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 03/18/2015

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 Complaint # 1561244 / IL 75553	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess and demonstrate the functional need and medical necessity for physical restraints for R1 and R2; the facility failed to implement a systematic and gradual plan to reduce physical restraints for two of three residents (R2, R1) reviewed with physical restraints on the sample of three. Findings include: 1. R2's Order Review Report dated 1/9/14 and 3/17/14 documents "resident may use full lap tray when OOB (out of bed) for positioning r & r (release and reposition) every 2 hours for toileting, exercise, ECT(etcetera) D/T (due to) poor upper body strength, leans forward in wheelchair, unsteady gait DX (diagnosis) Dementia, Pain, Agitation, Met (metastisized) Lung Cancer." R2's MDS (Minimum Data Set) dated 5/27/14 documents "Chair prevents rising" is used daily. The MDS documents R2 requires extensive assist with two people for transfers and extensive	F 221		

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 03/18/2015

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 221	Continued From page 1 assist with one person for ambulation in hall and room. On 3/17/15 at 11:40am E7, CNA (Certified Nursing Assistant) stated R2 "does try to stand and can walk short distances like when transferring." R2's Care Plan dated 3/10/14 documents R2 is "at risk for falls/hx (history) of falls: comfort care" with interventions including "res (resident) up in w/c (wheelchair) c (with) full lap tray when oob for positioning r&r q (every) 2 hrs (hours) et (and) prn (as needed) for toileting, exercise, ect d/t (related to) poor upper body strengths leans forward in w/c, unsteady gait. Dx: agitation, met lung ca (cancer), pain, dementia and ataxia of gait." R2's Electronic Physical Restraint Form dated 3/3/14, 5/21/14, 8/19/14, 9/12/14 and 12/10/14 are incomplete. The section of the form titled "Alternatives Considered" documents "wheelchair with safety belt" , but the sections asking "How long? and How recently were alternatives tried?" are all blank. The resident's response is documented "uneffective." The section of the form titled "Restraint parameters" documents "wheelchair with full lap tray" but the sections asking "Use, When, Where, How long? Under what circumstances? Who suggested?" are all blank. The section of the form asking "Do the benefits outweigh the negatives" is blank. The section titled "Benefits" asks if the restraint "enhances functional status/ability?" which is answered as "No", but there is nothing documented in the "Comments" as to what the functional benefit of the restraint is for R2. Each form above also documents referral to physical and occupational therapy. R2's written Physical Restraint Assessment dated	F 221		

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 03/18/2015

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 221	Continued From page 2	F 221		

3/3/14, 5/21/14, and 8/19/14 the section of the form "Alternatives Considered" documents "wheelchair with alarming seatbelt", but the sections to document "How Long" alternatives were tried and "Resident's Response" were blank. The section of the assessment "Implement Reduction or Elimination Program" documents "none @ (at) this time" for 3/3/14, 5/21/14 and 8/19/14. On 3/18/15 at 11:05 AM E3, Licensed Practical Nurse (LPN) Risk Manager stated a safety seatbelt was tried "several times" for R2 on 12/9/13 but verified there is no documentation of trials of less restrictive restraints.

The Initial Screen for Use of Physical Restraints dated 10/30/14 documents "will continue to refer to therapy for future attempts at reduction."

On 3/18/15 at 9:10 AM E3 stated we "try to refer to therapy especially for people with lap trays every quarter."

R2's "Interdisciplinary Resident Screen" dated 10/31/14 documents "Resident currently receiving skilled therapy services and we will address any applicable restraint reductions and implement the least restrictive device appropriate for the resident at this time" written by E4, Director of Rehabilitation, but there is no documentation regarding attempted reduction or what least restrictive devices were attempted.

On 3/18/15 at 9:10AM E4, Director of Rehabilitation verified that she received a referral for a screen for R2 on 10/31/14, but did not remember receiving any other referrals for R2. E4 verified there is no other documentation of referrals to therapy for restraint evaluation other than 10/31/14.

