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	145718	A. BUILDING _____ B. WING _____	C 12/14/2012

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

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F 367	Continued From page 12 stated, "Yes she sure did have whole milk yesterday I confirmed that with you. I will have to check and see why she got it." On 12/6/2012 at 1:40 PM, E8(Unit Director) stated, "It was a mistake for R1 to receive whole milk." On 12-6-2012 at 1:45 PM E30(Dietary Manager) stated " R1 should not receive whole milk, when mistakes happen we in-service the person. A lactose Free diet is one where there is no milk or cheese."	F 367		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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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.

This regulation was not met as evidenced by the following:

Based on interview and record review the facility failed to follow up on Scan results in a timely manner for 1(R1) of 6 residents reviewed for falls and failed to perform pain assessments for 1(R1) of 3 residents reviewed for pain in the sample of 21. This failure resulted in R1 being in the facility 7 days after a Computed Tomography Scan with a hip fracture and no pain assessments.

Findings include:

On 12-5-2012 at 9:56 AM during the initial tour with E3(Director of Nursing) R1 was laying in bed of regular height, asleep with a bed alarm attached to the bed. On 12-5-2012 At 11:50 AM, R1 was walking to the dining room using a rolling walker with E17(Certified Nursing Assistant).

Nursing Progress Notes dated 9-8-2012

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documents the following: "R1 fell and complained of hip pain. Range of motion assessments were done, vitals were taken, the physician and family were notified. The doctor ordered pain management and an x-ray, which were done on 9-8-2012. An Unusual Occurrence Report dated 9-8-2012 was completed for the unwitnessed fall. The Radiology Report dated 9-8-2012 documents "no fracture or dislocation seen; conclusion states, mild arthritis of the right hip correlate with a Computed Tomography Scan(CT) if there is concern for subtle acute fracture."

Physician Progress Notes dated 9-11-2012 documents the fall and x- ray results and orders a CT scan due to age and osteoporosis.
Nursing Progress Notes dated 9-13-2012 documents, "R1 is going out to the hospital for CT scan." There is no documentation in the Nursing Progress Notes from 9-13-2012 after the return from the CT Scan until 9-20-2012 (7 days).

The Nursing Progress Notes document from 9-8-2012 until 9-11-2012 pain assessments and medications. There is no documentation from 9-13-2012 through 9-20-2012 for pain assessment nor is there any documentation for pain medications given during this period. Medication Administration Record was reviewed from September until December 2012. There was no documentation of pain medicine administered from 9-11-2012 until 9-21-2012.

Nursing Progress Notes dated 9-20-2012 documents Z3 called and stated send R1 to the hospital as direct admit with a copy of the CT scan results. CT results dated 9-13-2012

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F9999	Continued From page 15 documents, "comminuted fracture the base of the greater trochanter is identified." On 12-6-2012 at 9:27 AM, E11(Nurse Manager) stated that "R1 was in the facility for 12 days with a fracture. The nurses' should have followed up each shift from 9-13-2012 when she went out for the CT Scan until they obtained the CT scan results. There is no excuse for why it was not followed timely. Pain Should have been addressed." On 12-11-2012 at 11:32 AM Z3 stated, "I remember R1's fall, I examined R1 on 9-11-2012 and the X- Ray results stated to correlate with a CT scan if concern with subtle fracture, I ordered a CT scan which was done on 9-13-2012 because of old age and osteoporosis. Usually the radiologist will call with the x- ray result if it is positive. The nurses should have called to get the results. I was sitting in my office on 9-20-2012 and looking at my computer and the results were there, I called the facility and informed them to send R1 to the hospital as a direct admit for fracture. The family decided that they did not want surgery for R1 so R1 was sent back to the facility with an order for physical therapy and to monitor." On 12-12-2012 at 11:35 AM, E11(Nurse Manager) stated, "the nurses should have done pain assessments for R1 from 9-13-2012. We need to correct that. They do 72 hour assessments after a fall but considering what was going on with R1 the nurses should have continued to assess her for pain whether R1 was having pain or not."	F9999		

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F9999	Continued From page 16 Pain Assessment and Management Policy dated 1/10 documents, "Conduct a comprehensive pain assessment upon admission to the facility at the quarterly review, whenever there is a significant change in condition, or when there is onset of new pain or worsening pain of existing pain. Assess the resident's pain and consequence of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain." B 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

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F9999	Continued From page 17 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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:	F9999		

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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.

These regulations were not met as evidenced by the following:

Based on interview and record review the facility failed to Follow their fall prevention program policy for two of six residents (R2. R3) all reviewed for falls, in a total sample of 21. This failure resulted in R3 being admitted to the hospital with a diagnosis and treatment of a hematoma to the forehead.

Findings Include:

1). According to the Care Center Short Report Form dated 9-22-2012, R3 has diagnosis of Falls, mental status change and heart diagnosis.

