STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014641	A. BUILDING: _____ B. WING _____	C 12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT MIDWAY	4437 SOUTH CICERO CHICAGO, IL 60632

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S 000	Initial Comments Complaint# 1988563/IL117706 & Facility Reported Incident to 11/10/2019 - IL117612 Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.2900d)2) 300.3100d)2) 300.3240a) 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 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. Restorative measures shall include, at a minimum, the following procedures: 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999	Attachment A Statement of Licensure Violations	

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and assistance to prevent accidents.

Section 300.2900 General Building Requirements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)

Section 300.3100 General Building Requirements-elopements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to supervise and conduct 15 minute checks for a resident who previously attempted to exit by a window, failed to secure a window in a different manner to prevent a resident from exiting when the resident demonstrated he was able to open it to exit, and failed to act on a psychiatric consultant suggestion to move a resident to a lower floor for one of three residents (R7).

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Findings include:

R7 was admitted 2/20/19 with diagnosis of weakness, lack of coordination, alcohol abuse, dysphagia, atrial fibrillation, degeneration disease of nervous system, alcohol dependence with alcohol induced dementia, encephalopathy.

R7's Care plan initiated/created 11/8/19 had identified problem as: anxiety r/t (related to) change lifestyle, cognitive deficit or decline, feelings of powerlessness as evidence by feeling down expressions of what appears to be unrealistic fears, recurrent statement that something terrible is going to happen; interventions document mood indicators, explain procedures, explore coping skills that have worked in the past, psychiatric evaluation and follow up. Impaired thought processes, judgment and decision making r/t dementia created. 3/22/19 interventions included: provide homelike environment, provide cues, use task segmentation. Another identified problem: Elopement risk disoriented to place, impaired safety awareness, wanders aimlessly initiated 2/28/19, interventions as followed: monitor for fatigue, monitor location every 60 minutes, wander alert.

R7's nursing progress note dated 11/1/19 at 2:11 PM by V23 (nurse) documents, "Writer called to resident room observed resident with window open looking outside, states he wanted to get some fresh air. Writer educated resident on safety, also educated resident on the importance on using the call light for any assistance. "

Facility reportable incident report dated 11/14/19 documents: Facility was notified on 11/12/19

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approximately 4:30 PM from unknown caller that they witnessed someone fall out the window and had called 911. Receptionist notified ADON (assistant director of nurses) who was at front desk at time went outside and found resident on the ground alert and called 911.

On 11/21/19 at 2:04 PM, V 23 (nurse) stated, an unknown staff reported that R7 had opened the window in his room. The window was open, but the resident was not by the window when she went into the room and R 7 said he was trying to get fresh air. V 23 stated the window was open enough for you to stick your head out and the window screen was missing. V 23 said she thought the lock was on the window. V 23 said she informed social services, management and maintenance about incident 11/1/19.

R7's social service note dated 11/1/19 by V 22 (Social Worker) documents, Writer was informed by staff that R7 was observed in his room with the window open and his head under the blinds. R7 is alert and oriented x 2 with periods of poor judgment and periods of intermittent confusion. R 7 was educated on the importance of safety at and around the window. R7 voiced an increase of feeling of depression, sleepiness and anxiety due to wound on foot and increased yelling nearby his room. Nurse Practitioner and nursing team explained treatment plan to R7 who verbalized acceptance and understanding of plan. R7 stated knowing what was going to happen with his foot made him feel much better. Staff to continue check in with R 7 and offer reminders about upcoming treatments and encouragement. R7 is being followed by psych and a referral made for follow up.

On 11/21/19 at 1:17 PM, V22 (social worker)

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stated staff reported that R7 was at the window with his head under the blinds 11/1/19. V22 stated she did not witness incident and unable to recall if window lock was removed or secure. V22 stated she talked to resident on 11/1/19 about incident but unable to recall if she informed maintenance about incident or to check windows. V 22 stated she was unable to recall any interventions for R7 after incident on 11/1/19 besides referral to psych services.

R7's nurse practitioner (NP) notes dated 11/1/19 by V20 (NP) documents, "Patient seen ambulating on unit. Later, nursing notified ADON and NP that patient was standing close to open window and was upset about his foot. When questioned, he stated he was really worried about his foot, but stated he did not want to hurt himself, he was trying to get fresh air."

On 11/21/19 at 3:12 PM, V20 (NP) stated she spoke to R7 in the social service office and did not witness resident by the window. V20 stated R7 was upset about his foot and stated he was not going to hurt himself. V20 stated she was unaware of any circumstances around what window or how the window was open, just that R7 was observed by an open window.

On 11/22/19 at 10:11 AM, V21 (maintenance) stated on 11/1/9 he had to replace a window screen in R7's room after staff called to inform. V21 said window lock was in place and he had to remove the lock to put the screen back. The screen was on the ground in front of the building. V21 stated the window lock was secure after replacing screen and no other screens were missing on that side of the building. V21 stated that V22 usually checks window locks and will report to maintenance as needed.

