STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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 2081038/IL119978 2081242/IL120203 Facility Reported Incident of 1-29-20/IL119999	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 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. 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.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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	Continued From page 1	S9999		

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 ensure resident safety during a transfer for a resident who was assessed and identified to require the assistance of a minimum of two staff for all transfers. The facility failure to implement the use of two person assist during a transfer resulted in a significant injury for 1 of 3 residents (R1), who sustained a fracture of the left leg requiring emergency medical treatment and services.

Findings include:

R1 is a 98-year old with diagnoses that include difficulty in walking, reduced mobility, limitation of activities due to disability, pain in left ankle and joints of left foot. unspecified dementia, without behavioral disturbance.

R1's Minimum Data Set (MDS) dated 11/21/2019 under Functional Status indicated that she required total dependence of 2+ persons and physical assist during transfers. The current MDS completed by facility staff on 2/12/2020, under the Functional Status section, documented that R1 required extensive assistance of 2+ persons and physical assist during transfers.

On review of the Fall Risk Screen dated 2/01/2020, facility staff identified that R1 was at high risk for falls. There was no documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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	Continued From page 2	S9999		

that facility staff completed a Fall Risk Screen assessment prior to the resident fall related incident of 1/29/2020.

The resident care plan initiated on 11/17/2019 indicated Focus: R1 requires extensive assistance with activities of daily living (ADLs) related to weakness, impaired mobility and dementia. Interventions Current ADL function: extensive x1 with bed mobility, transfers, locomotion, personal hygiene, dressing, and supervision with meals. The care plan did not accurately reflect the resident's assessed and identified requirements for staff assistance during transfers.

On review of the Certified Nursing Assistant's Plan of Care dated from December 2019-February 2020, the documentation reflects that R1 has received extensive assistance of one-person physical assist during staff transfers.

On review of the Nursing Progress note dated 1/29/2020 at 8:30 PM, facility staff documented that R1 was sitting on her bed with legs over the side of the bed and feet on the floor, left leg was bleeding and deformity noted on left lower leg.

Nursing Progress Note dated 1/29/2020 at 8:35 documented a physician order for R1 to be sent out to community hospital for evaluation and treatment.

On review of the Nursing Progress Note dated 1/30/2020 at 1:50 AM, facility staff documented that R1 was admitted to community hospital with a diagnosis of left leg fracture. According to the hospital medical record dated 1/29/2020, R1 presented with a left tibia open fracture and was admitted to the ortho team. The hospital record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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	Continued From page 3	S9999		

documented that R1's injury required surgical repair.

On 2/25/2020 at 2:48 PM, V5 (Certified Nursing Assistant/CNA) stated that the day of the incident she was took R1 to her room. V5 stated that R1 was crying because the bed was too low. V5 stated that she was encouraging R1 not to cry. V5 stated that she proceeded to transfer R1 from the wheelchair to the bed by herself and when she was pivoting R1, R1's leg slid to the side and under the bed. V5 stated that R1 began to scream "My leg, my leg." V5 said that when she saw R1's leg under the bed, she (V5) immediately called the nurse to assess R1. V5 stated that she had previously worked with R1 and was familiar with her (R1) care.

On 2/26/2020 at 12:03 PM, V8 (Licensed Practical Nurse/LPN) stated that she was in the hallway passing medications when a CNA (Certified Nursing Assistant) asked her to come to the room. V8 locked medication cart and went to the room. V8 stated that R1 was sitting on her bed, not on the floor, her legs were extended to the floor, and there was an obvious deformity to the left lower leg. V8 said that she grabbed a towel to apply pressure to the leg, as there was a significant puddle of blood on the floor. V8 then called the physician, then called 911 and R1 was transferred to the hospital.

V8 stated that she followed up with the hospital later that day and she was told that R1 was going to be admitted and R1 was given a diagnosis of left leg fracture. V8 stated that at that time, R1 was safe to be a one-person transfer because R1 could bear weight and pivot. V8 failed to identify that R1 required the assistance of 2+ staff for transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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	Continued From page 4	S9999		

On 2/27/2020 at 10:19 AM, V12 (Nurse Practitioner/NP) was asked if a one-person transfer was safe for R1. V12 stated that she could not say if one-person transfer should be safe for R1. V12 stated that physical therapy would be able to answer that question better.

On 2/27/2020 at 10:26 AM, V13 (Physical Therapy Director) stated that R1's prior level of functioning was dynamic standing fair+. Bed mobility independent, transfer stand by assistance, which indicated that R1 could transfer but needs someone standing by. V13 stated that the physical therapy assessment was based on R1's functional status prior to her admission to the facility. V13 stated that while in the facility, R1 got sicker and her functional status changed, requiring more assistance during transfers of at least a 2-people assist. V13 further stated that upon readmission from hospital, R1's bed mobility changed to max assistance, which indicates the R1 can initiate the task but less than 25%. Transfer changed total assistance, which means R1 was able to do the task less than 10% and requires the use of a mechanical lift or 2+ person assist.

On 2/27/2020 at 2:25 PM, V2 (Director of Nursing/DON) stated that R1 was a one-person transfer. During the interview, V2 was informed of the discrepancy of the care plan and transfer requirements as identified by facility staff on the MDS (Minimum Data Set). V2 stated that she was not aware of this issue and stated that R1's care plan should reflect MDS assessment.

(B)