

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/29/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF STREAMWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 EAST IRVING PARK ROAD</b> <b>STREAMWOOD, IL 60107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 492 SS=C	<p>Complaint Investigation #0892538/IL35469</p> <p>No extended survey was conducted.</p> <p>483.75(b) ADMINISTRATION</p> <p>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to publicly post statutorily mandated staffing data regarding the number of licensed and unlicensed nursing staff directly responsible for resident care on each shift.</p> <p>Findings include:</p> <p>During the tour of the facility on 7/15/08 which started at approximately 2:00 PM, information regarding the number of licensed and unlicensed nursing staff per shift was not posted in the facility.</p> <p>During the daily status meeting with the facility on 7/15/08 at 4:10 PM, E1 (administrator) stated that he did not realize that the information regarding the number of licensed and unlicensed staff was not posted. E1 stated that the person responsible for posting the information no longer works for the facility. E1 also stated that the person responsible left the facility about a week</p>	F 492			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 492	Continued From page 1 ago and that no one had been posting the information since then.	F 492			