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 12/21/2021

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: 2189176/ IL141191 2189236/IL141275	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 d)3) 300.1210 d)6) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	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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determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow its abuse policy; failed to protect R3 from physical abuse; failed to identify and report abuse immediately.
These failures affect 1 resident (R3) out of 3 residents (R1, R2 and R3) reviewed for abuse.
Failures resulted to bruising of R3's left eye periorbital area requiring transfer to acute facility for CT scan.

Findings include:

The Facility's Abuse Prevention Program states under Objective:
The objective of the Abuse Prevention Program is to comply with the seven- step approach to abuse and neglect detection and prevention.
II. Identification and Internal Reporting states:
The direct care staff is responsible for reporting

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S9999	Continued From page 2 the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. Internal Reporting states: Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observed, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Any employee who knows or suspects that abuse has not been reported the abuse or makes false allegations of abuse will face possible termination. Any employee who knows or suspect that abuse has occurred and makes immediate report out of a legitimate concern shall not be penalized or reprimanded for making such report. IV. Investigation states: As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the administrator or designee will initiate an investigation into the allegation which may include the following elements: - Interviewing all persons who may have knowledge of the alleged incident, including, but not limited to: All persons who reported the suspicion, allegation or incident; The alleged victim (if the victim is unable to be interviewed, this shall be documented); The alleged perpetrator; Any witnesses or potential witnesses to the alleged occurrence or incident; Any staff having contact with the resident during the period of the alleged incident; Roommates, other resident, family or visitors. - A review of the medical record, including care plan; - A review of all circumstances surrounding the	S9999		

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incident; and
- Physician will be notified of any incident and any medical treatment will be done as ordered.
The investigation shall be conclude whether the allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation can likely be sustained. Record of the investigation shall be maintained.
V. Reporting and Response states: An initial report to the State licensing agency, Illinois Department of Public Health, shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed.

R3 originally admitted in the facility on 7/10/20 with medical diagnosis of hemiplegia and hemiparesis, vascular dementia and muscle weakness. Brief Interview of Mental Status of R3 dated 9/15/21 has a score of 2 that means R3 status during the interview was cognitively impaired.

On 12/14/21 at 9:50 AM with V1 (Administrator) stated that R3 was sent to the hospital on 12/5/21 for CT scan due to left eye bruising. V1 then stated that upon investigation, V9 (Certified Nursing Assistant) admitted that she (V9) hit R3's left eye. V1 then stated that V9 did not report the incident when it happened. It was reported by a nurse that was scheduled 7:00 am to 3:00pm the following day. Per V1, V9 worked on 3pm to 11pm on 12/4/21 when the incident happened. V1 said, "I agree she (V9) should have reported it. I know this is a problem, she (V9) should have reported it to me or the nursing manager." V1 then stated, upon learning about the incident V9 was suspended on 12/5/21. Later V9 was terminated after investigation, V9 was informed when she was summoned in the facility that she (V9) was terminated.

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On 12/14/21 at 11:10 AM R3 was seen in R3's room in a wheelchair. R3 was alert but not able to be interviewed due to R3's cognitive status. R3 has discoloration / bruising on the left eye. At the Nurse's Station, V12 (Registered Nurse) said, "I worked on 12/5/21 day after the incident. And when I came on the unit reporting to work. I saw R3 sitting on the wheelchair at the Nurse's Station. Right away I noticed the left eye of R3 were swollen and bruising. I then called V1 (Administrator). V1 instructed me to call the doctor. And I (V12) was given an order to send R3 to Emergency Department of the hospital for CT scan. I do not know why the night shift nurse (V14) and all Certified Nursing Assistants working in the night shift (11pm-7am) did not catch or see the bruising of R3's left eye."

On 12/14/21 at 11:20 AM V13 (Nurse Manager) stated that she worked on 12/4/21 (Saturday) until 8:00 PM. When she left the facility R3 was in the dining room. V13 then said that on 12/5/21 I (V13) received a call from V12 that R3 has a bruising on R3's left eye and it was also swollen, he (V12) also sent me (V13) a picture of R3's left eye. I then called Certified Nursing Assistants working at that time. Eventually, I spoke to V9 (Certified Nursing Assistant) who worked on 12/4/21 3:00 PM to 11:00 PM shift. V13 said, "V9 told me that R3 was combative during the time that she (V9) was changing R3's clothes. And she (V9) said that she hit R3's left eye. I (V13) told her (V9) that she should have reported the incident right away. And not leave the facility without reporting it to either the nurse or nursing supervisor or the administrator. Because now it looks like she (V9) abused R3." V13 then said, "V10 (Certified Nursing Assistant) was assigned to R3. Nursing staff working in the night shift

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should have noticed (R3) left eye bruising. It should not reach for the morning shift or for V12 to see it. R3 needs help to transfer on the wheelchair. And whoever transferred her (R3) on the wheelchair should have seen R3's left eye bruising."

