

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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: 2380814/IL155891 Investigation of Facility Reported Incident of December 23, 2022/IL155164	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to implement fall prevention interventions as care planned for one resident (R9) and failed to provide adequate supervision to one resident (R4), while using a motorized wheelchair. This failure resulted R4 sustaining an acute fracture involving the base of the proximal phalanx of R4's right great toe which required R4 to wear a post op boot.</p> <p>Findings include:</p> <p>1. R4's face sheet documents that R4 was admitted to the facility on 03/02/2021 with a diagnosis which includes but not limited to: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Cerebral infarction unspecified, Unspecified osteoarthritis unspecified site, and unspecified</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>symptoms and signs involving the nervous system.</p> <p>On 02/06/23 at 1:33 pm, Surveyor observed R4 in bed awake and alert. R4 stated that R4 was given a motorized wheelchair a few months ago from R4's insurance. R4 stated when R4 received the motorized wheelchair, V11 (Occupational Therapist/OT) was showing R4 how to use R4's motorized wheelchair in R4's therapy sessions. R4 stated that V11 left R4 sitting in R4's motorized wheelchair in R4's room to go and find help with putting R4 to bed. R4 stated that while R4 was left alone sitting in R4's motorized wheelchair, R4 tried to back R4's motorized wheelchair next to R4's bed in R4's room and R4 bumped R4's right first toe on the wall in R4's room. R4 stated that R4 did not mention the incident to the therapist when the therapist returned to R4's room. R4 stated that R4 mentioned the incident to V11 the next day when V11 came to get R4 for therapy because R4's right first toe was hurting when V11 was trying to dress R4 and place R4 in R4's wheelchair. R4 stated, "I (R4) thought I (R4) knew what I (R4) was doing when I (R4) was trying to turn around in the wheelchair (referring to the motorized wheelchair), but I (R4) didn't know how to turn around in the wheelchair (referring to the motorized wheelchair) by myself (R4)."</p> <p>On 02/07/23 at 11:05 am, V11 (Occupational Therapist/OT) was interviewed regarding R4 motorized wheelchair and V11 stated that R4 received a motorized wheelchair a few months ago. V11 explained that R4 had orders for occupational therapy to teach R4's how to operate R4's motorized wheelchair and that R4's motorized wheelchair was only to be used while R4 was being supervised in R4's therapy session.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
S9999	<p>Continued From page 3</p> <p>V11 explained that R4 required assistance to operate R4's motorized wheelchair safely. V11 stated that V11 would get R4 up into R4's motorized wheelchair for R4's therapy sessions to teach R4 how to use R4's motorized wheelchair safely. V11 stated that R4 was not to be in R4's motorized wheelchair unsupervised or without assistance until R4 met R4's long term and short-term goals in therapy with R4's motorized wheelchair. V11 explained that R4's goals with R4's motorized wheelchair included but were not limited to: "R4 able to operate basic controls of R4's motorized wheelchair independently. R4 able to turn navigate turns, doorways independent with her motorized wheelchair. R4 able to navigate hallways independently with R4's motorized wheelchair. R4 able to park R4's motorized wheelchair in R4's room (navigating tight spaces) independently." V11 stated that on 12/23/23 after R4's therapy session, R4 asked V11 if R4 could stay in R4's motorized wheelchair a little longer. V11 stated that V11 informed R4 that R4 could stay sitting in R4's motorized wheelchair in the hallway outside of R4's room while V11 went to provide therapy services to another resident. V11 stated that V11 returned to R4 after about 30 minutes and that R4 was still sitting in R4's motorized wheelchair outside of R4's room. V11 then explained that V11 assisted R4 inside of R4's room with R4's motorized wheelchair and placed R4 back into bed. V11 stated that the next day on 12/24/23 V11 went to R4's room to get R4 up into R4's motorized wheelchair for R4's therapy session and that R4 complained of pain to R4's right first toe. V11 stated that when V11 looked at R4's toe R4's toe looked swollen and that V11 informed the nurse, and an x ray was performed on R4's right first toe. V11 stated that R4 then explained that the prior day (12/23/22) when V11 left R4 in R4's</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
S9999	<p>Continued From page 4</p> <p>motorized wheelchair, that R4 tried to maneuver R4's motorized wheelchair without assistance in R4's room and bumped R4's toe on the wall in R4's room while R4 was trying to turn around inside of R4's room. V11 stated that R4 never informed V11 or any staff on 12/23/22 of R4's attempt to maneuver R4's motorized wheelchair without assistance because R4 was not supposed to operate R4's motorized wheelchair without the assistance of V11. When V11 was asked why V11 left R4 unsupervised with R4's motorized wheelchair, V11 stated, "I (V11) was trying to trust R4 alone. R4 should have been supervised whenever R4 was operating R4's wheelchair."</p> <p>On 02/07/23 at 1:46 pm, V18 (R4's Physician) was interviewed regarding R4 and V18 stated that R4 is an alert and oriented resident at the facility. V18 stated that V18 recalled that R4 was being seen by therapy to operate R4's motorized wheelchair safely and properly. V18 stated that at the time of R4's incident on 12/23/22, R4 should have been supervised at all times while operating R4's motorized wheelchair until there was an order for R4 to be able to operate R4's motorized wheelchair without supervision. V18 stated, "If a resident who requires supervision while operating a motorize wheelchair, operates a motorized wheelchair without supervision the resident could run into things and injury themselves, injury other people or even cause property damage."</p> <p>On 02/08/23 at 1:09 pm, V2 (Director of Nursing/DON) was interviewed regarding R4's motorized wheelchair and V2 stated, "R4 was issued an electric wheelchair from therapy. R4 was given an okay to practice in open areas by R4's self and R4 decided that R4 wanted to practice in R4's room and R4 ran into the wall and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	--	---

