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 _____	C 09/01/2022

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 Complaint Investigation: 2286653/IL150379 & FRI of 8/18/22/IL150556	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b) 300.1210c) 300.1210d)6 300.3240b) 300.3240c) 300.3240e) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the	S9999		

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S9999	Continued From page 2 abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Reqiurements were NOT MET as evidenced by: Based upon record review and interview the facility failed to follow the abuse prevention policy, failed to ensure that one of six residents (R5), remained free from abuse (resulting in serious injury) and failed to provide 1:1 supervision to R4 immediately following aggressive behavior. These failures resulted in R5 sustaining a laceration (above left eye) on 8/18/22 which required suture repair. Findings include: R4's diagnoses include depression. R4's (8/5/22) cognitive assessment determined a score of 15 (cognitively intact). R4's care plan includes (4/6/22) resident presents with behavioral concerns as evidenced by initiating physical aggression towards peers. Intervention: staff to redirect resident when behaviors are present. (6/14/22) Resident may be at risk for potential abuse related to behavior problems as evidenced by combative behavior. Intervention: monitor resident behavior. (6/20/22) Resident has a behavior problem related to displaying verbally aggressive behavior with the potential for physically aggressive behavior related to poor impulse control. Intervention: intervene as necessary to protect the rights and	S9999		

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S9999	Continued From page 3 safety of others. Remove from situation and take to alternate location as needed. R4's (8/18/22) progress notes state writer responded to obscene language on unit in hallway and noted resident engaged in altercation with peer. Resident noted standing over peer while delivering blows and kicks to resident head, face and body. Writer able to restrain resident from further aggression at that time, approximately 5 minutes after separation of residents, resident approached peer and initiated another altercation with resident shoving peer to floor and delivering punches to face, head and body. R4 was transferred to the hospital on 8/18/22 at 2:34 pm and did not return to the facility prior to this investigation. R4's documentation excludes 1:1 supervision immediately following 8/18/22 incident. R5's diagnoses include schizophrenia. R5's (7/21/22) cognitive assessment determined a score of 10 (moderately impaired). On 8/29/22 at 2:24pm, surveyor inquired about the 8/18/22 incident R5 was slow to respond, became angry and stated "I ain't got a phone man!" and refused to answer any other questions. On 8/31/22 at 10:30am, surveyor inquired about the (8/18/22) incident V9 (LPN/Licensed Practical Nurse) stated that R4 and R5 had a physical altercation on the first floor. V9 separated R4 and R5 from the altercation. V9 sent R4 back to the room and took R5 to the nurse's station. R4 came out of the room and started rushing at R5 with	S9999		

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S9999	Continued From page 4 another physical altercation. R5 had a cut on the eye, skin was broken, more like a laceration with some bleeding. On 8/31/22 at 11:05am, surveyor inquired about R5's (8/18/22) injury V6 (LPN) stated R5 had blood coming from R5's eye. an abrasion on R5's cheek and inside lip was swollen and bloody. The (8/18/22) final incident investigation states at approximately 4:30am, (R4) stated that (R5) wandered into R4's room and tried to take R4's phone. (R5) admits to hitting (R4). (R5) returned (from the hospital) with sutures to left eyebrow. On 9/1/22 at 10:31am, surveyor inquired if R4 was immediately placed on 1:1 supervision post 8/18/22 incident V10 (Assistant Director of Nursing) stated social service had a 1:1 with him, I (V10) think they (social service) got here like 8:00am or something. The (11/22/17) abuse prevention policy states if the alleged perpetrator is a resident, the resident will be separated from the alleged victim and resident's condition will be evaluated as soon as reasonably possible to determine the most suitable therapy and placement for the resident. This will be done taking in consideration the safety of other residents and employees of the facility. The preliminary facility reported incident states on 8/18/22 at approximately 4:30am, two residents with behavioral diagnosis were observed in a physical altercation in (R4's) room. (R4) stated that (R5) came into his room, tried to steal his (R4) phone and that led to the altercation. IDPH was notified of incident on 8/18/22 at	S9999		

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S9999	Continued From page 5 10:03am [5.5 hours after the incident]. On 8/31/22 at 12:46pm, surveyor inquired about the regulatory for reporting abuse V1 (Administrator) stated "The regulation is that we report immediately after we assess that the resident is safe." Surveyor inquired when V1 was notified of the (8/18/22) incident involving R4 and R5 V1 responded "I had just gotten to work so about maybe 8:30am or 9:15am. They spoke to the ADON (Assistant Director of Nursing) who was calling me as soon as I got into the parking lot. I guess it had happened in the early hours of the morning." Surveyor inquired when the 8/18/22 incident should have been reported V1 replied "They should have called me immediately, I should have reported it by 6am if it happened at 4am." The (11/22/17) abuse prevention policy states in part an initial report to Illinois Department of Public Health, shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed. Immediately is defined as "as soon as possible" after being made aware of an allegation of abuse but is not more than 2 hours if the events that cause the suspicion result in serious bodily injury. The (8/18/22) final incident investigation stated (R5) returned (from the hospital) with sutures to his left eyebrow. (B)	S9999		