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
	IL6003958	A. BUILDING: _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY MORGAN PARK	10935 SOUTH HALSTED STREET CHICAGO, IL 60628

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S 000	Initial Comments Facility Reported Incident of August 21, 2022/IL150749 Facility Reported Incident of August 17, 2022/IL150755	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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**	

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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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interviews and record reviews, the facility failed to protect 2 (R2 and R10) of 3 residents reviewed for abuse in a total sample of 13. These failures resulted in R2 sustaining an injury to the back of the head and R10 being verbally abused. Findings include: 1.) On 10/12/2022 at 12:42 PM, R2 stated, I confronted R1 in the dining room on the 3rd floor about stealing my pants, and I told him to give them back. R1 got in my face, and he grabbed me, then pushed, me. I fell and hit the back of my head on a table. My head was hurting really bad, and I was bleeding from the back of my head. When I got up, R1 pushed me again. The nurse cleaned the blood off my head. The ambulance came took me to the hospital. They put stitches in the back of my head at the hospital and they sent me back to the facility. On 10/12/2022 at 11:00 AM, V21 (Licensed Practical Nurse) stated, I saw R2 getting up off the floor in the dining area. I saw R1 push R2 after he got up off the floor. R2 did have cut on the back of his head, and it was bleeding. I told	S9999		

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the doctor about the incident, and I was instructed to send R2 to the hospital to get evaluated. R1 is known to be verbally abusive and aggressive.

On 10/11/2022 at 01:20 PM, V4 (Certified Nursing Assistant) stated, I saw the incident between R1 and R2. I saw R1 push R2. R2 fell back and hit his head on one of the tables. When R2 got up, he had a gash on the back of his head that was bleeding. R1 can be verbally aggressive with other residents and staff.

On 10/11/2022 at 1:11 PM, V3 (Certified Nursing Assistant) stated, I saw the end of the incident with R1 and R2. R1 was about to hit R2, and I told R1 to stop. R2 had an injury to the back of his head. I did see blood coming from the back of R2's head. R1 was sent to be assessed by his nurse. R1 is usually angry, and he can be verbally aggressive to staff and residents.

On 10/13/2022 at 02:03 PM, V1 (Administrator) stated, I completed the abuse investigation for R1 and R2. R1 said he grabbed R2 and when he let R2 go, R2 fell backwards and hit his head. I did substantiate the abuse because R2 did fall, and he had an injury to his head.

R2 was admitted to the facility on 08/25/2021, with a diagnosis not limited to, Alcohol Dependence with Withdrawal Delirium. R2's emergency room records dated 08/21/2022 were reviewed. Records read: "Diagnosis: Scalp Laceration. Procedures: Laceration/Wound Repair - Head. Wound repaired with: Sutures. Number of Sutures: 2."

R1 was admitted to the facility on 12/04/2021, with a diagnosis not limited to, Unspecified Mood (Affective) Disorder. R1's behavior incident report

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S9999	Continued From page 3 dated 08/21/2022 was reviewed. Report reads: "Nursing Description: Per staff resident observed grabbing his peer to remove him from a chair he was sitting in previously." Resident Description: Resident stated his peer accused him of taking clothes from him and attempted to punch him. Resident stated, "I grabbed hm and when I let go, he fell and hit his head on table". Abuse investigation for R1 and R2, dated 08/21/2022, reads: On 08/21/22, R1 and R2 were involved in a physical altercation in the dining room ... ...R1 grabbed R2, and when he let him go; R2 lost his balance and fell. R2 fell and hit his head on the table. R2 had a small amount of blood coming from the back of his head ... ...the allegation can be substantiated because the staff and other residents witnessed the incident and R2 sustained and injury. 2.) On 10/11/2022 at 12:42 PM, R10 stated, V17 (PCT/Dialysis Tech) was verbally abusive to me during my dialysis sessions. V17's verbal abuse was getting to be too much, so I filed a grievance against her in August of this year. When V17 would do my dialysis, she would yell at me, and she would tell me to stop looking at her while she was hooking me up to the dialysis machine. During one of my dialysis sessions in August, V17 snatched on my dialysis cord, and I told her to stop. V17 yelled at me and told me to shut up and stop talking. I did not feel safe receiving dialysis from V17. V17 would talk about my clothes and call me a rich lady all the time. I told her to stop saying that because I didn't like it, and she wouldn't stop. After I filed the grievance against V17 she told me I always go and tell the boss on people. V17 came to my room and told me she has someone that would hurt me and my son if I got her fired.	S9999		

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S9999	Continued From page 4 On 10/12/2022 at 12:32 PM, R13 stated, V17 did yell a lot but I ignored her. On 10/12/2022 at 10:08 AM, V16 (Regional Nurse Consultant) stated, I interviewed R10 about the verbal abuse incidents that happened with her and V17 in August. After the investigation was completed, it was determined that R10 was verbally abused by V17. We used R10's statements to determine that verbal abuse did happen between her and V17. V17 was terminated from the dialysis center after the investigation was completed because verbal abuse was substantiated. The investigation showed that V17 was very condescending towards R10, and she made inappropriate comments to R10. I found out that V17 went to R10's room and confronted R10 about reporting her for abuse. R10 stated that V17 threatened her with physical abuse when she came to her room. During my interview with R10, R10 did report that V17 forcibly pulled on R10's HD catheter during one of her dialysis sessions. R10 said that V17 told her that she makes everyone in the dialysis unit feel bad because R10 comes to dialysis all dressed up. R10 said V17 kept calling her a rich lady. R10 also reported that V17 would tell her to shut up when she tried to defend herself. On 10/12/2022 at 10:22 AM, V18 (PCT/Dialysis Tech) stated, V17 has had complaints against her from other residents for being verbally aggressive. I have heard V17 being verbally aggressive to the dialysis residents. I did hear V17 talk about R10. V17 did talk about R10's clothes and she did call her a rich lady. On 10/12/2022 at 10:35 AM, V19 (Dialysis RN) stated, V17 is known to speak roughly to the	S9999		

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S9999	Continued From page 5 residents, and she can be rough when she is setting up her dialysis equipment. On 10/13/2022 at 02:03 PM, V1 (Administrator) stated, I did submit an investigation for R10's abuse investigation. The dialysis center substantiated verbal abuse and I substantiated abuse for R10's investigation. R10 was admitted to the facility on 12/24/2019, with a diagnosis not limited to, End Stage Renal Disease. R10 is cognitively intact, according to R10's most recent minimum data set. Abuse investigation for R10, dated 08/17/2022 reads: The allegation is substantiated because, R10 and other residents stated that V17 has a history of fussing and raising her voice at the residents, which is inappropriate and verbal abuse. Per V16, V17 has been permanently removed from her position. V17's termination letter was reviewed. Termination letter reads: This letter is to inform you that your employment is being terminated effective immediately. Your termination is the result of a comprehensive investigation, which included a multitude of interviews with various patients and staff members, which ultimately concluded that you committed multiple instances of unprofessional conduct, violations of patient care policies, and violations of Employee Handbook requirements. Combined with a previous record of unprofessional conduct, we regret that the dialysis center is left with no choice but to terminate your employment. Facility abuse policy reads: "This facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse, neglect,	S9999		

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S9999	Continued From page 6 exploitation, misappropriation of property, and mistreatment of residents. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (whether or not actually given). Verbal abuse is the use by a licensee, employee or agent of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident." (A)	S9999		