STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	io 2 ivi i io, vi io vi ivo ii b 2 i vi	A. BUILDING	G:		
	IL6012553	B. WING		1	C 07/2014
NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY,	STATE, ZIP CODE		777201-7
N OF SCHALIMBUR	G 675 SOUT	H ROSELL	E ROAD		
	SCHAUMI	BURG, IL 6	0193		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
Final Observations		S9999			
Statement of Licens	ure Violations:				
00.610a) 00.1210b)5) 00.1210d)6) 00.3240a)					
) The facility shall he rocedures governing acility. The written per formulated by a Formulated by a Formulated consisting discontinuities and other colicies shall comply he written policies are facility and shall by this committee, do not dated minutes of the complete of the facility shall per facility shall pe	nave written policies and and all services provided by the policies and procedures shall Resident Care Policy ag of at least the divisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting. The provide the necessary care and Care rovide the necessary care mor maintain the highest mental, and psychological ident, in accordance with orehensive resident care properly supervised nursing are shall be provided to each total nursing and personal				
	SUMMARY STATE (EACH DEFICIENCY REGULATORY OR LS Final Observations Statement of Licens (300.610a) (300.1210b)5) (300.1210b)5) (300.1210d)6) (300.3240a) (300.1210d)6) (300	IL6012553 OVIDER OR SUPPLIER STREET AD 675 SOUT SCHAUMBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Final Observations Statement of Licensure Violations: 600.610a) 600.1210b)5) 600.1210d)6)	IL6012553 STREET ADDRESS, CITY, 675 SOUTH ROSELL SCHAUMBURG, IL 6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Statement of Licensure Violations: Statement of Licensure Violations: Statement of Licensure Violations: Statement of Licensure Violations: Section 300.610 Resident Care Policies and rocedures governing all services provided by the acility. The written policies and procedures shall be formulated by a Resident Care Policy committee consisting of at least the diministrator, the advisory physician or the ledical advisory committee, and representatives finursing and other services in the facility. The written policies shall be followed in operating le facility and shall be reviewed at least annually yithis committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for urrsing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest acticable physical, mental, and psychological ell-being of the resident, in accordance with ach resident's comprehensive resident care and. Adequate and properly supervised nursing are and personal care shall be provided to each sident to meet the total nursing and personal	OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 675 SOUTH ROSELLE ROAD SCHAUMBURG SCHAUMBURG, IL 60193 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Final Observations Statement of Licensure Violations: Gection 300.610 Resident Care Policies on 1210d/B) 00.1210d/B) 00.3240a) Gection 300.610 Resident Care Policies of intrite policies and procedures shall be formulated by a Resident Care Policy committee consisting of at least the diministrator, the advisory physician or the ledical advisory committee, and representatives foursing and other services in the facility. The mitten 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. B. WING PROVIDER OR DEPOVICE ROAD PREFIX (EACH CORRECTIVE ACTION SHE (CROSS-REFERENCE) TO THE ADVISORY ACTION SHE (IL6012553 IL6012553

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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•	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	PLETED
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	WHO STORES OF THE STORES OF TH	IL6012553	B. WING		11/0	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LEVINO	ON OF SCHAILMEHE	675 SOUT	TH ROSELLI	E ROAD		
LEXING	ON OF SCHAUMBUR	SCHAUM	BURG, IL 6	0193		
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S9999	Continued From pa	ge 1	S9999			
	encourage resident transfer activities as	nnel shall assist and safe s with ambulation and safe often as necessary in an etain or maintain their highest functioning.				
	assure that the residual as free of accident hursing personnel s	cautions shall be taken to dents' environment remains nazards as possible. All hall evaluate residents to see eceives adequate supervision revent accidents.				
	agent of a facility sh	buse and Neglect ee, administrator, employee or all not abuse or neglect a ction 2-107 of the Act)				
	These Requirement by:	s are not met as evidenced				
	review, the facility fa residents to prevent	ons, interviews, and record illed to monitor and supervise falls. This failure applies to s (R2 and R4) reviewed for nine.				
		is cognitive impaired was left the toilet room and fell hitting			т не притиго положения положения положения положения положения положения положения положения положения положен	

