STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145899	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEXINGTON OF ORLAND PARK	**14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify a Pressure Injury for an incontinent resident at increased risk for pressure injury. The facility also failed to monitor and provide weekly wound documentation for 2 of 4 residents (R1 and R2) reviewed for pressure injury. As a result of this failure, R2 was initially discovered with a stage 4 Sacral pressure injury exposing the bone, with slough and undermining. The Findings Include: 1). The Face Sheet documents that R2 a Caucasian female was admitted on [DATE] without any pressure wounds. Care Plan dated [DATE] said R2 was at risk for altered skin integrity due to impaired mobility and incontinence and listed as an intervention to monitor skin daily during care. R2 also had care plans dated [DATE] for incontinence of bowel and bladder and required extensive assistance with activity of daily living skills due to immobility. physician progress notes [REDACTED]. The Facility Wound Care assessment dated [DATE] says a stage 4 sacral wound was discovered on this day. The measurements were as follow; 3.0 cm in length by 3.60 cm in width by .8 cm in depth with sloughing and bone exposure. The Wound Care Doctors Notes (Initial Wound Evaluation and Management Summary) dated [DATE] says R2 was seen for a stage 4 sacral wound of one day duration measuring 4 cm in length by 4 cm in width by .9 cm in depth with undermining of 1.5cm by 12 o' clock and 30 percent slough with bone exposure. On this day the large wound was debrided. On [DATE] at 9:02AM, V7(Wound Care Nurse) said it is a problem to initially discover a stage 4 sacral wound with bone exposure on a resident who is incontinent of bowel and bladder. On [DATE] at 10:06AM, V20(Wound Care Physician) said he saw R2 for the first time on [DATE] and she had a stage 4 sacral wound exposing the bone with slough and undermining. V20 said the facility did not provide a good explanation for discovering a wound of this size and depth on an incontinent resident. There is no good explanation. 2). The Face Sheet documents that R1 was admitted on [DATE] with the following pertinent Diagnosis: [REDACTED]. Progress Note dated [DATE] says R1, [AGE] year old black female was readmitted from the hospital on [DATE] and has the following Diagnosis: [REDACTED]. Head to toe skin assessment was done. Left knee scab/lower leg scab, Discoloration to the bilateral bottom foot. Right heel Deep tissue injury and stage 2 pressure ulcer to the coccyx area. Resident is susceptible to skin breakdown related to co-morbidities and decreased mobility. Family called . Staff will continue to monitor. Weekly Wound Assessments were reviewed and documentation showed the right heel was assessed on [DATE] and then on [DATE]. This was more than 3 weeks and the wound deteriorated. The Pelvic region wounds were assessed on ,[DATE], ,[DATE] and [DATE], again more than 3 weeks and the pelvic wound deteriorated. On [DATE] the Wound Care Doctors Notes (Initial Wound Evaluation and Management Summary) were reviewed. The notes document multiple wounds: site 1 unstageable sacral necrosis, site 2 left ischium unstageable necrosis and site 3 unstageable deep tissue injury to the left heel. There was no documentation about a right heel wound. Progress Notes dated [DATE] states R1 was hospitalized and returned on [DATE] with wound decline. Progress Notes review from [DATE] to [DATE] states, R1 returned on hospice, the wounds continued to decline and R1 expired on [DATE]. Care Plan dated [DATE] for skin alteration stage 2 pressure ulcer and deep tissue injury was reviewed. Interventions included: treatment as ordered, weekly documentation and monitor skin daily and report changes. On [DATE] at 9:02AM, Z7(Wound Care Nurse) said weekly documentation is done on all residents wounds. On [DATE] at 12Noon , V7 said this is all the documentation they have for R1.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE