IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 4, 2019

Illinois Corporation Service, Registered Agent
Symphony Jackson Square, LLC
801 Adlai Stevenson Drive
Springfield, Illinois 62703

RE: Complaint #: IL 107400
Survey Date: December 6, 2018
Docket #: 19-C0012
Violation Type: B Violation with Fine

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Symphony of Chicago West.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Symphony of Chicago West/December 6, 2018/19-C0012/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: SYMPHONY OF CHICAGO WEST COMPLAINT #: 0107400
LIC. ID #: 0053686
DATE COMPLAINT RECEIVED: 11/19/18 13:32:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	/

X The facility has committed violations as indicated in the attached*
__ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. SYMPHONY JACKSON SQUARE, LLC, D/B/A, SYMPHONY OF CHICAGO WEST, Respondent.	)))))))))	Docket No. NH19-C0012

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 6, 2018, at Symphony of Chicago West, 5130 West Jackson Boulevard, Chicago, Illinois 60644. On February 4, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$2,200.00**, as follows:

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1220b)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 4th day of February ,2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. SYMPHONY JACKSON SQUARE, LLC, D/B/A, SYMPHONY OF CHICAGO WEST , Respondent.	))))))))))	Docket No. NH 19-C0012

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Illinois Corporation Service
Licensee Info:	Symphony Jackson Square, LLC
Address:	801 Adlai Stevenson Drive Springfield, Illinois 62703

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 4th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 Statement of Licensure Violations Complaint Investigation: 1887516/IL 107400 - Licensure Violation	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)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. 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 practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

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.

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

These Regulations are not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure an effective pain management program. The facility failed to follow facility policy on pain management by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

1. Failing to determine and address the underlying cause of the pain
2. Failing to ensure that outside physician referrals were carried out
3. Failing to reassess, re-evaluate and implement individualized care plan interventions addressing new onset of pain
4. Failing to monitor effectiveness of treatment and interventions

These failures affected one resident (R1), out of 6 residents reviewed for pain in a sample of 7. R1 had a significant weight loss of 6.4% in one month, which, R1 had attributed to loss of appetite due to abdominal pain and discomfort. R1 was brought to the hospital by V9 (family) due to ongoing and unresolved abdominal pain for one month, was admitted, and had innumerable liver lesions with morphology consistent with metastatic disease, and abdominal and retroperitoneal lymphadenopathy per ultrasound and magnetic resonance cholangiopancreotopography (MRCP) results.

Findings include:

According to medical records, R1 is diagnosed with but not limited to epilepsy, hypertension, ethanol dependence, hyperlipidemia, major depressive disorder, abnormal results of liver function test, osteoarthritis, insomnia, migraine, cognitive communication deficit, abnormal gait, pain in left hip, acute kidney failure and history of displaced fracture.

R1's 11/15/18 hospital records documented that R1 presented with abdominal pain for 1 month and had intermittent vomiting for 1 week. It documented that SNF has given (R1) tramadol with no relief; R1 endorses occasional subjective night sweats, decreased appetite. Right upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

quadrant ultrasound on 11/14/18 shoes mild common bile duct dilatation, pericholecystic fluid and gallbladder thickening. MRCP showed innumerable liver masses and retroperitoneal lymphadenopathy concerning for metastatic disease versus primary multifocal liver malignancy.
11/19/18 - (R1) patient with known colon cancer, constipation.

R1's facility medical records were reviewed.

R1's nursing and medical progress notes documented
R1's nursing/medical progress notes documented the following:
On 9/14/18 at 19:41, naproxen sodium administered for pain for complains of abdominal pain, tenderness in bilateral lower quadrants on either side of the naval. At 22:28, V6 (Primary Physician) was notified regarding monitoring of abdominal pain.

On 9/15/18 at 5:56, naproxen sodium administered as needed for pain.

On 9/26/18, V7 (Nurse Practitioner) documented, R1 having intermittent nausea with 1 small episode of emesis 3-4 days ago and ongoing central/upper abdominal pain. V7 documents, (Calcium carbonate and peptobismol) taken without relief. V7 documented that R3's abdomen was slightly distended, possibly heartburn versus possible peptic ulcer and discontinued use of naproxen and started on PPI (proton pump inhibitor) and simethicone, if ongoing or symptoms worsen will set up gastrointestinal appointment. R1's medical records documented that R1 was given omerprazole daily and simethicone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

On 9/30/18 at 23:50, tramadol hydrochloride administered was administered for R1 but did not document location and type of pain and pain scale at time of medication administration.

