

Illinois Department of Public Health

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| 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 04/01/2014 |
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| NAME OF PROVIDER OR SUPPLIER LEXINGTON HLTH CR CTR-LOMBARD | STREET ADDRESS, CITY, STATE, ZIP CODE 2100 SOUTH FINLEY ROAD LOMBARD, IL 60148 |
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| S9999 | <p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a)</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</p> | S9999 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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| S9999 | <p>Continued From page 1 and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observations, interviews and record reviews, the facility failed to provide two confused residents, who have a history of multiple falls and at risk for harm, with interventions from staff to supervise and monitor them.</p> <p>These failures resulted in the residents experiencing multiple unwitnessed falls, resulting in one resident (R3) requiring treatment for a</p> | S9999 | | |

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| S9999 | <p>Continued From page 2</p> <p>head laceration. The other resident (R5) sustaining a fractured neck, and staff being unaware of her injuries.</p> <p>This applies to 2 of 3 residents (R3 and R5) in the sample of 5 residents, who were identified as experiencing falls in the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of R5's Face Sheet showed R5 is a 67 year old female with diagnosis including: Dementia. R5 has been a resident at the facility since 6/30/2013. <p>R5's Clinical Notes for social services, dated 1/16/14 and 1/17/14 documented that R5 had mental health issues or behaviors that put her at risk for harm. R5 was resistive to care and not getting along with others. The note documented the need to monitor R5's behavior.</p> <p>Review of R5's nursing noted showed the following falls for R5: "11/27/13 at 9 AM R5... slid out from her wheel chair and landed on her right side. Noted bruise and redness on right elbow ... 12/27/2013 at 2 AM CNA (certified nurses aide) heard a loud noise from the resident ' s (R5's) room... noted resident lying on the floor ... lying on the floor face down ... 12/27/2013 at 10:21 PM Resident was transferred to ... (hospital) still at ER (emergency room) at this time will be admitted with diagnosis of Acute Cephalgia and Acute LOC (Loss of Consciousness) ... 1/18/2014 at 3:46 PM Undersigned was making rounds and observed resident lying on the floor sleeping besides her bed ... 1/24/2014 at 7:45 AM Around 5:45 AM, while doing med pass, undersign heard somebody calling for help. Responded to room and noted resident sitting on the floor in front of wheel chair ... 1/24/2014 at 7:55 PM Called to resident ' s room (at 4:05 PM)... noted resident sitting on the floor inside of the bathroom in front of her wheel chair. Wheel chair was not locked when</p> | S9999 | | |

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| S9999 | <p>Continued From page 3</p> <p>checked ... 1/25/2014 at 8:17 AM Noted with hematoma of right side of forehead ... 1/28/2014 at 4:27 PM observed resident sitting on the floor in the bathroom. Resident attempted to take herself to the bathroom without assistance ... 1/30/2014 at 5:33 PM Heard somebody calling for help. Responded to room and noted resident sitting on the floor in front of her wheel chair ... 3/05/2014 3:30 PM Noted resident ' s forehead swollen with purplish discoloration on forehead and occipital areas, complaining of pain when touched, puffy on right eye lid ... 3/05/2014 at 4:14 PM ambulance staff here to pick up resident ... 3/05/2014 at 9:50 PM Resident admitted to hospital with diagnosis of C (Cervical) 2 fracture." Review of R5's hospital Admission Face Sheet, dated 3/05/14, showed: "Diagnosis/Chief Complaint: Head Pain, Fall, C2 Fracture..." R5's ED (Emergency Department) Summary, dated 3/05/14 at 5:05 PM, "R5 was found with her head leaning forward close to her knees, with an estimated time of 8 hours in that position. Patient (R5) has echymosis (bruising) to her forehead and right eye with edema..." Review of R5's hospital CT scan of her (R5's) Cervical Spine, dated 3/05/14, documented the following findings: "Impression: Bilateral fractures of C2. On the right the fracture is through the right lateral mass of C2..." R5's hospital Final CT scan Report, dated 3/05/14, showed: "Clinical Indication: Head trauma,..." R5's primary physician (Z1) documented the following about her condition at the hospital: "3/06/14... Impression: 1. Presumed fall with cervical C2 fracture, mechanism of fall is not clear and was not witnessed at the nursing home." The facility's Fall Management Policy, dated 8/10, showed: "The care plan is developed on a multi-disciplinary level to address acute and</p> | S9999 | | |

