Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005318	A. BUILDING: _____ B. WING _____	C 08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HLTH CR CTR-LOMBARD	2100 SOUTH FINLEY ROAD LOMBARD, IL 60148

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S 000	Initial Comments Investigation of Complaint Number 1975850/IL114723.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610c)4)A)B)C)F) 300.1210a) 300.1210b) 300.1210d)3)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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs; B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling; C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment; F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident; Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least	S9999		

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restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

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S9999	Continued From page 3 resident These Regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to ensure a resident was free from the use of side rails as a restraint, failed to assess a resident for the need of side rails, and failed to provide other less restrictive interventions prior to the application of side rails. This failure resulted in R1 becoming entrapped in the side rail and sustaining a 20 centimeter (7.8 inch) long, gaping laceration, down through the muscle to the bone. This applies to 3 of 4 residents (R1, R2, R3) reviewed for restraints in the sample of 4. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on March 28, 2019 at 4:30 PM with multiple diagnoses including altered mental status, rheumatoid arthritis, fracture of the patella (knee cap), muscle weakness, pneumonia, Vitamin D deficiency, osteoporosis, and history of fall. R1 was transported from the facility to the local hospital by paramedics on March 29, 2019 at 1:00AM. R1 did not return to the facility. R1's MDS (Minimum Data Set) dated April 5, 2019 shows R1 had required extensive assistance with bed mobility. All other ADLs (Activities of Daily Living) showed "activity occurred only once or twice" or "activity did not occur" during the observation period. R1 was occasionally incontinent of bowel and bladder. Other areas of the MDS were not completed due to the limited amount of time R1 was in the	S9999		

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facility.

R1's interim care plan dated March 29, 2019, failed to include a care plan or interventions for bed mobility and did not have any interventions in place for the use of assistive rail devices, side rails, or a pad sensor alarm.

Facility documentation shows R1 was admitted to the facility with four wounds including: a skin tear on the right upper shin measuring 2 cm. long x 1 cm wide x no depth documented (0.78 inches x 0.39 inches), a right lower shin skin tear measuring 3.5 cm long x 3.0 cm wide x 0 cm deep (1.37 inches x 1.1 inches x 0 inches), a right lateral lower extremity skin tear measuring 1.0 cm. x 1.0 cm. x no depth documented (0.39 inches x 0.39 inches), and a left upper shin skin tear measuring 3.0 cm x 2.0 cm. x no depth documented (1.1 inches x 0.78 inches).

R1's Nursing Admission Assessment dated March 28, 2019 and completed by V9 (RN) shows R1 was oriented to person only and had garbled speech. R1's range of motion was within normal limits, and R1 had no assistive devices. R1 had bilateral lower extremity weakness. R1's Fall Risk Assessment, completed during the admission assessment shows R1 had intermittent confusion, had a history of falls in the past three months, with the date of the last fall on March 19, 2019. The fall risk assessment showed R1 had a balance problem while standing and walking and decreased muscular coordination. R1 had multiple predisposing diseases. R1's fall risk score was 16, meaning R1 was a high risk for falls.

R1's nursing admission assessment did not have any documentation to show a side rail

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assessment was completed for R1.

On August 19, 2019 at 11:49 AM, V9 said, "When we admit a resident, if we notice the resident is only alert times one we put the side rails up, and a pad sensor bed alarm on. It is at the discretion of the nurse as to how we put the side rails." On August 21, 2019 at 9:55 AM, V9 said, "I did [R1's] assessment around 5:00 PM on March 28, 2019 and that is when I put up the side rails because she had tried to get out of the bed while I was doing the assessment."

On August 19, 2019 at 11:11 AM, V2 (DON-Director of Nursing) said the facility does not have a policy regarding the use of side rails. "Usually therapy or restorative will make the determination if side rails are needed. We don't have side rails here, we call the side rails assistive devices. All the beds in the facility have side rails and it's just a matter of if the side rail is up or down. I think the side rail assessment is part of the admission nursing assessment."

