STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145718	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CRESTWOOD	14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445

(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) COMPLETION DATE
F 323	Continued From page 3 Rehabilitative therapy had not been initiated at that time. On 6/21/12 at 1:55 AM, R2 was found lying on the floor at bedside in a large pool of blood underneath her face. There was a laceration to the right forehead and bleeding from the nose. R2 was sent to the hospital and treated for a closed fracture of facial bones. R2 returned to the facility that day. At this point, R2 still had not been evaluated for physical / occupational therapy. On 6/22/12, another telephone order was written stating, "PT to evaluate and treat as indicated. Skilled PT 5 times per week for 30 days for therapeutic exercises, neuromuscular reeducation, gait training and therapeutic activities." R2 did not receive the initial evaluation for physical and occupational therapy until three days later, on 6/25/12. On 8/15/12, 2:00 PM, E2, DON (Director of Nursing) stated that both the nursing and rehab departments were responsible for the delay of R1's therapy. On 8/15/12, 1:30 PM, E9, Director of a new rehabilitation company contracted by the facility stated that they took over on 7/02/12. Review of the facility policy of "Physician / Telephone Orders", presented on 8/15/12 by E2, DON showed that the unit nurse, Nursing Unit Manager and the Rehab Unit Manager should have been aware of the orders if the protocol was followed.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1210d)2)6)	F9999		

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F9999	Continued From page 4 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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 were not met as evidenced by the following: Based on interview and record review, the facility failed to provide the required assistance during transfer of 1 of 3 residents (R1). The facility also failed to implement the physician orders for skilled therapy to decrease the potential risk for falls for 1 of 3 residents (R2.) R1 and R2 were reviewed for falls in a total sample of 3. These failures resulted in both R1 and R2 being involved in fall incidents and both sustaining fractures. Findings include:	F9999		

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F9999	Continued From page 5	F9999		

1. R1 is 62 years old with left sided weakness related to a history of CVA (Cerebral Vascular Accident). R1 also has a history of osteoarthritis in the right knee. Per nurse's notes, R1 complained of right leg / knee pain and swelling off and on. On 8/03/12, a venous Doppler study was done of the right lower leg which was negative for deep vein thrombosis. The indication for the study was pain and swelling in the right knee. Then, on 8/06/12, an X-ray of the right knee showed osteoarthritis and the physician ordered warm compresses to the right knee daily. On 8/14/12, 12:30 PM, E6, R1's nurse stated that she was not sure if R1 was having problems with her knees. E6 stated that R1 requires one - person assist for transfer on /off the toilet.

Review of the quarterly restorative / mobility screen dated 6/28/12, said that R1 requires extensive assist to transfer on / off the toilet. On 8/14/12 at 2:55 PM, E4, Nurse (Care Plan Coordinator) stated that extensive assist would require that at least two persons assist R1 on / off the toilet. The annual MDS (Minimum Data Set) dated 3/26/12 and the quarterly MDS, dated 6/24/12, showed R1 to have impairment on both lower extremities and requiring extensive assistance for transferring.

Review of incident reports showed that R1 fell on 3/12/12 when her right foot slipped as she transferred herself from the wheel chair to the toilet. Then, on 8/08/12 at 12:20 PM, R 1 sustained a fracture of her left lower leg while being assisted by one person, E5, CNA (Certified Nurse Assistant) from the toilet to the wheel chair. On 8/14/12 at 12:00 PM, E5, CNA stated that she (E5) was the only person assisting R1 from the

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F9999	Continued From page 6	F9999		

toilet to the wheelchair on 8/8/12 when she (R1) fractured her left leg. E5 stated that R1 ' s "good leg" (right leg) gave out and R1 was lowered to the floor.

On 8/14/12 at 11:20 AM, E7, CNA stated that previous to R1's fall on 8/08/12; one person assist was used to assist R1 on / off the toilet. On 8/14/12 at 2:35 PM, E8, Restorative Nurse stated that R1 requires extensive assistance with transferring on / off the toilet. E8 defined extensive assist as requiring the assistance of 2 persons.

2. R2 is an 85 year old who was admitted to the facility on 6/07/12. According to the nurse's admission notes, R2 had bruising to the right side of her face as a result of multiple falls and had a very unsteady gait. Other admitting diagnoses included Osteoarthritis, Congestive Heart Failure and Generalized Weakness.

On 6/07/12, the admitting physician orders included an order for physical therapy and occupational rehab. Per review of the nurse's notes, on 6/12/12 at 9:45 PM, R2 was found on the floor of her room with a large hematoma to the forehead. R2 was sent to the hospital and returned after emergency treatment. Rehabilitative therapy had not been initiated at that time.

On 6/21/12 at 1:55 AM, R2 was found lying on the floor at bedside in a large pool of blood underneath her face. There was a laceration to the right forehead and bleeding from the nose. R2 was sent to the hospital and treated for a

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F9999	Continued From page 7 closed fracture of facial bones. R2 returned to the facility that day. At this point, R2 still had not been evaluated for physical / occupational therapy. On 6/22/12, another telephone order was written stating, "PT to evaluate and treat as indicated. Skilled PT 5 times per week for 30 days for therapeutic exercises, neuromuscular reeducation, gait training and therapeutic activities." R2 did not receive the initial evaluation for physical and occupational therapy until three days later, on 6/25/12. On 8/15/12, 2:00 PM, E2, DON (Director of Nursing) stated that both the nursing and rehab departments were responsible for the delay of R1's therapy. On 8/15/12, 1:30 PM, E9, Director of a new rehabilitation company contracted by the facility stated that they took over on 7/02/12. Review of the facility policy of "Physician / Telephone Orders", presented on 8/15/12 by E2, DON showed that the unit nurse, Nursing Unit Manager and the Rehab Unit Manager should have been aware of the orders if the protocol was followed. B	F9999		