STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

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S 000	Initial Comments Complaint Investigation: 2280508/IL142655	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 care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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, interviews and record review, the facility failed to have a system in place to alert staff when an illegal drug enters the facility, if a resident uses illegal drugs within the facility and discourage the possession of an illegal drug by a resident and failed to have a care plan and implement interventions to decrease a resident's repeated use of an illegal drug. This applies to one of three residents (R11) reviewed for illegal substances and has the potential to affect 56 residents who are known drug users. As a result, R11 with a known history of illegal drug use, had repeated overdose from illegal drugs while in the facility. Findings include:	S9999		

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S9999	Continued From page 2 1. According to a face sheet, R11 is a 58-year resident admitted to the facility on 09/24/2020. According to physician assistant note dated 09/25/2022, R11 has a history of drug and alcohol use. Nursing progress note dated 11/26/2021, documents R11's active use of drugs and drug overdose. R11's Minimum Date Set assignment dated 01/06/2022 indicated R11 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates resident has intact cognitive response. R11's care plan dated 02/08/2022 indicated resident has a history of substance abuse and interventions for monitoring and supervision listed are for resident to provide urine sample, resident to address chemical dependency by actively participate in group treatment program. A facility incident Report dated 02/07/2022 documented: "Writer (V15 a licensed practical nurse / LPN) was informed by another resident that R11 was found lying on the floor in his room unresponsive and sweating." Nursing Progress Note dated 02/07/2022 authored by V15 documented: "Writer was informed by another resident that R11 was found lying on the room floor unresponsive and sweating. Writer knows that the resident has a drug history and writer administered 4mg x4 Narcans in nostrils. Resident(R11) became responsive, and resident stated, "what all the staff in here for." Writer contacted (NP/Nurse Practitioner) about resident overdosing and NP stated, "resident is medically cleared to be discharged home and to revoke all passes." R11's progress note dated 11/26/2021 documented: "On rounding, resident was noted to be slumped over on a corner, food tray and	S9999		

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debris all over clothes. He was breathing very heavily, unable to respond by name or touch, even sternal rub. He was sweating profusely and drooling at the mouth. Writer recognized signs of overdose and administered a total of 4 narcans intranasally with full response after about 8 to 10 minutes. Writer attended to other roommate in same state, other staff members witnessed resident holding same yellow baggies found on roommate that contained the drugs. When resident got back to his feet and back to baseline, A0x4, he was able to hide drugs. Resident denied having them or turning them over even after staff witnessed him in possession of them. MD notified of overdose with new order to stop all passes, discontinue narcotic pain medications. Staff continuing to monitor resident closely. Will be referred to SSD/Social Services Director in AM."

On 02/08/2022 at 12:32pm, V1 (administrator) stated, "I am aware a resident, R11, overdosed inside the facility yesterday. I met with social services this morning to make sure things are put into place. I met with V7 (social worker) and V9 (social worker), our social services. The room search, behavioral contract and reassessment for community pass have not been done but we will do it. This resident is known to have problems with drug use. R11 has overdosed in the past, so we are aware that R11 has an issue with drug use."

On 02/09/2022 at 10:54am V15 (LPN) stated, "R11 has an order for Narcan because R11 has overdosed in the past. I was the nurse for R11 on the night that R11 overdosed. I was working during the 3-11 shift on 02/07/2022. R11 was out on pass on 02/07/2022 and returned about an hour before R11 was found unresponsive. I did

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my rounds at 4:10pm and R11 was not back yet because he was out on pass. I'm really not sure how long R11 was back for before R11 overdosed. I don't remember what time R11 returned, but it's possible that R11 returned between 5 and 6 pm. I was getting ready to start passing my 7pm medication and I found R11 lying flat, face down on the floor in his room. I found R11 lying face down on the floor, around 7:30pm. I assessed R11 and R11 was sweaty, and the other CNAs helped me turn the resident over and that's when I administered Narcan. I administered a total of 8 mg into each nostril. R11 received a total of 16mg of Narcan. After I administered the Narcan, a CNA and myself were giving R11 chest rubs and R11 came out of it and became responsive. I called 911. The ambulance came and the resident refused to go with them to the hospital. So R11 refused hospitalization. The supervisor on duty stated that R11 has the right to refused going to the hospital. This is not the first time that R11 overdosed, so R11 had the order for Narcan in place. R11 is not a resident that is safe to go out on pass because R11 has a drug use problem and R11 has overdosed in the past."

On 02/09/2022 at 2:34pm, R11 stated, "I was out on Monday, and I was drinking and then I passed out. I did use drugs on Monday, and I was drinking alcohol. I took cocaine. I used other drugs before, but I didn't like it. I used cocaine on Monday, and I passed out and they brought me back. I used to do a lot of drugs. I used cocaine couple times recently and I was drinking on Monday as well. They gave me a pass to go out and I was out on pass on Monday. I did overdose few months ago and they brought me back."

