DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		145372	B. WING			C 07/03/2013		
NAME OF F	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
SYMPHO	ONY 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION		
F 000	INITIAL COMMENTS		F(000				
F 333 SS=D	Complaint Investigation # 1372314/IL63651 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS		FS	333	3			
	The facility must ensure that residents are free of any significant medication errors.							
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer insulin medication as ordered and failed to follow the administration guidelines for a long acting and rapid acting insulin.							
	This applies to one of two residents (R1) reviewed for insulin administration.							
	The findings include:							
		gnoses including DM and right BKA (below knee						
	alert and oriented. noted on top of the 50 % of the meal or she was finished w time, R1 stated she	AM, R1 was observed in bed, R1's breakfast meal tray was overbed table, with more than onsumed. According to R1, ith her breakfast. During this e is still waiting for the nurse to gar level and to give her the						
	Practical Nurse) ch	M, E8 (LPN/Licensed ecked R1's blood sugar level DER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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145372			B. WING			C 07/03/2013		
NAME OF PROVIDER OR SUPPLIER					IREET ADDRESS, CITY, STATE, ZIP CODE			
SYMPHONY OF JOLIET					306 NORTH LARKIN AVENUE JOLIET, IL 60435			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 333	and obtained 161 m prepared R1's two medications. E8 fin 16 units, then using withdrew 12 units of of 28 units (Lantus mixed/combined). insulin to R1's left la received her insulin 45 minutes after ea R1's POS (Physicia through 7/9/13 shor glucose to be moni 6AM, 11AM, 4PM a sliding scale daily (Humalog per sliding 6AM, 11AM, 4PM a sliding scale, fo 81 - 150 mg/dl to gi blood glucose level give 11 units of Hut E8 administered 12 instead of the order On 7/2/13 at 11:45 Lantus (Glargine) is constantly release injection. While the acting insulin, which According to Z1, La mixed together in o manufacturer beca	ng/dl. At 9:42 AM, E8 sliding scale insulin st withdrew Lantus (Glargine) g the same insulin syringe, E8 of Humalog (Lispro) for a total and Humalog insulin At 9:45 AM, E8 injected the ower abdominal area. R1 n medications approximately ting. an Order Sheet) dated 6/10/13 wed orders for R1's blood tored four times daily (every and 8PM), to give Lantus per every 6AM) and to give g scale four times daily (every and 8PM). The same POS r blood glucose level between ive 12 units of Lantus and for between 151 - 200 mg/dl to malog.	F	333	3			

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DEPAR CENTE	RINTED: 07/08/2013 FORM APPROVED MB NO. 0938-0391						
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145372		145372	B. WING			C 07/03/2013	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 306 NORTH LARKIN AVENUE		
SYMPHO	ONY OF JOLIET				JOLIET, IL 60435		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	The Clinical Pharm an insulin glargine the same time ever manufacturer, insul diluted or mixed wit as the pharmacody glargine and/or the in an unpredictable Pharmacology state preferable administ before or immediate	acology copyright 2013 states is administered once daily at y day and that per lin glargine should not be th any other insulin or solution mamic profile of insulin other insulin may be altered manner. The same Clinical es for insulin lispro, the tration is within 15 minutes ely after a meal and until data ot mix insulin lispro in the	F	33:	3		

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If continuation sheet Page 3 of 3