STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. BUILDING _____ B. WING _____	C 02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF DECATUR	2530 NORTH MONROE STREET DECATUR, IL 62526

(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 000	INITIAL COMMENTS Original Complaint Investigation: 1460373/ IL# 67768-F315 and F353 1460313/ IL# 67701-no deficiencies	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide proper perineal cleansing following incontinence for one of four residents (R2) reviewed for incontinence care in a sample of four. Findings include: On 2-20-14 at 9:25 a.m. E4 CNA (Certified Nurse Aide) and E5 CNA washed R2's perineal area following urinary and fecal incontinence. E4 removed bowel movement (BM) from R2's perineal area using a back to front motion starting from R2's buttocks to R2's urethra (opening to the bladder). E4 then used a soapy wash cloth to cleanse R2's perineal area from back to front.	F 315		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. BUILDING _____ B. WING _____	C 02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF DECATUR	2530 NORTH MONROE STREET DECATUR, IL 62526

(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 315	Continued From page 1 On 2-20-14 at 9:40 a.m. E4 (Certified Nurse Aide) verified that incontinence care should be performed by cleansing the perineal area from front to back. On 2-24-14 at 8:40 a.m. E3 (Assistant Administrator) stated that staff are instructed to cleanse the perineal area from front to back to prevent BM (Bowel Movement) from entering the Urethra (opening to the bladder). Taber's Nursing Care: Theory and Practice (Fifth Edition 2009) documents to perform perineal cleansing by taking care to wash, "...from front to back to minimize the risk of contamination from the anal area."	F 315		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. BUILDING _____ B. WING _____	C 02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF DECATUR	2530 NORTH MONROE STREET DECATUR, IL 62526

(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 353	Continued From page 2	F 353		

nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to have the minimum required direct care staff hours for five of the 14 consecutive days prior to the survey. This has the potential to affect all 181 residents in the facility.
Findings include:
On 2-20-14 at 9:00a.m. E1 (Administrator) provided and verified a facility staffing schedule dated 2-06-14 to 2-19-14 which documents the actual hours worked by Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides, and all other ancillary personnel included as Direct Care staff.
R1 also provided the number of residents requiring either skilled or intermediate care during that same time period. Based on the average number of skilled and intermediate care residents' residing in the facility over the previous 14 days, the facility should have had 363.82 hours of Direct Care Staff hours per day. The staffing schedule provided by E1 documents that on 2-08-14, 2-09-14, 2-15-14, and 2-16-14 there was less than the required minimum Direct Care Staffing hours for each those days.

On 2-24-14 at 2:30 p.m. E1 (Administrator) again verified the staffing schedule for 2-06-14 to 2-19-14.

A Facility Data Sheet dated 2-20-14 and signed by E1 (Administrator) documents that, at the time of the survey, 181 residents resided at the facility.