Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001333	A. BUILDING: ____ B. WING ____	04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY ENCORE	**2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608**

(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 ANNUAL CERTIFICATION AND LICENSURE	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.625b) c)1)2) f)1 Section 300.625 Identified Offenders b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. f) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements: 1) The facility shall inform the appropriate county and local law enforcement offices of the identity of identified offenders who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense who are residents of the facility. If a resident of a licensed facility is an identified offender, any federal, State, or local law enforcement officer or county probation officer shall be permitted reasonable access to the individual resident to verify compliance with the requirements of the Sex Offender Registration Act, to verify compliance with the requirements of Public Act 94-163 and Public Act 94-752, or to verify compliance with applicable terms of probation, parole, or mandatory supervised release. (Section 2-110(a-5) of the Act) Reasonable access under this provision shall not interfere with the identified offender's medical or psychiatric care. These requiements were not met as evidenced by: Based on interview and record review facility failed to follow their policy for identified offenders for one resident (R74) out of three residents reviewed for abuse. This failure resulted in after	S9999		

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S9999	Continued From page 2 R74 was admitted to the facility on October 12, 2020 not being assigned to a private room but sharing a room with another resident (R34) two months and the facility failed to notify the Local Law Enforcement and State Police in a timely manner that R74 who is an registered sex offender was residing in the facility. Findings Include: Facility's sex offender policy denotes all sex offenders and felons under the supervision of the Department of corrections must have a private room in close proximity and in direct view of the nursing station. The facility shall notify the appropriate county and local law enforcement offices. The facility must inform Springfield IDPH, within three days after the identified offender becomes a resident. 10/12/2020 22:08 R74 Admission Note Text: Resident is a New Admission Acute Care Hospital Bipolar. R74's care plan dated 10/12/20 denotes R74 is an identified offender and has a criminal history of possession of controlled substance, theft labor/services, criminal damage to property, theft, burglary, rape, home invasion and criminal trespass to land. No level at this time. R74 stated on 4/15/21 at 12:30 pm that when he first got to the facility, he and R34 were roommates for about two months. R74 stated after about two months he was moved to a private room. R34 stated on 4/15/21 at 12:45 pm that he had a room by himself then R74 became his roommate. R3 stated he and R74 were roommates for about	S9999		

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S9999	Continued From page 3 1-2 months. R34 stated he did not like R74 because he was weird and would piss in the cups in their room and do other weird things that he did not like. R34 stated R74 never touched him inappropriately or tried to have sex with him. R34's census sheet dated 10/23/20 denotes in room 426B until 12/31/20; moved to room 118B R74's census sheet dated 10/26/20 in room 426A. 12/31/2020 20:04 R34's Health Status/Progress Note Text: This writer was informed that R34 was tested positive for Covid-19 infection. Resident was moved immediately to RM 118B for isolation. 12/31/2020 19:14 R74's Health Status/Progress Note Text: R74 is on quarantine due to roommate (R34) being tested positive for Covid-19 infection. No sign of any distress noted at this time. Resident denied cough, SOB, chills, body ache, headache, loss of taste/smell and diarrhea. Alert and oriented, up, and about in the room. Cooperative with isolation protocol at this time. All appropriate parties made aware and staff continue to monitor. 1/11/2021 19:22 Health Status/Progress Note Text: R74 remains on quarantine due to exposure from roommate (R34) being positive for Covid-19 infection. R74's notice to IDPH denotes they received receipt on 1/3/21 that R74 is a registered and/or convicted sex offender. R74's Illinois State Police criminal history data sheet denotes citation for Rape 10/15/80 and Home Invasion 10/15/80. 1/21/2021 13:25 R74's Social Service Note Text:	S9999		

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Note Text: Writer assisted resident w/call to Investigator for phone assessment on this day. Call was placed to 847-544-9703. Special instructions were provided to staff by State related to resident's current assessment that resident be placed in private room, and local police agency be contacted and made aware of resident's current placement in this facility. Also made aware that due to resident's current status, he must be registered. Resident's progress will be monitored, and team will follow up and assist as needed.

