

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/02/2018
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NAME OF PROVIDER OR SUPPLIER

LEXINGTON OF LAKE ZURICH

STREET ADDRESS, CITY, STATE, ZIP CODE

900 SOUTH RAND ROAD
LAKE ZURICH, IL 60047

(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 Facility Reported Incident of 7/28/2018 - IL104606	S 000		
S9999	Final Observations Statement of Licensure Violations 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. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

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S9999	Continued From page 1 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. These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise and ensure resident safety to prevent a resident with a diagnosis of dementia from spilling coffee on himself. This facility failure resulted in R2 spilling his coffee and having a second degree burn to his left upper thigh. This applies to 1 of 6 residents (R2) reviewed for safety in the sample of 6. The findings include:	S9999			

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S9999	Continued From page 2 The serious injury incident report for R2 dated July 29, 2018 shows, "Resident is an 84 year old, male, alert oriented x 1-2 and is able to verbalize needs with hx (history) of CVA (cerebrovascular accident) with hemiplegia, hemiparesis & aphasia, HTN (hypertension), vascular dementia with behavioral disturbance, Alzheimer's disease with late onset, a-fib (atrial fibrillation). Resident is on 1 assist with transfer & dressing and is incontinent at times of bowel & bladder. Resident complained of left thigh discomfort, upon assessment was noted with redness & small blisters on the left thigh. Per resident, he accidentally spilled the coffee he was drinking. Initial treatment was provided, MD (medical doctor) and family informed." On July 31, 2018 at 10:00 AM, R2 was assisted into bed. There was a large 13 centimeter (cm) X 8 cm burn and a smaller 4.5 cm X 7 cm burn to his upper and inner thigh. The burn was bright red with small areas of grayish slough (devitalized tissue) in the middle of the large burn. The area around the burns was pink and there were 2 fluid filled blisters that were still intact. R2 stated, he got the coffee in the dining room and spilled it on himself. The wound assessment details for R2 dated July 31, 2018 shows, "above wound dimension reflects an irregular shaped area of primarily an uncapped blister with a quarter size intact pink blister to inferior border. This wound is r/t (related to) a thermal burn from 7/29/2018." The nurse's notes for R2 dated July 29, 2018 from V6 Licensed Practical Nurse (Night shift nurse) (LPN) shows, "Resident got out of bed and watching TV (television) in the dining room. Resident c/o (complained of) pain on his lt (left)	S9999		

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S9999	Continued From page 3 thigh and tyl (tylenol) is not working. Resident pulled down the pant and observed there is a large reddened area with couple of blisters. Resident stated that he was having a cup of coffee after dinner in front of the nursing station. He accidentally dropped the cup and spilled hot coffee over him. He claimed that he showed it to the PM nurse and received PRN (when needed) tyl..." The nurse's notes for R2 dated July 28, 2018 from V5 Registered Nurse (PM shift nurse) (RN) shows, "Resident complained of left thigh discomfort, area checked no skin impairment noted and was able to move the leg within normal limits. PRN pain med given with some relief, will monitor for further complaints. Needs attended to, assisted to the washroom by staff." The medication administration record (MAR) dated July 28, 2018 shows, V5 gave R2 Tylenol 650 milligrams at 8:20 PM for aching pain to his right hip. The progress note for R2 dated July 31, 2018 shows, "Blood pressure is stable. NAD (no acute distress). Easily fatigued. Patient at baseline mentally. Agitated at times. Easily redirected. Patient appears comfortable. Weak and lethargic. General decline physically and mentally continues. Voice is very weak. Complex medical history. Multiple medical problems. Patient is alert, but confused and forgetful. Oriented X 1-2. Able to verbalize needs. Patient spilled coffee on his left thigh in front of nursing station right before bed time on Saturday evening. He initially c/o pain around 7:45 PM, and didn't explain why he had pain. Tylenol was given. Nurse checked his thigh and didn't chart any abnormal findings. Around 1:30AM he again c/o pain to a different nurse who charted redness and small blisters	S9999			

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S9999	Continued From page 4 were noted. Resident told that nurse he spilled coffee on his thigh. Treatment was initiated and Tylenol was again given for pain. I examined patient along with wound care nurse, and the facility nurse on 7/31/18. A 2nd degree burn was noted to left thigh. I refer to wound care nurse notes for further documentation..." On July 31, 2018 at 12:22 PM, V5 RN was interviewed via telephone stated, she was not aware of any incidents with R2 spilling coffee. She also stated he needs assist with activities of daily living (ADL's). On July 31, 2018 at 11:58 AM, V8 Certified Nursing Assistant (PM shift) (CNA) stated, she wasn't aware of any incidents with R2 spilling coffee. She also stated R2 "needs supervision." On July 31, 2018 at 10:25 AM, V14 R2's wife stated, "I'm not used to him getting his own coffee. They must of had the cart there. He has the attitude that he can do everything his self. Look what happened. Part of it is the evening shift, too much of this (motioning with her hands like talking) and not enough supervision." On July 31, 2018 at 12:10 PM, V6 R2's primary care physician stated, "my question is, why give someone with his dementia that hot of coffee that would burn him, really anyone on that floor?" R2 resides on the third floor, dementia unit at the facility. The facility's food log dated July 28, 2018 shows, the temperatures for the coffee for the day as 150-155 degrees Fahrenheit. The dinner temperature was 150 degrees Fahrenheit. The minimum data set dated June 6, 2018 for R2	S9999			

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S9999	Continued From page 5 shows, the brief interview for mental status for R2 has cognitive impairment. The same assessment shows R2 needs extensive assist of 2 people with ADL's and supervision of 1 person physical assist with eating. The current care plan for R2 shows, "Problems: ...Resident has weakness on upper and lower extremities and poor safety awareness. Resident needs to be reminded of safety precautions when completing a task..." The same assessment shows, "Problems: R2 has ADL deficits and requires extensive assist with bed mobility, transfer, walking, locomotion, dressing, toileting, hygiene and bathing, related to Hx (history) CVA with right hemiplegia (limitations R (right) arm, hand, leg, foot), aphasia, vascular dementia, depression, balance, gait, and positioning. Interventions: Supervise/assist R2 during mealtimes as needed." (B)	S9999			