STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD GLEN NURSING & REHAB CTR	30 WEST 300 NORTH AVENUE WEST CHICAGO, IL 60185

(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
K9999	Continued From page 14	K9999		

LICENSURE VIOLATIONS:

300.340a)1)F)
300.3020b)

Section 300.340 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:
1) Private and professional association standards:
F) For new facilities (see Subpart N), the following standards of the National Fire Protection Association (NFPA), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169

Section 300.3020 Codes and Standards

b) The 1981 Edition of the National Fire Protection Association (NFPA) Standard No. 101, Life Safety Code for existing structures and all appropriate references under Appendix "B" of that Code, but no subsequently amended edition of the Code, shall apply to and become a part of these standards. (A, B) Pursuant to the Medicare/Medicaid certification requirements of 42 CFR 405.1134(a) (1983) and 42 CFR 442.321(c) (1983), but no subsequently amended editions of these Federal regulations, any skilled nursing facility that on December 4, 1980 or on November 26, 1982, or any intermediate care facility that on November 26, 1982 complied with the requirements of the 1967 or 1973 edition of the Life Safety Code, rather than the 1981 edition of the Life Safety Code, will be accepted by the Department for licensure and certification as long as the facility continues to remain in compliance

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

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K9999	Continued From page 15 with the 1967 or 1973 edition of the Code. THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY THE FOLLOWING: BASED ON STAFF INTERVIEW, RECORD REVIEW AND OBSERVATION, THE FACILITY FAILED TO: 1) HAVE A WRITTEN FIRE SAFETY PLAN IN ACCORDANCE WITH NFPA 101, 2000 EDITION, SECTION 19.7.2, 19.7.2.1 AND 19.7.2.2. THIS DEFICIENT PRACTICE COULD EFFECT ALL 200 RESIDENTS, VISITORS AND STAFF. 2) ENSURE THAT THE FIRE ALARM SYSTEM WAS FULLY OPERABLE AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 19.3.4 AND 9.6. THIS DEFICIENT PRACTICE RESULTED IN THE LACK OF NOTIFICATION OF FIRE AT THE FACILITY AND TRANSMISSION OF ALARM SIGNAL TO THE FIRE DEPARTMENT. THIS FAILURE AFFECTED ALL RESIDENTS AT THE FACILITY. 3) CONTINUE A FIRE WATCH IN ACCORDANCE WITH NFPA 101, 2000 EDITION, SECTION 9.6.1.8. THIS DEFICIENT PRACTICE AFFECTED ALL RESIDENTS AS THE STAFF DID NOT INITIATE THE PROPER PROCEDURES WHEN THE FIRE ALARM SYSTEM WAS OUT OF SERVICE. 4) ENSURE THAT EXIT DOORS WERE OPERABLE AT ALL TIMES IN ACCORDANCE WITH NFPA 101, 2000 EDITION, SECTIONS 19.2 AND 7.2.1.7.1(2). THIS DEFICIENT	K9999		

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K9999	Continued From page 16 PRACTICE COULD RESULT IN THE ENTRAPMENT OF INDIVIDUALS IN THE WEST AND SOUTH WINGS EXITING THROUGH WEST AND SOUTH STAIR TOWERS WHILE ATTEMPTING TO ACCESS SAFETY OUTSIDE THE BUILDING. FINDINGS INCLUDE: 1) ON 7/31/2007 AT APPROXIMATELY 2:30 PM, THE FACILITY'S FIRE SAFETY PROCEDURE ("HANDOUT M-FIRE PREVENTION") WAS REVIEWED. THE FACILITY'S FIRE PROCEDURE WAS A DOCUMENT ADOPTED FROM A PROVIDER ASSOCIATION. ACCORDING TO THE DOCUMENT, IN THE EVENT OF A "MAJOR FIRE," "...STAFF MEMBER DISCOVERS OR RECOGNIZES A MAJOR FIRE, ONE THAT IS OUT OF CONTROL, OR A MINOR FIRE THAT CAN NO LONGER BE CONTROLLED..." CERTAIN RESPONSES WOULD GO INTO AFFECT INCLUDING, BUT NOT LIMITED TO, EVACUATING THE RESIDENTS AND ACTIVATING THE FIRE ALARM SYSTEM. THE FACILITY'S FIRE SAFETY PROCEDURE DID NOT REQUIRE THESE RESPONSES GO INTO AFFECT FOR WHAT STAFF PERCEIVED TO BE A MINOR FIRE. PER Z2'S REPORT: ON 7/28/2007 AT APPROXIMATELY 7:55 PM, Z2 OBSERVED SMOKE COMING FROM THE FACILITY'S ROOF. Z2 ENTERED THE FACILITY AND ASKED A RECEPTIONIST IF HE/SHE KNEW THERE WAS SMOKE COMING FORM THE ROOF. THE RECEPTIONIST STATED,"YES, WE HAVE A DRYER ON FIRE." Z2 ASKED IF THE FIRE DEPARTMENT HAD	K9999		

