STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001689	A. BUILDING: _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BRONZEVILLE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S 000	Initial Comments Complaintt: #2084826/IL124065 No deficiency Facility Reported Incident of 7/29/2020/IL125531- F689G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)6) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 and assistance to prevent accidents.

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 requirements were not met as evidenced by:

Based on interview and record review the facility

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S9999	Continued From page 2	S9999		

failed to ensure safe resident self-administration of medication, provide nursing education related to self adminstering medication, and monitor after methadone medication administration for a newly admitted resident on daily methadone with a history of substance abuse for 1 (R1) of 3 residents reviewed for supervision. This failure resulted in the resident falling and sustaining a laceration on the left eye leading to hospitalization.

Findings include:

71-year-old resident admitted to facility on 7/28/20 with diagnosis of Hypertension, Hyperlipidemia, Anemia, Opioid Abuse, Cocaine Abuse, and history of CVA. R1 admitted to the facility with orders for Methadone HCL concentrate (methadone) orally one time per day. R1's History and Physical provided by the facility from the preadmission referral packet notes R1 had been admitted to the hospital on 7/17/20 for cerebrovascular accident, heroine abuse on methadone, and cocaine abuse with a positive screen on hospital admission.

In an interview with V3, Social Services Director, on 7/31/20 at 12:50PM V3 said she met with R1 the morning of 7/29/20 before he went to his methadone clinic appointment. V3 said R1 told her about his struggle with substance abuse in the past and said the methadone had been working for him.

In an interview with V4, Social Service, on 7/31/20 at 11:43AM ,V4 said she accompanied R1 to an appointment to pick up methadone from the clinic on 7/29/20 and left the facility about 1:15PM. V4 said she remained with V4 during the appointment and the clinic counselor said R1

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S9999	Continued From page 3	S9999		

could have 2 weeks worth of methadone. V4 said she witnessed R1 drink one dose of his methadone before they left the clinic. V4 said on return to the facility R1 had 13 bottles of methadone in his possession. V4 said she last saw the methadone after she observed R1 place the bottles in the lock box around 2:40PM.

In an interview with V5, Certified Nursing Assistant (CNA), on 7/31/20 at 12:30PM, V5 said she was assigned to R1 on 7/29/20 3:00-11:00PM shift. V5 did not know anything about the lock box in the room and was not given any special instructions for providing care to R1. V5 said when she checked on R1 around 6PM "he was sleepy, he was groggy." V5 said she reported to the nurse when she saw R1 on the floor around 8:30PM. V5 said R1 had blood on his face and body and she called for the nurse. V5 said the nurse came and did an assessment and wiped R1's laceration.

In an interview with V6, Nurse, on 7/31/20 at 2:20PM, V6 said on 7/29/20 I knew R1 went to the methadone clinic and when he returned on my shift he went to his room. I spoke with him and introduced myself at the start of my shift. V6 said the report she received about R1 was that he had 13 bottles of methadone . Later that shift, she was notified he was on the floor. V6 said she did not see the 13 bottles of methadone. V6 said she did not know how the methadone was put in R1's lock box and was not aware that R1 had the methadone in the lock box. V6 said she saw him around 7:30PM and gave him his evening medications and she noticed he was "very sleepy." V6 said when she assessed him on the floor, she saw R1 was holding a bag with his methadone bottles, in his hand. V6 said R1 told her he drank methadone before his fall. V6 said

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S9999	Continued From page 4	S9999		

she took R1's vitals after he had fallen, but not prior to the fall. V6 said she did not know R1's baseline health status. V6 obtained a physcician order to send R1 to the hospital for further evaluation and for treatment of the open area on the left side of his left eye.

In an interview on 7/31/20 at 2:07PM V7, Nurse, said the nurses do medication education and discuss adverse effects of medication with the resident. V7 said the nurse documents if they did any education with the resident. V7 said the assigned nurse should monitor the resident when they take methadone.

