

DEPARTMENT OF PUBLIC HEALTH  
STATE OF ILLINOIS

|                                 |   |                       |
|---------------------------------|---|-----------------------|
| THE DEPARTMENT OF PUBLIC HEALTH | ) | Docket No. NH19-S0099 |
| STATE OF ILLINOIS,              | ) |                       |
| Complainant,                    | ) |                       |
|                                 | ) |                       |
| v.                              | ) |                       |
|                                 | ) |                       |
| LEXINGTON HEALTH CARE CENTER OF | ) |                       |
| SCHAUMBURG, INC.,               | ) |                       |
| D/B/A, LEXINGTON OF SCHAUMBURG, | ) |                       |
| Respondent.                     | ) |                       |

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED;  
NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF  
VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on January 24, 2019, at Lexington of Schaumburg, 675 South Roselle Road, Schaumburg, Illinois 60193. On March 14, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

- 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

- 2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
- 3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

#### NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of \$ 2,200.00, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health  
525 West Jefferson, 5<sup>th</sup> Floor, QA  
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

#### NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

#### NOTICE OF OPPORTUNITY FOR A HEARING

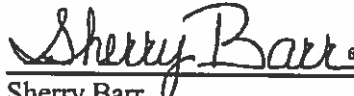
Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE  
WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POChearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.



Sherry Barr  
Division Chief of Quality Assurance  
Office of Health Care Regulation

Dated this 19<sup>th</sup> day of March, 2019.

BF300/19-S0099/Lexington of Schaumburg/January 24, 2019/S.Geer

Illinois Department of Public Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012553</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEXINGTON OF SCHAUMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>675 SOUTH ROSELLE ROAD<br/>SCHAUMBURG, IL 60193</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| S 000                                                              | Initial Comments<br><br>Facility Incident Report of 1/4/2019/IL 00108612                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | S 000                                                                                           |                                                                                                                          |  |                                                                    |
| S9999                                                              | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall<br>be formulated by a Resident Care Policy<br>Committee consisting of at least the<br>administrator, the advisory physician or the<br>medical advisory committee, and representatives<br>of nursing and other services in the facility. The<br>policies shall comply with the Act and this Part.<br>The written policies shall be followed in operating<br>the facility<br><br>Section 300.1210 General Requirements for<br>Nursing and Personal Care<br><br>b) The facility shall provide the necessary<br>care and services to attain or maintain the highest<br>practicable physical, mental, and psychological<br>well-being of the resident, in accordance with<br>each resident's comprehensive resident care<br>plan. Adequate and properly supervised nursing<br>care and personal care shall be provided to each<br>resident to meet the total nursing and personal<br>care needs of the resident. | S9999                                                                                           |                                                                                                                          |  |                                                                    |

**Attachment A**  
**Statement of Licensure Violations**

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

TITLE

(X6) DATE

02/21/19

Illinois Department of Public Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                               |                                                                                                                          |                          |                                                                    |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012553</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEXINGTON OF SCHAUMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>675 SOUTH ROSELLE ROAD<br/>SCHAUMBURG, IL 60193</b>                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| S9999                                                              | <p>Continued From page 1</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide safe environment by not checking the temperature of the coffee prior to serving to cognitively impaired residents. This deficient practice resulted in R1 sustaining second degree burns to bilateral inner thighs.</p> <p>This applies to 1 of 3 residents (R1) reviewed for safety/incidents.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) shows that R1 was admitted to the facility on March 16, 2018 with multiple diagnoses including heart failure, AHSD (atherosclerotic heart disease of native coronary artery without angina pectoris, PVD (peripheral vascular disease), anxiety disorder, muscle weakness, dementia without behavioral disturbance, abnormalities of gait and mobility</p> | S9999                                                                         |                                                                                                                          |                          |                                                                    |

Illinois Department of Public Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                       |                                                                                                                          |                                                                    |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012553</b>                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEXINGTON OF SCHAUMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>675 SOUTH ROSELLE ROAD</b><br><b>SCHAUMBURG, IL 60193</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S9999                                                              | <p>Continued From page 2</p> <p>and repeated falls.</p> <p>The MDS (Minimum Data Set) dated 12/12/2018 showed that R1's BIMS (Brief Interview mental Status) score was 3 (severely impaired). R1 also requires supervision and assistance for all aspects of ADLs (Activities of daily living).</p> <p>The facility's incident report dated 1/4/2019 at 10:45 A.M., showed R1 sustained a thermal burn with redness and blisters to bilateral inner thighs due to hot coffee that was served and spilled on her lap. The coffee was served in a Styrofoam cup by V11 (Activity Aid). V11 placed the hot coffee on top of the table within R1's reach. The hot coffee spilled on R1's lap when another resident (R2) was playing with a ball. R2 rolled the ball across R1's side making the hot coffee tip and its hot contents spill onto R1's lap. R1 sustained burn wound went from redness to blisters in a matter of five minutes over the bilateral inner thighs. The measurement shows 3.0 cm x 2.0 cm. The coffee temperature was tested after it was made by V11. The temperature was 198 degrees Fahrenheit. V11 placed the coffee in a non-regulated coffee carafe then V11 proceeded to serve the coffee to the third floor residents which was a designated dementia unit. V11 failed to check the coffee temperature before serving it to the third floor residents to ensure the temperature would not cause scalding or burn in case of spills. The staff members during the time of the accident were V11 and V5 (CNA, Certified Nurse Assistant). R1 and R2 resides on the designated dementia unit floor.</p> <p>R2's diagnoses included dementia macular degeneration, dementia, lack of coordination, and anxiety disorder.</p> <p>R2's MDS dated 1/10/2019 showed that R2's</p> | S9999                                                                                                 |                                                                                                                          |                                                                    |