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K9999	Continued From page 17 BEEN CALLED, TO WHICH THE RESPONSE WAS "NO, I WAS TOLD NOT TO CALL." Z2 THEN ASKED WHO HAD TOLD THE RECEPTIONIST NOT TO CALL. THE RECEPTIONIST RESPONDED, "...THE ENVIRONMENTAL PERSON...." Z2 ASKED THE RECEPTIONIST TO CALL HER/HIS SUPERVISOR, TO WHICH THE RESPONSE WAS THE ENVIRONMENTAL PERSON IS THE SUPERVISOR. Z2 THEN TELEPHONED THE FIRE DISPATCH CENTER AND REQUESTED A GENERAL ALARM FOR AN APPLIANCE FIRE WITH POSSIBLE EXTENSION. Z2 THEN MET THE "ENVIRONMENTAL PERSON (E-1)" AND ASKED WHY THE FIRE DEPARTMENT WAS NOT CALLED AND WHY THE BUILDING WAS NOT BEING EVACUATED. Z2 INSTRUCTED E1 TO BEGIN EVACUATING RESIDENTS FROM THE AFFECTED SOUTH WING OF THE BUILDING. ON 7/28/07, THE IMMEDIATE RESPONSE WAS FOR STAFF TO CONTROL THE FIRE ALONE, WITHOUT THE ASSISTANCE OF THE FIRE DEPARTMENT. IT WAS BY COINCIDENCE THAT Z2 SAW SMOKE, INVESTIGATED THE SITUATION AND INTERVENED TO ENSURE THAT THE FIRE WAS CONTAINED AND THE RESIDENTS MOVED TO ZONES OF PROTECTION. THE FACILITY'S FIRE PROCEDURE IS NOT IN COMPLIANCE WITH CODE REQUIREMENTS. A DELAY IN ACTIVATION OF THE ALARM SYSTEM IN THE EVENT OF ANY FIRE THAT COULD POSSIBLE GROW EXTREMELY QUICKLY INTO AN OUT OF CONTROL SITUATION WOULD JEOPARDIZE RESIDENTS SAFETY AND LIFE BY DELAYING THE	K9999		

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K9999	Continued From page 18 ARRIVAL OF THE FIRE DEPARTMENT AND ALLOWING SMOKE TO COMPROMISE RESIDENT SMOKE COMPARTMENTS. A DELAY IN FIRE ALARM ACTIVATION WOULD ALSO DELAY SMOKE COMPARTMENTALIZATION CONTAINMENT BY NOT CLOSING SMOKE DOORS IMMEDIATELY, BY ALLOWING SMOKE TO PENETRATE THE AIR HANDLING SYSTEM AND BLOW SMOKE INTO ALL RESIDENT AREAS INCLUDING RESIDENT ROOMS, AND BY NOT INITIATING FACILITY READINESS TO RESPOND TO THE SITUATION. THE PROCEDURE OF SORTING OUT A MINOR FIRE VERUS A MAJOR FIRE IS A POLICY THAT PUTS RESIDENTS LIVES AT RISK DUE TO UNACCEPTABLE TIME DELAYS. SECTION 19.7.2.1. OF THE LIFE SAFETY CODE STATES, " ...THE BASIC RESPONSE REQUIRED OF STAFF SHALL INCLUDE THE REMOVAL OF ALL OCCUPANTS DIRECTLY INVOLVED WITH THE FIRE EMERGENCY, TRANSMISSION OF AN APPROPRIATE FIRE ALARM SIGNAL TO WARN OTHER BUILDING OCCUPANTS AND SUMMONS STAFF, CONFINEMENT OF THE EFFECTS OF THE FIRE BY CLOSING DOORS TO ISOLATE THE FIRE AREA, AND THE RELOCATION OF RESIDENTS AS DETAILED IN THE HEALTH OCCUPANCY'S FIRE SAFETY PLAN..." THE CODE DOES NOT ALLOW FOR A DELAYED DISCRIMINATION AND EVALUATION AS TO WHEN IT IS TIME TO PULL A FIRE ALARM, ALERT THE STAFF AND RESIDENTS AND SUMMON THE FIRE DEPARTMENT. SECTION 19.7.2.2 STATES, "...A WRITTEN HEALTH CARE OCCUPANCY FIRE SAFETY	K9999		