On 12/14/21 at 1:19 PM. V9 (Certified Nursing Assistant) said, "I worked on 12/4/21, 3:00 PM to 11:00 PM shift and I was assigned to R3. It happened between the hours of 7:30 PM to 9:00 PM. R3 was wearing 2 shirts so it was hard for me to change R3's clothes. R3 was combative during that time and was holding down. I think because of my reflexes I hit R3's face. I did not report the incident, but I know I should have reported it. R3 refused R3's medication and was combative during that time. I was alone during that time and did not ask for help. I know that the right thing to do is to leave R3 alone and ask for help, but I did not do that. I started working at the facility around August this year and I was not given a training for abuse. I was trained for abuse when I got my certificate for Certified Nursing Assistant about 4 years ago. But I did not receive any abuse training from the facility. After I hit R3's left eye, I thought that it was just fine. I did not notify the nurse, it was V5 (Licensed Practical Nurse) working that day. I know that nurses are doing the assessment and I guess I should have notified her (V5). After the incident of hitting R3's left eye, I peeked into the room around 10:30 PM to 11:00 PM before I left the facility. But I did not see R3's left eye if there was bruising. So, I do not actually know if there was bruising or any injury to R3's left eye when I left the facility."

On 12/14/21 at 4:17 PM. V5 (Licensed Practical Nurse) stated that she was working on 12/4/21 3PM to 11PM shift and was assigned to R3. V5

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stated that V9 (Certified Nursing Assistant) put R3 to bed around 8:30 PM to 9:00 PM and that was the last time she V5 saw R3. V5 said "V9 did not inform me about the incident that she (V9) hit (R3) left eye. And being R3's (V9) charge nurse, I expect V9 to report it to me. V9 should have brought R3 back at the Nurse's Station if she was having problem with R3."

On 12/14/21 at 5:15 PM. V14 (Licensed Practical Nurse) stated that on 12/4/21 11:00 PM to 12/5/21 7:00 AM shift she took care of R3. And all through the shift she was not able to see the left eye bruising of R3. V14 also stated that V10 (Certified Nursing Assistant) was assigned to R3. And that the schedule provided to writer by the facility was incomplete. V14 further stated that V10 got R3 up and it was not possible to miss R3's left eye bruising. V14 said, "I expect nursing assistant to update me in case that resident have incidents or unusual situations." V14 then stated that the nurse (V5) on 3:00 PM to 11:00 PM shift did not mention to her that R3 needs to be monitored. And all nursing staff that worked that shift on 12/4/21 11:00 PM to 12/5/21 7:00 AM shift was not able to report to immediate supervisor or abuse coordinator left eye bruising of R3.

Physician Order dated 11/17/21 for R3 reads that facility staff needs to do hourly safe rounds.

On 12/14/21 9:50 AM, a request was made to V1 for the nursing staff that worked on 12/4/21 when the incident happened. V1 provided an incomplete schedule. Which does not include V10. V10 (Certified Nursing Assistant) was the nursing staff assigned to R3 on 12/4/21 11PM to 12/5/21 7AM shift the shift after the incident happened. V1 then informed through email and

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requested for the complete nursing schedule with V10's contact information. V1 provided a non-working number of V10. And said that he (V1) will inform V10 to provide for a working number. None were provided. V1 was requested multiple times (12/14/21, 12/15/21, 12/20/21) for contact information of V10.

