•		AND HUMAN SERVICES  & MEDICAID SERVICES	•			FORM	): 09/11/2007 APPROVED ): 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		145640	B. WII	۷G		07/20/2007		
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
CHURC	H CREEK				ELINGTON HTS, IL 60005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ge 9	F	323				
	Social Service Dire	ctor):					ŧ	
F9999	top of residents' bed rooms. Label states children.  2. A can of hair spraone resident.  3. A bottle of Nystat premium powder sk Cavillon emollient corresident.  4. A bottle spray of variet cream with pand Dermavase top one resident's bedsi external use only.  When interviewed of tour, E8 (Nurse) stamedications/chemic inside the cabinet.	al agents are supposed to be 88 further stated, that there obtained that there obtained that the state of the	F99	99				

300.1210 General Requirements for Nursing and

#### PRINTED: 09/11/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 145640 07/20/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1250 WEST CENTRAL ROAD CHURCH CREEK **ARLINGTON HTS, IL 60005** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (X4) ID COMPLÉTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F9999 F9999 Continued From page 10 Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the follwoing and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and

emotional changes as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be

breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

made by nursing staff and recorded in the

5) A regular program to prevent and treat pressure sores, heat rashes or other skin

resident's medical record.

# . DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X

PRINTED: 09/11/2007 FORM APPROVED OMB NO. 0938-0391

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145640			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		B. WING	<u> </u>	07/20/2007					
MME OF PROVIDER OR SUPPLIER HURCH CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 1250 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
F9999	Continued From page 11 300.3220 Medical and Personal Care Program		F9999						
	administered as ord physician orders she Director of Nursing within 24 hours after issued to assure factorders. (Section 2-1 300.3240 Abuse and a) An owner, license agent of a facility she	d Neglect ee, administrator, employee or all not abuse or neglect a							
	resident. (Section 2- These requirements	are not met as evidenced by:				,			
	review the facility fai procedures leading: sores for 2 of 4 resid concerns, R1 and R and proper assessm	on, interview and record iled to follow orders and to development of pressure dents with pressure sore 8. The lack of interventions nent led to R8's pressure sore ling to Stage IV with evidence							
:	Findings include:								
;	positioned only on he the afternoon hours. revealed a concern t always on her back.	d R8 on 7/7 and 7/8/07 er back in the morning and in Family interview on 7/10/07 hat on daily visits R8 is Also, the patient goes to her back and she is always isits.							
		10/07, regarding R8's sacral urse) stated to surveyor that	:						

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		145640	B. WI	NG		07/	20/2007
NAME OF PROVIDER OR SUPPLIER  CHURCH CREEK				1250 WES	RESS, CITY, STATE, ZIP T CENTRAL ROAD TON HTS, IL 60005	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX (E	PROVIDER'S PLAN OF ( EACH CORRECTIVE ACTI DSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	7/10/07 at 2:30 PM 7/10/07, without any was observed to be surveyor that she cl AM on 07/10/07.  R8 was readmitted reddened dark disc with skin intact which possibly necrotic. Thist with pus saturate that she would call the drainage which was readmitted from the explanation on how and the type of interfurther deterioration plan for the pressure plan did not reflect cand the intervention pressure sore got where the facility on 6/6/07 coccyx area.	eyor observed R8's wound on with E4, dressing was dated of time noted. R8's dressing a saturated with pus. E4 told hanged the dressing at 7:30 from a hospital visit with only coloration on the coccyx area can facility staff described as the area is now the size of a sing the dressing. E4 stated the doctor about the pus area. The pressure sore are cords for when R8 was hospital to the pressure sore got worse, ventions made to prevent. Also, requested was a care the sore as the current care current status of the wound simplemented when the orse. The facility staff did not end documents.  In the pressure ulcer in cility admission skin and R8 as high risk for the wound the order of the wound simplemented when the orse. The facility staff did not end documents.	F9	999			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETION DATE
F9999	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F99	999			

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 09/11/2007 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
		145640	B. WII	NG_		07/:	20/2007	
NAME OF PROVIDER OR SUPPLIER  CHURCH CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE  1250 WEST CENTRAL ROAD  ARLINGTON HTS, IL 60005					
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F9999	R1 was also obsert position and the prowas also not relieve the wheelchair. Du observation, R1 was pressure on the pressure on the pressure of	up from 11:00 AM to 1:00 PM.  ved in bed in semi-Fowler's essure to the pressure sores ed when the resident was up in ring the three days of as noted to be positioned with essure sores on the coccyx vas not repositioned to relieve	F9:	999				

(X2) MULTIPLE CONSTRUCTION