STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145899	A. BUILDING ______ B. WING ______	C 01/22/2020

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LEXINGTON OF ORLAND PARK	14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462

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F 000	INITIAL COMMENTS Investigation of Complaint # 2070395/IL 119263	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure safety measures were in place and working correctly to prevent falls for a resident identified as high risk for falls. This failure resulted in (R1) being hospitalized after a fall and sustaining multiple facial fractures and abrasions. This applies to 2 of 3 residents (R1) reviewed for falls in the sample of 3. The findings include: 1. Review of R1's EHR (Electronic Health Record) showed R1 was originally admitted to the facility 6/6/15 with diagnoses that included hypertension, dementia, osteoporosis, repeated falls, cognitive communication deficit and need for assistance with personal care. R1's annual MDS (Minimum Data Set) dated 10/14/19 showed R1 required extensive assistance of one-person physical assist with transfer and toilet use. The MDS shows R1 with impairment on both sides of	F 689	F 689 the facility will continue to ensure safety measures were in place and working correctly to prevent falls for a resident identified as high risk for falls. Corrective Action for Resident Affected: R1 returned fall risk assessment updated and fall interventions added. R3 bed placed in lowest position, provided bed alarm and floor mat placed next to bed. How Other Residents Will Continue To Be Identified: Facility initiated audit on high fall risk residents for current fall risk assessment. Assessment updated as indicated. Facility initiated audit on residents with physician orders for bed alarm and floor mat use. Observations rounds done on these residents in bed to check bed alarm in place and functioning, bed in lowest position and floor mat open and next to	2/7/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/03/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 the lower extremities. Review of R1's fall risk evaluation dated 6/12/19 showed R1 with a score of 16=High Risk for fall. Review of R1's fall risk evaluation dated 8/14/19 showed R1 with a score of 16=High Risk for fall. There was no fall risk evaluation done for R1 in (next quarter) November 2019. On 1/21/2020 at 9:10am, V10 (Hospital Social Worker) stated R1 was received at the hospital's emergency room on 1/16/2020 with multiple facial fractures. V10 stated R1 is presently admitted to the hospital and undergoing treatments for the injuries sustained from the fall. Review of R1's clinical notes dated 1/16/2020 and authored by V3 (Nurse) showed on 1/16/2020, V3 was walking down the hallway when she heard R1 crying out in pain". The note showed V3 opened R1's door to observe R1 on the floor lying on left side at the foot of the bed". The clinical note also shows (R1) noted with laceration to right forehead and bridge of nose, both sides actively bleeding, The note also shows R1 with left arm skin tear on elbow. Review of R1's physician order sheet (POS) has an order dated 2/1/19 for "Bed alarm-check for placement and proper functioning". Review of R1's care plan created 10/3/19 shows R1 at risk for falls as related to dementia, limited transitioning and balance performance, history of limited range of motion to bilateral lower extremities, nutritional health, anemia, diuretic prescribed, incontinence, hypertension, osteoporosis, osteoarthritis, difficulty hearing at times, other abnormalities of gait and mobility,	F 689	bed. Upon hire, nurses and nursing assistants receive education and training on facility's Fall Management Policy. Training includes use of alarms checking function, placement of floor mats and beds in lowest position. Fall safety measures (interventions) documented on resident's Care Giver Alert placed at bedside. Facility assigns compliance rounds to department managers that include observations on fall safety measures. System Revision: Reeducation to nurses on monitoring residents with physician orders for bed alarm, in place and functioning. Extra alarms placed in med room for easy access. Replace when broken. Floor mats in place as ordered and bed placed in lowest position. Reeducation to nursing assistants check Care Giver Alert every shift. Bed alarm use documented on alert monitoring alarm in place and functioning. If broken remove report to nurse and get a working alarm. Floor mats placed on floor next to bed when resident in bed and place bed in lowest position. Implement audit tool for nurse managers or designee to complete random audits on high fall risk residents with orders for bed alarm and floor mat. Monitor alarm in place and functioning, floor mat on floor and bed in lowest position. Forward audits to director of nursing. How Facility Will Monitor System: Director of nursing to review audits for	

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F 689	Continued From page 2 repeated falls, muscle wasting, atrophy and abnormal posture. The care plan shows: "Bed alarm ordered and check for proper functioning when in use". Review of restorative nursing program progress note dated 12/13/19 shows R1 "requires extensive assistance to complete most activities of daily living (ADL)". The note also shows R1 needs one person assistance to complete her transfers. Review of R1's incident report dated 1/16/2020 showed at around 2am, R1 was "observed on the floor next to the bed. R1 stated that she fell getting back in bed. The report further showed, R1 was sent to the hospital". The report also showed R1 was admitted to the hospital with multiple facial fractures. Review of hospital records show computed tomography (CT) of head for R1 with "Right periorbital soft tissue swelling with edema also noted overlying the nasal ridge and nasal bones. Moderate partial opacification of the paranasal sinuses with several collections of air identified in the soft tissues of the face consistent with underlying facial bone fractures". CT of R1's facial bones without contrast shows R1 with multiple bilateral facial bone fractures with moderate to severe opacification of the paranasal sinuses. R1 also noted with small frontal scalp hematoma with laceration and mild to moderate right periorbital soft tissue swelling consistent with posttraumatic edema, bilateral nasal bone fractures. Acute fracture noted along the anterior and posterior lateral walls. The hospital record dated 1/16/2020 showed R1	F 689	negative trends and address one to one with identified staff. Report findings to the QAPI Committee for review and resolution.	