V1 (Administrator) she stated on 4/15/21 at 11:10 am that when a resident is identified to be identified offender the Illinois State Police should be notified right away.V1 stated they did not know until January that R74 was a identified sex offender because when they did background check he had no hits under his name. V1 stated the staff member that documented that R74 was a sex offender made a mistake and it was a coincidence that he wrote an identified offender care plan last October. V1 stated any residents that is a sex offender is supposed to be in a private room. V1 stated when her department found out in January of this year that R74 was a sex offender he was moved to a private room.

V23 (Social Service Director) he stated on 4/15/21 at 11:30 am if a resident is admitted to the facility as a sex offender they should be put in a private room and have no roommates. V23 stated they did not know until January that R74 was a sex offender.

" C "

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300.610a)
300.1210b)
300.1210d)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 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.
d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

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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 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. (Section 2-107 of the Act)

These Requirements were not met evidencded by:

Based on observation, interview, and record review, the facility failed to ensure a resident was transferred to the appropriate medical asssitive equipment (wheelchair)and supervised. The facility also failed to identify and remove the risk of injury when a resident was transferred to the incorrect medical assistive equipment (wheelchair). This failure resulted in a fall with right lens dislocation, facial bruising and a laceration for 1 resident R92 in a sample of 37.

Findings Include:

R92 has diagnosis not limited to Hypothyroidism, Low Back Pain, Dementia, Insomnia, Major Depressive Disorder, Unspecified Cataract, and Parkinson's Disease. R92 fell out of a wheelchair on 04/07/21 sustaining facial bruising, and a laceration requiring sutures. R92 was transferred to the emergency room for evaluation/treatment,

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S9999	Continued From page 7 and returned to the facility 04/08/21 with discharge diagnosis of lens dislocation, and laceration. On 04/13/21 at 10:41 AM R92 was observed sitting in a recliner wheel chair. Bruising was observed to both eyes, right side of face, forehead, bridge of nose and a dark bruised area was observed under the right eye. R92 was observed looking over head with the neck hyperextended. On 04/14/21 at 09:42 AM V3 (Assistant Director of Nursing) ADON stated R92 fell on 04/07/21. On 04/13/21 at 10:45 AM V6 (Licensed Practical Nurse) LPN stated R92 had a fall on 04/07/21. She had a laceration to her right eyebrow. On 04/14/21 at 12:36 PM V6 (Licensed Practical Nurse) LPN stated R92 did not have any bruising to the face on 04/05/21. 04/07/21 was the first time that she had fallen since I have been working here. On 04/14/21 at 04:23 PM V7 (Licensed Practical Nurse) LPN stated I did not see any bruising on R92 face on the morning of 04/07/21. She usually sit up in the Broda Chair from hospice and had it the entire time that she was on hospice. I never experience her sitting in a regular wheelchair. On 04/14/21 at 11:13 AM V17 (Licensed Practical Nurse) LPN stated R92 is impulsive, has poor safety awareness and is alert to self. R92 had just gotten discharged from hospice and we were not aware the vendors were here to get the bed that was leased. We was rushing and in a hurry to get the process completed. I do not think anyone was in the room with her when she fell. She was in a	S9999		

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regular wheelchair. She did not have bruising to her face prior to the fall. I think one of her roommates may have pulled the call light when she fell. I found her lying face down on the floor. Once we got her up she had a laceration, and we administered first aid to stop the bleeding.

On 04/14/21 at 12:33 PM V22 (Psych Social Aide) stated R92 did not have any bruising to her face prior to the fall. When the fall happen they had put her in a regular wheelchair. She had not been in a regular wheelchair.

