(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		IL6012975	B. WING		C 05/02/2018	
	PROVIDER OR SUPPLIER	815 EAST	DRESS, CITY, IRVING PAI NOOD, IL 6			
(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 SHOUL) CROSS-REFERENCED TO THE APPROPRIES (EDITION OF THE APPROPRIES (EDITI	D BE COMPLETE	
\$ 000	Initial Comments		S 000			
	Complaint Investiga	ation				
	1892638/IL102088	1				
	FRI of 4-23-18/IL10	2312				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a)					
	a) The facility shall procedures governifacility. The written be formulated by a Committee consisting administrator, the a medical advisory conformers and othe policies shall complements.	dvisory physician or the ommittee, and representatives or services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed				
	Nursing and Persor b) The facility shall pand services to atta practicable physical well-being of the res	seneral Requirements for pal Care provide the necessary care in or maintain the highest prental, and psychological sident, in accordance with a prehensive resident care		Attachment A Statement of Licensure Viola	itions	

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(X2) MULTIPLE CONSTRUCTION

(X1) PROVIDER/SUPPLIER/CLIA

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 05/15/18

PRINTED: 06/13/2018 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6012975 05/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAST IRVING PARK ROAD **LEXINGTON OF STREAMWOOD** STREAMWOOD, IL 60107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 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. Restorative measures shall include, at a minimum, the following procedures: 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: Based on interview and record review the facility failed to follow its policy for transferring residents and failed to use the recommended sling size and

techniques for mechanical lift transfer. This failure resulted in R2 falling to the floor during a mechanical lift transfer and sustaining intracranial

hemorrhage that required hospitalization.

This applies to 1 of 3 (R2) residents reviewed for

117Z11

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6012975	B. WING		_	<i>,</i> 2/2018
	-		·		1 00/0	2/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LEXING	ON OF STREAMWOO		IRVING PAF			
		STREAMV	NOOD, IL 60	0107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	falls in the facility fr	om a total sample of 6.				
	The findings include	e:				
	with diagnoses which Generalized Muscle Psychosis according MDS (Minimum Dashowed R2 was ser R2 was totally dependent of transfers. R2's April 5, 2018 showed R2's care plan for for problems and problems and problems and problems. R2 reathere. R2's care plan for for formal problems.	the facility on July 17, 2010 ch include Dementia, a weakness, Anxiety and g to R2's face sheet. R2's ta Set) dated April 10, 2018 verely cognitively impaired and endent on 2 plus staff persons fall risk assessment dated at R2 at high risk for falls;R2 de of 10 and above is high risk, alls showed R2 had balance lems with strength. R2 has not and impaired safety ches out for things that are not an for activities of daily living ependent on 2 staff persons				
		last updated April 13, 2018 a full body mechanical lift ium (Red).				
	Nurse) stated during an assessment on stated she recomma mechanical lift with R2's weight was 15 red sling was recommanufacturer recommended with V16 also staff used a larger staff used	nmendations because of R2's ated that R2 has poor trunk nnot tell what could happen if sling size. V16 stated that she taff use the recommended				