Illinois Department of Public Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE	SURVEY LETED
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		IL6012553	B. WING		11/0	; 7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LEXING.	TON OF SCHAUMBUR	?G	TH ROSELLI BURG, IL 60			
/V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON	()(E)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	her head. This caus hemorrhage and sk	sed a traumatic brain cull fracture.	Portition to the contract of t			
	Findings include:					
	R2 was admitted to diagnoses of depres muscle weakness, cognitive communic. The incident report left unattended on the nursing assistant - Cattending to another room, E5 heard a dhallway falling. R2 feber. R2 struck the b3 centimeters (cm) her head and a 2 cm	ace sheet on 10/9/14 notes: facility on 9/15/13 with ssion, vascular dementia, difficulty walking, and cation deficits. dated 6/24/14 notes: R2 was he toilet by E5 (certified CNA). While E5 was resident in the adjacent oor slam and noted R2 in the ell before staff could reach eack of her head sustaining a X 3 cm bump to the back of m X 2 cm bump to the right ransferred to the hospital.				
	was diagnosed with acute respiratory fai	ls dated 6/24/14 notes: R2 traumatic brain hemorrhage, lure, skull fracture, right acute hematoma resulting from fall.			THE PROPERTY OF THE PROPERTY O	
	extensive assistance (ADL) such as bathing due to decreased strendurance, and impresson physical assistoileting. R2's care	aired balance. R2 requires 1 ist for ambulation and plan also notes R2 requires pervision with ADL's due to				
	dated 5/21/14 notes	rsing Program Evaluation : R2 requires a lots of cueing,				

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PRINTED: 12/03/2014 FORM APPROVED

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	ı	G:		PLETED
						С
		IL6012553	B. WING		11/	07/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		
LEVINO	ON OF SCHAUMBUR	675 6010	TH ROSELL			
LEXING	TON OF SCHAUWBUR	SCHAUM	BURG, IL 6	0193		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S9999	Continued From page	ge 3	S9999			
	complete a task. Riassistance with bed toileting, and persor cognitive skills, decidecreased endurance assistance to stabilizambulation. On 11/5/14 at 11am assigned to provide incident. E5 stated could get up and was he was not familiar E5 stated that follow by E2 (DON /directo only be toileted in the On 11/5/14 at 2:05pr stated R2 is confuse have been watching 2. R4's admission fa R4 was admitted to fi diagnoses of demen glaucoma. The facility's incident	2 also requires extensive mobility, transfer, dressing, hal hygiene due to poor reased strength, and ce. R2 needs human ze during transitions and E5(CNA) stated she was care to R2 at the time of the she was not aware that R2 lik independently. E5 stated with R2's level of functioning. ring this incident she was told of nursing) that R2 should be bed, not on the toilet. TM, Z1 (attending physician) and that someone should R2 to prevent fall. The sheet on 10/17/14 notes facility on 6/16/14 with tia, muscle weakness, and	S9999			
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	multiple falls (9). On R4 slid out of her whencident report dated sleeping in her whee was observed falling onto the floor sustain area. R4 was sent out out of the floor.	tes: R4 with history of 6/19/14, 7/7/14 and 9/13/14, eelchair onto the floor. 10/27/14 states R4 was lchair in the activity room and forward from her wheel chair ing bump on her left parietal at to the emergency room for				
F	Review of R4's care	plan on 11/5/14 at 2:45pm				

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notes R4 has impaired cognition, poor balance

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY
ANDFLAN	OFCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COV	MPLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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LEAING	TON OF SCHAUMBUR	SCHAUM	BURG, IL 6	0193		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		
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				DEFICIENCY)		
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	•	_	00000			
		sive assistance with activities	TOTAL CONTRACTOR AND A STREET OF THE STREET			
		ew of R4's Falls Risk	A DEMONSTRATE			
	Assessment dated	9/13/14 notes score of 14.	Wheelphane			
			Sylvania			
	Review of the facility	y's fall management policy				
	revised 6/4/14, note	s "The facility observes the	and the second s			
	physical and cogniti	ve function of each resident to		Para Carlos		100
WA		place them at risk for falling."				
10000	This policy also note	es a Fall Risk score of 10 or		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		PPA 6
0.00	higher is indicative of	of a risk for falls.				
On 11/5/14 at 1:25pm, E6 (Certified Nurses Aid -						
	CNA) stated she was assigned to monitor					
		sidents in the activity room				
	and assist E7 (activi	ity aide) with regrouping these				
		es. E6 stated that she was				
WHI		p in wheelchair with her head				
		ntinued to regroup the other				THE STATE OF THE S
		es. E6 stated R4 needed to				
3		e transport by one of the				
and the state of t		e attending to other residents				mypromy Addition
		she noted R4 was falling out				
***************************************		hurried over to R4 but could				
	not reach her in time					
	housekeeping had ju	ust finished mopping the floor.				
		as wet and she (E6) almost				
	fell while trying to rea	ach R4.				
-		(D)				
		(B)				
		THE PROPERTY OF THE PROPERTY O				
		Addition				***************************************
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		Militare				

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