LEXINGTON OF STREAMWOOD
815 EAST IRVING PARK ROAD
STREAMWOOD, IL 60107

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: LEXINGTON OF STREAMWOOD
STREET ADDRESS, CITY, STATE, ZIP CODE: 815 EAST IRVING PARK ROAD
STREAMWOOD, IL 60107

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012975

STATEMENT OF LICENSURE VIOLATIONS: 300.1210b)
300.1210b(3)
300.1210b(4)
300.1210b(4)(A)(B)(C)(D)
300.1210d(5)
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. Restorative measures shall include, at a minimum, the following procedures:
3) Objective observations of changes in a
resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
   A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
   B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.
   C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes.
   D) Each resident shall have clean bed linens at least once weekly and more often if necessary.

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
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**STATEMENT OF DEFICIENCIES**

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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:**

Based on observation, interview and record review the facility failed to identify and prevent facility acquired pressure sores for one resident (R15). The facility also failed to notify the wound care nurse in a timely manner to assist in the prevention and healing of R15's Pressure sores.

This resulted in R15 acquiring a stage 3 pressure sore to the right buttocks / thigh area; a stage 2 pressure sore to the coccyx area; and multiple open draining areas on his back and the need for oral antibiotics.

This applies to one resident (R15) of 5 residents reviewed for pressure sores in a total sample of 26.

The findings include:

R15’s admission electronic medical record showed he is a 73 year old male, has Multiple Sclerosis with paraplegia and hemiplegia of the right arm. R15 also has a history of colostomy, chronic indwelling catheter due to neurogenic bladder and obesity and has been in the facility since 1997.

R15 is shown to be cognitively intact with a score of...
Continued From page 3

of 15 on his Brief Interview for Mental Status (BIMS) on the 3/19/15 Minimum Data Set (MDS). R15’s functional status on the same MDS documents him to need extensive assist from two people with dressing and an extensive assist with one assist for personal hygiene.

On 5/27/15 at 10:00 AM, R15 was in his room in bed sitting up finishing breakfast. There was a very strong foul odor in the room. R15 stated the staff have not come to clean him up or change his bedding. R15 stated they usually come in the morning and change his bedding and cleaning once a day.

On 5/27/15 at 10:10 AM, E6 (Certified Nurse Aide - CNA) came in R15’s room and stated she was going to change his bedding. E6 proceeded to assist R15 with turning on his left side. R15 was noted to be saturated in a foul smelling brownish green fluid from his shoulders to mid thighs on both sides. There were two thick absorbent dressing on R15’s right buttock that were also completely soaked in this foul smelling fluid. Under these dressings there were open wounds on the coccyx area and multiple open areas on the right buttock. R15’s posterior skin from his shoulder to his mid thighs was completely discolored a dark brown color and open oozing areas. All the linen and mattress were completely saturated with foul smelling fluid. R15 stated he had not been cleaned up since yesterday. E6 stated, "I don’t know I wasn’t here yesterday." E6 then began saying, "I can’t do this, I can’t do this," and began to walk out of R15’s room to get assistance while leaving R15 exposed, until called back to cover him. E6 was also asked if R15’s nurse could come with her to assess him.

On 5/27/15 at 10:10 AM, E6 (CNA), E7 (Licensed
Practical Nurse - LPN), E8 (CNA) came back to R15's room. They turned him on his left side. When asked E7 how long R15 had been like this, she (E7) stated she didn't know. E7 stated she need to go and get medicine for R15's wounds and left. E6 proceeded to take a wash cloth and wipe down R15's back when pieces of R15's skin on his back was coming off and bleeding. R15 then stated, "Keep going down the spine, it itches." E7 and E9 (Registered Nurse) arrived in R15's room. E9 donned gloves and began washing R15's back and buttocks and sores with the same wash cloth. There was no protective cloth to cover the mattress. E7 also donned gloves and began wiping with a dry cloth across the buttock / coccyx wounds and R15's back. E7 then changed her gloves, no handwashing and began applying an antifungal cream to R15's back. E9 (RN) stated he had been using that anti-fungal cream for at least 2 years. The May 2015 Physician Order Sheet (POS) did confirm the antifungal cream was originally prescribed 8/22/13. E7 then changed her gloves again, without handwashing, and applied a barrier cream to R15's buttocks and then placed dry absorbent dressings on the area. R15's sheets were then changed and the mattress was never cleaned. R15 had an indwelling urinary catheter. No one provided catheter care or washed his groin area. R15 stated they are supposed to wash the groin area every shift and they don't do it. R15 stated, "I get a shower twice a week but I could use it more often, they just don't do it."

On 5/27/15 at 10:45 AM, E11 (wound nurse) came into the room and stated, she has not seen R15 in a long time. E11 stated the nurses will ask her to see a resident if they have wounds. E11 stated R15 has had problems with friction and shearing in the past because he refuses to get up.

Practical Nurse - LPN), E8 (CNA) came back to R15's room. They turned him on his left side. When asked E7 how long R15 had been like this, she (E7) stated she didn't know. E7 stated she need to go and get medicine for R15's wounds and left. E6 proceeded to take a wash cloth and wipe down R15's back when pieces of R15's skin on his back was coming off and bleeding. R15 then stated, "Keep going down the spine, it itches." E7 and E9 (Registered Nurse) arrived in R15's room. E9 donned gloves and began washing R15's back and buttocks and sores with the same wash cloth. There was no protective cloth to cover the mattress. E7 also donned gloves and began wiping with a dry cloth across the buttock / coccyx wounds and R15's back. E7 then changed her gloves, no handwashing and began applying an antifungal cream to R15's back. E9 (RN) stated he had been using that anti-fungal cream for at least 2 years. The May 2015 Physician Order Sheet (POS) did confirm the antifungal cream was originally prescribed 8/22/13. E7 then changed her gloves again, without handwashing, and applied a barrier cream to R15's buttocks and then placed dry absorbent dressings on the area. R15's sheets were then changed and the mattress was never cleaned. R15 had an indwelling urinary catheter. No one provided catheter care or washed his groin area. R15 stated they are supposed to wash the groin area every shift and they don't do it. R15 stated, "I get a shower twice a week but I could use it more often, they just don't do it."

