STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145678	A. BUILDING _____ B. WING _____	C 11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF SCHAUMBURG	**675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193**

(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 Complaint Investigation 1494503/ IL72490 Refer to F323 Incident Investigation IRI of 10/01/2014- IL 72486-No deficiency	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 failed to monitor and supervise residents to prevent falls. This failure applies to two of nine residents (R2 and R4) reviewed for falls in a sample of nine. As a result, R2 who is cognitive impaired was left unattended while in the toilet room and fell hitting her head. This caused a traumatic brain hemorrhage and skull fracture. Findings include: 1. R2's admission face sheet on 10/9/14 notes: R2 was admitted to facility on 9/15/13 with diagnoses of depression, vascular dementia, muscle weakness, difficulty walking, and cognitive communication deficits.	F 323		

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

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F 323	Continued From page 1 The incident report dated 6/24/14 notes: R2 was left unattended on the toilet by E5 (certified nursing assistant - CNA). While E5 was attending to another resident in the adjacent room, E5 heard a door slam and noted R2 in the hallway falling. R2 fell before staff could reach her. R2 struck the back of her head sustaining a 3 centimeters (cm) X 3 cm bump to the back of her head and a 2 cm X 2 cm bump to the right forehead. R2 was transferred to the hospital. R2's hospital records dated 6/24/14 notes: R2 was diagnosed with traumatic brain hemorrhage, acute respiratory failure, skull fracture, right acute on chronic subdural hematoma resulting from fall. R2's care plan on 10/17/14 notes R2 requires extensive assistance with activities of daily living (ADL) such as bathing, toileting and ambulating; due to decreased strength, decreased endurance, and impaired balance. R2 requires 1 person physical assist for ambulation and toileting. R2's care plan also notes R2 requires verbal cues and supervision with ADL's due to visual deficit and poor cognitive skills. R2's Restorative Nursing Program Evaluation dated 5/21/14 notes: R2 requires a lots of cueing, redirection, and prompting to participate and complete a task. R2 also requires extensive assistance with bed mobility, transfer, dressing, toileting, and personal hygiene due to poor cognitive skills, decreased strength, and decreased endurance. R2 needs human assistance to stabilize during transitions and ambulation. On 11/5/14 at 11am, E5(CNA) stated she was	F 323		

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F 323	Continued From page 2	F 323		

assigned to provide care to R2 at the time of the incident. E5 stated she was not aware that R2 could get up and walk independently. E5 stated she was not familiar with R2's level of functioning. E5 stated that following this incident she was told by E2 (DON /director of nursing) that R2 should only be toileted in the bed, not on the toilet.

On 11/5/14 at 2:05pm, Z1 (attending physician) stated R2 is confused and that someone should have been watching R2 to prevent fall.

2. R4's admission face sheet on 10/17/14 notes R4 was admitted to facility on 6/16/14 with diagnoses of dementia, muscle weakness, and glaucoma.

The facility's incident log for the period of 6/1/14 through 10/31/14 notes: R4 with history of multiple falls (9). On 6/19/14, 7/7/14 and 9/13/14, R4 slid out of her wheelchair onto the floor. Incident report dated 10/27/14 states R4 was sleeping in her wheelchair in the activity room and was observed falling forward from her wheel chair onto the floor sustaining bump on her left parietal area. R4 was sent out to the emergency room for evaluation.

Review of R4's care plan on 11/5/14 at 2:45pm notes R4 has impaired cognition, poor balance and requires extensive assistance with activities of daily living. Review of R4's Falls Risk Assessment dated 9/13/14 notes score of 14.

Review of the facility's fall management policy revised 6/4/14, notes "The facility observes the physical and cognitive function of each resident to identify factors that place them at risk for falling."

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F 323	Continued From page 3 This policy also notes a Fall Risk score of 10 or higher is indicative of a risk for falls. On 11/5/14 at 1:25pm, E6 (Certified Nurses Aid - CNA) stated she was assigned to monitor approximately 42 residents in the activity room and assist E7 (activity aide) with regrouping these residents for activities. E6 stated that she was aware R4 was asleep in wheelchair with her head bent forward; but continued to regroup the other residents for activities. E6 stated R4 needed to wait for her turn to be transport by one of the other CNAs that were attending to other residents in their room. When she noted R4 was falling out the wheelchair, she hurried over to R4 but could not reach her in time. E6 stated that housekeeping had just finished mopping the floor. E6 stated the floor was wet and she (E6) almost fell while trying to reach R4.	F 323		