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 03/18/2015

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 221	Continued From page 3 On 3/18/15 at 1:35pm E9, Occupational Therapist stated "I think we tried to work on sitting balance, but I don't think we got to the point of leaving him sit without the lap tray or changing from the lap tray." On 3/17/15 at 10:50 AM, Z1, R2's wife stated "I am here every day. He does have a lap tray on... I am not aware they have ever tried anything but the lap tray." On 3/17/15 at 11:45 AM, E7, CNA was standing in front of R2 during feeding him in dining area while the lap tray was secured to R2's wheelchair. The food tray was sitting on the dining room table. At 12:00 PM, the lap tray remained secured to R2's wheelchair, even though E7 remained within a couple of feet from R2. On 3/17/15 at 12:10 PM, R2 was in dining area and began pushing back and forth and trying to lift lap tray up and grimacing and becoming increasingly agitated. There were no staff present in the dining room at the time. 2. The MDS dated 11/28/14 states R1 ambulates with extensive assist of one. The MDS dated 2/18/15 states R1 ambulates with extensive assist of two, and has severe cognitive deficits with diagnoses of Dementia and Cancer of the Colon. On 3/17/15 at 11:00am E5, CNA (Certified Nurse Aid) stated R1 is able to ambulate with extensive assist of one. E5 stated R1 is unable to remove the lap tray from the wheelchair.	F 221		

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 03/18/2015

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 221	Continued From page 4 On 3/17/15 at 12:30pm E6, CNA stated R1 ambulates with two assist, one on each side. E6 stated R1 is unable to remove the lap tray from the wheelchair and "the lap tray is for his [R1's] safety-he will try to get up." The Physician's Order dated 3/26/14 states, "Wheelchair with full lap tray when OOB [out of bed] R & R [release and reposition] [every] 2 hours and prn [as needed] for meals, toileting etc. [related to] poor standing balance, unsteady gait, poor upper body control, leans forward in wheelchair....." The Care Plan dated 10/21/14 documents R1 "uses physical restraints (full lap tray)" with the following interventions identified: " Evaluate [R1's] record continuing risks/benefits of restraint, alternatives to restraint, need for ongoing use, reason for use." ; "Wheelchair with full lap tray..... R & R [every] 2 hours and prn for meals, toileting...." The Electronic Physical Restraint Form dated 12/3/14 and 3/3/15 states R1 has decreased lower extremity strength, poor trunk control, poor sitting posture and is at risk for falls. The form documents that R1 has had no falls. The section of the form titled "Alternatives Considered" documents "wheelchair" , but the sections asking "How long? What was the resident's response? How recently were alternatives tried?" are all blank. The section of the form titled "Restraint parameters" documents "wheelchair with full lap tray" but the sections asking "Use, When, Where, How long? Under what circumstances? Who suggested?" are all blank. The section of the form asking "Do the benefits outweigh the negatives" is blank. The section titled "Benefits" asks if the	F 221		

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 03/18/2015

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 221	Continued From page 5 restraint "enhances functional status/ability?" which is answered as "Yes", but there is nothing documented in the "Comments" as to what the functional benefit of the restraint is for R1. On 3/18/15 at 11:05 am E3, LPN, Risk Manager confirmed the Physical Restraint Assessments dated 12/3/14 and 3/3/15 are incomplete and no less restrictive alternatives are documented as being trialed. E3 stated therapy is usually asked to screen for restraint reduction every quarter. On 3/17/15 at 3:20pm E4, PTA (Physical Therapy Aide), Director of Rehabilitation stated R1 was screened on 10/31/14 , but "I don't think we have seen him (R1) since October (2014)." The undated facility "Restraint Reduction/Management Protocol" documents "...all residents have the right to be unrestrained. Restraints should be used only as a last alternative and only when less restrictive measures have been tried and proven unsuccessful....residents using a restraint must be evaluated and re-evaluated every 90 days. The evaluation must contain an assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives, an assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching their highest practical physical, mental, or psychosocial well being...The physician's order must be updated to reflect the reduction program plan, and this plan must be part of the care plan entry...."	F 221		