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 _____	05/29/2015

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

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Investigation of Complaint 1592631 - IL77276. No Deficiencies cited.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide activities of daily living (ADL's) including hygiene and grooming. This applies to one resident (R15) in a total sample of 26 residents reviewed for ADL's. The findings include. On 5/27/15 at 10:00 AM, R15 was seen in his room. R15 had long overgrown unkept beard. R15's left hand had very long overgrown fingernails with a brownish substance underneath them. R15's right arm is non-functioning and has long overgrown fingernails. There was a very strong mal odorous odor in the room and R15's hospital-type gown had food substance on it. R15's tooth brush was sitting in a small basin and was corroded with foreign material and old toothpaste. R15 stated no one has come in to	F 312		

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

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F 312	Continued From page 1 clean him up and change his linens yet and stated they usually do it once a day. R15 is shown to be cognitively intact with a score of 15 on his Brief Interview for Mental Status (BIMS) on the 3/19/15 Minimum Data Set (MDS). R15's functional status on the same MDS documents him to need extensive assist from two people with dressing and an extensive assist with one assist for personal hygiene. R15's bathing is documented as total dependence and his functional range of motion documents him to have impairment of both lower extremities and an impairment of one upper extremity which is consistent with the paraplegia and hemiplegia of his right arm. On 5/25/15 at 10:00 am, R15 had stated he stays in bed all the time because the staff does not know how to get him up in the chair. R15 stated, "They just put me in the wheelchair and leave me. I have to be pulled up straight and the foot rests have to be adjusted for my legs because I cannot move them myself." R15 also stated, "If you tell them now they will do it but once you leave it goes back to the same thing and then I am worse off than I was if I had just stayed in bed, trust me I know I have been here for 15 years." R15 also stated he did not know the last time his beard was trimmed or his nails. R15 stated the CNA's tell me all the time, they say your nails are really long but no one cuts them. R15 stated ,"The staff is supposed to wash my groin every day and put some kind of cream on there and they don't, maybe if they did, it would get better." On 5/28/15 at 10:00 E1 (Administrator) and E2 (DON) both stated R15 is resistive to care and declines treatment all the time.	F 312		

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F 312	Continued From page 2	F 312		

R15's Care plan with a goal date of 6/11/15 documents R15 to need total assistance with ADL's and with interventions to explain procedures, offer choices,allow time to complete task. This is not evident in the nursing documentation.

The facility nursing notes from 2/1/15 to 5/27/15 document R15 to refuse care and procedures during the night because he does not want to be disturbed. The only refusals that are documented on the other shifts is R15 refusing to be turned and repositioned. There is no documentation to support if the risks were explained to R15 in refusing care. There is no documentation to support Interdisciplinary Team management and education for R15's behavior of refusing care.

On 5/28/15 at 9:30 AM, R15 was seen in his room and had a new toothbrush, groomed beard, full shower, trimmed fingernails and no foul odor in the room or coming from the resident. There was no refusal of care evident from R15.

On 5/27/15 at 11:45 AM, E16 (Social Services) stated she has seen R15 multiple times in the past and has discussed some of his behavior issues with him and just tries to encourage him to get out of bed. E16 stated she was more focused on his "Quality of life than his quality of care. He likes to have his beer every day." E16 states she doesn't know what interventions may or may not be working for R15.

On 5/27/15, E16 documented R15 had been in the facility for a long period of time and was set in his ways. He is particular about caregivers and if they cannot attend to his needs right away he has

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F 312	Continued From page 3 negative things to say. E16 also documented the resident has a history of refusing to get out of bed and being repositioned and has repetitive behaviors of calling the front desk to ask what is on the menu. E16 provides no interventions to assist R15 or staff with these behaviors.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify and prevent facility acquired pressure sores for one resident (R15). The facility also failed to notify the wound care nurse in a timely manner to assist in the prevention and healing of R15's Pressure sores. This resulted in R15 acquiring a stage 3 pressure sore to the right buttocks / thigh area; a stage 2 pressure sore to the coccyx area; and multiple open draining areas on his back and the need for oral antibiotics. This applies to one resident (R15) of 5 residents reviewed for pressure sores in a total sample of 26.	F 314		

