

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001689</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SYMPHONY OF BRONZEVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3400 SOUTH INDIANA CHICAGO, IL 60616</b>
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S 000	Initial Comments  Statement of Licensure Violations  Compliant#s  #1780187/IL90990  #1780000/IL91004	S 000		
S9999	Final Observations  300.610a) 300.680c) 300.682a)1)2) 3)4) 300.1210b) 300.7050 b) d) e) 2) 3) 8) g)h) 300.3240a)  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 300.680 Restraints c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. Section 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when	S9999		

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>02/01/17</b>
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S9999	<p>Continued From page 1</p> <p>required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:</p> <ol style="list-style-type: none"> <li>1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective;</li> <li>2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being;</li> <li>3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and</li> <li>4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being.</li> </ol> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>Section 300.7050 Staffing</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>b) The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the severity of dementia, and the resident's physical abilities, behavior patterns, and social and medical needs.</p> <p>d) Nurses, CNAs, and social service and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall participate in a minimum of 12 additional hours of orientation within the first 45 days after employment, specifically related to the care of persons with Alzheimer's disease and other dementia. This orientation shall be defined in facility policies and procedures; shall be in a form of classroom, return demonstration, and mentoring; and shall define to new staff the elements contained in Section 300.7050(e)(1)-(10).</p> <p>e) Nurses, CNAs, and social services and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall attend at least 12 hours of continuing education every year, specifically related to serving residents with Alzheimer's disease and other dementia. (Completion of the 12 hours of orientation in accordance with subsection (d) of this Section may be counted as continuing education for the year in which this orientation is completed.) Topics shall include, but not be limited to:</p> <p>2) Promoting resident dignity, independence,</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>individuality, privacy and choice;</p> <p>3) Resident rights and principles of self-determination;</p> <p>8) Care of elderly persons with physical, cognitive, behavioral, and social disabilities;</p> <p>g) For each training requirement in this Section, staff shall be evaluated to determine if they have met or exceeded stated learning objectives. Results shall be documented.</p> <p>h) Training requirements of this Section are in addition to requirements for nurse aide training. Orientation requirements of this Section are in addition to regular staff orientation. Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident</p> <p>This requirement is not met as evidence by:</p> <p>1. ) Based on interview and record review, the facility failed to provide training for the dementia care staff member to effectively implement interventions to de-escalate a dementia care resident's aggressive behavior and honor the resident's right to make choices. This applies to one of six residents (R9) who resides on the Alleghenies' unite in a sample of 15.</p> <p>2.) Based on interview and record review, the facility failed to implement effective interventions to de-escalate a dementia care resident's aggressive behavior to prevent physical harm to the resident. This applies to one of six residents (R9) reviewed for behavior, falls and injury in the sample of 15.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>As a result, R9 sustained a bilateral shoulder dislocation while physically struggling with staff. Findings include: R9's medical record face sheet indicated that R9 was initially admitted to the facility on 3/14/2012 and latest admission was dated 3/12/15 with diagnosis that includes but not limited to Presence of Cardiac Pacemaker, Muscle weakness, Essential Hypertensions, and Unspecified Dementia without behavioral disturbances. Review of R9's progress notes documents that R9 was sent to a local hospital and was admitted with diagnosis Syncope and bilateral shoulder dislocation. R9's progress note dated 1/9/17 and timed 8:11am documented that R9 was very aggressive and agitated shouting and seems very confused when it was time to go to bed. On 1/11/17 at approximately 10:21am, E22 CNA (Certified Nurse Aide) stated that at 6:30am on 1/9/17 when (E22) was making the shift change rounds R9 was in bed with half curtain drawn sleeping. E22 further explained that at around 7am to 7:30am while getting R9 prepared for breakfast (E22) noted that R9's right arm looks twisted and the nurse was notified. The facility Preliminary 24 hour incident/injury investigation report dated January 9, 2017 documented at approximately 9:00am R9 was noted with lateral rotation, pain and bruising to his right arm and was transferred to a local hospital for evaluation and X-ray. On 1/11/17 at approximately 12:55pm, E15 (Dementia Unit Coordinator) stated that the staff did not handle the situation with R9 appropriately. E15 further explained that no physical hold should be used in de-escalating any behavioral situation with any resident. E15 stated that the staff should have stepped back and make sure the resident is</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>safe. E15 stated the facility staff is not CPI (Crisis Prevention Intervention) trained.</p> <p>On 1/11/17 at approximately 2:43pm, E18 (nurse) stated that during the night shift between 11pm and midnight, R9 became combative and aggressive. R9 was swinging, hitting staff and said he will not like to go bed. E16 CNA (Certified Nurse Aide) was trying to get R9 to bed. E16 wrapped his hands around R9 and began to take R9 to the room, R9 began to struggle trying to get out of the physical hold. R9 then slipped through (E16's) hold and went down to R9's knees on the floor at the bed side. E18 further explained that E16 then lifted R9 up with no gait belt use and instructed that R9 to lie down, R9 then told E16 that R9 will not fight any more. When E18 was asked about R9 assessment after fall, E18 answered " to be honest with you I did not know that was a fall until I was told in the morning to complete a fall assessment risk around 8:00am. " E18 stated in part that when (E18) checked on R9 at 2am it was a facial check because R9 was asleep.</p> <p>On 1/11/17 at approximately 11:52am, Z1 NP(Nurse Practitioner) stated in looking at the class of (R9) ' s injury which is a fracture, the bruises on the right chest wall and right hip it is highly a suspicion of fall.</p> <p>On 1/11/17 at approximately 12:55pm, E15 (Dementia Unit Coordinator) stated that the staff did not handle the situation with R9 appropriately. E15 further explained that no physical hold should be used in de-escalating any behavioral situation the staff should have stepped back and make sure the resident is safe.</p> <p>On 1/12/17 E1 (Administrator) stated that the facility staff are not CPI (Crisis Prevention Intervention) trained and they did not follow the facility protocol on addressing R9's aggressive or combative behaviors. E1 further explained that a</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>physical hold should not have been used. The facility guideline on Physical Restraints emergency dated 10/12 with revision date of 7/14 documented under guideline that although a nurse may determine the need for an emergency physical restraint, approval for use must be made by Health Care Provider Medical Director or a supervisor nurse and an order must be received within eight hours. The guideline further indicated under documentation that the date and time the physical restraint was applied and release should be documented. And the outcome of the application of emergency use of physical restraints should be documented. This guideline was not followed.</p> <p>The facility policy on Behavior Emergency dated 10/3 with revised date of 9/16 documented in part that, the goal of the guideline is to provide a safe, secure environment. The guideline documented that in order to foster a safe environment, a consistent staff approach to behavioral problems and emergencies are necessary. The guideline under policy indicated in part that if resident becomes violent to staff to call 911 (Emergency Help Line).</p> <p>The facility final investigation report dated 1/14/17 documented acknowledging that the action of the CNA (Certified Nurse Aide) contributed in R9's injury. The report further documented that the Nurse and the CNA involved did not follow the facility protocol for handling an aggressive/combative resident on post fall evaluation.</p> <p>(B)</p>	S9999		