STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014906	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT ARIA	4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 1991837/IL110360 1991702/IL110218 1991403/IL109884 1990820/IL109238 1991790/IL110302	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010h) 300.1210b) 300.3240a) Section 300.1010 Medical Care Policies h)The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014906	A. BUILDING: _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT ARIA	4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on interviews, and record reviews, this facility failed to assess and report the acuity of the assessment to the physician to obtain orders for an x-ray of the left shoulder after a fall incident and new onset of pain for 1 of 3 residents (R5). This failure resulted in R5 continued complaints of pain and being assessed by the physician 2 days post before an x-ray was ordered with results of an acute complete fracture of distal left clavicle.

Findings include:

On 3/21/19 at 3:45pm, V5 LPN (licensed practical nurse) stated that V5 did not witness R5's fall out of wheelchair on 3/2/19 but heard R5 call out for help. V5 stated that R5 does not have any upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014906	A. BUILDING: _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT ARIA	4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

body strength, can't support self, if R5 leans forward in wheelchair R5 will fall. V5 stated that head to toe assessment was done, R5 complained of left shoulder pain after the incident and the following day.

On 3/22/19 at 9:30am, V8 (attending physician) stated that V8 was informed R5 complained of shoulder hurting but wasn't clear on which shoulder was injured. V8 stated that V8 spoke with R5's nurse the following day regarding R5's arm. V8 stated "R5 is using arm, it did not sound like a big deal". V8 stated that V8 assessed R5 on 3/4/19 and ordered x-ray of left shoulder, and narcotic pain medication. V8 stated that R5 refused to go to dialysis on 3/4/19 due to left shoulder pain.

On 3/22/19 at 4:00pm, V7 LPN stated that R5 complained of left shoulder pain after the incident. V7 stated that V7 notified V8 (attending physician) regarding fall, and requested x-ray of left shoulder. V7 stated that V8 stated V8 would be in facility the following day to assess R5 and decide at that time if x-rays were needed.

Review of R5's fall event, dated 3/2/19, notes at 5:28pm R5 was riding in motorized wheelchair in the hallway and was observed bending over and fell out of wheelchair. Assessment notes weakness to both upper extremities. R5 complained of pain to left shoulder. ROM (range of motion) painful. It also notes 'nothing relieves the pain'. R5's physician was notified, an x-ray was requested due to pain in left shoulder, orders received for INR (international normalized ratio) only.

Review of R5's medical record notes the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014906	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT ARIA	4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 On 3/2/19 at 5:48pm, V5 LPN (licensed practical nurse) informed V7 (LPN) that R5 fell out of wheelchair. R5 stated "tried to pick something off floor and lost balance and landed on left shoulder and left arm. R5 complained of left shoulder pain upon movement. V8 (attending physician) notified, asked if x-ray to be done, V8 stated "get prothrombin time and INR (international normalized ratio) tomorrow and call results to V8, and V8 will then decide on x-ray of left shoulder and arm". On 3/3, R5 complained pain in left arm and shoulder. V8 stated V8 will be in facility to evaluate R5 tomorrow and assess whether R5 needs to have an x-ray done. On 3/4 at 3:43am, R5 refused to go to scheduled dialysis appointment. On 3/4 at 10:44am, V8's documentation notes R5 fell two nights ago and must have struck left shoulder because it hurts. It has continued to hurt since then. R5 did not go to dialysis today because of shoulder pain. On exam, R5's left lateral clavicle very tender. Left shoulder abduction (movement of arm away from body) is limited to 80 degrees. Right arm abduction extends to 90 degrees. On 3/4/19 at 2:00pm, STAT x-ray done, and results faxed over to V8. Review of R5's medical record, dated 3/4/19, notes R5 was seen by V8 (attending physician) with order to obtain x-ray of left arm, and shoulder STAT (emergently). R5 continued to complain of pain to left upper extremity. X-ray notes an acute complete fracture of distal left clavicle. V8 made aware with order for scheduled hydrocodone/acetaminophen (pain medication) and continue to monitor for pain.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014906	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT ARIA	4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 Review of R5's hospital medical records, dated 3/4/19, notes R5 arrived at hospital at 9:46pm. X-ray of R5's left shoulder notes vertical fracture of the distal third left clavicle. (B)	S9999		