According to R3's closed records, Nursing Progress Notes dated 9-22-2012 at 9:45 PM documents that "R3 arrived by ambulance. R3 is alert to name only and was placed in bed and covered with blankets. Vital signs stable temperature 98, pulse 74, respiration 18-20 and

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blood pressure 130/74 oxygen saturation level 97%. R3 has a history of end stage renal disease, congestive heart failure, hypertension , right breast cancer ..... history of fall with tail bone pain. 9-22-2012 at 10:00 PM I was called by certified nursing assistant to come CNA had observed resident on floor with left side legs bent noted a hematoma to left side of forehead, resident stated she hit her head a few days ago....vitals were taken temperature 98, pulse 80, respiration 20 blood pressure 114/77 ....ice pack to left head doctor gave order to send out to hospital for Computed Tomography (CT)Scan .. R3 admitted to the hospital with a diagnosis of hematoma."

On 12-6-2012 at 4:06 PM E14(Nurse) stated that R3 fell within 40 minutes of admission to the facility and could not recall what size bed R3 was placed in but did recall that E15(Certified Nursing Assistant) alerted her to the fall.

On 12-6-2012 at 4:35 PM, E15(Certified Nursing Assistant) stated, that "on 9-22-2012 at about 9:30 PM the roommate of R3 pulled the call light to the room he was assigned and upon entrance R3 was laying on the floor with a fresh knot on her left side of her head, holding the back of her head groaning. E15 stated that he was not aware of the resident being admitted so he alerted the nurse (E14) who was across the hall. E15 stated he believed the height of the bed to be at regular height, no floor mats. The roommate who is no longer a resident said that R3 rolled over the half side-rails and hit her head. I start my shift at 3 PM and if a new admission is coming the nurse will give the Certified Nursing Assistant(CNA) a report I was not even aware that the resident was here."

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F9999	Continued From page 20 On 12-7-2012 at 11:40 AM, E14(Nurse) stated, R3 came on a cot and vitals sign were taken in the hallway while on the cot. Paramedics took R3 to the room and put her in bed, I did not follow. R3 was a new admission, chart was on the desk at the time of my shift and the room number was assigned. E14 stated that she knew the resident had a diagnosis of falls and did not put any interventions in place. I did the admission report and the incident report at the same time. "I was supposed to do a fall assessment on the resident upon admission I did not do that. On 12-7-2012 at 12:44 PM, E3(Director of Nursing) stated when the paramedics bring residents in to the facility the assigned nurse is supposed to go in with them to do the admission and assessments. It is not acceptable for a nurses to allow the paramedics to place the resident in bed unsupervised, the nurse should have gone into the room with the paramedics and assessed R3. On 12-11-2012 at 12:45PM, E31(Admission Director) stated R3's chart was brought to the floor on Friday 9-21-2012 with the diagnosis sheet which states diagnosis of fall and mental status changes on the top of the chart. R3 was admitted on Saturday 9-22-2012, the nurses had the chart on Friday 9-21-2012. Fall Prevention Program Policy undated states, "Each resident is formally assessed for fall potential upon admission, quarterly, annually or any incidence of falls, The admitting nurse or designee completes the fall risk assessment. An Interim care plan should be developed and	F9999		

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F9999	Continued From page 21 instituted for all residents who have been identified at high risk for falls. Plan of care should include interventions to reduce falls and and injuries related to falls." On 12-14-2012 at 10:00AM Z8 stated, "The paramedics should have handed the resident over to staff when the resident arrived and staff caring for the resident should have assessed the resident, staff should have known that the resident was here. During report it was communicated that the resident had a diagnosis of fall, fall interventions should have been put in place. Fall interventions would have prevented the resident from falling." 2). According to the nurse notes dated 8/11/2012 at 3:50pm it states that R2 was found on the floor, sitting with back to the couch, R2 was assessed with no injuries. Nurses note dated 9/22/2012 at 11:30am notes that R2 was found on the floor still sitting in the shower chair while being assisted with a shower by a certified nurse aide. R2 was assessed with a skin tear to the left elbow. A review of R2's clinical record show there were no fall risk assessments completed after each fall, and R2's plan of care for fall risk was last updated 6/8/2012. A review of the facility's incident and accident reports reportable and non-reportable there are no reports found noting each fall. According to the facility's fall prevention program policy notes "if a fall occurs the nurse will complete a unusual occurrence/incident report.	F9999		

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F9999	Continued From page 22 The plan of care is updated and reviewed. A fall risk assessment should be completed to determine risk factors after a fall." On 12/11/2012 at 9:00am during the morning meeting both E1 (Administrator), and E2 (Director of Nursing), said that they were unable to locate the fall occurrence forms for R2 after the (2) falls of 08/111/2012 and 9/22/2012. They both said that they were unable to locate the fall risk assessment after the same mentioned falls. E1 said that there was no policy for incident reporting however it is covered in the fall prevention program policy. E1 said facility staff are required to complete incident reports after each fall. E2 said that all fall incidents are reviewed and the plan of care are updated and/or reviewed after each fall incident. On 12/11/2012 at 9:30am E4 (Assistant director of nursing), said that it is the nursing staffs responsibility to complete the fall occurrence form after each fall. E4 also said that the fall risk assessment are to be completed by the attending nurse after each fall to determine the possible risk factors, and to assist with developing fall prevention interventions. E4 also said after the fall risk assessment is completed the plan of care is reviewed and updated with new interventions as needed. E4 said that each fall is documented on the plan of care to note that the plan of care was reviewed. B	F9999		