

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 225 SS=D	<p>Complaint Investigation: 0894207/IL37355--No deficiencies. 0894304/IL37455--F225, F314, F323 and F442 cited.</p> <p>No extended survey was conducted.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>	F 225			
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: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to thoroughly investigate how 1 resident (R2) sustained multiple bruises with an unknown etiology.</p> <p>Findings include:</p> <p>R2 is 85 year old with diagnoses of CVA (cerebral vascular accident), CAD (coronary artery disease), DM (diabetes mellitus) and Alzheimer's. Per record, facility identified that R2 has difficulties with long and short term memory recall and has impaired cognitive skills for decision making. R2 who is non-ambulatory, requires total assistance with all activities of daily living. R2's recent MDS (minimum data set) dated 7/1/08 showed that R2 scored on the following: --3 (severely impaired with decision making) for cognition --4/3 for bed mobility--(total dependence with 2 plus person physical assist) --4/3 for for transfer--(total dependence with 2 plus person physical assist)</p> <p>Observations made on 10/1/08 at 10:00 A.M., 12: 00 noon, and 1:00 P.M. showed that R2</p>	F 225			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 225	<p>Continued From page 2</p> <p>was on the second floor dining room and was sitting in his reclining wheelchair.</p> <p>On 10/1/08 at 10:20 A.M., E3 (nursing supervisor) removed Kerlix wrap around R2's left arm. It was noted that R2 has multiple discolored brownish reddish spots, circular in shape on the left upper arm and left lower elbow. E3 stated that these multiple spots of reddish/brownish discoloration are petechiae. E3 also stated that these spots of discoloration might be related to R2's diagnosis of "Lichen Planus."</p> <p>Review of the incident reports showed that R2 was identified with the following: --7/16/08--found a scratch mark on the left medial knee --8/16/08--bruise on the left hand measuring 2x1cm with unknown etiology left hand, ""blood was present on the fingernails of the left hand, scratched himself." --8/28/08-- pinpoint redness on upper arm , left hand, left upper hand and right upper hand 9/17/08--bruise below right elbow measuring 3 x 3.5 cm, looks like ecchymosis --9/20/08--2 new bruises on the right forearm. bruise #1 measuring 2.5 cm x 3.0 cm.; bruise #2 measuring 1.0 x 2.0 cm. "2 new bruises origin is unknown."</p> <p>Further review of record showed no documentation to indicate that an investigation was done to determine what had caused the bruises. This concern was discussed with E1(administrator) on 10/1/08 during the daily status meeting. E1 stated that he could not find any information regarding the investigations of R2's bruises. As E1 added, the staff who was in charge of investigations was no longer working at</p>	F 225			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 225	Continued From page 3	F 225			
F 314	the facility and that some records of investigations could not be found.				
SS=D	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that 1 resident (R2) who was identified with altered skin integrity and a high risk for skin breakdown receives the following interventions according to plan of care for pressure ulcer prevention: --a protective skin barrier was applied according to physician order --frequent turning and repositioning for pressure relief was maintained --good perineal care was maintained  Findings include:  R2 is 85 year old with diagnoses of CVA (cerebral vascular accident), CAD (coronary artery disease), DM (diabetes mellitus) and Alzheimer's. Per record, facility identified that R2 has difficulties with long and short term memory recall and has impaired cognitive skills for decision making. R2 who is non-ambulatory, requires total assistance with all activities of daily	F 314			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 314	<p>Continued From page 4</p> <p>living. Facility staff identified that R2 is incontinent of both bowel and bladder and requires total assistance with incontinence care. R2 also requires total assistance with turning and repositioning. R2 was also identified as a high risk for skin breakdown.</p> <p>Observations made on 10/1/08 at 10:00 A.M., 12: 00 noon, and 1:00 P.M. showed that R2 was in the second floor dining room and was sitting in his reclining wheelchair. R2 was in the same sitting position while seated in his reclining wheelchair during the time of observations. During these observations, Z1 (R2's family's member) was at R2's side.</p> <p>R2 was being transferred to bed by a mechanical lift by E4 and E5 (CNA-certified nurse assistants) on 10/1/08 at 1:00 P.M. During the transfer, E3 (nurse supervisor) and E6 (nurse) and Z1 was at bedside. R2's diaper was removed by E4. Further observation showed that when R2's diaper was removed, the diaper was heavily saturated with soft stool and urine. The diaper was so saturated that it had leaked through the groin area. During this time of observation, E4 informed surveyor that R2's diaper was last changed between the hours of 8:00 A.M. to 9:00 A.M. on 10/1/08 after the shower was given to R2 by E4. E4 also added, that R2's diaper was not changed nor was he turned and repositioned because R2 was sitting in his reclining chair.