

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Statement of Licensure Violations Complaint Investigations 1776746/IL98221 1776815/IL98302	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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.	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 11/30/17
---	-------	-----------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/16/2017
NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 2</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure safe transfer.</p> <p>This applies to 1 of 3 residents (R1) reviewed for falls in a sample of 3. This failure resulted in R1 falling from the sling of a mechanical lift and sustaining multiple spinous process fractures.</p> <p>Findings include:</p> <p>The Face Sheet documents the following diagnoses for R1: hemiplegia following cerebral vascular accident (CVA) left nondominant side; muscle weakness, closed fracture; coronary artery disease; hyperlipidemia; peripheral vascular disease; congestive heart failure; dependence on wheelchair; repeated falls; dementia without behavior; anemia; depression; chronic kidney disease; and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>The POS (Physician's Order Sheet) documents R1 was receiving Aspirin, Lasix, Ferrous Sulfate, Losartan, Atorvastatin, Duoneb nebulizer treatments and Plavix.</p> <p>The MDS (Minimum Data Set) 10/31/17</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>documents: BIMs (Brief Interview for Mental Status score) 8/15 indicating some cognitive impairment; transfers- totally dependent on staff requiring 2 person physical assistance; Range of motion limitation on left upper extremity and both lower extremities; and wheelchair bound.</p> <p>The Care Plan documents: R1 has ADL (Activities of Daily Living) deficits related to functional, perceptual, neurological, emotional issues; Dementia, depression, anxiety, impaired vision, hearing, and communication. Remote CVA with left hemiplegia, heart disease, and chronic kidney disease III. Full body lift for transfers- unable to walk related to limitations of both legs, and left upper extremity. Interventions- full body lift X 2-3.</p> <p>Physician Progress Notes dated 10/5/17 documents: history of CVA with hemiparesis, obesity.</p> <p>The facility incident report dated 11/10/17 (Provided by E2/Director of Nursing on 11/15/17 at 11:52am) reads: As CNA was positioning the patient to put in the chair patient slipped out of the lift. What was resident doing when last observed: transferring to or from bed, chair. However, this computerized report was not finalized and still showed (EDIT) functions. E2 stated this is the incident report, but is not finalized until the entire investigation is completed.</p> <p>The "Serious Injury Incident Report" sent to the State Surveying Agency reads: Fall with physical harm or injury.</p> <p>The written statement by E4 (Certified Nursing Assistant/CNA) reads: "I placed the sling under R1; the full lift was in the resident's room. I placed the sling on the full body lift and went to</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>look for assistance."</p> <p>The written statement by Z3 (CNA/Agency) reads: "I went to the resident's room, and I observed staff hooking the last sling hook onto the machine."</p> <p>The nurse's notes dated 11/10/17, 5:52 PM reads: At approximately 7:50 AM, patient was sent to emergency room for evaluation and treatment due to fall and patient complain of pain to head and back. Spoke with local emergency room, informed that patient was admitted with acute multiple fractures to lumbar spine.</p> <p>On 11/14/17 at 11:34am, Z3 (Agency Certified Nursing Assistant/CNA) stated E4 (CNA) asked her to come help transfer R1 via mechanical lift. Z3 stated "I came in the room and the patient was already hooked up and everything. I asked if she needed help with hooking and E4 stated No, I'm OK. So she started lifting R1 up. R1 is a heavy patient." R1's medical record documented weight 11/8/17- 214#. Z3 stated "While I was pulling R1's butt back, E4 was turning the machine. As soon as we got directly on the side of the chair R1's hands went up, the hook came up and R1 came down. Only one of the hooks was off, the left side. I had R1's butt and E4 was guiding the machine. When I came in, I didn't touch nothing [sic]. R1 was already hooked. The only time when I touched the sling was when I grabbed the butt, next thing I know, it's like R1's top part came out. R1 is heavier at the top. R1's top came out then R1's head hit the wheelchair. R1 slid out of the sling. The foot hook came out. R1's left leg was still on the machine." Z3 added "The back of R1's head was bleeding. R1 had confusion and was screaming my head hurts." Z3 stated the policy for transfers via mechanical</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>lift is "you need to get 2 people to roll them on the sling and hook them up. Like I said, it was already hooked. I never touched the sling. No one else was in there." Z3 stated "this company doesn't in-service any one but their staff, but my company (Agency) in-serviced me. You need 2 people to hook up the sling." The statement was read back to Z3 who just kept repeating "the sling was already hooked to the machine before I came in the room."