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
	IL6001689	A. BUILDING: _____ B. WING _____	C 02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BRONZEVILLE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S 000	Initial Comments Complaint Investigation: 2180663/IL00130605	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.610 a) 300.1210 d)1) 300.1210 d)2) 300.1810 c)3) 300.3210 o) 300.3240 a) 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 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1810 Resident Record Requirements c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. Section 300.3210 General o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. 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) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to refill and administer medications according to the physician orders for one resident (R4) out of 4 residents reviewed for medication administration. This failure resulted in R4 not receiving significant medications, having an elevated blood pressure, and being taken to the hospital for further evaluation and treatment.	S9999		

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S9999	Continued From page 2 Findings includes: R4's diagnosis includes hypertension, atrial fibrillation, long term use of anticoagulants, symptoms and signs involving the nervous system, heart failure and sequelae of cerebral infraction. R4's progress note on 1/12/2021 at 12:59 PM by V8, LPN documents: "Writer placed called to pharmacy regarding resident medication. Per pharmacy resident has outstanding bill and insurance is not covering meds. Administrator and Business Office made aware. MD made aware new order to monitor resident if resident is in any distress transfer to Mercy for follow up. Family made aware of issue with meds. Resident remains stable at this time." R4's progress note on 1/29/2021 at 09:30 AM by V14, LPN documents: "Writer received resident up in wheelchair; Awake, alert and oriented x3, verbally able to make needs known; Resident denies any pain or discomfort at this time; Resident currently in dining room finishing breakfast." R4's progress note on 1/29/2021 at 10:47 AM by V14, LPN states: "Resident had c/o headache at this time PRN pain medication administered; No s/sx of distress noted at this time; Will continue to monitor." R4's progress note on 1/29/2021 at 11:16 AM by Social Service states: "Writer received a call from resident's sister (V22) reports that resident has abdominal pain and headache. Writer informed sister that message will be referred to Nurse for follow-up. Writer will continue to monitor as needed."	S9999		

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S9999	Continued From page 3 R4's progress note dated 1/29/2021 at 11:30 AM by V8 "Writer alerted facility SS resident family V22 (family member) called facility stated sister reported to her that she had abdominal pain and headache. Writer to 3rd floor day room resident alert and oriented x2. Resident c/o abd pain 5/10. Resident T 97.2 resident taking to room and rapid swab given with (-) result. NP in facility made aware of result. Resident has new orders carried out by assigned nurse for dicyclomine 10 mg capsule q6 for abd discomfort and pain. Family V22 given update on POC made aware." R4's progress note on 1/29/2021 at 12:25 pm by V14, LPN (Licensed Practical Nurse) documents: "Writer called to dining room at this time, Resident exhibiting seizure activity; Staff immediately transferred resident to bed; O2 initiated via non-rebreather mask; Resident head secured; Writer phoned 911 at this time, awaiting arrival." Review of City of Chicago Record Division record documents in part on "1/29/2021 at 12:22 vital sign Heart Rate 72, BP Systolic 180, BP Diastolic 100, 1/29/2021 at 12:32 HR 72, BP Systolic 160, Diastolic P, 1/29/2021 at 12:38 R 67, BP Systolic 150, Diastolic P." Review of emergency room medical record documents in part on "1/29/2021 at 13:41 CST arrival pt hypertensive 220 systolic, blood pressure triage /116 mmHg, latest /121 mmHg. History of Present Illness in part documented earlier today she (referring to R4) was complaining of mild headache prior to have a seizure. No history of seizures. Upon arrival to the emergency department, patient was initially hypertensive to 220 mmHg and had 1 episode of emesis. Per ED medical record R4 received 10 mg labetalol with improvement of BP."	S9999		

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R4's (1/21) Medication Administration Record documents in part:
Coumadin tablet 5 mg daily related to sequelae of cerebral infraction: not administered (1/22/21 thru 1/27/21 - 6 doses missed).
Gabapentin Capsule 400 mg daily for neuropathy: not administered (1/22/21 thru 1/23/21 - 2 doses missed and 1/25/21 thru 1/28/21 - 4 doses missed).
Diltiazem HCL tablet 120 mg by mouth twice daily for hypertension: not administered (1/22/21 thru 1/28/21 thru 14 doses missed.