Illinois Department of Public Health

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		COMPLETED		
	IL6012975		B. WING		C 05/02/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	-	
LEYING	TON OF STREAMWOO	815 EAST	IRVING PA	RK ROAD		
LEXING	TON OF STREAMWOO	STREAM	VOOD, IL 6	0107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
S9999	Continued From pa	ge 3	S9999			
	R2's body in support mechanical lift.	e other staff should cradle rt during transfer using the 2:00 PM V16 stated R2 had a forward.				
	On May 1, 2018 at 3 Care Physician) sta extremity muscles a a behavior of reach R2 was hospitalized	3:30 PM V15 (R2's Primary ted R2 had very weak upper and poor trunk control. R2 hading forward. On April 23, 2018 If and admitted to Intensive of a bleed in the brain due to a				
	Nurse Assistant) state assigned to work with during the 7:00 AM that she was transfer wheelchair with the (Certified Nurse Assating (blue) under V4 stated she held to operated the mechanishment. V4 stated bed and brought R2 R2 lean forward town over the right side of stated she was not sleg of the mechanic from the back of her check R2's care car size for R2 when she the correct sling for On May 1, 2018 at 2 encourages the staff	t 3:35 PM V4 CNA (Certified ated on April 23, 2018 she was th R2 and provide care for R2 and 3:00 PM shift. V4 stated erring R2 from the bed to the assistance of V11 CNA sistant). V4 stated she placed R2 while R2 was on the bed. R2 at the feet as V11 anical lift at the back of the that as V11 raised R2 off the that as V11 raised R2 off the away from the bed she saw vards the right side and R2 fell f the sling to the floor. V4 sure if R2 hit her head on the al lift but R2 was bleeding r head. V4 stated she did not d for the appropriate sling e transferred R2. V4 stated R2 was medium (Red).				

1.0

(X2) MULTIPLE CONSTRUCTION

PRINTED: 06/13/2018 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6012975 B. WING 05/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **815 EAST IRVING PARK ROAD LEXINGTON OF STREAMWOOD** STREAMWOOD, IL 60107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 S9999 Continued From page 4 On May 1, 2018 V2 (Director of Nursing) stated it was expected that the staff use the correct sling size for the resident. V2 said it was expected that nursing staff check R2's care card for the correct sling size and use the sling size that was recommended for R2. The manufacture's procedure guide for the mechanical lift used by the facility dated January 2014 showed the cross loop connection method: a) the patient must have predictable, cooperative behavior The manufacture's recommendations in the sizing and positioning the sling showed that when the correct size of the sling has been determined for the patient, the information should be documented in the patient's record and the information should be communicated to the nursing staff so the proper size sling is used in each transfer of the resident. The mechanical Sling/Belt color chart showed size medium (Red) 110 to 190 pounds average user weight and the size large (Blue) 180 to 250 pounds average user weight. The facility's policy on Mechanical Full Body Lift Safety and Use Procedure #1 (L) showed the lift requires two people to transfer patients. One employee will push the lift and one employee will hold onto the handles of the sling. (A)

117Z11

PRINTED: 06/13/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(2	(X3) DATE SURVEY COMPLETED	
		145701	B. WING			C 05/02/2018	
NAME OF PROVIDER OR SUPPLIER LEXINGTON OF STREAMWOOD			STREET ADDRESS, CITY, STATE, ZIP CO 815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107	DDE	00,	02/20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	Fo	00			
	CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must en §483.25(d)(1) The r as free of accident in §483.25(d)(2)Each supervision and assaccidents. This REQUIREMEN by: Based on interview failed to follow its por and failed to use the techniques for medifailure resulted in R mechanical lift trans hemorrhage that ref This applies to 1 of falls in the facility fro The findings include R2 was admitted to	- F689 - No deficiency - No deficiency - No deficiency - 2312 - F689 - Exards/Supervision/Devices 1)(2) - Its Sure that resident environment remains hazards as is possible; and - resident receives adequate sistance devices to prevent - NT is not met as evidenced - Y and record review the facility plicy for transferring residents are recommended sling size and hanical lift transfer. This 2 falling to the floor during a sifer and sustaining intracranial quired hospitalization. 3 (R2) residents reviewed for our a total sample of 6.	F 6	89			5/18/18
	Generalized Muscle Psychosis according	e weakness, Anxiety and g to R2's face sheet. R2's		TITLE			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

