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 _____	R-C 07/28/2015

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

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{F 000}	INITIAL COMMENTS First Certification Revisit to Survey 06/24/2015, Incident of 06/04/2015/IL77722	{F 000}		
{F 323} SS=E	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, interview and record review the facility failed to provide supervision during personal care for R1, failed to ensure that equipment was functioning properly for R2, failed to follow safety interventions for R3, R4, R5, and R6. This applies to 6 out 6 residents (R1-R6) reviewed for safety and supervision. The findings include: 1. R1 ' s report titled " Lexington Healthcare-Healthcare Safety Zone Portal " shows that on 6/25/15 that on 11:30 AM, the resident ' s husband called the nurse to help him. R1 was noted by the nurse lying on her left side of her body with her left arm underneath her on the bathroom floor. R1 was next to the toilet commode and her head was under the sink. R1 had two visible hematomas. One hematoma was noted on the left forehead and the other on the left occipital area with some oozing. The report also shows the fall was un-witnessed. R1 ' s	{F 323}		

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

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{F 323}	Continued From page 1	{F 323}		

document with title " Lexington Healthcare-Healthcare Safety Zone Portal " dated July 27/2015 sub-titled " Nurse Supervisor Follow-up " shows that upon staff interviews, that R1 had been left unattended on the toilet.
On July 22, 2015 at 4:45 PM, E3 RN (Registered Nurse) stated she was the supervisor that had done the follow-up investigation regarding R1 ' s fall that occurred June 25, 2015. E3 (RN) stated the investigation results determined the CNA (Certified Nursing Assistant) that was working with R1 the day of the incident had left her on the toilet un-attended. E3 (RN) stated R1 had fallen as a result of being left alone on the toilet. E3 (RN) stated R1 ' s fall should not have occurred. E3 (RN) stated as a result the CNA that left R1 alone on the toilet had been terminated from employment. E3 (RN) confirmed R1 was a high risk for falls with her admission, had a history of falls prior to her admission and was to be assisted with all her transfers.
2. On July 22, 2015 at 11:15 AM, R2 stated that he fell because his wheelchair was too far away and his right break does not work. R2 added that the wheelchair slid out from under him and he sat in the floor. R2 stated " look it still doesn ' t lock. " R2 attempted to lock both his wheels on his wheelchair and when he moved the wheelchair with his feet his, the right side moved. Z2 (Physical Therapy Assistant) was in the room and attempted to lock R2 ' s right wheel and R2 was still able to move the right wheel. Z2 (PTS) stated " Yes, it looks like it is not working right " . R2 stated it had not been working right for three to four weeks. R2 stated that when he had fallen a girl had come in and pick him up under the arms by herself and put him back into bed. R2 stated no gait belt was used when he was gotten up by the girl. When R2 questioned denied

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{F 323}	Continued From page 2	{F 323}		

anyone else coming to look at him on the day he fell. R2 stated he told physical therapy the next day he fell because he didn ' t feel very good and then someone came and talked to him about it.
R2 ' s document titled " Healthcare Safety Zone " with sub title (Nurse Supervisor Follow-up) dated July 2, 2015shows that on June 28, 2015, CNA (Certified Nursing Assistant) stated that from her observation, it appeared the resident attempted to transfer self and was unable to get his leg into bed. CNA stated she did not notify nurse of this incident as she did not think it was considered a fall. On June 30, 2015 patient told physical therapy staff that he had fallen and notified writer.
On July 22, 2015, E3 RN (Registered Nurse) stated she was the supervisor that had done the follow-up report for R2 dated July 2, 2015. E3 (RN) stated this was considered a fall by the facility because it was a change in the plane of surface. E3 (RN) stated the CNA ' s are to report falls immediately so nursing can assessment the resident and make sure there are no injuries. E3 stated she was not aware R2 ' s wheelchair was not working. E3 confirmed R2 was considered a fall risk and staff should be assisting with transfers.
3. R3 ' s clinical notes dated July 20, 2015 at 4:08 PM shows, at 7:35 AM, CNA (Certified Nursing Aid) came to inform the nurse that the resident had fallen. CNA reported the patient stated she needed to go to the bathroom. The patient stood up from the bed to grab her walker and lost her balance leaning toward the closet and sat on the garbage can. CNA assisted the patient back to the bed. X-ray to right knee per patient request and orthopedist-ordered for today.
On July 22, 2015 at 10:30 AM, R3 stated the day she fell the CNA did not have a gait belt on her when she was assisting her. R3 stated the CNA

