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	IL6007967	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY EVANSTON	820 FOSTER STREET EVANSTON, IL 60201

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S 000	Initial Comments Complaint Investigation: 2392883/IL158489	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240e) 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 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to follow/practice their abuse policy by failing to report an allegation that staff held and twisted resident's (R1) left arm/wrist. Staff (V2) remained on duty to work with other residents, placing residents at risk for abuse. This failure affects 1 of 4 residents (R1) reviewed for abuse. R1 was sent to hospital for evaluation where R1 was diagnosed with a left wrist hairline fracture.	S9999		

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S9999	Continued From page 2 This failure also has the potential to affect the other 86 residents residing in the facility. Findings include: R1 face sheet shows diagnosis of MDS (Minimum Data Set) dated 1/1/23 denotes in-part that R1 has BIMS score of 15 (cognitively intact). R1 Evanston Police Department Report denotes in-part: "date and time of report 4/5/23 at 6:39pm, crime/ incident; battery, victim (R1), narrative; on April 5, 2023, at 8:04 pm I (responding officer), spoke with R1 at Symphony of Evanston in regard to a possible battery. R1 stated around 630 pm, after she was done eating her scheduled dinner, she needed to take some medication for her blood pressure, stomach surgery and cholesterol. R1 said when the nurse came into her room to give her the pills, R1 requested it (medications) be left alone with R1 because R1 does not usually take it right away. R1 stated she did not wish to take the pills at that moment, so the nurse came back with a CNA worker to take the pills back. R1 stated the CNA worker walked up to R1 and grabbed her by the left wrist and dragged her by her hair. R1 stated the CNA worker yelled in her face saying, "your mother is a hoe". R1 stated she sustained a head injury on her forehead. I (officer) did not observe any fresh injuries on R1's head or pieces of hair on the floor in her room. I observed a small red mark on R1's nose, but the injury seemed inconsistent and not fresh from the altercation. R1 stated she threw her medication on the bed so they could leave, to which they did. R1 identified the nurse that was working and observed the altercation as "Nurse (V1 name is noted). R1 stated she did not know	S9999		

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the name of the CNA worker, but she described her as a short heavy black female, with long colored hair. R1 advised she will be contacting her lawyer for further help. After I spoke with R1, I (officer) was able to make contact with V1 and advised her the complaint. V1 stated after the residents get done with eating their dinner, they are prescribed their medication for the night. V1 said R1 was acting verbally aggressive after she told her that due to their policy, they could not leave the medication with the residents. V1 stated that R1 was out of control, so she left for a few minutes and came back, but R1 was still aggressive. V1 stated she handed the medication to R1, but she threw it across the room. V1 advised that CNA worker V2 walked in to see if everything was okay. V1 and V2 said upon their policy, if a resident is acting up, you leave their room until the episode was over. Both V1 and V2 advised the floor R1 stays on are for people with dementia disorder and other mental health problems and mentioned that was what the medication was for. V1 stated she did not observe V2 put her hands on R1 and mentioned V2 was not in the room that long for anything to happen. I (officer) spoke with V2 about the incident. V2 stated she did not put her hands on R1. V2 also advised that R1 was having dementia episodes this whole week so far. Both V1 and V2 stated R1 was the aggressor ever since they made contact with R1. Due to the lack of evidence, no arrest was made. No complaints were signed, and no follow up required. No further information."

On 4/9/23 at 8:50 am during an observation and interview with R1 at the hospital, R1 was observed to be alert and orient to person, place, time, and situation. R1 was observed to have a dime size yellowish discoloration to the forehead

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slightly on the right side. R1 was observed to have a quarter size yellowish discoloration to the left wrist. R1 said her wrist was broken, and it was painful. R1 said she does not want to move it too much. R1 said her wrist was broken when the CNA-Certified nursing aide (V2 was identified as the CNA) twisted her wrist. R1 said she don't know why V2 would do such a thing to her. R1 said she has never had any physical altercations with anyone at the facility. R1 said it all started Wednesday evening (4/5/23). R1 said V1 (Nurse) had come to her room to give her (R1), her (R1) medication. R1 said she was not ready to take the medication and asked V1 to leave the medication (R1 said the nurse has left her medications for her in the past). R1 said V1 told her that she would come back in 30 minutes to give her the medications. R1 said V1 mentioned something about the policy and not being able to leave the medication. R1 said she thought this was ridiculous because the nurse has left her medication for her in the past. R1 said she had her medications in the left hand and the milk in the right hand. R1 said as her and V1 were going back and forth about leaving the medication, V2 came in the room. R1 stated, V2 had on gloves, V2 grabbed her left wrist, and twisted her left wrist and said, "are you going to take the medication now". R1 said V2 also grabbed her hair and pulled her across the room toward the nurse. R1 said the milk got on V2 because V2 grabbed her left arm twisted it and as a result her right arm was not steady. R1 said she did not purposely throw milk on V2. R1 said when V2 let her wrist go R1 threw her medications on the bed because she was for sure not going to take them (medications) then. R1 said she was upset by what took place. R1 said she called the police that evening. R1 said when the police arrived, she spoke to the police and told them what happened.

