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	IL6005318	A. BUILDING: _____ B. WING _____	C 05/11/2016

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LEXINGTON HLTH CR CTR-LOMBARD	2100 SOUTH FINLEY ROAD LOMBARD, IL 60148

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S 000	Initial Comments Licensure Findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

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These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to implement individualized fall risk interventions for a resident identified as a high fall risk.

This applies to one of four residents (R4) reviewed for falls.

This failure resulted in R4 sustaining spinal cord injury.

The findings include:

R4 is no longer in the facility. The facility's face sheet for R4, dated May 11, 2016 shows R4 was admitted to the facility from a local hospital on May 9, 2016 at 1:00 PM, with multiple diagnoses, including: history of falling, other abnormalities of gait and mobility, pain in right knee, hemiplegia following cerebral infarction, muscle weakness and low vision one eye.

The facility's handwritten hospital report sheet, unsigned, and undated shows R4 had sustained a fall at home with no injury, had a history of CVA (cerebrovascular accident), difficulty ambulating, right side weakness, and needed a walker with one person assistance.

Emergency room documentation dated May 9, 2016 at 10:12 AM shows, "77 year old male with multiple medical problems including prior CVA. He has had difficulty ambulating since February 2014 due to right leg weakness. More recently he has basically been in a wheelchair with minimal

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transfer/ambulation. ...At 4:00 AM R4 fell in his bathroom trying to get from wheelchair to toilet. He landed on his bottom."

E8's (RN-Registered Nurse) admission assessment of R4, dated May 9, 2016 shows R4's last fall was on May 9, 2016 and R4's fall risk score was 10. The fall risk assessment shows "High Risk if score of 10 or above. Fall prevention protocol initiated." E8 did not document R4's history of CVA or any musculo-skeletal weakness.

R4's care plan created by E8 on May 9, 2016 at 3:52 PM shows: "At risk for falls related to DM (diabetes), HTN (hypertension), history of head injury. Interventions included: "Use alarm to monitor attempts to rise as ordered and check for proper functioning when in use, remind R4 to call when needing assistance, place call bell/light within easy reach."

On May 10, 2016 at 4:05 PM, E4 (RN-Registered Nurse) was standing in the hall by the nurses station, in the center of the unit. E4 pointed to R4's room at the far end of the hall. E4 said, "R4 was admitted on May 9, 2016 before I started my shift. I was told in shift report R4 came from the local hospital as a direct admit because he fell at home, and he was a high fall risk. The nursing assessment done on the shift before me shows he has a fall risk score of 10, which means he is a high fall risk, so the fall prevention protocol should have been initiated. That means bed and chair alarms should be put in place. We try to get alarms put on residents so if they try to get up we know. R4 did not have a bed or chair alarm. R4 did not use the call light before he ambulated to the bathroom. My shift started at 3:00 PM, and I know of three times R4 tried to ambulate by

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himself. R4 fell on the third attempt, and that was when he hurt himself. On May 9, 2016 around 5:00 PM, I was standing in the hallway by the nurse's station and saw him laying on the floor in front of his bathroom door. When I got to his room he was laying between the bathroom door and the doorway to his room with a pool of blood under his head. He seemed paralyzed. He could not feel painful stimuli. We called 911. R4 did not use the call light before he fell. He would have benefited from a room closer to the nurse's station" (a dining room, storage room and 6 residents rooms are located between the nurse's station and R4's room). E4 acknowledged no new interventions were put in place for R4 after his multiple attempts of ambulating without assistance.

On May 10, 2016 between 5:10 PM and 5:33 PM, E5 (CNA-Certified Nursing Assistant) said, "I started at 2:00 PM on May 9, 2016. I did not know R4's transfer status. Usually the nurse informs me how a resident transfers, but no one reported that to me on that day. I only knew what R4's daughter told me; that he needed a wheelchair or walker and assistance. I was helping a CNA in a different resident's room, and E7 (Restorative Nurse) came and told me she was getting an alarm for R4 because he kept getting up. That was about 90 minutes before R4 fell. She never put the alarm on. I thought it would have been done already. If he had an alarm on, I would have known he was out of bed. R4 was up out of bed without assistance 3 times that I was aware of from the time I started at 2:00 PM until he fell around 5:00 PM. Two times he used the call light but then got up anyway before I got there. I did not try giving him a urinal. The fourth time he fell was the time when we found him on the floor." E5 stood in R4's room and

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demonstrated the position R4 fell, stating R4 was found on the floor between the bathroom door and the entry door to the room. E5 said R4 was laying in a pool of blood (E5 drew a 3 foot circle with her finger to indicate where the blood was located under R4). E5 said R4 had walked to the bathroom by himself, but left his walker over the toilet, had his pants pulled down around his ankles and had socks on.

