STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011993	A. BUILDING: _____ B. WING _____	C 05/06/2014

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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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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 the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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:	S9999		

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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 requirments were not met as evidenced by:

Based on interview, observation and record review, the facility failed to properly implement fall prevention interventions for 1 of 4 residents (R1-R4) reviewed for falls.
The resident (R1) suffered two falls with fractures within a two month span of time;a fractured wrist 2/21/14 and a fractured hip 4/20/14.

Findings include:

R1 a 93 yo resident, was admitted to the facility 12/28/11. Documentation available shows R1 to be alert and oriented with moderately impaired cognition. R 1 did not have a history of falls prior to the fall she suffered in February.

E2 (DON) said that R1 had gone out on 2/21/14 with the activity department for lunch. R1 was in a wheelchair and rode on the bus to the destination. On arrival, R1 was taken off the bus by wheelchair and was being wheeled into the restaurant by E4 an activity aide who is also a trained CNA. E4 was interviewed and said that as she was pushing R1 up to the door in the chair R 1 suddenly got startled by the "sound of the

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concrete" and leaned forward. R1 was in a highback wheelchair and E2 was not able to reach down and stop her fall. She said that R1 had been on outings before and was always calm and had not ever acted like this before. She (E4), said she immediately called the facility who had them return R1 to the facility for evaluation. After return to the facility it was observed that R1's R hand was swollen. It was elevated on a pillow and the doctor notified. An X-ray was ordered and showed a "minimally displaced distal radial fracture."

E4 was asked if there were footrests on the wheelchair at the time of her fall and she stated that there were not any on at that time. E4 said that in the facility R1 would peddle herself around the facility, so she did not have them on there. Even though R1 was being taken out and would be transported by someone else at the location, no footrests had been placed on the chair for the trip.

Review of staff inservices dated 8/21/13, show that the policy of the facility was discussed concerning foot and leg rests. The information discussed was that :"All patients or residents who use a wheelchair must have a legrest/ footrest unless otherwise specified in their careplan." There is no evidence that this exclusion was present for R1, especially when being taken outside the facility. E4 said that R1 had put her feet down on the pavement while she was pushing her which caused R1 to fall forward.

After this incident, R1 is documented in the nursing notes as needing extensive assist with transfers and toileting. The MDS dated 3/27/14 that was done for a significant change in condition scored R1 as 3/3 for toileting needs.

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S9999	Continued From page 3 This translates to extensive assist by two persons. On 4/10/14, R1 had her cast removed by the orthopedic doctor and replaced by a splint. In the next week between 4/17/14 and 4/19, R1 showed signs of a GI problem that E2 (DON) said caused loose stools, nausea and vomiting. E2 said that this resulted in R1 being weaker than ususal. On 4/20/14, E7 (CNA) assisted R1 to the bathroom by herself. According to E2, the facility investigation documented that E7 claims that while she was changing the incontinence garment of R1, R1 was holding the grab bar. R1's knees buckled and she (E7) assisted R1 to the floor. This fall resulted in R1 suffering a fracture to the R hip. One of the first people to respond to E7's calls for help was the shift nurse, E6. E6 was interviewed as to what he saw when responding to the room. E6 said that he saw E7 behind R1 supporting her back. He recalled R1's legs being straight out in front of her. E6 claimed he did ROM on R1 and did not notice any problem. E6 said once placed back in bed, R1 expressed pain to the R hip area and X-ray was done that confirmed an intertrochanteric hip fracture. Surgery was required to repair the fracture. E7 failed to use two person assist with toileting as identified by MDS of 3/27/14. R1 was interviewed on 5/1/14 about her injuries. She was alert and verbal but unable to relate what had occurred with either incident. R1 was in bed with a splint to the R wrist and an abductor pillow between her knees. She was not aware of the purpose of either device.	S9999		

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