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 ____	03/05/2013

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

(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 329	Continued From page 10 out/yelling/screaming and #13 (refusing care), for the entire month of February 2013 this was marked " 0 " -no behavior . This was confirmed by E 7 and stated " she has the history of these entire but not anymore. " Review of R 17's nurse's notes have no documentation R 17 exhibiting any behavior and this was confirmed by the staff. This finding was discussed with the Director of Nursing /E 2 on 02-27-13 at 12:15 PM, E 2 confirmed and stated " she (R 17) doesn't exhibit any behavior anymore. The behavior being monitored does no longer exist. "	F 329		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)5) 300.3240a) 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,	F9999		

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 ______	03/05/2013

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

(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
F9999	Continued From page 11	F9999		

seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, the facility failed to address R14 and R4's risk factors in developing two areas of facility acquired pressure ulcers, develop and consistently implement interventions specific to the needs of R14 and R4 in order to promote healing.
This applies to two (R4 and R14) of three residents reviewed for pressure ulcer development in the sample of twenty four residents.
Findings include:
-At 10 AM on 2/28/2013, E3 (treatment nurse) was observed doing R14's dressing change on her (R14's) sacrum wound. R14 was observed to

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 ______	03/05/2013

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

(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
F9999	Continued From page 12 be alert with periods of confusion. R14 was also observed to have limited mobility because of her medical conditions (Dementia, Degenerative Joint Disease, Osteoporosis and Osteoarthritis) and fracture of the right ankle. E3 measured R14's wound and obtained the following measurements: 1.3 cm x 2 cm. E3 described R14's wound as a Stage II wound which developed in the facility. Review of R14's initial Wood Assessment Detail Report reads R14 is was at risk for the development of pressure sores based on her Braden score of 15, which was done on 11/23/2012. This initial wound assessment also documented R14's sacral wound was identified on 2/09/2013. The written description of the wound is: "size 1 x 1.5 cm... Wound bed has pink granulation tissue with light serous exudate, erythema to peri-wound." However, the initial wound assessment lacks documentation of any other factors in the development of R14's wound and only gives a description of the pressure sore. Review of R14's care plan identified her pressure sore as a focus in her care. The care plan was not specific in detailing the efforts staff will take to keep pressure off her sacrum and her tolerance for repositioning. The care plan's approaches to keep R14's heels off her bed, had nothing to do with the care of her sacral wound. Review of R 4's nurses notes dated 02-26-13 reads: resident was noted with Stage II pressure ulcer on the left and on the right sacrum. is incontinent of bowel and bladder, requires total assist with Activities of Daily Living, toileting and transfer ... On 02-28-13 at 3:00 PM, the Treatment Nurse (E3) stated " on 02-26-13 during incontinence care, the CNA noted a skin opening one on his left and one on the right sacrum both a Stage II'	F9999		

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 ______	03/05/2013

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

(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
F9999	Continued From page 13 s. " The wound assessment details report dated 02-26-13, (1) the left sacrum was measured at 2.0 cm X 1.0 cm- Stage II and (2) right lower sacrum measured at 1.5 cm X 1.0 cm- Stage II. Review of R4's clinical record showed no comprehensive assessment was done for R4. On 02-28-13 at 3:00 PM, E3 confirmed and stated, "What we use is the wound assessment where we document the measurement, site and description of the wound. The nurse's notes document we call the family and the doctor and we also use the Braden scale. We don't really assess the cause and how the sores develop. That's all we have as for pressure ulcer documentation. For him we didn't analyze if these pressure ulcers are avoidable or unavoidable." R4's left and right sacrum pressure ulcer care plan was not individualized and specific to the problem identified. R4's approach includes: elevate heels off of bed, provide medications as ordered and bilateral heel protectors ... When this finding was discussed with E3 on 02-28-13 at 3:00 PM, E3 stated , "We have a template - a computerized program." During the Daily Status Meeting with administrative staff (E1/administrator and E2/director of nursing), the comprehensive wound assessment for R4 and R14 was requested. E1 and E2 said the initial wound assessments only provided a description of the wound. (B) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a)	F9999		

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 ______	03/05/2013

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

(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
F9999	Continued From page 14 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:	F9999		

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 ______	03/05/2013

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

(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
F9999	Continued From page 15	F9999		

Continued From page 15

Based on observation, interview and record review, the facility failed to ensure one resident (R14), who has impaired cognitive status, weak physical condition and at risk for falls, received the appropriate safety measures (assistance of two staff members), while being transferred.

