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 _____	03/18/2021

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 Annual Licensure Survey Complaint Investigation: 2181712/IL131767	S 000		
S9999	Final Observations Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)1) 300.1220b)2) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident. Section 300.1210 General Requirements for	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These regulations were not met as evidenced by: Based on interviews and record review, the facility failed to timely notify a physician or nurse practitioner for a resident's change in condition, failed to accurately carry out a nurse practitioner's telephone order, failed to timely medicate and properly manage a resident's pain and accurately document administration or a resident's	S9999		

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medication for one (R569) of three residents reviewed for pain in a sample of 65. This deficient practice caused R569 to suffer with increased pain over a four day time frame.

Findings included:

R569's admission record documents, in part, diagnoses of multiple sclerosis, spinal stenosis and chronic pain. The quarterly minimum data set (MDS) for R569, dated 1/6/21, indicates a brief interview for mental status (BIMS) as 14 as cognitively intact.

On 3/16/21 at 3:00 pm, V14 (Licensed Practical Nurse, LPN) stated that on 2/23/21, he was working from 7:00 am to 7:00 pm in the facility and was reassigned to go work on the 4th floor from 3:30 pm-7:00 pm. V14 stated that he was finishing receiving report from the 4th floor off-going nurse (V13, LPN) and heard a loud noise coming from R569's room at 4:00 pm. V14 stated that he went to R569's room and saw R569 face down on the floor in front of her wheelchair in front of the bathroom door. V14 stated that R569 was alert, was complaining of right leg pain and stated that she was trying to get up and fell down. V14 stated that he performed vital signs that were stable and that he assessed R569's right leg for tenderness and sensation, saying, "It was normal to me." V18 (LPN) came into R569's room and assisted him with a manual transfer of R569 from the floor to her bed. V14 stated that he didn't give R569 any pain medications at this time due to his nursing report from V13 that Hydrocodone-Acetaminophen had been given to R569 three hours ago so she wasn't due yet. V14 stated that R569 was not over-sedated or lethargic. V14 stated, "(R569) will trick nurses to get more pain medications.

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S9999	Continued From page 3 (R569) has an addiction." V14 stated that R569 is "always complaining of pain" and has "drug seeking behaviors." V14 stated that R569 has had neck surgery and gets whenever needed pain medications every 4 hours. R569's medication administration record (MAR), dated February 2021, documents, in part, that "Hydrocodone-Acetaminophen 10-325 milligrams (mg) by mouth every 4 hours for pain as needed" was ordered for R569. On 2/23/21, R569's MAR indicates that no doses of Hydrocodone-Acetaminophen were administered to R569. On 2/23/21 at 4:00 pm, V14 documented, in part, that R569 was "complaining of mild right lower leg pain which manage with pain medication." On R569's pain evaluation, dated 2/23/21 at 5:18 pm, V14 documented that R569 was having right lower leg pain, present pain level of 4 out of 10, and with alleviating factors of medication of "(Hydrocodone-Acetaminophen) 5-325 mg." On R569's facility incident report, dated 2/23/21 at 5:18 pm, V14 documented as immediate action taken as, "500 mg Acetaminophen was given to ease the pain." Facility time record for V14 indicates that on 2/23/21, V14 worked from 6:58 am to 8:14 pm. On 3/16/21 at 3:00 pm, V14 (LPN) adamantly stated that he did not administer Hydrocodone-Acetaminophen to R569 on 2/23/21. V14 stated that he medicated R569 with a dose of Acetaminophen for her complaint of right leg pain on 2/23/21. V14 stated that he ended his 12 hour shift on 2/23/21 shortly after 8:00 pm.	S9999		

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S9999	Continued From page 4 On 3/17/21 at 7:30 am, V17 (LPN) stated that she was on 11:00 pm to 7:30 am nurse for R569 on 2/23/21. V17 stated that she received report from V18 that R569 had fallen to the floor earlier in the previous shift. V17 stated that as she is getting report from V18 at the nurse's station, she heard R569 "screaming in paranoia." V17 stated that R569 was screaming her name, so she went to see R569. V17 stated that R569 was in pain and asked her if "(R569's) daughter was dead?" V17 stated that she had never shown this behavior before. V17 stated that R569 wasn't moving and upon repositioning of R569 for comfort, she screamed, "My right leg!" V17 stated that R569 was clinching her teeth and "screaming over and over." V17 stated that she notified V20 (Physician) about R569's mental status change, intense pain and not being able to move her right leg. V17 stated that V20 gave her a telephone order to send out R569 to the hospital for further evaluation. V17 stated that she sent R569 to the hospital on 2/24/21 at 2:00 am. On 3/17/21 at 7:30 am, V17 stated that she was R569's primary nurse the next night on 2/25/21 after R569 had returned from the hospital. V17 stated that R569's right leg was swollen and that she "was in pain and screaming." V17 stated, "(F569) couldn't move her leg. (F569's) pain was over the top. (F569) was having legitimate pain." V17 stated that she did not notify a physician this night shift on 2/25/21 about R569's increased pain. R569's MAR, dated February 2021, documents, in part, that "Acetaminophen 500 mg by mouth every 6 hours as needed for moderate pain, Hydrocodone-Acetaminophen 10-325 mg by mouth every 4 hours for pain as needed" were	S9999		

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ordered for R569. R569's MAR indicates that V17 did not administer either pain medication to R569 on her night shift on 2/25/21.

