STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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 Investigation 1880658/IL99922 1880678/IL99943 1880944/IL100243	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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S9999	Continued From page 1	S9999		

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

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 are not met as evidenced by:

Based on record review and interview, the facility failed to monitor blood glucose levels as ordered for one of three residents (R2) and failed to notify the physician of elevated blood glucose level(s) for two of three residents (R2, R13) reviewed for change in condition in a sample of 14. On 1/21/18, R2 was admitted to the hospital with DKA (Diabetic Ketoacidosis) due to critical blood glucose level of 694.

Findings include:

1. R2's POS (Physician Order Sheets) include: (1/14/18) blood glucose check before meals and at bedtime.

On 1/21/18 at 10:24pm, R2's blood sugar was documented to be 450mg/dl (milligrams/deciliter).

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S9999	Continued From page 2 On 1/22/18, R2's blood glucose level was not documented (before breakfast). R2's (1/21/18) nursing progress notes state: 10:57pm, Blood sugar 450. [There is no documentation the physician was notified]. (1/22/18) 9:30am, Resident observed with a mental status change. Blood sugar reading high. Resident physician in building came and assessed the resident. Received orders for resident to be sent to hospital. R2's (1/22/18) physician progress notes state: Upon evaluation the patient was confused, minimally responsive. Glucose reading "high." Patient glucose in 300-400's range last week and no medical doctor was notified. Altered mentation, acute. Likely 2/2 DKA given glucose >500. Unclear why medical doctor was not called during the week given her readings in the 400's. R2's (1/26/18) re-admission progress notes state resident presented to the emergency room with DKA; upon presentation her blood glucose level was 694. On 4/2/18 at 12:25pm, V15 (Case Manager) stated, "We usually contact the doctor if the blood sugar is below 70 and over 250." V15 reviewed R2's EMR (Electronic Medical Record) and stated, "The (1/21) 9am blood sugar was 300, 17:32 (5:32pm) was 300 and 22:24 (10:24pm) was 450. On the day in question looking at the nursing notes per the documentation, it looks like they did not notify. It looks like the next day after the doctor came in he was notified." 2. R13's POS includes (11/21/16) blood glucose check daily; call medical doctor if below 60 or above 250. On 3/18/18, R13's blood glucose was	S9999		

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S9999	Continued From page 3 350. There is no documentation that the doctor and/or nurse practitioner were notified. The change in resident's condition policy and procedure (10/03) includes but is not limited to: It is the policy of the facility, except in a medical emergency, to alert the resident's physician/nurse practitioner of a change in condition. Nursing will notify the resident's physician or nurse practitioner when: it is deemed necessary or appropriate in the best interest of the resident. Communication with the physician/nurse practitioner will be documented in the resident's medical record. (B) 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a	S9999		

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S9999	Continued From page 4	S9999		

Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This requirement is not met as evidence by:

Based on record review and interview, the facility failed to ensure that IDPH (Illinois Department of Public Health) was notified of a reportable injury within regulatory requirements for one of five residents (R3) reviewed for falls, in a sample of 14.

Findings include:

On 4/3/18 at 9:35am, surveyor inquired about the regulatory requirements for reporting serious injury V1 (Administrator) stated, "As soon as we know about it. We send a report to IDPH within 24 hours. We investigate and within 7 days or 5 working days, the follow-up is sent to IDPH."

R3's incident report form indicates an event occurred on 7/6//17 at 7:11am. R3 sustained a small laceration to left side of head and was transferred to the hospital for evaluation and treatment.

R3's (7/13/17) follow-up investigation faxed to IDPH includes "staples to left back of head," however it was not received until 3:53pm and the injury was incurred at 7:11am.