On 04/15/21 at 12:26 PM V30 (Director of Therapy) stated currently R92 ADL's (Activities of Daily Living) are extensive to dependent. She has impaired vision and need help with everything. She is non ambulatory and is not independent with her trunk. Her neck tone is spastic and she is in extension with her head tilted backwards. She has poor trunk control and it is not adequate. I do not think that a wheel chair is appropriate for her. I feel that a reclining wheel chair is appropriate but the Broda chair has more appropriate padding and reclines. If she was in a wheel chair there is more of a potential of her falling. We are unable to reposition the wheel chair and she would require some reclining. She should not be in a wheel chair unattended and someone would need to be next to her so she does not fall out of the wheel chair.

On 04/15/21 at 03:26 PM V31 (Restorative Nurse) stated R92 is extensive with hygiene, transfers and feeding. She has cataracts with low vision and can move about in a squirming restless manner. She is in a reclining wheel chair but she was in a broader chair which is padded and comfortable where they can recline the back. When the tech came to get the bed and Broda

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chair the Certified Nurse Assistant's put her in a wheelchair. She is not capable of sitting in a wheelchair because her trunk is weak. I would not have recommended that she be in a regular wheel chair at any time. R92 had not been in a regular wheel chair in a while. Based on my investigation R92 had bilateral bruising across her eyes and bridge of nose. Based on the note the lens dislocation happen with the fall. They found her on the floor face down.

On 04/15/21 at 10:29 AM V32 (Certified Nurse Assistant) stated R92 has behaviors of being confused most of the time and is a little aggressive. She move about in the reclining wheel chair and have been in the reclining wheel chair since she was on hospice. The day she fell hospice came to take the chair and bed. We had to put her in another chair. Everyone was in a rush because they were taking the bed. She fell around 4 pm. She was in her room in the Broda chair. They asked me to transfer her to another chair because they were taking the bed and chair. We transferred her to a normal wheelchair. I had never seen R92 sit in a normal wheel chair. It was in the hallway and we asked the V33 (Second Floor Manager) could we use that chair to transfer R92. V33 said to use that chair because they were going to bring the new bed right away. We put her in that wheel chair because it was available and I asked the nurse. I believe I should have used another reclining wheel chair. That day she was moving a lot and I had to leave the room to get ice water for the other roommate. The Hospice guy came out of the room running and he was the one that told me R92 fell. We got her off of the floor and transfer her to the reclining wheel chair. I do not know where the reclining wheel chair came from. Her bed was not ready yet. There was no bruising to face before she fell.

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Definitely I would have brought her a reclining wheel chair.

On 04/15/21 at 11:18 AM V33 (Registered Nurse/2nd Floor Unit Manager) stated R92 is alert and oriented to self, combative, supervision with feeding and total care. She normally stay in bed and was just discharged from hospice. The supply company said they came for her bed and assistive devices. While I was finishing medication orders the Certified Nurse Assistant said R92 fell. She went in and saw her on the floor. When she became hospice she was in a reclining wheel chair. I assessed the patient, she was face down on the floor, her face was bleeding and I started first aide. She was fighting and combative. The staff was definitely rushed and it was around 4 pm. The rushing could be part of the cause she had fallen. It could have been avoided if we had known they were coming and if we had ample time. It was a big issue.

On 04/15/21 at 12:05 PM V34 (Nurse Practitioner) stated R92 was advance dementia. She was having a decline on hospice until the end of March. She was discharged because she is not appropriate at this time. I was called and told she R92 had a fall from the wheel chair. She was face down and had a laceration based on the fall. She went to the emergency department and received sutures to the right side of her head. The CT scan of the head showed her right lens was dislodged. The lens in the eye was not in the right place it had moved. I believe the fall contributed to the dislodging of the lens. She usually use the Broda chair and she is not able to sit up independently and has poor trunk control. It is better for her to be in the reclining wheel chair to decrease the risk of falls. Based on the 2 day frame to follow up with the ophthalmologist that

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could be something serious with the lens dislodging.

