

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2009
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	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 000	INITIAL COMMENTS	F 000			
F 323 SS=G	<p>Complaint Investigation 0895674/IL38909</p> <p>No Extended Survey was conducted</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observations, record reviews and staff interviews the facility failed to ensure that 2 of 3 (R1, R3) residents in the sample had the proper amount of staff necessary for transferring and that residents were transferred safely with lift equipment. (R3) was transferred by one staff member, and required a two (2) person assist. R3 subsequently received a fracture of the left tibia and fibula. R1 was transferred by staff using facility care lift equipment which malfunctioned, and R1 sustained a Right Closed Fracture Clavicle and Fracture Humerus Proximal Closed.</p> <p>Findings include:</p> <p>1. The investigative report completed by E2 (Director of Nursing) dated 11/13/08 depicts R3 was transferred with the assistance of E4 alone on 11/8/08 during the 3-11 shift. E4, the assigned Certified Nurse Aide (CNA) for R3, is quoted reflecting in part;"used (mechanical lift)</p>	F 323			

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

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2009
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	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 323	<p>Continued From page 1 alone." E4 was unavailable for an interview during the onsite visit.</p> <p>R3's minimum data set denotes in part under the category of physical functioning/transferring R3 requires a 3/3, which is defined as extensive assistance/two person assist.</p> <p>R3's X-ray report denotes in part the following: Left tibia and fibula</p> <p>History: Trauma</p> <p>Findings: AP, lateral, and oblique view of the left tibia, and fibula reveal marked diffuse osteopenia with oblique fractures through the mid tibial, and distal fibular shaft with apex posterior angulation the fracture sites.</p> <p>Impression: Oblique fractures through the mid tibial shaft, and distal fibular shaft.</p> <p>2. R1 is a 85 year old female and as denoted in the MDS (minimum data set) Transfer section is coded as 4/3, which means R1 is totally dependent on 2 persons to transfer. R1 was being transferred by the facility care lift equipment which malfunctioned, and according to the interview conducted with the Director of Nursing (E2) R1 sustained a injury, and was sent out to the hospital. E2 gave surveyor a copy of facility inservice training which in part depicted the following:</p> <p>Date:11/26/08 Topic/Title of Inservice- Proper Use of Mechanical Lift Summary of Inservice: Discuss proper application of belt strap; slings prior to operating machine.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2009
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	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 323	Continued From page 2 Ensure batteries are not low and machine is working properly. The facility Resident Assessment Readmission record for R1 dated 11/29/08 in part depicts the following: "Clavicle Closed Fracture;Fracture Humerus Proximal Closed." R1 was observed on onsite 1/27/09, R1 had on an immobilizer to the right arm, and did not respond to verbal greeting of surveyor. E3 (Assistant Director of Nursing) stated,"R1 is confused."	F 323			