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F 314	Continued From page 4 The findings include: R15's admission electronic medical record showed he is a 73 year old male, has Multiple Sclerosis with paraplegia and hemiplegia of the right arm. R15 also has a history of colostomy, chronic indwelling catheter due to neurogenic bladder and obesity and has been in the facility since 1997. R15 is shown to be cognitively intact with a score of 15 on his Brief Interview for Mental Status (BIMS) on the 3/19/15 Minimum Data Set (MDS). R15's functional status on the same MDS documents him to need extensive assist from two people with dressing and an extensive assist with one assist for personal hygiene. On 5/27/15 at 10:00 AM, R15 was in his room in bed sitting up finishing breakfast. There was a very strong foul odor in the room. R15 stated the staff have not come to clean him up or change his bedding. R15 stated they usually come in the morning and change his bedding and cleaning once a day. On 5/27/15 at 10:10 AM, E6 (Certified Nurse Aide - CNA) came in R15's room and stated she was going to change his bedding. E6 proceeded to assist R15 with turning on his left side. R15 was noted to be saturated in a foul smelling brownish green fluid from his shoulders to mid thighs on both sides. There were two thick absorbent dressing on R15's right buttock that were also completely saturated with this foul smelling fluid. Under these dressings there were open wounds on the coccyx area and multiple open areas on the right buttock. R15's posterior skin from his	F 314		

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shoulder to his mid thighs was completely discolored a dark brown color and open oozing areas. All the linen and mattress were completely saturated with foul smelling fluid. R15 stated he had not been cleaned up since yesterday. E6 stated, "I don't know I wasn't here yesterday." E6 then began saying, "I can't do this, I can't do this," and began to walk out of R15's room to get assistance while leaving R15 exposed, until called back to cover him. E6 was also asked if R15's nurse could come with her to assess him.

On 5/27/15 at 10:10 AM, E6 (CNA), E7 (Licensed Practical Nurse - LPN), E8 (CNA) came back to R15's room. They turned him on his left side. When asked E7 how long R15 had been like this, she (E7) stated she didn't know. E7 stated she need to go and get medicine for R15's wounds and left. E6 proceeded to take a wash cloth and wipe down R15's back when pieces of R15's skin on his back was coming off and bleeding. R15 then stated, "Keep going down the spine, it itches." E7 and E9 (Registered Nurse) arrived in R15's room. E9 donned gloves and began washing R15's back and buttocks and sores with the same wash cloth. There was no protective cloth to cover the mattress. E7 also donned gloves and began wiping with a dry cloth across the buttock / coccyx wounds and R15s back. E7 then changed her gloves, no handwashing and began applying an antifungal cream to R15's back. E9 (RN) stated he had been using that anti-fungal cream for at least 2 years. The May 2015 Physician Order Sheet (POS) did confirm the antifungal cream was originally prescribed 8/22/13. E7 then changed her gloves again, without handwashing, and applied a barrier cream to R15's buttocks and then placed dry absorbent dressings on the area. R15's sheets

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were then changed and the mattress was never cleaned. R15 had an indwelling urinary catheter. No one provided catheter care or washed his groin area. R15 stated they are supposed to wash the groin area every shift and they don't do it. R15 stated, "I get a shower twice a week but I could use it more often, they just don't do it."

On 5/27/15 at 10:45 AM, E11 (wound nurse) came into the room and stated, she has not seen R15 in a long time. E11 stated the nurses will ask her to see a resident if they have wounds. E11 stated R15 has had problems with friction and shearing in the past because he refuses to get up and change position.

The facility "wound Assessment"dated 2/3/14 documents the wound was initially identified on 7/19/13. The wound was documented as Moisture Associated Skin Damage (MASD) facility acquired and measured 5.0 cm x 4.5 cm x 0.05 (L x W x D). The last "wound Assessment documented 3/14/15 documents the wound size as 10.0 cm x 5.0 cm x 0.05 cm (L xW x D). R15 was not seeing the wound physician at that time. E11 stated the staff nurses were taking care of R15's skin and wound after that and was not diagnosed with a pressure sore at that time.