R4's blood pressure not documented 1/22/21 thru 1/28/21.
Review of R4's blood pressure log documents: (1/21/21) 178/92 mmHg and (1/29/21) 203/71 mmHg, no record of R4's blood pressure from 1/22/21 thru 1/28/21.

Review of R4's (10/18) care plan documents resident has hypertension. Intervention: Give anti-hypertensive medications as ordered. Monitor for side effects and effectiveness, obtain blood pressure per order. Surveyor unable to obtain physician order for blood pressure monitoring.

On 2/12/21, at 9:54 AM, V7, Business Office Manager said R4 has an attorney who pays her bills.

On 2/12/21, at 12:06 PM, V8 (LPN) said on 1/10/21 V9, LPN informed her R4 did not have all her medications. V8, LPN told V9, LPN to call the pharmacy and find out why medications were not there. V9, LPN informed V8, LPN that the pharmacy bill was not paid. V8, LPN told V9, LPN to get the authorization form and send it to

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V10, former Director of Nursing. The facility will pay for the medications if the bill is not over $500. V8 stated on 1/12/21 the pharmacy informed her that they will not send the authorization form because the bill was high, and resident was in collections. V8, LPN stated that she emailed V7,Business Office Manager and V18, former Administrator to let them know that R4 had a bill with the pharmacy, the pharmacy will not send any medications unless bill gets paid, and the bill needs to be paid immediately before the resident will run out of medications. V8, LPN stated, from that point V7, Business Office Manager took over the issue. V8, LPN stated that she told V9, LPN to call family and the doctor to let them know. V8, LPN stated she informed V17, Nurse Practitioner and V16, R4's Primary Physician. V8, LPN stated on the medication administration record any number means it was not given for a specific reason such as "9" means there is a note and a check mark mean the medication was administered.

Review of V8's, LPN email on 1/12/21 at 1:59 PM to V2 DON, V18 former Administrator and V7 Business Office Manager stating, "R4 has a bill with pharmacy that needs to be paid immediately. The pharmacy isn't sending any meds until Bill is paid."

On 2/12/21, at 12:31 PM, V7, Business Office Manager said R4 has private insurance that her attorney pays. V7, Business Office Manager stated, R4 was responsible for medication co-payment. However, the pharmacy bills were sent to the wrong address and therefore she acquired a high balance with the pharmacy.

On 2/12/21, at 12:36 PM, V8, LPN stated on 1/29/21 she heard rapid response code called.

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When she got to R4, the resident was having seizure like activity.

On 2/12/21, at 12:41 PM, V9, LPN stated on 1/10/21 she noticed R4's physician ordered medications were running low and the resident usually had extra medications. She called pharmacy to find out why they were not refilled. V9, LPN stated the pharmacy informed her R4's account was in collections, gave number to collections, and told her until the overdue bill was paid that the pharmacy would not send any medications. V9, LPN stated she made V8, LPN aware and V18, former Administrator. V8, LPN and V18, former Administrator told her facility will clear the matter up with the business office. V9, LPN stated on resident's medication administration record a "check" mean resident received the medication and any number means they did not. V9, LPN stated during the 1/10/21 phone call with the pharmacy, they gave the option for facility to pay off the past due balance and they would bill the appropriate party for the new medications. The pharmacy faxed a pay agreement and V9, LPN gave it to V10, former DON who said he would give it to the business office.

On 2/12/21, at 12:52 PM, V7, Business Office Manager stated R4's balance with the pharmacy was $2,353.52 and it was paid by her attorney.

