STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF MORGAN PARK	**10935 SOUTH HALSTED STREET CHICAGO, IL 60628**

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 0909 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.** Based on observation, interview, and record review, the facility failed to ensure that residents' beds frames are in good working condition to ensure the safety and comfort of residents. This affects two residents, (R2 and R3) of four residents, reviewed for safe and functional bed frames. Findings include: On 9/30/20 at 10:30am with V5 (CNA, Certified Nursing Assistant), R2's bed was observed to slide down while raising up the bed with the electronic bed control. V5 stated it has happened a few times while she was caring for the resident, and she reported this to maintenance, but it was not fixed. On 9/30/20 at 11.00am with V6 (Licensed Practical Nurse, LPN, Unit Manager), R3's head of bed was observed to not respond to the manual crank handle that was supposed to raise it up. V6 stated that she would call maintenance to fix it. V6 also went ahead to see R2's bed and stated that she would report both to the maintenance director. On 9/30/20 at 12:13pm, V10 (Maintenance Director) was interviewed regarding these broken beds. V10 stated he was not aware that the beds were broken. V10 added that there is a work order form at every nursing station and no one informed him. Facility's undated document titled Maintenance Assistant under Equipment and Supply Functions states: Ensure that the facility and its equipment is properly maintained for resident comfort and convenience. Report equipment malfunctions or breakdowns to your supervisor as soon as possible. The facility did not follow this recommendation.

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