STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145372	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF JOLIET	**306 NORTH LARKIN AVENUE JOLIET, IL 60435**

(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 R1 was observed with E2, on 6/13/12 at 1:45 PM. Neither R1's wheelchair nor bed were alarmed. E2 confirmed this during the observation. E5 (Rehabilitation RN/Director) was interviewed on 6/13/12, at 2:30 PM. She confirmed the investigative action plan was to place the alarms on R1's wheelchair and bed, however it had not yet been done.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a) 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 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: 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	F9999		

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F9999	Continued From page 4 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 REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on record review and interview, the facility failed to ensure : The bed alarm was functioning for 1 of 3 sample residents reviewed for falls, (R2) who sustained a fractured femur after falling. Additional fall precautions were implemented, according to the plan of care, for 2 of 3 sample residents (R1, R2) reviewed with histories of falls. Findings include: According to the record, R2 is a 77 year old with diagnoses of Alzheimer's Dementia, Syncope (fainting), and Osteoporosis. The most current Minimum Data Set (MDS), dated 3/15/12, states R2 needs one person assistance when ambulating. According to the safety assessment tool, dated 3/24/12, R2 is oriented to person only, is unsteady with ambulation, uses a wheelchair at times and has a history of falls. The careplan, revised on 3/20/12, states R2 requires, "Place bed alarm out of resident's reach. Apply sensor to bed." Incident reports reviewed from 12/1/2011, documented the following falls; 12/1/2011= Fell in room. No injury. 3/27/2012= Fell in room with resulting head scrape and elbow redness. Trying	F9999		

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F9999	Continued From page 5	F9999		

to remove alarm. Action taken included, "Place alarm out of resident's reach." 4/19/2012 = Fell in room. No injury. 6/4/2012= Fell in room. Fractured femur sustained. This resulted in a hospitalization and surgery for the fracture.
E3 (LPN) documented on the 6/4/12 incident report, "Discovered resident on the floor lying on left side. Resident was yelling out. Resident fell after walking across the room. Resident states she removed alarm. She unclipped her alarm."
The incident / investigative report for the 6/4/12 fall did not address whether or not the resident's alarm was sounding or the proper alarm was used, however E2 (Director of Nursing) documented in the report, "Wrong alarm and placement. Staff education. Safety and alarm will be re-evaluated when she [R2] returns."

E2 confirmed the incident report documentation on 6/13/12, at 2:10 PM.

E3 (LPN) stated on 6/13/12, at 3:30 PM, R2 was assigned to her on 6/4/12, at 6:30 AM, the time R2 fell. She said R2 had both alarms on in bed, the clip-on and the sensor pad, because R2 tries to remove the clip alarm. E3 said she and the Certified Nursing Assistant (CNA) heard R2 yelling and found her on her bedroom floor. She said it appeared R2 had gotten out of bed, walked across the room, and fell near her roommate's bed. E3 said it appeared R2 had removed her clip alarm, but that the bed sensor alarm was not sounding. After finding R2 on the floor, E3 touched R2's bed sensor pad and it started alarming.

R2 was observed with E2, on 6/13/12 at 1:30 PM. She was in bed with an alarmed mattress pad

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F9999	Continued From page 6	F9999		

which was attached to the sound apparatus, positioned near R2's shoulder. R2's wheelchair had a clip alarm on it, but not a pad sensor.

E5 (Rehabilitation RN/Director) was interviewed on 6/13/12, at 2:30 PM. She confirmed the investigative action plan was to re-evaluate R2's alarms and that she would be the person to do so. However, E5 said R2 had come back to the facility yesterday evening, 6/12/12, but E5 had not yet re-assessed the alarm usage. E5 said since R2 has disconnected her clip alarm in the past, she should have a pad sensor for the wheelchair, the clip alarm is not enough. E5 also said the sensor pad alarm can be disconnected from the sounding device, therefore R2's device should be positioned at the bottom of the bed, not at the top near the shoulder area.

2) According to the record, R1 has diagnoses which include Dementia. Incident reports documented the following, 4/19/12 = Resident fell in room, legs weak. Small abrasion right knee. Encourage to ask for staff help. 6/3/12= Resident fell in room. No injury. Reminded to ask for staff assistance. 6/12/12= Resident fell in room, going to toilet. Action taken; Pad alarm placed on wheelchair and bed. R1's careplan, revised 6/12/12, documented, "6/12/12 - Pad alarm placed on wheelchair and bed."

R1 was observed with E2, on 6/13/12 at 1:45 PM. Neither R1's wheelchair nor bed were alarmed. E2 confirmed this during the observation.
E5 (Rehabilitation RN/Director) was interviewed on 6/13/12, at 2:30 PM. She confirmed the investigative action plan was to place the alarms

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F9999	Continued From page 7 on R1's wheelchair and bed, however it had not yet been done. (B)	F9999		