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 10/28/2022

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 FRI of 10/7/20/22\IL152267 & FRI of 10/15/22\IL152498	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 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	S9999	Attachment A Statement of Licensure Violations	

PRINTED: 11/29/2022
FORM APPROVED
Illinois Department of Public Health

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S9999	Continued From page 1 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. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents remain free from abuse. This affected two(R8 abused by R9). This failure resulted in R8 requiring sutures for a forehead laceration. R9 with known aggressive behaviors; facility failed to ensure R1 was free from abuse by R2. R2, a resident with known aggressive behavior. Findings include: R8's medical record (Face Sheet, Minimum Data Set) notes R8 is a severely cognitively impaired 69-year-old admitted to facility on 4/17/2019 with diagnoses including but not limited to: Vascular Dementia, Wandering, Paranoid Schizophrenia, and History of Falling.	S9999		

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S9999	Continued From page 2 R8's care plan initiated 07/18/2022, notes in part, R8 may be at risk for potential for abuse related behavior problem as evidenced by wandering in peers' rooms. R8's care plan initiated 08/07/2022, notes in part, R8 has a behavior problem related to (touching staff, residents, the nurse's cart, walls, wheelchairs and objects on the unit) secondary to diagnosis of dementia. R9's medical record (Face Sheet, MDS-Minimum Data Set of 07/29/2022) notes R9 is a severely cognitively impaired 67-year-old admitted to the facility on 1/26/2018 with diagnoses including but not limited to: Dementia with Behavioral Disturbance, Restlessness and Agitation, Cognitive Communication Deficit and Bipolar Disorder. MDS Section E Behavior, notes in part, R9 exhibits delusions, physical behavioral symptoms (e.g., hitting, pushing) directed towards others and, verbal behavioral symptoms (threatening/screaming/cursing at others). R9's care plans initiated 01/29/2022 note in part, R9 has a behavior problem related to verbally and physically acting out when agitated and R9 has been physically towards peers and staff due to diagnosis of Dementia and poor impulse control. R9's care plan initiated 07/31/2022 notes in part, R9 may be at risk for potential abuse related to behavior problem as evidenced by: poor impulse control, verbally/physically acts out. R9's care plan initiated 09/16/2022 notes in part, R9 presents with behavioral concerns as evidenced by verbal and physical aggression. On 10/26/2022 at 10:50 AM, R9 was observed standing in hallway between Day Room and Nurses Station. Surveyor approached R9, R9	S9999		

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S9999	Continued From page 3 said, "Get the f*** away from me." Facility's final incident report (10/16/2022) notes in part, "The resident (R8) was walking on the unit and walked into another resident('s) personal space which resulted with the resident being pushed to the floor. Open area noted to forehead. On call called and order given to send to (Local Hospital) for evaluation and CT scan. (R8) returned to the facility with 3 sutures." V14 (Licensed Practical Nurse-LPN) on 10/26/2022 at 4:58 PM, said V27 (Certified Nursing Assistant-CNA) told me that R8 walked up to R9, tapped R9 on the shoulder. Before V27 could get up to intervene, R9 pushed R8 and R8 fell. R8 had a laceration to her head. R9 has hit staff. I'm not aware of him hitting any residents. R9 has gone to strike (residents) but we were able to intervene before R9 hit the person. R9 is easily agitated, R9's agitation leads to aggressive behavior. V14 said R8 does wander the hallway and is at risk for abuse. On 10/26/2022 at 5:25 PM, V27 (CNA) said, "I was monitoring the unit, doing my POCs (Point of Care documentation) at the nurses station. R8 came out of nowhere, R8 went up to R9 and R9 pushed R8. I couldn't get to them in time. V27 said "R8 is a wanderer. R8 goes into other resident's rooms. We try to redirect R8 to R8's room". V27 said, "I've seen R9 hit others". On 10/27/2022 at 12:00 PM, V3 (Assistant Director of Nursing-ADON) said, "Yes, R9 does have a history of aggression. R9's number one trigger is people getting in R9's space. Once R9 gets up and dressed in the morning, R9 has a spot that R9 likes to stand in. We try to re-direct R9 to a different spot. We have given R9 a chair	S9999		

