

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH	)	Docket No. NH18-S0107
STATE OF ILLINOIS,	)	
Complainant,	)	
	)	
v.	)	
	)	
LEXINGTON HLTH CARE CENTER –	)	
BLOOMINGDALE,	)	
Respondent.	)	

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED;
NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF
VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on February 16, 2018, at Lexington Hlth Care Center - Bloomingdale, 165 South Bloomingdale Road, Bloomingdale, Illinois 60108. On March 28, 2018, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

- 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

- 2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
- 3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **\$2,200.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)2), 300.1210d)3), 300.1210d)5) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)5) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE
WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POChearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.



Darlene F. Harney, RN, CPC
Bureau Chief, Long Term Care
Designee of the Director
Office of Health Care Regulation

Dated this 4th day of April, 2017.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

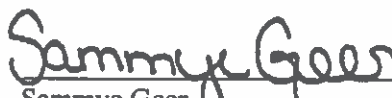
THE DEPARTMENT OF PUBLIC HEALTH	)	Docket No. NH 18-S0107
STATE OF ILLINOIS	)	
Complainant,	)	
	)	
v.	)	
	)	
LEXINGTON HLTH CARE CENTER –	)	
BLOOMINGDALE,	)	
Respondent.	)	
	)	

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type “B” Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	James Samatas
Licensee Info:	Lexington Health Care Center of Bloomingdale, Inc.
Address:	665 West North Avenue Lombard, Illinois 60148

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the
_____ 4th _____ day of _____ April _____, 2017.


Sammie Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/16/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-BLMNGDL		STREET ADDRESS, CITY, STATE, ZIP CODE 165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108		
(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) 300.1210d)2)3)5) 300.3240a) (1 of 1) 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	S9999		

Attachment A

Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/08/18

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/16/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-BLMNGDL			STREET ADDRESS, CITY, STATE, ZIP CODE 165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108		
(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	Continued From page 1 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/16/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-BLMNGDL			STREET ADDRESS, CITY, STATE, ZIP CODE 165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108		
(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	Continued From page 2 resident. (A, B) (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCE BY: Based on observation, interview and record review the facility failed to prevent unsecured catheter tubing from causing a pressure injury. This failure resulted in a Stage 3 pressure wound/injury for 1 of 3 residents (R97) reviewed for pressure ulcers. Findings include: Physician Order Sheet (POS) dated 5/2017 indicates R97 requires an indwelling urinary catheter for Neurogenic Bladder. On 2/13/18, 2/14/18 and 2/15/18 R97 was observed with an intact indwelling urinary catheter. Wound Assessment dated 1/11/18 indicates R97 was identified with a "facility acquired" Moisture Associated Skin Damage (MASD) due to "incontinence" pelvic region/right buttock. Assessment Note indicates "Noted MASD on right buttock due to incontinence as evidenced by partial thickness skin loss with redness and skin irritation around periwound to perianal area." Quarterly MDS (Minimum Data Set) dated 1/11/18 Section H/Bowel and Bladder indicates R97 uses an indwelling urinary catheter and is frequently incontinent of bowel. On 2/15/18 at 2:16pm R97 was transferred to	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/16/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-BLMNGDL		STREET ADDRESS, CITY, STATE, ZIP CODE 165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108		
(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	Continued From page 3 bed from a wheelchair and assisted with bowel incontinence by V4, CNA (Certified Nursing Assistant). Upon inspection, R97 was found to have diffuse, scattered widespread reddened open areas across lower buttocks and groin, linear demarcation of catheter tubing across right ischium, lower buttock - dark red/purple. Entire perineum, ischium and lower buttocks appeared "raw." R97's left ischium was also noted with recent indentation and demarcation of catheter tubing. V3, LPN (Licensed Practical Nurse/Wound Care Nurse) stated "The area is worse than when seen last week. Looks like the wound is from mechanical trauma from the catheter tubing." At that time, V11 (CNA Preceptor) stated R97 should have a catheter "legstrap" to keep (R97) from sitting on the catheter tubing. R97 did not have catheter tubing securement device in place and tubing was noted to be exactly consistent in size to wound. Physician Order Sheet dated 5/2018 indicates (Indwelling) Catheter Care every shift initiated on 5/3/17 with Note "Ensure that securement device is in place." Urinary Catheter Care Plan (effective 10/12/17) indicates staff are to ensure that indwelling catheter securement device is in place. Wound Assessment dated 2/15/18 at 3:27pm indicates R97 with "right buttock wound from catheter. Note indicates wound classified as a Stage 3 pressure wound - "full thickness" due to "Medical Device Related Injury." Note indicates Tissue 40% Non-Granulating, 60% Slough with small amount of serous exudate and reddened surrounding tissue. Note indicates "Upon	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/16/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-BLMNGDL		STREET ADDRESS, CITY, STATE, ZIP CODE 165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108		
(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	Continued From page 4 assessment, noted trauma wound right buttock with excoriation, redness and skin irritation around periwound and perianal." Note indicated wound measured 2.50cm and 0.40cm. Clinical Notes Report 2/15/18 at 4:28pm indicates a pressure wound was found on R97's right buttock "today." On 2/16/18 at 9:30am V3, LPN stated that R97 is High Risk for pressure ulcers and skin was already weakened in area that trauma occurred. V3 stated nurses who are doing daily skin treatments should notify Wound Care if the wound or skin changes or declines. Braden Scale For Predicting Pressure Sore Risk dated 1/11/18 indicates R97 at High Risk. Physician Order Sheet (POS) and TAR indicate orders for moisture barrier cream applied every shift to perineal area with staff documenting treatment completed every shift. No documentation was found or presented to indicate R97's wound was identified prior to surveyor request to assess skin on 2/16/18 and staff that were providing care every shift did not report skin changes. Facility Guidance (undated) indicates: Staff must ensure (urinary) catheter tubing is secured with proper device. Anytime a resident is positioned in his wheelchair, bed, etc. tubing must be checked to ensure it is tension free and resident is not laying on the tubing. This is to help prevent catheter from becoming dislodged and pressure injuries. Facility Policy/Skin Management dated 8/10	S9999		

NAME OF PROVIDER OR SUPPLIER

LEXINGTON HLTH CR CTR-BLMNGDL

STREET ADDRESS, CITY, STATE, ZIP CODE

165 SOUTH BLOOMINGDALE ROAD
BLOOMINGDALE, IL 60108

(X3) DATE SURVEY COMPLETED

02/16/2018

(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

\$9999

Continued From page 5

59999

indicates:
Head to toe observation of the resident's skin will be conducted on admission, readmission, weekly and during care.

(B)