On 04/15/21 at 12:58 PM V35 (Ophthalmologist) stated the lens is the part of the eye that does the focusing. It can get displaced and is a major injury depending on how it happen. If there was a follow up for 2 days and they are unable to get an appointment they should be sent to the emergency room. If possible one should not wait until next week to see the ophthalmologist. To be on the safe side she can be seen before next week. That is blunt head trauma. If it is a lens dislocation it may need to be relocated, removed and replaced with intraocular surgery.

On 04/15/21 at 02:37 PM V37 (Certified Nurse Assistant) C.N.A. stated I was not in the room when R92 fell. I was the one that
helped put her in a wheel chair after the fall. They were not able to find the reclining wheel chair so they put her in a regular wheel chair. She need a reclining wheel chair. She has poor trunk control and need to be supervised. I would have put her in a reclining wheel chair. She had no bruising to her face prior to the fall.

On 04/15/21 at 04:41 PM V38 (Certified Nurse Assistant) C. N.A. stated R92 has always been total care. She is a little aggressive and will scratch you. V32 (Certified Nurse Assistant) C.N.A. asked me to assist when R92 bed was being switched out. We transferred her to a regular wheelchair.
She should have been in a reclining wheelchair but we could not find one on the second floor. We let V33 (Second Floor Unit Manager) know we checked on one side or the hall for a reclining wheel chair and she said there were no reclining wheelchairs, just transfer her to a regular

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wheelchair since it is going to be a quick transfer. She would always use a reclining wheelchair. R92 had no facial bruising prior to the fall.

Record review of Hospice Physician's Orders/Plan of Care from 03/29/21 - 05/27/21 document in part DME (Durable Medical Equipment)/Supplies Bed with bolsters Broda chair for safety. Safety Measures: Fall precautions. Functional: Complete bed bound. Requires Broda chair for mobility. Total assistance with ADL's (Activities of Daily Living) and feeding. C right side. Clinical Update Progress Note document in part Patient received in Geri, poor trunk control and posture noted, head and neck kept tilted towards her back

Record review of Hospice documents indicate R92 was discharged from Hospice 03/29/21 related to no longer appropriate, No longer terminal.

Record review of Care Plan indicate R92 is a fall risk and is non-compliant with fall precautions, gets out of chair and bed without staff assistance, potentially resulting in injury and has impaired vision related to cataracts date initiated 07/31/20.

Interdisciplinary Resident Screen dated 01/29/21 indicate Dependent with Broda chair, non-ambulatory.

Record Review of Progress Note dated 04/07/21 document in part staff responded to room's call light. Noted resident on floor lying face down. Upon observation, noted with laceration with scant of amount of bleeding to face and bruising/edema to nasal septum. Pressure dressing applied to laceration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001333	A. BUILDING: ______ B. WING ______	04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY ENCORE	**2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608**

(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 13	S9999		

Record Review of Progress Note dated 04/08/21 document in part Patient seen and examined. Follow up post fall was sent out for imaging, and evaluation due to extensive evidence of head trauma related to fall. Facial laceration sutured and recommended for follow up with ophthalmologist for lens dislocation. Skin- extensive facial bruising, orbital swelling, laceration approximated with sutures. Accidental fall from wheelchair - patient sent out to ED (Emergency Department) for imaging, and evaluation due to extensive evidence of facial trauma related to fall.

Record review of hospital records dated 04/07/21 document in part R92 Procedures Performed: Simple repair, superficial wounds, Face/Ears/Eyelids/Nose/Lips/ Mucous Membranes; 2.5 CM or less Laceration-Single repair. Hospital CT Brain without Contrast Clinical indication status post fall at Nursing Home Bruising to forehead, orbits, nose. There is a scalp hematoma over the right frontal bone. The lens of the right eye has been dislodged and is in the dependent portion of the right eyeball. Final Diagnosis: Lens Dislocation Additional Diagnosis: Laceration

Policy:
Abuse Prevention Program dated 02/07/17 document the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Neglect means failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 " B "	S9999		