STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145510	A. BUILDING _____ B. WING _____	**09/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF LINCOLN PARK	**1366 WEST FULLERTON AVENUE CHICAGO, IL 60614**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed report alleged misappropriation of property and accident with injury to the state survey and certification agency. This deficient practice has the potential to affect two (R1, R4) out of six residents reviewed in sample of six. Findings include: 1. R1's nursing progress note dated 6/25/20 documents in part Note Text: Was being helped to the bathroom. According to CNA, patient had a wobbly gait and had to be slid to the floor, states he feels drunk, remains alert and oriented x 3, no external injuries noted. Assisted to toilet by 2 CNAs. Large amounts of blood clots with hematuria. BP 75/45, Pulse 116, R 23. Per progress notes, patient was sent out to the hospital and was admitted with [DIAGNOSES REDACTED]. Chronic fracture deformity involving the right lateral seventh rib, similar to prior. New displaced fracture through the right posterior lateral eighth rib. Record review of 2020 Binder for Reportable incidents does not contain any report regarding this incident. No investigation was completed, no report was sent to IDPH. On Sept. 25, 2020 at 3:30 PM, V2 (Director of Nursing) stated, If there was a report of fall, we have to investigate. For this patient, it was not treated as a fall. It's more for medical necessity; that's why the staff lowered him to the floor. I believe they called the ambulance to transfer him to the hospital because of [MEDICAL CONDITION] not, because of the fall. Fall is a change in patient's plane involuntarily or accidentally. In this instance, there was a change in plane because the patient was lowered to the floor by staff for his safety. The purpose is to prevent the fall. I know that he had an old fracture on the 7th rib. This was not reported to IDPH because there was no fall incident. Resident Assessment Instrument User's Manual. Version 3.0, Chapter 3, page J-27 documents in part: Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Facility presented a document titled Guideline: Falls dated 8/13 documents in part: GENERAL: All resident falls shall be reviewed and the resident's existing plan of care shall be evaluated and modifies as needed. 5. All incident and accident with serious physical injury will be reported to as required to the Health Department. A full written investigative report is required by the Department of Public Health within seven (7) days of the incident. 2. During facility tour on 9/25/20 at 11:50 am, R4 was observed in his room, sitting by the edge of the bed, room cluttered, lots of old milk cartons on top of bedside table, soiled clothes scattered in the room. R4 stated that somebody from the facility stole his watch, cash and [MEDICATION NAME]. R4 stated, When I first got here a few months ago, I think in April or March of this year, I got here in a room on second floor, they grabbed my shopping bags with all my properties in it. The Certified Nursing Assistant (CNA) said they are taking my belongings in the storage room and will give it back to me when I leave this facility. A few weeks after, all my clothes came back, I was told they washed all my clothes, but I was missing a lot of things. I had about $2879.00 in cash that was inside my socks, $87.00 in my coat pocket, $180 worth of gift cards, (2) month bus passes, my credit card, social security card and my bank card. I reported it to the Social Worker at that time and she told me she was making a formal complaint about it. They still have not given me back all my missing cash and cards. R4 is [AGE] years old, was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Brief Interview for Mental Status (BIMS) dated 7/3/20 score was 15/15 which indicates R4's cognition is intact. On Sept. 25, 2020 at 2:00 PM V1 (Administrator) stated, I just know hearsay because I wasn't here at that time. When R4 came in, he had scabies, so he had shopping bags full of his things, one had paper, and one had his clothing. It all went down to housekeeping for laundry. The Social Service person inventoried, I don't know before or after going down to housekeeping for laundry, it wasn't found. If that happened today, we would generate a Concern Form and it will be investigated. All parties concerned will be interviewed and this will warrant an abuse investigation and will be reported to the state and Chicago Police Department. Abuse Investigation binder in front of me does not contain any investigation regarding R4's allegation. Concern Log for 2020 in front of me does not have a form documenting R4's missing money, etc. V1 later presented a Concern Form dated 4/11/20 documenting the missing cash as reported by R4 but was not even signed or acknowledged by the Administrator. V1 presented document titled EVS Resident Clothing Inventory which did not note that any cash was found in his belongings. Facility presented an untitled document with a review date of 1/2019, which documents under the section External Reporting: Initial reporting of Allegations. When an allegation of abuse, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to thoroughly investigate an alleged misappropriation of property and accident with injury. This deficient practice has the potential to affect two (R1, R4) out of six residents reviewed in sample of six. Findings include: 1. R1's nursing progress noted dated 6/25/20 documents in part Note Text: Was being helped to the bathroom. According to CNA, patient had a wobbly gait and had to be slid to the floor, states he feels drunk, remains alert and oriented x 3, no external injuries noted. Assisted to toilet by 2 CNAs. Large amounts of blood clots with hematuria. BP 75/45, Pulse 116, R 23. Per progress notes, patient was sent out to the hospital and was admitted with [DIAGNOSES REDACTED]. Chronic fracture deformity involving the right lateral seventh rib, similar to prior. New displaced fracture through the right posterior lateral eighth rib. Record review of 2020 Binder for IDPH Reportable incidents does not contain any report regarding this incident. No investigation was completed, no report was sent to IDPH. On Sept. 25, 2020 at 3:30 PM, V2 (Director of Nursing) stated, If there was a report of fall, we have to investigate. For this patient, it was not treated as a fall. It's more for medical necessity; that's why the staff lowered him to the floor. I believe they called the ambulance to transfer him to the hospital because of [MEDICAL CONDITION], not because of the fall. Fall is a change in patient's plane involuntarily or accidentally. In this instance, there was a change in plane because the patient was lowered to the floor by staff for his safety. The purpose is to prevent the fall. I know that he had an old fracture on the 7th rib. This was not reported to IDPH because there was no fall incident. Resident Assessment Instrument User's Manual. Version 3.0, Chapter 3, page J-27 documents in part: Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for

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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