 (Administrator) said R1 should have fall mats on both sides of his bed.

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S9999	Continued From page 5 On March 19, 2019, between 1:20 PM and 1:50 PM, V6 Licensed Practical Nurse (LPN), V8, V9, V10 (CNA's), said R1 could be aggressive, he was a fall risk and had fallen before, and should have had fall mats beside his bed and his bed should be in the low position when he is in bed. On March 19, 2019, at 1:48 PM, V4 (Special Unit Director) said R1 could be aggressive and had sudden quick jolts. V4 said that interventions for residents who are high risk for falls should include, bed in the lowest position, increased supervision, mats on the floor next to the beds. (B)	S9999		