Illinois Department of Public Health

CTATES	MENT OF DEFICIENCIES	(V4) DDO) (IDED (0) (DD) (ED) (4)	· _ · · · · · · · · · · · · · · · · · ·				
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
		DENTI ICATION NOMBER.	A. BUILDING:		СОМ	PLETED	
						С	
		IL6012975	B. WING		•		
NAME C	E DDO\/(DED OD OLIDD) (ED				10/0	02/2014	
NAME C	F PROVIDER OR SUPPLIER			, STATE, ZIP CODE			
LEXIN	GTON OF STREAMWOO		r irving p				
			WOOD, IL	60107			
(X4) IC	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
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		,	iAG	DEFICIENC		DATE	
coor	00 5:101				,		
5998	99 Final Observations		S9999				
	Ctotomant of Linear	No. 1 / C - 1 - 1 - 1 - 1	****				
	Statement of Licens	sure Violations:					
				THE COLUMN TO TH			
	300.610a)		NO.				
	300.1210b)			77888			
	300.1210d)6)		arcan arcan				
	300.3240a)		No.				
	,		AND THE PROPERTY OF THE PROPER				
	**************************************		SKK KI K				
	Section 300.610 Re						
	a) The facility shall have written policies and						
	procedures governir	ng all services provided by the					
	facility. The written p	policies and procedures shall					
	be formulated by a F	Resident Care Policy					
	Committee consistir	ng of at least the					
	administrator, the ac	dvisory physician or the					
	medical advisory col	mmittee, and representatives					
	or nursing and other	services in the facility. The					
	The written policies	with the Act and this Part.					
	the facility and shall	shall be followed in operating be reviewed at least annually					
	hy this committee d	ocumented by written, signed		TOTAL		İ	
	and dated minutes of	ocumented by writtern, signed of the meeting				l	
		. a.o mooning.				I	
		THE PROPERTY OF THE PROPERTY O			MEDIOLOGIA I		
	Section 300.1210 Ge	eneral Requirements for					
	Nursing and Persona	al Care					
	b) The facility shall p	rovide the necessary care					
	and services to attain	n or maintain the highest			EL-P		
	practicable physical,	mental, and psychological				1	
	well-being of the resi	dent, in accordance with					
	each resident's comp	orehensive resident care				1	
	pian. Adequate and p	properly supervised nursing				İ	
	resident to meet the	are shall be provided to each				İ	
	care poods of the	total nursing and personal				I	
	care needs of the res	sident.					
	d) Pursuant to subse	ction (a), general nursing					
	, -, ·	SUSTRIBLE COLORD HURSHING					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/20/14

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	S:	COMPLETED	
					С	
IL6012975		B. WING		10/	02/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LEXING	TON OF STREAMWOO)L)	IRVING PA			
22.15	CURRANDVOTA		WOOD, IL			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	ON LD BE	(X5) COMPLETE
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39999	pa;	-	S9999			
	care shall include, a	t a minimum, the following	Net and and and and and and and and and and			
	and shall be practice seven-day-a-week b		90VVA/vidiommen			
	·					
	6) All necessary pre	cautions shall be taken to	MACATILIA DE LA CALIFORNIA DE LA CALIFOR			
	assure that the resident h	dents' environment remains nazards as possible. All				
	nursing personnel sl	hall evaluate residents to see				
	that each resident receives adequate supervision					
A	and assistance to pr	event accidents.	•			
	Section 300.3240 Abuse and Neglect					
	a) An owner, licensee, administrator, employee or					
	agent of a facility sha	all not abuse or neglect a tion 2-107 of the Act)				
	resident. (A, b) (360	aion 2-107 of the Act)				
		Advanced in the second of the				
	These Paguiromente	s are not met as evidenced				
	by:	s are not met as evidenced				
	•	OOO A A A A A A A A A A A A A A A A A A				
	Rased on intomiow of	and record review the feetite				
	failed to follow manu	and record review, the facility facturer's guidelines on				
	mechanical lift sling i	removal for one resident (R1)				
	out of three reviewed	for falls and transfer. This			ļ	
	obtaining a cerebral	ng from his recliner chair and				
	obtaining a corebrar	nemorriage.			SCHOOL STATE	
	Findings include:					
- And the second	R1 is a 74 year old fe	emale who was present in the				
	facility during this inc	ident investigation survey.				
	R1 's physician orde	r sheet in the EMR			TROUBLE	
	(Electronic Medical R	Records) includes but is not				
	Vascular Accident (C	g diagnoses: Cerebral VA) with left side hemiplegia,				į
	dysphagia, muscle w	eakness, brain injury and				İ
	obesity. R1's minim	rum data set dated 9/3/14	and the same of th			
	denotes that under fu	inctional status, R1 was	100			

