| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6001689 | A. BUILDING: ______ B. WING ______ | C 03/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYMPHONY BRONZEVILLE | 3400 SOUTH INDIANA CHICAGO, IL 60616 |

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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of March 26, 2023/IL157472 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.3210t)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.3210 General<br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure that two residents (R2 and R3) were free from resident-to-resident physical abuse. This failure affected R2 who sustained a nasal fracture. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>Findings include:<br><br>R2's Admission Record documents, in part, that R2's diagnoses include but are not limited to: Dependence on renal dialysis, hyperkalemia, essential (primary) hypertension, hypothyroidism unspecified, unspecified psychosis not due to a substance or known physiological condition, type 2 diabetes mellitus without complications, personal history of COVID-19, unspecified abnormalities of gait and mobility, unspecified symptoms and signs involving the nervous system, nicotine dependence unspecified uncomplicated, patient's noncompliance with renal dialysis, bipolar disorder unspecified Cognitive communication deficit, pneumonia due to other specified infectious organisms, anemia unspecified, end stage renal disease, and chest pain unspecified.<br><br>R3's Admission Record documents, in part, that R3's diagnoses include but are not limited to: Constipation unspecified, esophagitis unspecified without bleeding, other specified disease of esophagus, unspecified viral hepatitis C without obstruction on gangrene, iron deficiency anemia secondary to blood loss (chronic), schizophrenia unspecified, barrettes esophagus without dysplasia, long term (current) use of anticoagulants, major depressive disorder recurrent unspecified, personal history of COVID19, essential (primary) hypertension, hyperlipidemia unspecified opioid use unspecified uncomplicated, other age related incipient cataract unspecified eye, anemia unspecified, presbyopia, presence of other heart-valve replacement, and inflammatory polyps of colon without complication. | S9999 | | |

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R2's Brief Interview for Mental Status (BIMS) dated 01/10/23 shows 15 cognitively intact.

R3's BIMS dated 01/17/23 shows 11 some cognitive impairments.

On 03/27/23 at 10:00 am, V3 (Licensed Practical Nurse/LPN, Nurse Manager), provided the surveyor with the initial and final incident reports that were sent to the state agency for the alleged incident that occurred on 02/26/2023 between R2 and R3. The final report faxed to the state agency on March 3, 2023, documents, in part, "R3 and R2 were involved in a physical altercation. R2 noted with blood-tinged drainage from R2's nose and R3 sent to local hospital for psychiatric evaluation. R2 had a CT (Computed Tomography) scan of the head, diagnosed with a nasal fracture and prescribed Tylenol Extra Strength 500 milligrams (mg) oral tablet 2 tablets for 7 days as needed for pain.

On 03/27/23 at 10:41 am, R3 was observed in R3's room sitting in a chair awake, alert and oriented. R3 denied any knowledge of being in an altercation with R2 on 02/26/23. R3 stated, R3 and R2 were never roommates and R3 denied ever choking R2's neck or punching R2 in the nose causing injury.

On 03/27/23 at 10:47 am, R2 stated, about a month ago R2 and R3 were roommates for about six months when R3 physically attacked R2. R2 stated after breakfast, R2 was sitting in a chair next to R2's bed in R2 and R3's room. R2 stated, R3 walked to the doorway and then walked over to R2 punching R2 in R2's nose with R3's fist and then choking R2's neck with both of R3's hands. R2 stated, R2 fell from R2's chair to the floor and R2's nose began to bleed. R2 stated, while R2's

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| S9999 | Continued From page 3<br><br>nose was bleeding, R2 got off the floor and walked to R2's bathroom. R2 stated while R2 was in R2's bathroom V10 (Registered Nurse/RN) came into R2's bathroom to ask R2 what occurred. R2 stated, V10 then called the police and R2 completed a police report against R3. R2 stated, after R2 completed the police report R2 was sent to the local hospital and had an x-ray of R2's nose performed and was sent back to the nursing home. R2 said upon R2's return to the facility R3's room was changed and R2 has not seen R3 since the altercation.<br><br>On 03/27/23 at 12:54 pm, V10 (RN) stated, V10 was the nurse on 02/26/23 when the altercation between R2 and R3 occurred. V10 stated, 15 minutes after checking on R2 and R3's room, V10 was down the hallway near another resident's room when R2 came to V10 in the hallway with R2's nose bleeding and stated R3 choked R2 and punched R2 in the nose twice while R2 was alone sitting in a chair in R2's room. V10 stated, R2 stated R2 did not know why R3 choked and punched R2. V10 stated, V10 rendered care to R2's bleeding nose to stop the bleeding. V10 stated, V10 observed R3 in the day room while V10 was providing care to R2. V10 stated after V10 stopped R2's nose from bleeding V10 called V1 (Administrator) right away and informed V1 of R2 and R3's altercation. V10 stated, after calling V1, V10 called R2's and R3's physicians, families, and the police. V10 stated, when V10 spoke with R3, R3 stated that R3 was tired of R2 laughing at R3 about R3's missing money. V10 stated, both residents remained separated and placed on one-to-one monitoring by Certified Nursing Assistants (CNAs). V10 stated, R2 was sent to the local hospital for a CT (Computed Tomography) scan of R2's nose and head and, R3 was sent to the local hospital for a | S9999 | | |