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| S9999 | <p>Continued From page 4</p> <p>recurrent falls... 6. The care plan is developed to address the areas identified on the assessment and on the observations of the resident." Review of R5's Care Plan, dated 1/18/2014, showed R5 was at risk for falls due to physical limitations: Balance problems, gait, strength, endurance and psychotropic drug (S) ordered. The goal for R5 is " to be free of injuries related to a fall." Some of the approaches documented by staff were not specific in ensuring that R5 did not fall. The plan of care showed: "Educate patient on fall risks to ensure compliance with plans ... Remind to call when needing assistance ..." R5 has cognitive impairment and was forgetful so these interventions would not be effective, or specific for addressing what was causing her to fall. Several of the nursing interventions were noted to be written in a different manner as R5 continued to fall. R5's care plan showed: 12/28/2013 Encourage R5 to call for assistance ... 1/18/2014 Frequent reminder to use call light, 1/29/2014 monitor and assist with dressing ... 1/28/2014 Skilled physical and occupational therapy ... 1/30/2014 Call for assist prior to ADL's. The fall care plan showed on 5/17/2013 that staff had already implemented the above interventions, such as: "reminders to call when needing assistance, physical and occupational therapy evaluation and treatment." R5's care plan showed staff was directed to observe for medication side effects. R5 care plan did not identify the side effects that staff should be monitoring which put R5 at risk for falling. R5's care plan did not show any interventions that directed staff in the manner in which to supervise and monitor R5, which would prevent her from falling.</p> <p>R5's care plan, undated, also documents she (R5) will yell at staff and peers. R5's nursing approaches did not show documentation of staff</p> | S9999 | | |

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| S9999 | <p>Continued From page 5</p> <p>need/method to supervise R5 for these behaviors.</p> <p>Z4 is an emergency room nurse working in a local hospital. Z4 was interviewed on 3/07/2014 at 2:02 PM. Z4 said she took care of R5 when she presented to the emergency room on 3/05/2014. Z4 said the facility reported that R5 had facial bruising, but experienced no traumatic event. Z4 said the paramedics told her that facility staff reported R5 had been sitting in a wheel chair for 8 hours. Z4 stated that R5 presented with signs of trauma, such as: bruising to top of her head, forehead, right eye and side of head. Z4 said she knew that R5 needed a CT scan done. Z4 stated R5 bruising, indicated trauma, and the need to rule out head and neck injury.</p> <p>Z3 was the emergency room physician who initially examined R5 on 3/05/2014. Z3 was interviewed on 3/12/2014 at 11:36 PM. Z3 said R5's CT scan showed she had a fractured neck. Z3 stated we did not get the details about the cause of her injury. Z3 said she had experienced trauma, which caused the fractured to her neck. Z3 stated R5's neurologist and primary physician could give more details about her condition.</p> <p>The physician (Z2), treating R5 at the local hospital, was interviewed on 3/07/2014 at 2:19 PM. Z2 said she examined R5 when she was admitted to the hospital on 3/05/14. Z2 stated R5 was confused and unable to tell what happened to her. Z2 said R5 had a "hang man fracture" , which was completely broken and partly attached. Z2 stated R5's injuries of bruising (top of head, forehead and side of head) and fractured neck were more consistent with falling. Z2 said the paramedics reported that the facility staff told them (paramedics) R5 was sitting in a wheel chair for 8 hours. Z2 stated R5 could have fallen from the wheel chair and hit her (R5's) head on something on the way down. Z2 said R5 was</p> | S9999 | | |

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| S9999 | <p>Continued From page 6</p> <p>also on psychoactive medications that could make her more susceptible to falling. Z2 also stated R5 had a history of being seen several times in the emergency room after falling at the facility.</p> <p>R5 was observed in the intensive care on 3/07/2014 at 3:30 PM. R5 was wearing a neck collar because of her injury. She still had bruising on the top of her head, forehead, right eye and side of head. R5 said she knew she had a serious injury, but she could not remember what caused them.</p> <p>E11 (CNA/certified nurses aide) was interviewed on 3/06/14 at 2:59 PM. E11 said she usually took care of R5. E11 described R5 as being confused at times and was at risk for falls while in the wheel chair. E11 stated R5 always lean forward, and could fall out or slid out of the wheel chair. E11 said that R5 did not always want to leave her chair and sometimes slept in the wheel chair.</p> <p>E12 (CNA) was interviewed on 3/06/14 at 3:33 PM. E12 said R5 was confused. E12 stated R5 was at risk for falling because she tried to get up from her wheel chair and could not stand or walk.</p> <p>E13 (nurse) was interviewed on 3/06/14 at 3:46 PM. E13 said she recently admitted R5 from the hospital on 2/26/14. E13 said R5 was started on Geodon (psychoactive medication). E13 stated the nurse, who transferred R5 from the hospital, told her the Geodon put R5 at risk for falling. E13 stated the hospital nurse told her the Geodon would make R5 sleepy and could cause her to fall. E13 said the Geodon could contribute to R5 falling. E13 was asked if she updated R5's care plan to show the added risk factor for R5. E13 reviewed R5's care plan, then said R5's care plan did not get updated R5's plan of care to show the fall risk from Geodon.</p> <p>Another one of R5's nurses (E14) was interviewed on 2/06/14 at 2 PM. E14 also said</p> | S9999 | | |

