STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145473	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF ORCHARD VALLEY	2330 WEST GALENA BOULEVARD AURORA, IL 60506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician and/or the nurse practitioner of change in condition of a resident related to continued significant weight loss. This applies to 1 of 3 residents (R3) reviewed for change in condition in the sample of 12. The findings include: R3's face sheet showed that R3 was a [AGE] year-old who has multiple medical [DIAGNOSES REDACTED].), 3/3/20- 94.6 lbs., 3/12/20 97 lbs., 4/14/20- 92.6 lbs., 6/1/20- 84.4 lbs., 7/10/20- 78.8 lbs., 7/24/20- 76 lbs. R3 had a weight loss of 18.97% in 5 months (February-July) and a weight loss of 9.9% in 7 weeks (6/1/20-7/24/20). Progress notes from June through July does not show evidence that V22 (R3's Physician) and V23 (Nurse Practitioner/NP) were notified of R3's signinificant weight change. On 9/1/20 at 10:00 AM, V2 (Director of Nursing/DON) stated that the physician and the resident's family are notified if there's a significant weight loss to a resident. On 9/4/20 at 10:39 AM,V23 (NP) gave the following statement: V23 was notified about the weight loss on 5/13/20. However, V23 was not notified about R3's weight loss in June and July. V23 also said that if she had known about it, she would have ordered lab work, additional supplements or appetite stimulants and see if any of those things work for R3. V23 didn't get notification of R3's decline until 7/28/20 when facility staff asked V23 to evaluate R3 for possible palliative or hospice care. 9/4/20 at 12:05 PM, V22 (Physician) stated that normally facility staffs notify V22 when there's a change in condition. However, V22 couldn't recall staff calling him for R3's continued weight loss or change in condition. Facility's Policy and Procedure for Notification of Changes showed: It is the policy of the facility, except in medical emergency, to alert the resident, resident's physician/NP and resident's responsible party of a change in condition. Nursing will notify the resident's physician or NP when: - There is a significant change in the resident's physical, mental or emotional status. - It is deemed necessary or appropriate in the best interest of the resident.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide peri-care in a manner that would prevent urinary tract infection [MEDICAL CONDITION]. This applies to 2 of 5 residents (R5, R10) reviewed for peri-care, UTI and other infections in the sample of 11. The findings include: 1. On 8/27/20 at 7:35 PM, V9 (Certified Nursing Assistant/CNA) rendered incontinence care to R5 who had a bowel movement. V9 wiped R5's peri-area from front to back. However, V9 did not open R5's labia to clean and did not wipe groins to clean. 2. On 8/27/20 at 9:46 AM, V9 and V18 rendered morning care to R10. V9 started cleaning R10 from the face going down to the trunk, upper extremities, and lower extremities. When V9 reached R10's peri-area, V9 only wiped R10's pubic area, but she (V9) did not clean R10's outer and inner labia and bilateral groins. Per facility's UTI list, R10 has history of UTI. On 9/2/20 at 12:50 PM, V3 (Assistant Director of Nursing/ADON) stated that when a staff is providing incontinence or peri-care the staff must wipe or clean the peri-area from front to back. Make sure to open the labia (if resident is female) to thoroughly clean groin as well. This is to prevent infection, provide dignity and comfort. Facility's Policy and Procedure for Perineal Care showed: Perineal care is provided to clean the perineum, prevent infection, and provide comfort.