STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145678	A. BUILDING _____ B. WING _____	**08/18/2020**

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

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a gait belt was applied, and a resident at risk for falls with a history of falls, was safely transferred for 1 of 6 residents (R1) reviewed for safety/supervision in the sample of 6. The findings include: R1's face sheet shows R1 was admitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. R1's care plan shows R1 is at risk for falls with a history of falls on 9/11/18, 10/16/18, 2/19/19, 3/17/19, 12/31/19, 4/19/2020, 5/3/2020, 5/21/2020 and 7/23/2020. The same care plan shows R1 requires assistance from 1-2 staff with transfers and a gait belt should be applied when staff are transferring her. The care plan also shows R1 requires assistance from staff with her ADL's (Activities of Daily Living) including bed mobility, and toileting. R1's completed incident report investigation shows on 7/23/2020 at 6:40 AM, R1 was being assisted out of bed by a CNA (Certified Nursing Assistant), V9. While he was transferring her, R1's leg suddenly gave out and she fell to the floor. R1 initially denied having pain. At 10:06 AM that same day, R1 reported that her left knee was hurting. An X-ray was ordered which showed R1 had an old supracondylar fracture to the left distal femur. R1 was sent to the hospital for further evaluation due to the swelling and pain in her knee. Hospital records show that R1 was admitted to a local community hospital on [DATE] and discharged back to the facility on [DATE] with a [DIAGNOSES REDACTED]. R1 was sent back with an order to have an immobilizer on her left knee and non-weight bearing on her left leg. A witness statement, dated 7/23/2020 and signed by V9, states, At about 6:40 AM resident tried to stand up and lost balance to mitigate the impact of the fall I eased resident down to the floor then immediately notified the nurse. A facility Termination/Discipline note was completed by V3 (Memory Care Clinical Manager) on 7/25/2020, and shows V9 is being disciplined for violating the company policy stating, You violated the company policy by not using a gait belt while transferring a resident (R1). On 8/17/2020 at 10:46 AM, V3 said she did an investigation into R1's 7/23/2020 fall, and it was discovered that V9 did not use a gait belt while transferring R1. V3 said that he should have had a gait belt on R1, and they should be used for all transfers. V3 said that after the incident, V9 just did not return to work again at the facility. V9 was attempted to be contacted by this surveyor and did not return the call. On 8/17/2020 at 10:40 AM, V4 (R1's physician) said that R1 had an injury resulting in a fracture to her left knee over [AGE] years ago. V4 said that R1 must have landed on her left knee during this incident and the impact caused the pain and swelling. The facility's Transfer, Ambulation and Re-positioning policy, with a revised date of 8/10, states, The facility will promote safety for residents and staff during transfers, ambulation and re-positioning through the use of body mechanics and safety devices. Injuries will be reduced and safety awareness increased through: . utilization of gait belts .

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.