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| S9999 | <p>Continued From page 7</p> <p>R5 was confused at times. E14 said R5 would try to get up to the bathroom or stand by herself, and would not ask for the help she (R5) needed. E14 said R5 had chair and bed alarms to prevent her from falling, but E14 did talk about method to supervise and monitor R5.</p> <p>During interview with E15 on 3/27/14 at 12 PM, E15 said R5 could be resistive to care. E15 said R5 slept in her wheel chair and he (E15) was concern she may fall out of it (wheel chair), so he asked E11 to put R5 to bed. E15 said R5 became resistive to care while being transferred by E11 on 3/03/2014.</p> <p>E24 is a physical therapy assistant. E24 was interviewed on 3/13/14 at 1:55 PM. E24 said she had assessed and provided services to R5. E24 stated R5 could not ambulate without assistance. E24 said R5 needs supervision because of her posture, which is flexed and forward leaning.</p> <p>The director of nursing (E1) was interviewed on 3/07/14 at 11:20 AM. E1 said she was responsible for investigation the resident's fall occurrences. E1 said she investigated each of R5's fall occurrences. E1 stated R5 was becoming more confused, and having multiple falls in the facility. E1 was asked to identify what interventions were put into place when R5 fell on 12/27/14, 1/18/14, 1/24/14, 1/28/14 and 1/30/14. E1 said interventions such as: to remind R5 to use her call light, or call for staff assistance. E1 did not provide explanation of any nursing interventions being put in place for staff to monitor/supervise R5 to prevent possible falls. E1 said she analyzed R5's falls after each occurrences. E1 said an investigation was conducted into R5's neck fracture of 3/05/14.</p> <p>The facility staff identified R5 was at high risk for falls/harm because of multiple factors (mental confusion, trying to get up by herself, resisting care from staff, sleeping, leaning forward in her</p> | S9999 | | |
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| S9999 | <p>Continued From page 8</p> <p>wheel chair, and sliding out of her wheel chair) and had several unwitnessed falls. Yet, E1 said the facility did not have any knowledge of when/how R5 had fractured her C2.</p> <p>The nurse consultant (E21) was interviewed on 3/27/14 at 11:14 AM. E21 said staff were interviewed and asked who did they (staff) think could have harm R5. E21 said several of the staff identified R6, who was observed being verbally abusive to R5. (However, R5's care plan did not address method use to supervise R5 with R6.). E21 said the facility could not determine the cause of R5's injury. The facility's staff lack of knowledge did not provide evidence of staff giving R5 the monitoring and supervision her physical and mental condition required.</p> <p>2. R3 is a 94 year old female with a diagnosis of Dementia, Alzheimer, abnormality of Gait and History of Falls.</p> <p>Review of the facility's Accident Log showed R3 had unwitnessed falls on the following days: 2/10/14 at 4:41 PM, 2/06/14 at 3:13 PM and 2/05/14 at 8:45 PM.</p> <p>Review of R3's Fall Occurrence Report, dated 3/03/14, showed: "R3 is a long term resident, ...is alert ...periods of confusion. Staff hear alarm sounding in the dining room, responded and observed R3 lying on the floor in supine position with a lacerated wound to the back of the head... R3 was sent to the hospital... R3 returned to the facility the same day with sutures intact to on the back of the head."</p> <p>Review of R3's care plan, dated 5/18/2014, showed R3 is at risk for falls due to decrease in functional mobility and history of falls. The goal was to keep R3 free of falls and injury. The nursing interventions were not specific in providing R3 with the supervision and monitoring she needed. The interventions were: remind R3 to call for help, use the call light, and report any</p> | S9999 | | |

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| S9999 | Continued From page 9 decline in mobility. R3 is confuse. R3 will not remember to use the call light or ask for help. R3 already had a decline in mobility and was not able to be mobile without assistance from staff. E1 was interviewed on 3/07/14 at 11:20 AM. E1 reviewed each fall occurrence for R3, and interventions put in place to prevent R3 from possible falls or harm. E1 did not identify any method put in place for staff to monitor and supervise R5 to prevent falls or possible harm. (A) | S9999 | | |