

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER LEXINGTON OF LAGRANGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4735 WILLOW SPRINGS ROAD LA GRANGE, IL 60525
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</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>	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</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> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to use the required number of staff during a resident transfer, failed to use the appropriate safety device during a resident transfer, and failed to perform a complete investigation following a resident injury during a transfer (a leg wound with uncontrollable bleeding), which required hospitalization. These failures affected one of three residents (R2) reviewed for accidents/incidents in a sample of 22.</p> <p>Findings include:</p> <p>A policy on Transfer, Ambulation, and Re-Positioning dated 2/2010 says, "Injuries will be reduced and safety awareness increased through: Identification of the residents' physical limitations by assessments." The policy also says, "Gait belts are provided by the facility and</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>are to be used during ambulation, and/or transfer of a resident...Investigation of resident injuries which occur during transfers...should include information regarding the use of all safety devices and safe transfer techniques prior to the incident."</p> <p>A Minimum Data Set Assessment, dated 5-15-14, documents R2 is cognitively intact and requires extensive assistance of two people for transfers.</p> <p>A Physical Therapy assessment dated 4/2014 documents that at the time of the assessment R2 was totally dependant on staff for transfers.</p> <p>A Physician's Order, dated 6-23-14, documents that R2 has medications which include the anticoagulant Coumadin.</p> <p>On 6-25-14 at 10:50 a.m., R2 stated that on 4-11-14, E14 (Certified Nurse Aide) was assisting R2 to transfer from the bed to the wheelchair. R2 stated that during the transfer, E14 transferred R2 to the wheelchair without using a gait belt and also without the assistance of another staff person. R2 stated E14 had difficulty with the transfer which caused R2's leg to hit the wheelchair, cutting R2's leg. R2 stated that when E15 (Registered Nurse) was providing care to R2 later that day, E15 noted that R2's leg was bleeding and applied a dressing. R2 stated that when E15 was unable to stop the bleeding, R2 was sent to the hospital. R2 stated that R2 was not interviewed about the incident and not informed whether an investigation of the incident was conducted by the facility.</p> <p>An incident report dated 4-11-14 documents that on 4-11-14 R2, "...bumped R2's right lower leg against the side of the wheelchair," during a transfer from the bed to the chair. The incident</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>report documents that R2 had bleeding from the right lower leg wound which was, "not controlled with application of pressure."</p> <p>An incident investigation, dated 4-15-14, documents that, "R2 continued to have moderate to heavy bleeding hours after skin tear...Was sent to ER (Emergency Room)..." The incident investigation follow-up states, "Investigation included chart review, and staff interview." An interview with R2 was also not included in the investigation.</p> <p>On 6-26-14 at 7:40 a.m. E9 (Physical Therapist) verified that during R2's 4/2014 assessment, R2 was totally dependant on, "either two staff or a mechanical lift for transfers."</p> <p>On 6-25-14 at 12:25 p.m. E7 (Post Acute Manager) stated that E7 investigated the right lower leg injury which occurred to R2 while being transferred from the bed to the wheelchair by E14. E7 verified that E14 (Certified Nurse Aide) transferred R2 from the bed to the wheelchair without another staff person assisting. E7 was unable to verify if R14 used a gait belt during the transfer. E7 also verified the incident investigation did not include an interview with R2, stating, "R2 was in the hospital during the investigation."</p> <p>(B)</p>	S9999		
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