On 2/26/21 at 5:17 am, V17 documented that R569 is "grimacing in pain every time (F569) is moved / repositioned. (R569) needs much assisting."

On 3/17/21 at 7:30 am, V17 stated that she was R569's primary nurse on the night shift of 2/28/21. V17 stated that R569 remained in pain and was confused. V17 recalled how on the night shift before R569 fell on 2/23/21, she was wheeling around the floor, heating up chicken in the microwave and having normal, oriented conversation with V17. Again, V17 stated that she did not notify a physician this night shift on 2/28/21 about R569's pain, confusion and application of oxygen.

On 2/28/21 at 11:40 pm, V17 documented that she "received (F569) trashing about. Screaming on occasion, moaning and confused. Alert and oriented times 1-2. SaO2 (oxygen saturation) 91% on room air. (F569) placed on 2 liters per nasal cannula."

R569's MAR, dated February 2021, documents, in part, that "Acetaminophen 500 mg by mouth every 6 hours as needed for moderate pain, Hydrocodone-Acetaminophen 10-325 mg by mouth every 4 hours for pain as needed" were ordered for R569. R569's MAR indicates that V17 did not administer either pain medication to R569 on her night shift on 2/28/21.

On 3/17/21 at 11:05 am, V21 (ADON) stated that she was briefly assessed R569 after she had fallen on 2/23/21 and that she was crying in pain,

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complaining of pain to her right leg and that when V21 tried to perform ROM of the right leg, R569 "screamed out in pain." V21 also stated that R569 was incoherent and "appeared high on something." V21 stated that she told V18 (LPN) to see if there was an order for Naloxone for R569 and that V18 later administered Naloxone to R569. V21 stated that she told V18 when he calls the physician to ask for stat X-rays and to give her pain medication. V21 stated that she did not stay with R569, but did return one hour later and that V18 informed her that he was giving R569 her pain medication and that stat X-rays had been ordered. V21 stated that she didn't know the pain medications that R569 was on at this time on 2/23/21. V21 stated that nurses are to perform pain assessments at least once a shift, at the beginning of shift and then reassess for pain one hour after any medication is administered for pain. V21 stated that on the following day, she realized that R569 was sent out to the hospital overnight due to X-rays not being performed stat. V21 stated "We should have sent (R569) out (to the hosipital on 2/23/21) since we couldn't get the X-rays done as stat.

In R569's facility document, titled "Fall Event" and dated 2/23/21 at 5:18 pm, V18 (LPN) documented, in part, that R569 had a deviation from usual mental status, range of motion (ROM) was painful in lower extremities and that V19 (NP) was notified at 6:48 pm on 2/23/21.

On 3/17/21 at 12:21 pm, V18 (LPN) stated that he assisted V14 (LPN) when R569 fell on 2/23/21 in the facility. V18 stated that V14 was R569's primary nurse and that he did not witness R569's fall. V18 stated that when he responded, he observed R569 on the floor in her room and that R569 was saying that she was trying to go to the

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bathroom. V18 stated that R569 was complaining of leg pain, but could not remember which leg. V18 stated that when R569 was back in bed, she was in pain, not coherent and her "eyes were rolling back." V18 stated that R569 was "lethargic like" and "coming in and out." V18 stated that R569 is normally "completely alert," so this was a mental status change. V18 stated that he then discussed this new finding with R14 and that they both "tried to figure it out." V18 stated that per his nursing judgement and thinking about R569's history of overdose, he speculated that R569 may have connected with "somebody to receive illicit drugs" to cause her altered mental status. V18 stated that he administered Naloxone to R569 via her nostrils. V18 stated that after 10 seconds, R569 was alert, eyes were open and that she was still complaining of leg pain. V18 stated that he's not sure if V14 medicated R569 for the leg pain and that R569 usually gets Hydrocodone-Acetaminophen every 4 hours whenever needed for pain.

R569's medication administration record (MAR), dated February 2021, documents, in part, that "(Naloxone) Liquid 4 mg/0.1 milliliter (ml), 1 spray in both nostrils as needed for opioid overdose" was ordered for R569. V18 did not document administration of Naloxone to R569 on 2/23/21.

