STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013098	A. BUILDING: _____ B. WING _____	07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF ELMHURST	420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126

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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210 d)6) 300.3240 a) 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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. (Section 2-107 of the Act) These requirements were not met as evidence by: Based on observations, interviews and record reviews, the facility failed to ensure Certified Nurses Aides follow the safety procedures and measures which physical therapy assessed for one resident required to be transferred in a safe manner. This applies to one of four residents (R14) reviewed for accidents and incident occurrences in the sample of 19 residents. The findings include: R14 was observed lying in bed on 7/23/2015 at 2:30 PM. The treatment nurse (E4) was observed to remove a large dressing from R14's right outer leg. Under this large dressing, R14 had an extremely long sutured wound in the shape of a big inverted seven with multiple sutures along the length of the wound. R14 also had large black and yellow bruising to the back of her knee. E4 said the wound and bruising occurred when R14 was being transferred by two	S9999		

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S9999	Continued From page 2	S9999		

CNA's. E4 stated she was working that day and had been called to R14's room to assess her injury. E4 said R14's skin was torn away from the muscle. Because of this injury, E4 stated R14 required 17 sutures to close her wound, and needs dressing changes done daily. E4 said R14 was giving pain medication because she continues to have pain because of the wound.

R14's nurse (E10) was interviewed on 7/23/2015 at 9:30 AM. E10 said R14 is alert, but with periods of confusion. E10 stated R14 can tell you of her basic needs like pain. E10 said R14 has pain because of her injury to her leg and is being given pain medication. E10 stated R14's injury to her leg happened when she was transferred by two CNA's. E10 said R14 did not have control of her lower extremities.

One of the CNA's who transferred R14 on 7/14/2015 was E6. E6 was interviewed on 7/23/2015 at 10:45 AM. E6 stated she was operating the full body sling mechanical lift and E5 (the other CNA) was standing on the opposite side of the bed. E6 stated she thought she had R14's in the sling, but it slipped out and E5 was on the opposite side of the bed. This left R14's leg unsupported and not being guided by anyone. E6 said R14's leg hit the bed's side rail and R14 sustained an injury.

E5 was also interviewed on 7/23/2015 at 10:30 PM. E5 stated she did not see how R14's leg got injured, because she was not guiding and supporting R14's leg during the transfer.

Two CNA's, E12 and E13 were interviewed on 7/23/2015 at 9:55 AM. E12 and E13 stated that it was the facility's policy to have one person operate the full body sling mechanical lift. They

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S9999	Continued From page 3 (E12 and E13) said the other person should guild and support the residents extremities during the transfer. The facility's Accident/Incident Reports and Incident Investigation showed the following for R14: "1/23/2015 is a 94 year old female admitted to ... on 10/09/2014. R14's diagnoses include Congestive Heart Failure, late effects Cardiovascular Accident, Osteoarthritis, history of C-Diff... and generalized muscle weakness. R14 is alert and verbal with periods of confusion and is dependent upon staff for ADL's (Activities of Daily Living). On 1/20/2015 R14 was being transferred from her wheelchair to the bed and sustained a skin tear to the right lower leg... Nurse Practitioner on site assessed the patient (R14) and recommended her to be sent out... order confirmed to send out for further treatment. R14 returned to the facility with staples to the leg... Upon investigation, two staff members were transferring the resident (R14) from the wheelchair to her bed when her right leg was accidentally caught to the... rail... sustaining a skin tear." The investigation for this 1/20/2015 incident showed the two CNA's involved in R14's transfer on 1/20/2015 did not follow transfer procedures, which are required to transfer R14 in a safe manner. R14 was assessed by Physical Therapy Assessment (10/10/2014) showed R14 to need the use of a full body sling mechanical lift to be safely transferred by staff. The two CNA's transferred R14 using a gait belt on 1/20/2014, and were unaware of the correct procedures needed to transfer R14 safely. The Accident/Incident Report and and	S9999		