On 2/12/21, at 1:06 PM, V2, Director of Nursing (DON) stated if medications are unavailable then the staff can take the medications from the stock medication cart and if that medication is not available nurses will call the doctor to get a "stat" medication order. V2, Director of Nursing further stated, she was not made aware R4 was not receiving her medications. V2, Director of Nursing

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S9999	Continued From page 7 stated, normally facility will pay for residents' medications, so they do not run out. On 2/12/21, at 1:56 PM, V2, DON stated she had no idea as to why R4's pharmacy bill was not paid by the facility. V2, DON stated the process for this kind of situation is the facility would pay for it. V2, DON stated she does not know what the communication regarding the matter was. V2, DON further said facility must have medications for residents and the facility will pay for the current medications, so the residents do not run out. V2, DON also said, the expectation of the nurse is when medications are not available to call the physician, ask for directions, and make sure to communicate the matter to the supervisor. V2, DON stated the extra medications in the facility is accessed per individual resident and does not know if staff can open it when the resident's account is in default to retrieve extra medications. On 2/12/21, at 2:14 PM, V1, Administrator stated "If he was told about R4's medication situation, he would have paid the entire bill (referring to the total amount due $2353.52), this is what he would do to avoid this situation and have state agency in the facility. V1 said, he is the new facility administrator, but residents come first, and he would have paid the bill." On 2/12/21, at 2:20 PM, V8, LPN stated, on 1/12/21 R4's physician said to monitor R4 after being made aware of pharmacy billing issues and if there is any distress send the resident out for hospital evaluation. V8, LPN stated, R4's physician and V17, Nurse Practitioner on 1/12/21 were made aware about billing issues and that the medications were getting low, but she still had medications. V8, LPN said there was no order to	S9999		

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hold R4's medications. V8, LPN also said she wrote a progress note to monitor R4 but did not enter an order in R4's chart under physician orders. When surveyor inquired why an order was not written V8, LPN stated, "I am not sure, I did not write it. Normally an order is put in."

On 2/12/21, at 3:15 PM, V8, LPN said the extra medications the facility has on hand is pulled under each individual resident and if a resident is in default due to a balance the computerized device will not allow the staff to take the medication.

On 2/12/21, at 3:21 PM, V17, R4's Nurse Practitioner said he was familiar with R4. He was informed there was an issue with billing related to the pharmacy. V17 stated there was nothing for him to do because it was a billing issue. He was not informed of the duration R4 was not receiving her medications. V17 stated he was not made aware of the resident not receiving the medications only about the initial issue with balance the resident had with the pharmacy. There could be many complications for R4 not taking her medications from a stroke to anything, or death. R4 was taking Gabapentin for neuropathy so, it was for pain. R4 had no history of seizures. The risk of R4 stopping Coumadin, is another cerebral infraction. Medications must be taken and taken correctly.

On 2/12/21, at 2:55 PM, V16, R4's Primary Physician stated he believes he was made aware by V8, LPN about issues with R4's medications and pharmacy and it was possible he could have said to monitor the resident. V16 further stated, "how can a pharmacy stop sending residents medications?" V16 said if R4 stopped taking her medications, it is possible for her to have

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complications. V16 further stated, it is unbelievable this happened and who else at the facility is this happening to. V16 also said, it is possible he instructed V8, LPN if the facility cannot get R4's medications to monitor the resident and if there is change of condition then send the resident to the hospital.

On 2/12/21, at 5:12 PM, V16, R4's Primary Physician said R4 had an unfavorable outcome (referring to hypertension, seizure, and emergency room visit) and the pharmacy did not dispense her medications. V16 said, he was made aware there were billing issues and facility was working on getting R4 her medications. V16 said, "Usually there is 1or 2-day delay (referring to resolving the pharmacy being paid and the medication being dispensed) however he was not aware R4 was not getting her ordered medications every day." V16 also stated he was upset at this whole situation and asked how the pharmacy can be allowed to do this. V16 stated, "When medications are withheld, the risk to a resident is the same risk as the medication is for, so if hypertensive medications are withheld then hypertension is the risk, gout medication then gout is the risk, pain medications withheld then pain and if coumadin is withheld cerebral infraction is a risk, but mainly the medication is for atrial fibrillation."

