

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145995	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2015
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF MIDWAY			STREET ADDRESS, CITY, STATE, ZIP CODE 4437 SOUTH CICERO CHICAGO, IL 60632		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 441 SS=D	<p>Complaint Investigation:1586375/IL81646 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of</p>	F 441			

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 441	<p>Continued From page 1 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow policy regarding hand hygiene for one of three residents(R8) in the total sample of 9, reviewed for infection control.</p> <p>Findings include:</p> <p>On 12/1/15 at 2:55pm E4 (Certified Nurse Aide) transported R8 by wheelchair to his room, E4 stated in part, the resident just returned from a day program I will check him and put him into bed. E4 applied gloves to remove R8 ' s coat and clothing and transferred R8 to bed by a mechanical lift with assistance from E9 (Certified Nurses Aide). E4 gathered a wash basin filled with water and a washcloth with the same gloves on. E4 removed R8 ' s incontinence brief and provided perineum care, applied a new incontinence brief without changing gloves. E4 went into the bathroom to empty the water from the wash basin and removed gloves without performing hand hygiene before or after incontinence care. E4 proceeded to exit the room with the soiled linen bag. Surveyor asked E4 when should hand hygiene be performed. E4 stated in part, I should wash my hands before and after patient care. I totally forgot to use the hand sanitizer inside the residents room.</p> <p>On 12/2/15 at 10:30am E2 (Director of Nursing) stated in part, when providing incontinence care the staff should wash their hands before and after care.</p>	F 441			

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F 441	Continued From page 2 The facility policy " Hand washing/cleansing " dated 5/05, review date 7/14 documents in part, Proper hand washing/cleaning is necessary for the prevention and the transmission of infectious disease. #1. Hand washing /cleaning is done before and after resident contact, before and after any procedure. The facility policy " Incontinence Care " (dated 10/03) revision date (7/14) documents in part, #2. " wash hands and don gloves "	F 441		