		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/08/2010 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
145711			B. WI	NG _		09/02/2009		
NAME OF PRO	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 420 WEST BUTTERFIELD ROAD			
LEXINGTO	ON OF ELMHURST				ELMHURST, IL 60126			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999 F	R133 became comb put him to bed. 10. On 8/26/09 at 9 Aide (CNA) wheeler and forth in a rockin had no foot rests th feet getting caught I wheel chair. 11. On 8/26/09 from called residents who doll' several times. FINAL OBSERVAT LICENSURE VIOLA 300.1210a) 300.1210b)6) 300.1220b)2) 300.1220b)7) 300.1220b)7) 300.3240a) 300.1210 General F Personal Care a) The facility must and services to atta practicable physical well-being of the resident's com- plan of care. Adequinus for each resident to poersonal care need	Suring 3.5 cm x 0.1 cm when bative while staff was trying to 30 am E16 a Certified Nurse d R16 backwards and back ing manner. R16's wheel chair ere was a potential risk of her between the floor and the a 9:20 am to 10:00 am E15 o were holding a doll 'ye baby IONS ATIONS ATIONS Requirements for Nursing and provide the necessary care in or maintain the highest I, mental, and psychosocial sident, in accordance with prehensive assessment and uate and properly supervised ersonal care shall be provided meet the total nursing and		999	3			

If continuation sheet Page 27 of 35

		AND HUMAN SERVICES				FORM	0: 02/08/2010 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		/ULTI	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		145711	B. WI	NG		09/0	)2/2009
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LEXING	TON OF ELMHURST				20 WEST BUTTERFIELD ROAD ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	a 24-hour, seven d 6) All necessary pro- assure that the resi as free of accident nursing personnel s that each resident r and assistance to p 300.1220 Supervis b) The DON shall s nursing services of 2) Overseeing the of the residents' need defined conditions 7) Coordinating the residents in the nur 300.3240 Abuse ar a) An owner, licesn or agent of a facility resident. (Section 2) These requirement by: Based on observat review the facility fa (1) Supervise R10 wanderer with unst (2) Analyze and ev multiple falls and in (3) Implement the p R10 when ambulat caution X 1 assist a when agitated/anxi	ring and shall be practiced on ay a week basis: ecautions shall be taken to idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. ion of Nursing Services upervise and oversee the the facility, including: comprehensive assessment of s, which include medically and medical functional status. care and services provided to rsing facility. and Neglect ee, administrator, employee y shall not abuse or neglect a 2-107 of the Act) s are not met as evidenced ion, interview and record ailed to: who was identified as eady gait. aluate the root cause of R10's njuries. blan of care to supervise/assist ing, to transfer R10 with and provide close supervision	F9	999			

Facility ID: IL6013098

If continuation sheet Page 28 of 35

		AND HUMAN SERVICES				FORM	02/08/2010 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		145711	B. WI	NG		09/02	2/2009	
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LEXING	TON OF ELMHURST				420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	R10's needs and to needed. (5) Provide adequa staff are adequately in dealing with resid and implement plar and accidents for R (6) Ensure the facil analyze these incid prevent the reoccur These failures resu (1) R10 sustaining humerus with slight shaft on 04-13-09 a after). R10's right s a comminuted fract humerus with signif the right humeral sl humeral head fract (2) R12 sustaining 8/7/2009 and an al head and right knee attendance with a C (3) R23 sustaining d This is for 4 of 14 re R23) in the sample risk for falls. Findings include: (1) The facility's inc to the Department of following: R10 was	o revise the interventions as the supervision by ensuring y trained to transfer, proficient dent behaviors and develop ns of care to prevent incidents 212, R23 and R6. ity has a system in place to lents to rule out abuse and to rrence of them. lited in: a fracture of the right proximal t rotation of the head lateral to and on 05-01-09 (19 days houlder fracture worsened to ture of the right proximal ficant medial displacement of haft with respect to the ure. a fracture of the left femur on brasion to the right side of the e after a fall while in the Certified Nursing Aide (CNA). a 2 inch laceration to the back eing showered by CNA.	F9!	999				