On 3/17/21 at 12:21 pm, V18 stated that he documents in the electronic MAR any resident medication that he administers. V18 stated that he did not notify a physician or nurse practitioner of administering Naloxone to R569 for a suspected overdose. V18 stated that V14 (LPN) stayed and finished his shift from 7:00 am to 7:00 pm and that no other nurse came to relieve V14 after he left. V18 stated that he took over care for R569 until he gave report to the on-coming nurse

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(V17, LPN) at 11:00 pm. V18 then stated that he "most likely" had a phone conversation with V19 (NP) on 2/23/21 and notified him of R569's fall with right leg pain. V18 stated that he then gave report to the oncoming night shift nurse (V17, LPN) on 2/23/21 at 11:00 pm. V18 stated that with a change of condition, such as altered mental status or acute pain after a fall, it would be criteria to send a resident to the hospital for further evaluation. V18 stated that did not medicate R569 for her pain on 2/23/21 and that R569 did not receive any X-rays on 2/23/21.

R569's MAR, dated February 2021, documents, in part, that "Acetaminophen 500 mg by mouth every 6 hours as needed for moderate pain, Hydrocodone-Acetaminophen 10-325 mg by mouth every 4 hours for pain as needed" were ordered for R569. R569's MAR indicates that V18 did not administer either pain medication to R569 on 2/23/21 from 7:30 pm to 11:30 pm.

On 3/17/21 at 2:00 pm, R569 was interviewed and stated that her pain is "not good" because she has spinal stenosis. R569 stated that on 2/23/21 at 4:00 pm, she fell to the floor when trying to go to bathroom as she stood up from her bed. R569 stated that she "hollered out" with the room door open and that nurses responded to her. R569 stated that she didn't know the names of the nurses. R569 stated that she was in pain with her right leg hurting and that she couldn't lift her right leg. R569 stated, "I was hurting so bad" and that she was sent out to the hospital.

On 3/17/21 at 2:00 pm, R569 was interviewed and stated that when she returned from the hospital on 2/25/21, her right leg was swollen and that the pain in her right leg "got worse." R569 stated, "It made me feel terrible inside. I was

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S9999	Continued From page 9 suffering and no one was doing anything to help me." R569 stated that she did then have an X-ray performed due to her my right leg being so painful and swollen. R569 stated, "I was still in terrible pain. I was acting out and crying in terrible pain. After I fell, I cried more as a grown woman than I ever did as a kid." On 3/18/21 at 11:00 am, V19 (NP) stated that on 2/23/21, he was notified over the phone by a nurse of R569's fall incident, but he couldn't recall the nurse's name. V19 stated that he remembered being informed that R569 fell down to the floor from her wheelchair and fell face forward. V19 stated, "I gave the nurse an order to send R569 out to the emergency room." V19 stated that he did not recall being informed of R569's new right leg pain after her fall incident on 2/23/21. V19 stated that he was not informed on 2/23/21 of R569 being administered Naloxone. V19 stated that the standard of standard of practice for a chronic pain resident is receiving "a lot of opiates" is to have a whenever needed order of Naloxone available. However, V19 stated that if V18 (LPN) administered Naloxone to R569 for seeing an altered mental status or unresponsiveness, he should have been notified. On 3/18/21 at 4:00 pm, V20 (Physician) stated that received a call from V17 (LPN) on 2/24/21 at 12:55 am notifying her of R569's pain of 10 out of 10, not able to move her right leg, confusion and hallucinations post fall. V20 stated that she gave a telephone order to V17 to send R569 out to the hospital via 911 emergency services. On 2/25/21 at 3:12 pm, V22 (Registered Nurse, RN) documented that R569 returned to the facility from the hospital with computerized tomography (CT) scans of the head, spine and right hip that	S9999		

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S9999	Continued From page 10 were negative for fracture. On 3/18/21 at 11:00 am, V19 (NP) stated that he has been R569's practitioner for 5-7 years. V19 stated that R569 has pain, gets her pain medications and that she's not a "difficult patient." When asked if there's any non-pharmacological interventions that facility nursing staff could have used to help with R569's pain, V19 stated, "Give (R569) her pain medications on time. That's what (R569) wants." This surveyor asked V19 that when R569 returned from hospital on 2/25/21 and was having increased pain to her right leg, what did V19 expect was being done by the nursing staff? V19 then replied, "Medicating (R569) with pain medications every 4 hours." This surveyor informed V19 that from 2/25/21 to 3/1/21, multiple nursing notes documented that R569 was screaming and thrashing in pain, with confusion and hallucinations, and V19 stated, "I wasn't told about having the increased right leg pain." With R569's increased right leg pain from 2/25/21 to 3/1/21, while screaming and thrashing out in pain, with confusion and hallucinations, and not receiving her pain medications every 4 hours, this surveyor asked V19 how could this effect R569? V19 stated, "Trauma to the brain. A psychosis from pain. It would be traumatic torture (for R569)." On 3/17/21 at 11:27 am, V22 (RN) stated that on the day shift of 3/1/21, she sent R569 out to the hospital for mental status changes from an order from V19 (NP). V22 stated that she assessed R569 and found that R569 didn't recognize V22 (which was unusual), couldn't say where she was at and was "calling out somebody's name." V22 stated that she informed V19 (NP) who came to assess R569 in person. V22 stated that V19 started and intravenous (IV) site on R569 and IV	S9999		