05/15/2018

PRINTED: 06/13/2018 FORM APPROVED OMB NO: 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145701	B. WING				C 02/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON OF STREAMWOOD				81	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST IRVING PARK ROAD TREAMWOOD, IL 60107	1 00	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL! CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	MDS (Minimum Da showed R2 was se R2 was totally deper for transfers. R2's April 5, 2018 shows scored 12 on a sca R2's care plan for f problems and prob cognitive impairme awareness. R2 rea there. R2's care pl showed R2 to be d for transfers. R2's caregiver aler showed staff to use with sling size med On April 30, 2018 a Nurse) stated during an assessment on stated she recomma a mechanical lift win R2's weight was 15 red sling was recommanufacturer recommanufacturer recommanufacturer recommended a larger should expect that sling size for R2. Vitransferring R2, one the machine and th R2's body in supposition.	sta Set) dated April 10, 2018 verely cognitively impaired and endent on 2 plus staff persons fall risk assessment dated ed R2 at high risk for falls;R2 le of 10 and above is high risk. alls showed R2 had balance lems with strength. R2 has nt and impaired safety ches out for things that are not an for activities of daily living ependent on 2 staff persons It last updated April 13, 2018 e a full body mechanical lift ium (Red). It 2:51pm V16 (Restorative g interview that she performed R2 on April 13, 2018. V16 ended R2 be transferred using th a medium sling because to pounds. V16 added that the nmended per the mmendations because of R2's ated that R2 has poor trunk nnot tell what could happen if sling size. V16 stated that she etaff use the recommended 16 stated that while e staff member can operate e other staff should cradle rt during transfer using the	F	889			

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PRINTED: 06/13/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145701	B. WING			1	C / 02/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON OF STREAMWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	On May 1, 2018 at Care Physician) state extremity muscles at a behavior of reach R2 was hospitalized care unit because of hard fall during transon April 26, 2018 at Nurse Assistant) states assigned to work with the Cartified Nurse Assistant with the Certified Nurse Assistant (blue) under V4 stated she held operated the mechanism achine. V4 stated bed and brought R2 R2 lean forward town over the right side of stated she was not leg of the mechanic from the back of he check R2's care can size for R2 when she the correct sling for On May 1, 2018 at 2 encourages the state connection method On May 1, 2018 V2 was expected that the size for the resident nursing staff check	3:30 PM V15 (R2's Primary sted R2 had very weak upper and poor trunk control. R2 had ing forward. On April 23, 2018 if and admitted to Intensive of a bleed in the brain due to a sfer. 13:35 PM V4 CNA (Certified ated on April 23, 2018 she was lith R2 and provide care for R2 and 3:00 PM shift. V4 stated erring R2 from the bed to the assistance of V11 CNA sistant). V4 stated she placed R2 while R2 was on the bed. R2 at the feet as V11 anical lift at the back of the that as V11 raised R2 off the away from the bed she saw wards the right side and R2 fell of the sling to the floor. V4 sure if R2 hit her head on the all lift but R2 was bleeding the head. V4 stated she did not red for the appropriate sling to transferred R2. V4 stated R2 was medium (Red). 2:00PM V16 stated she fit to only use the cross loop when applying the sling. (Director of Nursing) stated it the staff use the correct sling. V2 said it was expected that R2's care card for the correct sling is size that was	F6	89			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		145701	B. WING			1	C / 02/2018	
	PROVIDER OR SUPPLIER	סס		815	REET ADDRESS, CITY, STATE, ZIP CODE EAST IRVING PARK ROAD REAMWOOD, IL 60107	1 03/	102/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	mechanical lift used 2014 showed the craim a) the patient must behavior The manufacture's sizing and positioning the correct size of the patient, the indocumented in the information should hoursing staff so the each transfer of the Sling/Belt color chaim 110 to 190 pounds a size large (Blue) 18 weight. The facility's policy of Safety and Use Prorequires two people	procedure guide for the diby the facility dated January ross loop connection method: have predictable, cooperative recommendations in the ng the sling showed that when he sling has been determined information should be patient's record and the be communicated to the proper size sling is used in resident. The mechanical it showed size medium (Red) average user weight and the 0 to 250 pounds average user on Mechanical Full Body Lift cedure #1 (L) showed the lift it to transfer patients. One the lift and one employee will	F6	89				