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
	IL6002463	A. BUILDING _____ B. WING _____	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF JOLIET	306 NORTH LARKIN AVENUE JOLIET, IL 60435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1773237/IL94383	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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. 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to implement preventative fall measures. This applies to two of four residents (R1, R4) reviewed for falls in a sample of 13. This failure resulted in R1 incurring a right femoral neck fracture and R4 incurring a left forehead laceration requiring sutures. Findings include: 1. The Admission Record dated June 18, 2016 documents R1 with diagnoses to include Vascular Dementia, Pneumonia, Chronic Obstructive Pulmonary Disease and Anxiety Disorder. The Progress Notes document R1 admitted to the	S9999		

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facility on June 18, 2016 at 6:10pm.

R1's hospital Skilled Nursing Facility Communication Form dated June 18, 2016 documents R1 with discharge fall precautions recommended as to utilize a bed and chair alarm for safety measures.

On June 1, 2017 at 8:59am E5 (Evening Nursing Supervisor) stated on June 18, 2016 E5 assisted with R1's admission to the facility. E5 stated hospital recommended fall interventions are initiated at the time a resident is admitted to the facility.

The Fall Event form dated June 19, 2016 documents R1 as being found on the floor and as sitting just prior to the fall. R1 reported she was looking for a key to start the plane to fly and lost balance falling on right hip, knee and elbow. This form documents a bed alarm checked as an intervention for R1 and the chair alarm is not marked as in place.

On May 31, 2017 at 2:05pm E7 stated E7 heard R1 fall and was the first responder to R1's room. E7 went to R1's room and found R1 on the floor. E7 stated no alarms were sounding in R1's room.

On May 31, 2017 at 2:28pm, E8 (Nurse) stated E8 was R1's nurse during the day shift at the time of the fall on June 19, 2016. E8 stated R1 spent most of day in the bedroom and was confused and required assistance to ambulate. E8 stated R1 had to be re-oriented to the call light during the shift because R1 kept getting up unassisted.

The Final Incident Report form dated June 24, 2016 documents on June 19, 2016 at 2:48pm, R1 was found on the floor in R1's bedroom. R1 was

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complaining of pain to the right hip, elbow and knee and was transferred to the hospital for evaluation. At the hospital R1 was diagnosed with a right femoral neck fracture requiring surgical repair. This report also documents R1 with delusions, weakness and anxiety noted at the time of admission to the facility on June 18, 2016. This report documents R1 falling due to impulsive behaviors likely associated with worsening pneumonia. The report further documents if R1 returns to the facility R1 will be re-evaluated for the most appropriate assistive devices "...as well as increase monitoring on her..."

On June 1, 2017 at 2:43pm, E1 (Administrator) stated if a resident is repeatedly non-compliant, making attempts to get up unassisted E1 expects staff to offer non-pharmacological interventions such as activities, place at nursing station for supervision, etc. E1 stated staff are to implement measures to keep residents safe.

The hospital Orthopedic Consult dated June 20, 2016 documents R1 with a right femoral neck fracture.

On June 1, 2017 at 1:06pm, E13 (Medical Director) confirmed the facility should implement measures to keep a resident safer and to additionally implement hospital discharge recommended fall interventions.

2. The Admission Record dated September 19, 2016 documents R4 as a 96 year old with diagnoses to include Muscle Weakness and Dementia. The Brief Interview of Mental Status dated February 1, 2017 documents R1 as severely cognitively impaired.

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The Incident Report Form dated March 5, 2017 documents R4 was found on the floor near R4's bed at 5:25pm with a laceration to the left forehead. R4 was sent to the hospital and received 6 sutures to close the wound. R4 is documented as ambulatory with no assistive devices in this report. This report documents shortly before dinner a staff entered R4's room and R4 was walking around in the bedroom at the time the staff person entered. R4 was asked to come to the dining room and began following a staff member out of the bedroom; the staff member exited the bedroom and thought R4 was following. A few minutes later a different staff member noticed R4 wasn't present in the dining room prompting the staff to go to R4's room to get R4 again for dinner at which time R4 was found on the floor of R4's bedroom.

R4's Occupational Evaluation and Plan of Treatment dated February 22, 2017 documents reason for referral as: "Per nursing report of decline in self performance referred to therapy...patient referred to therapy due to exacerbation of decrease in strength, decrease in transfers, increased need for assistance from others, reduced static and dynamic standing balance..."

On June 1, 2017 at 11:18am, E9 (Certified Occupational Therapy Assistant) stated R4 was referred for services in February 2017 due to increased weakness of both upper and lower extremities, declining ambulation for long distances and cognitive decline requiring both verbal and tactile cues to push off and for hand placement to stand up. E9 stated at the time of R4's fall R4 required stand by assistance with a rolling walker and verbal cues by staff.

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S9999	Continued From page 5 On June 1, 2017 at 1:25pm, E2 (Director of Nursing) stated therapy recommendations are discussed and followed. E2 stated E2 was unaware therapy had made recommendations for R4 to be a stand by assist with a rolling walker for ambulation. The hospital Emergency Room Report dated March 4, 2017 documents R4 as being evaluated after a fall at the facility with a laceration requiring repair to the left forehead area. On June 1, 2017 at 1:06pm, E13 (Medical Director) confirmed staff should follow therapy recommendations to provide a safe environment for the residents. E13 stated, "I am not sure where the communication breakdown occurred." The facility Fall policy dated August 2014 documents the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies and facility as safe an environment as possible. (A)	S9999		