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

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>hit R4's foot. When V2 was asked if R4 was supervised by therapy or a staff member during the time of R4's injury, V2 stated, "I (V2) am not sure if therapy was supervising R4 at the time of R4's injury to R4's foot V11 (Occupational Therapist) informed nursing the next day after R4's injury. V11 stated that R4 informed V11 of R4's injury to R4's foot the day after R4's injury occurred. Once nursing was made aware of R4's injury to R4's foot, nursing informed R4's physician who order for an x ray to R4's foot. R4's foot was x rayed and R4's x ray results showed that R4 had a fracture to R4's foot. Whatever orders R4's physician gave for R4's fractured foot was carried out. I (V2) am not sure which foot R4 injured or what the exact physician orders for R4's fracture foot was." When V2 was asked what could happen to a resident who should be supervised while operating a motorized wheelchair is operating a motorized wheelchair unsupervised and V2 stated, "The resident could injure themselves. A lot of possibilities of things can happen."</p> <p>R4's Brief Interview for Mental Status (BIMS) dated 02/03/2023 documents that R4 has a BIMS score of 13 which indicates that R4 is cognitively intact.</p> <p>Facility's document dated 12/25/22 and titled "Patient Report" documents, in part: "Findings: Trauma to foot. Right Foot: 5 images... Impressions: 1. Acute fracture involving the base of the proximal phalanx of the right great toe."</p> <p>R4's Occupational Therapy Recertification and Updated Plan of Treatment dated 12/12/2022 through 03/09/2023 and documents, in part: "STG (Short Term Goal): R4 able to operate basic controls of R4's motorized wheelchair</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	--	---	---