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow dietary care plan and maintain adequate nutritional status of a resident who is already experiencing impaired nutrition. This applies to 1 of 3 residents (R3) reviewed for weight loss in the sample of 12. The findings include: R3's weight record from February to July 2020 showed the following: 2/27/20- 93.8 pounds (lbs.), 3/3/20- 94.6 lbs., 3/12/20 97 lbs., 4/14/20- 92.6 lbs., 6/1/20- 84.4 lbs., 7/10/20- 78.8 lbs., 7/24/20- 76 lbs. R3 had a weight loss of 18.97% in 5 months (February-July) and a weight loss of 9.9% in 7 weeks (6/1/20-7/24/20). Physician order [REDACTED]. Dietary note in May showed that R1 was evaluated by V5 (Registered Dietitian) and recommended multiple dietary supplements as reflected in the POS. POS dated 5/14/20 showed that R3 was prescribed Multivitamins once a day, Vitamin D 2000 units once a day, Zinc Sulfate 220 milligrams once a day as dietary supplements for 2 weeks only and 2 Calorie per ml supplement (given 60 milliliter/ml) three times daily. R3 was not weighed in May due to Covid. By 6/1/20, R3 already weigh 84.4 pounds (lbs.). and continued to lose weight in June and July. The Medication Administration Record [REDACTED]. Physiatrist Note dated 6/9/20 and 6/11/2020 showed: Unspecified calorie protein malnutrition. May benefit to be seen by dietary. Dietary Note dated 7/21/20 showed: V5 reviewed R3 due to change in condition. R3's height is 60, her BMI is 15.38 which is low for geriatric standard for age 90. laboratory results dated [DATE] showed: BCR: 59-H which may indicate dehydration. R3 has unplanned weight loss related to increased chewing difficulty with loss of her dentures and need for modified diet. V5 recommended to continue med pass 60 ml three times a day to support weight gain, add super cereal for breakfast, super pudding with meals, honor meal preferences, offer snacks between meals, CTM for change. On 8/27/20 at 12:48, V8 (Nurse) stated that she remembers R3 as having poor appetite. R3 prefers to eat the food that her daughter brought in she would eat about 25 %. On 9/1/20 at 2:00 PM, V5 (Registered Dietitian/RD) gave the following statement: V5 was aware of R3's weight. V5 recommended med pass supplement, R3 was eating but variably. On May19th, R3 had covid there was decline in appetite, 2 cal was added per daughter's request. R3 was sent to hospital emergency roiagnom on ,[DATE] where R3 received IV fluids. The doctor ordered Zinc, [MEDICATION NAME] Acid, MVI, Vitamin D3. R3 has age related depletion and weakness as evidence by low BMI and acute [MEDICAL CONDITION] infection (Covid). R3 returned from the hospital on [DATE]. V5 did a significant change notes (7/21/) due to weight loss, difficulty chewing, because she was missing her dentures since 6/30. On 9/3/20 at 2:23 PM, V20 (Nurse) stated that he (V20) believes that the main concern for R3 was her poor appetite. Care Plan showed that R3 has nutritional problem. R3's goal was to maintain adequate nutritional status as evidenced by maintaining weight within 4% of (95-100), no signs and symptoms of malnutrition, and consuming at least (50-75) % of at least 3 meals daily through review date. In addition, R3 has multiple care plan interventions which include the following: Obtain and monitor weight, report for any significant change, observe intake and record every meal. R3's meal intake report for May 2020 showed poor to fair appetite. The June meal intake showed mostly poor intake. There was no evidence that July meal intake was monitored. Progress note dated 7/28/20 showed that R3 was sent to the hospital for medical evaluation. On 7/29/20, facility was informed by hospital staff that R3 was admitted for [DIAGNOSES REDACTED]. Guidelines: - Weekly weights will be done with a significant change of condition, food intake decline that has persisted for more than a week, or with a physician order. - Dietary recommendations will be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) forwarded to the Health Care Provider. The physiatrist notes for 6/9/20 and 6/11/20 identified R3's protein-calorie malnutrition. V5 (RD) was aware that R3 was losing weight in May. The Zinc, [MEDICATION NAME] Acid, MVI, Vitamin D3 that V5 mentioned during the interview was only given to R3 from 5/10/20 through 5/24. However, there was no follow up dietary assessment until 7/21/20. There was no evidence that V5's recommendation to add super cereal for breakfast, super pudding with meals, honor meal preferences, offer snacks between meals, was referred or forwarded to V22 (R3's Physician nor to V23 (Nurse Practitioner). There was no evidence that R3's care plan was being updated for her continued weight loss. There was no evidence that R3's weight was closely monitored despite poor appetite and significant weight loss.