There is no documentation in the nurses notes concerning R15's skin, malodorous drainage from his wounds and there is also no documentation on what the wounds looked like, the measurements or what type of care was provided to them. R15 had been using the same topical cream to his back for two years and there is no documentation of improvement or worsening of the area and if the medication is effective after this period of time. There is also no

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documentation to support whether R15's primary physician was aware of the decline in wound status.

On 5/28/15 at 10:30 E2 (DON) stated she did not know why the staff nurses did not alert E11 (Wound Nurse) of R15's worsening wounds. E2 stated it was obvious he didn't get the care he needed yesterday. E2 also stated she did not know why R15 had been on the same topical medication for two years with unknown results and also was not aware of R15's worsening skin condition.

On 5/27/15 at 2:35 PM, Z1 (Physician) stated, "R15 Refuses care a lot and if he was cooperative this wound could be prevented." Z1 also stated he was aware R15 had a wound caused from a mix of "sliding or pressure." Z1 stated he hasn't seen the wound in awhile but would assess it the next day during rounds.

It was documented R15's Nurses Notes indicating he refuses ADL care, turning and repositioning, but there is no documentation to show if any one explained and educated R15 with the risks and benefits so R15 could make informed decision to accept or decline care and services.

The facility care plan with a goal date of 6/11/15 (Per E2 on 5/29/15 at 10:00 AM, the care plans are written quarterly so if the goal date is June then the care plan would have been written in April 2015) documents "Alteration is skin integrity MASD on ___ Right lower buttocks / Right upper thigh____ related to alter intertriginous." It is unknown what the blank spaces are for and this is repeated in the care plan three times. The interventions listed are to educate resident,

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treatment as ordered with weekly documentation and bed linen changing. Monitor and report skin changes, changes in drainage , odor or surrounding tissue. Notify physician of failure to respond to treatment. These interventions were not followed.

The facility care plan with a goal date of 6/11/15 also documents seven different problems for, "At risk for skin breakdown." R15 already had a breakdown in skin integrity and it is unknown if these interventions were re-assessed if not working. The care plan does not mention R15's impaired skin on his back or intervention to improve or promote healing.

R15 was seen by the wound physician on 5/28/15 and documented R15 has a stage II pressure sore on the sacrum measuring 8.0 cm x 2.0 cm with moderate serous drainage. R15 also has a stage III pressure sore to the right buttock measuring 9.5 cm x 10.5 cm x 0.2 cm with moderate serous drainage. The treatment was also changed at that time.

R15's name was not in the facility list of pressure sores that was given to the survey team on the survey entrance date, 5/26/15. It was on 5/27/15 when the surveyor observed R15's ADL's care, R15's pressure sore was identified for the first time. It was on 5/28/15 when the wound care physician saw R15, his (R15's) Sacral pressure sore was identified as a Stage II (8.0 cm x 2.0 cm) and right buttocks pressure sore was identified as a State III (9.5 cm x 10.5 cm x 0.2 cm).

On 5/29/15 R15 was also seen by Z1 (primary physician) and started on oral antibiotics.

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F 314	Continued From page 9 The facility policy titled "Skin Management" with a date of 8/2010, documents resident will have a Braden scale done (to determine risk assessment) on admission, re-admission, quarterly, or following a change in status. The earliest documented Braden Score is 4/20/14 and documents R15 to be moderate risk with a score of 14. On 3/11/15 the Braden score was documented at 13, moderate risk. On 5/15/15 the Braden score was documented to be 15, at risk. The skin management policy also documents a head to toe observation will be done on admission, readmission, weekly and during care and areas of concern will be reported to the nurse and physician. The May 2015 treatment notes for the head to toe skin check documents on 5/4/15 "no impairment." On 5/11/15 PM shift "excoriation" and 5/25/15 PM shift "impairment." The heading under the skin check states,"If skin is impaired, please write a note explaining." There are no notes explaining R15's impaired skin condition." On 5/28/15 at 10:00 AM E2 stated she did not know why it was documented as no skin impairment on 5/4/15 and also does not know why further documentation was not done.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to handle indwelling urinary catheter to prevent potential Urinary Tract Infection (UTI).

