STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145946	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY AT ARIA	**4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have interventions in place that aided in the healing of a wound for a resident with documented risk for skin breakdown and resulted in the worsening of a wound on the right foot for one resident (R3) reviewed for pressure ulcers. Findings include: R3 is a [AGE] year old male admitted on [DATE], with most recent re-admission on 5-5-2018 with medical [DIAGNOSES REDACTED]. 3-11-2020 at 12:20P.M. R3 said, I developed a sore that was very painful to my right foot, the wound care doctor saw me a few months after, the nurse was just applying gauze, they did not take care of my wound and they amputated my right leg. Wound assessments reviewed include the following: 8-14-2019 (R3) developed a 2.0X1.50X0.00 trauma to the right foot without any drainage, Braden score is 16 at risk for skin breakdown, PUSH (Pressure Ulcer Scale for Healing) score of 6 8-22-2019 measurements were 3.0X2.50X 0.10 with light amount of serosanguinous drainage, skin 70% intact and 30% bright pink or red PUSH score of 10 9-11-2019 measurements were 3.0X2.0X0.0 with light amount of serosanguinous drainage, skin 20% bright pink or red and 80% slough non-adherent, PUSH score 11, clinical stage Full Thickness under comments indicates that R3 constantly bump his foot running into objects 10-15-2019 measurements were 4.20X2.40X0.40 with moderate serosanguinous drainage, skin 10% bright pink or red and 90% slough non-adherent, PUSH score 13, under comments reads that R3 was seen by wound doctor with new orders for laboratory work, Doppler and new treatment 10-22-2019 measurements 6.30X4.50X0.40 with moderate serosanguinous drainage, PUSH score 15, under comments reads R3 to see vascular doctor 10-29-2019 measurements 7.0X5.50X0.40 under comments reads R3 has vascular appointment on 10-30-2019. Wound care note reads: the wound is classified as a full thickness, there is a large (67% to 100%) amount of necrotic tissue within the wound bed including adherent slough, wound worsening. R3 complaints of pain 8/10 and has tenderness when the wound is examined 3-11-2020 at 1:50 p.m. V14 (LPN, WCC WOUND CARE COORDINATOR) said, R3 was admitted with a left above the knee amputation, I do not see any updates in care plan when R3 had the trauma to the right foot, we are supposed to update the care plan with any new skin issues including pressure or trauma but I do not see any updates on R3's care plan. 3-12-2020 at 3:00p.m. V3 (Assistant Director of Nursing) said, we are supposed to update the care plan with any new skin issue, the care plan directs how the patient care is given. Wound care plan created on 10-12-2017 includes (R3) at risk for impaired skin integrity, there are no interventions documented to address the right dorsal wound and no interventions addressing non-compliance with electrical wheel chair use and of bumping R3's foot. Fall care plan focus includes: (R3) is at risk for falls related to impaired mobility due to bilateral above the knee amputation and interventions include: encourage and assist guest as needed to wear non-slip footwear/ well fitted shoes. Policy titled, Care Plans (revised on 9-2016) documents: each resident will have a care plan individualized and consistent with their medical regimen. The care plans are updated at least every 90 days or with a significant change of the resident.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide schedule showers twice a week, as scheduled, for two residents (R2 and R5) reviewed for showers. Findings include: R2 is a [AGE] year old male admitted on [DATE] with most recent readmission on 12-9-2019 with medical [DIAGNOSES REDACTED]. Minimum Data Set (MDS) (assessment tool) dated 2-3-2020 documents: R2 needs extensive assistance of one person for bed mobility, transfer, dressing, toilet use and personal hygiene. Total dependence for bathing. R5 is a [AGE] year-old male admitted on [DATE] with most recent readmission 2-17-2020 with medical [DIAGNOSES REDACTED]. R5 has a [MEDICAL CONDITION] and gastrostomy tube. MDS dated [DATE] documents: R5 is totally dependent of one staff member for bed mobility, dressing, personal hygiene and bathing. Totally dependent of two staff members for toilet use. Bathing schedule dated 3-11-2020 for R2 reads: Wednesdays and Saturdays on 3-11. No documented showers listed on 3-15-2020, 3-19-2020, 3-22-2020, 3-26-2020, 3-29-2020, and 3-7-2020. Bathing schedule dated 3-10-2020 for R5 reads: Tuesdays and Fridays on 3-11. No documented showers listed on 2-18-2020 and on the following dates (R5) received a bed bath: 2-21-2020, 2-28-2020, 3-3-2020, 3-6-2020 and 3-10-2020. 