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 _____	**08/14/2020**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their policy and procedure and notify the family of a fall and resident injury. This affects R6 one of 3 resident reviewed for notification. Findings include: R6 fall investigation report dated 5/3/2020 completed by V4 (Nurse) shows why did the resident fall? Fall from bed. Why did that happen? Impaired mobility. Why did that happen? Unable to ambulate. Why did that happen? Rolled from bed. Root cause of fall shows resident possibly attempting to turn over rolling from the bed to floor. Impaired mobility poor safety awareness. Individualized interventions related to root, to be determined, evaluated upon return. Fall investigation notes show on 5/3/2020, R6 fell from bed observed laying on floor beside bed by CNA (Certified Nursing Assistant) on his right side. No visible injuries or deformity, s/p (status [REDACTED]. MD made aware X-ray ordered. Right elbow X-ray shows arthritic changes with suspected distal humeral fracture (acute) [MEDICAL CONDITION], receiving D3 supplement, send to the hospital. Interventions to be implemented upon return. V4 signature noted at bottom of page. On 8/11/2020 at 12:50p.m V4 said she gathered this information from V20 (LPN- Licensed Practical Nurse) and V31 (CNA-Certified Nursing Assistant) verbally. V4 said she was not at the facility during the fall incident, V4 said she initiated this fall investigation from home on 5/3/2020. On 8/11/2020 at 12:50p.m V4 (Nurse) identified herself as the restorative nurse and the person who conducts the fall investigations in the facility. V4 said the fall incident document is not valid because she was not at the facility when the fall took place and she should have not documented on that incident when she was not in the facility during the incident, therefore she struck out the information. V4 said if the notes do not show that the family was notified then they were not notified. V4 said the family should be notified of a resident fall. On 8/11/2020 at 2:20pm V20 (LPN- Licensed Practical Nurse) said she was made aware by V13 (LPN- Licensed Practical Nurse) and an aide that R6 had a fall and was on the floor in his room on 5/2/2020. V20 said this occurred on the 3-11pm shift in the earlier part of the shift. V20 said it was not 5/3/2020. V20 said the 3rd was a Sunday and she does not work on Sundays and she is sure of that. V20 said she called V4 and informed her of R6 fall but she did not give V4 any details of the fall. V20 said it would be impossible to have provided that information because she was working another unit on 5/2/2020 and she did not go to the first floor where R6 had fallen. V20 said the detailed description that's documented in V4 fall investigation was not provided by her (V20). V20 said a CNA reported to her that R6 had a fall, and she guess the CNA thought she was the manager on duty because she was in fact the manager on duty during the 7-3pm shift. V20 said the first floor did not have a nurse on the unit for some time, she just knew the nurse came late that day. V20 said she did not give R6 anything for pain. V20 said she did not notify R6 family of a fall. On 8/12/2020 at 9:15a.m V31 (CNA- Certified Nursing Assistant) said she did not have any information regarding R6 fall on 5/3/2020 or 5/2/2020. V31 said she does not work the second shift when R6 fell on [DATE]. V31 reviewed the post fall huddle document dated 5/3/2020 and said she did not complete that document. V31 said the signature on the bottom of that form is not her signature, she did not sign the form. V31 said she did not verbally report any of that information that documented on the form either. V31 said she does not know if R6 received anything for pain she was not there. On 8/12/2020 at 10:14am V13 (LPN- Licensed Practical Nurse) said she was working the second floor unit on 5/2/2020 when it was reported to her that R6 had a fall by V32 (CNA- Certified Nursing Aide). V13 said V32 asked for assistance to get R6 off the floor. V13 said she went to R6 room on the 1st floor, she observed R6 on the floor, V13 said she did not help to get R6 off the floor, V13 said she did not complete the assessment either. V13 was asked who helped to get R6 off the floor and who completed the assessment. V13 insist V20 completed the assessment. V13 said she does not know if R6 had complaints of pain during the assessment she just was standing there. V13 said she did not