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R1 said she feels like the policeman was making a mockery of her and what happened. R1 said she told the police that she did not want to go to the hospital at that time and that she would wait until tomorrow and see how she felt. R1 said she did not tell the police that the nurse pulled her hair and grabbed her wrist. R1 said she told the police it was the big girl with the reddish auburn hair. R1 said she did call V1 an awful name when V1 was going back and forth with her about taking her (R1) medication. R1 said she does not drink the water from the facility and she does not take her medications with the water from the facility because it has too much chlorine in it. R1 said she takes her medication with the milk she gets from the nursing home.

On 4/9/23 at 9:00 am V9 (Rounding Hospital Physician) said R1 has an acute hairline fracture to her left wrist. V9 said this kind of fracture is the result of trauma from the wrist being twisted or a fall. V9 said in her opinion R1 did not do this to herself. V9 said she has been working with R1 and she has not observed R1 with any behavior episodes and she has not received any reports of R1 having any behavior episodes while in the hospital.

On 4/8/23 at 9:48 am V1 (Nurse) said on Wednesday (4/5/23) during evening medication pass she went to R1's room to give her (R1) medication. V1 said R1 did not want the medication at that time. V1 said she told R1 that she would be back in 5 minutes. V1 said when she went back in 5 minutes R1 was still not ready to take her medication. V1 said R1 asked her to leave the medication and V1 informed R1 that it was not the policy of the facility to leave the medication. V1 said V2 (CNA-Certified Nursing Aide) came into the room to tell her something

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about another resident. V1 said while her and V2 were in the room, R1 threw the medication at her (V1) and as she went to pick up the medication R1 threw milk on V2. Both V1 and V2 exited R1's room. V1 said later she was putting on her coat to leave the facility for the evening and she got a call from V5 (manager on duty) that R1 had called the police and the police wanted to speak to her (V1). V1 said she told the police the same thing that she told the surveyor. V1 said the police informed her that R1 did not accuse her of pulling her hair. R1 accused V2 of pulling her hair. V2 said the police did not mention anything else to her. V1 denied pulling R1's hair. V1 denied twisting R1's arm. V1 denied having a physical altercation with R1. V1 denied seeing V2 twist R1's wrist. V1 denied V2 had any physical contact with R1. V1 said, "no one touched R1". V1 said the milk did not get on her, only on V2.

On 4/9/23 at 12:00 pm during a follow up interview V1 denied hearing R1 say that V2 twisted her wrist when V1 was standing there with them (V1 and V2). V1 said she saw milk on V2. (V1) said she figured R1 threw milk on V2, but she doesn't know how the milk got on V2 because she did not see R1 throw milk on V2. V1 said she was bending down to pick up the pills off the floor, she could not see anything. V1 said V2 was standing in one spot in R1's room and when V1 had finished picking up the pills V2 was standing in another spot in R1 room. V1 denied that her and V2 went back in R1's room after they (V1 and V2) exited R1's room.

On 4/8/23 at 10:05am V2 (CNA-Certified Nursing Aide) said on Wednesday (4/5/23) she was working with another group of residents. V2 said she exited her residents room to get something for that resident (socks or something). V2 said

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she heard yelling coming from down the hall. V2 said as she got closer, she heard yelling coming from R1's room. V2 said she went into the room because it's important for the staff to have witnesses when something is going on. V2 said as she entered the room, she saw medication on the table. V2 heard the nurse (V1) telling R1 that she could not leave the medication in the room, and it was against the facility policy. V2 said R1 threw her pills at V1 and then threw her (R1) milk on her (V2). V2 said R1 called V1 a derogatory name. V2 said after R1 threw the milk on her they left the room. V2 denied twisting R1's wrist. V2 denied pulling R1's hair. V2 denied physical altercation with R1. During follow up interview, V2 informed surveyor V2 spoke to the police on 4/5/23 and the police informed her that R1 described her as the person that pulled her (R1) hair. V2 said the police informed her that R1 said the girl with the red hair pulled her hair. V2 said she did have colored hair, her hair was dark purplish red. V2 said the police officer told her that R1 did not appear to be harmed, that R1 just looked disheveled and that the police were not pressing any charges on her (V2) or the nurse (V1). V2 said abuse allegation should be reported immediately. V2 said she had gloves on because she was going to get something for her other resident.

