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
	IL6005318	A. BUILDING: ______ B. WING ______	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HLTH CR CTR-LOMBARD	2100 SOUTH FINLEY ROAD LOMBARD, IL 60148

(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
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

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

This Regulation is not met as evidenced by:

Based on observation, interview and record review facility failed to ensure that a resident was

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safely transferred by staff. The facility also failed to ensure that the wheelchair monitoring devices are kept working condition.

The failure to safely transfer a resident (R9) resulted in a traumatic fall causing a complete displaced spiral fracture involving the distal left femoral shaft,

This applies to 1 of 8 residents (R9), reviewed for falls in a sample of 24.

The findings include;

1) R9's diagnoses include dementia without behaviors, weakness, personal history of osteoporosis, abnormal gait and history of hip fractures.

R9's minimum data set assessment (MDS) dated April 6, 2017 includes:
R9 requires extensive assistance of two staff with transfers and bed mobility and requires extensive assistance of one staff with dressing and personal hygiene.

A final incident report dated April 7, 2017, timed 8:15 AM documents that R9 sustained a fall at bedside, during A.M. care. The report further describes "After receiving a.m. care at bedside, the resident reported sitting at the edge of the bed as staff attempted to transfer the resident he started sliding to the floor, staff attempted to break the fall, unable to do so and lowered the resident to the floor."

Z1's (Agency Certified Nursing Assistant), R9's assigned caregiver, in a written statement, stated "I got him dress this morning; he was helping me

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do that. He was able to put his legs down to sit to the side of the bed when I was transferring him from the bed to the wheelchair, while sitting in the wheelchair he was at the edge of the wheelchair, he (R9) told me that he could not turn because his knee hurt. When he couldn't move in the wheelchair I lowered him to the floor. I did not look at the care giver alert because I had that group in the past. I was educated on this process with care giver alert and I didn't look because I thought I knew the residents on that assignment. I didn't know where my gait belt was because I left it in the room and couldn't find it after I returned. He was my last resident I got up. I didn't need to use the gait belt with anyone else after that incident. No one helped me with my resident's transfer today, I transferred those who needed to be transferred by myself. The resident was wearing regular shoes at the time of fall."

On August 17 2017, at 9:30 am, Z1 (by telephone) affirmed the accuracy of her written statement by stating that she transferred R9 from his bed to his wheelchair and R9 was sitting at the edge of his wheelchair and R9 stated he could not pivot (turn) because his knee hurts, so she lowered R9 to the floor. Z1 further stated that she transferred R9 by herself. Z1 also stated that the care cards were either in the door of the resident's closet or in his medical record and she did not check to see what R9's transfer status was.

R9's progress note dated April 7, 2017 at 2:19 PM documents R9 has left knee swelling and lower leg pain. Stat x-ray was ordered and the result was displaced left femur fracture, the physician was notified and R9 will be send to the local hospital for Orthopedic evaluation.

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S9999	Continued From page 4 The transfer form from the local hospital dated April 12, 2017, documents a primary diagnosis of Left Femur Fracture status post fall. The transfer form under the subheading of surgeries and invasive procedure also documents Retrograde Left Femoral Intramedullary Nailing was done on April 9, 2017. On August 17, 2017 at 12:30 PM, Z6 (R9's physician) stated by telephone, the spiral fracture is consistent with an attempt to pivot. He further said that there has not been a decline in R9's health of condition since the fall. (A)	S9999		