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	IL6014195	A. BUILDING: _____ B. WING _____	C 04/11/2023

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SYMPHONY BUFFALO GROVE	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

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S 000	Initial Comments Complaint Investigation 2312984/IL158572	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210c) 300.1210d)1) 300.1210d)2) 300.1210d)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and 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. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident on oxygen had an oxygen supply, failed to ensure a resident with a recent hospitalization for pulmonary edema (buildup of fluid in the lungs leading to shortness of breath) followed physician orders, failed to have a policy and procedure for	S9999		

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weaning a resident off oxygen, failed to ensure oxygen tubing was dated, and failed to ensure oxygen tubing not in use was stored in a bag for 6 (R1, R2, R3, R5, R6, R7) of 6 residents reviewed for oxygen in the sample of 9. This failure resulted in R1 being admitted to the hospital for a second time within a month for pulmonary edema.

The findings include:

R1's face sheet showed she was originally admitted to the facility on 3/20/23 from an acute care hospital with diagnoses of type 2 diabetes, pulmonary hypertension, heart failure, chronic obstructive pulmonary disease, stage 5 chronic kidney disease, acute respiratory failure with hypoxia, pleural effusion, and dependence on renal dialysis.

On 4/10/23 at 4:06 PM, V5 (local fire department paramedic) said R1 told him she had shortness of breath, called the nurse, she put the thing on her (R1) finger and told her (R1) she was fine. V5 said he was called to the facility after a basic life support ambulance was to transfer her to a medical appointment and found R1 with a nasal cannula in her nose without oxygen running, a low oxygen saturation, high respiratory rate, high heart rate and three empty nonfunctional oxygen apparatus' in R1's room. V5 stated, "The facility did absolutely nothing but print a face sheet which we already had from the first ambulance crew."

On 4/11/23 at 11:25 AM, V4 (Certified Nursing Assistant/CNA) said on 4/10/23, R1 was supposed to go to a doctor appointment and the emergency medical tech (EMT) found her oxygen low.

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S9999	Continued From page 3 On 4/11/23 at 11:30 AM, V6 (Transportation) said on 4/10/23 around 9:15 AM, the lady from the ambulance told V9 (Unit Manager) and V7 (Registered Nurse/RN) R1 was having trouble breathing and they wanted to send R1 to the emergency room. On 4/11/23 at 12:21 PM, V11 (Emergency Medical Tech/EMT) said on 4/10/23 he and another crew member arrived to transport R1 to a medical appointment. V11 said it was a prescheduled transport and non-emergent. When they arrived at R1's bedside, R1 could only speak in one-to-two-word sentences before needing to take a deep breath to continue. R1's respiratory rate and heart rate were elevated. R1's oxygen saturation was 86-87% and she had a nasal cannula in her nose connected to an empty portable oxygen tank. V11 said he turned on an oxygen concentrator that was next to R1's bed and it was inoperable. V11 then turned on a portable oxygen tank attached to R1's wheelchair and it was empty. V11 said as there was no supplemental oxygen available in R1's room, he connected R1 to his portable oxygen tank. R1 was able to tell him she had been short of breath for about a day and was normally on oxygen. V11 said he contacted his company to send an Advanced Life Support (ALS) unit to transport R1 to the emergency room and the company told him it would be about an hour. V11 said he then called 911 for transport to the emergency room. V11 said he didn't know how long she was without oxygen, but it was long enough to make her oxygen level low and short of breath. V11 said the facility was made aware of the resident's respiratory difficulties, issues with the oxygen being empty, and the plan to call 911. On 4/11/23 at 12:29 PM, V3 (Medical Director)	S9999		