On 4/11/23 at 2:47 pm during a follow up interview, V2 said she did not report the occurrence on 4/5/23 because she thought that V1 reported the incident. V2 said she had an extra shirt in her car and so she changed her shirt after it was wet with milk. V2 was asked about the statement she allegedly made to V4 (CNA). V2 responded that V4 came to R1's room door but did not come inside the room. V2 continue to say she did not touch R1. V2 said she did not report

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S9999	Continued From page 8 the incident of R1 throwing milk on her because she thought V1 was going to report it. On 4/8/23 at 2:51 pm V5 (Manager on Duty/supervisor) said she was notified by the front desk staff that the police were at the facility to respond to a 911 call. V5 said she went downstairs to escort the officers to R1's room. V5 said R1 did not want to speak to her (V5) but she did speak to the officer. V5 said the officer informed her that R1 alleged that a "big fat" CNA pulled her hair. V5 said she asked V2 about pulling R1's hair and V2 denied pulling R1 hair. V5 said the police did not mention anything about R1 wrist/arm being twisted. V5 said V2 did not inform her that R1 allegedly threw milk on her. V5 said she did not see V2's clothing soiled with milk either. V5 said V1 nor V2 made her aware of any incidents. She (V5) found out when the police arrived at the facility. V5 said she overheard the police officer tell V2 that she was not going to be arrested because he didn't see any marks or signs that R1 was abused. V5 said V2 did not inform her that R1 identified her (V2) as the person that pulled her hair and twist R1's arm. During a follow up interview V5 said V4 did not inform her (V5) that R1 told him (V4) that V2 twisted her arm and that V2 responded and said, "because she (R1) tried to throw milk on me (V2)". V5 said she was not aware of anything until the police arrived. V5 said she should have been made aware of R1 allegation of V2 twisting her wrist/arm right away. V5 said V1 (Nurse) was suspended pending investigation, and V2 was not allowed to work with R1 for the remainder of the shift per directives of V6 (Administrator). On 4/8/23 at 4:08 pm V6 (Administrator) said he was made aware on the evening of 4/5/23 that R1	S9999		

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alleged that a nurse had pulled her hair. V6 said he reported to the department that R1 alleged that a nurse was physically rough with her because that was his initial report and he wanted to get the report to the department timely. V6 said he was not aware that R1 alleged that her wrist was twisted. V6 was made aware of the allegation that R1's wrist was twisted. V6 was made aware that V2 reported to surveyor that the police informed her (V2) that R1 identified her (V2) as the person that pulled her (R1) hair. V6 said he was not aware of that. V6 said his investigation is ongoing.

On 4/9/23 at 1:19pm V6 made aware of V4's admission of acknowledgement of R1 allegation of having her wrist twisted by V2, and V2's response of "because she tried to throw milk on me". V6 said he was not aware of that.

On 4/9/23 at 11:45am V4 (CNA-Certified Nursing Aide) said he was working on Wednesday (4/5/23) evening. V4 said he was caring for another resident when he heard commotion and yelling so he went to see where it was coming from. V4 said it was coming from R1's room, so he went into the room and he saw V2 face and shirt wet with milk. V4 said he looked at R1 and R1 looked him right in his face, in his eyes, and said "she (V2) twisted my arm" and V2 then said "because she tried to throw milk on me". V4 said R1 said, "get this ape out of my room, get out!" V4 said all of them (V1, V2, V4) left R1's room. V4 said he saw V2 go back inside R1's room and V1 followed her back into R1's room. V4 said he did not go back in the room with them and he don't know what they (V1, V2) were doing in R1's room at that time. V4 said he could not figure out why V2 was in R1's room because V2 was not working on that side. V4 said V2 was assigned to