3-10-2020 at 10:45 A.M. V10 (Certified Nurse Assistant) said, we shower the patients two times a week, if patient refuses we tell the nurse and they follow up with the patient and document it. 3-11-2020 at 6:45 P.M. V3 (Assistant Director of Nursing) said, R5 is total care, all patients have two showers a week, bed baths are not showers. I do not see any shower documented for R5 on 2-18-2020. 3-12-2020 at 3:50 P.M. V3 (Assistant Director of Nursing) said, R2 needs total care with showers, when the shower is given, it is documented under the task for bathing. I do not know why it is not documented for R2 on 3-15-2020, 3-19-2020, 3-22-2020, 3-26-2020, 3-29-2020 and 3-7-2020. Policy titled, Activities of Daily Living (revised on 9-2016) reads: showers are scheduled and assistance is provided when required.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy on implementation of infection control protocol by failure to perform hand hygiene and changing gloves when providing pericare and administration of medication. This deficiency affects (R2, R9 and R15). Findings include: R2 is a [AGE] year old male admitted on [DATE] with most recent readmission on 12-9-2019 with medical [DIAGNOSES REDACTED]. 3-10-2020 at 10:38 A.M. V4 (Licensed Practical Nurse / LPN) went into R2's room and gave medications to R2. V4 did not perform hand hygiene or hand washing prior to preparing or giving the medications to R2. At 10:40 A.M. V4 said, I did not wash my hands, I should have before I started preparing and giving them (medications) to R2. R9 is [AGE] year old female admitted on [DATE] with most recent re-admission on 1-14-2018 with medical [DIAGNOSES REDACTED]. R9's care plan revised on 1-21-2019 reads, R9 requires total to extensive assist with ADL's (activities of daily living) related to generalized weakness and pain. 3-10-2020 at 11:10 A.M. V13 (Certified Nursing Assistant) put on a pair of gloves and provided perineal care on R9. V13 removed the wet (soiled) incontinence brief and with the same gloves grabbed the clean incontinence brief, opened it up and applied it to R9's body without performing any hand hygiene or changing gloves. 3-10-2020 at 11:17A.M. V13 said, I used the same pair of gloves for cleaning and putting on the clean incontinence brief for R9. I was never told that I need to change my gloves when I am providing perineal care. R15 is a [AGE] year old female originally admitted on [DATE] with most recent re-admission on 2-25-2020 with medical [DIAGNOSES REDACTED]. 3-12-2020 at 12:10 P.M. V11 (Certified Nursing Assistant) washed her hands, put gloves on and removed the soiled incontinence brief that was saturated with urine and feces, then cleaned the perianal area and proceeded to changed her gloves. V11 did not perform any hand hygiene before applying the new

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) pair of gloves and then continue to apply a clean incontinence brief on R15. 3-12-2020 at 12:20P.M., V11 said, I was supposed to wash my hands with soap and water after I clean the feces and before applying a new pair of gloves but I did not do it. 3-10-2020 at 1:40P.M. V3 (Assistant Director Of Nursing) said, the staff needs to make sure they perform hand hygiene before they put gloves on, they will need to make sure to change their gloves and wash their hands before they put a new pair of gloves, for the nurses if they are passing medications they need to do hand hygiene before they start preparing the medications for the patient and after they give the medications. Facility policy titled, Hand Hygiene (revised date 03-2019) reads: Hand hygiene is essential for preventing the spread of infectious organisms in healthcare settings. Wearing gloves is not a substitute for hand hygiene. Dirty gloves can soil hands. Always clean your hands after removing gloves.