notify R6 family of a fall. On 8/12/2020 at 12:00p.m V32 (CNA- Certified Nursing Assistant) said on 5/2/2020 during rounds, she saw R6 on the floor. V32 said she went to get the nurse, the nurse assessed R6 and they picked R6 up off the floor with a mechanical lift. V32 said R6 did not complain of anything that she could remember, she's not sure what R6 said happened, V32 said all she remembers is she was looking for help, it's been so long she can't remember who the nurse was or other details of the incident. V32 said she did not notify R6 family of R6 falling. R6 Medication Administration Record [REDACTED]. On 8/12/2020 at 11:06a.m V29 (LPN- Licensed Practical Nurse) said she does not remember R6, she does not remember R6 having a fall, she does not remember anyone reporting that R6 had a fall on 5/2/2020. R6 pain assessment on the MAR indicated [REDACTED]. V29 said if the pain assessment shows no pain then R6 did not have pain. V29 said she does not remember notifying R6 family of any fall incident with R6. R6 X-ray report dated 5/3/2020 at 4:54p.m shows R6 name, R6 date of birth, patient ID, facility name, and R6 room number. Date of service 5/3/2020, referring physician V14 (Nurse Practitioner), technologist and interpreting company. Procedure is right elbow 2 views, findings show see impressions. Impressions shows examination, radiographs of the right elbow. Comparison study shows none. Findings show there is a normal bony [DIAGNOSES REDACTED] of the elbow. Subtle deformity involving the distal humeral metaphysis. Moderate arthritic changes are noted at the elbow. No bursitis identified. Impression show arthritic change of the elbow with suspected acute distal humeral fracture. X-ray report has hand written note showing on 5/4/2020 new order, send out to ER for evaluation, V14 (Nurse Practitioner) FNP. South suburban hospital per family request. On 8/12/2020 at 12:16pm V30 (radiology company rep) said the X-ray was ordered by V29 (Nurse) on 5/2/2020 at 5:30pm, V30 said it was a routine exam not a stat exam. V30 said it was a telephone order, the company uses a [MEDICATION NAME] process now. V30 said the X-ray was ordered due to resident having symptoms of pain. V30 said the results were faxed to the facility on [DATE] and the company confirmed the facility received the results on 5/4/2020. V30 said the procedure is to complete the X-ray and fax the results to the facility and when the X-ray has a positive findings, the X-ray Company would call to confirm that the facility received the report. On 8/13/2020 at 8:00a.m V23 (R6 family) said she was not made aware that R6 had a fall on 5/2/2020 until 5/4/2020 and at that time she found out that R6 had a fractured elbow and request that he be sent to a hospital for further evaluation. R6 face sheet shows that V23 is the power of attorney for R6. On 8/13/2020 at 11:40a.m V2 (Director of Nursing) said the family and or next of kin should be made aware if the resident has a fall, injury and or if there's a change in condition in the resident status. Facility Falls policy dated 8/13 with review dated of 8/14 shows in-part responsible party RN, LPN, DON. Facility guidelines following a fall incident 1. Evaluate the resident for any injury and alert the health care provider and emergency contact. 2. Complete a fall event, this event includes the circumstance surrounding the fall, devices in use, full body observation for injury, pain, range of motion, and neuro checks.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **Provide appropriate treatment and care according to orders, resident's preferences and goals.**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to follow their policy and procedures and notify the provider of a resident's injury, this failure affects R6 who was subsequently sent to the local hospital for further care. Findings include: R6 MDS dated [DATE] shows section C for cognitive patterns shows R6 has memory problems, and daily decision making skills are severely impaired. R6 physician order [REDACTED]. R6 fall investigation report dated 5/3/2020 completed by V4 (Nurse) shows why did the resident fall? Fall from bed. Why did that happen? Impaired mobility. Why did that happen? Unable to ambulate. Why did that happen? Rolled from bed. Root cause of fall shows resident possibly attempting to turn over rolling from the bed to floor. Impaired mobility poor safety awareness. 