STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012975	A. BUILDING: _____ B. WING _____	C 10/02/2014

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LEXINGTON OF STREAMWOOD	815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 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	S9999		

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S9999	Continued From page 1 care shall include, at a minimum, the 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to follow manufacturer's guidelines on mechanical lift sling removal for one resident (R1) out of three reviewed for falls and transfer. This failure led to R1 falling from his recliner chair and obtaining a cerebral hemorrhage. Findings include: R1 is a 74 year old female who was present in the facility during this incident investigation survey. R1 ' s physician order sheet in the EMR (Electronic Medical Records) includes but is not limited to the following diagnoses: Cerebral Vascular Accident (CVA) with left side hemiplegia, dysphagia, muscle weakness, brain injury and obesity. R1 ' s minimum data set dated 9/3/14 denotes that under functional status, R1 was	S9999		

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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 (R1) slid 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 lifts which does not indicate how full body 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 on the floor. On arrival, (R1) was observed to be

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on her side behind the recliner chair. When asked what happened, E6 and E7 stated that while they were removing the sling from underneath (R1), the recliner chair tilted backward, and (R1) slid off while being held slowly to the floor. (R1) was assessed, repositioned, and assisted back to the recliner chair. Staff was instructed on proper positioning techniques. "

Nursing notes dated 9/23/14 indicate Z1 (Medical doctor) gave order to send R1 to nearest local community hospital at 10:29am. At 2:59pm, facility followed up with emergency room staff who stated that R1 was admitted with a diagnosis of brain hemorrhage.

On 9/25/14, R1 was readmitted back to facility with a diagnosis of traumatic brain injury. Computerized Tomography scan reports indicate that R1 suffered an intercranial hemorrhage on the right temporal lobe in the area of encephalomalacia from a previous stroke.

On 9/30/14 at 3:00pm, E5 (Assistant Director of Nursing/ Second Floor Clinical Manager) 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 reenactment of incident, two staff was in the room performing the transfer. R1 ' s recliner chair was locked. E6 was standing behind the recliner chair and was the one who tried to pull the mechanical lift sling underneath her. E7 was standing in front of R1 and used her foot to hold the bottom part of the chair. As per her observation, E6 pulled the sling a little harder causing the chair to fall backwards. Per demonstration of the incident, staff observed not following appropriate way in removing sling from R1. Root cause of fall: staff not following appropriate way in removing sling from R1. Staff instructions and counseling/disciplinary action

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was provided immediately, staff involved were retrained on TARP (Transfer, Ambulation and Re-Positioning) trained by Restorative aide for appropriate transfer technique especially with removing the mechanical lift sling out from R1. Facility wide inservice is ongoing on how to properly remove the sling from a resident to prevent further incidents. Random audits to be rendered to determine if staff was following appropriate technique in removing the sling from the resident. "

On 9/30/14 at 3:46pm, E5 stated, " I came in early that day. I had E6 and E7 do return demonstrations how they transferred and removed the mechanical lift sling from R1. They never brought R1 forward in the chair and E6 kept pulling and pulling really hard which made the chair fall backwards.

On 9/30/14 at 1:20pm, 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 her. According to E6, she pulled the sling from the back of her head. The chair started to tilt and (R1) fell. I was told later that the correct way of removing the sling is to turn (R1) side by side. "

On 9/30/14 at 2:00pm, Z1 (medical doctor) stated the following: Yes, this accident could have been prevented if the proper transfer techniques were followed. (R1) fell and had a small bleed (cerebral hemorrhage) in the space of the brain where she had a prior stroke. I discontinued her Coumadin. "

On 9/30/14 at 2:40pm, E2 came into the conference room and stated, " I ' m sorry. I was wrong. Moving the resident from side to side to remove the mechanic lift transfer sling is not the proper way. The correct way is to come behind

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the resident and pull straight up to remove the sling. I just talked to the restorative nurse and she ' ll come down in a few to talk to you. Sorry about that. "
On 9/30/14 at 2:48pm, E8 (Restorative Nurse) stated the following: " I ' ve been here for three months. The correct way to remove a mechanical lift transfer is to have the resident lean forward. One person should be in front of the resident. The second person should be behind the resident and pull the sling straight up. Based on my restorative knowledge, I know that sling should cover the buttocks of a resident halfway and not entirely. I was not here when (R1) fell, but my best guess would be that sling covered her buttocks entirely. I don ' t have a policy on how to remove a sling. I will try to find one. "
At 3:00pm, E2 submitted manufacturer ' s guidelines entitled Care Lift Operations which denotes in part the following: 1.) To position sling, gently lean patient/resident forward. Position sling handles so they face away from patient/resident. Tuck the sling behind the patient/resident until it comes in contact with seating surface. 2.) The sling should touch the seat of the chair, conforming to patient ' s/ resident ' s tailbone area. The top of the sling should rest on patient ' s/resident ' s shoulders, and the center positioning handle should be centered between the patient ' s/resident ' s shoulder blades. "
On 10/1/14 at 8:56am, telephone interview was conducted with E6. E6 stated, " Yes, I removed the mechanical lift sling the improper way. E7 and myself did not lean (R1) forward. The sling covered the entire buttocks. It should have gone down, but not covering the entire buttocks. I pulled the sling straight up and the chair fell backward. And R1 slid and hit her head. I was

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S9999	Continued From page 6 re-inserviced the correct way of removing the sling by E5. " On 10/1/14 at 9:10am, telephone interview was conducted with E7. E7 stated, " I helped transfer (R1) with E6 to the recliner chair from her bed using the mechanical left. I was in front of her. E6 pulled a little too hard on the sling, and the chair fell backwards. (R1) fell down and hit his head. I was re-inserviced by E5 that the correct way is to roll (R1) side to side and remove the sling through the side instead of pulling straight up from behind. " Based on investigation, facility staff did not follow manufacturer's guidelines on removing a mechanical lift sling for R1. This resulted in R1 falling and obtaining a cerebral hemorrhage. Furthermore, there were many inconsistencies from staff interviews in how to correctly remove a mechanical lift sling. (B)	S9999		