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	IL6004832	A. BUILDING: _____ B. WING _____	C 06/16/2021

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SYMPHONY OF CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

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S 000	Initial Comments Complaint Investigation 2183615/IL134263	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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) These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient nursing staff and failed to follow their medication policy to ensure residents received essential medications to treat their medical conditions as ordered by their physician. There was no nurse to pass medications on one portion of a resident hallway and as a result, 26 residents (R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32) did not receive their scheduled medications on 5/15/2021 and 5/16/2021 on the day shift (7:00 AM - 3:00 PM). These failures had the potential to cause negative medical outcomes for all 26 residents.	S9999		

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S9999	Continued From page 2 Findings include: During interview on 5/20/21 at 2:51 PM, R7 stated the weekend was bad. R7 stated "I did not get my morning medication at all this weekend. No one got their medication on this end of the hall. There was only one nurse and I asked her if she could give me my medication and she said no." R7 stated "I don't feel good about not getting my medication. It makes me angry." After speaking with R7, surveyor immediately went down stairs to conference room and reviewed the electronic medication administration records for R7 and other resident's on the same end of the third floor and obtained time stamped copies. All of the resident's electronic medication administration records reviewed were missing medications on Saturday 5/15/2021 and Sunday 5/16/2021 (the spaces were blank). Surveyor requested from V1, Administrator the electronic medication administration record, face sheet, and Physician orders for R7. During an interview on 5/20/21 at 4:35 PM, with V1, V7, DON (Director of Nursing) and V4 (House Supervisor), V7 stated she was getting the information requested and before she gives information she looks at it. V7 stated that she noticed that medication was missing for all the residents on half the floor for the weekend. V7 stated she spoke to V8, LPN (Licensed Practical Nurse) about not passing the medications. V7 stated that V8 told her she did not give any medication to the other half of the floor. V7, V1, and V4 all stated that they were unaware that the residents on the 3rd floor did not receive their medication until just now when they spoke with V8. V7 stated that they just learned that no one	S9999		

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S9999	Continued From page 3 passed medications to the other half of the 3rd floor on Saturday and Sunday. On 5/20/21 at 4:55 PM, V8 stated that there wasn't a nurse scheduled for the other half of the 3rd floor on the weekend. "I was the only nurse on the schedule. I was the only nurse on the 3rd floor morning shift. I just heard today when I was called down to see the DON that if there is no other nurse on the floor that I am responsible for passing medication to everyone on the floor. I only passed medications for rooms 301 - 314." V8 stated, "I did not tell anyone that medications had not been passed or that I was the only nurse on the floor because they knew I was the only nurse on the schedule. I know that for 2 days no one received their medications on the other side of the third floor because I worked both days." On 5/20/21 at 5:15 PM, V6 (Staffing Coordinator) stated that on the 3rd floor there was only one nurse for Saturday and Sunday 5/15 and 5/16 and no other nurses or supervisors helped out on that floor those days. Surveyor requested staffing record for 5/15/2021 and 5/16/2021 and only one nurse (V8) was scheduled to work on the 3rd floor. On 5/21/21 at 9:56 AM, R23 stated there was no nurse on the weekend day shift. "I don't get my medication every day. I didn't feel good on the weekend. I felt sick because I need my insulin. I should get insulin three times a day at breakfast, lunch and dinner. I told the nurse on the other side that I needed my medication and she said I had to wait for my nurse to get here. I take medication for seizures." On 5/21/2021 at 11:40 AM, V13 (Primary Care Physician for R23) stated that "Xarelto (to prevent	S9999		

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S9999	Continued From page 4	S9999		

blood clots) and Keppra (to treat seizures) are significant medications. Xarelto and Keppra are the most important medications. It is not good if a resident missed those medications because it could reduce the therapeutic level. Resident is at risk for compromised patient care if medications were missed."

The facility Medication Administration policy documents the following:
General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis.

An In-service, Education, and Staff Development Attendance Record dated 4/26/2021 documents: Topic: Sufficient Nursing Staff; Summary of Contents: RN/LPN's are running behind with administering medications, the RN/LPN will contact house supervisor/VM/Nursing Supervisor to assist with medication pass.

On 6/3/21 at 12:43 PM, R7 stated, " I don't feel good when I don't get my medication. I feel physically off. My blood pressures was 179. I get lactulose for my liver in the morning and in the evening. When I don't get my morning medication by 10:00 AM or 11:00 AM that is not acceptable."

6/3/2021 at 1:06 PM, R28 stated that he has not been getting his medications. R28 stated "I have a hip fracture. I am not getting my pain pills 3 times per day. I'm getting it twice a-day. When they miss my morning medication I'm in a lot of pain. They ask me if pain is 1-10, but when I do not get my pain medication my right hip hurts and the pain is more than a 10."