Illinois Department of Public Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |  |                                                                 |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>IL6012553</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEXINGTON OF SCHAUMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>675 SOUTH ROSELLE ROAD<br/>SCHAUMBURG, IL 60193</b>                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| S9999                                                              | <p>Continued From page 3</p> <p>BIMS was 4 (Severely impaired). R2's requires supervision to extensive assistance for different aspects of ADLs.</p> <p>On 1/15/2018 at 10:00 A.M., V5(Nurse Aide) stated she was in the dining room on 1/4/2019 at around 10:45 A.M. observing residents. V5 said she heard R1 yell and saw that the coffee had spilled onto R1's lap. V5 stated that R2 rolled a ball that tipped over R1's coffee. V5 stated she was not sure how R2 obtained the ball. R2 was ambulatory with a walker.</p> <p>On 1/15/2019 at 10:30 A.M., R1 was in the dining room attending an activity. After R1 was taken to her room by V5, V7 and V5 provided burn treatment to R1. R1's bilateral inner thighs have burn wounds with redness around the wound perimeter. There was also slough at the center of the wound. V7 measured the burn wounds as follows and classified it as a second degree burn as follows: 11 x 4.8 cm for the right inner thigh; 4.4 cm x 1.4 cm for the left inner thigh.</p> <p>On 1/15/2019 at 3:25 P.M., V11(Activity Aide) stated that she made coffee and placed it in a non-regulated carafe container. V11 stated that the temperature of the coffee was 198 Degrees Fahrenheit. V11 added that she brought the coffee immediately to the third floor dementia unit. V11 immediately served the coffee to the third floor residents by pouring the coffee in a Styrofoam cup. V11 stated that both she and V5 were in the dining room. V11 added that when she served coffee to R1 and R2 were at same table. V11 said that when she turned her back, she heard R1 yell and saw that the coffee had spilled on R1's lap. V11 said R2 had rolled a ball towards R1 which tipped the Styrofoam cup with the hot coffee. V11 said the activity was "coffee</p> | S9999                                                                      |                                                                                                                          |  |                                                                 |



Illinois Department of Public Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012553</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEXINGTON OF SCHAUMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>675 SOUTH ROSELLE ROAD<br/>SCHAUMBURG, IL 60193</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| S9999                                                              | Continued From page 4<br><br>and Snacks" but was not sure how R2 was able to get hold of the ball. V11 stated that she did not check the coffee temperature prior to serving it to the third floor residents including R1 and R2.<br><br>On 1/15/2019 at 4:00 P.M., V19 (Activity Director) stated that V11 did not follow facility's protocol when V11 failed to check the coffee temperature prior to serving it to residents. V19 added that the coffee temperature should be between 135- 150 Degrees Fahrenheit prior to serving to avoid burns or scalding in case of spillage. V19 further added that this was a preventable accident if the coffee temperature was checked and ensure it was at a safe temperature before serving to residents.<br><br>On 1/16/2019 at 10:20 A.M., V20 (Registered Dietician) stated that coffee temperature should be 120 and no more 130 degrees Fahrenheit to serve to residents to ensure safety and avoid burns in case of spillage. V20 stated that the carafe was an insulated carafe and the temperature was not regulated. V20 further added that the temperature of the coffee should have been checked prior to serving it to the residents. V20 said that if the temperature is 120 degrees it was safe, but if it is 120 degrees or higher, it could possibly cause a burn.<br><br>On 1/16/2019, V8 (Wound Certified Treatment Nurse/ RN, Registered Nurse) stated R1 sustained a second degree burn on bilateral inner thighs caused from a hot coffee spillage. V8 added that the burn wound was provided treatment with wound care specialist physician. V8 added that the burn wound was getting better.<br><br>On 1/17/2019 at 10:15 A.M., V9 (Wound care specialist physician) stated that R1 sustained a | S9999                                                                                           |                                                                                                                          |  |                                                                    |

Illinois Department of Public Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                       |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012553</b>                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEXINGTON OF SCHAUMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>675 SOUTH ROSELLE ROAD</b><br><b>SCHAUMBURG, IL 60193</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| S9999                                                              | Continued From page 5<br><br>second degree burn from the hot coffee spillage<br>and added that the wound burn shows healing<br>and no signs of infection.<br><br>The facility's policy "Hot Liquids" dated 8/28/2018<br>shows: "Purpose: To safely serve hot liquids such<br>as hot water, coffee and soup ..... 1. Hot liquids<br>such as hot water, coffee and soup should be<br>served between 135-155 Degrees Fahrenheit. ..<br>2. Hot liquid temperature will be recorded prior to<br>meal service. 4. Additional resident supervision<br>may be necessary for those found to be at high<br>risk of liquid spills."<br><br>(B) | S9999                                                                                                 |                                                                                                                          |  |                                                                    |