On August 19, 2019 at 2:16 PM, V5 (Restorative Nurse) said, "Typically we aren't supposed to use side rails. Side rails are more for restraints. As a restorative nurse, I don't have any sort of assessment for the use of side rails. Per policy, both siderails aren't supposed to be up because that's considered a restraint. I don't do anything as far as the use of a side rail. The side rails are already attached on the bed the way they are. When someone comes from the hospital, there's no assessment per se to see who goes into the room with the side rails."

On August 19, 2019 at 4:24 PM, V7 (Director of Rehab) said, "The side rails are ordered by the facility. We work with what's in place on the bed,

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we don't make the recommendations. We do assess for bed mobility, but we do not do an assessment for the safety or use of a side rail assistive device."

On August 20, 2019 at 9:31 AM, V1 (Administrator) said, the facility does not have any documentation to show an assessment had been completed for the use of the side rail assist devices for R1. V1 could not say what specific criteria had been met to determine the need for the side rails for R1.

On March 29, 2019 at 2:05 AM, V8 (Nurse) documented: "Around 12:30 AM, while doing rounds to [R1's room], noted patient screaming. Went to check on her. Noted large amount of blood on the floor near her bed. She was sitting on the bed. Her right leg was caught on the assistive device (bottom part) and her left leg caught on the middle part. Bed alarm was not sounding. Her right leg skin was scraped. Called for help right away. Co-nurses and supervisor came. 3-11 RN able to move assistive device up to release legs. Supervisor applied pressure dressing to right leg. Bleeding stopped and applied steristrip. [R1] verbally responsive. Open area 20 x 4. Depth 1 cm., blood pressure 158/79, pulse 104. While supervisor doing [applying treatment] to her right leg, patient noted resisting. 3-11 RN notified [V12-Physician] and called family. Patient out to ER thru 911 per MDs order."

Paramedic documentation shows they arrived at the facility at 12:59 AM on March 29, 2019 and transported R1 to the local hospital at 1:12 AM.

Hospital documentation dated March 29, 2019 at 1:35 AM by V16 (Physician) showed, R1 "Got her

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legs caught in a bar causing extensive lacerations to her right lower extremity, which go all the way down to the bone, and involved the muscle, and she also has lacerations to the anterior aspect of her left lower extremity and right calf area. There is a very deep right anterior lower leg laceration extending almost the entire length of the tibia on the right side and down through the muscle down to the bone, no foreign bodies identified, the wound is gaping open and actively bleeding. This laceration is approximately 20 cm [7.87 inches], there is a 4 cm [1.57 inches] U-shaped skin tear on the right calf which is superficial, epidermis only. There are 9 cm [3.5 inches] worth of lacerations to the anterior aspect of the left leg which extends through the dermis, one is proximal, and one is distal, distal pulses and distal motor and sensory function grossly intact, and there is bruising and hyperpigmentation to the lower legs bilaterally."

Emergency Department Patient Summary dated March 29, 2019 shows, "Laceration repair: Simple (single layer only) repair of bilateral lower extremity lacerations were performed. Total length of wounds repaired was 29 cm [11.4 inches]. Greater than 20 sutures were placed to reapproximate the wounds. Final diagnosis: #1 acute lateral lower extremity soft tissue injuries/lacerations totaling 29 cm; sutured, #2 dementia, #3 bilateral lower extremity contusions."

On August 19, 2019 at 11:49 AM, V9 (RN-Registered Nurse) said, "I remember the situation with [R1]. I was the admitting nurse that day, so I did her admission assessment, but I was not assigned to her care. The night nurse found her, and she called us and we all went to the room to help her. When we went in the room,

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there was a lot of blood on the floor, and a cut on the left side of her lower leg on her shin. Her legs were caught in the side rail. Her head was at the head of the bed, and that's why the alarm didn't go off. We cleaned her legs and removed them from where they were caught. After we cleaned her we called 911 and sent her to the hospital. We called 911 because there was a lot of blood on the floor, not due to any behaviors she was having. I don't know when the last time was that someone saw her."