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S9999	Continued From page 4 to sit in. The more we try to re-direct R9, the more likely R9 is to become aggressive and attempt to strike out. V3 said "R8 doesn't respect the boundaries and personal space of others. R8 is a wanderer. Facility's Abuse Prevention Policy (effective November 22, 2017) notes in part: -Residents have the right to be free from abuse. -Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. -Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. -Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. R1 is a 68-year-old individual admitted to the facility on 6/25/2018. R1 Brief Interview for Mental Status (BIMS) completed on Oct 11, 2022, document R1 BIMS score as 9/15, indicating R1 has some cognitive disabilities. On 10/26/2022 at 10:20am, R1 was observed in the in the hallway being assisted by staff in combing R1 hair. at 10:32am, R1 was observed in R1 room. R1 said someone pushed R1 but R1 does not remember the name of the person. R1 is alert and oriented to person and place, and R1 has confusion. R2 is a 46-year-old individual with initial admission date to the facility on a 4/21/15, readmitted to the facility on 6/10/22 band discharged from the facility on 10/7/22. R2's Brief Interview for Mental Status (BIMS), completed on Jul 21, 2022 document R2' BIMS as 10/15, indicating R2 has some cognitive	S9999		

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S9999	Continued From page 5 deficits. On 10/26/2022 at 5:34pm, V1(Administrator) said it's the facility expectation is for residents not get physical with each other. V1 said if a resident is physically abused, they can feel unsafe, violated and afraid, and it's the facilities responsibility to keep residents safe. On 10/26/2022 at 12:48PM, V6 (Certified Nurses' Assistant-CNA) V6 said R1 is not aggressive and usually likes to stay in R1 room. V6 said that R2 used to pace and wander a lot, going into other residents' rooms looking for cigarettes and R2 has been involved in altercations with other residents, but no alterations with staff. V6 said in most of the altercations, R2 was the physical aggressor. V6 said residents should not be hitting other residents, and staff do their best to redirect residents. V6 said when a resident is hit by another resident, the resident can feel scared and afraid. On 10/26/2022 at 1:11pm, V5 (Restorative Nurse/LPN (Licensed Practical Nurse) said R1 has psychiatric issues, and likes to sit in the basement on the floor, but R1 is not aggressive at all V5 said that on 10/07/2022, on the fourth floor, between 7:15am 7:30am, V5 said V5 heard a loud noise while at the nursing station and one of R5's coworker said R1 went flying and hit the floor. V5 said V5 went to R1's room and saw R2 outside R2 room sitting on R1 buttocks. V5 said R1 said "he (R2) pushed me (R1). V5 said R2 was standing in the doorway. V5 said V5 asked R2 why R2 pushed R1. V5 said R2 denied pushing R1. R2 said R2 told R1 to "get F..out of my(R2) room." V5 said R1 said R2 shoved R1 and told R1 to get out of R2 room. V5 said V5 did an assessment on R1 to make sure R1 did not	S9999		

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S9999	Continued From page 6	S9999		

break anything. V5 said (V5) told R1 to go to R1 room, and R1 kept saying "He (R2), pushed me(R1)" V5 said R1 did not sustain any injuries and R2 went to R1 room. V5 said R2 remained in R2's room until it was time for R2 to get R2 medications and after R2 got his medications, R2 started daily routine. V5 said V5 notified V1(administrator) V5 said residents should not be pushed or hit by another resident. V5 said when a resident is pushed or hit, they can feel unsafe and can be fearful and residents are supposed to feel safe in the facility.
On 10/26/2022 at 12:33pm, V24(Certified Nurses' Assistant-CNA) said that R1 was mostly quite and R1 was not aggressive. V24 said that R1 is a little confused sometimes, talks to self, and V24 has not seen R1 go into other resident's room and R1 very compliant with ADL care. V24 said residents should be kept free from harm because they can feel scared and unsafe. V24 said staff try their best to keep residents safe.

Facility Final Investigation Report dated 10/10/2022 documents;
-Based on the details of this investigation, it is believed R1 did abuse R2 by pushing R2 out of the room and causing R1 to fall onto R1 buttocks.
Facility Abuse Prevention Program -Policy, effective November 22, 2017, documents;
-Abusee means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident.
-Physical Abuse is the infliction of injury on a resident that occurs other than by means of accidental means.
-Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior

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S9999	Continued From page 7 through corporal punishment. (B)	S9999		