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S9999	Continued From page 4 said generally speaking, if a resident is connected to an empty oxygen tank and requires oxygen, it could cause low saturations and increased respiratory and heart rates. On 4/11/23 at 12:31 PM, V12 (R1's spouse) said R1 remained hospitalized for "basically had difficulty getting oxygen." V12 said, "The night before last, Sunday (4/9/23) R1 had difficulty breathing and felt like she wasn't getting enough oxygen. They had to change the oxygen tank because it was empty. R1 requires oxygen and gets short of breath without it. I would have expected more from the rest home. There's a lack of urgency, experience, and TLC (tender loving care)." V12 said this is the second time R1 had "ended up" in the hospital since admission for this. V12 stated, "One time it's the oxygen tank, the next time it's the machine (concentrator). I absolutely would expect the facility would make sure she wouldn't run out of oxygen." On 4/11/23 at 12:33 PM, V2 (Director of Nursing/DON) said she and V1 (Administrator) called the ambulance transport company around 11:00 AM today to find out why they didn't notify facility staff before calling 911. V2 said she wasn't aware of the situation until today. V2 said there was no facility policy or procedure to wean oxygen. V2 stated, "This can result in inconsistent interpretation of how weaning of oxygen is done and the facility's expectations. One nurse could do it one way and another nurse do something different. There's no clear guideline on what to do and when. We have quite a few new graduates (nurses)." On 4/11/23 at 1:46 PM, V2 (DON) stated, "Oxygen tubing should not be on the floor.	S9999		

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Bacteria or germs can get into the cannula and enter the respiratory system of the patient. Oxygen tubing should be labeled weekly for infection control. You only want to use it for so long to maintain the quality of the product and prevent wear and tear. When oxygen tubing is not in use, it should be placed in a plastic bag if not in use for infection control. Portable oxygen tanks should be checked every 1-2 hours to make sure they're not empty. We don't use tanks unless something is wrong with the concentrator. Like the concentrator wasn't working for R1 on Sunday. I believe. We only keep oxygen tanks in storage. Concentrators are rented as needed. If a resident is connected to an empty or defective oxygen apparatus, they're not going to provide oxygen as intended. If this occurs, hypoxia, shortness of breath, a resident could be adversely affected, cause hospitalization or death."

R1's medical record had no documentation showing oxygen weaning attempts, interventions and outcomes. There was no documentation showing if or when oxygen was applied or removed.

R1's 3/27/23 1:20 PM Nurse Practitioner note showed she was paged by the nurse due to R1's increased shortness of breath (SOB) that started 3/26/23. This note showed R1 had chest pain since "last night" and increased SOB since last night.

R1's 3/27/23 5:56 PM discharge summary note showed R1 was sent by ambulance to a local hospital for shortness of breath (SOB), lethargy and poor intake.

R1's 4/1/23 7:39 PM progress note showed R1

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S9999	Continued From page 6 was readmitted from a local hospital. R1's local hospital discharge instructions showed R1 was hospitalized from 3/27/23 to 4/1/23. This instruction sheet showed R1 was diagnosed with heart failure and for heart failure, daily weight monitoring was crucial. Common symptoms of heart failure included: chest pain, fatigue and weakness, rapid or irregular heartbeat, shortness of breath, persistent cough, and decreased alertness. R1's 4/1/23 hospital discharge orders showed daily weights and oxygen at 3 liters per nasal cannula. A 3/27/23 hospital diagnosis included acute respiratory failure with hypoxia (low oxygen). R1's 4/1/23 9:35 PM progress note showed the doctor verified the hospital transfer orders. R1's 4/2/23 2:03 PM, progress note authored by V3 (Medical Director) showed R1 was sent to the hospital for shortness of breath (SOB) and was found to be volume overloaded. R1 was currently on oxygen at 3 liters per nasal cannula (NC) on exam. R1 was alert and oriented X 3. R1's 4/5/23 1:20 PM note showed the Nurse Practitioner was notified due to a productive cough. R1's 4/5/23 2:30 PM nurse practitioner note showed a registered nurse requested a follow up due to a congested cough that started that afternoon. This note showed R1 was on oxygen at 3 liters and had an intermittent congested cough. R1's 4/5/23 10:06 PM note showed R1 was on	S9999		