On 10/1/18, V7 documented improvement in nausea but with ongoing decreased appetite and worsening abdominal pain, (R1) stating sharp shooting intermittent 7/10 pain to right upper quadrant that started yesterday morning. V7 documented that abdominal pain to right upper quadrant stabbing and (R1) very sensitive to light palpation; abdomen with slight distention, positive bowel sounds, possibly related to constipation. V7 documented that was unable to assess for hepatomegaly due to pain. V7 had ordered for KUB (Kidney Ureter Bladder) x-rays, CBC, CMP.

On 10/1/18, V8 (Dietary) also documented in dietary notes, "will follow up abdominal pain discomfort with (V7)."

On 10/3/18, V7 documented x-ray results = ileus. V7 documented that R1 stated minimal improvement in pain with pain medications, no change in type of pain and no change in decreased appetite. V7 documented, no change, slight improvement with tramadol, (R1) notified of kidneys, ureter and bladder x-ray results for mild colonic ileus and most likely cause of pain. It also documents that R3 was started on medication - metoclopramide to address the nausea/vomiting.

On 10/5/18, V7 documented that (R1) states improvement in abdominal pain but denies resolution. V7 documented R1 requesting for stronger pain medicine to eliminate abdominal pain. V7 documented abdominal pain ongoing but improved; described as discomfort instead of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

stabbing pain, tolerating clear liquids. V7 documented that (R1) was educated that stronger pain medication cannot be provided due to side effects of mobility paralysis, and to continue with metoclopramide, clear liquid diet and tramadol.

On 10/10/18, V7 documented that (R1's) abdominal pain is ongoing but continues to slowly improve and is tolerating clear liquid diet. No additional orders made.

On 10/10/18 at 20:26, tramadol hydrochloride administered was administered for R1 but did not document location and type of pain and pain scale at time of medication administration.

On 10/14/18 at 06:01, tramadol hydrochloride administered was administered for R1 but did not document location and type of pain and pain scale at time of medication administration.

On 10/26/18 at 18:52, V6 documented that (R3) complained of mild abdominal pain; Gastrointestinal system - slight distension, tender to light palpation in right upper quadrant

On 11/2/18 at 14:53, tramadol hydrochloride administered was administered for R1 but did not document location and type of pain and pain scale at time of medication administration.

On 11/3/18 at 22:04, tramadol hydrochloride administered was administered for R1 but did not document location and type of pain and pain scale at time of medication administration.

On 11/5/18 at 5:26, tramadol hydrochloride administered was administered for R1 but did not document location and type of pain and pain scale at time of medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

On 11/12/18 at 16:01, V8 documented weight history: (11/7/18) 158.4 pounds, (10/4/18) 169.3 pounds reflective of a 10.9 pound decline past month which triggers at of 6.4% significant weight decline. V8 documented that "R1 attributes weight decline to abdominal pain which at times on right side and other times left side and not much of an appetite due to abdominal discomfort."

On 11/14/18, R1 while out on pass with V9 (R1's family), R1 went to a (local hospital) emergency room and was admitted for unknown abdominal pain.

R1's medical records documented an order for hepatology consultation on 6/11/18 at 11:45am. R1's medical records did not document that R1 went to this appointment. V7's progress notes documented on 8/17/18 notes "Hepatitis C previously managed at outpatient unit - instructed nurses for follow up with hepatology." On 9/26/18, 10/1/18, 10/3/18, 10/5/18, V7 documents - "(Appointment) Pending." V1 (Administrator) and V2 confirmed during an interview on 12/5/18 at 2:00 pm that there was no evidence of going to hepatology appointments as ordered after April 2018, V2 stated that staff did not remember anything regarding hepatology appointments. R1's medical record did not document that R1 was referred to any gastroenterology (GI) specialist. V7 was interviewed and confirmed that V7 had wrote on NP notes regarding referral for R1 to be seen by GI but don't know how staff schedules these referrals. V7 also stated that it is staff who schedules appointments for hepatology referral and "not sure how they (staff) do that."

