STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146143	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF HANOVER PARK	2000 WEST LAKE STREET HANOVER PARK, IL 60133

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a physician's order prior to administering a medication. This applies to one of three residents (R2) reviewed for medication administration in the sample of 13. The findings include: Review of R2's electronic health record (EHR) showed R2 was originally admitted to the facility on [DATE] and was discharged from the facility 6/7/20. At admission, R2 was noted with [DIAGNOSES REDACTED]. R2's Minimum Data Set (MDS), dated [DATE], showed R2 with Brief Interview for Mental Status (BIMS) of 14, which meant R2's cognition was intact. R2's MDS showed R2 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS showed R2 with no impairment on both sides of upper and lower extremities. R2's MDS showed R2 is frequently incontinent of bladder and occasionally incontinent of bowel. Review of R2's incident report generated by V14 (Former Agency Nurse), dated 10/29/19, showed, R2 with new complaint of pain or physical discomfort, redness to right eye. On 9/9/20 at 11:43 AM, V14 stated on 10/29/19, he applied [MEDICATION NAME] cream to R2's face because R2 initially asked for his face cream. V14 stated he applied the [MEDICATION NAME] roll-on to R2's shoulders and rubbed it on R2's shoulders. When asked whether there was an order for [REDACTED]. R2's MAR indicated [REDACTED]. There was no order for [MEDICATION NAME] roll-on R2's POS and/or MAR. On 9/8/20 at 9:35 AM, V13 (Nurse Practitioner) stated nursing staff should have obtained an order for [REDACTED]. route, at the correct rate, at the correct time, for the correct resident . 4.1.2 Confirm that the MAR indicated [REDACTED]
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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, facility failed to perform hand hygiene and failed to wear proper PPE during provision of care. This applies to 6 of 13 residents (R3, R4, R5, R10, R11 and R12) observed during provision of care. The findings include: 1. On 9/4/20 at 6:02 AM, V4 (Certified Nursing Assistant, CNA) was observed wearing a surgical mask covering only her mouth. V4's nose was exposed. V4 was seen walking around the unit from 6:02 AM through 6:50 AM before V4 was prompted. On 9/4/10 at 6:10 AM, V4 was in R10's room getting R10 ready for [MEDICAL TREATMENT]. R10 had a surgical mask on, but V4's surgical mask was worn improperly while transferring R10 from bed to a recliner chair. Review of R10's Electronic Health Record (EHR) showed R10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Date Set (MDS) showed R10 with Brief Interview for Mental Status (BIMS) of 14, which showed R10's cognition was intact. The MDS showed R10's requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS showed R10 with no impairment on both sides of upper and lower extremities. R10's MDS showed R10 is frequently incontinent of bladder and bowel. 2. On 9/4/20 at 6:30 AM, V4 was in R3's room to assist with transfer of R3 from bed to the recliner chair. V4's surgical mask only covered her mouth and not her nose. On 9/4/20 at 6:40 AM, V4 was observed removing her gloves after assisting R3 with transfer, and failed to perform hand hygiene. Review of R3's EHR showed R3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS, dated [DATE], showed R3 with Brief Interview for Mental Status (BIMS) of 12, which showed R3's cognition is intact. The MDS showed R3's requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS showed R3 with no impairment on both sides of upper and lower extremities. R3's MDS showed R3 is always incontinent of bladder and frequently incontinent of bowel. 3. On 9/4/20 at 6:30 AM, R12 asked for his urinal to be emptied. V6 (Certified Nursing Assistant, CNA) was assisting R3 with transfer and stated she would be right back. V6 removed her gloves, and failed to perform hand hygiene prior to donning a new set of gloves. On 9/4/20 at 6:47 AM, V6 rushed back to R12's side of the room and picked up R12's urinal, which was half full of urine, and emptied the urinal in to the toilet. V6 removed her gloves and came out of R12's room without performing hand hygiene. On 9/4/20 at 6:50 AM, V6 stated she was very sorry for not washing her hands but that she was running late to get home. 4. On 9/4/20 at 7:02 AM, R11 had diarrhea. R11 stated, I am not sure if the bowel infection is back. V7 (CNA) performed incontinence care to R11. V7 used the same pair of gloves throughout the incontinence care for R11. V7 also used the same gloved hand to open R11's bedside drawer to pick the barrier cream. V7 then took R11 out of the room to be weighed, but returned without weighing the resident as she was told that the weighing scale was broken. V7 failed to change the soiled gloves, and failed to perform hand hygiene in between tasks. R11's MDS, dated [DATE], showed R11 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS showed R11 with no impairment on both sides of upper and lower extremities. R11's MDS showed R11 is frequently incontinent of bladder and bowel. 5. On 9/4/20 at 9:02 AM, V8 (Wound Care nurse) was performing wound care dressing change to R5's wound. V8 took a pair of scissors from her uniform pocket, laid scissors on R5's bed, and continued with the dressing change. V8 took the pair of scissors, which were on the top of R5's bed, to cut R5's adhesive foam before placing it on R5's right lateral wound. V8 put the pair of scissors into her uniform pocket without sanitizing them. V8 removed her gloves, and failed to perform hand hygiene. R5's wound assessment details, report dated 9/2/20, showed R5 with right lateral foot facility acquired deep tissue pressure injury. 6. On 9/4/20 at 9:25 AM, V8 (Wound Care nurse) was performing wound care dressing change on R4's sacral wound. V8 removed R4's old dressing, cleansed R4's wounds, removed her gloves, and failed to perform hand hygiene. V8 further applied treatments to R4's wound, and failed to remove her gloves and perform hand hygiene prior to adjusting R4 in bed. V8 then removed her gloves, was heading towards the door, touched the door knob, before turning back to the washroom to wash her hands. Review of R4's MDS, dated [DATE], showed R4 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use, eating and personal hygiene. The MDS showed R4 is always incontinent of urine and frequently incontinent of bowel. 7. On 9/8/20 at 8:29 AM, V15 (CNA) was in R3's room to perform incontinence care on R3. V15 stated, I am ready to change you now. R3 was found to have large bowel movement. V15 performed incontinence care to R3, removed her soiled gloves, and failed to perform hand hygiene. V15 further used the same hands to open R3's room door and the laundry room door across the hall to obtain another pair of gloves. After coming back to R3's beside, V15 used her bare hands to pick up R3's nasal cannula that was on the floor, and attempted to apply it into R3's nostrils before she was prompted. On 9/8/20 at 8:42am, V15 stated, Tell me what I am supposed to do with the nasal cannula? should I get a new one? On 9/8/20 at 9:05 AM, V2 (Director of Nursing, DON) stated staff are required to wear face mask covering both nose and mouth throughout the building at all times. V2 stated staff are expected to perform hand hygiene after removing gloves. V2 further stated V15 should have asked the nurse for a clean nasal cannula and not attempt to apply an unclean cannula into R3's nostrils.

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.