Illinois Department of Public Health

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE B. WING		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAST IRVING PARK ROAD	(X3) DATE SURVEY COMPLETED	
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STREAMWOOD, IL 60107		
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assessed as 3/3 (extensive assistance) during transfers. R1 's occupational therapy notes denote R1 is a 100% total assist with activities of daily living and functional transfers. On 9/23/14 at 1:02pm, E2 (Director of Nursing) stated, "There were two CNA's (Certified Nursing Assistants)(E6,E7) that were transferring (R1) from the bed to the recliner chair using a mechanical lift. One CNA was attempting to remove the mechanical lift sling from behind (R1) and the other CNA was in front of R1 while she was in the in recliner chair. One CNA pulled the sling from the back very hard several times. The recliner chair tipped back and hit the bottom of her head on the floor, while the other half of her body was still on the recliner chair. They are not supposed to pull the sling from behind. They are supposed to turn (R1) side by side and then remove the sling. Both CNA's were disciplined and they and the rest of the house were retrained on proper transferring and how to correctly remove the mechanical lift sling by the restorative aide. (R1) was sent to the hospital. R1 had a bleed in the weak part of the brain where she had the CVA. So the doctor stopped the Coumadin." E2 submitted sign in sheets by the facility's employees for the in-services on proper way to apply and remove a mechanical lift sling from a resident without the appropriate literature attached to the sheets. E2 submitted the facility's policy on mechanical lift slings should be removed. At 1:20pm, E2 stated, "We don't have a policy on how mechanical lift slings should be removed from a resident." E2 submitted the incident report for R1 's incident of 9/23/14. Incident report denotes the following: "At 6:45am, E6 called that (R1) was		

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING	G:	COMPLETED	
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		IL6012975	B. WING		i .	
			<u> </u>		1 10/	02/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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LLXIII	- ON OF OTHERWOOD	STREAM	WOOD, IL 6	60107		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
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		the recliner chair. When	National desiration			
3	asked what happen	ed, E6 and E7 stated that	Oliocopy management of the control o			
WAA de la constant de	while they were rem	oving the sling from				
	underneath (R1), the	e recliner chair tilted	WILLIAM TO THE THE THE THE THE THE THE THE THE THE			
	backward, and (R1)	slid off while being held	SILLIANA			
	slowly to the floor. (R1) was assessed,				
	repositioned, and as	ssisted back to the recliner				
	chair. Start was inst	tructed on proper positioning				
A CONTRACTOR OF THE PERSON OF	techniques. "	10/00/44 (2013)				
	doctor) gave order to	I 9/23/14 indicate Z1 (Medical o send R1 to nearest local				
	Community hospital	at 10:29am. At 2:59pm,				
		vith emergency room staff				
AND VALUE OF THE PARTY OF THE P	who stated that R1 v	was admitted with a diagnosis				
	of brain hemorrhage	s				
		readmitted back to facility				
	with a diagnosis of ti	raumatic brain injury.				
	Computerized Tomo	graphy scan reports indicate				
	that R1 suffered an i	ntercranial hemorrhage on				
	the right temporal lol	be in the area of				
	encephalomalacia fr	om a previous stroke.				
	On 9/30/14 at 3:00pi	m, E5 (Assistant Director of				
	Nursing/ Second Flo	or Clinical Manager)				
PPO A MONTH	submitted the initial	and final reports of R1 's				
	incident of 9/23/14.	Final report by E5 denotes				
	the following: "Per	staff investigation and				
	porforming the trans	ent, two staff was in the room				
	performing the trans	fer. R1 's recliner chair was				
	chair and was the on	ne who tried to pull the				
	mechanical lift sling i	underneath her. E7 was				
THE PARTY NAMED IN COLUMN TO THE PARTY NAMED	standing in front of R	11 and used her foot to hold				
l i	the bottom part of the	e chair. As per her				
	observation. E6 pulle	ed the sling a little harder				
	causing the chair to f	fall backwards. Per				
(demonstration of the	incident, staff observed not	A			
f	following appropriate	way in removing sling from				
F	R1. Root cause of fa	all: staff not following			:	
á	appropriate way in re	moving sling from R1. Staff				
j	nstructions and cour	nseling/disciplinary action				

