

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2020
NAME OF PROVIDER OF SUPPLIER SYMPHONY OF LINCOLN PARK		STREET ADDRESS, CITY, STATE, ZIP 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 0689 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, the facility failed to use a gait belt, as determined necessary by the facility's safe patient lifting policy, during a transfer from R1's wheelchair to bed, resulting in the resident sustaining a laceration requiring sutures. This failure affected one resident (R1) out of three residents reviewed for accidents in a sample of 4 residents. Findings Include: On 7/22/2020 at 2:25 PM, R1 stated, Before I was transferred to my bed, I told the CNA I wanted to stand and pivot into the bed and she wouldn't listen to me. The CNA picked me up out of my wheelchair and lifted me over to the bed. When she lifted me over to the bed my right leg got cut on my wheelchair bracket on the right side. R1 stated, The CNA that transferred me did not use a gait belt. On 7/21/2020 at 12:50 PM, V6 (Certified Nursing Assistant) stated, After I put R1's legs into the bed I saw blood on my glove and I saw the cut on her right lower leg. V6 stated, I think R1 rubbed her leg against the wheelchair when she was transferring to the bed. V6 stated, I transferred her by myself because I could not find anyone to help me. I did not use a gait belt when I transferred R1. On 7/21/20 at 1:40 PM, V7 (Registered Nurse) stated, V6 told me that when she was transferring R1 to bed, R1's leg got caught into something on the wheelchair and it caused a cut. V7 stated, V6 did not ask me for help with transferring R1. I don't know if she asked the other CNA working for help. V7 stated, CNAs are supposed to use gait belts when doing any type of resident transfer to prevent injuries. On 7/22/20 at 11:50 AM, V1 (Administrator) stated, V6 should have used a gait belt when transferring R1 from her wheelchair to the bed. Our policy on safe patient lifting states gait belt usage is mandatory for all resident handling with the exception of bed mobility and medical contraindications. On 7/22/2020 at 12:19 PM, V9 (Nurse Practitioner) stated, I am aware that R1 got a laceration on her right lower leg in June during a transfer. I was notified after it happened and I am aware that she received 10 stitches for the laceration at the hospital. V9 stated, R1 has been getting ordered wound care for the laceration and it is almost healed. R1's hospital records dated 6/24/2020 read: Laceration was cleaned thoroughly and debrided, good granulation tissue, no signs of infection, repair without difficulty. 8 centimeter (CM) laceration noted to right calf. Repaired with ten 3.0 Nylon. V6 signed the safe patient lifting policy on 1/11/2019. The facility's safe patient lifting policy reads: Gait belt usage is mandatory for all resident handling with the exception of bed mobility and medical contraindications. The gait belt will be considered a part of the certified nursing assistant's uniform. An ambulating belt may be used as an appropriate substitute. V6 signed the gait and back support procedure acknowledgement form on 1/11/2019. The gait and back support procedure acknowledgment form reads: The advantage, protection, and safety through the use of gait and back support belts during transfers have been fully explained to me during my orientation. I understand that gait belts are a requirement for all personnel involved in transferring or lifting of residents.</p>		
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.