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 12/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2289263/IL153516	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 300.690 b) 300.690 c) 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. 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. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.	S9999		

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S9999	Continued From page 2 These Requirments were NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the safety of residents by not monitoring and preventing a resident (R4) from receiving and using an illegal drug. This failure resulted in R4 overdosing on heroin, requiring transfer and treatment at local hospital for treatment. Findings include: R4's current medical record (Face Sheet, Progress Notes, MDS-Minimum Data Set) documents: R4 is a cognitively intact 56-year-old admitted to the facility on 11/01/2022 with diagnoses including but not limited to: Opioid Abuse, Opioid Dependence, Cocaine Use, Acute Respiratory Failure with Hypoxia and Congestive Heart Failure. Progress note dated 11/8/2022 at 3:20 AM documents in part: "Nurse on duty notified by CNA to come to check to room to check on R4. Writer immediately rushed in resident('s) room and observed resident unresponsive, no movement of the entire body. Eyes rolled to back of head, extremely diaphoretic, unresponsive to sternal rub, and with agonal respirations. Code blue/rapid response initiated immediately, and staff responded. 911 called. Resident was taken to (local hospital). Facility's investigation (undated) documents in part: 11/8/22, (R4) noted to be unresponsive at 03:20 (AM). Code Blue called, Narcan administered and effective. Evidence of substance abuse note by nurse-small blue empty	S9999		

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S9999	Continued From page 3	S9999		

bag with whitish brown powder and rolled up bill/powdery residue. Transferred to ER for evaluation. Resident returned to the facility with no new orders. Hospital paperwork indicates that drug screen was positive for opioids.

Progress note dated 11/08/2022 at 3:15 AM documents in part: "Writer was told by staff that resident(R4) was in room, unresponsive and then a code blue/rapid response was overheard in speakers. Upon entering room, resident(R4) observed with eyes rolled to back of head, extremely diaphoretic, unresponsive to sternal rub, and with agonal respirations. 911 already called. Open carrier bag sitting on top of resident while code ongoing and all staff responding. Writer found a blue small empty drug bag with only a residual whitish brown powder and rolled up bill also with powdery residual. He(R4) was given multiple rounds of Narcan. Slowly, resident(R4) began to come out of stupor and respirations increased. He(R4) soiled himself and began to vomit. 911 EMTs and police arrived and were given report on his(R4's) status and presentation."

Progress Note dated 11/08/2022 at 7:02 AM documents in part: "Received a telephone call from (local hospital) regarding resident(R4), spoke with RN, who stated resident will be returning back to facility. DX (diagnosis) Opioid overdose."

Emergency Room Record Note 11/08/2022 documents: opiate OD s/p Narcan in (is) bedridden resident(R4) of nursing facility. Unexplained access to heroin.

12/08/2022 at 12:21 PM, V6 (LPN-Licensed Practical Nurse) said, when I called R4's name

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S9999	Continued From page 4 there was no response, no rising/fall of chest. I shook R4, checked pulse. There was no response to sternal rub. I called 911, called code blue. Nurse Supervisor (V10) responded, requested Narcan because V10 knows R4 has history of drug overdose. I remembered small black pouch or purse next to resident on bed, V10 saw the bag. There was a little, small plastic clear bag on top R4 with a whitish residue. I did see a male resident go into R4's room an hour or so before R4 was (found unresponsive). I don't know the resident's name; he is no longer at the facility. V6 stated their bags are not checked by security when they come to work. 12/07/2022 at 9:13 PM, V10 (Registered Nurse/Evening Nurse Supervisor) said, I was the manager on duty, they called rapid response/code blue. When I got there, R4 was extremely diaphoretic, sweating bullets, agonal respirations of 2-3 per minute, eyes rolled to back of head, and was non-responsive to sternal rub. I saw a black bag in bed by the resident, it was open. I saw a blue baggy with white residue and a rolled-up bill. I called for nasal Narcan; I gave it but R4 didn't respond. I couldn't appreciate pulse, or it was faint. I gave second round up Narcan. At that point we thought we were going to have to start compressions. Then 30-40 seconds later, R4 took a deep breath, like R4 was coming out of the water. R4 started breathing normally. R4's respirations gradually returned to normal. Then R4 just woke up. 12/09/2022 at 10:20 AM, R4 said R11 sold R4 heroin. "R11 came into my room. I gave R11 $20 dollars for two bags of heroin. The next thing I remember is the paramedics in my room. Everyone knew R11 was the go-to guy (to get heroin). V1 (Administrator) met with me after I	S9999		

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S9999	Continued From page 5	S9999		

returned to the facility from the hospital." V1 asked me, "who gave you the heroin? I told V1, "I had it with me." V1 said, "no you didn't. I saw (on the camera) R11 coming out of your room. I said to V1, "then why are you asking if you already know?" They knew R11 was selling it, R11 kept coming to my room. Drugs are still coming in (to facility), residents are still using (did not provide any additional information).

12/07/2022 at 3:52 AM, V1 said they didn't know how R4 got the heroin. V1 said they did not review tape and that V11 (Regional Nurse Consultant) completed an investigation.

12/09/2022 at 4:44 PM, V11 (Regional Nurse Consultant) said, "I completed the investigation. I don't feel that I could come up with a concrete way that R4 got the heroin. For this situation, we suspect that something may have come over the patio (fence). I did not review tape."

12/08/22 at 4:13 PM, V12 (Licensed Practical Nurse/3rd Floor Nurse Supervisor) said, "What I know is that R11 visited R4's room that night. I was told by my night nurse (V6). V6 was working the 3rd floor that night. I was told R1 visited R4's room at approximately 1 or 2 in the morning and approximately 30 minutes to an hour after R11 went into R4's room, R4 was found unresponsive.

R4's care plan for substance abuse (created and initiated on 11/09/2022) documents under focus: "resident has a history of substance abuse while in the community"; under goal: "resident will address chemical dependency by attending program as well as external chemical dependency treatment through next review." There are no interventions documented. Facility did not provide documentation that R4 attended

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S9999	Continued From page 6 programs. (A)	S9999		