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 09/30/2022

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

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S 000	Initial Comments Complaint Investigation: 2287799/IL00151721	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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements were not met as evidenced by: Based on observation, interviews and record review the facility failed to follow the facility policy and the Minimum Data Set (assessment) to ensure the correct number staff are providing physical assistance to residents. This affects 2 out of 3 (R1, R2) for a total of 3 residents reviewed for safety. These failures resulted to R1 sustaining a C6 neck fracture and R2 being left unattended and at risk for falls. Findings include: On 9/29/2022 R1, R2, and R3 were reviewed for the allegation of facility's failure to provide safety that resulted to resident injury.	S9999		

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S9999	Continued From page 2 R1 was not in the facility during survey review. Per clinical progress notes: R1 fell on 9/27/2022 and was sent to the hospital. Per CT scan result, R1 had a C6 fracture. Notes written by V4 (Nurse Practitioner) include: R1 is 71 years old, initially admitted on 10/1/2021 with medical diagnosis of Hemiplegia and Hemiparesis following Cerebral Infraction affecting left non-dominant side. On 9/29/2022 at 11:44 AM. V4 stated, "I was the one who sent R1 out. Staff told me R1 fell on the floor and hit his knees. When I talked to R1, he said that he slightly hit his head on the drawer of his right side. R1 said also he hit his knees. I was not happy because R1 was taking 2 blood thinners medicine and had nausea and dizziness for 2 hours. Yes, the drawer was on R1's right side. R1 has medical diagnosis of CVA with left sided weakness on both upper and lower extremities. R1 requires total assistance for all care. I don't know how it was possible for R1 to turn to his right when he has weakness on his left. An investigation must be done. Yes, as a result of the fall, R1 has a neck fracture." On 9/29/2022 at 12:22 PM, V2 (Director of Nursing) stated, "There was only 1 Certified Nursing Assistant helping R1 at that time which was V7. A fall could have been avoided if the MDS assessment was followed and 2 staff assisted. R1 was being cleaned by V7. V7 was turning R1 on his right side when R1 fell. I think R1's dominant side is his left." After reading R1's medical diagnosis V2 stated, "Oh, I mixed it up his weakness is on his left side. I think you are right; it would not be possible for him to turn to his right and fall by himself. Yes, the fall could have been avoided if there were 2 staff helping R1."	S9999		

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S9999	Continued From page 3 On 9/29/2022 at 12:40 PM, V11 (Restorative Nurse) said, "R1 needs total, or at the very least, extensive assistance with 2-persons for bed mobility and transfers. R1 wouldn't be able to turn to his right because he has left sided weakness. R1 has medical diagnosis of hemiparesis or hemiplegia. It would not be possible. Yes, R1 needs 2-persons helping him during incontinence care." On 9/29/2022 at 6:28 PM, V3 (Licensed Practical Nurse/LPN), stated she was the nurse assigned to R1 and that she was informed by V7 (Certified Nursing Assistant) that R1 fell when he was "reaching for something". V3 stated she does not know R1's capacity related to bed mobility and V3 is not familiar with R1's activities of daily living (ADL). On 9/29/2022 at 6:52 PM, V7 (Certified Nursing Assistant) said, "Yes, I was the CNA (Certified Nursing Assistant) that was present when R1 fell. I was changing him, turning him to his right side of the bed. R1 was trying reach and grab on to the closet or drawer with his right hand and he fell. I was not sure if R1 hit his head. I think he said "no" when I asked if he hit his head. R1 was on the floor, and it is hard to describe but he was like in a fetal position. R1's head was near the closet or drawer. I (V7) always perform incontinence care with R1 by myself. Every time I perform incontinence care or transfer residents, I 'kind of' assess them to see if I can do it by myself. It is also always a good thing if another CNA will help me. I agree, R1's fall could have been prevented if another CNA was helping me. " R1's Minimum Data Set dated 9/2/2022 under functional status, documents R1 needs 2-person physical assistance, total dependence on bed	S9999		

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S9999	Continued From page 4	S9999		

mobility and transfers. R1's care plan dated 10/4/2021 states: self-deficit and assistance with ADLs identified problem. The use of mechanical lift on all transfers for intervention. Care plan dated 7/22/2022 modified on 9/14/2022 states, limited physical mobility and generalized weakness identified problem. Care Plan dated 10/4/2021 modified on 9/14/2022 states, decreased ability to transfer self from wheelchair to chair/bed due to decreased functional mobility and generalized weakness. Related to left side hemiparesis/hemiplegia/contracture. Requires mechanical (Hoyer) lift 2-person assist.

On 9/29/2022 at 11:28 AM, writer observed a walker in R2's room and R2's bed in low position. There was no occupant on R2's bed. R2 was found on toilet alone. V6 (Licensed Practical Nurse) was asked if it was safe for R2 to be in the toilet by himself. V6 said, "Oh yes, he (R2) can go to toilet by himself. He does not need help. He does not need assistance when in the toilet."

R2's MDS dated 7/7/2022 states, functional status R2 needs 1-person assist on toileting. Per R2's Fall Event dated 2/26/2022 by V9 (Registered Nurse), R2 had a fall which R2 stated he hit his head. R2's care plan dated 3/23/2020 revised on 7/20/2022 identifies fall as a problem due to poor safety awareness and impulsiveness. Intervention includes allowing nursing staff to assist with transfers to ensure safety and for R2 to ask staff for assistance.

On 9/29/2022 at 12:22 PM, V2 (Director of Nursing) was informed R2 was left alone in the toilet even though per R2's assessment, R2 needs assistance during toilet. V2 stated, "I have to check on this, nursing staff needs to follow the residents' assessments. I need to in-service both

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S9999	Continued From page 5 nursing staff and MDS (Minimum Data Set) staff. " Facility's Fall Management guidelines dated 6/21/2022 in part reads: Facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. The facility will identify and evaluate those residents at risk for falls, plan for prevention strategies, and facilitate as safe an environment as possible. (A)	S9999		