STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014641	A. BUILDING: _____ B. WING _____	C 03/24/2023

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SYMPHONY MIDWAY	4437 SOUTH CICERO CHICAGO, IL 60632

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S 000	Initial Comments COMPLAINT INVESTIGATION 2382286/ IL157729 Facility Reported Incident of February 25, 2023/IL157471	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210a) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 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 were not met as evidenced by: Based on observations, interviews and review of records the facility failed to protect the resident's right to be free from sexual abuse for 2 (R3, R4) out of 3 residents reviewed for abuse. The facility failed to place safeguards in place for both residents (R3, R4) after sexual abuse incident. Both residents (R3, R4) remained on the same	S9999		

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S9999	Continued From page 2 floor accessible to each other. These failures resulted in 1 resident (R4) who is severely cognitive impaired, to be sexually touched by another resident (R3). Findings includes: R3 is 64 years old, initially admitted on 08/01/2010. R3's medical diagnosis includes Alcohol Dependence with Alcohol-Induced Persisting Dementia. R3's brief interview of mental status (BIMS) dated 12/20/2022 assessment reference date (ARD) was 6 which means R3 has moderate impairment with his cognition. R4 is 76 years old, initially admitted on 04/04/2018. R4's medical diagnosis includes Dementia, Delusional Disorder, and Wandering. R4's brief interview of mental status (BIMS) dated 01/04/2023 assessment reference date (ARD) was 0 which means R4 has severe impairment with her cognition. Per resident census provided by facility, R3 and R4 reside on the same floor. Observation showed R3 and R4 rooms were found on the same floor. On 03/21/2023 at 11:03 AM. R4 was seen walking back and forth the hallway wandering, going in and out of other residents' rooms. R4 was not able to respond to the questions asked within topic during interview. R4 was talking or mumbling but not able to make connection to the questions being asked. On 03/21/2023 at 11:10 AM. V5 (Licensed Practical Nurse) stated R3 uses wheelchair for ambulation. R3 can transfer independently from chair to bed, or from chair to toilet. R3 was seen	S9999		

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S9999	Continued From page 3 in the hallway on his wheelchair able to wheel himself. R3 then went to the toilet and said that he would talk to writer after he is done. R3 then called writer to come into his room. R3 was calm and able to answer questions with yes or no at first. After R4 was mentioned and R3 was asked if he could speak English, R3 became agitated and did not want to answer questions. All questions were answered by R3 with "No." On 03/21/2023 at 11:50 AM during lunch time R4 was observed in the dining room eating. On 03/21/2023 at 12:11 AM after lunch, R4 was seen approaching residents at different tables who were conversing. R4 was talking or mumbling words towards other residents. R4 was observed unable to converse with other residents due to her cognitive state. V8 (Certified Nursing Assistant) said, "R4 walks around wandering, sometimes in and out of peoples' room. That is her usual routine. Even during nighttime, R4 does the same thing." On 03/21/2023 at 12:20 PM. R3 was observed sitting in his wheelchair near the entrance / exit of the dining room where R4 was after eating lunch. R4 was seen going near R3 mumbling / talking with R3 for a while until staff came and redirected R4. On 03/21/2023 at 02:25 PM. V3 (Certified Nursing Assistant/CNA) said, "I saw it directly, I was taking care of a resident and when I came out of the room, I saw R3 at his door in a wheelchair and R4 was next to him (R3). R3 was holding R4's hand when R3 put R4's hand between his (R3) legs. Then I saw that the other hand of R3 was on R4's breast. Immediately I ran to them, and I told them it was not proper. I	S9999		

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S9999	Continued From page 4	S9999		

immediately reported to V5 (Licensed Practical Nurse) and V5 called the V4 (Social Worker) immediately. V4 went to 4th floor and spoke to V5. R3 can tell you his thoughts. R3's action is deliberate. If R3 tells R4 to do things, R4 will follow R3. Whatever R3 asked R4, R4 is going to do it. R4 does not know what she was doing. R4 cannot give consent to what R3 was making her (R4) do."