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K9999	Continued From page 19 PLAN SHALL BE PROVIDED FOR THE FOLLOWING: (1) USE OF ALARMS; (2) TRANSMISSION OF ALARM TO FIRE DEPARTMENT; (3) RESPONSE TO ALARMS; (4) ISOLATION OF FIRE; (5) EVACUATION OF IMMEDIATE AREA; (6) EVACUATION OF SMOKE COMPARTMENT; (7) PREPARATION OF FLOORS AND BUILDING FOR EVACUATION; (8) EXTINGUISHMENT OF FIRE. E1 CONCURRED WITH THE FINDINGS. 2) THE FACILITY FAILED TO MAINTAIN THE FIRE ALARM SYSTEM (FAS) IN WORKING CONDITION. BY ALLOWING PROBLEMS TO GO UNCORRECTED THAT WERE EVIDENT ON 7/27/2007, PRIOR TO A FIRE ON 7/28/2007, THE FACILITY PUT ALL RESIDENTS SAFETY AT RISK BY NOT HAVING A SYSTEM THAT FUNCTIONED PROPERLY. ON 7/28/2007, THE FIRE ALARM SYSTEM FAILED TO WORK DURING A DRYER FIRE. THE SMOKE DETECTOR IMMEDIATELY OUTSIDE THE LAUNDRY ROOM FAILED TO BE ACTIVATED BY THE SMOKE PRODUCED FROM THE FIRE. IT WAS LEARNED IN INTERVIEW ON 7/31/2007 WITH E1 AND E7 (SECURITY GUARD) THAT THERE HAD BEEN TROUBLE WITH THE SYSTEM SINCE FRIDAY (7/27/2007). THE SYTEM WAS CONTINUALLY GOING INTO THE "TROUBLE MODE." IT WAS LEARNED FROM THE CONTRACTED ALARM RECEIVING COMPANY [Z3] THAT ON 7/27/2007 AT 1:16 PM, THE FACILITY HAD TAKEN THE FAS OFF LINE TO CONDUCT A FIRE DRILL AND FAILED TO PUT THE	K9999		

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K9999	Continued From page 20 SYSTEM BACK ON LINE. ELECTRONIC RECORDS SHOW THAT THE SYSTEM RETURNED THE FAS TO SERVICE AUTOMATICALLY AT 9:16 PM. FURTHER, E7 REPORTED THAT AT ABOUT 5:30 AM ON 7/27/2007, THE SYSTEM WAS CONTINUALLY GOING INTO "TROUBLE MODE" AND WHEN E7 QUESTIONED E6 [MAINTENANCE STAFF] WAS TOLD THAT IT WAS JUST A "SENSOR" PROBLEM. PER Z2'S (FIRST DEPUTY CHIEF FOR LOCAL FIRE DEPARTMENT) REPORT: ON 7/28/2007 AT APPROXIMATELY 7:55 PM, Z2 OBSERVED SMOKE COMING FROM THE FACILITY'S ROOF. Z2 ENTERED THE FACILITY AND ASKED A RECEPTIONIST IF HE/SHE KNEW THERE WAS SMOKE COMING FROM THE ROOF. THE RECEPTIONIST STATED , "YES, WE HAVE A DRYER ON FIRE." Z2 ASKED IF THE FIRE DEPARTMENT HAD BEEN CALLED; TO WHICH THE RESPONSE WAS "NO, I WAS TOLD NOT TO CALL". Z2 THEN ASKED WHO HAD TOLD THE RECEPTIONIST NOT TO CALL; THE RECEPTIONIST RESPONDED , "...THE ENVIRONMENTAL PERSON...". Z2 ASKED THE RECEPTIONIST TO CALL HER/HIS SUPERVISOR , TO WHICH THE RESPONSE WAS THE ENVIRONMENTAL PERSON IS THE SUPERVISOR. Z2 THEN TELEPHONED THE FIRE DISPATCH CENTER AND REQUESTED A GENERAL ALARM FOR AN APPLIANCE FIRE WITH POSSIBLE EXTENSION. Z2 WENT TO THE FIRE ALARM PANEL TO CHECK THE CONDITION OF THE ALARM. THE RECEPTIONIST FOLLOWED Z2 AND STATED THAT "...MY JOB IS TO COME IN EVERY DAY AND PRESS THIS BUTTON...." THE BUTTON	K9999		