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R6 fall investigation incident report dated 5/3/2020 at 11:22a.m with strike out date of 5/5/2020 completed by V4 shows R6 was observed laying on the floor on his right side. Head to toe assessment observation completed with no visible injuries noted. Resident complain of pain to right arm with movement with no visible injuries. Resident medicated for pain, all other extremities freely moveable with no pain. Neurological checks initiated with no abnormalities. Medical doctor notified with X-rays ordered of bilateral upper extremities. Fracture suspected/ rule out in right forearm. No witnesses found. On 8/11/2020 at 12:50p.m V4 (Nurse) identified herself as the restorative nurse and the person who conducts the fall investigations in the facility. V4 said the fall incident document is not valid because she was not at the facility when the fall took place and she should have not documented on that incident when she was not in the facility during the incident, therefore she struck out the information. V4 said if the notes do not show that the family was notified then they were not notified. V4 said the family should be notified of a resident fall. On 8/11/2020 at 2:20pm V20 (LPN- Licensed Practical Nurse) said she was made aware by V13 (LPN- Licensed Practical Nurse) and an aide that R6 had a fall and was on the floor in his room on 5/2/2020. V20 said this occurred on the 3-11pm shift in the earlier part of the shift. V20 said it was not 5/3/2020. V20 said the 3rd was a Sunday and she does not work on Sundays and she is sure of that. V20 said she called V4 and informed her of R6 fall but she did not give V4 any details of the fall. V20 said it would be impossible to have provided that information because she was working another unit on 5/2/2020 and she did not go to the first floor where R6 had fallen. V20 said the detailed description that's documented in V4 fall investigation was not provided by her (V20). V20 said a CNA reported to her that R6 had a fall, and she guess the CNA thought she was the manager on duty because she was in fact the manager on duty during the 7-3pm shift. V20 said the first floor did not have a nurse on the unit for some time, she just knew the nurse came late that day. V20 said she did not give R6 anything for pain. On 8/12/2020 at 9:15a.m V31 (CNA- Certified Nursing Assistant) said she did not have any information regarding R6 fall on 5/3/2020 or 5/2/2020. V31 said she does not work the second shift when R6 fell on [DATE]. V31 reviewed the post fall huddle document dated 5/3/2020 and said she did not complete that document. V31 said the signature on the bottom of that form is not her signature, she did not sign the form. V31 said she did not verbally report any of that information that was documented on the form either. V31 said she does not know if R6 received anything for pain she was not there. On 8/12/2020 at 10:14am V13 (LPN- Licensed Practical Nurse) said she was working the second floor unit on 5/2/2020 when it was reported to her that R6 had a fall by a V32 (CNA- Certified Nursing Aide). V13 said V32 asked for assistance to get R6 off the floor. V13 said she went to R6 room on the 1st floor, she observed R6 on the floor, V13 said she did not help to get R6 off the floor, V13 said she did not complete the assessment either. V13 was asked who helped to get R6 off the floor and who completed the assessment. V13 insist V20 completed the assessment. V13 said she does not know if R6 had complaints of pain during the assessment she was just standing there. On 8/12/2020 at 12:00p.m V32 (CNA- Certified Nursing Assistant) said on 5/2/2020 during rounds, she saw R6 on the floor. V32 said she went to get the nurse, the nurse assessed R6 and they picked R6 up off the floor with a mechanical lift. V32 said R6 did not complain of anything that she could remember, she's not sure what R6 said happened, V32 said all she remember she was looking for help, it's been so long she can't remember who the nurse was or other details of the incident. R6 Medication Administration Record [REDACTED]. On 8/12/2020 at 11:06a.m V29 (LPN- Licensed Practical Nurse) said she does not remember R6, she does not remember R6 having a fall, she does not remember anyone reporting that R6 had a fall on 5/2/2020. R6 pain assessment on the MAR indicated [REDACTED]. V29 said if the pain assessment shows no pain then R6 did not have pain. R6 X-ray report dated 5/3/2020 at 4:54p.m shows R6 name, R6 dated of birth, patient ID, facility name, and R6 room number. Date of service 5/3/2020, referring