</p> <p>Review of R2's current POS (Physician order sheet) showed an order for "Proshield cream Plus to buttocks every shift." Review of TAR (treatment administration record) showed that Proshield was not applied as ordered from</p>	F 314			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 314	Continued From page 5 9/23/08 night shift to 9/27/08 day shift.  Review of current care plan showed that R2 is high risk for skin breakdown, due to incontinence, impaired mobility, and history of healed pressure ulcers. Further review of the care plan also showed the following interventions to be implemented for R2 to be free of any skin breakdown: --turning and repositioning every 2 hours and if needed for pressure point relief --provide good perineal care after every incontinence . --apply skin barrier as ordered. Further review of the care plan also indicated that Proshield and Xenaderm are the protective skin creams to be used related to skin integrity.	F 314			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  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.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility has not provided an environment free of hazards for one resident (R2) who is totally dependent on staff for mobility and transfer by failing to: -- assess if the mechanical lift device (sit to stand lift device) is the appropriate device to ensure safety for R2 during transfer --revise plan of care for specific interventions to	F 323			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 6 address R2's multiple bruises.</p> <p>Findings include:</p> <p>R2 is 85 year old with diagnoses of CVA (cerebral vascular accident), CAD (coronary artery disease) , DM (diabetes mellitus) and Alzheimer's. Per record, facility identified that R2 has difficulties with long and short term memory recall and has impaired cognitive skills for decision making. R2 who is non-ambulatory, requires total assistance with all activities of daily living. R2's recent MDS (minimum data set) dated 7/1/08 showed that R2 scored on the following:</p> <ul style="list-style-type: none"> <li>--3 (severely impaired with decision making) for cognition</li> <li>--4/3 for bed mobility--(total dependence with 2 plus person physical assist)</li> <li>--4/3 for for transfer--(total dependence with 2 plus person physical assist)</li> </ul> <p>Observations made on 10/1/08 at 10:00 A.M., 12: 00 noon, and 1:00 P.M. showed that R2 was in the second floor dining room and was sitting in his reclining wheelchair .</p> <p>On 10/1/08 at 10:20 A.M., E3 (nursing supervisor) removed Kerlix wrap around R2's left arm. It was noted that R2 has multiple discolored brownish reddish spots , circular in shape on the left upper arm and left lower elbow. E3 stated that these multiple spots of reddish/brownish discoloration are petechiae. E3 also stated that these spots of discoloration might be related to R2's diagnosis of "Lichen Planus."</p> <p>Review of the incident reports showed that R2 was identified with the following:</p>	F 323			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 7</p> <p>--7/16/08-- found a scratch mark on the left medial knee</p> <p>--8/16/08--bruise on the left hand measuring 2x1cm with unknown etiology</p> <p>--8/30/08--skin tear on the right arm measuring 0.3 x 0.4 cm. Scratch mark was also noted on both arms, a small skin tear with very slight bleeding noted on the right arm, "blood was present on the fingernails of the left hand, scratched himself."</p> <p>--8/28/08-- pinpoint redness on upper arm, left hand, left upper hand and right upper hand</p> <p>9/17/08--bruise below right elbow measuring 3 x 3.5 cm, looks like ecchymosis</p> <p>--9/20/08--2 new bruises on the right forearm. bruise #1 measuring 2.5 cmx3.0 cm.; bruise #2 measuring 1.0 x 2.0 cm . "2 new bruises origin is unknown."</p> <p>R2 was observed during transfer from the reclining wheelchair to bed with a mechanical lift (sit to stand lift) by E4 and E5 (CNA-certified nurse assistants) on 10/1/08 at 1:00 P.M. During the transfer, E3 (nurse supervisor) and E6 (nurse) and Z1 (R2's family member) was at bedside. Before the transfer, E4 and E5 applied the harness of the sit to stand lift transfer device around R2's upper back, chest area and underarms. During the transfer process, R2 was observed being totally lifted by the harness of the mechanical lift device. R2 was also observed that during the time when R2 was pulled by the harness at a standing position, R2's legs had buckled up, thus pushing his knees towards the knee pads that was attached to the pole of the lift. E4 and E5 stated that R2's transfer capability had been always the same as observed. After the transfer, E4 and E5 immediately lifted R2's upper clothing to check back area. Together with</p>	F 323			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 8</p> <p>surveyor, E3 and E6 were checking R2's skin integrity on the back area. It was observed that R2 has a fresh red horizontal linear scrape mark approximately 4 inch long on the right mid back area. E4 confirmed that this red linear mark is something new and did not exist in the morning of 10/1/08 while R2 was provided with shower.