On 2/15/21, at 2:01 PM, V14, LPN said she is familiar with R4 however, does not recall the specifics of the 1/29/21 occurrence. V14 stated whatever she documented in R4's chart that was what happened. V14 stated R4 was fine, stable, and later it looked like she was having a seizure, so she was sent out for evaluation.

On 2/15/21, at 2:10 PM, V13, Pharmacy said the

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facility was aware R4 had a balance of $2,353.52, was at risk to have her medications discontinued, and for pharmacy to refill medications, residents balance must be under $500. V13 stated R4's account balance was paid on 1/26/21. V13 further stated, "On 1/14/21 pharmacy was directed by the facility to send the bill to R4's attorney because they were not going to pay it."

On 2/23/21, at 9:29 AM, V13, Pharmacy said residents who have a balance with pharmacy are at risk to have their medications discontinued. V13 stated there is a specific balance but he was not sure of the actual amount. V13 stated the facility was made aware initially on 10/6/20 and the second notice to the facility was on 12/5/20. R4's account was placed on discontinued on 1/4/21 and the facility was made aware.

On 2/23/21, at 9:41 AM, V20, Pharmacy stated there is a limit of $500 and over, so when a resident reaches that amount of past due, their medications are at risk of being discontinued. However, it is a 90-day process for resident's medications to be discontinued and resident has the 90 days to pay off the balance. V20 said, on 9/30/20 facility was called, and voice mail was left for V7, Business Office Manager. V20 said, R4's medication discontinuing process was started on 10/6/20. V20 also stated on 10/7/20, the pharmacy called the facility and receptionist transferred the call to V7, Business Office Manager however, her voicemail was full. The 10/7/20 phone call was followed by a fax to the facility. V20 stated on 11/6/20, a call was made again to V7, Business Office Manager without answer and a fax was sent to follow up. V20 stated the pharmacy reached out to the facility on 12/9/20, was unsuccessful, and they followed up with a faxed letter regarding R4's medication

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S9999	Continued From page 11 discontinuing status. V20 stated on 1/4/21, R4's medication refills were shut off with the pharmacy. On 2/23/21, at 10:10 AM, V20, Pharmacy stated she is unable to provide the "90-day policy" and the sent faxes or any communications with the facility to the surveyor, only verbal. On 2/23/21, at 11:02 AM, V21, Pharmacy Supervisor stated the pharmacy made repeated attempts to make the facility aware R4 was at risk to have her medications discontinued. V21 said the pharmacy sent faxes which were received by the facility on 10/7/20 for the first notice of non-payment, second notice on 11/6/20, the last notice on 12/9/20, and R4's medication refill was placed on hold on 1/4/21. V21 also said, the faxes were sent along with calls to the facility. However, they were not able to get in touch with anyone. The pharmacy was transferred by the receptions or the calls were dropped. V21 also stated he is not at liberty to provide the surveyor with the faxes, the notes regarding R4, and their "90-day policy", only is able to do it verbally. On 2/24/21, at 11:21 AM, V17, Nurse Practitioner stated R4 missed blood pressure medications and Coumadin. They are significant medications because we do not order unnecessary medications, otherwise we would take the resident off them. V17 said, to be on blood pressure medications is to maintain and control a blood pressure. If a resident does not take their medications, then their blood pressure reading will go up. It is a significant medication because you should take the medications to maintain the blood pressure. V17 said, Coumadin is a lifesaving medication. V17 also said, R4 was taking Gabapentin for neuropathic pain.	S9999		

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S9999	Continued From page 12 Facility's (10/03) "Medication Administration" policy documents in part: GENERAL: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. 18. If a medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider. 20. Medications are held as specified by the Health Care Provider. Facility's "Charge Nurse" Drug Administration Functions documents in part: Prepare and administer medications as ordered by the physician. (A)	S9999		