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R7's psychiatric progress note dated 11/5/19 by V19 (psych NP) documents: under diagnosis comments, "Rule out depressive symptoms, increased anxiety, history of alcohol abuse, restless, demanding." Under interdisciplinary team observations documents, "Social service refers patient for evaluation. Patient reportedly opened the window of his room. Denies depressive symptoms. Denies suicidal ideations and homicidal ideations. High risk for elopement. Patient stated "am not suicidal, send me to 2nd floor." Under suicide protective factors comments documents, "Patient reported to be risk for elopement and had opened the window in his room on the fourth floor. He denies feeling depressed at the moment, denies suicidal ideations and homicidal ideations, denies past suicidal attempts, anxious, restless, fixated on being transferred to lower level-1st or 2nd floor. Claimed to be treated better on the lower floors. Report poor sleep and requesting for medications." Under additional comments documents, "Adjustment disorder with anxiety, start Buspar and Melation. "Consider moving patient to lower floor and still maintain patient on elopement precaution, continue to provide supportive, consistent and structured environment. I discussed my findings regarding medications started and the possibility of moving the patient to lower level floor for safety reason with V22 (social worker) and nurse.

On 11/21/19 at 11:20 AM, V19 (psych NP) stated he was referred to see R7 by social worker to see if R7 was a risk to himself after R7 had removed the lock from his window in his room and had opened the window. He said resident was not suicidal but high elopement risk and suggested to move R7 to lower floor for safety reasons. V19

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said he was not aware of facility not following recommendations related to room change. V19 stated he would have wanted R7 evaluated again and possibly sent to hospital.

R7's social service note dated 11/6/19 by V22 (social worker) documents, "R7 continues to exhibit increase restlessness and anxiety. Staff reports that R7 states other are calling him names, but staff have not observed this. R7 was moved to room another room on the 4th floor due to this matter. R7 attempts to get on the elevator, he is easily redirected but only for short periods. He wears an electronic monitoring device for safety. R7 was seen by psych NP yesterday who verbalized high risk for elopement. Due to R7 verbalizing desire /attempt to leave unit/facility, 15 minutes checks in place. Nursing aware. "

On 11/21/19 at 1:17 PM, V22 (social worker) stated that after V19 (Psych NP) saw R7 and was informed of high elopement risk informed V19 (Psych NP) would consider moving R7 to lower floor but probably would not happen due to R7 increased anxiety on second floor in the past. V22 stated she initiated 15 minutes checks on the resident because of V19 recommendations. V22 stated 15 minutes check for R7 included a visual check of the resident and staff signing at appropriate time interval on the sheet.

Facilities 15 minute checks dated 11/12/19 documents time intervals every 15 minutes with staff initials next to corresponding time stopping at to 4:00 -4:15 PM.

On 11/20/19, the surveyor reviewed the facility video surveillance on unit on 11/12/19 from 3:00-4:35 PM which shows R7 on unit. R7 was observed going in and out of his room, walking

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the hallways sitting on common bench in hallway. Around 4:15pm, R7 was observed in the hallway. At 4:18 PM R7 entered his room. At 4:35, staff observed going into R7's room. No observations of staff entering R7's room prior to 4:35 PM.

R7's progress notes dated 11/12/19 at 5:30 PM documents, R7 observed on the ground.

On 11/21/19 at 1:21 PM V6 (maintenance) stated they check window locks monthly. Window locks consisted of a screw that went through the window frame. Windows were able to be opened about 4 inches. V6 stated it appeared R7 had removed the window lock by pulling it out from the window frame. The screw was still in tack in the lock and staff found the lock on the floor near window after R7's incident on 11/12/19. V6 stated the locks are hard to take off but possible if force is applied.

Review of facility nursing schedule dated 11/12/19 for evening shift document, V 9 (CNA /certified nurse aide), V 11 (CNA), V 16 (CNA), V 17 (CNA), V 18 (CNA), V 12 (nurse) and V 10 (nurse). V16 and V9 were not on the unit at the time of incident.

On 11/20/19 at 3:56 PM, V10 (nurse) stated R7 was on 15 minutes checks. The nurse is responsible to see where the resident is at on the unit. V10 stated this was a new intervention for R7 and unsure why it was implemented. On 11/12/19, V10 stated she saw R7 in the hallway.

On 11/20/19 at 4:37 PM, V12 (CNA) stated not sure who R7 is or any interventions for R 7. V12 stated not assigned to R7 on 11/12/19.

On 11/22/19 at 12: 18 PM V17 (CNA) stated she

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was assigned to 4th floor unit and does not recall seeing R7. V 17 stated V9 (CNA) was assigned to R7. V17 said not familiar with unit and not aware of 15 minutes checks for R7.

On 11/22/19 at 10:44 AM, V18 (CNA) stated she was assigned on the side of unit and does not recall seeing R7. V18 said not familiar with unit or not aware of 15 minutes checks for R 7.

On 11/21/19 at 9:54 Am, V14 (nurse) stated R7 was on 15 minutes check because of being an elopement risk. Nurses are responsible for the checks and we need to visually see the resident.

R7's hospital record dated 11/12/19 document fractures of right femur (upper leg), right medial malleolus (right ankle), left calcaneus (heel), left medial and lateral malleolus (left ankle), open fracture of right hummers (upper arm), left radius (lower forearm), and bilateral pelvic bones. R7 died at hospital on 11/13/19.

R7's death certificate documents under cause of death multiple blunt force injuries and fall from height.

(A)