On August 19, 2019 at 3:28 PM, V9 (RN) went to an empty resident room and demonstrated the type of bed R1 was using at the facility and the type of side rails that were in place when her legs became entrapped in the side rail. V9 demonstrated the side rail placement on R1's bed at the time of the incident. V9 showed bilateral side rails and said R1's side rails were in the up position on each side of R1, with both rails extending from approximately her chest to her mid-thigh or knee. V9 said, "We found her in the bed with her legs caught between the rails. Her legs were very skinny and fit between the rails. Her one leg was hanging down low and was hitting the sharp part of the side rail and it was bleeding a lot. Mostly in this facility everyone gets side rails and the rails will be half rails like we used on [R1]. It is up to the nurse's discretion how to place the rails, especially if we think they will try to get out of bed. She could not remove the side rail on her own." At 4:18 PM, V9 said, "The 20-centimeter laceration that happened from the side rail was not one of the same skin tears I assessed when I did [R1's] initial assessment, it was a new wound."

On August 19, 2019 at 3:33 PM, V8 (Nurse) said, "I remember [R1]. I was the incoming nurse. I

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heard her screaming. She was sitting at the edge of the bed with her legs between the rails of the side rail. There was a lot of blood all over the floor. I called a bunch of other nurses. They had to release the side rail to get her legs out."

On August 20, 2019 at 2:52 PM, V14 (RN) said, "We heard someone calling out for help, with her foot caught underneath the siderail. I do remember there being a lot of blood. I was one of the people who put the steri-strips on to control the bleeding. I remember the wound was deep. I know the incident happened over an hour after nurse handoff. She had dementia. I do remember asking to move her to a bed closer to the nurse's station, so I could keep an eye on her and I was told that the bed we had available was for a resident coming the next day. I wanted her closer to me because she was a fall risk and I didn't want her getting out of the bed. The bed she was in was behind a wall and I could not directly see the resident from the hallway."

On August 20, 2019 at 3:07 PM, V12 (Physician) said, "I came and saw the resident the night R1 was admitted to the facility, and I talked with the family. I believe I saw R1 around 9:00 PM. R1 was not acting aggressive or inappropriate at that time. R1 was easily confused, and R1 was trying to get out of the bed, so the side rails were used. I think the nurse used his own judgement to put up the side rails. R1 did get up and go to the bathroom on R1's own. I don't know the details of the facility's protocol for the use of side rails. I think it's not a bad idea to have a protocol, so all nursing staff are on the same page with using the side rails and trying less restrictive measures like mattress bolsters, low beds or floor mats. The laceration on R1's leg was caused by the rail or something on the bed."

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On August 20, 2019 at 3:20 PM, V13 (RN) said, "I was the supervisor that night of [R1's] accident in March. When I came that night they had a bunch of admissions. I was checking to see what I can help with, and they said help with the care plans. Somebody called me to see [R1], and they said the patient was stuck in the side rail. I got to the room, and both of R1's legs were stuck in the side rails. One was in the upper part of the rail, and the other leg was stuck in the lower part. There was a lot of blood everywhere. The one leg was caught in the lower, section that was tight; the leg with the biggest laceration. I yelled for them to get the treatment cart. Someone had to pull the side rail off to free R1's leg. I tried to put the steri-strips on, but they wouldn't stick because it was a big laceration. I could see some white in the deep wound, but I'm not sure if it was the bone. I could see some ligaments. They said R1 was confused when R1 arrived. I told them to call 911 because it was a lot of bleeding and they will stitch it right away at the hospital. I think that when R1's leg got caught, it was rubbing and rubbing, and it caused the laceration. R1 was sitting nicely in the middle of the alarm, so it wasn't making a sound. The side rails were up because R1 had a history of falls and was trying to get out of the bed. That's just an intervention we put in place, put up the side rails and put on a bed alarm. They tell us if they have a history of falls, or try to get up without assistance, that's what we should do. When R1's legs were through side rails, R1's foot was not touching the ground. The hospital told us that it was an acute laceration injury. I don't remember R1 being combative. R1 was combative when we were trying to treat R1's laceration. 911 was called strictly for the laceration, not due to R1's behavior. The bed and the floor were full of