This failure resulted in R14 having an avoidable accident, sustaining a right ankle fracture, and requiring medical treatment.

This failure applies for 1 out of 10 residents reviewed because of their fall occurrence in a sample of 24.

Findings included:

Review of R14's Admission Face Sheet documented R14 is a 101 year old female, who was original admitted to the facility on 1/20/2006. R14 has diagnosis including: Osteoporosis, Osteoarthritis, Degenerative Joint Disease and Dementia.

Review of R14's Fall Risk Assessment, dated 11/23/2012 and 2/20/2013 documented R14 as assessed for being at risk for falls.

Review of R14's MDS (Minimum Data Set) Assessment, dated 11/27/2012, documented R14 required extensive assistance from 2 staff member to transfer.

Review of R14's plan of care documented she (R14) required the extensive assistance form 2 staff members.

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 ______	03/05/2013

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

(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
F9999	Continued From page 16	F9999		

R14's had a "Resident/Patient Transfer Status Form " , dated 11/23/2012, which documented the following instruction for staff:
"Assist of 2 (staff members to transfer) " .

Review of the facility's Incident Report documented the following for R14:

"R14 requires extensive staff assistance x 2 for all transfers. On 1/23/2012 resident's right ankle was noted to be swollen with discoloration ... The X-ray result showed a spiral fracture involving the distal tibial diaphysis with modest displacement, joint ... When R14 was interviewed she stated her leg may have twisted upon transfer but later she stated her leg may have caught in the leg rest. The CNA (certified nurses aide identified as E8) who was assigned to care for the resident on January 23, 2013 morning shift was interviewed. She (E8) stated she did transfer the resident (R14) by herself ... Injury may have occurred during the transfer ..."

Review of the facility's policy on "Transfer, Ambulation and Re-Positioning" documented the following:
"Procedure ... Transfer status will be based on the number of staff needed to perform the task ... This information is recorded on the Care Giver Alert and in the medical record." When R14 was transferred on 1/24/2013, the CNA did not transfer R14 with the number of staff identified in R14's medical record.

On 2/28/2013 at 9:40 AM, R14 was observed and interviewed in her room. R14 was alert to self and place. R14 ' s right foot was swollen and she was wearing a splint. The treatment nurse (E3)

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 ______	03/05/2013

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

(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
F9999	Continued From page 17 was present. E3 stated R14 had a spiral ankle fracture, which caused her pain. E4 is the hospice nurse working with R14, and she (E4) was interviewed on 2/27/2013 at 11:33 PM. E4 said, " It was the hospice CNA who discovered R14 ' s leg red and swollen, and was later found to be broken. " After R14's fractured ankle, E4 stated that she (R14) required 2 weeks of bed rest, and treatment with "round the clock " doses of Narco to control her pain. The nursing manager (E5), who conducted the investigation of R14's 1/24/2013 incident, was interviewed on 2/28/2013 at 1:33 PM. E5 said her investigation found E8 (CNA) transferred R14 on 1/24/2013 by herself. E5 stated R14 required assistance from 2 person/staff member. E5 said R14's accident may not had happened, if E8 transferred R14 using 2 people. E8 was interviewed on 3/01/2013 at 2 PM. E8 stated she transferred R14 without any assistance on 1/24/2013. E8 said she did not review the transferred requirements on R14 ' s Care Alert Card, which is maintain in R14's closet. E8 did not follow the the appropriate safety measure based on her (R14's) assessments as documented in her Care Alert Card and medical record. (B)	F9999		