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S9999	Continued From page 5 6/3/2021 1:20 PM, R35 stated we are always missing medications. R35 stated "I have a heart condition and when I don't get my water pill 2 times a day I feel short of breath." I am really short of breath when I walk around, because the fluids build up. I have told V1 (Administrator) and the old DON numerous times that we are not getting our medication. When you complain about not getting your medication most of the staff are mean and curse you out. They talk to us like we are in-humane. They say they will get to you when they can." Review of physician orders for R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29 R30, R31, and R32 and electronic medication administration record for these residents and the medication record signature spaces were blank (indicating not given) on 5/15/21 and 5/16/21. An Employee Education and Employee Report documents V8's acknowledgment that she failed to administer medication to the residents on an entire section of the 3rd floor. Staffing schedules were reviewed for 5/15/21 and 5/16/21, surveyor verified that on the 3rd floor unit only one nurse was working but there should be two nurses working on all units/floors. Current face sheet documents the following: 27 residents (R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29 R30, R31, R32, R35 [Interviewed on 6/3/2021] have the following medical diagnoses and per medication administration record of 5/15/21 and 5/16/21 missed the following medications:	S9999		

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S9999	Continued From page 6 R7- essential hypertension (HTN), Metabolic encephalopathy, Liver cirrhosis, right and left knee pain. Missed medications: Hydrochlorothiazide (HCTZ), Lisinopril, and Lactulose. R8- Essential hypertension, hyperlipidemia, unspecified convulsions, Epilepsy, seizures. Missed medications: Carbamazepine, Levetiracetam, Losartan potassium and HCTZ, Potassium. R9 - Essential Hypertension, Gout. Missed medication(s): Amlodipine R10 - Essential Hypertension, Chest pain, Dyspnea. Missed medication(s): Amlodipine R11 - Cellulitis of left lower limb, essential hypertension, diabetes. Missed medication(s): Isosorbide Monitrate, metoprolol, Cyclobenzaprine, Metformin. R12 - Essential Hypertension, Amnestic Disorder. Missed medication(s): Amlodipine, Lisinopril R13- Pain left hip, Essential hypertension, chronic kidney disease. Missed medication(s): Amlodipine, Valsartan HCTZ R14 - Chronic Obstructive Pulmonary Disease (COPD), Heart failure, HTN. Missed medication(s): Lasix, Albuterol Sulfate R15 - History of venous thrombosis and embolism, Pulmonary embolism, HTN, Peripheral vascular disease (PVD). Missed medication(s): Lisinopril, Plavix, Metformin R16 - Seizures, Schizophrenia. Missed medication(s): Lamotrigine, Risperdal, Seroquel R17 - HTN, Cerebral Infarction (CVA) Missed medication(s): Amlodipine, Losartan, Plavix R18 - Hyperlipidemia, HTN, COPD, Schizophrenia; Missed medication(s): Carbidopa-Levodopa, Benztropine Mesylate R19 - HTN, Cerebral atherosclerosis, PVD, Anxiety disorder, Delusional disorder; Missed medication(s): Clopidogril Bisulfate, Risperdal	S9999		

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S9999	Continued From page 7 R20 - HTN, Glaucoma; Missed medication(s): Amlodipine, HCTZ R21 - Diabetes, CVA, HTN, COPD, Pain in leg; Missed medication(s): Humalog, gabapentin, Aspirin, Plavix, Advair diskus, Metformin, Metoprolol tartate R22 - Epilepsy, HTN, Congestive Heart Failure (CHF) , Angina, Asthma, Diabetes, Chronic Kidney disease. Missed medications: Amlodipine, Aspirin, Breo Ellipta, Clopidogrel Bisulfate, Furosemide, metoprolol, Gabapentin, Levetiracetam, Humalog sliding scale R23 - Epilepsy, Diabetes, HTN, Deep Vein Thrombosis (DVT) of right lower extremity Missed medications: Aspirin, HCTZ, Liraglutide, Lisinopril, Xarelto, Carvedolol, Levetriracetam, Metformin R24- Emphysema, HTN; Missed medication(s): Budesonide Formoterol Fumarate Aerosol, Carvedolol R25 - Atrial Flutter, Diabetes, HTN; Missed medication(s): Amlodipine, Apixaban, HCTZ, Jardiance, Basaglar, Metoprolol R26 - Osteoarthritis, Schizophrenia, Venous thrombosis and embolism, HTN, pain in back, right and left hip; Missed medication(s): Losartan/HCTZ, Potassium, Diclofinac R27 - PVD, HTN, Epilepsy; Missed medication(s): Keppra, HCTZ, Meclizine, Meloxicam, Zoloft R28 - Osteoarthritis of hip, PVD, Pain right hip, edema, CHF. Missed medications: Lasix, Enalapril, Aspirin, Diclofenac, Carvedolol R29 - Osteoarthritis of hip, PVD; Missed medication(s): Nifediac, Suboxone, Metformin R30 - Unspecified convulsion, Venous Thrombosis and Embolism, HTN Missed medication(s): Apixaban, Levetracetam, Mirtazapine R31- Low back pain, chronic kidney disease, Malignant Neoplasm of the bone; Missed	S9999		