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blood. The whole side of the bed on the floor, the side rails and the side of the mattress were full of blood. R1 had a lot of blood on R1's hands. Alert residents can have one side rail up to help them move about their bed and bathroom. If the resident isn't alert, two side rails will be more appropriate, the half side rails, to keep the resident in the bed. We don't have to do any special documentation for the use of a restraint. Both side rails were up, full rails from R1's chest to R1's thighs."

2. On August 19, 2019 at 3:23 PM, R2 was sitting in the wheelchair next to R2's bed with family at R2's bedside. V4 (family member) said R2 sleeps in the bed all the time with the side rails up, from R2's shoulders to R2's thighs. "The side rails and pad sensor alarm have been in place since the day (R2) was admitted. I don't remember signing any consents for the side rails or pad sensor alarm, but I was told they were in place to prevent (R2) from falling or getting out of the bed. (R2) cannot move the side rail by (R2's) self." R2 was confused, not interviewable, and not able to demonstrate the use of the bed side rails.

On August 20, 2019 at 12:05 PM, R2 was lying in bed. R2's bilateral side rails were up on both sides of R2's bed, from R2's shoulders to R2's thighs.

The EMR shows R2 was admitted to the facility on August 3, 2019 with multiple diagnoses including left arm humerus (long bone of upper arm) fracture, traumatic subdural hemorrhage, left tibia (lower leg bone) fracture, muscle weakness, heart failure, acute bronchitis, COPD (Chronic Obstructive Pulmonary Disease) with acute exacerbation, fall, atrial fibrillation,

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hypertension, presence of cardiac pacemaker, hemiplegia following cerebral infarction, diabetes, chronic kidney disease, major depressive disorder, lack of coordination, cardiomyopathy, pressure ulcer of right buttock, pressure ulcer of left buttock, insomnia, and difficulty walking.

R2's MDS dated August 16, 2019 shows R2 has severe cognitive impairment, is totally dependent on facility staff for bathing, and requires extensive assistance with all other ADLs. R2 is incontinent of bowel and bladder. The MDS shows R2 walked in the room and corridor only once or twice. The MDS does not show the use of a bed rail or sensor alarm for R2.

As of August 19, 2019, at 5:58 PM, the facility did not have interventions on R2's care plan for the use of assistive side rails or a sensor pad alarm in the bed. R2's care plan for extensive assistance for bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene, and bathing, effective August 13, 2019, shows interventions with a goal date of November 13, 2019 that include: While in bed, assist R2 to turn/reposition self. Use pillows and foam wedges to maintain position. Transfer using the transfer board/lift devices (specify) (no device specified). PT to evaluate; set goals for distance/support; provide appropriate assist devices.

R2's admission nursing assessment, dated August 3, 2019 shows R2 is a high fall risk. R2's nursing admission assessment did not have any documentation to show a side rail assessment was completed for R2.

3. On August 20, 2019 at 8:22 AM, R3 was lying in bed. Bilateral side rails were in the up position,

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	IL6005318	A. BUILDING _____ B. WING _____	C 08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HLTH CR CTR-LOMBARD	2100 SOUTH FINLEY ROAD LOMBARD, IL 60148

(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) COMPLETE DATE
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extending from R3's chest to R3's upper thighs. V15 (CNA-Certified Nursing Assistant) was present in the room delivering a meal tray. V15 said, "The side rails are in place like that to keep (R3) from getting out of the bed. Sometimes (R3) puts his legs over and tries to get out of the bed and to stand up."