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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		B. WING		10/02/2014			
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LEXING.	TON OF STREAMWOO	JD	FIRVING PA				
		STREAM	WOOD, IL	50107			
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			IAG	DEFICIENCY)	FRIATE	DATE	
20000	Continued Francis						
S9999	Continued From pa	ge 4	S9999				
	was provided imme	diately, staff involved were	-				
	retrained on TARP (Transfer, Ambulation and	Octobrilla Vision			VIII	
		ned by Restorative aide for	William Control				
	appropriate transfer	technique especially with	o notation of the contract of				
	removing the mecha	anical lift sling out from R1.	MARIA				
	Facility wide inservi	ce is ongoing on how to					
		sling from a resident to	MILLER				
		ents. Random audits to be					
	rendered to determine if staff was following						
	appropriate technique in removing the sling from		TELEVISIA				
	the resident. "		and the second				
	On 9/30/14 at 3:46pm, E5 stated, " I came in		The state of the s				
	early that day. I had E6 and E7 do return		manaran manaran manaran manaran manaran manaran manaran manaran manaran manaran manaran manaran manaran manaran			No.	
	demonstrations how they transferred and removed the mechanical lift sling from R1. They		Water				
	nover brought D1 fo	nical lift sling from R1. They	AND THE PROPERTY OF THE PROPER				
		rward in the chair and E6 ing really hard which made	ni.				
	the chair fall backwa	arde					
		m, telephone interview was					
	conducted with E3 (LPN, Licensed Practical					
	Nurse). E3 stated.	" I was working as the nurse					
	that night. I went to	room and I saw (R1) on the					
	floor. Her lower part	was on the recliner chair. I					
	called my supervisor	who came and checked on					
		6, she pulled the sling from					
		I. The chair started to tilt and					
	(R1) fell. I was told I	ater that the correct way of					
-	removing the sling is	to turn (R1) side by side. "					
		m, Z1 (medical doctor)			I		
		Yes, this accident could					
	have been prevented	d if the proper transfer			***************************************		
	techniques were folk	owed. (R1) fell and had a					
	small bleed (cerebra	I hemorrhage) in the space					
	of the brain where sh	ne had a prior stroke. I					
i i	discontinued her Cou		To the state of th				
	On 9/30/14 at 2:40pr		and the second s				
	wrong Moving the	d stated, "I'm sorry. I was				ľ	
	remove the machani	esident from side to side to					
remove the mechanic lift transfer sling is not the				ALEAST AND A STATE OF THE STATE			

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proper way. The correct way is to come behind