On 03/21/2023 at 02:31 PM. V1 (Administrator) was informed that R3 and R4 were on the same floor and that it was observed R4 was routinely wandering everywhere on the floor. Due to proximity of both residents interaction could not be avoided. V1 said, "I am new to this position, and I see what you mean. We think that R3 will have the same problem even if we transfer him into another floor but I think you are right, R3 needs to be transferred to avoid recurrence of the same incident. Yes, I agree with you that any person who is cognitively intact being touched by another person in a sexual way without his or her consent will feel violated."

On 3/22/2023 at 12:30 AM. V11 (Social Service Director) said, "I am aware of what happened between R3 and R4. R3 was being sexually inappropriate with R4. R4 was confused and cannot give consent. I know R4 cannot understand, but any reasonable person having the right cognition, will really feel violated and upset."

On 3/23/2023 at 10:30 AM. V14 (Nurse Practitioner) said, "R4 cannot give consent, she (R4) mumbles non-sensible words. I remember R4, she is the resident with short hair. In terms or medical needs, R4 is maintaining the same needs. R3 is Spanish speaking resident,

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sometimes I have medical students with me and R3 can answer with short sentences. If it happens to me what happened to R4, I would feel violated."

On 3/23/2023 at 10 45 AM. V4 (Social Worker) said, "I was the manager on duty (MOD), I was doing my rounds, checking how many CNAs and nurses were on each floor. Making sure everybody was where they are supposed to be. I was approaching the 4th floor when they told me what happened. V5 (LPN) told me to talk to V3 (CNA). V3 told me V3 witnessed R3 had his hand on R4's breast and proceeded to move R4's hand inside his pants. R4 has dementia, severely impaired, she did not respond. Yes, R4's orientation is 0. I talked to R3 with V3 (CNA) translating. I believe that R3 does know that he was wrong. R4 cannot give consent. Any reasonable person would feel bad. If it happens to me, I will surely feel really traumatized. We did a 3-day wellbeing. R3 and R4 were not seen by the psychiatrist or psychologist."

Initial Facility Reported Incident dated 02/25/2023 with Final report dated 02/28/2023, in part reads:

Witness statement confirmed that R3 was observed touching the breast of R4 and putting R4's hand on R4's penis. At the conclusion of this investigation, it is determined that unwanted touching is substantiated.

R3's notes dated 02/25/2023 by V5 (LPN), in part reads: V5 was informed by staff that she (V5) witnessed R3 exhibiting inappropriate behavior towards another resident (R4).

Signed interview of V3 (Certified Nursing Assistant), with V5 (Social Worker) taking the

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S9999	Continued From page 6 statement dated 2/25/2023, in part reads: V3 saw R4 in the doorway with R3 with one of his (R4) hands her (R3) breast and the other hand of R4 put R3's hand on his penis. Signed interview of V3 (Certified Nursing Assistant) with V4 (Social Worker) interviewer dated 2/25/2023, in part reads: R3 with his hand put R4's hand on his penis. R3's other hand was on R4's breast. Plan of Care of both R3 and R4 documents potential for abuse, to wit: R3's Care Plan reads in part as follows: - R3 can make decision regarding which activity that he enjoys dated 03/22/2023. - R3 was target of aggression and R3 becomes increasingly agitated or upset dated 04/04/2022. R4's Care Plan reads in part as follows: - R4 was target for sexual inappropriate behavior by another peer dated 02/25/2023. - R4 at risk for abuse related to physical and/or communication challenge as evidence by R4 being verbal but has difficulty communicating, rarely understood dated 10/09/2022. - R4 at risk for abuse related to behavior problem as evidenced by R4 wandering, has impaired cognition/dementia dated 10/09/2022. - R4 wandering in and out of peers' room dated 10/09/2023. - R4 socially inappropriate behavior urinates in inappropriate places dated 10/09/2022. - R4 inappropriate behavior, R4 likes to remove clothes in front of others dated 07/03/2022.	S9999		

