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
	IL6004550	A. BUILDING: ______ B. WING ______	C 04/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY PALOS PARK	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

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S 000	Initial Comments FRI of 3/9/2022\IL145081	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to safely conduct a resident transfer using a mechanical lift device, and failed to follow residents care plan for 1 of 4 residents (R1) reviewed in the sample. This failure resulted in R1 sustaining a fracture of the humerus (upper arm) and being sent out to hospital. Findings include: R1 is a 79 year old with diagnoses listed in part with vascular dementia, anxiety disorder, fracture of shaft of humerus, right arm and history of falling. R1's care plan dated 2/17/21 (revised 3/10/22) reads in part (but not limited to), "(R1) has an ADL (Activities of Daily Living) self-care performance deficit related to (Left) Below the Knee Amputation and Polyneuropathy. Fracture of distal right humerus with long arm splint. Goal: will maintain current level of function turning repositioning in bed through the review date. Interventions: Bed mobility: Requires 2 person when repositioning and turning in bed every 2 hours and as necessary. Transfer: Mechanical Lift x 2 assist with transfers." R1's MDS (Minimum Data Set) dated 3/25/22 showed R1 is total dependence on transfers and bed mobility with a required minimum 2-person assist. Hospital records dated 3/9/22 written by V14 (hospital physician) reads in part, "Chief	S9999		

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S9999	Continued From page 2 complaint: Arm Injury. Patient presents from nursing home with swelling and bruising to right elbow from unknown fall. 79 year old female presents from nursing home for evaluation after suffering fall. Patient reportedly was found by staff on the floor. They are uncertain as to when she fell. Patient has swelling and bruising to her right elbow and forearm. Clinical impressions as of 3/9/22: Closed fracture of distal end of right humerus." On 4/14/22 at 10:30 AM, Surveyor asked V1 (administrator) if R1 had any recent falls, V1 stated, "No, this was never a fall. (R1) was in her mechanical lift sling and she may have banged her elbow against the door or something." Surveyor asked where she got this information from, V1 stated, "The staff who was taking care of her. We did an investigation and we had varying stories from the two cna's (certified nurses aides) who were taking care of (R1) that day. Our c.n.a (V6) and the hospice c.n.a (V5) transferred R1 from the dining room back to her room to her bed and I think in the process, banged her elbow on the door or something. V6 claimed she used a mechanical lift but V5 said she didn't use it so their stories didn't match.V6 no longer works here but we let her go, and not related to this incident but, due to customer service reasons." On 4/15/22 at 3:45 PM, interview with V7 (agency c.n.a.-certified nurses aide.) stated, "When I saw (R1), she was already in bed. I didn't mess with her because she was fidgeting and she tried to lift her right arm and when I gave her her dinner tray is when she just started hollering and screaming. She screamed like she was in the most of pain and it looked like her bone or something was popping out of her arm. I called the nurse	S9999		

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(V10-Licensed Practical Nurse) and she was looking at it and we both heard a "pop" sound. We brought in the other nurse, V8 (RN), and she even said that it looked like it popped out." Surveyor asked when this happened, V7 stated, It was Tuesday (3/8/22) on the 2:30 PM shift to 11 PM shift. I know because I was suspended after this. I was later told me that (R1) transferred wrong on the morning shift.and that they didn't use the mechanical lift, and threw R1 in bed or something like that." Surveyor asked who he was referring to, V7 stated, "It was V6 (c.n.a.), that's what all the nurses said. V6 was supposed to transfer her with the hospice c.n.a but they're both blaming each other I heard. V6 transferred her and grabbed her wrong. R1's arm banged up against the door and she must've fell on it. I mean, I know because her bone was sticking right out. I'm not a nurse yet but you can't tell me that her bone just started to pop out her skin like that without something hitting it or banging it." Surveyor asked how R1 should be transferred from bed to chair and back, V7 stated, "She should be transferred using a (mechanical) lift with two people because she's an amputee. We all knew this but, that didn't happen I guess when V6 had her."

