| 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 10/07/2022 |

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| SYMPHONY ENCORE | 2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608 |

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| S 000 | Initial Comments<br><br>FRI of 9/11/2022\IL151750 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These Requirements were NOT MET as evidenced by:<br><br>Based on interviews and record reviews, the facility failed to provide adequate supervision for 2 residents (R7 and R8) of 8 residents reviewed for supervision. This failure resulted in R7 sustaining a 2cm (centimeter) forehead laceration that required three sutures.<br><br>Findings include:<br><br>R7's medical diagnoses include but are not limited to unspecified dementia with behavioral disturbance, weakness, unspecified lack of coordination, wandering in diseases classified elsewhere, unspecified bilateral hearing loss, history of falling, other abnormalities of gait and mobility, and vascular dementia. | S9999 | | |

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| S9999 | Continued From page 2<br><br>R7's MDS (Minimum Data Set) Assessment dated 08/01/2022 documents in part: R7 is rarely/never understood. R7 also has short and long-term memory problems and no memory/recall ability. R7's cognitive skills are severely impaired. R7 has inattention and disorganized thinking that are continuously present.<br><br>Surveyor reviewed R7's comprehensive care plan. Care plan initiated 04/12/2022 documents in part that R7 has impaired cognitive function/dementia or impaired thought process related to dementia and paranoid schizophrenia as evidence of inattention, disorganized thought content, confusion, and forgetfulness. Care plan initiated 07/18/2022 documents in part that R7 may be at risk for potential abuse related to behavior of wandering into peers' rooms. Care plan initiated 08/22/2022 documents in part that R7 has potential for falls related to progressive dementia, hard of hearing, impaired cognition, poor safety awareness, history of falls, and history of bending over to pick up invisible objects from the floor.<br><br>R8's medical diagnoses include but are not limited to unspecified dementia with behavioral disturbance, restlessness and agitation, unspecified hearing loss in bilateral ears, vascular dementia with behavioral disturbance, cognitive communication deficit and Alzheimer's Disease.<br><br>R8's Quarterly MDS Assessment dated 7/29/2022 documents in part: R8 has inattention that fluctuates and disorganized thinking that is continuously present. R8 has delusions and physical, verbal and other behaviors that occurred 1 to 3 days during the look back period. The behaviors significantly intrude on the privacy or | S9999 | | |

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| S9999 | Continued From page 3<br>activity of others.<br><br>Surveyor reviewed R8's comprehensive care plan. Care plan initiated 01/29/2022 documents in part that R8 is at risk for altered thought process related to diagnosis of Alzheimer's Disease. Care plan initiated 01/29/2022 documents in part that R8 has a potential to demonstrate verbally abusive behaviors related to dementia. Care plan initiated 01/29/2022 documents in part that R8 has been physically aggressive towards peers and staff due to diagnosis of dementia and poor impulse control. Care plan initiated 01/29/2022 documents in part that R8 has a behavior problem related to verbally and physically acting out when agitated.<br><br>Facility's Report of Resident Incident/Accident reads "[R7] was walking on the unit and walked into [R8's] personal space which resulted with [R7] being pushed to the floor."<br><br>On 10/04/2022 at 2:19 PM, V13 (Nurse) stated R7's dementia has progressed and gotten worst. V13 cannot make out what R7 says due to R7's disorganized thinking. V13 stated R7 wanders around the unit a lot.<br><br>On 10/05/2022 at 10:42 AM, V15 (Nurse) stated R7 gets up and wanders a lot. V15 stated R7's gait is steady but R7 is frail. V15 stated R8 stands in the hallway and sometimes tries to grab people.<br><br>At 11:09 AM, V17 (Nurse) stated [V17] was on break when the incident between R7 and R8 occurred. V17 did not witness the incident but described R7 as someone that likes to touch people or pat people's shoulders. V17 stated R7 needs one-to-one monitoring because R7 is | S9999 | | |

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| S9999 | Continued From page 4 | S9999 | | |

always busy and [R7's] dementia has progressed. V17 stated R7 has poor safety awareness. V17 stated R8 with history of physical and verbal aggression. V17 stated R8 gets easily agitated. R8 gets irritated when someone gets in [R8's] personal space. V17 stated if someone gets too close to R8 then staff need to immediately diffuse the situation. V17 stated it is not safe to have R7 near R8 because R7 doesn't know what [R7] is doing. V17 stated R7 does not know to stay away from R8. R7 just wanders and does own thing.

At 11:25 AM, V18 (Certified Nurse Aide) stated R7 wanders a lot and requires one-to-one monitoring. V18 stated the facility cannot accommodate R7's safety because they have multiple residents to look after. V18 stated R7 requires a lot of redirection because R7 is constantly wandering.

At 12:26 PM, V19 (Nurse) stated V19 was in a resident's room when the incident between R7 and R8 occurred. V19 did not witness the incident but describes R7 as oriented to self only and is confused. V19 stated R7 needs a lot of monitoring because R7 wanders and sometimes goes into people's rooms. V19 stated R7 does not have safety awareness. V19 stated R8 is territorial of the area that [R8] stands in. V19 stated R7 would not know to avoid R8. V19 stated "We shouldn't have let [R7] get that close to [R8]. I don't know how it happened. [R7] doesn't even follow instructions. You have to hold [R7's] arm to guide [R7] into the room. [R7] can't follow verbal instructions."

At 3:09 PM, V20 (Certified Nurse Aide) stated R7 is very confused. Staff need to monitor R7 because [R7] is a wanderer. V20 stated R7 requires one-to-one monitoring. V20 stated R8

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| S9999 | Continued From page 5 | S9999 | | |

stands in the hallway most of the time and does a lot of fussing. V20 stated R8 is hard to redirect and bothers people. R8 bothers people when people are walking past. R8 doesn't like people walking too close to [R8.] V20 stated R7 and R8 cannot be in the same area together. R7 does not understand to be clear of R8. V20 stated R7 cannot follow verbal direction. R7 won't understand if you tell [R7] to stay away from R8. V20 stated staff have to physically pull R7 away and redirect. V20 stated during R7 and R8's incident, V20 was sitting at the nurses' desk charting. V20 stated "R7 came out of nowhere. My head was down in the computer. R8 started fussing on R7. Before I could get up to remove R7 from R8's personal space, [R8] pushed [R7] and [R7] fell. [R7] fell forward and had a gash on [R7's] forehead that was bleeding." V20 stated "I was too busy working on the computer. I didn't see R7 approach [R8]. I heard R8 talk to R7. That's when I looked up. When I started to walk up and redirect R7, that's when R8 pushed R7 and [R7] fell in the floor." V20 stated facility sent R7 to the hospital for evaluation due to gash on the forehead.

R7's hospital records dated 09/11/2022 documents in part a diagnosis of facial trauma. R7 sustained a 2cm laceration that required three sutures.

Facility's "Dementia" policy created 05/2022 documents in part:
"A resident who displays or is diagnoses with Dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. ...
Treatment and Services: ...
2. Ensuring that the necessary care and services

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| S9999 | Continued From page 6<br>are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;"<br><br>Facility's "Wandering, Unsafe" policy created 05/17/2022 documents in part:<br>"The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk of elopement."<br><br>Facility's "Safety and Supervision of Residents" policy created 10/2021 documents in part:<br>"Resident supervision is a core component of the systems approach to safety."<br><br>(B) | S9999 | | |