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

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6</p> <p>independently ... LTG (Long term Goal): R4 will be able to navigate turns doorways independently with R4's motorized wheelchair ... STG: R4 will be able to navigate hallways independently with R4's motorized wheelchair ... LTG: R4 will be able to park R4's motorized wheelchair in R4's room (navigating tight spaces). independently."</p> <p>Facility's document dated 09/27/22 and titled "Motorized Wheelchair Evaluation" documents, in part that R4 received a motorized wheelchair evaluation on 09/27/22.</p> <p>Facility's Initial Reportable to local agency dated 12/25/22 at 2:13 pm, documents, in part that on 12/23/22 R4 bumped R4's right big toe while in R4's motorized wheelchair, reviewed.</p> <p>Facility's Final Reportable to local agency dated 12/30/22 at 5:47 pm, documents, in part that R4 incurred injury while maneuvering R4's motorized wheelchair, reviewed.</p> <p>Facility's Policy dated 10/2021 and titled "Safety and Supervision of Residents" documents, in part: "General: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wife priorities ... Facility-Oriented Approach to Safety: 1. Our facility-oriented approach to safety addresses risks for groups of residents ... 4. Employees shall be trained and in serviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents ... Resident-Oriented Approach to Safety: ... 2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS (Minimum Data Set) ... Systems Approach to Safety: ... 2. Resident</p>	S9999		
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
S9999	<p>Continued From page 7</p> <p>supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment."</p> <p>2. On 2/6/23 at 11:59 AM, R9 was observed lying in bed in R9's room. No fall mats were observed on either side of R9's bed. The surveyor inquired about the most recent fall that R9 had on 12/10/22. R9 stated "I slipped out the bed."</p> <p>On 2/6/23 at 12:10 PM, the surveyor inquired if V7 (Registered Nurse/RN) saw any floor mats on the floor or in R9's room. V7 replied, "No floor mats."</p> <p>On 2/8/23 at 9:13AM, the surveyor observed R9 sleeping in bed with the floor mat propped up against the wall across from the bed. The rolling bedside table was noted with one end towards the bed and the other pushed away from the bed with a covered plate on it. At 9:14 AM, this observation was brought to the attention of V12 (LPN/Licensed Practical Nurse/Unit Manager). The surveyor inquired if R9 had a floor mat on the floor. V12 replied, "No he (R9) doesn't. It's on the wall. They probably moved it because he (R9) has his breakfast tray. It (floor mat) should be on the side that he (R9) dominates. That's the side where his (R9) tray is." V12 called V22 (Certified Nursing Assistant/CNA) and instructed her (V22) to pick up breakfast tray and put down the floor mat.</p> <p>On 2/8/23 at 1:05 PM, V2 (DON) stated, "My expectation is that if we have established someone as a fall risk, and if they have</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 8</p> <p>interventions care planned, then my expectation is that they are in place." V2 added that staff will move fall mats if the resident is eating because the bedside table will not roll over the mat, but as soon as the resident is through with eating, then "I (V2) expect them to put the mat back in place. I would expect for it (fall mat) to be in place to the side that was identified." The surveyor inquired where it would be documented which side the fall mat should be placed. V2 replied, "I would expect that they would say in the care plan either mat to right side or mat to left side." The surveyor inquired what is the risk to the resident if a fall mat is not in place? V2 answered, "If they fall, they could potentially injure themselves."</p> <p>R9's Admission Record documents diagnoses including but not limited to history of falling, lack of coordination, hypotension, and acquired absence of right leg below the knee.</p> <p>R9's 01/20/23 BIMS (Brief Interview for Mental Status) determined a score of 15, indicating R9's cognition is intact.</p> <p>R9 is listed on the facility's "High Fall Risk" list provided by V1 (Administrator) on 02/06/23.</p> <p>The facility "Incidents by Date" list with a date range of 11/1/22 - 2/6/23 documents that R9 had four falls on the following dates and times: 11/2/22 at 9:31 PM, 11/7/22 at 10:15 PM, 11/12/22 at 5:55 AM, and 12/10/22 at 10:31 AM.</p> <p>R9's 2/10/22 care plan documents, in part, "Focus: (R9) has experienced an actual fall r/t (related to) impaired mobility, weakness and comorbidities." Interventions include but are not limited to "Unilateral floor mat placed at bedside while in bed and removed when patient out of bed</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2023
--	---	---	---

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

(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
S9999	<p>Continued From page 9 (initiated 9/30/22)."</p> <p>The reviewed 6/21 "Falls Management" policy documents, in part, "General: This facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed ...Fall Prevention Guidelines for all residents upon Admission/Re-admission: ... 2. Residents at risk for falls will have Fall Risk identified on the interim plan of Care with interventions implemented to minimize fall risk."</p> <p>"B"</p>	S9999		