On 4/15/22 at 4:30 PM, interview with V8 (RN), stated, "I'm mostly PRN nurse (as needed). I was there on duty when that incident happened. I remember after dinner time around 6 PM, the agency nurses' aide (V7) came to the nurses station and told the the other nurse on duty (V10-Licensed Practical Nurse) that he noticed that something was going on with R1's arm. I remember V10 who was in charge of (R1) took awhile in her room and came back and she mentioned to me that it looked like a protuberance on her elbow. V10 said that she

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tried to move her arm and it was hurting and unable to move it, and that it really looked weird. She asked me because I'm the RN and if she should call the doctor to see what was going on and to order some x-rays. I took a look at R1 myself and when I was approaching (R1), she started screaming and told me to go away and asked me to call her daughter. I approached her again and tried to calm her down. My presence made her more distressed but, I tried to look at her arm and there was definitely a protuberance on her right elbow." Surveyor asked her what she meant by protuberance, V8 stated, "Her bone was sticking out under her skin, it was weird. There was abrasions but no redness or swelling just a protuberance. My shift started early and I was there since the morning and this happened in the PM shift. R1 normally sits in a special high back wheelchair. She was fine in the morning and I don't think she fell in the PM shift."

On 4/16/22 at 12:10 PM interview with V12 (hospice Triage manager) stated, "I can confirm that V5 (hospice c.n.a.) and V11 (hospice RN) were the staff that cared for (R1) for the day in question. I can reach out to both of them but they are both off duty but I can try having them call you. Both leave computer records of their visit and it shows that V5 received (R1) in the dining room and transferred her to the room for bath, maxium assist for transfer, and provided a bath with the assistance of facility c.n.a (V6). The date V5's visit is on 3/8/22 and lasted from 12:35 PM to 12:59 PM." Surveyor asked if she thought that to be a short visit to accomplish a maximum assisted lift transfer and bath care, V12 stated, "It does sound a bit short but I'm just reading to you the time she clocked in and what she wrote." Surveyor asked about V11 (hospice RN), V12 stated, "It shows that V11 was there to visit on 3/8

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as well but did not document that there was any injury or pain and no new concerns. V11 visited before our c.n.a got there so that's probably why she documented there were no new concerns because the incident may have happened after her visit."

Efforts to reach V5 (hospice c.n.a.) and V11 (Hospice RN) for interview were unsuccessful after several attempts.

V5 (hospice c.n.a.) provided a witness statement taken by V2 (director of nursing) dated 3/10/22 which reads in part, "V5 stated that on 3/8/22, she was with R1 from about 12:30-1:00 after lunch. She stated that "facility c.n.a. helped to take her to the room. She stated that they then transferred her from the chair to the bed. When asked how they transferred her, she said, "2-person transfer". She stated they did not use the mechanical lift. When asked who the facility c.n.a. was, she stated her name was (V6). She said (V6) was on her right side and "I was on her left side and we did a pivot transfer. She denied having used a gait belt, either. She stated that V6 then left and she gave R1 a bed bath. We asked if she knew that R1 requires 2 assist for bed mobility and she said, "yes but I can use the pad to turn her easily, so V6 just pushed her to the room, helped with the transfer, and then left." I clarified, "V6 pushed the chair to the room? V5 answered, Yes. I asked if V6 mentioned to get the mechanical lift along the way and she said, "No." I asked if it was possible (R1) elbow could have been bumped on something and she said "no"."