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got her up and then went and got the nurse. R3 stated the CNA still did not put on a gait belt when she got her up off the floor.
On July 23, 2015 at 10:00 AM, E3 RN (Registered Nurse) stated she was doing the investigation into R3 ' s fall that occurred on July 20, 2015. E3 stated that it had been determined that the CNA had not being using a gait belt during care of R3 and subsequent fall. E3 stated it is the facilities protocol for staff to always use a gait belt when transferring a resident and the CNA should have been using one for R3. E3 confirmed that R3 is considered to be at high risk for falls. 4. On July 23, 2015 at 11:55 AM, E5 CNA (Certified Nursing Assistant) placed R4 at the dining room table. R4 was in her reclining wheelchair. R4 ' s front wheels were not locked.
On July 23, 2015 at 12:10 PM, R4 was still at dining room table and front wheelchair wheels were not locked. E5 (CNA) stated she had placed R4 at dining room table. E5 (CNA) was asked if she could move R4 ' s reclining wheelchair. E5 (CNA) was able to move chair from left to right. E5 was asked if this was secure and she stated " No, I guess I should lock all the wheels "
On July 23, 2015 at 10:45 AM, E4 Restorative Nurse stated R4 was totally dependent on staff for all of her care.
On July 23, 2015 at 11:00 AM, E2 DON (Director of Nursing) stated if a chair is to be stationary and not moving then all the brakes should be locked so it can ' t move. E2 stated this is part of what is included with nursing staff when they do their TARP. E2 (DON) stated TARP training is Transferring, Ambulation and Re-positioning/positioning training. E2 (DON) stated all the wheels should also be locked for safety purpose to prevent injuries and falls if the chair is to remain stationary.

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{F 323}	Continued From page 4 5. On July 23, 2015 at 12:05 PM, R5 was in the Memory Care Dining room on the third floor and was at the dining room table. She was sitting in a reclining wheelchair. Her back wheels were not locked. At July 23, 2015 at 12:05 PM, E7 CNA (Certified Nursing Assistant) stated she was the one who had put R5 at the table. E7 CNA stated she guess maybe she forgot to lock all the wheels. When asked E7 (CNA) if she was able to move R5 ' s wheelchair, E7 (CNA) was able to move it left to right. E7 (CNA) stated she had placed R5 at the table around 10:00 AM. R5 had no chair alarm on her chair at that time. On July 23, 2015 at 2:55 PM, R5 was in her room in bed. R5 was noted to only have a fall mat on her left side. There was no fall mat on her right side. R5 ' s bed alarm was dangling over the corner of her dresser drawer. R5 still had no chair alarm present. On July 23, 2015 at 3:00 PM, E7 CNA (Certified Nursing Assistant) stated R5 was totally dependent on staff for her care. E7 (CNA) stated R5 is to have the fall mats and alarms because she has seizures. E7 (CNA) stated R5 also had a history of behaviors where she could become very aggressive. E7 (CNA) stated the bed alarm should be secured to the side of R5 ' s dresser with a piece of Velcro but, R5 had a new alarm and there was no place to stick the alarm.. E7 (CNA) confirmed R5 is to have fall mats on both side of her beds and E7 stated there was only one when she came in this morning. 6. On July 23, 2015 at 12:00 PM, R6 was in the third floor Memory Care dining room. R6 was in a reclining wheelchair sitting at the dining room table. R6 ' s back wheels were locked and her front wheels were not locked and secure. E6 CNA (Certified Nurses Aid) stated that R6 had been in	{F 323}		

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{F 323}	Continued From page 5 the dining room when she had entered at 11:30 AM and E6 stated all the wheel should be locked on R6 ' s chair. E6 was able to move R6 ' s wheelchair from left to right because the back wheels were not locked. On July 23, 2015 at 5:00 PM, E2 DON (Director of Nursing) stated if a wheelchair is in a stationary position then all of the brakes should be lock. E2 (DON) stated this is part of their TARP (Transfer, Ambulation and Re-Positioning) program. E2 (DON) states making sure the brakes are locked ensures for safety and helps prevent injuries. The facility ' s document titled " Transfer, Ambulation and Re-Positioning (TARP) " with revision date of 2/10 shows the facility will promote safety for residents and staff during transfers, ambulation and re-positioning through the use of body mechanics and safety device. Transfer status will be based on the number of staff needed to perform the task and/or if a mechanical lift, slide board or other adaptive equipment is required. This information is recorded on the Care Giver Alert and in the medical record. Gait belts are provided by the facility and are to be used during ambulation and/or transfer of a resident. Investigation of resident injuries when occur during transfers or ambulation should include information regarding the use of all safety devices and safe transfer techniques prior to the incident. TARP training will be provided to all nursing staff within the first week of employment by the therapy department or nursing restorative staff. The Manufacture guidelines provided on July 23, 2015 for the Midline Full Recliner used by the facility states on page 5 shows the special casters found on the chair have total lock brakes which prevent the wheels from turning and	{F 323}		

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{F 323}	Continued From page 6 swiveling. The brakes must always be applied when: 1.) The chair is not in use 2.) A resident is being transferred (moved) into or out of the chair and 3.) The chair is not being moved by a caregiver.	{F 323}		