If continuation sheet Page 29 of 35

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO.	02/08/2010 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		145711	B. WII	NG _		09/0	2/2009
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LEXING	ON OF ELMHURST				420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	right upper arm and some swelling, com has limited movema and moved X ray proximal humerus . She has a recorded and follow ups show until 04-13-09. R10's nurses notes 03-01-09 at 7:00 PI another resident's w 03-12-09 at 5:00 PI hand (6.0 cm X 4.0 04-04-09 at 6:30 PI discoloration noted 04-08-09 at 7:00 PI tiny bruises on the 04-13-09 at 1:55 PI to right upper arm a swelling noted, com (hand). R10's fall care plan R10's fall care plan R10's risks for fall r not use assistive de hallway, impaired s agitation and wand are to supervise/as transfer resident wi provide close super These approaches interventions were and injuries.	<ul> <li>purplish discoloration on the dright shoulder area with aplaint of moderate pain and ent when area was touched v result revealed fracture of</li> <li>d fall on 04-08-09. Assessment wed no significant findings</li> <li>d disclosed the following:</li> <li>M - right toe was hit by wheelchair.</li> <li>M - bruise noted on the right cm).</li> <li>M - fall - right elbow</li> <li>M - fall - observed with some left hand.</li> <li>M - with purplish discoloration and right shoulder with some aplaint of pain, unable to lift up</li> <li>dated 10-21-08 disclosed that elated to unsteady gait, does evice, holds on to rails at the afety awareness, periods of ering. The approaches listed sist when ambulating, to th caution X 1 assist and rvision when agitated/anxious. were not implemented and not individualized based on vent her from sustaining falls</li> </ul>	F9	999			

If continuation sheet Page 30 of 35

		HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/08/2010 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145711	B. WII	NG _		09/02	2/2009
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LEXING	TON OF ELMHURST				420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	11-10-08 - noted or 11-11-08 - noted or 12-14-08 - noted or 12-14-08 - noted in 01-10-09 - remains 04-04-09 - assisted 04-08-09 - noted or 04-16-09 - falls 2 X Confused with perior unsteady gait, may safety awareness. 05-09-09 - slid out of Due to observable 04-13-09 at 1:55 Pl and right shoulder ability of R10 to lift 04-13-09), an x-ray fracture on the righ rotation of the head 05-01-09 (19 days fracture worsened of the right proximal h displacement of the respect to the huma (2) R12 was initially with a diagnosis of fall at home. R12 w 10/14/08 for a fract home. In a review of prepared by the fac facility on 8/7/09 at calling for help, lyin R12 was found to h his left eyebrow an dated 8/7/09 record	n the floor at hallway n the floor at her room. a the floor at the dining room. a trisk for falls d on the floor. n the floor. with in the last 2 weeks ods of agitation, wandering, be difficult to direct, impaired of wheelchair. purplish discoloration noted on M on R10's right upper arm with swelling, pain and in hand (nurses notes dated v was done and revealed a tt proximal humerus with slight d lateral to shaft and on after) R10's right shoulder to a comminuted fracture of numerus with significant medial e right humeral shaft with eral head fracture. y admitted to the facility 5/4/08 subdural hematoma from a vas readmitted to the facility on ture of right elbow from a fall at to f the incident reports cility R12 sustained a fall at the 6:50 a.m. R12 was found ing on the floor on his left side. nave a 1.0 cm x 1.0 cm cut on d pain to his side. X-ray report ds a displaced subcapital shortening. There was no	F9	999			

