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
	IL6014641	A. BUILDING: ______ B. WING ______	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT MIDWAY	4437 SOUTH CICERO CHICAGO, IL 60632

(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# 1980893/IL109321 Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.1210b) 2) 300.3240a) 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Section 300.3240 Abuse and Neglect	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 follow their Active and Passive Range of Motion Protocol and failed to initiate a treatment plan to prevent further decrease in range of motion for 1 of 3 residents (R2) reviewed for restorative services in a total sample of 9. This failure resulted in R2 developing a severe right lower extremity muscle contracture, or a tightened muscle that cannot stretch normally.

Findings Include:

The Face Sheet documents that R2 was admitted to the facility with a diagnosis of Dementia with behavioral disturbance, adult failure to thrive, and cognitive impairments. The Minimum Data Set (MDS) dated 1/9/19 documents that R2 requires 1-2 person physical assist with all activities of daily living.

The Physical Therapy Assessment dated 12/18/18 documents that R2 had bilateral knee flexion contractures vs hamstring tightness and impaired muscular strength deficits. R2's range of motion and strength was impaired. R2 is dependent with basic mobility and has unstable and unpredictable characteristics. R2 reached the maximum potential with physical therapy and was referred for restorative services and range of motion.

The Restorative Assessment dated 12/27/18 documents that R2 was receiving restorative

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services for transfers as the resident is able to scoot/pivot, and the resident is receiving services for assistance with eating only; there were no services to address the resident's impaired mobility and range of motion.

The Nurse's Notes dated 2/2/19 documents that R2 was hospitalized related to a fall. The hospital records dated 2/2/19 documents that R2 had a significantly contracted right leg with pain and grimacing on movement.

On 2/14/19 at 2:30pm V8 (Restorative Nurse) stated "The resident was being seen for restorative. R2 was on a transfer and eating program. Staff would go in and assist the resident with transferring from the bed to the wheelchair. The resident required 2 person assist with transferring due to weakness and behaviors of grabbing on to the wheelchair. R2 was unable to do any other transfers other than staff assisting the resident to the wheelchair. I saw the resident weekly and did a quarterly assessment. I never noticed any contractures. The resident was not on a program for range of motion."

On 2/20/19 at 1:10pm V9 (Physician) stated "I don't recall if the resident had any contractures, but any resident with decreased range of motion would benefit from a restorative program for prevention."

The Active and Passive Range of Motion Protocol documents that range of motion is performed on any resident who has a functional limitation or loss of voluntary movement to an extremity. A Joint Mobility Form is completed for all residents, if decreased range of motion or voluntary movement is present then passive or active

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range of motion is initiated.

(B)
Licensure 2 of 2
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 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,

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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.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to follow their Falls Policy and failed to implement interventions to maintain the safety of a cognitive impaired resident with impulsive behaviors for 1 of 3 residents (R2) reviewed for falls in a total sample of 9. This failure resulted in R2 falling out of the bed and sustaining a laceration to the left eye, bilateral brain bleeds, and a possible right hip fracture.

Findings Include:

The Face Sheet documents that R2 was admitted to the facility with a diagnosis of Dementia with behavioral disturbance, adult failure to thrive, and cognitive impairments.

The Physical Therapy Assessment dated 12/18/18 documents that R2's range of motion and strength was impaired. R2 is dependent with basic mobility and has unstable and unpredictable characteristics.

The Incident Report dated 2/2/19 at 5:39am

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documents that R2 was found on the floor on the side of the bed with a laceration to the left eye. The MD and family were notified and the resident was transferred to the local hospital for evaluation and treatment.

The Hospital Records dated 2/2/19 were reviewed and documents that a CT scan of the head was done and showed that R2 had a right frontal and left parietal subdural hematoma. An x-ray of the right lower extremity showed a possible right femoral neck fracture. R2 also had a laceration to the left eye.

The last Fall Risk Assessment done by the facility was dated 6/13/17 and documents the resident as a low fall risk.
The most recent care plan documents the resident has impulsive behaviors related to dementia but no interventions were put into place.

On 2/7/19 at 2:30pm V4 (CNA) stated "I was changing another resident and I heard R2's voice. When I went in, R2 was on the floor on the side of the bed. I called the Nurse and the resident was sent out to the hospital. R2 is able to move around in bed but is not able to walk. The resident moves a lot from side to side. There were no interventions in place at the time of the fall."

On 2/8/19 at 11:15am V5 (Nurse) stated "Around 5:15pm the resident was observed lying on the left side on the side of the bed. R2 had a raised area on the side of the left eye. There were no interventions in place at that time. R2 can move around in bed but is not ambulatory."

On 2/20/19 at 1:10pm V9 (Physician) stated "The right frontal and left parietal subdural hematomas

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can occur as a result of a fall. There is always a risk for injury with cognitively impaired residents and even with interventions in place things can still happen. I don't recall if the resident had any interventions in place at the time of the fall."

The Falls Policy documents that the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. A Fall Risk will be completed on admission, readmission and quarterly. Residents at risk for falls will have Fall Risk identified on the plan of care with interventions implemented to minimize fall risk.

(A)