STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145710	B. WIN	IG	<del></del>	05/2	25/2012
	ROVIDER OR SUPPLIER	BOLINGBROOK	•	STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	х	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 497	The facility has no deficit during their training based on the E14 had no training cognition impairmed with them during note that the sum of the E14 had no training note that the sum of the E14 had been been summer of the E14 had no training on the E14 had no training on the E14 had no training on the E14 had no training cognition impairment of the E14 had no training on the E	g time or identified skill deficit. system to determine CNA skill annual evaluation and provide the identification of skill deficit. g to work with residents who ent, yet E14 has been working ight shift alone on 3rd floor cility administrator verified the ew and the facility employee e administrator stated she will to track CNA training record. TIONS	F 2	999			
	a) Comprehensive with the participation resident's guardian applicable, must docomprehensive calincludes measural meet the resident's and psychosocial in	Resident Care Plan. A facility, on of the resident and the or representative, as evelop and implement a re plan for each resident that ole objectives and timetables to medical, nursing, and mental needs that are identified in the					
	allow the resident	nensive assessment, which to attain or maintain the highest f independent functioning, and					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  NG	COMPLE	COMPLETED	
		145710	B. WIN	1G _		05/2	5/2012	
NAME OF PROVIDER OR SUPPLIER  MEADOWBROOK MANOR - BOLINGBROOK				4	REET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
F9999	restrictive setting baneeds. The assess the active participat resident's guardian	ge 15 ge planning to the least ased on the resident's care ment shall be developed with ion of the resident and the or representative, as 3-202.2a of the Act)	F99	999				
	and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal esident.						
	care shall include, a and shall be practic seven-day-a-week I  5) A regular program pressure sores, head breakdown shall be seven-day-a-week I enters the facility widevelop pressure social condition de sores were unavoid pressure sores shall							
		essure sores from developing.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145710	B. WIN	IG		05/2	5/2012	
NAME OF PROVIDER OR SUPPLIER  MEADOWBROOK MANOR - BOLINGBROOK				4	REET ADDRESS, CITY, STATE, ZIP CODE 31 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440			
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	Continued From pa Section 300.3240 A		F99	999				
		nall not abuse or neglect a						
	These regulations v	vere not met as evidenced by:						
	Based on observati review the facility fa	on, interview and record illed to:						
	pressure ulcers to Frisk for developing (2) Develop and implementation plan of cat (3) Evaluate R 6 and develop and implement fective repositioni plan.  (4) Revise the plan specific needs of the	plement preventative skin are for R5 and R6. d R5's tissue tolerance to nent an individualized and ng and pressure off loading of care based on R 5's e resident to promote healing sore and development of						
	acquired pressure uprogressed to Stage (2) Stage II pressur foot progressed to I and (3) Stage II on (B) R5's Stage II progressed to Stage This applies to 2 of	ent of three areas of facility clicer to R 6 ( (1) Stage II that e IV on the sacrum / coccyx e ulcer on the Right lateral Unstageable pressure ulcer the Left medial foot. essure ulcer on her coccyx e IV with undermining.  3 residents (R6 and R 5) in sidents who have pressure						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	E CONSTRUCTION (X3) DATE SU COMPLE		
		145710	B. WI	NG		05/2	5/2012	
NAME OF PROVIDER OR SUPPLIER  MEADOWBROOK MANOR - BOLINGBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440				
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	in bed and non-veridisposable incontined is lower extremities not off loaded; there observed.  During treatment of Nurse / E 5 on 05-2 and identified the foliated in Sacrum / Cocc Stage II initially not a Stage IV with under measured at 9.5 cm undermining from 1 with 2.5 cm deepes gray color eschar with clock area. E 5 identined in yellowish exuded in yellowish ex	11:00 AM, R 6 was observed oal. R 6 was observed with ence brief soiled with BM, R 6 is were resting on a pillow, foot e was no heel protectors observation with the Treatment 23-12 at 11:15 AM measured	F9:	9999				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	IULTIF ILDING	PLE CONSTRUCTION	JRVEY ETED		
		145710	B. WI	NG		05/2!	5/2012	
NAME OF PROVIDER OR SUPPLIER  MEADOWBROOK MANOR - BOLINGBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ULD BE	(X5) COMPLETION DATE		
F9999	discontinued plan) 6 will be turned and hours while in bed up in chair. This placare plan dated 04 evaluated or asses order to implement individualized posit An interview with E Restorative nurse (PM, both stated R dependent on staff living.  II. On 05-23-12 at in the dining room schair, sitting directly for water.  At 12:10 PM, R 5 'after she had a stroor in her chair (regulation or in her chair (regulation who 's working, (re-positioned), it's disappointed when way it was explained when I saw it I said "they're changing I little too late now."  Treatment observation of Nursing E 5 identified and control of Coccyx - Stage currently a Stage I cm X 1.4 cm with un 1 o 'clock with 1.6	dated 02-06-12 showed that R I reposition at least every 2 and at least every hour while an was not revised on the new 18-12. The facility has not sed R 6 's tissue tolerance in more specific and	F9	999				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145710		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP ILDING	LE CONSTRUCTION	URVEY ETED	
		B. WII	NG		05/25/2012		
NAME OF PROVIDER OR SUPPLIER  MEADOWBROOK MANOR - BOLINGBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	all her activities of observed with left k R 5 's skin assess pressure sore risk showed that R 5 w for developing pres Review of R 5 's p body with pillows / prominences, this i implemented during plan of care is to rehours while in bed up in chair, the faci	daily living. R 5 was also knee amputation. ment sheet for predicting dated 04-20-12 thru 05-17-12 as identified as moderate risk sure ulcer (scored 13). lan of care showed position wedge to protect bony ntervention was not g the survey (05-24-12). R 5 's eposition R 5 at least every two and at least every hour when lity has not evaluated R 5 's implement an effective turning	F9	999			