DEPART CENTER	PRINTED: 07/11/2012 FORM APPROVED OMB NO. 0938-0391						
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145221	B. WI	NG		C 04/20/2012	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FAIRVIE	W CARE CENTER OF	JOLIET			22 NORTH HAMMES IOLIET, IL 60435		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	bridge of nose (suti description of the c the extent of bruisin documentation of the bruises or laceratio found regarding ren nose. No further do 2/10/12 regarding F Further review of the documentation to the Health for R5's fall reports)showed no fracture. 2. Observation of F noted R20 to be sitt attempting to stand of incident docume at the facility on 4/1 hospital, and was d fracture. Review of nursing r 4/1/12 showed, "Re with fx of the hip." specific as to which reportable incident R20 had sustained Review of documer plans for R20 addre 4/17/12) showed R2 hip. During interview with fractured hip E14 s fractured hip. No or	Ares intact)." There was no oboring of the bruises and/or ng. There was also no ne healing process of the ns. No documentation was noval of sutures from R5's ocumentation was found after R5's lacerations and bruises. e reportable incident ne Illinois Dept. of Public of 2/3/12 (preliminary and final notification of cervical spine R20 on 4/5/12 at 12:00 noon ing on the side of his bed with his roller walker. Review ntation showed R20 had a fall /12, was sent to a nearby iagnosed with a right hip note documentation date sident admitted to the hospital The documentation was not was fractured. Review of a report dated 4/6/12 showed a fracture of the right hip. thation on two separate care essing falls (4/6/12 and 20 had a fracture of the "left"		514			
F9999	FINAL OBSERVAT	ONS	F99	999			

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES			FORM	07/11/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
145221			B. WING	G	C 04/20/2012	
	PROVIDER OR SUPPLIER	JOLIET	S	STREET ADDRESS, CITY, STATE, ZIP CODE 222 NORTH HAMMES JOLIET, IL 60435		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	A facility shall comp Worker Background the Health Care Wo (77 III. Adm. Code S Based on record re the facility failed to background checks not employed with o work. This applies t files reviewed for H Background Check Findings include: Interview with E6 (h showed that E15 ce allowed to resign or became aware of a stated she began a she was hired on 1/ audit E 15 was four conviction a (batter check record. This dated 1/30/12. E6 s (administrator). E6 or responsible for a background checks 2011, when E15 wa assistant. The indiv for checking for em no longer employed E6 stated that until clearance to comple backgrounds from o the employee 's file were done at anoth her until now. E6 st	The Worker Background Check oby with the Health Care d Check Act [225 ILCS 46] and orker Background Check Code 955). view and facility staff interview conduct Health Care Worker is to ensure individuals were disqualifying Convictions to to one of 15 employee (E15) ealth Care Worker s. numan resources) on 4/4/12 ertified nursing assistant was in 1/31/12 after the facility disqualifying conviction. E6 uditing the employee files after /17/12. E6 said that from this ind to have a disqualifying y charge) in his background background check record was said she informed E1 stated she was not employed equiring the Health care is a the facility in November as hired as a certified nursing ridual employee responsible ployee background checks is d at the facility. 4/3/12 she had not received	F999			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6004766

If continuation sheet Page 100 of 101

STATEMENT OF DEFICIENCIES (Y) PROVIDERSUPPLIERCUA (X2) MULTIPLE CONSTRUCTION (X2) DATE SUPPLIER AND OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X2) DATE SUPPLIER MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, 2P CODE C FAIRVIEW CARE CENTER OF JOLIET STREET ADDRESS, CITV, STATE, 2P CODE C Image: SUMMARY STATEMENT OF DEFICIENCES IEACH CORRECTIVE ACTION HOULD BE OWNER CARE CENTER OF DEFICIENCES Image: REGULATORY OR LISC IDENTIFIVING INFORMATION) PRETX (EACH CORRECTIVE ACTION HOULD BE OWNER F9999 Continued From page 100 employee's background checks. F9999 F9999	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							APPROVED 0938-0391
C 145221 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 NORTH HAMMES JOLIET, IL 60435 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLETION DATE F9999 Continued From page 100 F9999 F9999 F9999	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
143221 04/20/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FAIRVIEW CARE CENTER OF JOLIET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x5) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (x5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE (x5) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE F9999 Continued From page 100 F9999 F9999 F9999 F9999 F9999							С	
FAIRVIEW CARE CENTER OF JOLIET 222 NORTH HAMMES JOLIET, IL 60435 (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 F9999 Continued From page 100 F9999	l			D. WI	1		04/20/2012	
FAIRVIEW CARE CENTER OF JOLIET JOLIET, IL 60435 (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 F9999 Continued From page 100 F9999 F9999 Continued From page 100 F9999								
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F9999 Continued From page 100 F9999	FAIRVIE	V CARE CENTER OF	JOLIET					
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE
	F9999		-	F9	999			

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 07/11/2012