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| S9999 | Continued From page 4<br><br>psychiatric evaluation. V10 stated, R2 and R3 both return to the facility from the local hospitals within a few hours and upon R3's return to the facility R3's room was changed to another floor. V10 stated, R2's hospital report stated, R2 sustained a nasal fracture and that R2's neurology status was monitored for changes and change of mental status. V10 stated, R3's hospital report stated R3 was cleared by psychiatry and could return to the facility.<br><br>On 03/28/23 at 1:17 pm, V1 (Administrator) stated, V1 is the facility's abuse coordinator. V1 stated, V1 recalled the incident reported where a resident was assaulted by another resident however V1 was not able to recall what resident was assaulted between R2 and R3. V1 stated, R2 and R3 was immediately separated after the altercation and sent to the local hospitals. V1 also stated, a police report was made and both residents returned to the facility residing on different floors. V1 was asked what facility measures are put into place to prevent resident-to-resident abuse. V1 stated, "We try to make sure residents are compatible, cognitive intact residents are placed together, residents with like BIMS scores are place together and chose appropriate roommates. Staff should be rounding on residents as needed."<br><br>On 03/28/23 at 1:32 pm, V2 (Director of Nursing/DON) stated, V2 was made aware that R3 hit R2 without reason. V2 stated, V2 was not in the facility when the incident occurred. V2 also stated, after the altercation with R2 and R3, R3 was sent out to the local hospital for a psychiatric evaluation and returned to the facility after a couple of hours. When V2 was asked if any resident was injured during the altercation between R2 and R3, V2 stated, V2 was informed | S9999 | | |

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| S9999 | Continued From page 5<br>that R2 had some bleeding from R2's nose.<br><br>On 03/28/23 at 2:02 pm, V4 (Social Service Director) stated, V4 was not in the facility when the altercation between R2 and R3 took place on a weekend. V4 stated, V4 was made aware of R2 and R3's altercation when V4 returned to work. V4 stated, upon V4's return to the facility R3's room was changed to another floor.<br><br>Facility's initial incident report to local State Agency dated 02/26/23 at 1:11 pm, documents that R3 and R2 were involved in a physical altercation. R2 noted with blood-tinged drainage from R2's nose and R3 sent to local hospital for psychiatric evaluation.<br><br>Facility's final incident report to local State Agency dated 03/03/23 at 6:55 pm, documents that R2 had a CT of head and was diagnosed with a nasal fracture and prescribed Tylenol Extra Strength 500 milligrams (mg) oral tablet 2 tablets for 7 days as needed for pain.<br><br>R2's hospital record dated 02/26/23 at 2:07 pm shows that R2 sustained a nasal fracture.<br><br>R3's hospital record dated 02/26/23 at 2:00 pm, shows that R3 was seen at local hospital for stress management.<br><br>R2's progress note dated 02/26/23 authored by V10 (RN) documents that at 9:00 am R2 reported to V10 that R3 grabbed R2's neck and punched R2 in the face. At 3:25 pm CT scan revealed R2 with a nasal fracture.<br><br>R3'S progress noted dated 02/26/23 at 9:01 am, authored by V10 (RN) documents that R3 stated that R3 punched R2 in the face because R3 got | S9999 | | |

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tired of R2 smiling and laughing at R3.

R3'S care plan dated 01/03/22 documents, in part, "R3 may be susceptible to potential abuse/neglect related to (r/t) resident demonstrating difficulty with behaviors by others that can be characterized as provoking, antagonizing, disrespectful, angry, insensitive an annoying. The resident has a history and/or personality that draws him/her into unhealthy or even abusive relationships."

R2's care plan dated 03/03/23 documents, in part, "R2 maybe at risk for potential abuse related to (r/t) mental/emotional challenges."

The facility's undated policy titled "Abuse Prevention Program-Policy" documents, in part, "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment ...Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment."

"B"