On May 11, 2016 at 9:07 AM, E7 (Restorative Nurse) said R4's daughter was walking into the facility on May 9, 2016. She had two pairs of shoes with her. "We saw R4 was standing up in the bathroom, and I assisted him to bed. I explained to R4's daughter to use the shoes with good grip on the bottom. I told the daughter I was going to tell the nurse R4 needs an alarm. I informed E8 (RN) and E9 (Supervisor) that R4 needed an alarm. I informed E5 (CNA) that R4 had an unsteady gait and he was a fall risk. I could tell by R4's unsteady gait and confusion he was a fall risk. When I informed E8 and E9 about the alarm, they should have retrieved the alarms. I clocked out around 3:35 or 3:40 PM."

On May 11, 2016 at 9:25 AM, E2 (DON-Director of Nursing) said the facility lacks a high fall risk protocol for nurses to follow. "The nurses should use the interventions on the fall care plan as the fall protocol." E2 provided a copy of a policy entitled Fall Management dated June 4, 2014. The policy shows: "The facility observes the physical and cognitive function of each resident to identify factors that place them at risk for falling. A care plan is developed defining those risks and interventions are implemented."

On May 11, 2016 at 8:08 AM, Z1 (Physician) said, "R4 has been a resident at the facility before.

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Last time I saw him was November 2015. He had right leg weakness and he ambulated with a walker. I know he fell at home on May 9, 2016 on his butt. He did not have a head injury. R4's daughter wanted him admitted to the facility for rehabilitation. Later that day he fell at the facility and sustained a spinal cord injury. In hindsight, an alarm should have been in place and they would have caught him sooner before he fell. The spinal cord injury was a direct result of the fall."

On May 11, 2016 at 9:47 AM, Z2 (Physician) said, "I was the admitting physician for R4 in the emergency room after his fall at the facility. He came in with a laceration on his forehead, spinal cord shock and a spinal cord injury. He incurred severe, permanent harm and is now a quadriplegic due to the fall. I was told by Z3 (family member) that she witnessed R4 getting up without assistance at the facility, alerted nursing staff and was assured a safety alarm would be put in place, so she went home."

On May 11, 2016 at 9:59 AM, Z3 (family member) said, "R4 fell on the morning of May 9, 2016 at home and he was going to the facility because he was a fall risk, was weak, and wanted long-term care. I went home to get slippers and when I came back, I saw him walking alone to the bathroom. I yelled and E7 (Restorative Nurse) ran down to the room and helped him back to bed. E7 told me she was getting an alarm for him. I left at 3:00 PM thinking he was safe, and two hours later they called me and told me he was being taken to a trauma center. They said they could try to surgery on him but he would end up being ventilator-dependent and require a feeding tube. He is paralyzed from the neck down and we had to put him in hospice."

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(A)

Comments to Licensure Findings
Lexington of Lombard
May 24, 2016

The facility denies that is was deficient with regards to the requirements of:
300.610a
300.1210b
300.1210c
300.1210d6
300.324a

The facility does have written policies and procedures governing all services provided by the facility; provides the necessary care and services to attain/maintain the highest practicable physical, mental and psychological well-being of the resident in accordance with each resident's comprehensive care plan. The facility provides adequate and properly supervised nursing and personal care; assures direct care have access to the resident's plan of care communication to direct care staff and takes all necessary precautions that the resident's environment remains as free of accident hazards as possible.
The facility submits the following timeline of events that occurred throughout the admission process of a 3.5 hour stay for R4 which reveals a higher than adequate level of supervision; R4's fall was not **ABUSE OR NEGLECT.**

R4 admitted to the facility directly from ER. R4 is alerted and oriented X3, living at home with his wife, ambulates with use of a walker and uses a wheelchair. R4 has history of CVA and sustained a fall at home in the bathroom during the early morning.