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S9999	Continued From page 10 work in the front. V4 said V1 and V2 were right there when R1 said V2 twisted her (R1's) wrist. V4 said he forgot to report the allegation to V6. V4 said V6 interviewed him on 4/8/23 regarding the situation. V4 said he forgot to tell V6 again what happened. V4 said his mind went blank and that's why he forgot to report what he saw and what R1 and V2 said. V4 apologized and said he was going to report this to V6. V4 said he is supposed to report allegation of abuse right away. V4 said his mind was not clear that's why he did not report it on 4/5/23 and on 4/8/23. On 4/9/23 at 1:52pm V8 (Social Services) said R1 was sent to the hospital on 4/6/23 per her (R1) request to be checked out because she was "attacked" last night. V8 said R1 has never been physical with anyone at the facility. V8 said R1 was non-compliant with her psychotropic medication because R1 felt that she did not need the medication and she did not agree with the diagnosis. V8 said R1 had episodes of not wanting to be bothered with staff. V8 said after giving R1 time to calm down, R1 would sometimes allow interactions with staff. V8 said the plan was to monitor R1 for behaviors, psychotherapy weekly and consult with the psychiatric nurse practitioner. V8 said she was not aware R1 would refuse to drink the water at the facility. V8 said R1 has the right to refuse to take psychotropic medications. R1 facility nursing home to hospital transfer form dated 4/6/23 denotes in-part, additional relevant information-resident claimed that a staff attacked her last night and continues to call 911 multiple times despite being addressed on 4/5/23. Today resident called 911 3 times and requested to be assessed in the hospital. Resident has bipolar diagnosis and has been refusing psych	S9999		

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medications the past few months and is on close monitoring for behaviors, waiting for neuro-psych eval at this time. State guardian aware of the situation.

R1 emergency room records dated 4/6/23 denotes in-part, 73-year-old with history of schizophrenia, hypertension, and perforated cholecystitis s/p ex lap BIBEMS (brought in by emergency medical services) from SNF with concern for physical assault yesterday. States that a CNA at SNF grabbed her wrist and twisted it several times in an attempt to make her take her medication. Also states that the CNA pulled her hair is complaining of scalp pain. Patient states she reported the incident to officer (name) of Evanston police department. She was sent in by the SNF given concern that she was having paranoid delusions about being assaulted. Hypertensive to the 200s, however afebrile and SATing well on RA (room air). Well appearing. Exam with focal tenderness of the L (left) distal radius with intact ROM (range of motion). XR (Xray) wrist with lucency of distal radius c/f hairline FX (fracture). She is neurovascularly intact. Given evidence of wrist trauma, will d/w (discuss with) SW (social worker) regarding reporting incident to the state. At this time patient is not comfortable returning to the SNF, so will admit for placement. No concern for psychosis. Xray wrist left PA lateral oblique (final result). Clinical location: wrist pain, findings: there is a soft tissue swelling surrounding the wrist. The scaphoid appears intact. Linear lucency runs parallel to the distal diaphysis and metaphysis of the radius and in the setting of acute trauma, hairline fracture cannot be excluded. Correlation patients' site of pain is suggested.

Facility policy titled resident rights with created

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007967	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY EVANSTON	820 FOSTER STREET EVANSTON, IL 60201

(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
S9999	Continued From page 12	S9999		

date of 5.22 denotes in-part employees shall treat all residents with kindness, respect, and dignity. Federal and state law guarantee certain basic rights to all residents of this facility.

Facility policy titled Abuse Prevention Program policy denotes in-part residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat the residents' medical symptoms. The facility prohibits abuse, neglect, misappropriation of property and exploitation of its resident, including verbal, mental, sexual, or physical abuse, corporal punishment, and involuntary seclusion. The facility has a "no tolerance" philosophy; persons found to have engaged in such conduct will be terminated.

V6 left message for surveyor that the facility video surveillance is not available and that a ticket was put in to request recording.

Review of the police report V1 (nurse) stated to responding officer that R1 threw her medication across the room. V1 told surveyor that R1 threw her medication at her (V1). The police report did not denote any information regarding R1 allegedly throwing milk on V2. The police report denotes V1 and V2 reported to the responding officer that R1 had dementia. Review of R1 face sheet and care plan show there is no diagnosis of dementia noted. R1 MDS dated 1/1/23 denotes R1 BIMS score of 15 (cognitively intact). Using reasonable concept, V1 and V2 statement to responding officer is inconsistent with the statement they (V2, V1) gave the surveyor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 Review of V2 timecard, V2 timecard shows V2 worked on 4/5/23 from 2:42 pm to 10:38 pm. V2 worked 4/7/23 from 3:12 pm to 8:58p m. V2 worked on 4/8/23 from 6:54 am to 6:06 pm. Review of R1 social service potential for abuse and neglect assessment dated 4/3/23 denotes in-part behavioral challenges- history of self-injurious behavior, no is checked. Review of R1 social service potential for abuse and neglect assessment dated 4/11/23 denotes in-part behavioral challenges- history of self-injurious behavior, no is checked. (B)	S9999		