STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145638	A. BUILDING _____ B. WING _____	01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HLTH CR CTR-BLMNGDL	165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108

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F 328	Continued From page 10 said R10's MAR should have some documentation of flushes given in the MAR. However, E10 did not find any evidence of these services being given to R10. E10 said that R10's dressing was last changed on 1/09/2012 at 10:25 PM. During the Daily Status Meeting on 1/19/2012 and 1/20/2012 with the administrator (E1) and director of nursing (E2), the survey team expressed concerns that R10 did not receive appropriate assessment and care of his Midline Central Catheter . E 1 and E 2 stated they would inservice staff on the care of R10's Midline Central Catheter and other types of central lines. However, E1 nor E2 did not provided any evidence to support R 10 were given the assessments and care/service he required.	F 328		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS : 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in	F9999		

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F9999	Continued From page 11 the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for	F9999		

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F9999	Continued From page 12 each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following: Based on observation, record review and interview the facility failed to: - Ensure that the call light was readily accessible, - Develop and implement individualized and specific interventions to monitor R15 to prevent falls. As a result: - R15 sustained left ankle fracture due to his falling on 8/24/11 at 10:25 PM from his bed to the floor when reaching for his television remote control. - On 9/6/11 at the hospital it was determined that R15 sustained a non-displaced left ankle fracture. This is for one of one residents R 15 in the sample of 24 residents who have pain.	F9999		

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F9999	Continued From page 13	F9999		

Findings include:

On 1/19/12 at 10:30 am R15 was seated in his adult high back chair stationed in his room, he leaned to his left side watching TV. R 15 was alert, but could not recall what happened on 8/24/11, but was able to say he had severe pain for a long time. R15 could not explain where his nurse call cord was. R15's nurse call cord was on the floor between his chair and bed.

On 1/20/12 at 10:45 am R15 was seated in his high back chair, he had dark eye glasses, was alert when called his name. R 15 had no nurse call cord accessible, he did not know what happened to it. The call cord was between the wall and head board of his bed. E3 (Assistant Director of Nurses) verified the observation. E3 also verified the nurse call cord was not accessible to his room mate who was lying in his bed; his call cord was also behind his head board. E 3 said she will speak to direct care staff about keeping the call light available all the time. E 3 confirmed that R15 is capable of using nurse call light.

R15's 8/24/11 at 10:25 PM it was noted in the nurses notes indicating staff found him on the floor beneath the bed lying on his right side. R 15 holding the battery cover of the TV remote at the right. R 15 complained of pain on his back and right hip. The facility sent R 15 to Hospital at 11:00 PM and he returned back to the facility on 8/25/11 4:15 am. After R 15 had fallen on 8/24/11 the following entries were made in his nurses notes:

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On 8/26/11 R15 moving around more than usual, when asked is he in pain, he moaned and had facial grimacing; receive acetaminophen with hydrocodone 5-325 mg for pain in addition to a regular dose of acetaminophen 325 mg three times daily. R 15 continued to receive acetaminophen with hydrocodone 5-325 mg for pain on 9/2/11, 9/4/11, 9/5/11 and 9/6/11.

R 15 continued to receive acetaminophen 325 mg three times daily and acetaminophen with hydrocodone 5-325 mg from from 8/25/11 to 9/5/11.

R15 on 9/5/11 at 8:00 PM complained of left ankle pain to family members. R15's family requested to do X-Ray of left ankle. R15 received acetaminophen with hydrocodone 5-325 mg for pain. On 9/6/11 the staff made a late entry to reflect R15's left ankle which indicated 'R15 complained of left ankle pain, ankle found to be swollen, facial grimacing noted.

On 9/6/11 at 10:30 am X-Ray of R15's left ankle was done, which indicated he sustained a non-displaced fracture of left distal tibia and fibula. On 9/8/11 a short cast was placed on his left foot.

On 1/20/12 at 10:45 am E3 stated during her investigation of the incident the nurse stated she did not conduct assessment of R15's left foot because he did not complain of pain. E3 stated the nurse should have conducted a complete assessment of R15 when he complained of pain after he returned from the hospital.

The facility documented an incident on 8/24/11 to

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F9999	Continued From page 15 indicate R15 had fallen, he was sent to the hospital. R15's 8/24/11 investigation noted he stated to his sister to indicate the TV remote control flipped when attempted to reach it. On 9/6/11 after it was diagnosed R15 sustained a left ankle non-displaced fracture, the investigation report indicated the fracture was from his falling on 8/24/11. R15's 7/26/11 Resident Assessment Protocol (RAP) summary noted he is at risk of falling due to impaired mobility, decreased safety awareness and use of psychotropic medication and care plan to have interventions to prevent fall. R15's plan of care interventions for falls prior to his falling on 8/24/11 is not specific or individualized to his risk factors (mobility, decreased safety awareness and use of psychotropic medications) identified in his 7/26/11 RAPs. The examples are: (a) frequently used items are within reach at all time; (b) keep call light within reach at all times and answer promptly. These interventions are not implemented on 1/19/12 and 1/20/12. The facility failed to implement specific and individualized interventions and monitor R15 to prevent from falling. As a result R15 sustained a preventable non-displaced left ankle fracture. B	F9999		