This applies to one of three residents (R15) in the sample of 26 residents reviewed for indwelling urinary catheters.

The findings include:

R15's admission electronic medical record showed he is a 73 year old male, has Multiple Sclerosis with paraplegia and hemiplegia of the right arm. R15 also has a history of colostomy, chronic indwelling catheter due to neurogenic bladder and obesity and has bee in the facility since 1997.

R15 is shown to be cognitively intact with a score of 15 on his Brief Interview for Mental Status (BIMS) on the 3/19/15 Minimum Data Set (MDS). R15's functional status on the same MDS documents him to need extensive assist from two people with dressing and an extensive assist with one assist for personal hygiene. R15's bathing is documented as total dependence and his functional range of motion documents him to have impairment of both lower extremities and an impairment of one upper extremity which is consistent with the paraplegia and hemiplegia of

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F 315	Continued From page 11 his right arm. On 5/27/15 at 10:00 AM, R15 was in his room in bed sitting up finishing breakfast. There was a very strong foul odor in the room. R15 stated the staff have not come to clean him up or change his bedding. On 5/27/15 at 10:10 AM, E6 (Certified Nurse Aide - CNA), E7 (Licensed Practical Nurse - LPN), E8 (CNA) came to R15's room to provide Activities of Daily Living (ADL) care. They turned him on his left side. E9 (Registered Nurse) arrived in R15's room to assist R15. E9 donned gloves and began washing R15's back and buttocks and sores with the same wash cloth. There was no protective cloth to cover the mattress. E7 also donned gloves and began wiping with a dry cloth across the buttock / coccyx wounds and R15's back. E7 then changed her gloves, no handwashing and began applying an antifungal cream to R15's back. E7 then changed her gloves again, without handwashing, and applied a barrier cream to R15's buttocks and then placed dry absorbent dressings on the area. R15's sheets were then changed and the mattress was never cleaned. R15 had an indwelling urinary catheter. In the process of providing ADLs care R15 was turned to his right and left and E6 lifted the urine bag with urine in it, over R15's body twice and there was urine back flow from the bag to his bladder. No one provided catheter care or washed his groin area. R15's groin, scrotal and penile area had dry, crusted substance. When E6 and E7 were made aware no one provided care to his perineal area or provided urinary catheter care. R15 stated they are supposed to wash the groin area every shift and they don't do it. R15 stated, "I get a shower twice a week but I could	F 315		

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F 315	Continued From page 12 use it more often, they just don't do it." R15's 8/22/13 Physician Order showed to provide urine catheter care every shift and as needed. R15 also has a history of UTI and received antibiotic therapy for the treatment of UTI. R15's March 2015 care plan for impaired urinary elimination and uses indwelling urinary catheter for Neurogenic bladder interventions are vague and not specific for the use of urinary catheter. The facility identified eight residents having indwelling urinary catheters. The facility has no system to conduct urinary catheter assessment. On 5/28/15 at 2:00 pm E2 (Director of Nurses) stated they do not conduct assessment for the use of urinary catheter. They use MDS information for their assessment. The MDS assessment is not comprehensive to show why an indwelling urinary catheter is required or did not provide any removal plan, if the catheter use is not required.	F 315		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		

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F 328	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper dressing applied to prevent possible infection to a midline catheter for one resident (R17). This applies to one of one resident (R17) in the sample of 26 residents evaluated for the use of midline catheter. The findings include: On 5/27/15 at 11:30 AM, R17 was in his room sitting in a chair with an antibiotic infusing through his right arm midline catheter. The midline had a folded 2 x 2 over the insertion site and a clear tegaderm over that and was dated 5/23/15. The 2 x 2 obstructed the view of the insertion site and unable to visualize possible signs of infection. On 5/29/15 at 12:15 PM, E15 (Nurse) stated, the midline dressing was changed every Friday on the PM shift and had last been done on 5/23/15. On 5/29/15 at 1:40 PM R17's midline catheter dressing dated 5/29/15 was still noted to have a folded 2 x 2 dressing over the insertion site and obstructing the view of the site and then a clear tegaderm over that. E15 stated there should not be a 2 x 2 gauze dressing on there. E15 stated, "Maybe there was drainage there because its still new." There is no documentation of drainage from the midline catheter. The facility care plan with a goal date of 8/21/15 documents to monitor the midline site for any signs of infection such as redness, swelling or the	F 328		