On 416/22 at 12:45 PM, interview with V10 (LPN-Licensed Practical Nurse) stated, "One of our c.n.a's (V9) and the agency c.n.a (V7) called me and asked me to look at R1's elbow and said

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to me that her bone was sticking out and she was in pain but there was no discoloration or redness. I assessed it myself and saw the same thing but she was definitely in pain so I gave her Tylenol and it helped her. I called V 13 (GNP) to get an x-ray but she said she's palliative and hospice so she just ordered hot packs and cold packs and monitoring, Her elbow was so bony and c.n.a.'s thought it was sticking out. Surveyor asked what she thought, V10 stated, "She's bony but I called the doctor and that's the order I got was for hot and cold packs." Surveyor asked when R1 could have sustained an injury, V10 stated, "R1 was transferred on the previous shift and when I received her she (R1) was already in bed. I know that V6 (c.n.a.) had transferred her from her chair to bed and V5(Hospice c.n.a.) helped her according to the director of nursing." Surveyor asked if R1 required a mechanical lift to be transferred from bed to chair and back, V10 stated, "She definitely needs two persons using a Hoyer (mechanical) lift. I think that was the problem. I heard that it wasn't used and somehow that's how she got a fracture."

On 4/16/22 at 12:15 PM, interview with V9 (c.n.a.) stated, "My manager told me that R1 must have fell but I didn't take care of her that day, she wasn't mine. The nurses all said and her arm was fractured but I didn't find this out until the next day when she came back from the hospital. I never helped her, she wasn't my patient. I don't even know why they gave you my name I didn't take care of her. I know V7 (agency c.n.a.) had her as an aide that day. I also heard V6 (c.n.a) was supposed to be helped by the hospice c.n.a (V5) to put her back in the bed but just one of them did that." Surveyor asked what she meant, V9 stated, "She (R1) is supposed to have 2 people do Hoyer (mechanical) lift, and that didn't happen, so

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something happened to the resident."

On 4/17/22 at 9:30 AM, interview with V6 (C.N.A.) stated, "Yes I took care of (R1). We always put her in the dining room and I took her back because it was time for her bath after lunch." Surveyor asked how (R1) got to the dining room to begin with, V6 stated, "I put her there after I got her ready in the morning." Surveyor asked how she would normally transfer R1 from the bed to her chair, V6 stated, "I put her there myself." Surveyor asked when she returned R1 from the dining room to her bedroom, whether anyone else assisted her, V8 stated, "No, she was in her wheelchair and wheeled her back myself and put her back to bed." Surveyor asked how R1 got back into the bed, V6 stated, "I put her back to bed and then the hospice cna came in and we gave her a bed bath." Surveyor asked again how R1 was placed back to bed, V6 stated, "Oh yes, I used a the hoyer (mechanical) lift on her." Surveyor asked how many people were supposed to help transfer R1 using the mechanical lift, V6 stated, "It's supposed to be two but I did it myself because I had a lot of other people to do." Surveyor asked whether R1 hit her arm or elbow anytime during her transfer, V6 stated, "When I transferred her, she might have hit her elbow on the ground because I had to lower (R1) back down and I remember she said "ouch" but I checked and she was fine." Surveyor asked if she informed anyone of what she just told the surveyor, V6 stated, "I told the nurse (V8) and the V5 (hospice CNA) knew. I also told the DON (V2) when they interviewed me about it. I told them she (R1) banged it."

A facility employee report provided to surveyor disputes V1's (administrator) earlier statement that V6 (c.n.a.) was discharged due to "customer

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S9999	Continued From page 8 service" reasons. This employee report dated 3/14/22 drafted by V2 (DON-director of nurses) reads: "(V6). Employee action/discipline: Discharge. Date of incident 3/8/22. Improper transfer of a resident. (V6) failed to follow proper procedure by not using hoyer (mechanical) lift for safe transfer. This may have potentially resulted in resident injury. (V6) has received corrective action / education for this in the past as well." Signed by V2 (DON). On 4/17/22 at 11:12 AM, Interview with V14 (Physician) stated, "R1's fracture is not of pathological origin, meaning it's not related to any disease process. Her (R1)'s injury occurred due to some traumatic event most likely associated with blunt force such as hitting it onto something very hard." Surveyor asked if a fall could cause such an injury, V14 stated, "More than likely. I was under the impression that was due to a fall in the nursing home which would be more plausible than the patient hitting it onto something. A fall could cause such a fracture." (A)	S9999		