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K9999	Continued From page 21 THE RECEPTIONIST INDICATED WAS THE ALARM SILENCE BUTTON. PER Z2, THE ACTION TAKEN BY THE RECEPTIONIST SHOULD NOT HAVE HAD AN EFFECT ON THE ABILITY OF THE FIRE ALARM TO ACTIVATE. THE REPORT FURTHER STATES, WHEN FIRE PERSONNEL MADE ENTRANCE TO THE BASEMENT OF THE FACILITY, THEY FOUND SMOKE AT THE CEILING LEVEL IN THE HALLWAY AND A FIRE IN THE CENTER DRYER IN THE LAUNDRY ROOM. ON 07/29/2007, A REPRESENTATIVE OF Z3 CALLED THE LOCAL FIRE DEPARTMENT TO INFORM THEM THAT Z3 WAS FORCED TO TAKE THE FACILITY OFF LINE DUE TO THE CONSTANT "TROUBLE SIGNAL" THEY WERE RECEIVING AND THE CONCERN THAT THIS CONDITION COULD EFFECT OTHER CUSTOMERS. AT THAT POINT, THE LOCAL FIRE DEPARTMENT VISITED THE FACILITY TO CHECK ON THE CONDITION OF THE SERVICE/FIRE ALARM CONTROL PANEL (FACP) AND THE FACILITY WENT ON A FIRE WATCH. ON 07/29/2007, THE FACILITY HAD Z1 TEST THE FACP. ON 7/29/2007, PER THE FIRE ALARM INSPECTION REPORT, Z1 NOTED THAT THE PRINTER FOR THE FACP WAS OUT OF PAPER. Z1 WROTE THAT, "...TESTED SEVERAL DEVICES. ALL HAVE SLOW RESPONSE..." ACCORDING TO THE FIRE WATCH LOG DATED 7/29/2007, COVERING BETWEEN 11:00AM AND 415PM, THE FACILITY WENT BACK ON LINE THAT AFTERNOON. 3) FOLLOWING THE FIRE INCIDENT ON 7/28/2007, THE FIRE ALARM PANEL WAS NOT INSPECTED BY A THIRD PARTY/OUTSIDE	K9999		

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K9999	Continued From page 22 CONTRACTOR AS DIRECTED BY THE LOCAL FIRE DEPARTMENT. INSTEAD, PER THE LOCAL FIRE MARSHAL (Z4), A MEMBER OF THE FACILITY'S MAINTENANCE STAFF (E5) TOOK THE RESPONSIBILITY OF CHECKING THE FIRE ALARM PANEL TO ENSURE IT WAS IN PROPER WORKING ORDER. THERE WAS NO RECORD OF A CALL INTO THE CONTRACTED ALARM RECEIVING COMPANY (Z3) DISCOVERED IN INSPECTION OF THE ACTIVITIES SURROUNDING THE FIRE. THE FACILITY WAS NOT PLACED ON A FIRE WATCH EVEN THOUGH THE FIRE ALARM HAD NOT ACTIVATED DURING THE FIRE. ON 7/29/2007, THE CONTRACTED ALARM RECEIVING COMPANY (Z3) CALLED THE LOCAL FIRE DEPARTMENT TO INFORM THEM THAT Z3 WAS FORCED TO TAKE THE FACILITY OFF LINE DUE TO A CONSTANT 'TROUBLE SIGNAL" BEING RECEIVED AND Z3 WAS CONCERNED THIS CONDITION COULD EFFECT OTHER CUSTOMERS. ACCORDING TO Z3, PERSONNEL FROM THE LOCAL FIRE DEPARTMENT THEN WENT TO THE FACILITY TO CHECK ON THE CONDITION OF THE FIRE ALARM CONTROL PANEL AND THE FACILITY WENT ON A FIRE WATCH. ON 7/29/07, THE FACILITY HAD THE SERVICE CONTRACTOR REPRESENTATIVE (Z1) TEST THE FIRE ALARM CONTROL PANEL. ACCORDING TO FIRE WATCH LOG SHEETS, THE FACILITY WAS BACK ON LINE THAT AFTERNOON AT 4:15PM. 4) ON 7/31/2007 AT 3:00 PM, WHILE IN THE COMPANY OF E-1 [ENVIRONMENTAL SERVICES DIRECTOR] AND E-2[DIRECTOR OF NURSING], THE LOCAL FIRE	K9999		

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K9999	Continued From page 23 DEPARTMENT'S FIRE REPORT FORM DATED 7/28/07 WAS REVIEWED. BASED ON REVIEW OF THAT REPORT, THE DECISION WAS MADE TO CHECK THE FACILITY'S STAIR TOWER DOORS. THIS FIELD TEST FOUND THAT THE SOUTH EXIT DOOR FROM THE STAIRWELL TO OUTSIDE THE BUILDING FAILED TO OPEN USING EXCESSIVE FORCE. THE DOOR AT THE WEST STAIRWELL WHICH WAS NOTED AS BEING "...HARD TO OPEN..." ON 7/28/07 ACCORDING TO THE FIRE DEPARTMENT'S REPORT , WAS OBSERVED TO HAVE BEEN EQUALLY STIFF FROM NON-USE AND WEATHERING. (A)	K9999		