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F 328	Continued From page 14 presence of drainage and refer to the physician. The 2 x 2 obstructs the view of the insertion site and therefore would be unable to correctly asses the midline site. The facility policy titled, "Central Venous Dressing Change." with a revision date of July 2012, documents : 1. The catheter insertion site is a potential entry site for bacteria that may cause a catheter related infection. 2. A transparent dressing is the preferred dressing unless the resident is allergic then gauze and tape may be used. 3. When a transparent dressing is applied over a sterile gauze dressing it is considered a gauze dressing and is changed 24 hours post insertion , every two days or if the integrity of the dressing becomes compromised. 4. Assessment of the venous access is performed, every 2 hours during continuous therapy, before and after intermittent infusions and at least once a shift when not in use.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

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F 329	Continued From page 15 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to identify, track, care plan targeted behaviors for the residents with Dementia who are using antipsychotic medications. The facility also failed to investigate the cause of behaviors and change non-pharmacological interventions when they did not work and failed to document additional interventions when the first intervention was not successful in changing behavior. This applies to three of five residents (R9, R10 and R 21) in the sample of 26 residents evaluated for antipsychotic medications. The Findings include: 1. R21 is a 70 year-old female with diagnoses including Depression, Schizophrenia, Alcohol abuse, Psychosis and Senile Dementia. Psychiatry note dated 2/25/15 documents that R21 has a stable mood, with no delusions, no	F 329		

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anxiety, no mania and no psychosis. At that time, her dosage of Seroquel was decreased from 250 mg a day to 225 mg a day. As of 5/29/15, there have been no further reductions.

Care plan provided 5/28/15 states that R21 requires psychotropic medication due to her diagnoses of depression, schizophrenia and psychosis. This care plan does not target any specific behaviors for R21. R21 is also care planned for having a depressed affect. Again, no specific behavior is identified. While R21's behavior tracking identifies R21 as having anxiety and delusions, these behaviors are not contained in her care plan provided 5/28/15.

Behavior Tracking for R21 (contained on forms entitled, "May 2015 treatments" and "non-PRN treatment notes" identifies R21's behaviors as anxiety and delusions. (There is no description provided as to what R21's delusion is. This treatment sheet also states that non-pharmacological interventions are to allow R21 to express thoughts and emotions, validate her feelings, encourage activities and provide reassurance. Non-PRN (as needed) treatment notes indicate the following: no behaviors are indicated for R21 for May; however, on 5/15/15 on the evening shift, there is a notation that R21's behavior was improved. There is no description of any behavior present, nor is there an accompanying nursing note describing any behavior. Therefore, there are no behaviors documented for May 2015.

April behavior tracking reflects 2 occurrences of behavior for R21, both on 4/10/15 on the evening shift. The behavior is coded as "crying out/yelling/screaming". The interventions

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documented were "reorient, redirect/refocus". The outcome was that the behavior was improved. There is no accompanying nursing note for that shift which describes which behavior was present or which provides what the trigger, if identified, was. There is no further documentation of any behavior for R21 in April 2015.

On 5/28/15 at 2:20 pm, E2 (DON-Director of Nursing) stated that, when documenting behaviors, the staff choose the behaviors and interventions from a drop down box in their electronic medical record system, and they don't have the ability to differentiate which behavior is actually present, or which intervention was specifically used, when more than 1 are listed. According to E2, the only way to get additional information about the behavior would be if a nursing note was written at the time.

March behavior tracking for R21 reflects the following: 3/15/15 on the night shift, the behavior of "crying out/yelling/screaming" is indicated, with the intervention of re-orient /refocus, with behavior identified as improved. There is no further description of the behavior described in any nursing note.

There is no evidence that the facility has investigated the cause or triggers of R21's behaviors. There is also no documentation or evidence presented showing that these 3 episodes of behavior of crying out over a 3 month time-frame have been harmful to R21 or other residents and require the use of anti-psychotic medication.