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S9999	Continued From page 8 medication(s): Pomalidomide, acyclovir R32 - Chronic Viral Hepatitis, HTN, asthma; Missed medication(s): Salmeterol Xinafoate aerosol The Facility document Resident-Centered Medication Administration Policy dated 5/2021 documents: Purpose: To provide each patient with an evidence-based, person-centered care approach across the entire medication use process in the facility. To help accomplish this goal, the facility will use a liberalized block-style medication administration schedule, when appropriate, for each patient. Definitions: Time-Critical Scheduled Medication, as defined by Institute of Safe Medication Practice (ISMP), is a medication where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy or pharmacological effect. On 6/8/2021 at 12:32 PM, V3 (Medical Director) stated they have Quality Assurance Performance Improvement (QAPI) meeting monthly and he attends. V3 stated, in regards to medication administration "in the meeting 2 weeks ago, there was a concern that one staff member did not give medication to half of the unit." V3 stated this was the first time he has heard of anything like this happening and that "In the March and April meetings they discussed medication administration but there were no major concerns." Surveyor asked if V3 has heard of any other occasions of residents not receiving medication or not receiving their medication in a timely	S9999		

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manner. V3 stated he has not heard that any residents outside of the regular 1 or 2 a month that call, were not getting medications or not getting them in a timely manner. V3 stated he does not remember the plan discussed in the meeting to address this issue, but "V1 (Administrator) and the new DON (V2) are handling it." V3 stated he has not heard of any of the previous tags in regards to this. V3 stated, in regards to medication pass, "I do not see a pattern."

On 6/8/2021 at 1:30 PM -1:55 PM, V2 (DON) stated she has been working at the facility since 5/17/21. V2 stated she did not know the severity and level of tags when she arrived. "I knew facility had annual and complaint. I didn't get around to seeing what was what until around Wednesday or Thursday. I started working on staffing and medication pass issues. The facility was working on building the staff, which they had been working on for a while, and making sure medications were being passed to residents as ordered. The facility has gotten some new staff. Our focus and management team focus is to make sure that medications are being passed. I took on the responsibility to get more staff and make sure medication is being passed in a timely manner. There has been a big improvement in medication pass and staffing. The previous DON wasn't doing what she should have. She had no checks and balances."

V2 further stated, "we had QAPI (Quality Assurance and Performance Improvement) meeting the week after I got here. Everyone who should have been there was there including administrator and medical director. To address the issues we have done in-services: we had 2 hours to get medications pass completed and

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nurses were running late. We have now transitioned to a liberalized medication pass and block charting that started about 10 days ago. I had to get orders from the medical director and individual doctors to tell them we were switching to block charting and asked if it was okay with them." V2 stated all the nurses like the new charting. "I have gotten positive feedback. Nurses have told me that it gives them time to assess their patients, and provide care because now they are not rushed by the medication time. We have managers on floor to assist." Surveyor asks what they are doing on the weekends for staffing. V2 stated nurse manager on duty is coming in, manager on duty that is non-clinical, and "I am on call I've been here the last 2 weekends. We are still using same staffing grid. Nursing is not calling off too much. Staffing is doing much better."

On 6/8/2021 at 1:55 PM, R37 stated he is the vice president of resident council meeting. R37 stated "the facility has not been having resident council meetings because of COVID-19. R37 stated that residents have complained that medications are not on time. Residents have said that they have not gotten their medications. "People want medications right away as soon as they are due."

On 6/8/2021 2:00 PM, V1 stated that once she got back from leave, in order to address medication pass issue," the facility had to get a new DON. The previous DON probably needed to get more DON training. We brought back nurses and CNA's who didn't want to work with previous DON. We started in April 2021 a temporary program." V1 stated QAPI is always the last Wednesday of the month at 11:00 AM in person (not a zoom) 5/26/21. We had April one on

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S9999	Continued From page 11 4/28/21. V1 stated she scans everyone's reports and put them on the screen during the QAPI meeting. Surveyor asked when did QAPI team discuss the tags on medication administrations? V1 stated "I will get back to you. I'm not sure if it was in the April meeting because of the date we received the 2567." V1 stated "the QAPI meeting on 5/26/21 was attended by DON, Medical records, Medical Director, Pharmacy representative, Dialysis tries to come, Administrator, Human Resources, Admissions, V4 LPN (House Supervisor). We have a Quality Assurance (QA) audit tool to check if residents are getting medication at scheduled time." Review of Resident council minutes documents that for March and April of 2021 V5 (Ombudsmen) was on site. On 6/11/21 at 10:30 AM, V5 (Ombudsman) stated "there has been chronic confirmed complaints all year of lack of staffing and residents not getting their medications especially on the weekends and night shift. There has been a massive turnover of staff." V5 stated he is in the facility 3-4 times a week. (A)	S9999		