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S9999	Continued From page 4 Investigation showed a second occurrence of R14 being injured by staff during a transfer. The Accident/Incident Report and Investigation, dated 7/14/2015 and 7/17/2015, showed: "...The resident (R14) has been identified as requiring a 2 person mechanical lift transfer. Her assigned CNA was transferring the resident from her wheelchair back to her bed with the assistance of another CNA, utilizing the full body mechanical lift when one of the staff heard a bump and the other staff noted blood on her scrubs and the residents leg was bleeding. The injury suggest that while maneuvering the mechanical lift to the resident's bed the resident's leg accidentally slipped in the sling and hit the side rail." R14 was sent to the hospital again for "skin tear", which required staples. The investigation for R14's 7/14/2015 incident occurred because R14 was not "position ...with proper alignment... supporting bilateral extremities through the transfer" while transferring R14 in the full body sling mechanical lift. The CNA's were still not following the correct procedures to safely transfer R14. The facility's policy on Mechanical Full Body Lift Safety and Use, dated 8/2010 showed: Mechanical lifts will be used to provide safe transfer and prevent ...injuries... Procedure 1. Safety a. Refer to the manufacturer's user manual for additional information..." The manufacturer's manual, dated 2013, showed: "...Transfer Criteria... Warning... Before using... professional rehabilitation staff to determine which patients are suitable for transfer... technique to use...) However, the facility's CNA did not allows follow the safety procedures identified to transfer R14 in a safe manner.	S9999		

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S9999	Continued From page 5 (B) Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of those checks. If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check unless the fingerprint based check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check. Based on observation, interview and record	S9999		

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S9999	Continued From page 6 review, the facility failed to conduct a fingerprint background check within the required time-frame upon receipt of an inconclusive background check result. This applies to one resident (R5) out of two reviewed for Identified Offender status. Findings include: On 7/21/15 at 9:50 am, E1 (Administrator) identified that the facility currently has two identified offenders, R5 and R9. E1 stated recently, R5 began exhibiting unusual behavior and was attempting to grab the genitals of male CNAs (certified nursing aids). E1 stated she has only been Administrator in this building for 5 months, and when she looked at R5's initial background check done upon his admission to the facility in September of 2014, the background check came back inconclusive. The background check indicated R5 had been convicted of indecent liberties with a child, but did not identify R5 as a sex offender. According to E1, the normal procedure would be to do a follow-up fingerprint background check, but this had not been done. E1 was unable to say why a fingerprint background check had not been done when the initial background check result was received. When E1 read the initial background check, she had R5 moved to a private room and a fingerprint background check was initiated. E1 stated she had just received the results of the fingerprint background check today which identifies R5 as an Identified Sex Offender. R5's plan of care had also been modified to have female staff caring for R5. E1 denied receiving any complaints about any behavior by R5 from any resident or family member. R5's admission face sheet reflects an admission date of 9/6/14. Admission diagnoses include	S9999		

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S9999	Continued From page 7 Diabetes, Hypertension, Below-Knee Amputation, Chronic Kidney Disease, CVA (Cerebro-Vascular Accident) and CHF (Congestive Heart Failure). R5's date of birth is 7/20/1943. On 7/23/15/at 1:40 pm, E4 (RN) stated that R5 uses a motorized wheel chair for mobility but spends most of his time in his room. E4 stated she had never had any complaints from any resident or family member about R5. On 7/22/15 at 10:15 am, R5 was observed to be in his room with no other residents in the room. Nursing notes dated/timed 7/14/15 at 12:56 PM documents discussion with R5 of inappropriate behavior (touching) towards staff and that further behaviors would result in discharge. Social Service notes dated 7/15/15 at 11:18 AM documents R5's room change made. Identified Offender Reporting Form completed by E1 on 7/21/15 documents R5's initial background check was done 9/11/14 and rerun 7/17/15. Illinois State Police report identifies R5 as being convicted of Indecent Liberties with a child in 1973. Illinois Sex Offender Public Website did not identify R5 as a sex offender, stating that no records were found matching the search with R5's name. This result was also dated 7/21/15. However, E1 presented a letter which had been faxed and also mailed to the facility from the Identified Offenders Program identifying R5 as an Identified Sex Offender. This letter is also dated 7/21/15. (B)	S9999		