On 5/29/15 E2 provided a physician's order for R21 dated 5/29/15 (after this information was

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presented to E1 (Administrator) and E2 on 5/28/15) to monitor for behaviors, depression, resistance of staff assist for cares and transfers, auditory disturbances, delusion (again not specific as to the actual delusion). An updated care plan was also provided which states under intervention column that R21 has history of paranoia, auditory delusions and alcohol abuse, and to monitor for associated behaviors. There was no documentation provided in either the behavior tracking provided nor in nursing notes or care plan provided 5/28/15 of resistance to care or auditory delusions for the time period March through May of 2015.

On 5/29/15 between 9:35 am and 9:50 am, E10, (2nd floor manager), E13 (CNA) and E14 (nurse) all denied knowledge of R21 having behaviors. E10 stated that R21 has been on that floor for several months, and she was not aware of any behaviors for R21 since she came to that floor, and she denied R21 being disruptive.

2. R10 is an 84 year-old female admitted to the facility 1/2/15 with numerous diagnoses including Senile Dementia, Psychosis and Alzheimer's disease.

Pharmacy recommendation for R10 dated 4/23/15 documents that R10 is on Risperidone .25 mg daily. This document recommends considering a dosage reduction or discontinuation of the medication. The physician declined the recommendation, stating to see his note of 4/29/15. Psychiatry note of 4/8/15 documents that R10 reported some low mood, low energy and tearfulness, but had no mania, no psychosis and no anxiety. At that time, R10 was begun on an antidepressant medication (Zoloft). Psychiatry

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F 329	Continued From page 19 note dated 4/29/15 documents improved mood, with periods of vague delusions, believing her family is waiting for her. It also states R10 can wander and be difficult to redirect. At that time, R10's Aricept was decreased and her Risperidone was continued. The pharmacy recommendation notes that Risperidone can cause or be a contributing factor in falls. This psychiatry note documents a fall for R10 on 4/15/15. This note indicates that Aricept was decreased due to increased risk of side effects (fall, anemia, agitation, psychosis), and the Risperidone was continued for psychosis and mood stabilization. R10's care plan received 5/27/15 documents the following: Behavior status has improved since last assessment, and also documents that R10 has exhibited wandering behavior. The intervention is to use an electronic monitoring device. R10 is also care planned to require psychotropic drugs due to psychosis, and targeted behaviors are listed as wandering, agitated behavior (not specified). Interventions on the psychotropic care plan include educating R10 on available activities, providing R10 with activity calendar, removal from stressful situations (no evidence as to investigating what causes R10 stress), allowing R10 to discuss emotions and concerns. Non-drug interventions included calm environment, have resident call family, reorientation and redirection, allow resident to verbalize feelings. Section E of R10's current MDS (minimum data set) of 4/2/15 which documents behavior reflects the following: E 0100 which documents potential indicators of psychosis indicates that R10 has neither hallucinations or delusions. Section E 0200 scores R10 with a "0" for either physical,	F 329		

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verbal or other behavioral symptoms directed towards others. Section E 0300 scores R10 as "0" indicating no presence of behavioral symptoms. Section E 0800 scores R10 with a "0" indicating no behavior of refusing care. This assessment does reflect the presence of wandering in Section E 0900, which is assessed as impacting R10, but not impacting other residents. R10's behavior was assessed as improving in Section E 1100. This assessment does not reflect that this behavior is harmful to R10 or others.

R10's behavior monitoring information provide for the time period of March through May 2015 reflects that R10 is to be monitored for the behaviors of wanting to go home, being difficult to redirect. Non-drug interventions were a calm environment, encourage activity participation and contacting family when wanting to go home. These non-drug interventions are a statement on the behavioral tracking form, but in the section where the interventions are documented, none of these interventions are used.