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S9999	Continued From page 7 Abuse Policy not dated, in part reads: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of resident from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. The facility prohibits abuse, neglect misappropriation of property, and exploitation of its resident, including verbal, mental, sexual, or physical abuse. Sexual abuse is non-consensual sexual contact of any type with a resident. (B) Statement of Licensure Violations (2 of 2): 300.610a) 300.1210b) 300.1210d)2)5) 300.1220b)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	S9999		

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S9999	Continued From page 8 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. 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 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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S9999	Continued From page 9 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on review of records and interviews the facility failed to provide person-centered plan of care for resident who stayed in wheelchair for long period of time and failed to provide accurate assessment for a resident who acquired pressure ulcer in the facility for 1 out of 4 residents (R1) reviewed for improper nursing care. These failures resulted in 1 resident (R1) pressure ulcer to develop into stage 4 and become infected. Findings include: R1 is 75 years old, initially admitted on 04/17/2020 and was discharged on 02/04/2023. R1's medical diagnosis includes paraplegia. Based on brief interview of mental status (BIMS) with assessment target date (ARD) 01/18/2023	S9999		

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S9999	Continued From page 10 scored 15 which means R1's cognition was intact. R1's active wounds at the time of discharge (02/04/2023) are as follows: - Left Achilles/posterior lower leg identified on 09/03/2022, categorized as vascular, arterial insufficiency. - Right Achilles identified on 01/05/2023, categorized as vascular, arterial insufficiency. - Right Ischial Tuberosity identified on 06/30/2022, categorized as pressure ulcer. Facility Wound Assessment for Right Ischial Tuberosity/Right Buttocks (Facility-Acquired) are as follows: - Initial Assessment dated 06/30/2022 pressure ulcer was classified as unstageable. Area of 7.00 centimeter squared. Necrotic Soft, Adherent Tissue 80% and Red/Bright Pink Tissue 20%. - Assessment dated 02/02/2023 pressure ulcer was classified as stage 3. Area 5.23 centimeter squared. Red/Bright Pink 90% and Deep Maroon 10%. V17's (Wound Doctor) assessment for Right Ischial Tuberosity/Right Buttocks (Facility-Acquired) are as follows: - Assessment dated 01/10/2023, 01/24/2023 and 01/31/2023 all reads in part as follows: The wound is currently classified as Category/Stage 4 wound with etiology of Pressure Ulcer and is located on the Right Ischial Tuberosity. There is muscle and fat layer (Subcutaneous Tissue) exposed. Per National Pressure Ulcer Advisory Panel (NPUAP) dated 2016 definition of Stage 4 Pressure Ulcers are as follows: Full-thickness skin and tissue loss Full-thickness skin and tissue	S9999		

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S9999	Continued From page 11 loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. On 03/23/2023 at 01:15 PM. V7 (Wound Coordinator / Licensed Practical Nurse) said, "We did not follow what is charted by V15, because when I asked V16, she said that we will follow our inhouse doctor (V17). We do not use doughnut. R1 does not listen, R1 stayed on the wheelchair for a long time. When asked to be repositioned, R1 refuses." V7 was asked if the identified problem of R1 sitting on the wheelchair for prolonged time was addressed or care planned. V7 said, "I don't have specific documentation or care plan about R1 sitting on his wheelchair for a long period of time. I just notice that my assessment for R1's Right Ischial Tuberosity was stage 3 and V17's (Wound Doctor) assessment was stage 4. I think I missed that; it should have been stage 4. I think V17 did a debridement that is why it was staged as stage 4." V7 was reminded that her assessment was dated 02/02/2023 and V17's assessment was dated 01/31/2023. After V17 did debridement, the wound became lowered in stage from 4 to 3. V7 said, "I am not sure it may be a simple debridement. Yes, debridement is performed by V17 in the facility." R1's care plan by V7 (Wound Coordinator / Licensed Practical Nurse) dated 10/31/2022 (Pressure Ulcer was identified 06/30/2022) for Right Ischial Tuberosity/Right Buttocks pressure injury under interventions, in part reads: Monitor for infection - Peri-wound erythema-increased drainage and increased pain, peri-wound swelling, exposed bone, pressure wound deterioration.	S9999		