On 02/09/2022 at 2:45pm, V14 (receptionist) stated, "R11 left out of the facility at 10:30am on

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S9999	Continued From page 5 02/07/2022. R11 signed R11 out at 10:30am but never signed back in so we don't know what time R11 actually returned." On 02/09/2022 at 3:35pm, V10 (social worker) stated, "R11 overdosed on 02/07/2022 and they revoked his community pass privilege. R11 had his pass revoked in December 2021 because R11 overdosed on drugs. R11 had his pass reinstated after that just recently. The other social worker reinstated the community pass by the end of January. So R11 just had his pass reinstated. R11 did not have any behaviors recently, except drug use in November or December. We have to revoke resident's pass privilege for a specified amount of time. I did not reinstate R11's community pass privileges, that was the other social worker that used to work here. I know that R11 has a drug use problem, and I was not the one who reinstated R11's community pass. The nurse practitioner and the doctor also help to determine if the resident is safe to go out into the community. R11 has overdosed in the past and I was not the one who reinstated R11's community pass. I'm not sure why they allowed R11 to go back out into the community unsupervised." On 02/10/2022 at 11:11am, V25(NP) stated, "I am the nurse practitioner for R11. R11 has a history of drug use, and R11 did overdose on 02/07/2022. R11 is usually a quiet resident and a stable resident. R11 did overdose. R11 does have a standing order for Narcan which was ordered on 12/15/2022. R11 was prescribed Narcan because it helps to bring the resident back when they overdose on drugs. Narcan is generally prescribed to counter the effect of the opioid, it is used to save someone's life when they overdose on drugs. On 11/26/2022 R11 overdosed also. That's why the Narcan was prescribed because	S9999		

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this is not the first time that R11 overdosed. R11 is not safe to be out in the community not supervised. R11 will not be given permission to go out into the community unsupervised. R11 was not safe to be out in the community independently because R11 is a known drug used and R11 did overdose in the past, so R11 was not safe to be in the community. R11 was out on pass on 02/07/2022, but R11 was not supposed to be out on pass because of R11's drug and overdose history. I don't remember giving R11 a pass to go out into the community, because R11 is not safe to be out in the community unsupervised. I am not sure why R11 was out in the community, but I did not give R11 a pass because R11 is not safe given R11's drug history. If R11 was not on pass, this drug overdose which occurred on 02/07/2022 could have been avoided."

On 02/18/2022 at 9:41am, V1 (administrator) stated, "I don't know how R11 was able to get into the building, I have to check with the receptionist. When the resident is returning into the building, the receptionist must make sure that the resident is signing back in. R11 does not have a pass to go back out into the community. When the pass is reinstated for R11, R11 will be searched when returning into the facility, as well as room searches. R10 has been restricted, we do room monitoring on R10 and we also do searches when R10 returns into the building. We will also provide R10 education. We will be searching the residents who are returning into the facility from pass. The residents are aware now that when they go out on pass, they will be searched upon return to the facility. We will also monitor the visits in the facility, and we have to make sure that we report any suspicious activity. We will search the visitors if they are brining bags into the building to make sure that drugs are not being brought into

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S9999	Continued From page 7 the facility." Front Desk Sign Out Book documents that R11 went out on pass on 02/07/2022 at 10:30am. R11 signed self out. R11 failed to sign self-back in when returned to the facility on 02/07/2022. Social Service: Behavioral Contract signed by R11 on 1/29/2022. Behavior Contract explains the nature of resident's behavior that presents an infringement to the health, safety, welfare, and rights of other individuals. Social Service: Behavioral Contract signed by R11 on 02/08/2022. Behavior Contract explains the nature of resident's behavior that presents an infringement to the health, safety, welfare, and rights of other individuals. 2. According to social service interview on 02/15/2022 at 1:47pm, V7 (social service director) stated that the facility has a total of 56 residents with a known history or current use of illegal drugs. On 02/08/2022 at 10:20am, R8 stated, "There are drugs being brought in and sold inside this facility. I told them repeatedly about the drug problem here, but they don't want to listen to me. I told the social workers and the administrator, but they ignore me. Last night, on 02/07/2022, by friend from the second floor, R11, overdosed here. R11 was out on pass and returned. I was visiting R11 in R11's room when R11 returned. R11 was doing good, we were talking and then a nurse asked me to leave the room, so I left and returned to my room on the 3rd floor. About an hour later, R11's nurse, V15 (Licensed Practical Nurse) called my nurse and informed my nurse that R11 was found	S9999		

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lying on the floor, unresponsive, because R11 overdosed on drugs. See they did not want to listen to me. I told them before that I know who sells the drugs inside the facility. R10, is a known drug dealer. R10 is the one who sells the drugs inside the facility. They did not do anything about it, because they ignore me. I have been R10 selling drugs to other residents inside the facility in the past, and I informed them of this, but nothing was done. R11 overdosed here in the facility. I told V1 (administrator) that drugs are being sold and distributed here, however, V1 would not listen to me."

On 02/08/2022, surveyor informed V1 (administrator) that R8 identified R10 as the resident who sells the illegal street drugs inside the facility. V1 informed surveyor that V1 will inform two social workers, V7 and V9, and a search will be conducted with the assistance of the police department.

On 02/08/2022 at 1:05pm, surveyor observed V4 (staffing coordinator) warning and informing the resident, R10, that the police is on the way and that the resident will be searched for possession of drugs. This incident was corroborated by video surveillance which captured the visual and audio evidence of V4 impeding on the investigation by informing R10 of the upcoming search.

Employee Report (dated 02/08/2022) documents: V4 (staffing coordinator) was suspended due to providing information to a resident of an investigation, therefore, impeding on the investigation.

On 02/09/2022 at 11:10am and 2:30pm, contraband policy was requested. Facility failed to provide contraband policy.

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S9999	Continued From page 9 On 02/09/2022 at 2:45pm, surveyor requested resident admission packet which provides notification for non-use or possession of illegal drug within the facility. Facility failed to provide resident admission packet. When asked if the facility allow a resident to have possession of illegal drug, the administrator responded, "The residents are not allowed to use or possess illegal drugs or alcohol in the facility. Residents are made aware of this strict non-tolerance policy on admission into the facility." (A)	S9999		