R10's May 2015 Behavioral Monitoring sheet (entitled May 2015 treatments and non-prn treatment notes) reflects the following: On the evening shift of 5/7/15 staff documented an episode of wandering/elopement (unable to differentiate which behavior was observed); no intervention was needed per the documentation and the behavior was unchanged. Day shift on 5/9/15 "delusions" documented, with the intervention of redirect/refocus, with the behavior unchanged; no information is provided as to what the delusion was. 5/10/15, evening shift, staff documented "paranoia, wandering/elopement" with no specific description as to the actual

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behavior relating to the paranoia; the intervention was redirect/refocus, with no change in R10's behavior. On 5/20/15 on the evening shift, staff documented the behavior of wandering with the intervention of redirection/refocusing, again with no impact on the behavior. None of the above-described interventions were documented as having any impact on R10's behavior, and yet there is no further documentation/description of any other interventions attempted. Again, there is no investigation into the cause of R10's behaviors. The Behavior tracking information provided does not reflect attempting the use of the specified non-pharmacological interventions except for redirection, and when that was not successful, no further interventions were used..

April 2015 behavior tracking reflects 8 instances of wandering (4/1, 4/2, 4/3, 4/12, 4/21, 4/22, 4/26, 4/28) with redirection/refocusing used for all the behaviors, with behaviors all unchanged/not impacted by the interventions and no additional interventions attempted. There was also one instance of pacing documented on 4/16/15 with redirection/refocusing used, again with no change in R10's behavior. There is no indication as to how this behavior is harmful to R10 or any other resident.

March 2015 behavior tracking reflects the following: 7 instances of behaviors of wandering/elopement, with redirection/refocusing used, with no change in her behavior (3/3,3/6, 3/12, 3/13, 3/14, 3/27, 3/28). There was one documented behavior of pacing included with the wandering, on 3/28. Again, there was never any change in R10's behavior with the intervention used, and the same intervention was used for all behaviors. There was no additional attempts at

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use of alternate interventions when the first intervention was not effective, and no documentation of non-drug interventions being tried.

3. R9 is an 85 year old female with diagnoses including vascular dementia, Alzheimer's dementia, anxiety and manic depression.

R9's care plan provided 5/27/15 documents that R9 has been more tearful lately, with interventions including supportiveness, and addressing by name and smiling, providing reassurance, and offering to call family. She is care planned as requiring the use of psychotropic medication for Bipolar disease, anxiety and psychosis. There are no specific targeted behaviors on this care plan, and interventions are vague, including encouraging activity participation, ask her how she is feeling, psych services as needed, assess and record behaviors, trial period of dose reduction. There is one identified behavior of R9 having episodes of refusing care, with interventions of using a calm manner, explaining what care will be rendered, evaluating the best time of day to provide the care, calm environment, maintaining dignity, psych consult as needed, medication as ordered, document and report refusals of care.

Physician orders for R9 include an order for Seroquel 200 mg once a day; this order was continued from the hospital upon her admission of 12/3/14.

Section E of R9's MDS of 5/6/15 documents the behavior of delusions. R9 exhibits no physical, verbal or other behavioral symptoms directed towards others. Section E 0300 documents no

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F 329	Continued From page 23 overall behavioral symptoms. Section E 0800 scores R9 as a "0" for rejection of care, indicating this behavior was not exhibited. There was also no wandering noted. Behavior monitoring documentation reflects targeted behaviors of crying/tearfulness, and OCD (obsessive-compulsive disorder) behavior while in bathroom (not specified what the behavior is). Examples of behaviors are documented as follows: 5/2-crying out, yelling,screaming, with reorientation used, with improvement of behavior. 5/4/15 crying out/yelling/screaming, with redirection/refocusing used, with no change in behavior. 5/12/15-disruptive behavior, insomnia documented, with redirection/refocusing used, with no change in behavior. 5/14-insomnia documented, with comfort care/redirection/refocusing used, with no change in behavior. 5/17-crying,yelling screaming and disruptive behavior, with intervention not successful (redirection/refocusing).Same behavior and outcome for 5/20/15 . 5/23/15-crying out, yelling, screaming and wandering documented, with interventions of re-orienting, redirecting/refocusing and reduction of stimuli, with no change in behavior. 5/26/15-disruptive behavior, with no change after redirection attempted. For all of these behaviors, there were no documented additional interventions attempted to impact the described behavior. The behaviors were vague and not specified. The targeted behaviors in R9's care plan was tearfulness and refusal of care which differ from the targeted behaviors on R9's behavior monitoring, in part, which document OCD behavior in the bathroom, which was unspecified.	F 329		