</p> <p>On 11/14/17 at 2:19pm, E4 was interview with E2 (Director of Nursing) witnessing per E4's request. E4 stated she worked with R1 on the day shift when the fall occurred. E4 stated "I hooked the sling to the mechanical lift. Then Z3 came." E4 stated "Z3 was at the feet guiding R1 and I was at the head of the lift. I had the controller. After we already started lifting R1, R1 was sitting up over the bed. I was bringing the machine out from the bed moving it towards the wheel chair and one of the slings like dropped and R1 just went with it. R1's ear was bleeding. I think R1 hit R1's ear on the wheelchair, the back of R1's head was wet with blood but I think it was from the ear. R1 fell out of the sling." E4 stated "the policy is for 2 people to hook the sling up." E4 again admitted she was the only one who hooked the sling up. E4 stated she had received an in-service on transfers and mechanical lifts prior to the incident. When asked if E4 had followed the policy, E4 stated "I guess not, but I thought it was ok." E2 stated "we don't allow them to sign statements. The statement was read back to E4 who voiced no changes.</p> <p>On 11/14/17 at 2:35pm, E3 (Restorative Nurse) stated she is responsible for in-servicing all staff on transfers and mechanical lifts. E3 stated she had recently in-serviced all staff as part of annual</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 6</p> <p>training on transfers. E3 stated R1 had left sided weakness. E3 stated "R1 could raise the left arm to shoulder level. R1 can't really raise it that high. R1 can't raise the arm above R1's head, the extremity is weak." E3 added "We tell them you need 2 persons before you could hook the sling up. We don't want nobody or 1 person in the room prior to hooking the sling up." E3 stated all staff are in-serviced to have 2 people hook the sling to the mechanical lift prior to lifting residents. E3 stated she in-serviced nursing staff and they signed the attendance sheet. E3 stated staff had to complete return demonstration with 2 people hooking up the sling and transfer the patient to pass the in-service.</p> <p>On 11/4/17 at 3:01pm, E2 stated E3 is responsible for in-servicing all staff for transfers. E2 stated "I expect the CNA to call somebody else to hook them up." E2 stated "the policy for mechanical lift transfers requires 2 person assist." E2 stated Z3 and E4 followed the policy because 2 people transferred R1. The facility was then asked to provide all staff in-servicing on mechanical lifts. Documentation showed Z3 was in-serviced on 3/21/17 with return competency, and E4 was in-serviced on 12/08/16.</p> <p>On 11/14/17 at 3:30pm, Z1 (Geriatric Nurse Practitioner/Provider) stated R1 had a CVA with left hemiplegia. Z1 added "R1 was pretty compromised. R1 had a contracture of the left upper extremity."</p> <p>On 11/14/17 at 3:57pm, Z2 (Medical Doctor/Provider) stated he was aware R1 sustained a fall because R1 came to the hospital where Z2 is also on staff. Z2 stated R1 sustained "a scalp hematoma and left small laceration, a contusion to the left flank, and spinous process</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 7</p> <p>fractures of L2, L3 and L4."</p> <p>On 11/15/17 at 9:08am E1 stated "R1 has left sided neglect and right sided weakness. The left side extremity is weak. There's no way R1 could unhook the straps while in the sling. R1 really doesn't have strength capacity to unlatch that strap. I saw R1 at the hospital. R1 was weak."</p> <p>On 11/16/17 at 12:30pm, Z2 verified R1's diagnoses of heart failure, chronic kidney disease, anemia and COPD (Chronic Obstructive Pulmonary Disease). Z2 stated R1 was hypotensive with fluid volume depletion related to bruising/bleeding from the flank injury. This according to Z2 led to acute kidney failure and elevated Potassium. The bleeding also led to the lower hemoglobin in which R1 received blood transfusion per Z2. Z2 also added that R1 has chronic shortness of breath with COPD (Chronic Obstructive Pulmonary Disease) and Asthma. Z1 stated the hospital treated R1 for COPD flare with steroids.</p> <p>The policy for "Mechanical Full Body Lift Safety and Use" documents: This lift requires two people to transfer patients. One employee will push the lift, and one employee will hold onto the handles on the sling to prevent the patient from swinging.</p> <p>The policy for Transfer, Ambulation and Re-Positioning (TARP) documents: -TARP training will include the safe use of mechanical or electronic lifts and a competency demonstration.</p> <p>(A)</p>	S9999		
-------	---	-------	--	--