physician V14 (Nurse Practitioner), technologist and interpreting company. Procedure is right elbow 2 views, findings show see impressions. Impressions shows examination, radiographs of the right elbow. Comparison study shows none. Findings show there is a normal bony [DIAGNOSES REDACTED] of the elbow. Subtle deformity involving the distal humeral metaphysis. Moderate arthritic changes are noted at the elbow. No bursitis identified. Impression show arthritic change of the elbow with suspected an acute distal humeral fracture. X-ray report has hand written note showing on 5/4/2020 new order, send out to ER for evaluation, V14 (Nurse Practitioner) FNP. South suburban hospital per family request. On 8/12/2020 at 12:16pm V30 (radiology company rep) said the X-ray was ordered by V29 (Nurse) on 5/2/2020 at 5:30pm, V30 said it was a routine exam not a stat exam. V30 said it was a telephone order, the company use a [MEDICATION NAME] process now. V30 said the X-ray was ordered due to resident having symptoms of pain. V30 said the results were faxed to the facility on [DATE] and the company confirmed the facility received the results on 5/4/2020. V30 said the procedure is to complete the X-ray and fax the results to the facility and when the X-ray has a positive findings, the X-ray Company would call to confirm that the facility received the report. On 8/12/2020 and 8/13/2020 at 9:48a.m attempt was made to call V29 to clarify the information received from the X ray company regarding the indication of the X ray which showed pain, and the X ray was called into the X-ray company by her V29 at 5:30pm, during the time frame V29 documented on the 5:00pm medication administration for R6. V29 did not answer, message left for V29 on how V29 could reach surveyor. Upon exiting the facility, V29 did not return call. R6 MAR indicated [REDACTED]. R6 POS dated 5/4/2020 shows orders for pain assessment every shift with order date of 4/7/2020. R6 POS dated 5/4/2020 shows orders for [MEDICATION NAME] tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for general discomfort with order date of 4/7/2020. R6 MAR indicated [REDACTED]. On 8/13/2020 at 11:40a.m V2 (Director of Nursing) said the expectations would be for the nurse to administer medication if the resident is experiencing pain according to the physician orders. V2 said the provider should be made aware of any resident injury right away so that they could give further direction on plan of treatment. V2 said if the nurse ordered an X-ray then they should be checking the fax machine for the results and if the results are there within hours they should be in communication with the X-ray Company on the status of the results. On 8/12/2020 at 1:04p.m V14 (NP) said she was not made aware of the X-ray results until 5/4/2020 and at that time she gave orders to give [MEDICATION NAME] and send to local hospital for further evaluation. V14 said she should have been made aware as soon as the facility received the information on 5/3/2020. V14 said if the resident is experiencing pain she would expect the nurse to administer medication as ordered. V14 said she was not made aware of the fall on 5/2/2020. V14 said she did not order the X-ray for symptoms of pain for R6 on 5/2/2020. V14 said at minimum if the resident is experiencing pain she would have ordered [MEDICATION NAME]. V14 said she did not get the results right way, is a delay in treatment, however she does not feel like R6 treatment plan would have been different if she would have gotten the results on 5/3/2020. V6 said she does not feel like R6 had any decline in his current level of function due to the fall with fracture. On 8/13/2020 at 9:58a.m attempt was made to clarify the information that V4 documented on the fall investigation that V4 said she gathered from V20 and V31. V4 said do you expect me to remember the information from May. R6 POS dated 5/3/2020 shows orders for X-ray of bilateral shoulders and elbows. Review of the orders screen in the electronic records show V12 (LPN-Licensed Practical Nurse) created the X-ray order on 5/3/2020. On 8/12/2020 at 11:37a.m V12 (Nurse) said when she was working on 5/3/2020, the X-ray company arrived to the facility and stated that they were there to complete an X-ray for R6, V12 said she realized the order was not in the computer and so she put the order in based on the information reviewed on the electronic record provided by the diagnostic company. V12 said she did not inquire about why the X-ray needed to be completed. V12 said she did not conduct any further assessment of R6 either. V12 said she doesn't know if she reported to the next shift that R6 had an X-ray completed and she was awaiting results. Review of facility 24 hour report dated 5/3/2020 there is no documentation that R6 was awaiting results of an X-ray, there is no documentation that R6 had an X-ray