The fall policy and procedure (8/13) includes but

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S9999	Continued From page 5 is not limited to: All incident and accident with serious physical injury will be reported 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. (No Violation Issued)	S9999		

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F 000	INITIAL COMMENTS Complaint Investigation 1880431/IL99681 - F657, F689 1880658/IL99922 - F558, F684, 1880678/IL99943 - F657, F689 1880839/IL100120 - No deficiency 1880944/IL100243 - F684 1881094/IL100400 - F550, F558, F677, F842 1881294/IL100626 - No deficiency 1881449/IL100790 - F558 1882077/IL101480 - F558, F677 1880760/IL100041 - No deficiency 1881741/IL101107 - No deficiency 1881773/IL101145 - No deficiency	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		

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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide notification of room change to one of four residents (R5) reviewed for residents rights in a sample of 14. Findings include: The facility census affirms that R5's room was changed on 2/6/18. On 3/21/18 at 10:10am, V1 (Administrator) stated that R5 "was recently moved from a private room to a semi-private room; he was not happy with that. I explained that we moved him to isolate a patient there." On 3/21/18 at 10:14am, R5 stated "It was unfair that I was not informed of the room change. They	F 550		

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F 550	Continued From page 2 tried getting me up to move me to another room; they didn't tell me why. It was explained 5 to 6 days later. They said somebody was isolated so they took me outta there." The transfers within the facility policy and procedure (11/17) includes but is not limited to the following: Explain the reason for room change to the resident. Document the transfer in the progress notes. R5's February 2018 progress notes were reviewed. There is no documentation that R5 was notified of the 2/6/18 room change.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that call lights were within reach for two of four residents (R10, R11) reviewed for accommodation of needs in a sample of 14. Findings include: 1. On 3/21/18 at 10:38am, R10 was sitting upright in a chair adjacent the bed. R10's call light was on the floor and out of reach. 2. On 3/21/18 at 10:42am, R11 was laying in bed;	F 558		

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F 558	Continued From page 3 her call light was in the trash can and out of reach. R11 stated that when she needs assistance she uses the call light. Surveyor inquired if R11 could reach the call light. R11 responded "No." The call light policy and procedure (revised 11/14) includes but is not limited to: Residents capable of using the call light appropriately will have their call light accessible at all times.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

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F 657	Continued From page 4 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise the care plan interventions (post fall) for one of five residents (R1) reviewed for falls. Findings include: R1's occurrence reports affirm that R1 fell on 1/15/18 and 1/16/18. Both occurrence reports include general follow-up procedures which state: Care plan updated "N/A" (not applicable). R1's fall risk care plan includes prevention interventions created on (1/7/18). R1's fall risk care plan was not revised post aforementioned fall(s). On 4/2/18 at 3:05pm, V17 (Care Plan Coordinator) stated that the Nurse Manager revises the care plan (post fall) with new interventions for that particular patient. V17 reviewed R1's care plan and affirmed that it was not revised post aforementioned fall(s). The fall policy and procedure (revised 7/14) includes but is not limited to: All resident falls shall be reviewed and the resident's existing plan of care shall be evaluated and modified as needed.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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F 677	Continued From page 5 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide ADL (Activities of Daily Living) care to three of five dependent residents (R5, R11, R14) reviewed in the sample of 14. Findings include: 1. On 3/21/18 at 10:14am, R5 stated that when he requests assistance with ADL care, several CNA's will come to the room and state that they are not assigned to him. About 20-30 minutes transpire between each CNA (Certified Nursing Assistant) and the assigned CNA is not aware that he needed help. 2. On 3/21/18 at 10:42am, surveyor entered R11's room. A strong urine odor was noted. V5 (CNA) affirmed that she was assigned to R11. R11's incontinence brief was saturated with urine, the pull pad and fitted sheet were visibly wet. Surveyor stated that the linens are wet all the way through. V5 responded "Yeah." Surveyor inquired when R11's incontinence brief was last changed. V5 replied, "I'm not sure; they're short so they pulled me down from 4th floor at 6:30am. This is the first time I changed her." 3. On 9/30/18 at 9:05am, surveyor inquired about the incontinence care provided by staff. R14 did not respond. V12 (Friend) stated (R14) hadn't been cleaned good enough and was complaining of hemorrhoid pain so she cleaned her up. The (10/03) ADL policy and procedure includes	F 677		

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F 677	Continued From page 6 but ia not limited to: A program of assistance and instructions in ADL skills is care plan and implemented. Showers or baths are scheduled and assistance is provided when required. The incontinence care policy and procedure (revised 7/14) includes but is not limited to: Incontinence care is provided to keep residents as dry, comfortable and odor free as possible.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to monitor blood glucose levels as ordered for one of three residents (R2) and failed to notify the physician of elevated blood glucose level(s) for two of three residents (R2, R13) reviewed for change in condition in a sample of 14. On 1/21/18, R2 was admitted to the hospital with DKA (Diabetic Ketoacidosis) due to critical blood glucose level of 694. Findings include: 1. R2's POS (Physician Order Sheets) include: (1/14/18) blood glucose check before meals and at bedtime.	F 684		