		HAND HUMAN SERVICES				FORM	02/08/2010 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145711	B. WI	NG _		09/02	2/2009
NAME OF F	PROVIDER OR SUPPLIER		-		REET ADDRESS, CITY, STATE, ZIP CODE		
LEXING	TON OF ELMHURST				420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	On 8/28/09, R12 w wheelchair. R12 w reasons for the fall, the facility fall common R12, E2 stated the process of updating evaluated because for him. Record review doct p.m., staff was info R12 was on the floo floor at the end of h go to the bathroom lying on the floor. R abrasion to the righ knee. A 6/16/09 incident to being walked by Ca foot missed the floo balance. Resident to floor. From review of the with staff, the facilit the falls for R12. A dated 5/18/09 for fa of 6/16/09 and 7/17 (3) R23 was admitt 2/18/09 with diagno cerebral vascular a the facility's incider incidents and a larg On 3/21/09 at 9:30	as observed to be seated in a ras not able to verbalize the . Interview with E2 as to how mittee analyzed the falls for facility was currently in the g their system. R12 was not E2 was only aware of one fall uments on 7/17/09 at 11:20 rmed by R12's roommate that or. R12 was found lying on the his bed. Resident was trying to . Urine and diaper were noted R12 was noted to have an ht side of his head and right records at 8:00 a.m., R12 was ertified Nursing Aide. R12's or pad, and he slightly lost his was assisted gently to the incident reports and interview ty did not have an analysis of A review of R12's plan of care alls does not address R12 falls	F9	999			

If continuation sheet Page 32 of 35

		AND HUMAN SERVICES	_			FORM	02/08/2010 APPROVED 0938-0391
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145711	B. WI	NG _		09/02	2/2009
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	٦IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	report notes the CN few seconds to read when she heard a so observed sitting on patient was sitting in rolled out under here back on it and R23 shower chair hit here have a 2 inch lacers During interview wit to remember the fa A review of the clinit the facility document plan of care for at read 3/21/09 falls are no Based on interview analysis of the falls origin. E2 states the formulating and she (4) R6 is an 80 yea including weakness Degenerative Joint R6 is assessed as with transfers, amb toileting, to have de both lower extremit R6's 9/15/08, 12/12 plans include "Resi impaired balance, of and ADL (activities impairment, history incontinence, decret	A turned her back from R23 a ch for R23's personal items, sound behind her. R23 was the floor. Statement notes in the shower chair when it r when she attempted to scoot slipped to the floor and the r head. R23 was observed to ation to the back of the head. th resident. R23 was not able II or the bruise. ical record and plan of care, its an 8/13/09 concern on the isk for falls. The 7/21/09 and	F9	999			

		AND HUMAN SERVICES				FORM	: 02/08/2010 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		145711	B. WI	NG	;	09/0	2/2009
	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE 420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	approaches includid during transfer with toileting." R6's nurses notes i - 5/02/09 11:30 AM of right ankle pain a strength. - 5/03/09 10:00 AM pain at a 3 out of 10 the right foot and an distal fibula fracture - 5/03/09 8:10 PM r bruising. -5/04/09 R6 was tal in a cast to the righ the bones. R6's 5/02/09 above not included with fa accident reports. During an 8/27/09 i (Administrator), E1 was not completed not know why. On 8/28/09 E1 prov labeled "Follow-up included that on 5/0 by a nurse aide tha to the right ankle bu abnormal alignmen were given, foot im applied. No fall inci- recorded. On 8/28/09 E1 also	ng "assist X1-2 as needed a gait belt and assist with include: I, nurse notified of complaints and decreased right foot I, right ankle with bruise and 0. At 4:00 PM X-ray taken of nkle which showed a right without displacement. right ankle with swelling and ken to the hospital and placed t lower foot/leg to immobilize	F9	99	99		

If continuation sheet Page 34 of 35

		AND HUMAN SERVICES				FORM	02/08/2010 APPROVED 0938-0391
STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145711	B. WI	NG	j	09/0	2/2009
NAME OF P	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE 420 WEST BUTTERFIELD ROAD	-	
LEXING	TON OF ELMHURST				ELMHURST, IL 60126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	on 5/02/09 R6 was bathroom with toile the toilet grab bar w from the resident to under the sink whe documents that he wheel chair after w right foot pain so th R6 was followed up 5/18/09 (Z1). Z1 5/ "About 2 weeks ag pain in the right and that's still there. (R6	This statement included that being assisted in the ting. R6 was standing up by when the aide turned away o obtain R6's wheelchair from n R6's leg gave out. The aide caught R6 and sat her in the hich R6 began complaining of the aide summoned a nurse. by an orthopedic surgeon on 18/09 progress report includes o (R6) slipped and fell and has kle. There's some ecchymosis 6) brought with her X-rays 17/09. They show a slightly	F9	99			

Facility ID: IL6013098

If continuation sheet Page 35 of 35