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S9999	Continued From page 7 oxygen at 2 liters. R1's 4/6/23 6:00 AM note showed R1 was alert and oriented and reported a productive cough. R1's 4/7/23 nurse practitioner note showed R1 was unable to feed herself, oxygen was on at 3 liters per NC (Nasal Cannula). R1's 4/10/23 3:43 PM notes showed R1 was sent to a local hospital emergency room and admitted with a diagnosis of pulmonary edema. R1's physician order sheet (POS) showed orders for follow up appointment with a physician on 4/10/23 at 9:45 AM, (4/2/23) oxygen (O2) to be administered at 3 liters per minute via nasal cannula (NC) and maintain O2 saturation at 90% or greater every shift, wean off oxygen if O2 saturation is greater than 93% one time a day, and weigh three times a week on hemodialysis days, every day shift Tuesday, Thursday, and Saturday (ordered 4/1/23). R1's weights showed no weights recorded for 4/5, 4/7, 4/9, or 4/10/23. R1's 4/3/23 care plan showed the resident has oxygen therapy at 3 liters per minute per NC. Maintain O2 saturation at 90% or greater. Stay with resident during episodes of respiratory distress. R1's 4/6/23 transportation referral showed V1 (Administrator) authorized ambulance transportation for R1 to go to an appointment 4/10/23. This referral form showed R1 was on oxygen at 3 liters per nasal cannula. The facility's 7/22 Oxygen Administration policy	S9999		

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S9999	Continued From page 8 showed to check the tank/device being used to be sure they are in good working order. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. The tubing will be dated to assist with tracking of when tubing should be changed. If the nasal cannula/mask/tubing is not in use, it must be stored in a clean bag. The facility's 6/21 Weight Policy showed weekly weights will be done with a significant change in condition or with a physician's order. The Mayo Clinic website showed pulmonary edema is caused by too much fluid in the lungs making it difficult to breathe. Pulmonary edema can sometimes cause death. Treatment includes additional oxygen. Symptoms include difficulty breathing, a cough that produces frothy sputum, a rapid, irregular heartbeat, new or worsening cough, rapid weight gain, fluid buildup due to kidney disease can cause pulmonary edema. 2. R2's face sheet showed a 62 year old male admitted on 2/18/23 with diagnoses of end stage renal disease, dependence on renal dialysis, acquired absence of right leg above the knee, acquired absence of toes, left foot, pleural effusion, cardiomegaly, hypertension, obesity, and Type 2 diabetes. On 4/11/23 at 9:35 AM, R2 was in his bed. His oxygen was on at 4 liters per nasal cannula. R2 said the oxygen is new to him. He just started it about three months ago. R2's oxygen tubing in his nose was not dated. There was an oxygen concentrator in the bathroom with tubing extending from the bathroom along and on the floor to the top of R2's mattress where the nasal cannula laid on top of the mattress. R2's bed was	S9999		

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the furthest away from the bathroom. R2's oxygen tubing that was not in use was not in a bag. There was an open gallon of distilled water on the bathroom floor next to the toilet.

At 11:45 AM, R2 was assisted by therapy with ambulation in the hallway. R2 had an oxygen cannula in his nose that was not labeled. R2 was short of breath and sat down in the wheelchair. This surveyor checked the oxygen tank and the needle on the gauge was on the border of the red (empty). This surveyor asked V8 to look at the gauge and the tank was replaced with a full one.

On 4/11/23 at 12:04 PM, V8 (Occupational Therapist/OT) said she usually checks a resident's oxygen tank at the beginning of a session to ensure there's enough to get through a session. V8 said she joined the session (started by someone else) with R2 today in the gym, so she did not check his oxygen tank. V8 stated, "The tank was on the border of red when we (this surveyor and V8) looked at it. I would not have used that tank to begin a therapy session. I would have exchanged it for a full one first."

R2's POS showed 3/13/23 order for oxygen at 3 liters per NC, maintain O2 saturation at 92% or greater.

