STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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 - 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** 35541 Based on interview and record review the facility failed to supervise a cognitively impaired resident (R1) while being toileted which resulted in R1 falling off the toilet and requiring emergent transport to a local hospital where she was admitted with diagnosis of a basal ganglia hemorrhage (brain bleed) and a frontal scalp hematoma. This failure applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3. The findings include: R1's admission nursing note dated 4/26/24 showed R1 was admitted to the facility with a diagnosis of CVA (cerebrovascular accident/stroke) which resulted in weakness to R1's right arm and right leg. R1 was nonverbal due to her stroke. The note showed, Per POA (power of attorney), patient is a fall risk and will attempt to get out of bed. R1's nursing note dated 4/27/24 showed facility staff found R1 attempting to get out of bed without assistance. R1's care plan dated 4/26/24 showed R1 was at risk for falls due to her impaired cognition, poor safety awareness, overall weakness, and need for assistance with activities of daily living (ADLs). R1's resident assessment dated [DATE] showed R1 was dependent on staff for toileting and transfers. R1's nursing noted dated 5/7/24 showed R1 sustained a fall off the toilet after two staff members (V9 Certified Nursing Assistant/CNA and V12 Licensed Practical Nurse/LPN) left her unsupervised in the bathroom. R1 was found on the floor by staff, lying on her right side, with swelling and bruising noted to the right side of R1's forehead. R1 was emergently transported to a local hospital via ambulance. The note showed, Patient was admitted for intracranial bleeding. R1's hospital neurology progress note dated 5/9/24 showed R1 presented to the ER (emergency room) on 5/8/24 after multiple falls. She sustained head contusion. CT head (computed tomography scan) showed hemorrhage in the left BG (basal ganglia) region . (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Actual harm Residents Affected - Few	On 5/13/24 at 10:36 AM, V12 (LPN) stated she and V9 (CNA) placed R1 on the toilet on 5/7/24. V12 stated, I told (V9) to go get the shower chair. It was (R1's) shower day. I would stay with (R1) in the bathroom. I heard someone yelling in the hallway outside of (R1's) room. I ran out of (R1's) room to see what was going on. Just as I turned around to go back to (R1), I heard a thud. I found (R1) lying on her right side, on the floor next to the toilet. She was awake but had a large bump on her forehead . I shouldn't have left her alone. On 5/13/24 at 11:04 AM, V9 (CNA) stated, I had taken care of (R1) before. She was a fall risk. She isn't someone that can be left alone on the toilet. I didn't see her fall (on 5/7/24). I had left to go get the shower chair. V12 (LPN) was going to stay with (R1) while she was on the toilet. I came back to her room to find her on the floor with (V12) next to her. On 5/13/24 at 9:45 AM, V2 (Director of Nursing) stated due to R1 being at a high risk for falls, staff should not have left her on the toilet unsupervised on 5/7/24. On 5/13/24 at 11:00 AM, V11 (R1's Physician) stated, (R1) was here for more rehab. She had a history of a CVA with deficits to one side of her body. When I saw her, she was pretty weak all over. She couldn't walk. She was nonverbal but would occasionally shake her head yes or no when asked questions. It was hard to tell how cognitively intact she really was. No, she was not someone who should be left alone on the toilet. The facility's Safety and Supervision of Residents policy dated July 2017 showed, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the resident's assessed needs and identified hazards in the environment .