The EMR shows R3 was admitted to the facility in December 2018 with multiple diagnoses including COPD, hypertension, abnormal gait and mobility, lack of coordination, abnormal posture, pain in right knee, dementia, chronic kidney disease, depression, muscle weakness, difficulty walking, and lack of coordination. R3 was recently readmitted to the facility on June 4, 2019 from the local hospital with diagnoses of dementia with aggressive behavior, hypertension, arthritis, diabetes, and alert and oriented to name only.

R3's MDS dated July 17, 2019 shows R3 has moderate cognitive impairment, is totally dependent on facility staff for transfers between surfaces and bathing, requires extensive assistance with bed mobility, locomotion on and off the unit, dressing, toilet use, and personal hygiene. R3 is always incontinent of bowel and bladder. The MDS does not show the use of a side rail for this resident.

As of August 20, 2019, at 3:07 PM, the facility did not have care plan interventions for R3 for the use of side rails, or any other interventions to prevent R3 from exiting the bed.

The bed manufacturer's undated User Manual shows: "Patient entrapment with Assist Bar may cause injury or death. Mattress must fit snugly within the mattress keepers to prevent patient entrapment. Use only a mattress of

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recommended specifications with the bed. Monitor patient frequently. Assess the needs of the resident prior to using the Assist Bar. Patient Safety: Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe. Historically, physical restraints (such as vests, ankle or wrist restraints) were used to try to keep patients safe in health care facilities. In recent years, the health care community has recognized that physically restraining patients can be dangerous. Although not indicated for this use, bed rails are sometimes used as restraints. Regulatory agencies, health care organizations, product manufacturers and advocacy groups encourage hospitals, nursing homes and home care providers to assess patients' needs and to provide safe care without restraints. Potential risks of bed rails may include: Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. More serious injuries from falls when patients climb over rails. Skin bruising, cuts, and scrapes. Inducing agitated behavior when bed rails are used as a restraint. Feeling isolated or unnecessarily restricted. Preventing patients who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. When bed rails are used, perform an on-going assessment of the patient's physical and mental status; closely monitor high-risk patients. Consider the following: Lower one or more sections of the bed rail, such as the foot rail. Use a proper size

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mattress or mattress with raised foam edges to prevent patients from being trapped between the mattress and rail. Reduce the gaps between the mattress and side rails."

The facility's undated Admission Contract shows: "Every resident will be individually assessed upon admission regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay at Facility. Facility does not use side rails as a restraint. Side rails have been removed from the bed as a result of a government recommendation regarding the dangers of bed entrapment. Some of our residents benefit from an "assist device" which enhances the residents' need for mobility to turn in bed without assistance or exit the bed on their own. These "assist devices" meet requirements to prevent entrapment; however, these are only used if the Resident's assessment results meet specific criteria and are not considered a restraint. Resident or Resident's Representative understand and agrees with this policy."

The facility's Physical Restraints Policy, revised February 28, 2014 shows the facility, "Supports the resident's right to be free from physical restraints. Further, the facility will assess and determine that a device is required to treat a resident's medical symptom prior to application and periodically thereafter. Procedure: 1. Complete the Restraint Assessment prior to application of the device. 2. Obtain a physician order specifying the medical necessity for the restraint and the timeframe for its use. A. The type of physical restraint. B. The interventions utilized or considered prior to the physical restraint and the impact of these interventions. C. The length of time the physical restraint is to be

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S9999	Continued From page 16 applied. 3. Notify the family and provide education regarding the risks and benefits related to the use of restraint. 4. Assess the effectiveness of the restraint quarterly and with a change of condition. Make changes to insure the least restrictive device is utilized. 5. Develop the care plan to identify restraint use, risks, benefits, timeframe for use, restraint reduction and interventions to prevent decline and/or to maintain the highest practicable physical, psychosocial and mental well-being. 6. The resident will be routinely released from the device based on the plan of care to provide: a. 1:1 supervision, b. Repositioning and pressure relief, c. To meet toileting or other care needs, d. During meals and activities as indicated by the plan of care." (A)	S9999		