On 12/15/21 at 10:25 AM. V1 (Administrator) stated that a complete investigation was requested. And he submitted a final incident report without details of facility staff that was interviewed. V1 stated that V13 (Nurse Manager) and V14 (Licensed Practical Nurse) were interviewed. When asked if he confirmed that V10 (Certified Nursing Assistant) was taking care of R3 on 12/4/21 11:00 PM to 12/5/21 7:00 AM. V1 said, "Yes V10 was assigned to R3, V10 came in the facility today and was vague. V10 said that she saw R3's left eye bruising on Thursday 12/2/21. And when I (V1) looked at the camera R3 does not have a bruise on R3's left eye." V1 stated that it was not credible. V1 said, "V10 statement was vague so I did not include it." On 12/16/21, V1 submitted handwritten document dated 12/4/21 timeline that V10 assisted R3 to Nurse's Station. V1 was then asked why V10 or any of the nursing staff (V14/LPN, V17/CNA, V18/CNA, V19/CNA and V20/RN) that worked 12/4/21 11PM to 12/5/21 7AM did not report R3's left eye bruising. V1 did not answer. A request was made to V1 to see camera footage on 12/4/21 to 12/5/21 since he was able to access prior date (12/2/21 / Thursday). V1 stated that he will check because it may be erased (V1 was not able to confirm request). V1 was then asked why any of the nursing staff both nurse and certified nursing assistants that worked 12/4/21 11PM to 12/5/21 7AM did not notice or report the bruising

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of R3's left eye. And R3 was on the Nurse's Station transferred by V10 to the wheelchair and R3 needs assistance during transfers. V1 did not comment. V1 was informed that according to V9 (Certified Nursing Assistant) during changing of clothes R3 was with behavior. And it was by her reflexes that she (V9) hit R3's left eye. V1 said, "I did not know about that because she (V9) told me different things. But if that was the case it is an abuse." V1 was asked that since yesterday morning a request was made to him of all documentation related to R3's incident including statement of V9 and V10. And that it was not included in the submitted documents although it is pertinent to the investigation. V1 did not reply. V1 was also asked that since R3 was in hourly interval monitoring for safety as ordered and there are 5 to 6 nursing staff on the floor why was none of the nursing staff noticed or observed the bruising on R3's left eye. V1 said that they (nursing staff) must be doing other things. V1 was then asked after knowing the incident about R3 left eye bruising if he (V1) came to look at R3's left eye? V1 said, "Yes, I did come and see R3's left eye, the bruise was big purple."

On an email dated 12/20/21, V1 (Administrator) submitted a picture taken by V12 showing the extent of R3's left eye bruising on R3's periorbital area.

12/15/21 at 11:05 AM. V11 (Detective) that came responded and came on 12/5/21 said, "The nature of her investigation is criminal. And part of her responsibility is to coordinate with the State if the facility reported the incident to the State. Because there are instances that facility do not report incidents to the State. And to notify immediate family of R3 in this case V15 (R3's Son). I (V11) spoke to V15, the facility did not

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inform him (V15). V15 is the Power of Attorney (POA) and he lives just walking distance from the facility. Not informing family members is a violation of the law and a case can be filed for not informing the family. R3 has a pretty bad bruise, and (R3) family does not know. I can't lie. V9 can also be arrested but I was considering that she is just 22 years old with no prior record. But this should be a lesson to her that she needs to notify proper authority. I will put in my report that she (V9) strike (R3) whether she (V9) intended or not and cause injury to the (R3)."

Progress notes of R3 have incidents of injuries reads:
V16 (Registered Nurse) documented on 1/1/21 that she (V16) was informed by Certified Nursing Assistant that R3 was in bed sleeping. When R3 awoke R3 attempted to scratch Certified Nursing Assistant, R3 lost balance and fell on left elbow. On the date 1/1/21 X Ray was done on left elbow and left ribs. Left elbow has a result of distal humeral fracture. And left ribs have acute left lateral eight rib fracture.

V12 (Registered Nurse) documented on 2/18/21 that R3 complaint of pain on right hand. Right hand tender to touch. X Ray on the right hand was ordered and performed.

V12 (Registered Nurse) documented on 3/28/21 that R3 was noted with redness on the left elbow with small open area. X Ray on the left elbow was ordered and performed.

A request through email was made to V1 (Administrator) for detailed investigation and report to State Agency related to the above noted incidents dated 1/1/21, 2/18/21 and 3/28/21. No report and details of the investigation was

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S9999	Continued From page 10 received. Care plan of R3 reads: R3 requires assist with ADL (Activity of Daily Living) related to co-morbidities. R3 needs extensive assist of 1 staff with dressing, toileting, personal hygiene, bathing, bed mobility, transfer, locomotion. Progress notes of R3 dated 12/5/21 by V12 (Registered Nurse) documented that due to left eye bruise and swelling R3 was sent to hospital for CT scan of the head. "B"	S9999		