</p> <p>Review of record showed no indication that there was an assessment or an evaluation made for the use of the mechanical sit to stand up lift transfer device to ensure safety during transfer for R2. Furthermore, review of R2's care plan showed no revised interventions to address R2's bruises with unknown origin. This concern was discussed with E1(administrator) and E2 (Director of Nursing) on 10/1/08.</p> <p>Together with E2 (Director of Nursing), R2 was observed again during transfer from bed to shower chair on 10/7/08 at 10:50 A.M.. R2 was transferred with the mechanical sit to stand lift device and in the same manner as observed on 10/1/08. E2 stated that R2 was not able to put weight on lower extremities and has to be lifted totally from upper torso with the sling/ harness of the device.</p> <p>When interviewed on 10/7/08 at 10:45 A.M., E7 (PT-physical therapist, rehab. manager) stated that any type of stander lift is appropriate as long as resident is able to bear weight. E7 also stated that R2 was not standing fully on lower extremities therefore it is causing excessive pressure to R2's underarms . E7 also added that for safety reason a (total lift mechanical transfer device) would be appropriate for R2.</p> <p>When interviewed on 10/8/08 at 10:30 A.M.,</p>	F 323			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 9 E8 (physical therapist) stated that he was informed by the facility on 10/2/08 to evaluate R2 for proper and safe transfer. As E8 stated, R2 was evaluated regarding the use of mechanical sit to stand lift on 10/2/08. E8 further stated that the mechanical lift device's harness was totally lifting R2 on the upper torso and it is causing excessive pressure on R2's underarms. E8 also stated that a (total lift transfer device) would be the appropriate transfer device for R2 to prevent any possible injury most specially bruising.  Review of the sit to stand manufacturer's specifications showed that this transfer device "is designed to assist caregivers in raising weight bearing residents to a standing position."  Review of facility's policy for the use of any mechanical transfer device indicated that therapy should assess for the use of transfer device.	F 323			
F 442 SS=E	483.65(b)(1) PREVENTING SPREAD OF INFECTION  When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to : ---ensure that a physician order for a diagnostic test to rule out scabies was implemented for 3 residents (R3, R5 and R6). ---follow appropriately it's policy on infection control for scabies outbreak in order to provide prompt treatment and preventive measures to	F 442			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 442	<p>Continued From page 10</p> <p>prevent cross contamination involving 2 of 3 nursing floors with total of 118 residents that were identified with either a confirmed diagnosis of scabies and or identified with signs and symptoms indicative of scabies.</p> <p>Findings include:</p> <p>Review of the facility's log for residents who received Elimite treatment (scabicide medication cream) between the dates of 9/15/08 to 9/30/08 showed the following :</p> <p>--50 of 51 residents on the second floor had received Elimite cream treatments; 18 out of 50 were identified with signs and symptoms indicative of scabies such as pruritus, rashes and some with papules. These symptoms were identified with approxiamtely same timeframe.</p> <p>--68 of 70 residents on the third floor had received Elimite cream treatments; 5 were identified with outbreaks of rashes and pruritus with same time frame.</p> <p>During the interview on 10/7/08 at 3:30 P.M., E2 (Director of Nursing) and E3(nursing supervisor) both stated that Elimite treatments were provided between the dates of 9/15/08 to 9/30/08 to 118 residents as indicated on the log. E2 added, residents on the second and third floor did not receive the Elimite scabicide cream simultaneously because of the lack of supply of this medication plus facility had considered the availability of staff to provide showers after the scabicide cream had been applied. E3 stated that it was on the day before a weekend (9/26/08) when she had first learned of R3's confirmed scabies . E3 also added that since it was the day before the weekend, prompt interventions and treatments to address scabies outbreak were not</p>	F 442			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 442	<p>Continued From page 11</p> <p>done until 9/29/08 (Monday). Both E2 and E3 confirmed that some residents did not received their Elimite treatment until 9/30/08. E2 and E3 also stated that 23 residents were identified with rashes and itchiness indicative of scabies on or around same time frame (9/12/08-9/30/08 ).</p> <p>Review of record showed that R4 was noted with rashes and pruritus on 9/12/08. R4 had an order for Elimite scabicide cream on 9/12/08 and this cream was applied on same day. R4 also has an order for scabies scrape which was done on 9/12/08. Result of the scrape revealed a positive confirmed scabies for R4. This result was made available on 9/14/08 to the facility by the laboratory. Further review of record showed that when R4 was confirmed positive with scabies, R4 had roommates in room (R7 and R8).