Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014682	A. BUILDING: ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF ORLAND PARK	14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462

(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) COMPLETE DATE
S9999	Final Observations	S9999		

Statement of Licensure Violation:
1 Of 1 Violation

300.1210b)
300.1210d)6)
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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

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. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to utilize wheelchair foot pedals during a wheelchair transport for one of one residents (R143) reviewed for locomotion in the sample of 51. This failure resulted in R143 receiving a fractured left fibula.

Findings Include:

R143's Face Sheet dated 5/8/19 documents Diagnoses of Dementia without Behaviors and Muscle Weakness.

R143's MDS (Minimum Data Set) dated 2/5/19 documents R143 has severe cognitive impairments, is non-ambulatory in R143's room and requires extensive assist of one for

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locomotion in a wheelchair while on and off the unit.

R143's Clinical Notes dated 3/4/19 documents, R143 complained of R143's leg being in excruciating pain. R143 stated R143's leg went under the wheelchair while R143 was being pushed up the hallway. X-rays ordered, awaiting results.

R143's Radiology Report dated 3/4/19 by V11 DO (Doctor of Osteopathic Medicine) documents, "The visualized osseous structures demonstrate a subacute incomplete nondisplaced fracture involving the proximal left fibula. Mild to moderate joint space narrowing is noted."

R143's Clinical Notes dated 3/5/19 documents R143 was sent to the Emergency Department to be evaluated and returned the same day with a knee immobilizer to the left leg, for a fractured left fibula.

R143's Serious Injury Incident Report dated 3/11/19 documents R143 was on the way to the dining room when R143 felt a pain in R143's leg, x-rays revealed a proximal subacute fibula fracture. The Trigger Investigation Report included in the Serious Injury Incident Report documents R143 stated R143 was performing a normal routine of rolling in the wheelchair then staff provided assistance as requested and on way into the dining room, R143 heard a pop.

A witness statement dated 3/4/19 from V12 CNA (Certified Nursing Assistant) documents, R143 was wheeled into the dining room and began to cry. R143 stated that while R143 was being pushed in her chair, R143's foot went underneath the chair and R143 heard a pop. R143 couldn't

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rate the pain but stated, "it hurt really bad."

Another witness statement dated 3/4/19 from V7 CNA documents, V7 assisted R143 by pushing R143 into the dining room and during the transport, R143 began to complain of pain in R143's foot. R143 stated the pain is "real bad."

On 5/8/19 at 12:14 PM, V1 Administrator stated that during the investigation, V1 could not prove that V7 did anything on purpose to hurt R143 however "the incident didn't sit well with me {V1} so we {facility} let him {V7} go for not keeping {R143} safe during transportation." V1 stated that R143 did not have foot pedals on the wheelchair at the time of the incident.

On 5/08/19 at 12:22 PM, V3 ADON (Assistant Director of Nursing) stated R143 could propel R143's self in the wheelchair so R143 did not have foot pedals. V3 stated V3 "don't know if {R143} is cognitive enough to know to keep her {R143's} feet up when staff were propelling {R143}. V7 CNA "should have gotten some {foot pedals} for {R143's} chair prior to pushing {R143}. Some residents have the foot pedals in their rooms but if not, they {staff} can ask therapy to get a set." All residents who are propelled by staff are to have foot pedals on their chair.

(B)