STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145701	A. BUILDING _____ B. WING _____	C 06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF STREAMWOOD	**815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Incident Report Investigation IRI of 6-4-15/ IL77722 - F 323 Incident Report Investigation IRI of 6-10-15/ IL 78044 - No deficiency	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to avoid hitting a resident's leg while transporting the resident in a wheelchair for one of five resident (R1) reviewed for accidents and supervision. This failure resulted in R1 sustaining a right tibia and fibula fracture. Findings Include: June 10, 2015 at 12:40 pm, R1 is sitting in special wheel chair in the dining room. Chair back was at a 30 degree angle. R1 has a right leg cast that extends from the foot to the knee. R1 had heel booties on both feet. R1 is severely contracted with the left leg and upper extremities. R1 has a diagnosis of end stage multiple sclerosis.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 323	Continued From page 1 June 11, 2015 at 9:50 am, R1's was lying back in the special wheel chair while at the table with other residents during activities. R1 was asked to be interviewed and agreed. R1 stated I can't hear so well in my left ear, I can hear you better in my right ear. R1 was wearing a hearing aid in the right ear and responded to questions asked appropriately. R1 was asked what happened to your leg. R1 responded "E4 was pushing me in my chair while looking back and talking to another staff. E4 was not looking at what she was doing when E4 ran into the door and hit my foot and leg. E4 is always talking and bumping into something when she pushes me back and forth. It was not intentional." R1's Minimum Data Set (MDS) assessments dated, April 30, 2015 and February 4, 2015 indicated R1 had no significant cognitive impairment and requires two person assist for all activities of daily living. Care Plan - Dated 4/30/15, Self Care Deficit denotes, R1 is a total assist and requires 2 staff assistance for transfer and repositioning. R1 is totally dependent on staff to meet all Activities of Daily Living (ADL) needs. June 10, 2015 at 1:40 pm, E2 (Director of Nursing /DON) stated I did not do the actual interviews with staff in the investigation. E3 (Assistant Director of Nursing (ADON) asked the questions. I did the report to Illinois Department of Public Health (IDPH). E2 was asked how the incident happened; E2 stated " I was aware that R1 stated foot was hit by E4 certified nurse aide/CNA). I did not state in the report to IDPH that E4 bumped R1's foot into the door."	F 323		

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F 323	Continued From page 2 June 11, 2014 at 10:53 am, E3 stated E4 said while trying to fix R1's booties, E4 noticed R1's right leg was bigger than the left leg. E3 stated E4 took R1 to the nursing station so the nurse could assess R1's leg. E3 stated R1 was interviewed twice to see if R1 would change the story on how the injury happened. E3 stated R1 said E4 ran into the door and hit my foot on the door. E3 stated R1 said E4 and E5 (CNA) were involved in the incident. E3 stated both E4 and E5 was suspended pending investigation. June 10, 2015 at 12:25 pm, E4 (CNA who started working at 7am) stated; I fixed the sling to transfer R1 into the chair like I do every morning. I got help from another CNA to transfer R1, when we transferred R1 into the chair I noticed one of R1' s leg looked bigger than the other. I pulled back the sock to check for redness or bruising. I did not see anything. I put the sock back on R1; I gave R1 glasses and took R1 to the nurse ' s station. I asked the treatment nurse does R1 ' s leg look bigger than the other. The treatment nurse grabbed the foot of R1 a little but R1 pulled back leg indicating pain. The nurse said I am going to call the doctor for an x-ray. That day I was really sick so I did not put R1 back to bed, I went home about 9:30 am. The next day E3 called me and stated I was being suspended for what happened to R1. E3 said R1 stated every time E4 takes me to the dining room I am always bumping R1 ' s feet into the door. " Sometimes I will be pushing R1 and looking back answering or talking to someone; the chair rolls all over the place so I will lock the	F 323		

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F 323	Continued From page 3 wheels on one side to have better control of the chair. " June 10, 2015 at 12:50 pm, E5 (CNA) stated as I was going down the hallway, E4 asked me to help with transfer of R1. R1 was on isolation so I gowned up and went in to help. R1 was already lying on the sling for transfer when I arrived in the room to help. E4 took control of the lift remote, I was guiding R1's feet onto the broad chair; I made sure R1 ' s feet were in good position on the chair and I left the room with E4 still in the room with R1. E5 was asked if the special wheel chairs is hard to control. E5 stated " yes the chair goes all over the place and is hard to control. E5 stated we lock the chair on one side to control it better." June 10, 2015 at 1:10 pm, E6 (Treatment Nurse), stated at the beginning of my shift about 7:15 am; E4 asked me to look at R1 ' s right foot and stated that R1 ' right foot looked weird. I went to assess R1 ' s foot but R1 jerked back when I attempted to touch leg. I stopped and told R1 ' s nurse to call the doctor and ask for order to x-ray R1 ' s foot. June 10, 2015 at 1:25pm, 2:50 pm and 3:15 pm several attempts were made to contact nurse on duty. Was not able to reach nurse, several messages were left to contact writer. Clinical Note: Dated June 4, 2014 at 2:09 pm. E4 reported right ankle to be swollen in the a.m. Assessment completed right ankle noted swollen and warm to touch. R1 noted to retract leg when touched. Doctor notified of R1's symptoms. STAT x-rays were ordered to right ankle. Physician ordered Tylenol for pain. Doctor's office called	F 323		

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F 323	Continued From page 4 back at 1:45 pm to request resident be sent directly to hospital Emergency room (ER) for evaluation. Power of Attorney (POA) notified. June 4, 2014 at 1:05 pm, Z1 (Primary Physician) stated " I feel R1 is a good historian at times. I feel R1 did get hurt during a transfer or repositioning. R1 is totally dependent on staff for transfer and all care. No one told me about the CNA bumping R1 only that R1 was found by CNA with swollen ankle. " Policy entitled Transfer Ambulation and Repositioning (TARP) revised 2/10 denotes: Investigation of resident injuries which occur during transfers or ambulation should include information regarding the use of all safety devices and safe transfer techniques prior to the incident.	F 323		