</p> <p>Record showed that R7 also was noted with rashes and papules on abdomen and chest area on 9/12/08. As record indicated, R7 and R8 did not receive Elimite treatment simultaneously with R4 (Elimite received on 9/12/08). R7 and R8 had received Elimite on 9/14/08 which was 2 days after R4 had received her Elimite treatment. Furthermore, R4 was with R7 and R8 as roommates until 9/14/08. R7 and R8 were not placed on contact isolation even after a confirmed diagnosis of scabies with roommate R4. However, R4 was moved to another room and was placed on contact precautions on 9/14/08. E2 (Director of Nursing) confirmed during the interview on 10/7/08 that R7 and R8 go out of their rooms and joined other residents in the common areas (dining/activity room).</p>	F 442			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 442	<p>Continued From page 12</p> <p>Review of record showed that R3 has roommates (R5 and R6) in room. Record showed that R3 has had ongoing rashes and pruritus since 6/2008. R3 had been seen by a dermatologist, however on 9/15/08, the attending physician had ordered Elimite scabicide cream and to do scabies scrape for R3 due to continued rashes and pruritus. R3's scabies scraping was not done as ordered by the physician. As indicated on the record, R3 went out to her dermatologist clinic on 9/26/08 and was confirmed with positive diagnosis of scabies. R3 was moved to another room for contact precautions, on 9/26/08, but neither of the roommates R5 and R6 were placed on the same precautions.</p> <p>Review of record showed that R5 had rashes and pruritus noted on 9/10/08. R5 had received Elimite scabicide cream on 9/15/08 according to the physician order. R5 also had an order for scabies scrape on 9/15/08, however it was not done as ordered.</p> <p>Review of record showed that R6 had rashes and pruritus noted on 9/10/08. R6's physician ordered for Elimite scabicide cream and a scabies scrape due to the rashes and pruritus. Again, scabies scraping was not done as ordered by the physician.</p> <p>R3, R5 and R6 were roommates when they have signs and symptoms indicative of scabies. Scabies scraping was not done according to physician orders. As explained by E2 (Director of Nursing) on 10/7/08, the scabies scraping for R3, R5 and R6 was not done because of non availability of scraping kit that was supposed to be provided by the contracted laboratory to the</p>	F 442			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 442	<p>Continued From page 13 facility. E2 also added that R5 and R6 were not on contact precautions even after the fact that their roommate R3 was confirmed positive with scabies. E2 continued to state, R5 and R6 were out of their rooms, had stayed with other residents in the common areas such as the dining area /activity area even if R5 and R6 were symptomatic with scabies and had received scabicide treatments.</p> <p>As record indicated, the following residents were noted with signs and symptoms indicative of scabies and had received Elimite scabicide cream:</p> <p>---R9, with noted rashes on 9/15/08; Elimite applied on 9/16/08</p> <p>---R10, rashes on 9/18/08; Elimite applied on 9/19/08</p> <p>---R11, rashes on 9/15/08; Elimite applied on 9/17/08</p> <p>---R12, rashes and Elimite applied on 9/18/08; scabies scrape not done as ordered on 9/18/08</p> <p>---R13, rashes 9/29/08; Elimite applied on 9/29/08</p> <p>----R 14, rashes on /21/08; Elimite applied 9/29/08</p> <p>----R15, rashes on 9/22/08; Elimite applied 9/24/08</p> <p>----R16, rashes on 9/27/08; Elimite applied on 9/27/08</p> <p>----R17, rashes on 9/28/08 "left arm bleeding from scratching his rashes"; Elimite applied on 9/29/08</p> <p>-----R18, rashes 9/29/08; Elimite applied on 9/29/08</p> <p>----R19, rashes 9/29/08; Elimite applied on 9/29/08</p> <p>----R20, rashes and Elimite applied on 9/29/08.</p> <p>--- R21 was identified with rashes and itchiness</p>	F 442			

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(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 442	<p>Continued From page 14 outbreak on 9/12/08. Elimite was applied on 9/12/08.</p> <p>During a random observation on the second floor on 10/1/08 at around 10:30 A.M., E2 (Director of nursing) informed surveyor that she had just finished helping staff with providing showers to residents who had received Elimite treatment from 9/30/08. It was also observed that some CNAs were giving residents some showers on the second floor.</p> <p>Review of the facility's infection control for scabies indicated the following measures to reduce the spread of infection: --if 2 or more residents in different rooms are diagnosed with scabies, further precautions to reduce spread of infection will be taken such as requesting physician orders for scabicide treatment of all residents on the nursing floor at one time and scabicide treatment should be processed stat. --if resident who was confirmed with scabies has a roommate, the roommate should also be placed on contact precautions.</p> <p>As indicated on the above, the facility has failed to implement scabies scraping as ordered by the physician. Furthermore, residents were not provided with scabicide treatments simultaneously and were not processed timely. Lastly, roommates (R5 and R6; R7 and R8) were not placed on contact precautions even after their other roommates were confirmed positive with scabies. These concerns were discussed with E2 during the daily status meeting on 10/8/08.</p>	F 442			