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S9999	Continued From page 12 R1's notes dated 12/09/2022 by V16 (Nurse Practitioner) reads: V10 (Wound Nurse / Licensed Practical Nurse) reported that R1 is having foul smell discharge from wound from last 2 to 3 days. Evaluated wound with V10, noted pus discharge. Kept on antibiotic Doxycycline 100 MG for 10 days. V16's order dated 12/09/2023 are as follows: Doxycycline Antibiotic Oral Tablet 100 MG, give 1 tablet by mouth every 12 hours for wound infection - right ischial, foul smell for 10 days. R1's notes dated 01/03/2023 by V15 (Licensed Practical Nurse) reads: R1 returned from appointment at Wound Care Clinic Medical Doctor with wound care order: Keep pressure off wounds. Wound are caused by undue continual pressure. Sit on a doughnut devise to offload pressure from wounds when resting. On 03/23/2023 at 01:55 PM. V7 said, "We did not follow what is charted by V15, because when I asked V16 she said that we will follow our inhouse doctor (V17). We do not use doughnut. R1 is not compliant, he sits on his wheelchair for a long time and will not listen." V7 was asked if R1 being not compliant was addressed, since R1 developed and worsen and even got infection on his Right Ischial Tuberosity/Right Buttocks pressure ulcer. V7 said, "I might have a care plan." Later V7 said, "I don't have a care plan specific to R1 being non-compliant and sitting on his wheelchair for a long time." On 03/23/2023 at 2:45 PM. V16 (Nurse Practitioner) said, "V10 (LPN) called me and told R1 was having "funky" smell on the wound or bad smell on the wound for 2 to 3 days. I did an	S9999		

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S9999	Continued From page 13 assessment, V10 opened the dressing, and then I pressed on the wound, blood was coming out. Ordered antibiotics for the wound's foul smell. The order for antibiotic was for R1's wound infection. I saw he has been sitting longer in wheelchair. R1 needs to be repositioned, frequently changing diaper to avoid moisture, even stool can go inside, dressing also needs to be changed often. All of these can be done by facility so its avoidable. I want to cover everything to avoid septicemia because there is also pus coming out of R1's suprapubic area, R1 has suprapubic catheter and also in his penis." On 03/24/2023 at 10:34 AM. V17 (Wound Doctor) said, "Yes, I saw R1's Right Ischial Tuberosity pressure ulcer. When there is foul smelling on the wound we consider infection, but there are many factors that may cause foul smell. Like bowel movement if the resident is incontinent. Pus discharges, some may look at discharges and may call it pus, but it is not pus. But if it is genuinely pus, it means contamination or infection. In my current assessments, I staged the wound as 4 because of exposure of muscle or necrotic muscle tissue. I am not comparing my initial assessment on 07/05/2022 to my assessment on 01/31/2023. Prolonged sitting on the wheelchair can cause worsening of R1's pressure ulcer. That is why offloading is necessary. The origin of R1's pressure ulcer was pressure to the specific part of his body. That is why it is called pressure ulcer. I did not know if R1 got it before he came in the facility." V17 was informed that per R1's documentation it was facility acquired. V17 said, "Oh, well those wounds are caused by prolonged pressure." Per facility policy for Wound Evaluation and Documentation dated as revised 12/19, in part	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014641	A. BUILDING: _____ B. WING _____	C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY MIDWAY	4437 SOUTH CICERO CHICAGO, IL 60632

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S9999	Continued From page 14 reads: When the Wound Care Team assesses the resident, they will take a photo, complete Braden, measure the wound, review the orders, and update any notes and care plans as appropriate. (A)	S9999		