In an interview with V2, Director of Nursing, on 7/31/20 at 11:10AM V2 said when a resident returns from the methadone clinic, the resident is given a key to store his methadone in the box. R1 was given a box and a key. At 12:20PM V2 said the facility has nothing to record the count of methadone a resident receives from the clinic. At 1:40PM V2 said we can only ask the resident to show us the lock box to see the medication inside because the methadone is the responsibility of the resident.

In an interview on 7/31/20 at 3:34PM V8, Physician, said it's hard to say if R1 took too much methadone and if that caused the fall. Regarding methadone clinic residents and self-administration V8 said he expects the facility to follow the policies they have.

In an interview on 7/31/20 at 1:15PM V9, Clinic Counselor, said the expectation is that the facility will monitor the patient. V9 said R1 has an opioid disorder.

In an interview on 8/4/20 at 10:47AM V11, Nurse

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S9999	Continued From page 5	S9999		

stated: " We don't give the residents who are treated by the clinic the methadone. They use a lock box, the resident will give their own medication. We are not to touch the methadone. We are not to touch, even if they can't open it."

In an interview on 8/4/20 at 11:49AM, V2, Director of Nursing, said the nursing department has a key for each lock box that is kept by me (V2). R1's methadone is in the lock box in the administrator office now. V2 said the purpose of policies is to educate and inform staff of proper procedures to do. V2 said procedures are established to establish a baseline for residents in a facility and baselines ensure the safety of the resident. V2 said nursing will do education of self-administration of medications. V2 said V5 is not a nurse and the Self Administration tool does not state education was done on it. V2 stated "As a prudent nurse I would ask the resident to show me the methadone. If assigned to a patient that returns from the clinic, I should ask about the methadone bottles, follow resident, watch the storing, check vitals, and that the resident remains stable." V2 said she would expect to be monitoring the resident for side effects during the shift and instruct the aide to help keep an eye on him. V2 said she would expect monitoring the resident's condition throughout the shift, at least every 2 hours. V2 did not comment on the policy for resident Self Administration of Medications and treatments regarding a 3-day supply of medication being dispensed initially, as stated in policy.

A record entry titled Self Administration of Medication dated 7/29/20 at 2:25PM signed by V2 does not include an education section.

A record entry titled Resident / Family Education

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S9999	Continued From page 6	S9999		

dated 7/29/20 at 3:09PM is signed by V4, Social Services. No nurse signature is included on the document.

A record entry titled Progress Note dated 7/29/20 at 8:15PM written by V6 reads observed on left side on the floor, resident is noted with an open area on left side of face by his eye. Vitals obtained 151/82, 71, 20, 97.1. Resident eyes round and responds slowly to light. Doctor gave order to send out for head injury and further evaluation.

A record entry of R1's blood pressure summary has an entry on 7/28/20 at 5:52PM of 109/68 and a second entry on 7/29/20 at 8:15PM of 151/82. No other blood pressure were noted documented in the resident chart.

A record entry titled Neuro Intensive Care Unit History and Physical dated 7/30/20 at 2:13AM reads the patient had laceration on left eye and was brought to hospital.

Review on 8/4/20 of the facility policy for Self Administration of Medications and Treatments, review date 06/2015, states, in part: Self administration of medications and treatments are done to prepare a resident for discharge and to help the resident maintain independence. Resident teaching will be performed by nursing staff. Nursing will dispense medication in a similar system that the resident was utilizing at home. A 3-day supply will initially be dispensed. It will be the responsibility of the nurse to check the number of oral medications and document to determine if the proper medications and dose was taken. Nursing will review the resident's compliance of self adminstered medication at the time of each medication pass. A care plan is for

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S9999	Continued From page 7	S9999		

resident who self administer (as written) and documentation should be present in the nursing notes of teaching related to self administration of the medications or treatments.

Review on 8/4/20 of the facility policy for Methadone Administration, review date January 2018, states nursing is not responsible for administration or documenting administration of medication.

(B)