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F 689	Continued From page 3	F 689		

with clinical impression of: Fall, closed head injury, laceration of nose, right eyelid laceration, laceration of forehead, multiple closed fractures of facial bone.

On 1/21/2020 at 11am, V6 (Restorative Nurse) stated fall risk assessments are done by nursing staff on resident's admission, quarterly, annually and with each fall or significant change.

On 1/21/2020 at 12:11pm, V2 Acting DON (Director of Nursing) stated residents with risk assessment fall score of 10 and above are considered high risk for fall. V2 stated nursing staff are expected to pay extra attention to such residents, apply a red dot by the name by resident's door, perform appropriate interventions like assist in toileting. V2 stated nursing staff are trained to properly fill out resident's risk assessment form and are responsible for completing the forms as expected after each fall, on admission, and quarterly.

On 1/21/2020 at 2:29pm, V5 CNA (Certified Nursing Assistant) stated she is the regular staff that cares for R1 on night shift. V5 stated R1 is high risk for fall. V5 stated R1 always requires extensive assist of one staff to go to the bathroom or move in and out of the bed. V5 stated on 1/15/2020 at 10pm, she observed R1 trying to move her legs out of bed when she went in R1's room to provide R1 with assistance to the bathroom. V5 stated she could not recall if R1 was placed on bed alarm at that point. V5 stated she was not sure if R1 was supposed to have bed alarm on and did not place R1 on bed alarm after returning from the bathroom. V5 stated around 2am on 1/16/2020, she was called by V3 (Nurse) to come to R1's room, she also saw other staff

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F 689	Continued From page 4 members rushing towards R1's room. V5 stated on getting there, R1 was on the floor bleeding. On 1/21/2020 at 2:44pm, V4 (Night Nurse Supervisor) stated she was rounding on the floor when she was alerted to R1's fall. V4 stated she assisted in providing first aid to R1 because of the extent of her injuries. V4 stated if resident is high risk for fall, they are supposed to have bed in low position, mat on the floor, and alarms on if ordered. V4 stated she was not sure if R1 had a floor mat on 1/16/2020 because R1's bed had been pushed aside to accommodate staff providing first aid to R1. On 1/21/2020 at 3:25pm, V3 (Nurse) stated she was not familiar with R1 and could not recall if she ever took care of R1 prior to 1/16/2020. V3 stated on 1/16/2020 at 2am, she was walking in the hallway when she heard R1 crying with pain. V3 stated she opened R1's door and found R1 on the floor on her left side by the foot of the bed face down and bleeding. V3 stated R1 was saying, "I fell, I fell". V3 stated R1's cry drew her attention to R1's room and she did not hear a bed alarm activation. V3 stated R1 was supposed to have an alarm on. V3 stated she does not really work with R1 and was not sure if R1 needed help to the bathroom. V3 stated R1 had gone to the bathroom herself and was returning to bed when she fell. V3 stated she called the physician and was asked to send R1 out because of the injuries. V3 stated R1 is a high risk for fall. On 1/22/2020, at 12:27pm, V11 (Physician) stated she saw R1 on 1/17/2020 and today (1/22/2020) at the hospital. V11 stated R1's injuries are very extensive. V11 stated R1 was not going to have surgery due to her age (100 years old). V11	F 689		

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F 689	Continued From page 5 stated she expects the facility to care extensively for R1 when providing care because R1 has dementia and would not be able to comprehend instructions. V11 stated she would expect nursing staff to carry out any order written in the POS. On 1/22/2020 at 12:42pm, V2 (DON) further stated bed alarm orders and other fall prevention interventions should be followed if it was active in the POS and the care plan. V2 stated nursing staff are expected to familiarize themselves with resident's care plan. 2. R3's EHR shows R3 was admitted to the facility on 10/3/17 with diagnoses that included atrial fibrillation, cardiac pacemaker, repeated falls, altered mental status, syncope, collapse, sepsis and dementia. R3's MDS dated 1/5/2020 shows R3 requires extensive assistance of one to two persons physical assist with bed mobility, transfer, personal hygiene, and toilet use. R3's care plan created 1/6/2020 shows, R3 is at risk for falls due to status post pneumonia, muscle wasting, and atrophy, need for assistance with personal care, repeated falls, history of malnutrition, limited transitioning and balance performance, incontinence, arthritis, cardiovascular diseases, hypothyroidism, and dementia. The care plan intervention included: Bed alarm ordered and check for proper functioning when in use. Review of R3's fall risk evaluation dated 9/8/19 showed R3 with a score of 11=High Risk for fall. Review of R3's fall risk evaluation dated 12/10/19 showed R3 with a score of 18=High Risk for fall. Review of R3's fall risk evaluation dated 1/14/2020 showed R3 with a score of 13=High	F 689		

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F 689	Continued From page 6 Risk for fall. On 1/21/2020 at 1:30pm, R3 was observed in bed. R3's bed was high and R3 did not have bed alarm on or floor mat around her bed. R3 was alert but slightly confused. On 1/21/2020 at 1:33pm, V9 (CNA) stated R3 is high risk for falls and was supposed to have bed alarms on and floor mat around her bed. V9 stated she did not know why R3 did not have these things on. Review of facility's policy titled, 'Fall Management' with a revised date 6/4/14 shows, the facility observes the physical and cognitive function of each resident to identify factors that place them at risk for falling. A care plan is developed defining those risks and interventions are implemented. The policy also shows 3. A score of 10 or higher is indicative of a risk for falls. 5. The facility will observe for the use of safety devices always selecting the least restrictive device to meet the individualized needs of the resident. 6. The care plan is developed to address the areas identified on the review and on the observations of the resident.	F 689		