STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. BUILDING _____ B. WING _____	05/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 3/13/20, the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH revised on 3/13/20, Nursing Home guidance from the Centers for Disease Control (CDC), observation, interview and record review, the facility failed to prevent the spread of infections such as COVID-19 as evidenced by failures to ensure (1) laundry was stored in a sanitary manner; (2) social distancing was strictly observed; and (3) face masks were consistently used for source control. These failures had the potential to affect all 210 residents residing in the facility. Findings include: According to the Centers for Disease Control and Prevention (CDC) .Given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from severe infections, hospitalization s, and death .Recent experience with outbreaks in nursing homes has also reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these settings. In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community. Action to take now .Enforce social distancing among residents. Ensure all residents wear a cloth face covering for source control whenever they leave their room . 1. On 4/28/20 at approximately 11:00am during an observation with the Director of Nursing (DON) the following were observed: A. Unit linen cart outside room [ROOM NUMBER] was not fully covered, leaving linens and towels exposed. When asked about the observation the DON stated, These (linen carts) should have been closed. B. Unit linen cart outside room [ROOM NUMBER] was not fully covered, leaving blankets and fitted sheets exposed. C. Unit linen cart outside room [ROOM NUMBER] was not fully closed, because the cover was too small for the size of the linen cart. Towels and blankets were exposed and some of the sheets touched the floor. 2. On 4/28/20 at approximately 1:20pm, observation in the laundry room with the Administrator and E1, the Laundry Housekeeping Manager, revealed a linen cart full of clean laundry that was not fully covered resulting in exposed linens. A puddle of water from a ceiling leak was observed on the floor directly next to the laundry cart. (The leak had previously been identified by the Maintenance Director as being from a grease trap in the kitchen directly above the laundry room that overflowed, causing the kitchen to flood (cross refer F921.)) When asked about the observation, the Administrator replied, We are going to fix this. It is important for infection control purposes. Review of the facility's Laundry Operations policy dated 3/12/20 indicated the following under, B. Transferring Soiled Linens .All soiled linen and clean linen must be covered during transportation and while being stored on units or floors. Additionally, no clean linen should touch the floor. Review of an article titled Handling Clean Linen in a Healthcare Environment revealed, .Research shows that outbreaks of infectious diseases associated with laundered health care textiles .Exposure of clean textiles to environmental contamination is most often cited as the cause. Under Storage, it revealed, Adequate storage space for HCTs (healthcare textile) is especially important. Ideally, space is set aside where the linen can be both stored and prepared for distribution, and kept separate from any soiled linen and other possible contaminants. Nothing should be stored in the area except the clean linen. https://industryperspectives.com/wp-content/uploads/2017/04/hygienic-clean-linen.pdf 3. On 4/28/20 at approximately 1pm on the second floor (not a COVID-19 floor), six residents were observed to enter the elevator, only two residents had face masks on. One resident was in his wheelchair while the rest were standing closely next to him. LPN1 and NA1 witnessed the occurrence but did not remind the residents to observe social distancing, nor did LPN1 and NA1 ask the residents to wear facemasks. LPN1 was asked how many residents were allowed to use the elevator (a typical standard elevator for a low-rise building) to observe proper social distancing. LPN1 responded, I am not sure, I think one. When asked about the residents who did not have facemasks on, LPN1 did not provide an answer. On 4/28/20 at approximately 1:10pm, R1 was asked why he did not have a facemask on. R1 responded, I want to but I do not have one. I know it's important nowadays. R1 further stated that he was not aware of the facility providing facemasks to the residents and that if they had, he had not been included. During an interview on 4/28/20 at approximately 2:15pm, DON and the Administrator were asked about social distancing and the residents' use of facemasks. The DON stated that she expected staff to remind residents not to congregate closely together. The DON further stated that social distancing was important especially during elevator use. The Administrator added that staff who witnessed such occurrences as that witnessed with multiple residents on the elevator together, should have immediately reminded the residents and implemented social distancing. The Administrator stated that residents should have facemasks on and planned to distribute cloth facemasks to all the residents for source control. Review of an article from CDC titled, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes revealed 1 .these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community .Resident Monitoring and Restrictions: Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others) . 2. Remind residents to practice social distancing and perform frequent hand hygiene . 3. Educate residents and families, including information about COVID-19; actions the facility is taking to protect them and/or their loved ones, including visitor restrictions; and actions they can take to protect themselves in the facility, emphasizing the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and wearing a cloth face covering . https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html#cases-in-community According to QSO 20-14-NH in the section titled, Guidance for Limiting the Transmission of COVID-19 for Nursing Homes revealed the following: .Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility .This includes communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care .Additional guidance: 1. Cancel communal dining and all group activities, such as internal and external group activities. 2. Implement active screening of residents and staff for fever and respiratory symptoms. 3. Remind residents to practice social distancing and perform frequent hand hygiene .
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review, the facility failed to ensure that a clean, safe and functional

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) environment was maintained as evidenced by damaged walls, ceilings, light fixtures and floor tiles. This had the potential to affect all 211 residents in the facility. This noncompliance was identified during COVID-19 Focused Surveys activities. Findings include: On 4/28/20 at approximately 1:20pm during observations of laundry practices related to isolation linens with the Administrator and the Laundry and Housekeeping Manager (LHM) the following were observed: A. Fluid leaks from different parts of the ceiling including around the light fixtures. B. The ceiling was soggy and bulging with brown and black stains. C. Water marks, bubbling paint and cracks on the wall D. Cracked floor tiles E. Water puddled on the floor in close proximity to a full laundry storage cart containing clean linens which was not fully enclosed F. Three soaked blankets on the floor used to absorb water. Employee1 (E1) and E2 were asked when the water leak had started. E1 stated, I think a month or so, it comes and goes. E2 added, I cannot remember exactly when it started but it's been there. The LHM verbalized that the Maintenance Supervisor (MS) was aware of the concern. When asked when and how maintenance was notified, the LHM stated, During our morning meetings and staff tell him directly too since his office is near the laundry area. The Administrator is also asked about the observation. The Administrator stated, It's concerning since there are clean laundry here. On 4/28/20 at approximately 2:30pm, the MS was asked about the concern. The MS explained that the leak came from the kitchen directly above the laundry room due to a grease trap that overflowed. The MS was asked how he was made aware of the building's maintenance concerns. The MS stated that staff would tell him directly and fill up a maintenance request sheet. When asked whether there was a completed maintenance request specific to the identified concern, the MS stated that he would look and provide if available. There was no completed maintenance request documentation provided by the facility prior to the survey's exit. On 4/28/20 at approximately 2:30pm the Administrator was asked about the repairs that needed to be done. The Administrator stated that she was not aware of the above mentioned concerns until today when it was brought to her attention by the Surveyor. The Administrator was asked to provide the facility's policy on environmental and building maintenance. The Administrator confirmed they did not have one and provided a blank maintenance room checklist. The facility was requested to provide a completed checklist that addressed the maintenance concerns in the laundry room. There was no documentation provided prior to the survey exit. Review of the facility's undated Maintenance Room Checklist under indicated, ____ Check Ceiling condition, broken tiles, cracked drywall, holes etc. ____ Check flooring tiles for cracks, broken tiles, grout lines, odors & condition ____ Check walls for holes, paint touch ups & patching ____ Check laundry equipment & chemical feeding system for safety hazards ____ Check electrical (lighting, light switches & sockets) Replace bulbs and switches as needed .t