

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/15/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SYMPHONY EVANSTON HEALTHCARE

**820 FOSTER STREET
EVANSTON, IL 60201**

(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 Investigations 1893695/IL103208 - F689 1893423/IL102927 - F675	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 1 of 2 Violations 300.610a) 300.1210b) 300.1210c)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
NAME OF PROVIDER OR SUPPLIER SYMPHONY EVANSTON HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 820 FOSTER STREET EVANSTON, IL 60201		
(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
S9999	Continued From page 1 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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 Regulations were not met as evidenced by: Based on interview and record review the facility failed to assess a significant change in condition and notify the physician order for one (R3) resident reviewed for resident assessment and transfer. This failure resulted in R3 being admitted to the local hospital and assessed with a diagnosis of pneumonia, pleural infusion, and empyema requiring admission to the intensive care unit (ICU) with insertion of two chest tubes.	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
NAME OF PROVIDER OR SUPPLIER SYMPHONY EVANSTON HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 820 FOSTER STREET EVANSTON, IL 60201		
(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	
S9999	Continued From page 2 Findings include: Record review on nursing progress note dated on 5/7/18 documents that the family was insisting to transfer R3 to the hospital due to bilateral feet swelling and low grade fever (99.1 F) On 6/13/18 at 3:45PM V12 (R3's daughter) stated, "On 5/7/18, I visited my mom and her condition was very bad. I was telling the facility to transfer my mom to the hospital as her symptoms were getting worse. She had shortness of breath, fever and lower extremity swelling was getting worse. V13 (Nurse Manager) told me that if we transfer my mother to the hospital R3's physician would get mad. After repeated requests they allowed me to take my mom to the hospital where she had to go through a thoracentesis to drain fluid from her right lung and had to insert chest tubes and was admitted to ICU." On 6/14/18 at 9:40 AM V13 (Nurse Manager and Dementia Coordinator) stated, "We treated R3 for back pain which was the resident's complaint. She had temperature of 99.1 F. Her edema was very mild. There were no signs and symptoms of shortness of breath. I called the resident's physician and informed physician of the family's request and he stated that if family want to take patient to hospital, let them take the patient to hospital" Review of the hospital record indicates that R3 was admitted to hospital on 5/7/18 due to fever and cough. Admitting diagnosis included pneumonia, pleural infusion, and empyema. Admission vital signs documented a temperature of 100.7 F and lab work indicated an elevated white blood cell (WBC) count of 16.5. Hospital	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
NAME OF PROVIDER OR SUPPLIER SYMPHONY EVANSTON HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 820 FOSTER STREET EVANSTON, IL 60201		
(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
S9999	Continued From page 3 chest X-ray dated on 5/7/18 indicated a fluid accumulation in right upper lobe (right lung) and right lower lobe airspace. Computerized Tomography (CT) of chest dated on 5/8/18 documented a moderate to large right lung pleural effusion. Pt was planned for IR (Interventional Radiologist) thoracentesis and was cancelled as R3 was combative. The hospital record documents that R3 subsequently underwent VATS (Video Assisted Thoracoscopic) decortication with placement of two right lung chest tubes and was admitted to ICU. On 6/13/18 at 3:45PM V12 stated, "They should have sent my mom to the hospital earlier than my visit to prevent complications." Facility presented policy on Change in Resident's Condition revised on 9/16 document: Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: a. There is a significant change in the resident's physical, mental or emotional status. (B) 2) Statement of licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/15/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SYMPHONY EVANSTON HEALTHCARE

**820 FOSTER STREET
EVANSTON, IL 60201**

(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
S9999	Continued From page 4 a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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 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	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
NAME OF PROVIDER OR SUPPLIER SYMPHONY EVANSTON HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 820 FOSTER STREET EVANSTON, IL 60201		
(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
S9999	Continued From page 5 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to implement effective fall prevention interventions to prevent and/or reduce the risk of frequent falls for two residents (R1, R2) reviewed for fall prevention interventions. This	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/15/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SYMPHONY EVANSTON HEALTHCARE

**820 FOSTER STREET
EVANSTON, IL 60201**

(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
S9999	Continued From page 6 failure resulted in (R2) being involved in a fall incident that required admission to the local hospital with diagnosis of a non-displaced fracture of the left pubic body extending to the inferior pubic ramus. Findings include: Record review on fall risk assessment (1/10/18) upon admission indicates that R1 was a moderate risk for falls and the facility initiated a care plan to prevent falls. Record review of the facility provided fall log indicates R1 had frequent falls that occurred on 1/26/18, 5/26/18 and 6/1/18. On 6/12/18 at 10:00 AM, observed R1 lying on a low bed with bed bolsters and low air mattress. A floor mattress was observed against sidewall. On 6/12/18 at 10:00 AM, R1 stated, "I fell out of bed four times. Last fall was on 6/1/18 and my lip was bleeding, chin was bruised and a bluish color on the left forehead. They were putting pillows on my side and placed chairs with the back support along the bed to prevent falls. They do not have side rails on the bed or use a bed alarm to prevent falls. Two weeks ago they transferred me to this room because it was closer to the nurse's station." On 6/12/18 at 11:50AM V3 (R1's family) stated, "R1 fell out of bed on 6/1/18. She hit her left forehead and her lips and legs were bleeding. She was sent to the hospital and a Computerized Tomography (CT) scan of the head did not show a fracture. They do not use side rails to prevent falls. They are using chairs with the back support touching the bed to prevent falls."	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/15/2018
NAME OF PROVIDER OR SUPPLIER SYMPHONY EVANSTON HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 820 FOSTER STREET EVANSTON, IL 60201		
(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
S9999	Continued From page 7 On 6/14/18 at 11:35AM V2 stated, "As we have had many incidences of a patient being trapped in the side rails and jumping over side rails, we are not using side rails. We consider a bed alarm as a restraint and that's why we are not using bed alarms. We encourage staff to make purposeful rounds to meet resident's needs as most of the falls are happening when a resident is trying to get something from their table/cabinet. But sometimes a fall is unavoidable. When R1 came back from the hospital we moved her to a room closest to nurse's station, bed bolsters were applied and placed on a low bed with a floor mattress." On 6/14/18 at 11:20 AM, observed R2 in activity room in a wheelchair talking to herself. R2 wasn't able to respond to the surveyor's questions. Record review on facility's fall log indicates that R2 falls occurred on 1/26/18, 2/18/18, 3/17/18, 3/23/18, 3/29/18 and 4/19/18. A review of the facilities state agency reported incidents documents that the facility reported an injury of unknown origin (R2) on 2/18/18. CT shows a non-displaced fracture of the left pubic body extending to the inferior pubic ramus. Record review on reportable indicates that R2 had a fall with injury on 2/18/18. Facility's post fall body assessment does not indicate any fracture. Next day R2 complained of pain and the facility administered pain medication. Physician assessed R2 on 2/22/18 and a CT was ordered. CT of the abdomen and pelvis indicated a new non-displaced mid left inferior pubic rami fracture. Record review on care plan revision indicates that	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/15/2018
NAME OF PROVIDER OR SUPPLIER SYMPHONY EVANSTON HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 820 FOSTER STREET EVANSTON, IL 60201		
(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	
S9999	Continued From page 8 documented falls for both residents no new documented fall interventions were included in the care plan to prevent frequent falls. Facility presented fall policy reviewed dated August 2014 document: Fall prevention guidelines for all residents upon Admission/Re-admission 3. Residents at risk for falls will have Fall Risk identified on the interim plan of care with interventions implemented to minimize fall risk. (C)	S9999			