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The facility "wound Assessment" dated 2/3/14 documents the wound was initially identified on 7/19/13. The wound was documented as Moisture Associated Skin Damage (MASD) facility acquired and measured 5.0 cm x 4.5 cm x 0.05 (L x W x D). The last "wound Assessment documented 3/14/15 documents the wound size as 10.0 cm x 5.0 cm x 0.05 cm (L x W x D). R15 was not seeing the wound physician at that time. E11 stated the staff nurses were taking care of R15's skin and wound after that and was not diagnosed with a pressure sore at that time.

There is no documentation in the nurses notes concerning R15's skin, malodorous drainage from his wounds and there is also no documentation on what the wounds looked like, the measurements or what type of care was provided to them. R15 had been using the same topical cream to his back for two years and there is no documentation of improvement or worsening of the area and if the medication is effective after this period of time. There is also no documentation to support whether R15's primary physician was aware of the decline in wound status.

On 5/28/15 at 10:30 E2 (DON) stated she did not know why the staff nurses did not alert E11 (Wound Nurse) of R15's worsening wounds. E2 stated it was obvious he didn't get the care he needed yesterday. E2 also stated she did not know why R15 had been on the same topical medication for two years with unknown results and also was not aware of R15's worsening skin condition.

On 5/27/15 at 2:35 PM, Z1 (Physician) stated,
"R15 Refuses care a lot and if he was cooperative this wound could be prevented." Z1 also stated he was aware R15 had a wound caused from a mix of "sliding or pressure." Z1 stated he hasn't seen the wound in awhile but would assess it the next day during rounds.

It was documented R15's Nurses Notes indicating he refuses ADL care, turning and repositioning, but there is no documentation to show if any one explained and educated R15 with the risks and benefits so R15 could make informed decision to accept or decline care and services.

The facility care plan with a goal date of 6/11/15 (Per E2 on 5/29/15 at 10:00 AM, the care plans are written quarterly so if the goal date is June then the care plan would have been written in April 2015) documents "Alteration is skin integrity M ASD on ___ Right lower buttocks / Right upper thigh____ related to alter intertriginous." It is unknown what the blank spaces are for and this is repeated in the care plan three times. The interventions listed are to educate resident, treatment as ordered with weekly documentation and bed linen changing. Monitor and report skin changes, changes in drainage, odor or surrounding tissue. Notify physician of failure to respond to treatment. These interventions were not followed.

The facility care plan with a goal date of 6/11/15 also documents seven different problems for, "At risk for skin breakdown." R15 already had a breakdown in skin integrity and it is unknown if these interventions were re-assessed if not working. The care plan does not mention R15's impaired skin on his back or intervention to improve or promote healing.
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| S9999 | Continued From page 7 | R15 was seen by the wound physician on 5/28/15 and documented R15 has a stage II pressure sore on the sacrum measuring 8.0 cm x 2.0 cm with moderate serous drainage. R15 also has a stage III pressure sore to the right buttock measuring 9.5 cm x 10.5 cm x 0.2 cm with moderate serous drainage. The treatment was also changed at that time.

R15's name was not in the facility list of pressure sores that was given to the survey team on the survey entrance date, 5/26/15. It was on 5/27/15 when the surveyor observed R15's ADL’s care, R15's pressure sore was identified for the first time. It was on 5/28/15 when the wound care physician saw R15, his (R15’s) Sacral pressure sore was identified as a Stage II (8.0 cm x 2.0 cm) and right buttocks pressure sore was identified as a State III (9.5 cm x 10.5 cm x 0.2 cm).

On 5/29/15 R15 was also seen by Z1 (primary physician) and started on oral antibiotics.

The facility policy titled "Skin Management" with a date of 8/2010, documents resident will have a Braden scale done (to determine risk assessment) on admission, re-admission, quarterly, or following a change in status. The earliest documented Braden Score is 4/20/14 and documents R15 to be moderate risk with a score of 14. On 3/11/15 the Braden score was documented at 13, moderate risk. On 5/15/15 the Braden score was documented to be 15, at risk.

The skin management policy also documents a head to toe observation will be done on admission, readmission, weekly and during care and areas of concern will be reported to the nurse. | S9999 | | | | | | | | |
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<th>Summary Statement of Deficiencies</th>
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<td>and physician. The May 2015 treatment notes for the head to toe skin check documents on 5/4/15 &quot;no impairment.&quot; On 5/11/15 PM shift &quot;excoriation&quot; and 5/25/15 PM shift &quot;impairment.&quot; The heading under the skin check states, &quot;If skin is impaired, please write a note explaining.&quot; There are no notes explaining R15’s impaired skin condition.&quot; On 5/28/15 at 10:00 AM E2 stated she did not know why it was documented as no skin impairment on 5/4/15 and also does not know why further documentation was not done.</td>
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*Illinois Department of Public Health*

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If continuation sheet 9 of 9