R1's current plan of care was reviewed. R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

care plan addresses hip pain and has identified interventions. R1's care plan did not identify R1's abdominal pain and did not document any related abdominal pain care plan goals and interventions. V2 confirmed that the care plan was not revised to include interventions addressing onset of abdominal pain, as care plan should have updated and revised.

R1's medical records documented comprehensive pain evaluations on 11/28/17 and 11/20/18. There were no documented pain assessments during on quarterly and with new pain onset. V2 stated that per facility policy, comprehensive pain evaluations should be completed on admission, readmission, quarterly, during change of condition and with new onset of pain but did not find any other documented comprehensive pain assessments for R1, other than the ones provided.

R1's 9/4/18 Minimum Data Set Assessment under section C0500 BIMS (Brief Interview of Mental status) result of 15/15 (Cognitively intact). According to V5 (Licensed Practical Nurse), R1 is alert and oriented to person, place, time and situation. R1 was interviewed in the room on 12/3/18 at 2:30 pm. R1 verbalized, "They (facility) are now much better with addressing my pain."

On 11/28/18 at 9:40 am, V9 (R1's family) was interviewed via telephone that R1 had been consistently complaining about abdominal pain for a long time and that it was not addressed and that the facility staff kept telling R1 that the x-ray result was negative. V9 stated that R1 informed V9 that R1 wanted to go to the hospital because pain is not going away and facility staff is not addressing it. V9 stated that V9 brought R1 to a local emergency room and after extensive testing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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	S9999		

R1 was diagnosed with cancer.

On 12/5/18 at 3:30 pm, V7 (Nurse Practitioner) was interviewed via telephone. V7 stated that R1 is alert and oriented x 3 and currently being treated for pain, as was recently diagnosed with metastatic colon cancer and liver and still waiting for results of biopsy. V7 stated that R1 complained of abdominal pain and an x-ray of abdomen was done which showed a result of ileus - which is a partial blockage of colon tract. V7 confirmed that x-ray will not reveal diagnosis of cancer. V7 stated that ileus was treated with clear liquid diet to rest the stomach and pain control. V7 stated that while assessing R1, R1 was having abdominal pain, slightly relieved but not improving. V7 stated that V7 had wrote for a referral R1 to be seen by GI for further evaluation and management of abdominal pain, but didn't know what had happened and "don't know how staff schedules these." V7 also stated that it is staff who schedules appointments for hepatology referral and "not sure how they (staff) do that." V7 confirmed that R1 did ask for stronger pain medications to alleviate the pain but V7 stated that R1 could not have stronger medication due to diagnosis of ileus, as the stronger pain medication slows down gastrointestinal tract and will make the symptoms worse. V7 was asked what the treatment plan was and stated that the plan at that time was to continue with clear liquid diet and pain control with tramadol. V7 stated that the next step would have been to do an ultrasound of the abdomen, which was not done because by the time V7 was going to see R1, R1 already went to the hospital.

The facility's revised 7/2014 policy on pain management documents under guidelines:
1. Pain management program is based on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 9	S9999		

facility wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does.
2. Pain management is defines as the process of alleviating the resident's pain a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals.
3. Pain management is a multidisciplinary care process that includes the following:
a. Observing for the potential for pain
b. Effectively recognizing the presence of pain
c. Identifying the characteristics of pain
d. Addressing the underlying causes of the resident's pain
e. Developing and implementing approaches to pain management
f. Identifying and using specific strategies for different levels and sources of pain
g. Monitoring for the effectiveness of interventions
h. Modifying approaches as necessary
5. Conduct an admission pain management observation upon admission to the facility, then complete the pain form if pain is identified and whenever there is a change in condition, and when there is onset of new pain and at least in stable chronic pain

Guideline:

1. The pain form and corresponding documentation is completed by nursing upon admission and readmission. The quarterly pain screen is completed quarterly.
6. Development of the care plan - based on the documentation, a pain management care plan will be developed, maintained or updated.
7. If pain has not been managed consistent with the resident's goals and needs, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 10 interdisciplinary team may need to reconsider current interventions and revise those interventions as needed; or if pain has been maintained or resolved, the nursing staff will work with the physician to taper or discontinue analgesics. (B)	S9999		