STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014682	A. BUILDING: _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF ORLAND PARK	14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462

(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
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.	S9999		

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S9999	Continued From page 1	S9999		

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:

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 safely transport 1 of 3 residents (R1) reviewed for wheel chair mobility. This failure resulted in R1 being transferred to the local hospital with a diagnosis of an intracranial bleed.
Findings Include:
The Incident Report dated 11/4/14 documents that E4 (Certified Nursing Assistant) was pushing R1 down the hall in a wheelchair while the resident pushed a portable oxygen cylinder. There were no leg rests on the wheelchair at the time of the transport and R1 fell out of the chair and hit her head on the floor. R1 was noted to have a contusion above the left eye, bleeding

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S9999	Continued From page 2	S9999		

from the lower lip, and swelling to the right hand. The MD was notified and orders were received for a stat x-ray of the skull, the results were negative for fractures and the resident was monitored closely for safety. On 11/5/14 R1 had complaints of a worsening headache, dizziness, and pain in the right hand. R1 was transferred to the local hospital and was admitted with a diagnosis of an intracranial bleed.
On 11/18/14 at 2:25pm E4 stated "I was bringing the resident from therapy back to her room. The resident was in the wheelchair and had oxygen in a carrier with wheels. There was no oxygen holder on the back of her wheelchair and there was no one around to help me so I asked the resident to push the oxygen while I push her. The resident's feet were dragging because she did not have a foot rest and she fell out of the chair and hit her head on the floor. She had a knot on the side of her head and I went and told the nurses."
On 11/18/14 at 2:45pm E3 (Clinical Manager) stated "I did the investigation for this incident and I concluded that the CNA used poor judgment. The CNA was educated on utilizing her staff members with transfers involving a wheeled oxygen carrier. This resident did not have a holder on the back of the wheelchair so the CNA should have used a second person to push the oxygen. I also educated her on using leg rests while transporting residents in wheelchairs. The resident was able to stand and pivot but she did use leg rests as well and there were no leg rests being used at the time of the fall."
On 11/18/14 at 1:25pm E2 (DON) stated "Oxygen should be in a carrier on the back of the wheelchair when residents are being transported in a wheelchair, and foot rests should be on at all times unless the resident is self-propelling."
On 11/18/14 at 1:35pm Z1 (MD) stated" I was notified on 11/5/14 that the resident had a fall

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S9999	Continued From page 3 from the wheelchair. I did not know that she was pushing an oxygen cylinder at the time of the fall. I was told that the resident had some general pain throughout which is somewhat normal for the resident. The next day I got a call of a worsening headache with no change in mental status and the resident was sent out to the hospital. This resident does not have any history of intracranial bleeding so any bleeds would be most likely related to the fall from the wheelchair." The facility's policy on Oxygen Safety documents that trained personnel shall provide and enforce regulations for the storage and handling of cylinders should be secured at all times. (B)	S9999		