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	separament of Fabile							
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
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		120012973			10	/02/2014		
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I EVINO	TON OF STREAMMO	815 EAS	T IRVING PA	ARK ROAD				
LEXING	LEXINGTON OF STREAMWOOD STREAMWOOD, IL 60107							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T					
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TAG				CROSS-REFERENCED TO THE APPRO	PRIATE	DATE		
			Constitution	DEFICIENCY)				
S9999	Continued From page	ge 5	S9999					
		-	00000					
	the resident and pul	I straight up to remove the	The state of the s					
	sling. I just talked to	the restorative nurse and						
	sne il come down i	n a few to talk to you. Sorry						
1	about that. "		MATTER CONTRACTOR OF THE CONTR					
***************************************	On 9/30/14 at 2:48p	m, E8 (Restorative Nurse)						
		"I've been here for three	The second secon					
	months. The correct	t way to remove a	O PROPERTY AND A PARTY AND A P					
	mechanical lift trans	fer is to have the resident	WWW.					
	the resident. The	person should be in front of	IDOGGGGA					
	the resident. The second person should be behind the resident and pull the sling straight up. Based on my restorative knowledge, I know that		in an annual section of the section					
W.			STILLING AND AND AND AND AND AND AND AND AND AND					
	cling chould cover the	alive knowledge, I know that	liki berrangan					
-	halfway and not anti-	ne buttocks of a resident	NAME OF THE PARTY					
	halfway and not entirely. I was not here when		2000					
	(R1) fell, but my best guess would be that sling covered her buttocks entirely. I don't have a							
			TO STATE OF THE ST					
	one. "	nove a sling. I will try to find	WAS STORYGON					
		itted manufacturer 's						
	auidelines entitled C	are Lift Operations which	910000000					
***************************************	denotes in part the fo	ollowing: 1.) To position	or comments of the state of the					
	sling cently lean nat	ient/resident forward.	9					
	Position sling handle	es so they face away from						
MINISTER AND AND AND AND AND AND AND AND AND AND	natient/resident Tue	ck the sling behind the						
	patient/resident until	it comes in contact with						
PAGE 1	seating surface 2)	The sling should touch the						
	seat of the chair cor	nforming to patient 's/						
	resident 's tailbone a	area. The top of the sling						
	should rest on patien	at 's/resident 's shoulders,						
	and the center position	oning handle should be						
	centered between the	e patient 's/resident 's						
	shoulder blades. "	o patient encoluent 3						
		n, telephone interview was						
	conducted with E6. I	E6 stated, "Yes, I removed						
1	the mechanical lift sli	ng the improper way. E7				7		
	and myself did not le	an (R1) forward. The sling						
	covered the entire his	ittocks. It should have gone						
	down, but not covering	ng the entire buttocks. I						
	oulled the sling strain	ht up and the chair fell						
ŀ	packward. And R1 s	lid and hit her head. I was						

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
IL6012975		B. WING		10/	02/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LEXING	TON OF STREAMWOO	טט	IRVING PA			
(V4) ID	SHIMMADVSTA		WOOD, IL			
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	re-inserviced the cosling by E5. " On 10/1/14 at 9:10a conducted with E7. (R1) with E6 to the rusing the mechanica E6 pulled a little too chair fell backwards head. I was re-inserway is to roll (R1) sides sling through the side up from behind. " Based on investigation manufacturer's guide mechanical lift sling falling and obtaining Furthermore, there we	rrect way of removing the am, telephone interview was E7 stated, "I helped transfer recliner chair from her bed al left. I was in front of her. hard on the sling, and the . (R1) fell down and hit his rviced by E5 that the correct de to side and remove the le instead of pulling straight son, facility staff did not follow elines on removing a for R1. This resulted in R1 a cerebral hemorrhage.				
	(B)				111111111111111111111111111111111111111	
					and the state of t	
and the second						
			and the state of t			
The state of the s		THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PR	TO THE STATE OF TH			
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		DEFECTAL ACTIONS AND ACTIONS A			and the second	
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