R2's oxygen care plan showed to administer oxygen per physician's orders. This care plan showed the oxygen is prn (as needed) to keep his oxygen saturation greater than 90%.

3. R3's face sheet showed a 78 year old male admitted to the facility 3/4/23 with diagnoses of pleural effusion, dependence on renal dialysis, respiratory failure with hypoxia, end stage renal disease, myocardial infarction, hypertension, and

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S9999	Continued From page 10 cerebral infarction. On 4/11/23 at 9:53 AM, R3 was not in his room. There was a portable oxygen tank in the room and the attached nasal cannula was not in a bag. An oxygen concentrator was next to the bed and the attached nasal cannula was not in a bag. At 11:25 AM, R3 was in bed on his side with his eyes closed. R3 did not have oxygen on. At 9:55 AM, R3's spouse entered the room and said R3 would be returning from dialysis soon. R3's spouse said she had difficulty speaking English and requested I speak to her son. R3's spouse called her son, V14 (Physician) on the phone. V14 said there was a problem with R3's oxygen tank running out "every night." V14 stated, "That's why they have the machine in there now. I started making them change the tank before I left so it wouldn't run out during the night. R3 would call me at 4:00 AM to tell me the oxygen ran out. Then, I'd call the facility to have them change the tank." R3's medical record showed an oxygen saturation at 10:04 AM was 95% and R3 was on a nasal cannula. At 12:15 PM, V10 (Registered Nurse) said she had not rechecked R3's oxygen saturation since 10:04 AM when he was on oxygen. V10 was unaware of any facility procedure for weaning oxygen. R3's medical record had no documentation showing oxygen weaning attempts, interventions and outcomes. There was no documentation showing if or when oxygen was applied or removed. R3's POS showed a 3/24/23 order for oxygen at 3	S9999		

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S9999	Continued From page 11 liters per nasal cannula to maintain an oxygen saturation of 92% or greater every shift. There was a 4/3/23 order to wean off oxygen as able if oxygen saturation was greater than 92% every shift. R3's oxygen care plan showed to administer oxygen per physician's orders. 4. R5's face sheet showed an 80 year old male with diagnoses of acute respiratory failure, cardiac pacemaker, pulmonary hypertension, malignant neoplasm of the prostate, deaf, non-speaking, senile degeneration of the brain, and chronic kidney disease stage 4. On 4/11/23 at 1:08 PM, R5 was in bed. R5's oxygen tubing was lying on the floor. The tubing and nasal cannula were unlabeled and connected to an oxygen concentrator. The concentrator was on and set at 4 liters per minute. R5's physician order sheet showed an 11/10/22 order for oxygen 2-4 liters per nasal cannula to maintain an oxygen saturation of (blank) or greater every shift. There were no saturation parameters identified in the order. 5. R6's face sheet showed a 91 year old female with diagnoses of chronic obstructive pulmonary disease, dependence on supplemental oxygen, heart failure, obesity, developmental disorder of speech and language, dementia, and end stage renal disease. On 4/11/23 at 1:16 PM, R6 was in bed. R6 had oxygen tubing in her nose. The oxygen tubing was not labeled. R6's oxygen was running at 2 liters per nasal cannula via a concentrator. R6 was unable to communicate.	S9999		

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S9999	Continued From page 12 R6's 9/20/22 physician order showed to administer oxygen at 2-3 liters per minute per NC to maintain an oxygen saturation of 92% or greater. 6. R7's face sheet showed an 84 year old female with diagnoses of sleep apnea, rheumatoid arthritis, heart failure, cardiac pacemaker, obesity, and type 2 diabetes. On 4/11/23 at 1:20 PM, R7 was in a chair in her room. R7 had a nasal cannula in her nostrils. The cannula tubing was not labeled. R7's 2/9/22 physician order showed to administer oxygen at 2-3 liters per NC to maintain an oxygen saturation of 92% or greater. (A)	S9999		