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F 329	Continued From page 24 For the above residents, there was no evidence of investigation into the cause of the behaviors and no evidence provided that these behaviors are harmful to the resident justifying the use of anti-psychotic medication.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that bedtime snacks are offered to all residents. This affects 4 residents (R23, R27-R29) out of 8 reviewed for bedtime snacks; one resident (R23) out of a sample of 26 and three residents (R27 - R29) from the supplemental sample.	F 368		

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F 368	Continued From page 25 The Findings include: On 5/28/15 at 10:30 am, R23 stated that bedtime snacks are available if you let your CNA (certified nursing assistant know that you want one; they are not offered. On 5/28/15 at 10:30 am, R27 stated that he has been in the facility since April 16, 2015, and has never been offered a bedtime snack. He stated that he was unaware he could get a bedtime snack and that he could get one by letting staff know he wanted one. He stated he would like an evening snack and was going to tell his CNA that evening that he wished for an evening snack. On the same date and time, R28 also stated that she is not offered an evening snack and wasn't aware she had to let anyone know she would like one. R29 stated that she was not offered an evening snack, but she did have snacks during activities. She also was not aware she could get an evening snack by letting staff know she wanted one. On 5/28/15 at 11:55 am, E12 (Food Service Supervisor) stated that Dietary staff make up a tray of bulk snacks such as milk, cookies, crackers, juice, fresh fruit, etc, and dietary staff bring that tray to the nursing unit. Nursing staff call down to notify dietary staff who wants a snack, and enough snacks are sent to the floor for those who have requested snacks and some extras. Snacks are ordered by CNAs on the evening shift for residents who said that they want one. Typically, CNAs pass those snacks out. To E12's knowledge, they do not document dispersal of snacks.	F 368		

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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 368	Continued From page 26 On 5/28/15 at 2:30 pm, E2 (DON-Director of Nursing) stated that the facility does not have any written policy on snacks. On 5/29/15 E1 (Administrator) stated that they had inserviced staff on the dispersal of snacks, and provided the inservice evidence of the inservice for review. E1 stated that dietary would continue to deliver snacks to the nursing units and CNAs would then offer snacks to all residents.	F 368		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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 _____	05/29/2015

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F 441	Continued From page 27 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to wash hands while providing care for activities of daily living and wound care. This applies to one resident R15 in a total sample of 26 reviewed for handwashing and infection control. The findings include: On 5/27/15 at 10:10 AM, E6 (Certified Nurse Aide - CNA), E7 (Licensed Practical Nurse - LPN), E8 (CNA) came in to R15's room. They turned R15 on his left side. E7 stated she need to go and get medicine for R15's wounds and left. E6 proceeded to take a wash cloth and wipe down R15's back when pieces of R15's skin on his back was coming off and bleeding. R15 then stated, "Keep going down the spine, it itches." E7 (LPN) and E9 (Registered Nurse - RN) arrived in R15's room. E7 then changed her gloves, but did not wash her hands. E9 donned gloves and began washing R15's back and buttocks and sores with the same wash cloth and no protective cloth to cover the mattress. E7 (LPN) also	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 28 donned gloves and began wiping with a dry cloth across the buttock / coccyx wounds and R15s back. E7 then changed her gloves, did not wash her hands and began applying an antifungal cream to R15's back. E7 then changed her gloves again, without washing her hands, and applied a barrier cream to R15's buttocks and then placed dry absorbent dressings on the area. E7 again changed her gloves, did not wash hands, and R15's sheets were then changed and the mattress was never cleaned. There were dry wound drainage stains on the mattress. During this time E6 had noted a soiled towel on the floor and proceeded to pick it up and place it on R15's bed. The facility policy titled "hand Hygiene" dated 8/2010, documents the facility uses soap and water and alcohol based products decrease the risk of infection. The policy also states hand hygiene is performed...."when hands/gloves are visibly soiled, before and after resident contact, before and after invasive treatment...after handling contaminated objects or linen and after removing gloves."	F 441		