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) due to symptoms of pain. R6 progress notes dated 5/4/2020 at 1:02pm shows results of right elbow X-ray reads arthritic change of the elbow with suspected an acute distal humeral fracture. NP phoned and made aware, new orders to send pt (patient) to hospital for evaluation r/t (related to) abnormal X-ray. POA made aware, prefers resident to transfer to south suburban hospital ER (emergency room). NP made aware orders for transfer to south suburban hospital ER for evaluation. Appropriate staff aware. South suburban hospital ER charge nurse given report. Ambulance phoned ETA 45-60 minutes. Resident (R6) prepared for transfer. R6 X-ray was ordered for pain. R6 X-ray show that the results was faxed to the facility on [DATE] at 4:56pm. R6 has cognative communication deficits, It was 21 hours before the facility reconized R6 had a fracture to the elbow and needed further care. Facility Falls policy dated 8/13 with review dated 8/14 shows in-part responsible party RN, LPN, DON. Facility guidelines following a fall incident 1. Evaluate the resident for any injury and alert the health care provider and emergency contact. 2. Complete a fall event, this event includes the circumstance surrounding the fall, devices in use, full body observation for injury, pain, range of motion, and neuro checks. Facility policy titled Physician Notification dated 11/03 with review date 11/17 shows in-part to provide a policy for notification of the physician and a reasonable time for physician notification. In an emergency situation the physician is contacted at the same time or will be notified following 911 and once the resident is transferred to the hospital. In non-emergent but acute medical situations (including critical lab values and other diagnostic test results) the physician will be paged and if there is no return call in 15 minutes , the physician will be notified again. If there is no return call in 5 minutes the medical director will be notified. In non-emergent, non-acute medical situation such as normal lab the physician can be notified at their convenience.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations, interviews and record reviews, the facility failed to wear masks appropriately and failed to maintain social distancing of 6 feet during dining affecting 6 (R7, R8, R9, R10, R11 and R12) of the 10 residents reviewed for infection control. Findings include: On 08/11/2020 at 12:36 PM, surveyor observed 3rd floor dining room near the nurses' station for lunch activities. Observed V9 (CNA, Certified Nursing Assistant) and V10 (CNA) passing out lunch trays with their KN95 masks landing below their nose. Masks were not covering the nose; nostrils were exposed. On 08/11/2020 at 12:39 PM, surveyor observed residents eating in the same dining room. Two dining tables were pushed together. Six residents were sitting around the two dining tables. R7 was wearing a red shirt and sitting by the window facing towards the wall adjacent to the nurses' station (east). R8 was sitting directly to the left of R7 less than 6 feet away. R9 was sitting at the head of the table facing south. R9 was sitting less than 6 feet away from R8. R10 who was sitting directly across from R8 was also sitting less than 6 feet away from R9. R11 was sitting directly to the left of R10 who was less than 6 feet away. R12 was at the other head of the table sitting less than 6 feet in between R7 and R11. On 08/11/2020 at 2:07 PM, V12 (Nurse) stated to prevent COVID-19 spread, staff and residents are to maintain social distancing of 6 feet. Residents should be kept apart in the dining room. V12 stated the dining room has small square tables and should have one resident per table. V12 stated the tables are not 6 feet in length or width. On 08/13/2020 at 10:49 AM, V3 (Assistant Director of Nursing) stated face masks are supposed to cover the nose and mouth. Reviewed R7, R8, R9, R10, R11 and R12's care plans. Care plans' focus regarding residents' risks for COVID-19 reads an intervention to Practice social distancing. Avoid crowded environments and group activities.