1. 5/9/16 around 1:00 PM R4 admitted to the facility accompanied by his daughter
2. 1:00- 1:45 PM admission process initiated R4 under direct supervision by staff nurse and daughter
3. **Fall Risk Assessment Completed** (Attachment 1-1C)
4. **Fall Interventions: bed assignment next to bathroom and instruct on use of call light**
5. 1:35 PM R4 request toileting **provide walker supervised** ambulates to bathroom
6. 2:15 PM R4 given lunch daughter remains at bedside R4 request toileting with walker **staff provide supervised toileting**
7. 2:30 PM **wheel chair given to R4** daughter remains at bedside
8. 2:45 PM restorative nurse observes patient going to bathroom **provides assistance educations R4 and daughter on footwear; 2nd restorative nurse gives report to next shift C.N.A**
9. 3:00-3:30 PM shift to shift report with walking rounds **staff observe R4 in bed**
10. 3:15 PM daughter request alarm discusses with restorative nurse; reports to staff nurse admission process still in progress; intention was to get alarm from central supply and call placed to the on call physician for to verify orders.
11. 3:45 PM social service designee conducting interview R4; **direct supervision by staff**
12. 4:00 R4 activates call light request toileting **staff assist supervision** R4 ambulates to bathroom
13. 4:30 PM nursing assistant **rounding** on unit R4 observed lying in bed **call light within reach**
14. 4:45 PM staff working on admission interim **Fall Care Plan** (Attachment 2-3-3G)
15. 5:15 PM R4 observed on the floor near bathroom staff responded
16. 5: 45 PM R4 transferred to ER

Supervision facility provided to R4 during 3.5 hour stay was more than adequate; compliance with Fall Management Policy and fall interventions were implemented.
The facility requests that the incorrect statement be removed from public record made by surveyor on page 5 of licensure findings: "3 times R4 tried to ambulate by himself. R4 requested toileting and received assistance from staff as well as his daughter.

Attachment B
Imposed Plan of Correction

The facility strongly disagrees with the inference that an alarm would have prevented the fall. **On the contrary referencing an article in the Journal of Nursing Care Quality: *"Little evidence exists to demonstrate alarms prevent falls. Alarms can be counterproductive by fostering a false sense of security creating a reactive rather than proactive paradigm".*** (Attachment 4)
2nd Article: State Nursing Homes Pilot Alarm-Free initiative by Lisa Chedekel; (Attachment 5-5B).

While this facility still employs the use of alarms to alert staff that someone is getting up "a response mechanism"; alarms do not necessarily prevent falls but are a standard of practice expectation of IDPH. The staff did respond immediately. The facility was still in the midst of admitting R4 and developing his plan of care. It is unreasonable to expect that all things related to the development of an initial plan of care occur simultaneously and despite that, the facility did meet the regulatory requirements for F 323. An alarm would not have prevented R4's fall and therefore the fall was an unavoidable and unfortunate accident. We respectfully request the findings be dropped.

Respectfully Submitted
Administrator
Danielle Gilbert

Comments Reviewed

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Lexington Health Care, Lombard

DATE AND TYPE OF SURVEY: May 11, 2016

Complaint Investigation 1672498/IL85365

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.

Section 300.1210 General Requirements for Nursing and Personal Care

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.1210 General Requirements for Nursing and Personal Care

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.*

THIS WILL BE ACCOMPLISHED BY:

I. A committee consisting of, at a minimum, the Medical Director, Administrator and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

A. Recognition of situations that could be interpreted as abusive or neglectful.
B. Appropriate reporting procedures for staff.
C. Appropriate and thorough investigations of alleged abuse or neglect.
D. The facility's responsibilities to prevent further potential abuse while investigation is in progress.
E. The facility taking appropriate corrective action when an alleged violation is verified.

II. The facility will conduct mandatory in-services for all staff within 30 days that addresses, at a minimum, the following:

A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this plan of correction.
B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
C. Documentation of these in-services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the administrator's office.

III. The following action will be taken to prevent re-occurrence:

A. The above in-service education will be reviewed with all staff on a regular basis.
B. Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations (reporting and follow-up) are followed.

IV. The Administrator and Director of Nursing will monitor items I through III to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten days from receipt of the Imposed Plan of Correction.

AA/6/9/2016