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F 684	Continued From page 7 On 1/21/18 at 10:24pm, R2's blood sugar was documented to be 450mg/dl (milligrams/deciliter). On 1/22/18, R2's blood glucose level was not documented (before breakfast). R2's (1/21/18) nursing progress notes state: 10:57pm, Blood sugar 450. [There is no documentation the physician was notified]. (1/22/18) 9:30am, Resident observed with a mental status change. Blood sugar reading high. Resident physician in building came and assessed the resident. Received orders for resident to be sent to hospital. R2's (1/22/18) physician progress notes state: Upon evaluation the patient was confused, minimally responsive. Glucose reading "high." Patient glucose in 300-400's range last week and no medical doctor was notified. Altered mentation, acute. Likely 2/2 DKA given glucose >500. Unclear why medical doctor was not called during the week given her readings in the 400's. R2's (1/26/18) re-admission progress notes state resident presented to the emergency room with DKA; upon presentation her blood glucose level was 694. On 4/2/18 at 12:25pm, V15 (Case Manager) stated, "We usually contact the doctor if the blood sugar is below 70 and over 250." V15 reviewed R2's EMR (Electronic Medical Record) and stated, "The (1/21) 9am blood sugar was 300, 17:32 (5:32pm) was 300 and 22:24 (10:24pm) was 450. On the day in question looking at the nursing notes per the documentation, it looks like they did not notify. It looks like the next day after the doctor came in he was notified."	F 684		

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	145977	A. BUILDING _____ B. WING _____	C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

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F 684	Continued From page 8 2. R13's POS includes (11/21/16) blood glucose check daily; call medical doctor if below 60 or above 250. On 3/18/18, R13's blood glucose was 350. There is no documentation that the doctor and/or nurse practitioner were notified. The change in resident's condition policy and procedure (10/03) includes but is not limited to: It is the policy of the facility, except in a medical emergency, to alert the resident's physician/nurse practitioner of a change in condition. Nursing will notify the resident's physician or nurse practitioner when: it is deemed necessary or appropriate in the best interest of the resident. Communication with the physician/nurse practitioner will be documented in the resident's medical record.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement fall prevention interventions for one of five residents (R1) reviewed for falls, in a sample of 14. Findings include:	F 689		

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F 689	Continued From page 9 R1's diagnoses on the face sheet include repeated falls. On 3/21/18 at 10:50am, R1 was sitting upright in a wheelchair. A personal alarm was dangling from R1's wheelchair, however it was not attached to the resident. Surveyor inquired about R1's fall prevention interventions. V4 (Minimum Data Set Coordinator) stated, "I would have to check her care plan to be specific but for now she has an alarm attached." Surveyor inquired if the alarm was attached to R1. V4 inspected her alarm and stated "No it was not." The falls policy and procedure (revised 7/14) includes but is not limited to: Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk.	F 689		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		

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F 842	Continued From page 10 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 11 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the resident roster was accurate for nine of 13 residents (R1, R5, R7, R8, R9, R10, R11, R12, R13) in the sample. Findings include: On 3/21/18 at approximately 9:50am, V3 (Nurse Manager) provided the resident roster. The initial tour was subsequently conducted from 10:02am through 11:05am. The following was noted: R5's room/bed was documented on the 100 unit, however at 10:10am, V1 (Administrator) affirmed that R5 was assigned to the 200 unit. R7's room/bed was documented on the 400 unit, however R7 was assigned on the 300 unit. R13's room/bed was documented on the 400 unit, however R13's room was assigned on the 200 unit. R1, R8, R9, R10, R11 and R12 were not inclusive on the roster but were observed in the building. On 3/22/18 at 10:55am, V6 (Admissions) stated, "The census is updated each morning based on what transpired the night before, roughly about 9am."	F 842		

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F 842	Continued From page 12 The transfers within the facility policy and procedure (11/17) includes but is not limited to the following: document room change on appropriate census forms.	F 842		