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S9999	Continued From page 11 fluids; then gave order to send out R569 immediately to the hospital. On 3/18/21 at 11:00 am, V19 (NP) confirmed V22's statement. R569's hospital records indicate that on 3/2/21, a CT scan of R569's bilateral lower extremities was performed and compared to the CT scan of R569's pelvis, right hip and right femur. This 3/2/21 CT scan for R569 indicated a "displaced fracture of the right proximal tibial diaphysis and healing fracture of the right fibular neck." On 3/10/21 at 10:31 pm, V30 (LPN) documented, in part, that R569 was readmitted from the hospital back to the facility. On 3/11/21 at 12:38 pm, V31 (NP) documented, in part, that an orthopedic surgeon was consulted after the CT results of R569's right proximal tibial fracture and that R569 had a surgical operation on 3/4/21 for a "right tibial nail." On 3/18/21 at 11:42 am, V2 (DON) stated that nurses should notify a physician or nurse practitioner of any change in condition, change of mental status, abnormal vital signs, pain not controlled or anything outside of a resident's baseline status. V2 stated that resident pain assessments are to be performed on an as needed basis, but at least every 8 hours. V2 stated that if a resident expresses pain, then nurse needs to address it, medicate the resident and the reassess for pain 30 to 45 minutes after the medication. V2 stated that if the pain is not controlled at the reassessment, the nurse should review the resident's available pain medications or perform non-pharmacological interventions. V2 stated that the nurse will notify the physician or nurse practitioner if a pain medication is not effective.	S9999		

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 _____	03/18/2021

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S9999	Continued From page 12	S9999		

R569's care plan, dated 1/16/2020, indicates a goal for R569 is to be free of any discomfort or adverse side effects from pain medication, and interventions included to "administer medication as ordered" and to "monitor for altered mental status." R569's care plan, dated 5/1/16, indicates a focus of alteration in musculoskeletal status, and interventions included to "give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness."

Facility policy, titled "Pain Management" and dated 7/14, documents, in part: "General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents that means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Responsible Party: Nursing, DON. Guideline: 1. The pain management program is based on a facility wide commitment to resident comfort. Pain is defined as what ever the experiencing person says it is and exists whenever he or she says it does. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Observing for the potential for pain b. Effectively recognizing the presence of pain c. Identifying the characteristics of pain d. Addressing the underlying causes of the resident's pain e. Developing and implementing approaches to pain management f. Identifying and using specific

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S9999	Continued From page 13	S9999		

strategies for different levels and sources of pain g. Monitoring for the effectiveness of interventions and h. Modifying approaches as necessary ... 6. Observe, verify, and confirm the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain ... Guidelines: 3. A licensed nurse may initiate a Pain Form under the following circumstances: a. Change in resident condition that occurs and requires pain control b. New pain is reported. 4. A licensed nurse may repeat the Pain Form under the following circumstances: a. Resident is on routine pain medication and the pain is not managed, persistent or worsening ... c. A change in pain related behavior, cognition or mood occurs ... 6. Licensed Nursing may notify the Health Care Provider of any new development of pain, change in pain, change in condition that could potentially cause pain, for pharmacological interventions based on the individual's pain factors."

Facility policy, titled "Medication Administration" and dated 7/14, 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. Level of Responsibility: RN, LPN. Guideline: ... 14. Document as each medication is prepared on the MAR ... 21. Document reason and response for any PRN (whenever needed) medication."

Facility policy, titled "Change in Resident's Condition" and dated 9/16, documents, in part: "General: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician/NP and resident's responsible party of a change in condition. Responsible Party: RN, LPN, Social Services.

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S9999	Continued From page 14 Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: a. The resident is involved in an accident or incident. There is a significant change in the resident's physical, mental or emotional status ... e. It is deemed necessary or appropriate in the best interest of the resident ... 3. The communication with the resident and their responsible party as well as the physician/NP will be documented in the resident's medical record or other appropriate document." (A)	S9999		