STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Radford Green		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Note: The nursing home is disputing this citation.	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 observation, interview, and record review the facility failed to ensure a resident's safety while providing cares which applies to 1 of 4 residents (R1) reviewed for safety in a sample of 4. This failure resulted in R1 falling out of bed and receiving a fracture.The findings include:R1's admission Record printed on 3/30/26 showed R1 was readmitted to the facility on [DATE] with diagnoses which include hemiplegia and hemiparesis affecting the right dominant side, multiple neoplasm sites, lack of coordination, and abnormalities of gait and mobility.R1's Minimum Data Set, dated [DATE] showed R1 has a cognitive deficit and needs partial to substantial assistance with activities of daily living (ADLs) of self-care. These areas of self-care include turning in bed, showering/bathing, toileting, dressing, and personal hygiene.The facility's Final Incident Report dated 3/8/26 Showed on 3/4/26 R1 was receiving incontinent care, turned to R1's right side away from the caregiver, and fell out of the bed. This report showed R1 was admitted to a local hospital with a diagnosis of a femur (large leg bone) fracture.On 3/30/26 at 9:40 AM, V11 (Certified Nursing Assistant/CNA) stated when providing peri-care to a resident you should make sure they are in the middle of the bed prior to having the resident turn or assist turning the resident to their side so they do not go too far and fall out of the bed.On 3/30/26 at 11:15 AM, V14 (CNA) stated she was performing peri-care to R1. V14 stated she had completed cleaning up R1's front and asked R1 to turn on her side. R1 turned on her right side, her legs went over the side of the bed, and R1 fell out of the bed.On 3/30/26 at 11:05, V8 (Registered Nurse) stated V14 told them R1 fell out of bed when cleaning R1 up and needed V8 to look at R1. After assessing and getting R1 back to bed R1 nodded when asked if R1 had pain. V8 stated R1 was sent out per V18 (R1's Power of Attorney) to their hospital of choice.On 3/30/26 at 12:30 PM, V17 (Nurse Practitioner) stated V17 saw R1 up in R1's wheelchair about 8:15 AM on 3/4/26. R1 was not showing signs of pain until V17 palpated R1's right hip and thigh. V17 stated V18 requested R1 to be sent to the hospital. V17 stated it was unusual to have a resident fall out of bed during peri-cares.R1's Hospital Record faxed on 3/31/26 showed R1 was admitted to the hospital on [DATE] with an intertrochanteric right femur fracture (a fracture to top end of the femur bone). This record showed R1 was transferred to a second hospital to receive surgery to fix the fracture.On 3/31/26 at 9:10 AM V3 (Medical Director) stated the type of fracture R1 received (intertrochanteric fracture) is associated with a traumatic event.

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